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Behavioral Health Funding Study

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Alphabetic List of Acronyms and Abbreviations Used in the Report

Acronym/Abbreviation	
ABC- NE	Access Behavioral Care - Northeast (A Behavioral Health Organization)
ABC-D	Access Behavioral Care - Denver (A Behavioral Health Organization)
ACA	Affordable Care Act
ACC	Accountable Care Collaborative
AHCCCS	Arizona Health Care Cost Containment System
AllHealth	AllHealth Network (A Community Mental Health Center)
AspenPointe	AspenPointe, Inc. (A Community Mental Health Center)
AspenPointe	AspenPointe Health Network (A Managed Service Organization)
Aurora	Aurora Mental Health Center (A Community Mental Health Center)
AwDC	Adults Without Dependent Children
Axis	Axis Health System, Inc. (A Community Mental Health Center)
BHI	Behavioral Healthcare Inc. (A Behavioral Health Organization)
BHO	Behavioral Health Organization
CBHC	Colorado Behavioral Healthcare Council
CCAR	Colorado Client Assessment Record
CDHS	Colorado Department of Human Services
CDPHE	Colorado Department of Public Health and Environment
Centennial	Centennial Mental Health Center (A Community Mental Health Center)
CHAS	Colorado Health Access Survey
CHI	Colorado Health Institute
CHP	Colorado Health Partnerships (A Behavioral Health Organization)
CHP+	Children's Health Plan Plus
CMH	The Center for Mental Health (A Community Mental Health Center)
CMHC	Community Mental Health Center
CMHI	Colorado Mental Health Institutes
CMS	Centers for Medicare and Medicaid Services
COD	Co-Occurring Disorder
Community Reach	Community Reach Center (A Community Mental Health Center)
CY	Calendar Year (Jan 1 – Dec 31)
DACODs	Drug/Alcohol Coordinated Data System
EBP	Evidence-based practices
ECT	Electro-convulsive therapy
FBHP	Foothills Behavioral Health Partners (A Behavioral Health Organization)
FFS	Fee for Service
FPL	Federal Poverty Level
FTE	Full-time equivalent
FY	Fiscal year (July 1 – June 30)
HCPF	Department of Healthcare Policy and Financing
Health Solutions	Health Solutions (A Community Mental Health Center)
HIV	Human Immunodeficiency Virus
IMDs	Institutions for Mental Diseases
Jefferson	Jefferson Center for Mental Health (A Community Mental Health Center)
MH	Mental Health
MHCD	Mental Health Center of Denver (A Community Mental Health Center)
MHP	Mental Health Partners (A Community Mental Health Center and a Managed Service Organization)
Mind Springs	Mind Springs Health (A Community Mental Health Center)
MMIS	Medicaid Management Information System
MOE	Maintenance of effort
MSO	Managed Service Organization
North Range	North Range Behavioral Health (A Community Mental Health Center)
NRI	National Association of State Mental Health Program Directors Research Institute, Inc.
OBH	Office of Behavioral Health
OSPB	Office of State Planning and Budget
PCMP	Primary Care Medical Providers
PIN	Population in Need
RAE	Regional Accountable Entities

Acronym/Abbreviation	
RBHA	Regional Behavioral Health Authority
RCCO	Regional Care Collaborative Organization
RFP	Request For Proposals
RVU	Relative Value Unit
SAMHSA	Federal Substance Abuse and Mental Health Services Administration
San Luis Valley	San Luis Valley Behavioral Health Group (A Community Mental Health Center)
SBHD	Serious Behavioral Health Disorder
SED	Serious Emotional Disorder
Signal Denver	Part of Signal Behavioral Health Network (A Managed Service Organization)
Signal NE	Part of Signal Behavioral Health Network (A Managed Service Organization)
Signal SE	Part of Signal Behavioral Health Network (A Managed Service Organization)
SIM	State Innovation Model
SMI	Serious Mental Illness
Solvista	Solvista Health
Southeast	Southeast Health Group
SSA	Single State Authority
SSPA	Sub-State Purchasing Areas
SUD	Substance Use Disorder
SummitStone	SummitStone Health Partners (A Community Mental Health Center)
TANF	Temporary Assistance to Needy Families
TPI	Third party insurance
Westslope NW	Part of West Slope Casa (A Managed Service Organization)
Westslope SW	Part of West Slope Casa (A Managed Service Organization)
WICHE	Western Interstate Commission for Higher Education

EXECUTIVE SUMMARY

This study examines funding for public behavioral health services in Colorado. A key focus of the study is funding provided by the Colorado Office of Behavioral Health (OBH) for indigent[1] (non-Medicaid) individuals. The study reviews the state systems for providing public behavioral health services, including the funding allocation and reimbursement methodologies utilized by the Colorado Department of Health Care Policy and Financing (HCPF), OBH, and behavioral health service providers. Funding is analyzed in the context of the impacts of Medicaid expansion and the Affordable Care Act. An in-depth examination of the clinical characteristics of the OBH indigent populations is provided in an attempt to identify any unique or distinct needs of the indigent population in an effort to inform the allocation of state funds for this population.

1 - An Overview of Colorado's Public Behavioral Health System

- The state's behavioral health (mental health and substance use) service delivery system is comprised of multiple agencies, funding sources, and focuses of care. In addition to the two primary behavioral health agencies, the Office of Behavioral Health (OBH) and the Department of Health Care Policy and Financing (HCPF), an array of additional agencies deliver or fund behavioral health services (e.g., education, child welfare, juvenile and adult corrections) or offer other critical supports to people with behavioral health needs (such as housing, employment, and recovery supports).
- OBH largely focuses on behavioral health programs and services for individuals who are designated as "indigent," or who earn less than 300% of the Federal Poverty Level (FPL) and have no other source of funding (e.g., Medicaid) to pay for behavioral health services. However, OBH also administers and funds services for clients who are not indigent.
- HCPF administers behavioral health services for Medicaid eligible individuals. Services are provided through several funding streams that are separately organized and that have different benefit levels. The majority of behavioral health services are provided through a managed care system (capitation).

2 - Changes to the Public Behavioral Health System Since FY 2011-12

Overview of Changes

- While Colorado's population increased by 5% from 2012 to 2015, the total number of persons served in the public behavioral health system increased by 50%.
- State spending for behavioral health services across all state programs totaled nearly $1 billion in Fiscal Year (FY) 2014-15, increasing by 63% from FY 2011-12, primarily due to Medicaid expansion. During this time, OBH spending for community programs increased by 36%, largely as a result of new funding for crisis services and community transition services, while Medicaid capitation and fee-for-service program spending increased by 109%.
- The number of individuals enrolled in the Medicaid capitation program grew by 83% from FY 2011-12 to FY 2014-15, and is expected to continue to grow by nearly one-fifth from FY 2014-15 to FY 2016-17.
- The number of indigent persons receiving OBH funded community mental health services decreased by 43% from FY 2011-12 to FY 2014-15, likely as a result of Medicaid expansion.

Medicaid Expansion in Colorado

- The Colorado Legislature approved ACA expansion in May 2013 to be effective January 1, 2014. As a result of the ACA, Colorado added the Adults without Dependent Children (AwDC) population and the Parents/Caretakers population earning between 101% and 138% of the FPL.
- Medicaid expansion clients represented 34% of total behavioral health capitation clients in FY 2014-15.
- The Adults without Dependent Children (AwDC) expansion category accounted for 29% of total capitation clients and 31% of capitation services in FY 2014-15. The Parents/Caretakers expansion category represented 5% of total capitation clients and 2% of total capitation services in FY2014-15.
- On average, both the Parents/Caretakers and the AwDC populations received more substance use services than mental health services in FY 2014-15. AwDC received 34% more substance use services, while Parents/Caretakers received 65% more substance use services.

Other State Changes in Response to Medicaid Expansion

- States expanding Medicaid expected reductions in state general fund expenditures for uninsured individuals between $7 million and $190 million in 2015, with total savings to exceed $610 million.

[1] "Indigent" refers to individuals OBH defines as indigent: individuals who have an income of 300% of the Federal Poverty level (FPL) or less, who are uninsured or have Medicare only, and who are not eligible for Medicaid except during a 30-day period of non-Medicaid eligibility.

- While some states chose to reinvest savings from Medicaid expansion into their state behavioral health budgets or provider networks, others chose to reduce state behavioral health budgets and appropriate funds elsewhere or offset future Medicaid expansion costs.
- Two vulnerable populations, the incarcerated and the homeless, are either ineligible or unlikely to enroll in Medicaid but will still need behavioral health treatment. For these reasons, SAMHSA's block grants will still be important as safety net funding for specialty behavioral health treatment.[2]

Uninsured and Underinsured Populations

- The number of uninsured individuals declined by 58% from 2011 to 2015, while the number of underinsured individuals increased by 30%. The underinsured are defined as having health insurance but also having out-of-pocket medical costs greater than 10% or more of annual income or 5% or more of income for those below 200% of the FPL.
- The most common reasons cited statewide for lack of insurance coverage was high cost, followed by lack of employer-sponsored coverage and change in job or loss of job.
- An estimated 21% (or 73,015) of the total uninsured (352,664) in 2015 meet the OBH indigent definition. The majority of these individuals indicate they received mental health care in the past twelve months (89%) and reported being in good mental health in the past month (88%).

The Estimated Population In Need of Behavioral Health Services

- A large number of Medicaid eligible and indigent individuals with a Serious Behavioral Health Disorder (SBHD)[3] need services, particularly individuals with a Substance Use Disorder (SUD).[4]
- The estimated number of individuals in Colorado (with incomes below 300% of the FPL) with a SBHD increased by 11% from 2007 to 2014 (from 219,112 to 242,740 individuals). An estimated 142,423 of these individuals received services in FY 2014-15.
- An estimated 100,316 individuals with an SBHD were not served in FY 2014-15; of these individuals, 54% were adults with a SUD, 20% were adults with a Serious Mental Illness (SMI),[5] 20% were youth with a Serious Emotional Disorder (SED),[6] and 6% were adults with a Co-occuring Disorder (SMI and and SUD).

3 -The OBH Indigent and Medicaid Capitation Systems

The Behavioral Healthcare Needs of the OBH Indigent Population

- OBH indigent funding served a slightly more clinically severe population than the population served by Medicaid capitation in FY 2014-15. Multiple indicators of severity indicate that OBH indigent funding was critical for serving the most severe clientele. Although both funding sources served the whole range of the behavioral health population, the capitation program served more clients with less severe needs, as well as more children and youth.
- Services to reduce homelessness and unemployment were critical for the OBH indigent population. A significant proportion of the OBH indigent population was struggling with homelessness and unemployment, and homelessness, in particular, appeared to be associated with poor functioning and a higher cost of care. Similarly, recovery supports were needed to support individuals' post-acute treatment and prevent relapse.
- Nearly 80% of OBH indigent clients served in FY 2014-15 had an SMI, compared to 46% of Medicaid capitation clients. The percentage of OBH indigent and Medicaid capitation clients with an SED was more similar; nearly 20% of OBH indigent clients had an SED, compared to approximately 25% of Medicaid capitation clients.

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[2] Woodward, A. *The CBHSQ Report: The Substance Abuse Prevention and Treatment Block Grant is still Important even with the expansion of Medicaid*, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, 2015. Retrieved from: http://www.samhsa.gov/data/sites/default/files/report_2080/ShortReport-2080.html.

[3] A serious behavioral health disorder includes adults with an SMI, an SUD, and a COD, as well as children and adolescents with an SED, which include co-occurring disorders.

[4] A substance use disorder (SUD) is defined as when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. Retrieved from http://www.samhsa.gov/disorders.

[5] A serious mental illness among people ages 18 and older is defined as having, at any time during the past year, a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities. Retrieved from http://www.samhsa.gov/disorders.

[6] The term serious emotional disturbance (SED) is used to refer to children and youth who have had a diagnosable mental, behavioral, or emotional disorder in the past year, which resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities. Retrieved from http://www.samhsa.gov/disorders.

Costs of the OBH Indigent Population

- OBH indigent individuals with an SED/SMI who were homeless and unemployed were more likely to have increased cost of care.
- Overall, OBH indigent clients with an SED/SMI had a higher average service cost ($2,573) than indigent clients without an SED/SMI ($2,110). However, in 65% of the Community Mental Health Centers (CMHCs),[7] indigent clients without an SED/SMI had a higher average service cost than indigent clients with an SED/SMI.

Service Utilization by Medicaid Capitation and OBH Indigent Populations

- The difference in the average number of mental health services received by OBH indigent clients, in comparison to Medicaid capitation clients, may indicate that disparities exist in meeting the needs of these two populations.
- On average, capitation clients received 28% more mental health services (28) in FY 2014-15 than OBH indigent clients (22). Adult capitation clients received 9% more mental health services (31) than adult indigent clients (29), while capitation clients under the age of 18 received 65% more mental health services (22) than indigent clients under the age of 18 (13).
- OBH SUD service data was underreported in FY 2014-15 as SUD providers began submitting substance use encounter data as of July 1, 2014 and many are still implementing data reporting to OBH. Thus, OBH substance use service and cost data is excluded from analyses since these data were neither complete nor representative of the total number of SUD services provided.

Average Cost of Services Costs by Medicaid Capitation and OBH Indigent Populations

- Variations in the average cost of services between capitation clients and OBH indigent clients are not directly comparable, as Medicaid capitation includes a broader range of services, including inpatient and residential treatment, than OBH indigent funding.
- Average FY 2014-15 capitation mental health services cost per client ($2,425) was 39% higher than the average OBH indigent cost per client ($1,749).
- Average FY 2014-15 Medicaid capitation SUD services cost per client equaled $1,040 in FY 2014-15, significantly below the average capitation *mental health* services cost per client of $2,425.
- Cost variations may be due to several factors, including differences in operating costs between Behavioral Health Organizations (BHOs), [8] differences in client service needs, and differences in the resources available by BHO to meet client service needs.

Intermittent Medicaid Eligibility

- Frequent changes in eligibility for Medicaid benefits place an administrative and financial burden on HCPF, the BHOs, and other insurers. These changes, or "churn," refer to the exit and re-entry of individuals from Medicaid eligibility.
- During FY 2014-15 there were 48,460 out of 1,467,550 individuals (3%) with at least one gap in Medicaid eligibility. Nearly all of those with a gap in eligibility experienced just one gap (98%) and the average gap duration for these individuals was 85 days.[9]
- 436 Medicaid eligible individuals received an OBH indigent service during an eligibility gap period in FY 2014-15.
- A significant relationship exists between indigent gap clients and all indigent clients and diagnosis, suggesting that individuals with more serious illnesses were less likely to experience gap periods and would consequently have less churn.

Review of OBH Encounters

- A review of a representative sample OBH indigent and Medicaid encounters was conducted to determine if OBH indigent, Medicaid, and other third-party payers (e.g., private insurance) were appropriately utilized. Encounters were reviewed to determine if OBH indigent encounters were used to reimburse a CMHC for a Medicaid eligible individual who was enrolled with a BHO at the time of service, if duplicate/identical encounters were submitted, and if the correct payer was utilized.
- 3,674 Medicaid eligible individuals who received OBH indigent funded services during FY 2014-15 were enrolled with a BHO. Of these individuals, 664 (18%) were enrolled with a BHO on the date services were provided by the CMHC. Thus, it is assumed OBH made case rate payments of $3,186 per client (the FY 2014-15 case rate amount)

[7] A Community Mental Health Center means either a group of services under unified administration or affiliated with one another, and including services provided for the prevention and treatment of mental illness in persons residing in a particular community.
[8] A Behavioral Health Organization is an entity that has contracted with HCPF to provide a specific group of behavioral health services to Medicaid eligible individuals meeting eligibility, diagnosis, and medical necessity definitions determined by HCPF.
[9] The number of individuals who experienced more than one eligibility gap in FY 2014-15 cannot be reported due to HCPF data suppression requirements.

to CMHC's for clients who were also funded by Medicaid capitation. The total estimated amount of these payments is approximately $2.1 million.

Medicaid Capitation and OBH Indigent Allocation and Reimbursement

- HCPF employs a mix of capitation and FFS payments to pay providers. Capitation payments to the BHOs represent a pre-determined monthly amount for each Medicaid client who is eligible for behavioral health services within each respective BHO region. The "per-member-per-month" rates paid to BHOs are unique for each region and for each Medicaid eligibility category within each region. The BHO receives the payment and agrees to provide covered services to each individual requiring care, assuming the individual meets medical necessity for services and the diagnosis is covered under the capitation program.
- OBH payments to providers are based on a variety of payment methodologies. One of OBH's primary goals for its reimbursement requirements is to ensure that providers are not spending OBH funds for services provided to individuals that have insurance (including Medicaid, Medicare, and private insurance) that would pay for the service. This challenge is compounded by the fact that CMHCs receive a sub-capitation payment from the BHOs that is not based on actual services provided (similar to FFS or case rates).

An Alternative Management Model

- The provision of behavioral health services by several state agencies, including continued segregation of the management and administration of Medicaid and non-Medicaid programs by HCPF and OBH (respectively), creates challenges, complexities and inefficiencies. OBH and HCPF are aware of the difficulties created by the current administrative structure and work together to attempt to address these challenges. The agencies have partnered to address contracting, allocation, data system, performance measure, and service definition issues.
- The state's current behavioral health service delivery and reimbursement system is outdated and its structure prevents any significant increases in efficiency and effectiveness. It seems inevitable that the current system requires funds and resources that could otherwise be directed to providing direct care.
- Arizona's system for the management of publically funded behavioral health services provides an alternative model to Colorado's system, as it combines responsibility for eligibility determination and service delivery for both Medicaid and non-Medicaid clients with one entity in each region of the state.
- A similar system to Arizona's may hold promise for Colorado as it implements ACC Phase II and selects new administrative entities, Regional Accountable Entities (RAEs), to manage Medicaid service delivery. For example, OBH could contract with the RAEs to administer all indigent and non-Medicaid services and supports currently funded by the state, SAMHSA block grants, and other discretionary grants. Another option would involve the merger of OBH and HCPF to create a single state behavioral health authority that contracts with the RAEs.

4 - Community Mental Health Costs and Revenues

- Based on discussions with CMHC and Colorado Behavioral Healthcare Council (CBHC) representatives, there was a consensus that it is nearly impossible to project the costs of maintaining the capacity to respond to a particular community's behavioral healthcare needs, including costs required in times of disaster or significant crisis.
- Examination of available data and discussions with CMHC and CBHC representatives resulted in the conclusion that estimating CMHC costs to provide the community with a full range of expected services is not currently possible.
- CMHC revenues exceeded total costs for both FY 2013-14 and FY 2014-15 by $37 million and $43 million, respectively. Revenues are projected to exceed costs in FY 2016-17 by $39 million.
- The CMHCs reported using surplus revenue to fund capital improvements, expansion efforts, and other needs that arose due to the increase in clients as a result of Medicaid expansion. In FY 2014-15, this capital spending was approximately $56 million.

5- Conclusions and Recommendations

Colorado has Increased Behavioral Health Services and Funding for Safety Net Populations, Yet Challenges Remain

- As a result of Medicaid expansion, more individuals are receiving behavioral health services than ever before.
- The ACA and the creation of the Colorado Health Insurance Exchange has served to reduce the number of uninsured Coloradoans by 58% from 2011 to 2015; however, the number of underinsured has increased by 30% during this same time. The increase in underinsured may reflect that while more individuals are insured, they are challenged by the cost of insurance and health care, including out of pocket expenses to reach annual deductable amounts and for copayments related to services.
- A significant number of safety net individuals with a serious behavioral health disorder have not received services,

particularly those individuals with a SUD.

- The difference in the average number of mental health services received by OBH indigent clients, in comparison to Medicaid capitation clients, may indicate that disparities exist in meeting the needs of these two populations.

Despite Stronger State Agency Partnerships, the System is Still Fragmented and Complex

- Given the numerous state agencies providing services at many points along the behavioral health continuum from prevention to inpatient treatment, there is no simple solution to improving the efficiency and effectiveness of the state's behavioral health organizational structure.
- Unilaterally moving the authority and control of all behavioral health funding, planning, programs, and regulations into a single department and agency would not necessarily improve the situation and could create increased inefficiencies. On the other hand, centralizing the authority and funding for behavioral health prevention programs, which is currently dispersed over several agencies, could lead to increased efficiencies, and perhaps effectiveness.
- While HCPF and OBH staffs often work in partnership, the continued segregation of the management and administration of Medicaid and non-Medicaid behavioral health programs by HCPF and OBH (respectively) creates administrative challenges, funding and reimbursement complexities and inefficiencies.

Funding Allocation and Reimbursement Methodologies are Complicated and Error Prone

- OBH is to be credited by building accountability and transparency into its reimbursement methodologies in an effort to prevent overpayments for services. However, the requirement that providers use multiple methods for obtaining reimbursement for contracted services creates an administrative burden and requires more resources be directed to these administrative and billing activities when the resource may be better allocated toward providing services to clients. As detailed in Section 3 of the report (Review of OBH Encounters), The complexity of reimbursement requirements has led to payment errors. OBH indicates it plans to implement a risk-based process for implementing standardized compliance monitoring of the highest risk contracts that includes a risk assessment based on contract size, potential for billing twice for the same service, complaints, and compliance with fiscal protocols (e.g. incorrect invoices, missing documentation).
- Despite the efforts of OBH and HCPF, significant challenges remain for clients and providers. In the absence of alignment of state agencies, contractors and regions, the state relies largely on provider self-monitoring and limited audits to ensure that contractors abide by their contract terms and do not use two sources of funding to support the same service. In addition to the opportunity for double billing, having multiple administrative oversight entities (BHO, Managed Service Organizations, crisis contractors) involved in the delivery of the same service is inefficient. Clients who have complaints must contact OBH if they are indigent and HCPF if they are Medicaid eligible. CMHCs, the Managed Service Organziations (MSOs),[10] and other SUD providers must contract with both the BHOs and OBH (in addition to other state and local government agencies) under a myriad of separate reporting and accountability, reimbursement, licensure, regulatory, and quality of care requirements. OBH is required to maintain fairly complex contractual and administrative requirements to attempt to ensure OBH funds targeted for indigent individuals are not used to provide services to Medicaid eligible individuals.

Recommendation #1

The Governor's Office of State Planning and Budgeting (OSPB) should conduct a detailed review of each state behavioral health program administered outside of HCPF and OBH. The review should examine each program's cost and benefits, including the costs and benefits of relocating the program to a centralized behavioral health agency such as HCPF or OBH. The review should include qualitative input from agency and program staff, along with input from individuals receiving services and providers and other identified stakeholders. The program reviews should also include a "revenue maximization" analysis of whether or not services currently funded entirely by General Fund are eligible for Medicaid reimbursement.

Recommendation #2

The Governor's Office and OBH should examine the behavioral health and health insurance policy implications created as a result of the increase in the number of underinsured individuals and investigate methods to assist these individuals, particularly those with an SMI or SED, in obtaining behavioral health services.

[10] A Managed Service Organization is an organization designated by CDHS to provide substance use treatment services in a designated region of the state.

Recommendation #3

OBH should continue to explore alternative payment approaches for the use indigent funds, including funding provided through the "Services for Mentally Ill Clients" appropriation for:

- Individuals who meet the current OBH indigent definition as Target and Non-Target clients. OBH should explore alternatives to target number requirements, including providing funding for underinsured individuals and individuals who move on and off Medicaid or remain uninsured.
- Individuals who are currently covered by Medicaid but need behavioral health services not currently covered by Medicaid to support their recovery needs.

OBH should continue to explore ways to expand support for prevention and early intervention, supportive housing, supportive employment, and peer/navigation services in coordination with the Medicaid benefit.

Recommendation #4

OBH should take immediate action to significantly reduce or eliminate the payment of indigent client funding to CMHCs for individuals who are Medicaid eligible and enrolled in a BHO. Actions could include conducting periodic and regular comparisons of encounter data files, including the methodology used in this study, and the risk-based compliance monitoring process described by OBH. OBH may also find benefit in grouping or segregating the specific encounters and CCARs submitted by CMHCs as a basis for case rate payment.

Recommendation #5

OBH should continue to examine the funding allocation methodologies for each of the programs and services it administers and work to refine these methodologies to incorporate and reflect current behavioral health needs and the resources of the state's communities. When examining new contract entities or new funding sources, OBH and HCPF should create a more objective allocation formula that takes into account the changing state demographics, behavioral health needs and trends, and the distribution of resources and services within and between the geographical regions used to allocate funds.

Recommendation #6

OBH should continue to explore options to reduce or simplify reimbursement methods used in order to minimize payment for services that are covered by Medicaid and simplify the accounting for both the state and providers. One strategy that OBH and HCPF continue to explore is use of the Medicaid Management Information System (MMIS) to streamline eligibility checking and payments for applicable programs. CDHS should prioritize investment in this integration of eligibility determination and payment processing. CDHS should review the legislative intent of the various General Fund appropriations that are being offset based on the OBH capacity-based protocol. HCPF should examine options to simplify and align Medicaid reimbursement for SUD providers with mental health services. This may include examining sub-capitation and standardized BHO contract provisions to address the administrative and reimbursement complexities created by the need for SUD providers to contract with multiple BHOs.

Recommendation #7

HCPF should complete its work to implement suspension, rather than termination, of Medicaid benefits for institutionalized individuals, including Colorado Department of Correction inmates and Colorado Mental Health Institute patients.

Recommendation #8

OSPB, HCPF, and CDHS should examine options to place administrative responsibilities for non-Medicaid behavioral health services and supports with the Regional Accountability Entities created by HCPF as part of Phase II of the Accountable Care Collaborative, either under the state responsibility of OBH or under the responsibility of a state behavioral health authority. Making this structural change to the state's behavioral health system could strengthen the coordination and equity of care provided to individuals across the state, while also improving effectiveness and efficiency in the use of state and federal funds.

INTRODUCTION

In April 2016, the Colorado Governor's Office of State Planning and Budgeting (OSPB) contracted with the Western Interstate Commission for Higher Education Mental Health Program (WICHE) to complete a study of behavioral health funding in Colorado. A key focus of the study is funding provided by the Colorado Office of Behavioral Health (OBH) for indigent[11] (non-Medicaid) individuals. The study reviews the state systems for providing public behavioral health services, including the funding allocation and reimbursement methodologies utilized by the Colorado Department of Health Care Policy and Financing (HCPF), OBH, and behavioral health service providers. Funding is analyzed in the context of the impacts of Medicaid expansion and the Affordable Care Act. An in-depth examination of the clinical characteristics of the OBH indigent populations is provided in an attempt to identify any unique or distinct needs of the indigent population in an effort to inform the allocation of state funds for this population.

The primary data for the study were obtained from two state agencies: the Department of Health Care Policy and Financing (HCPF), which administers Colorado's Medicaid Program, and the Colorado Department of Human Services (CDHS) Office of Behavioral Health (OBH). Fiscal Year (FY) 2011-12 and FY 2014-15 data were used to reflect the behavioral health system before and after ACA implementation. (FY 2014-15 was the most recent year for which data were available.) HCPF provided data for all mental health capitation processed claims in FY 2011-12 and FY 2014-15 and substance use processed claims for FY 2014-15.[12] OBH provided FY 2011-12 and FY 2014-15 substance use admissions data from the Drug/Alcohol Coordinated Data System (DACODS), data for all encounters submitted by mental health providers in FY 2011-12 and FY 2014-15,[13] as well as FY 2011-12 and FY 2014-15 data from the Colorado Client Assessment Record (CCAR), the clinical instrument used to assess the behavioral health status of a client in treatment. This study was also informed by a number of other data sources, including the 2015 WICHE Colorado Statewide Behavioral Health Needs Analysis,[14] the 2009 WICHE Colorado Population in Need (PIN) study,[15] Behavioral Health Organization (BHO)[16] annual performance measure reports, BHO service authorizations and claims, the Colorado Health Institute's (CHI) 2015 Colorado Health Access Survey (CHAS), OBH crisis services data, and Medicaid eligibility records. A literature review of the impact around the nation of Medicaid expansion on behavioral health services was also conducted.

The *OSPB Behavioral Health Funding Study* began in April 2016 and concluded with the final report submission in November 2016. During this time, the project team examined the following four specific study requirements:

1. An inventory of behavioral health funding sources in Colorado, including changes from the ACA, mental health parity laws and regulations, and other state level investments into the behavioral health system.
2. An inventory of changes to populations covered by public and private health insurance for behavioral health services, including the behavioral health funding needs of individuals who are insured, uninsured, and underinsured.
3. The costs of operating a Community Mental Health Center (CMHC)[17] to effectively serve its community and respond to disasters, including current funding sources for these costs.
4. Recommendations regarding the alignment of behavioral health funding across state agencies, including oversight and management of behavioral health services, allocation of OBH funds, reimbursement for behavioral health services, and services provided to indigent clients with OBH funds.

[11] "Indigent" refers to individuals OBH defines as indigent: individuals who have an income of 300% of the Federal Poverty level (FPL) or less, who are uninsured or have Medicare only, and who are not eligible for Medicaid except during a 30-day period of non-Medicaid eligibility.
[12] On January 1, 2015 substance use services provided by Medicaid were added to the capitation program. Prior to this date, the services were reimbursed through the Medicaid Fee-for-service program.
[13] FY 2011-12 OBH encounter data included only mental health services, whereas FY 2014-15 data reflected the updated business requirement for OBH licensed substance use providers to submit encounters.
[14] WICHE, *Needs Analysis: Current Status, Strategic Positioning, and Future Planning*, April 2015.
[15] WICHE, *Colorado Population in Need-2009*, November 2009.
[16] A Behavioral Health Organization is an entity that has contracted with HCPF to provide a specific group of behavioral health services to Medicaid eligible individuals meeting eligibility, diagnosis, and medical necessity definitions determined by HCPF.
[17] A Community Mental Health Center means either a group of services under unified administration or affiliated with one another, and including services provided for the prevention and treatment of mental illness in persons residing in a particular community.

1 – Colorado's Public Behavioral Health System

Overview of the Behavioral Health System

In Brief

- The state's behavioral health (mental health and substance use) service delivery system is comprised of multiple agencies, funding sources, and focuses of care. In addition to the two primary behavioral health agencies, the Office of Behavioral Health (OBH) and the Department of Health Care Policy and Financing (HCPF), an array of additional agencies deliver or fund behavioral health services (e.g., education, child welfare, juvenile and adult corrections) or offer other critical supports to people with behavioral health needs (such as housing, employment, and recovery supports).
- OBH largely focuses on programs and services for individuals who are designated as "indigent," or who earn less than 300% of the Federal Poverty Level (FPL) and have no other source of funding (e.g., Medicaid) to pay for behavioral health services. However, OBH also administers and funds services for clients who are not indigent.
- HCPF administers health services for Medicaid eligible individuals. Services are provided through several funding streams that are separately organized and that have different benefit levels. The majority of behavioral health services are provided through a managed care system (capitation) involving five Behavioral Health Organizations (BHOs) that serve single county (e.g., Denver) and multi-county catchment areas.

Colorado's public behavioral health service system is administered by multiple agencies at the state and sub-state levels, with overlapping jurisdictions as well as requirements for funding, managing, overseeing, authorizing and/or providing behavioral health services. The following state agencies receive funding for behavioral health services:[18]

- The Colorado Department of Health Care Policy and Financing (HCPF)
- The Colorado Department of Human Services (CDHS), Office of Behavioral Health (OBH)
- CDHS Office of Children, Youth, and Families, Division of Child Welfare
- CDHS Office of Children, Youth, and Families, Division of Youth Corrections
- CDHS Office of Early Childhood
- CDHS Office of Community Access and Independence, Division of Regional Center Operations
- The Colorado Department of Corrections (DOC)
- The Colorado Department of Education (CDE)
- The Colorado Department of Public Safety (CDPS)
- The Colorado Department of Public Health and Environment (CDPHE)
- The Colorado Department of Labor and Employment (CDLE), Division of Vocational Rehabilitation
- The Colorado Department of Local Affairs (DOLA), Division of Housing
- The Colorado Judicial Branch, Division of Probation Services

In addition, the Governor's Office administers the State Innovation Model (SIM) program. The SIM program supports the development and testing of models for transforming health care payment and delivery systems.

Two state agencies, OBH and HCPF, are responsible for the majority of public behavioral health services. Five organizational structures exist, each with a role in the delivery of behavioral health care:[19]

1. Seventeen Community Mental Health Center (CMHC) catchment areas.
2. Seven regions for administration of substance use disorder services.
3. Four crisis services regions.
4. Five Behavioral Healthcare Organization (BHO) regions.
5. Seven Regional Collaborative Care Organization (RCCO)[20] regions.

Office of Behavioral Health

OBH administers policy and funding for community-based behavioral health services using state General Fund, federal block grant funds, and discretionary grant funds. OBH also oversees the two state-operated psychiatric hospitals (the Colorado

[18] See Appendix A for more detail about these State agencies, the services they provide, and FY 2011-12 and FY 2014-15 behavioral health expenditures.
[19] See Appendix B for maps of geographic catchment and service areas for each of these entities and Appendix C for a crosswalk of agencies and their service areas.
[20] A Regional Care Collaborative Organization (RCCO) connects Medicaid clients to Medicaid providers and helps clients find community and social services in their area.

Mental Health Institutes, or CMHIs) located in Pueblo (CMHI-Pueblo) and in Denver on the Fort Logan campus (CMHI-Fort Logan). OBH is the federally designated state agency to oversee distribution of federal block grant funding for mental health services and substance abuse treatment and prevention. Under Colorado statute, OBH oversees the following community providers of services:

- 17 CMHCs and two specialty mental health clinics serving 17 single and multi-county catchment areas. [21] (A CMHC is an entity that provides services for the prevention and treatment of mental illness for persons residing in a community.)
- Four Managed Service Organizations (MSOs) that coordinate and contract for the provision of Substance Use Disorder[22] (SUD) treatment services across seven geographical areas. (An MSO is an organization designated by OBH to provide SUD treatment services in one or more of the OBH designated geographical areas of the state.)
- Four crisis services agencies, which are conglomerations of various CMHCs.
- Various small prevention efforts and community based organizations.

OBH largely focuses on programs and services for individuals who are designated as "indigent." Throughout the remainder of this report, "indigent" refers to individuals OBH defines as indigent: individuals who have an income of 300% of the Federal Poverty level (FPL) or less, who are uninsured or have Medicare only, and who are not eligible for Medicaid except during a 30-day period of non-Medicaid eligibility. However, OBH also administers and funds services for clients not defined by OBH as indigent. OBH defines eligibility criteria for services in both the contracts with providers and in OBH "Finance and Data Protocols." ("Protocol 2," effective as of July 1, 2014, provides eligibility requirements for both mental health and SUD services funded by OBH.)

MENTAL HEALTH COMMUNITY PROGRAMS

In FY 2014-15, the majority (76%) of OBH mental health community program funding was spent for "Services for Indigent Mentally Ill Clients." OBH allocates these funds to CMHCs based on a designated number of clients to be served at a defined rate per client. The number of clients to be served (including both "target" and "non-target" clients) varies by CMHC. Current (FY 2016-17) OBH contracts define "target" clients as adults with a Serious Mental Illness (SMI)[23], adolescents (ages 12 to 17) with a Serious Emotional Disturbance (SED)[24], and children (ages 0 to 11) with either a SED or "who have emotional or mental health problems that are in need of early intervention." "Non-target" clients include adults or adolescents without an SMI or SED but with a diagnosis that is covered by Medicaid. Beginning with FY 2016-17, OBH made "flexible fund" allocations to each CMHC to be used for services proposed by the CMHCs and approved by OBH. The amount of flexible funding varies by CMHC and is negotiated based upon each CMHC's historical budget allocation. Under the terms of the OBH contract, each CMHC is responsible for providing a set of core services including:

- assessment;
- rehabilitation;
- emergency services;
- clinical treatment services;
- residential services;
- inpatient services;
- vocational services;
- psychiatric/medication management;
- interagency consultation;
- public education;
- consumer advocacy and family support;
- case management; and
- day treatment, home-based family support, and/or residential support services.

[21] Section 27-66-101(2), C.R.S.
[22] A substance use disorder (SUD) is defined as when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. Retrieved from http://www.samhsa.gov/disorders.
[23] Serious mental illness among people ages 18 and older is defined as having, at any time during the past year, a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities. Retrieved from http://www.samhsa.gov/disorders.
[24] The term serious emotional disturbance (SED) is used to refer to children and youth who have had a diagnosable mental, behavioral, or emotional disorder in the past year, which resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities. Retrieved from http://www.samhsa.gov/disorders.

The "Services for Indigent Mentally Ill Clients" appropriation also includes:

- Funding to Mental Health Center of Denver (MHCD) for the "AIM" program, which provides Assertive Community Treatment (ACT) and intensive case management services for 766 individuals.
- Funding to support the operations of two licensed inpatient facilities: (1) a 32-bed licensed psychiatric hospital in Grand Junction that is operated by the local CMHC - Mind Springs Community Health (Mindsprings); and (2) a 16-bed acute treatment unit in Durango that is operated by the local CMHC - Axis Health System, Inc. (Axis).
- Funding that is transferred to the Division of Vocational Rehabilitation and then matched by federal funds for the provision of case management and vocational services for mental health clients.
- Funding to reimburse licensed CMHCs for the provision of mental health services to medically indigent clients.

Other OBH funded services and programs for indigent clients include: medications for indigent clients, school-based health services, ACT, alternatives to inpatient hospitalization at a CMHI, and mental health services for juvenile and adult offenders.

SUBSTANCE USE PROGRAMS

OBH provides funding to support SUD services that are delivered primarily by four MSOs. The MSOs subcontract with local treatment providers across the state to deliver these services. Based on federal block grant requirements, OBH contracts require the MSOs to place an emphasis on providing services to: persons involuntarily committed by the courts, pregnant women and women with dependent children, adult and adolescent intravenous drug users, drug-dependent adults and adolescents with human immunodeficiency virus (HIV) or tuberculosis, and uninsured individuals. OBH also contracts with statewide and local prevention programs for services designed to prevent the illegal and inappropriate use of alcohol, tobacco, and other drugs. Services include: mentoring, tutoring, life skills training, parenting training, creative arts, education/resource centers, driving under the influence (DUI) prevention programs, and employee assistance programs (EAPs). Depending on the program or service, OBH substance use funding is available to serve both individuals defined as "indigent" along with individuals irrespective of income level.

CRISIS SERVICES

The primary goals of the statewide crisis response system are to: improve access to the most appropriate resources and services as early as possible and promote recovery for the individual, and decrease the number of unnecessary involuntary civil commitments, and decrease the utilization of hospital emergency departments, jails, and homeless programs for individuals experiencing a behavioral health emergency. Crisis services are available to all Colorado residents irrespective of an individual's ability to pay. OBH requires crisis providers to assess each individual's ability to pay and bill all available payer sources. Crisis services include:

- *Telephone hotline:* A statewide 24-hour telephone crisis service that is staffed by skilled professionals who are capable of assessing child, adolescent, and adult crisis situations and making the appropriate referrals.
- *Walk-in crisis services/crisis stabilization unit(s):* 24-hour urgent care services with the capacity for immediate clinical intervention, triage, stabilization, and connection to services.
- *Mobile crisis services*: 24-hour mobile crisis services with the ability to respond within one hour in urban and two hours in rural areas to behavioral health crises in the community, providing immediate clinical intervention, triage, stabilization, and connection to services.
- *Crisis residential/respite*: An array of short-term crisis residential and respite services.
- *Communications/marketing*.

COMMUNITY TRANSITION SERVICES

This funding supports intensive behavioral health services and support for individuals with an SMI who transition from a CMHI back to the community, or who require more intensive services in the community to help avoid institutional placement.

JAIL-BASED BEHAVIORAL HEALTH SERVICES

OBH funds the provision of jail-based behavioral health services to offenders. Funds are used to screen and treat adult inmates with an SUD, including individuals who have a co-occurring mental health disorder (COD).[25] In addition, services provide continuity of care within the community after the inmate's release from jail.

[25] An individual with a Co-Occurring Disorder has an SMI and a SUD.

RURAL CO-OCCURRING DISORDER (COD) SERVICES

OBH provides funding for a full continuum of behavioral health services for adolescents and adults with a COD who live in southern Colorado and the Arkansas Valley.

Department of Health Care Policy and Financing[26]

HCPF is the state's Medicaid agency and administers health services for Medicaid eligible individuals. Behavioral health services are provided through several funding streams that are separately organized and that have different benefit levels:

- The majority of Medicaid eligible individuals receive behavioral health services from a managed care system (capitation) administered by five BHOs serving single county (e.g., Denver) and multi-county catchment areas. [27]
- The Medicaid behavioral health fee-for-service (FFS) program serves individuals not eligible for BHO membership or not enrolled in a BHO, including inpatient services in children's residential treatment facilities and certain patients at the CMHIs and at the state regional centers for individuals with developmental/intellectual disabilities.
- Child Health Plan *Plus* (CHP+), administered by HCPF, also provides a FFS mental health benefit.
- The Medical Services Premiums appropriation covers the following expenditures: inpatient medical treatment for individuals with acute medical conditions that involve a SUD diagnosis ($111 million in FY 2014-15); behavioral health-related pharmaceutical expenditures ($52 million after rebates in FY 2014-15, including $37 million related to antipsychotic drugs); and inpatient SUD treatment for children and youth under age 21 provided under the early and periodic screening, diagnostic and treatment benefit ($2 million in FY 2014-15).
- The Accountable Care Collaborative (ACC) program currently provides physical health, as opposed to behavioral health services, to Medicaid eligible individuals in Colorado. RCCOs administer and managed the ACC provider network and provide support to ACC members with questions or complaints. Under Phase II of the ACC program (estimated to begin on July 1, 2018) Medicaid eligible individuals will receive both physical and behavioral health services from Regional Accountability Entities (RAEs) which will take the place of the RCCOs and the BHOs.

BEHAVIORAL HEALTH CAPITATION PROGRAM

HCPF contracts with BHOs to provide services through a statewide managed care or capitation program. In order to receive services through a BHO, a client must be eligible for BHO enrollment and require a service that is medically necessary for a covered diagnosis. The following groups of Medicaid clients receive behavioral health services through BHOs:[28]

- Adults 65 years of age and older.
- Children and adults with disabilities through age 64.
- Parents and caretakers (*broadened with Colorado's Medicaid expansion*).
- Adults without dependent children (*added with Colorado's Medicaid expansion*).
- Eligible children.
- Children in (or formerly in) foster care through age 26.
- Adults served through the Breast and Cervical Cancer Treatment and Prevention Program.

Covered services include traditional Medicaid State Plan services such as:

- Behavioral health assessment.
- Individual, family, or group therapy.
- Targeted case management.
- Medication management.
- Outpatient psychiatric care and intensive outpatient SUD services.
- Detoxification services.
- Emergency/crisis services.
- Inpatient psychiatric hospital mental health services.[29]

In addition, the BHOs provide services not traditionally covered by Medicaid that are designed to support clients' recovery, including prevention and intervention, employment assistance, clubhouse or drop-in centers, respite care, and residential

[26] Information in this section from: Kampman, C. *FY 2016-17 Staff Figure Setting, Department of Health Care Policy and Financing*, Colorado General Assembly Joint Budget Committee, March 2016. Retrieved from: http://www.tornado.state.co.us/gov_dir/leg_dir/jbc/2015-16/hcpfig2.pdf

[27] A BHO is an entity that has contracted with HCPF to provide a specific group of behavioral health services to Medicaid eligible individuals meeting eligibility, diagnosis, and medical necessity definitions determined by HCPF.

[28] 10 CCR 2505-10 (8.212)

[29] While the State Medicaid Plan does not cover inpatient hospitalization for substance use disorder, HCPF pays inpatient hospitalization costs during the assessment period of a client's hospitalization, even if the client's primary diagnosis is ultimately determined to be a substance use disorder.

mental health services. These services are commonly called b3 services because they are authorized through a federal 1915 b3 waiver that allows plans to provide nontraditional services as long as doing so results in no additional expense. (Please see Appendix D for a list of covered behavioral health procedure codes.)

HCPF pays each BHO a per-member-per-month amount for each Medicaid client who is eligible for behavioral health services within the BHO's region. The BHOs assume the risk for all costs, except for pharmaceuticals, to serve the number of clients needing care. Thus, the payment system incentivizes the BHOs to ensure appropriate levels of care are provided while not exceeding anticipated utilization rates. The per-member-per-month rates paid to BHOs are unique for each Medicaid eligibility category within each geographic region. These rates are adjusted annually based on historical rate experience and recent encounter data (e.g., statewide average costs by diagnosis category). Each BHO shares this risk with the CMHCs within the BHO's region. The BHOs make sub-capitated payments to the CMHCs based on the number of clients in the BHO's region served by the CMHC.

FEE-FOR-SERVICE PROGRAM

This program includes behavioral health services for Medicaid individuals who are not enrolled in a BHO, or whose diagnosis is not covered by the BHO contract (i.e., autism spectrum disorder, developmental disability, and dementia). Examples of clients who are not included in BHO enrollment are:

- Individuals enrolled in the Program of All-inclusive Care for the Elderly (PACE Program).
- Children and youth in the legal custody of a county department of human services or the Division of Youth Corrections who are placed in a psychiatric residential treatment facility (PRTF) or a residential child care facility (RCCF).
- Certain individuals receiving treatment at a CMHI.
- Certain individuals with intellectual and developmental disabilities (IDD).

Finally, a Medicaid client may request and receive an individual exemption if BHO enrollment is not in their best clinical interest. The FFS program covers all Medicaid State Plan mental health and SUD services.

FFS reimbursement provides payment to providers for each service rendered to Colorado Medicaid clients. The FFS reimbursement rates are determined through the Colorado legislative budgetary process. Providers are responsible for preparing and submitting FFS claims in compliance with Medicaid claim filing requirements, and all FFS claims are processed by the State's Medicaid fiscal agent. Claims include the client's diagnoses, services provided, and other demographic information.

ACCOUNTABLE CARE COLLABORATIVE (ACC)[30]

HCPF provides physical health care coverage and services through the ACC program. The ACC is designed to provide a person-centered approach to care. It connects members to medical and community resources, minimizing barriers to access. The goal is better health outcomes at lower costs. The first ACC clients were enrolled in May 2011 and as of August 2015 more than 940,000 of the 1.26 million total Medicaid enrollees were in the ACC. To date, the ACC has demonstrated cost and system efficiency results, including more than $29 million in net savings in FY 13-14. HCPF plans to issue contracts for the implementation of Phase II of the ACC effective July 1, 2018.
Key concepts of the ACC Phase II model:

- Integrate physical and behavioral health care by contracting with one regional entity, the Regional Accountable Entity that focuses on whole person care.
- Further advance coordinated care by supporting a system of multidisciplinary Health Teams that, based on a client's needs, can include specialty behavioral health providers, long-term services and supports, case management agencies, and certain specialists.
- Automatically enroll all full-benefit Medicaid clients in the ACC.
- Increase use of value-based payment for both RAEs and providers.

Behavioral health goals included in Phase II:

- Increase access to services.
- Reduce barriers to care.
- Create flexibility to pay for integrated services within primary care settings.

[30] ACC Phase II Concept Paper, Pg. 4. Retrieved from https://www.colorado.gov/pacific/hcpf/accphase2

Following behavioral health stakeholder input in December 2015, HCPF released documents providing guidance about how behavioral health services will be reimbursed under ACC Phase II.[31] HCPF will retain the capitation payment methodology for core behavioral health services, with RAEs receiving the capitation payment. The current continuum of services provided under the capitation program will remain. In addition, current HCPF rules about medical necessity for services will still apply. Requirements for use of a covered diagnosis will be limited, where possible, in an effort to improve access to care. For example covered diagnoses will continue to be required by RAEs to reimburse providers for emergency department visit inpatient hospitalizations, and laboratory tests.

STATE INNOVATION MODEL[32]

SIM encourages states to develop and test models for transforming health care payment and delivery systems. The SIM is an initiative of the Center for Medicare & Medicaid Innovation (CMMI), which is part of the federal Center for Medicare and Medicaid Services (CMS). CMMI awarded Colorado a $2 million planning grant and a $65 million implementation grant to strengthen Colorado's Triple AIM strategy. The Triple AIM strategy is: improve the individual experience of care, improve the health of populations, and reduce the per capita costs of care for populations. The goal of SIM is to "Improve the health of Coloradans by providing access to integrated physical & behavioral health care services in coordinated systems, with value-based payment structures, for 80% of Colorado residents by 2019."

In February 2016, the SIM office announced that seven of Colorado's health insurers will coordinate with the SIM office to support efforts that transform the way physical care and behavioral health care are delivered and financially supported in Colorado. Anthem Blue Cross Blue Shield, Cigna, Colorado Choice Health Plans, Kaiser Permanente, Rocky Mountain Health Plans, United Healthcare, and Colorado's Medicaid program will each provide its own "value-based" payment system and clinical model as part of the Colorado SIM initiative. The initiative will integrate behavioral and physical health care in order to provide better care for Coloradans while decreasing costs. Changing the payment models from one based on FFS is designed to ensure that the newly integrated system is sustainable for care providers, health plans and patients.

State Oversight and Management of Behavioral Health Services

As noted earlier, there are multiple Colorado agencies with overlapping jurisdictions and different approaches to funding, managing, overseeing, authorizing, and/or providing behavioral health services. The behavioral health services provided by these agencies represent an impressive investment by state and local governments in the behavioral health of Coloradans. The development of these services and supports was achieved through multiple efforts across many years to better organize, fund, expand access to, and improve the quality and responsiveness of behavioral health services; nevertheless, and despite recent and very successful attempts at increased coordination, these agencies still tend to operate in "silos," with each having its own structure and organization, goals and purpose, eligibility requirements, service definitions, payment rates, payment mechanisms, financial reporting system(s), client eligibility and service utilization data tracking system, standards; program requirements, provider or practitioner registration and/or credentialing process, contract requirements, and criteria for quality or success.

This situation creates inefficiencies: ineffective use of public resources; inability to account for overall system impacts on services, funding, and provider capacity; strains on providers and practitioners trying to navigate the various systems and requirements; difficulty for clients and families trying to obtain access to services and sometimes file complaints about services; inefficiencies in the quality monitoring and oversight of provider performance and service delivery; and inability to plan for or meet Colorado's behavioral healthcare needs in a coherent, organized, and coordinated fashion. While OBH is the federally identified agency in Colorado with respect to block grant funding and HCPF is the federally identified Medicaid agency, there is no identifiable behavioral health system leader with responsibility or authority across all the behavioral healthcare services in the state.

As an example, the CDHS Division of Child Welfare purchases residential supports and community-based services that include mental health and substance use services targeted to children and families with needs related to abuse and neglect. Many of these children and families are also eligible for services through Medicaid, CHP+, state-funded CMHCs, MSOs, and private insurance. However, the child welfare system purchases services directly to address gaps in covered services (e.g., residential care for a child with insurance that does not cover residential care); preferences for services that are more tailored to goals of the child welfare system (e.g., achieving a permanent placement for a child); and real and perceived barriers in eligibility (an example of the former would be an uninsured parent with major depression who did not meet

[31] "ACC Phase II Program Decision: Reimbursement for Behavioral Health Services." (February 2016) and "Accountable Care Collaborative Phase II: Framework for Behavioral Health Reimbursement." (March 2016).
[32] SIM: Health Transformation in Colorado: How SIM Can Leverage And Support Colorado's Healthy Spirit. Retrieved from: https://www.colorado.gov/pacific/sites/default/files/Colorado%20SIM%20Powerpoint%20for%20Cost%20Commission.pdf

targeting criteria for CMHC services, and an example of the latter would be a child welfare provider unwilling to go through the hassles of enrolling with the local BHO as a Medicaid provider).

Funding for school-based mental health services provides another example of fragmentation of state funding and administrative complexities. CMHCs provide behavioral health counseling and prevention services in hundreds of schools across the state. The majority of funding is provided by CDPHE, while OBH also provides funding to CMHCs for these services. As a result, the CMHCs must contract with two different state agencies to receive funds and deliver services. Each agency has different contract terms and payment methods. For example, in order to receive approximately $71,000 annually from OBH, OBH requires Jefferson Center for Mental Health (Jefferson) to maintain a separate account for its expenses and revenues associated with the program.

Efforts to improve the coordination of funding and reimbursement methods across departments and agencies have been discussed and examined for several years; however, it appears not much progress has been made. The Behavioral Health Transformation Council, established by the Colorado Legislature in 2010, has a statutory goal of "financing reform to maximize and efficiently utilize funds."[33] A review of Council minutes indicates the Council has a Payment Reform Subcommittee; however, it is not clear from the minutes if the Subcommittee or Council have developed recommendations related to their statutory goal. More recently, OBH, HCPF, and CDPHE released a report examining several barriers to integrated care, including administrative rule barriers, non-rule barriers, state global barriers, and federal barriers. The report does not examine the challenges to integrated care posed by the various behavioral health programs in the agencies listed earlier, although it does describe the need to coordinate state agency goals to "promote greater collective action among clinical providers to meet these broader state goals."[34]

Given the numerous state agencies providing services at many points along the behavioral health continuum from prevention to inpatient treatment, there is no simple solution to improving the efficiency and effectiveness of the state's behavioral health programs. Unilaterally moving the authority and control of all behavioral health funding, planning, programs, and regulations into a single department and agency would not necessarily improve the situation and could create increased inefficiencies. For example, authority over behavioral health services delivered to adult and juvenile corrections populations while incarcerated should most likely remain with the agencies legally responsible for their care. On the other hand, centralizing the authority and funding for behavioral health prevention programs, which is currently dispersed over several agencies, could lead to increased efficiencies, and perhaps effectiveness.

In addition, there are several behavioral health programs that receive state General Fund where the services provided may be eligible for Medicaid reimbursement. Examples include behavioral health services provided to individuals involved in the state's criminal justice system, including programs in the Department of Corrections, Department of Public Safety, Judicial Department, and CDHS Division of Youth Corrections. Some portion of these funds may be able to be refinanced to earn Medicaid reimbursement for behavioral health services for clients served by these agencies.

Recommendation #1: The Governor's Office of State Planning and Budgeting (OSPB) should conduct a detailed review of each state behavioral health program administered outside of HCPF and OBH. The review should examine each program's cost and benefits, including the costs and benefits of relocating the program to a centralized behavioral health agency such as HCPF or OBH. The review should include qualitative input from agency and program staff, along with input from individuals receiving services and providers and other identified stakeholders. The program reviews should also include a "revenue maximization" analysis of whether or not services currently funded entirely by General Fund are eligible for Medicaid reimbursement.

[33] Section 27-61-102(3)(a)(V), C.R.S.

[34] *Tri-Agency Regulatory Alignment Initiative to Support Integrated Care*, Colorado Department of Human Services-Office of Behavioral Health, Health Care Policy and Financing, and Public Health and Environment, Page 14. Retrieved from: https://drive.google.com/file/d/0B6eUVZvBBTHjekVCRzJBN3lpZFk/view.

2 - Changes To The Behavioral Health System Since FY 2011-12

Overview of Changes

In Brief

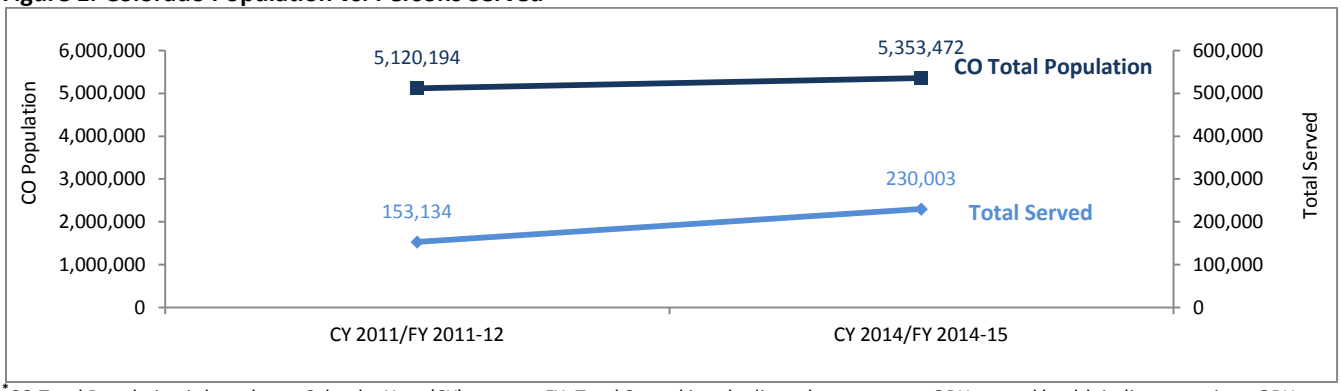
- While Colorado's population increased by 5% from 2012 to 2015, the total number of persons served in the public behavioral health system increased by 50%.
- State spending for behavioral health services across all state programs totaled nearly $1 billion in FY 2014-15, increasing by 63% from FY 2011-12, primarily due to Medicaid expansion. During this time, OBH spending for community programs increased by 36%, which was largely a result of new funding for crisis services and community transition services, while Medicaid capitation and FFS program spending increased by 109%.
- The number of individuals enrolled in the Medicaid capitation program grew by 83% from FY 2011-12 to FY 2014-15, and is expected to continue to grow by nearly one-fifth from FY 2014-15 to FY 2016-17.
- From FY 2011-12 to FY 2014-15, the number of indigent persons receiving OBH-funded community mental health services decreased by 43%, which is likely a result of Medicaid expansion. During the same period, the number of persons receiving OBH-funded substance use treatment increased by 11%. The number of persons served by Colorado Crisis Services increased by 196% from July 2015 to May 2016.
- The FY 2014-15 CMHI-Fort Logan and CMHI-Pueblo average daily occupancy rates of 97% and 93%, respectively, indicating that demand for inpatient hospital beds remains high and that the CMHIs tend to stay near capacity.

Colorado's behavioral health system has changed significantly over the last several years, and more people are receiving behavioral health services today than at any time in the past. The Affordable Care Act (ACA) is largely responsible for these changes. Two major Colorado ACA components include Medicaid expansion and the creation of the Colorado Health Exchange. Health insurance exchange plans are available to qualifying individuals and, as a result of federal parity legislation, include behavioral health benefits. In addition to increases in Medicaid expenditures, the Legislature has increased state General Fund support for behavioral health programs and services available to all individuals, including crisis services, since FY 2011-12. This section of the report examines changes in the various populations receiving behavioral health services from FY 2011-12 to FY 2014-15.

Overview of Changes in the Number of Persons Served[35]

More individuals are receiving public behavioral health services in Colorado than in FY 2011-12. As illustrated in Figure 1, while Colorado's total population increased by 5%, the total number of persons served in the public behavioral health system increased by 50%, largely due to Medicaid expansion. The state's overall Medicaid enrollment rate is projected to continue to grow, but at a lower rate than compared to the initial years of expansion.[36] Thus, the growth in the number of individuals receiving Medicaid behavioral health services should also slow.

Figure 1. Colorado Population vs. Persons Served*



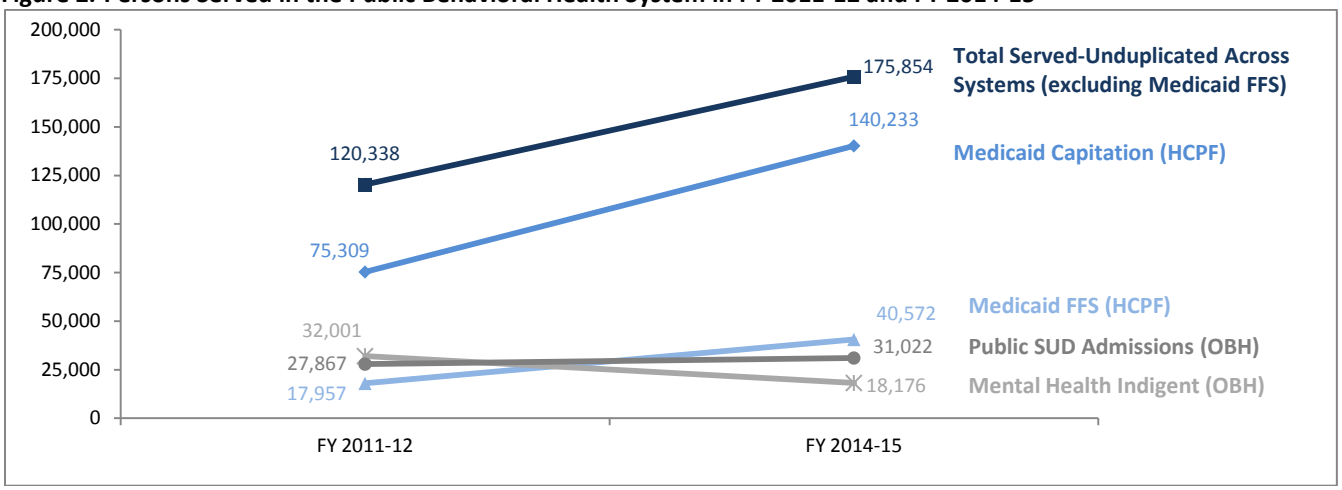
*CO Total Population is based on a Calendar Year (CY) vs. state FY. Total Served is a duplicated count across OBH mental health indigent services, OBH licensed SUD providers, Medicaid capitation, and Medicaid FFS.

[35] See Appendix E for details on the data obtained for this study and the data processing methodology and Appendix F for detailed information on the number of persons served in the public behavioral health system in FY 2011-12 and FY 2014-15.

[36] *Medicaid Expansion in Colorado: An Analysis of Enrollment, Costs and Benefits-and How They Exceeded Expectations*. The Colorado Health Institute, May 2016. Retrieved from: http://www.coloradohealthinstitute.org/uploads/postfiles/MK_Expansion_Report.pdf.

As shown in Figure 2, from FY 2011-12 to FY 2014-15 there was an 86% increase in persons served by Medicaid capitation, a 126% increase in persons served by Medicaid FFS, an 11% increase in persons receiving publically funded SUD services, and a 43% decrease in persons receiving OBH indigent mental health services.[37] The number of persons receiving services from more than one system (excluding Medicaid FFS) increased by 46%. The significant increases in the number of Medicaid capitation persons served and the reduction in OBH indigent mental health persons served is largely a result of Medicaid expansion.

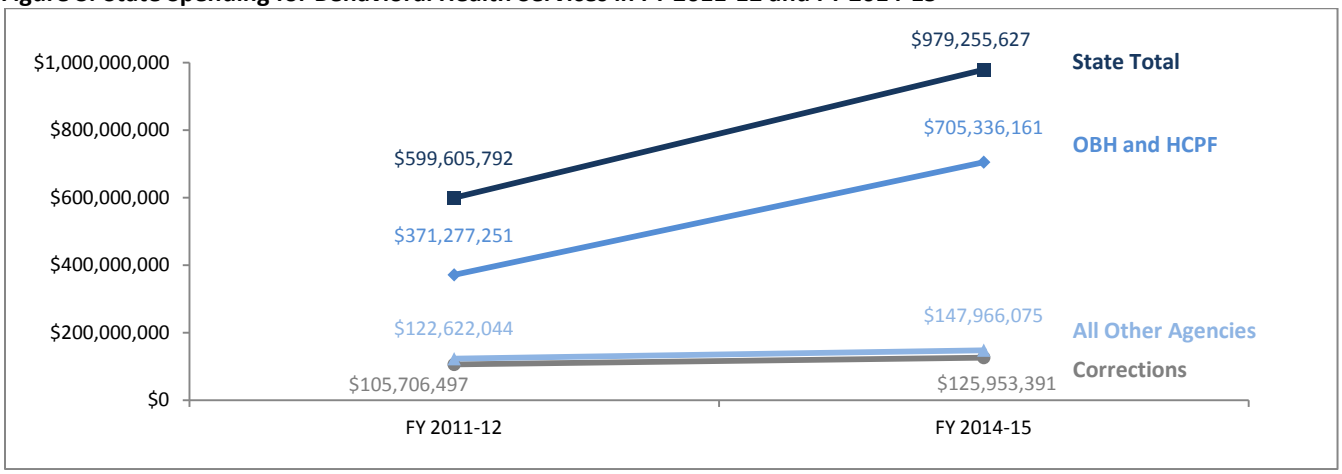
Figure 2. Persons Served in the Public Behavioral Health System in FY 2011-12 and FY 2014-15[38]



Overview of Changes in State Spending

As shown in Figure 3 below, state expenditures for behavioral health services increased by 63% from FY 2011-12 to FY 2014-15. This increase is largely a result of Medicaid expansion. Spending for behavioral health for individuals involved in the criminal justice system (shown as "Corrections" in Figure 3) represents about 13% of the state total in FY 2014-15, while spending by all other agencies (the state departments listed on page 7 of this report) represents about 15% of the state total.

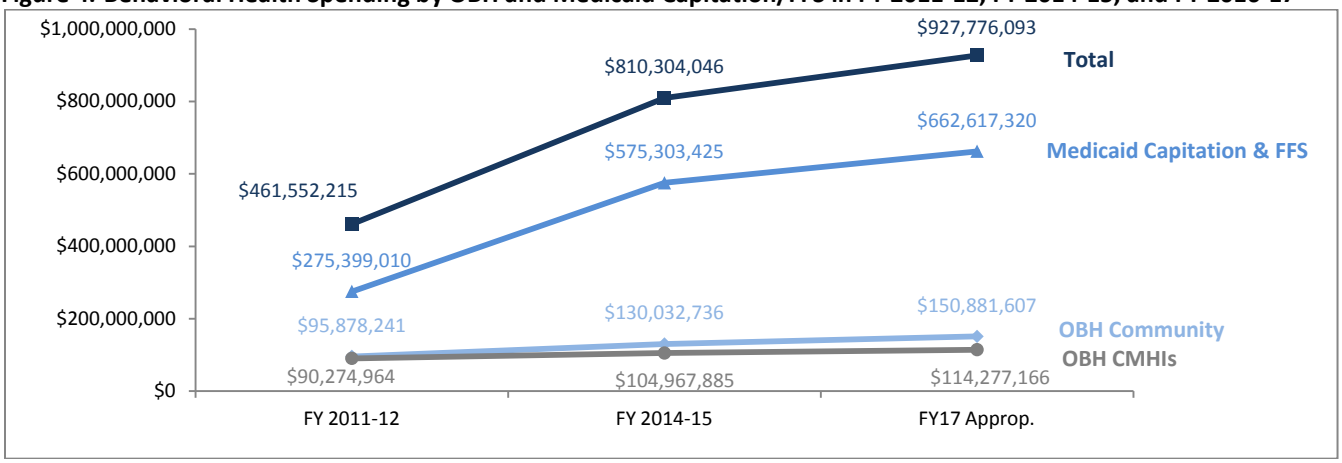
Figure 3. State Spending for Behavioral Health Services in FY 2011-12 and FY 2014-15[39]



As illustrated in Figure 4, total OBH and Medicaid capitation/FFS expenditures increased by 76% from FY 2011-12 to FY 2014-15. OBH spending for community programs increased by 36%, while Medicaid spending for capitation and FFS increased by 109%. Spending for the CMHIs increased by 16%. Total spending is estimated to increase by 14% from FY 2014-15 to FY 2016-17, based on current appropriations for FY 2016-17.

[37] OBH indigent mental health services represents individuals with an encounter designated by the provider as "indigent."
[38] Appendix F for detailed information on the number of persons served in the public behavioral health system in FY 2011-12 and FY 2014-15.
[39] See Appendix A for more detail about these State agencies, the services they provide, and the FY 2011-12 and FY 2014-15 behavioral health expenditures.

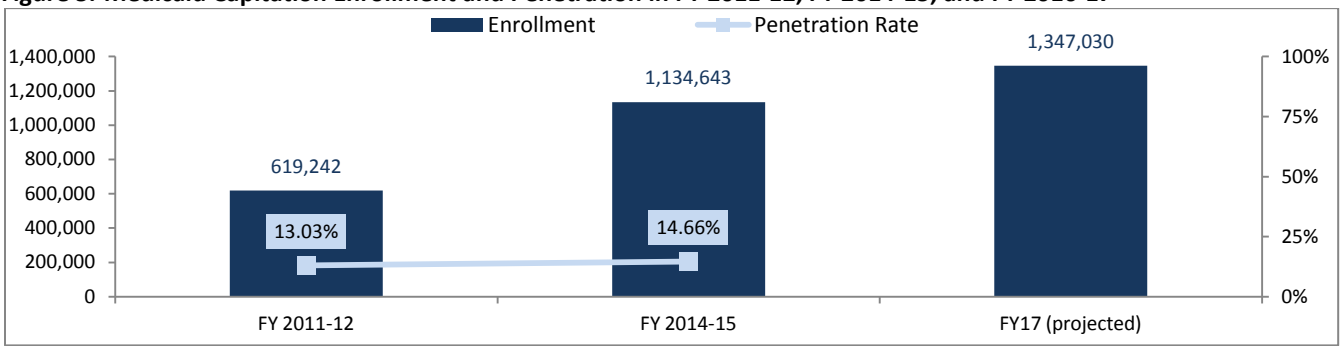
Figure 4. Behavioral Health Spending by OBH and Medicaid Capitation/FFS in FY 2011-12, FY 2014-15, and FY 2016-17



Medicaid Capitation Changes

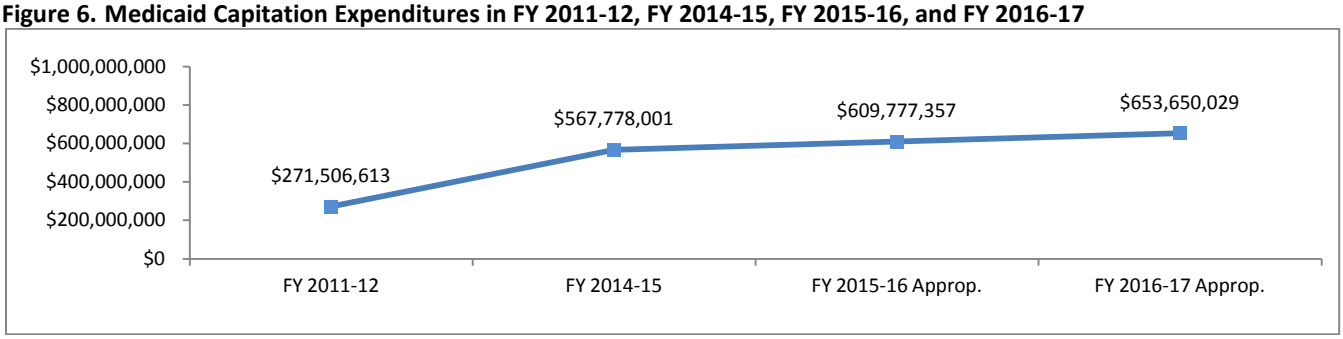
The number of individuals enrolled in the capitation program grew by 83% from FY 2011-12 to FY 2014-15 and is projected to grow by nearly one-fifth from FY 2014-15 to FY 2016-17, as illustrated in Figure 5. In addition, the percentage of enrolled individuals who received behavioral health services (referred to as the "penetration rate") increased slightly from 13% to 15%. Increases in capitation enrollment since FY 2011-12 are largely due to eligibility expansion, including the addition of Adults without Dependent Children (AWDC) with incomes of 0 to 138% of the FPL and parents (Parents/Caretakers) earning between 61% and 138% of the FPL. See Appendix G for the number enrolled, the number served, and penetration rates by BHO.

Figure 5. Medicaid Capitation Enrollment and Penetration in FY 2011-12, FY 2014-15, and FY 2016-17



As detailed in Figure 6, capitation expenditures grew significantly (109%) from FY 2011-12 to FY 2014-15, primarily as a result of Medicaid expansion. Expenditures are projected to increase by 7% in both FY 2015-16 and FY 2016-17. Capitation expenditures are impacted by caseload changes, rate changes, and changes to the Medicaid State Plan or waiver program that affect the diagnoses, services, and procedures covered for Medicaid clients. Caseload changes include changes in Medicaid eligibility, as well as demographic and economic changes that affect the number of individuals eligible within each category. The state's share of expenditures is also impacted by changes in the percentage of funding contributed by the federal government to support state Medicaid programs.

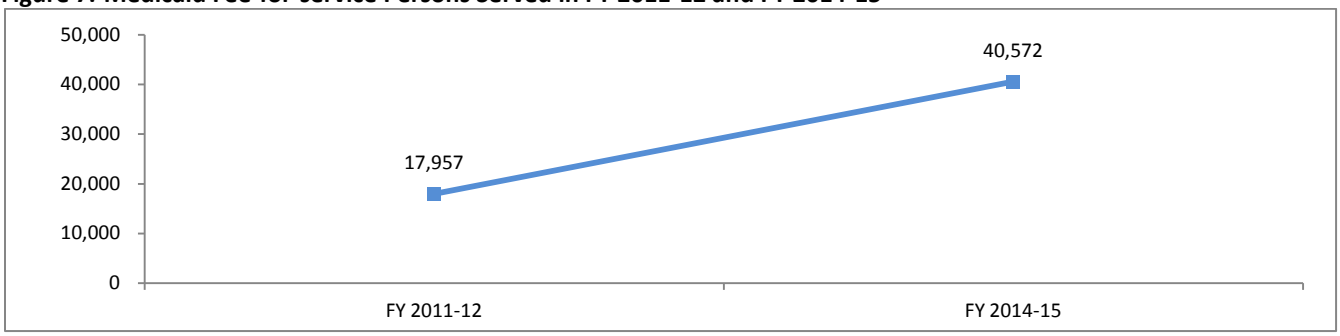
Figure 6. Medicaid Capitation Expenditures in FY 2011-12, FY 2014-15, FY 2015-16, and FY 2016-17



Medicaid Fee-For-Service Changes

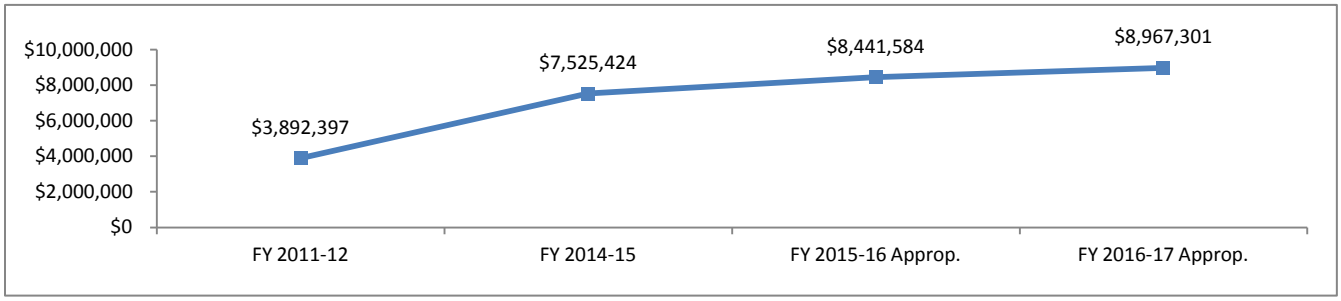
The number of persons served by Medicaid behavioral health FFS increased substantially from FY 2011-12 to FY 2014-15 (126%) as shown in Figure 7. HCPF indicates this increase was primarily due to increases in persons served as a result of Medicaid expansion. SUD services covered under Medicaid FFS were moved to the capitation program effective January 1, 2014. Prior to this date the services were reimbursed through the Medicaid FFS program.[40]

Figure 7. Medicaid Fee-for-service Persons Served in FY 2011-12 and FY 2014-15



Medicaid FFS expenditures increased by over 93% from FY 2011-12 to FY 2014-15. Expenditures are projected to increase by 12% and 6% in FY 2015-16 and FY 2016-17, respectively, as illustrated in Figure 8. The expenditure increases are primarily due to increases in persons served as a result of Medicaid expansion.

Figure 8. Medicaid Fee-for-service Expenditures



OBH Mental Health Community Programs Changes

Mental health community programs include funding for mental health services provided by the CMHCs and other providers. The majority of these programs are limited to individuals OBH defines as "indigent," while other programs are available to individuals based on other eligibility criteria.[41] These programs are primarily supported by General Fund, the federal Community Mental Health Services block grant, and tobacco litigation settlement moneys that are credited to the Offender Mental Health Services Fund.

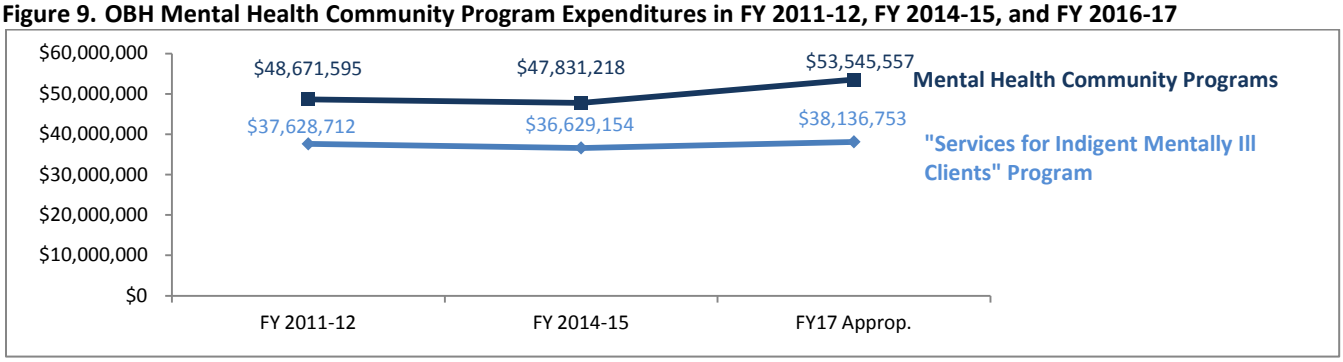
OBH indigent data presented in this report includes only individuals receiving mental health services as OBH did not require SUD providers to submit client level data until FY 2014-15. SUD providers are still working to fully comply with the requirement to submit this data. Indigent status of OBH clients was identified via a matching CCAR marked as indigent in FY 2011-12 or an OBH encounter record marked as indigent in FY 2014-15. See Appendix E for additional details about the methodology of this study.

OBH MENTAL HEALTH COMMUNITY PROGRAMS EXPENDITURES

As shown in Figure 9, OBH mental health community program's expenditures decreased by 2% from FY 2011-12 to FY 2014-15. This decrease was primarily due to a $1.0 million expenditure reduction in the "Services for Indigent Mentally Ill Clients" appropriation. Based on the FY 2016-17 appropriation, spending will increase by 12% from FY 2014-15 to FY 2016-17. Services for Indigent Mentally Ill Clients expenditures represented 76% of total OBH mental health community program spending in FY 2014-15.

[40] Letter from Optumas to John Bartholomew, HCPF, November 14, 2013, Page 2.
[41] OBH defines "indigent" as individuals who have an income of 300% of the FPL or less, who are uninsured or have Medicare only, and who are not eligible for Medicaid except during a 30-day period of non-Medicaid eligibility

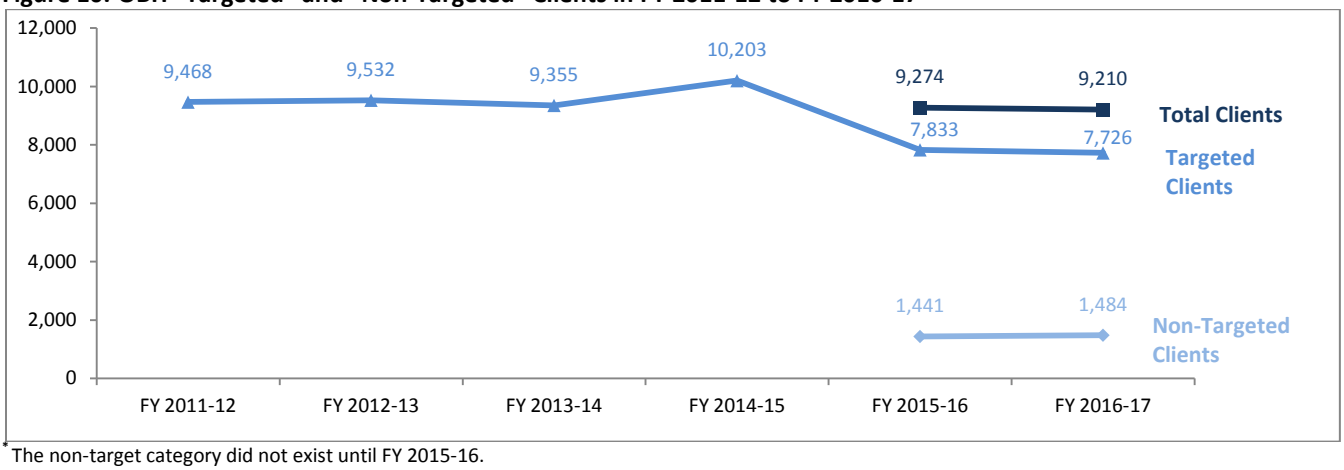
Figure 9. OBH Mental Health Community Program Expenditures in FY 2011-12, FY 2014-15, and FY 2016-17



OBH "SERVICES FOR INDIGENT MENTALLY ILL CLIENTS"

As noted in Section 1 above, the majority of OBH mental health community funding (76%) and services are provided through the "Services for Indigent Mentally Ill Clients" line item. OBH allows CMHCs to use indigent funds to provide mental health services as defined in the contract to serve "target" and "non-target" clients. In FY 2014-15 (and prior fiscal years) these funds were allowed to be used to serve only target clients.[42] As a result of Medicaid expansion, the number of SED and SMI indigent clients served with these funds declined by 9% from FY 2014-15 to FY 2015-16. Consequently, for the latter part of FY 2015-16, OBH broadened the clinical criteria of individuals who may be served with the funds by adding non-target clients.[43] In addition to broadening the clinical eligibility criteria for indigent funding, OBH has reduced the per client case rates and the number of clients to be served. In FY 2014-15 the case rate was $3,186 and the case rates for FY 2016-17 are $2,338 for a target client and $1,189 for a non-target client. Beginning with FY 2016-17, CMHCs are allowed to reallocate up to 20% of funds between SMI and non-SMI allocations up to 20% of the total indigent contract budget, upon written approval by OBH, without a contract amendment.[44] As noted in Section 1 above, OBH also made "flexible fund" allocations to each CMHC starting in FY 2016-17. As Figure 10 indicates, the number of target individuals served remained relatively consistent until FY 2015-16, when the number decreased by 23%. The number of target and non-target clients funded in FY 2015-16 decreased by 9% from FY 2014-15. For FY 2016-17, OBH estimates a total of 9,210 target and non-target clients.

Figure 10. OBH "Targeted" and "Non-Targeted" Clients in FY 2011-12 to FY 2016-17*



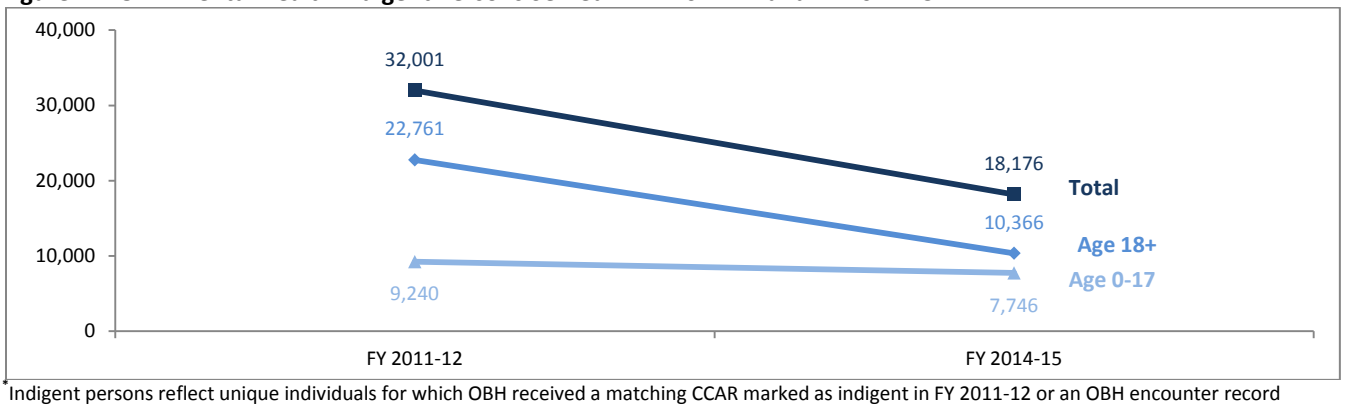
* The non-target category did not exist until FY 2015-16.

OBH MENTAL HEALTH INDIGENT CHANGES IN NUMBERS SERVED

The total number of indigent individuals who received OBH mental health community services decreased by 43% from FY 2011-12 to FY 2014-15 as indicated in Figure 11. This decrease appears to be due to the impact of Medicaid expansion. The number of indigent individuals aged 18 or older decreased by 55% and the number of indigent individuals less than 18 years of age decreased by 16%. (See Appendix F for OBH indigent individuals served by CMHC by age and gender.)

[42] Target clients include adults with an SMI, adolescents (ages 12 to 17) with an SED, and children (ages 0 to 11) with either a SED or "who have emotional or mental health problems that are in need of early intervention."
[43] Non-target clients include adults or adolescents without an SMI or SED but with a diagnosis that is covered by Medicaid.
[44] FY17 contracts between OBH and the CMHCs. See Exhibit B "Clients to be Served Work Plan."

Figure 11. OBH Mental Health Indigent Persons Served in FY 2011-12 and FY 2014-15*



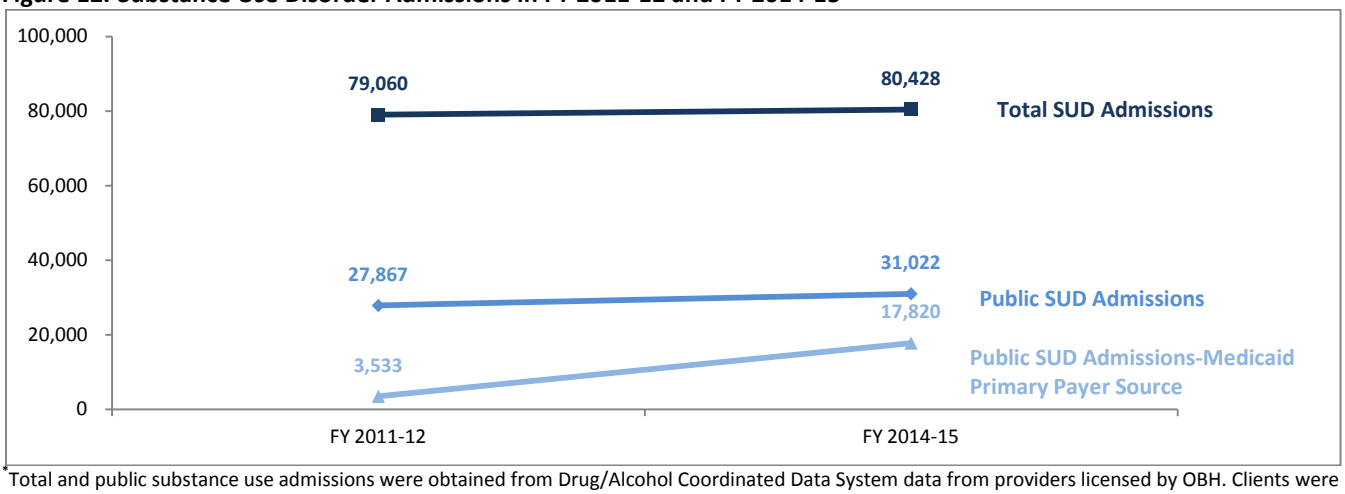
*Indigent persons reflect unique individuals for which OBH received a matching CCAR marked as indigent in FY 2011-12 or an OBH encounter record marked as indigent in FY 2014-15. Numbers served by age groups will not sum to the overall total due to missing data.

OBH Substance Use Services Changes

OBH contracts with four MSOs to provide SUD treatment services in seven geographical regions. The MSOs subcontract with local treatment providers with locations around the state to deliver these services. Based on federal block grant requirements and state priorities, OBH contracts with MSOs require an emphasis on providing services to persons involuntarily committed by the courts, pregnant women and women with dependent children, adult and adolescent intravenous drug users, drug-dependent adults and adolescents with human immunodeficiency virus (HIV) or tuberculosis, and uninsured individuals. As required by federal block grant, OBH also contracts with statewide and local prevention programs by providing partial funding for services designed to prevent the illegal and inappropriate use of alcohol, tobacco, and other drugs. OBH substance use funding is available to serve both individuals defined as "indigent" along with individuals irrespective of income level.

OBH uses the Drug/Alcohol Coordinated Data System (DACODS) to track client level SUD service data. The DACODS contains all admissions (defined as the first face-to-face therapeutic contact with a clinician) to SUD treatment by OBH licensed SUD providers. The total number of OBH admissions for a SUD increased slightly (2%) from FY 2011-12 to FY 2014-15, as described in Figure 12. The number of public SUD admissions increased by 11% during this period, most likely due to Medicaid expansion. Public admissions include individuals whose care was primarily administered through the MSOs and funded with federal Substance Abuse Prevention and Treatment Block Grant, General Fund, Marijuana Cash Tax Fund, Medicaid, Medicare, or other government or Temporary Assistance to Needy Families (TANF) funds. (See Appendix F for SUD public admissions by MSO by age and gender.)

Figure 12. Substance Use Disorder Admissions in FY 2011-12 and FY 2014-15*

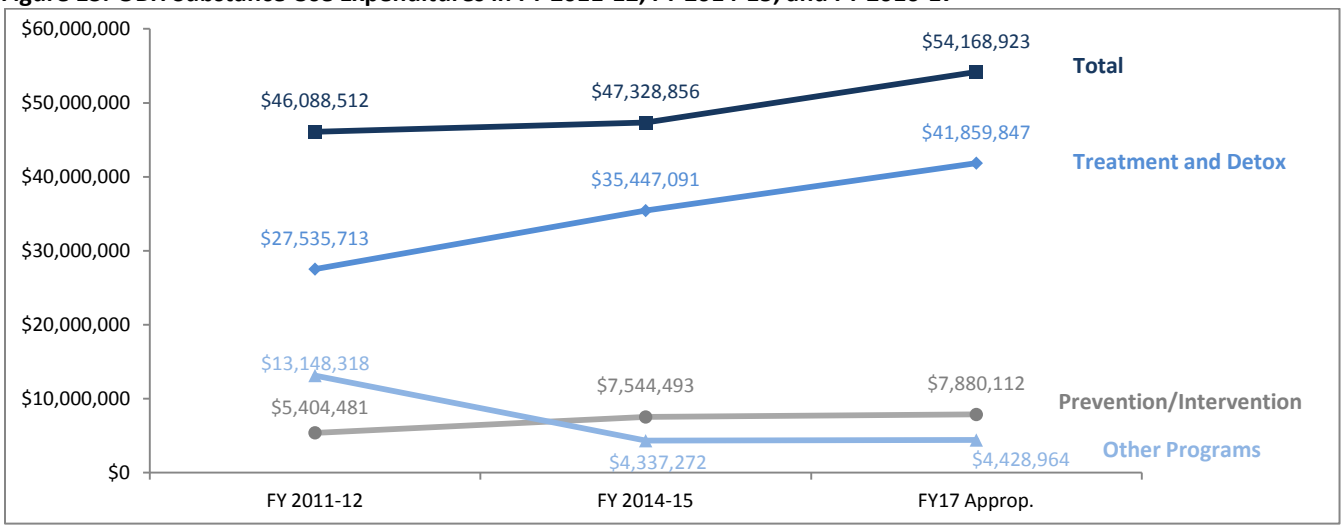


*Total and public substance use admissions were obtained from Drug/Alcohol Coordinated Data System data from providers licensed by OBH. Clients were classified according to primary payer of services and unduplicated.

Expenditures for OBH substance use services increased slightly from FY 2011-12 to FY 2014-15 as shown in Figure 13. Treatment and detoxification service expenditures increased by 29%, and prevention expenditures increased by 39% from FY 2011-12 to FY 2014-15. The increase in treatment and detoxification expenditures and decrease in other programs' expenditures from FY 2011-12 to FY 2014-15 resulted from a FY 2014-15 administrative transfer of funds from other

programs to treatment and detoxification services. FY 2016-17 expenditures are projected to increase by 15% from FY 2014-15 due to a $5.8 million increase in treatment services provided by Senate Bill 16-202.

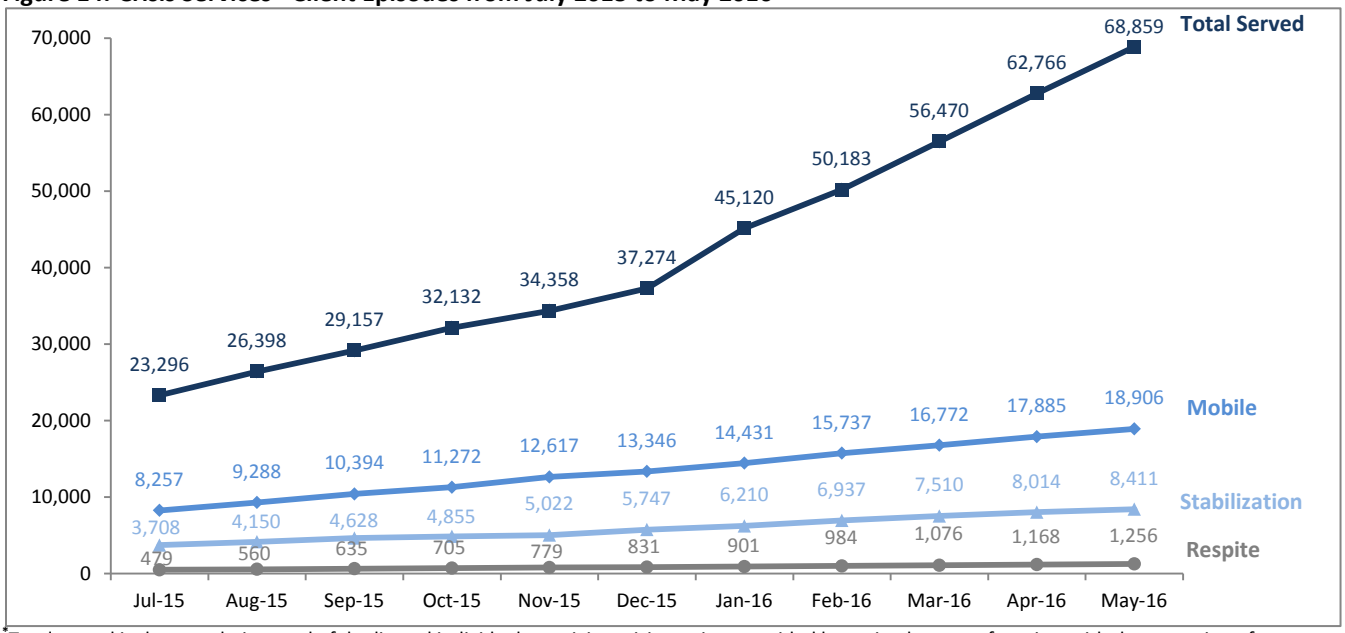
Figure 13. OBH Substance Use Expenditures in FY 2011-12, FY 2014-15, and FY 2016-17



CRISIS SERVICES CHANGES SINCE FY 2011-12

A significant expansion of crisis services has occurred since FY 2011-12. Crisis services have been a covered service under Medicaid capitation for several years. In 2013, the Legislature authorized and funded an expanded crisis services program for all Colorado residents, irrespective of insurance coverage (called "Colorado Crisis Services"). Colorado Crisis Services became fully operational during FY 2014-15. As illustrated in Figure 14, the number of episodes has increased by 196% from July 2015 to May 2016. An episode represents a client's utilization of services. The same client may have more than one episode.

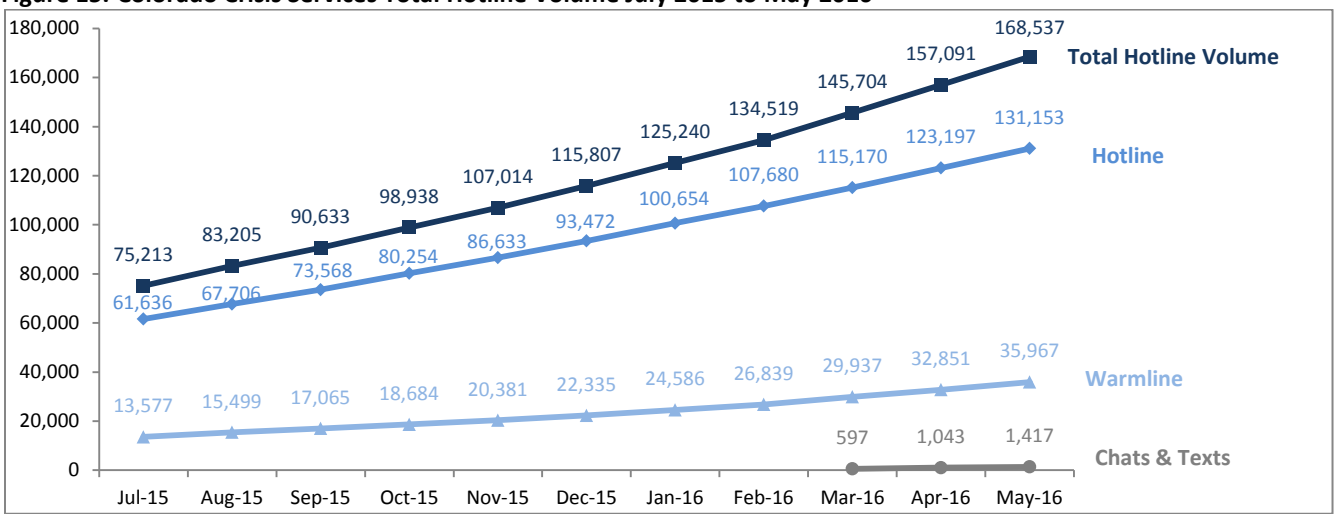
Figure 14. Crisis Services - Client Episodes from July 2015 to May 2016*



*Total served is the cumulative total of duplicated individuals receiving crisis services provided by region by type of service, with the exception of Community Crisis Connection (CCC), which was only able to provide total served data. Thus, CCC is not reflected in the Mobile, Stabilization, or Respite counts. Data are a cumulative total of all services provided since the inception of CCS (December 2014).

As displayed in Figure 15, the total Colorado Crisis Services statewide crisis hotline call and text volume steadily increased from July 2015 to May 2016 (124%). The hotline volume increased by 113%, while the warm line volume, an option within the hotline to speak with a peer specialist versus a licensed clinician, increased by 165%. Chat and text services increased by 137% in the three months, since those services began in March 2016.

Figure 15. Colorado Crisis Services Total Hotline Volume July 2015 to May 2016*

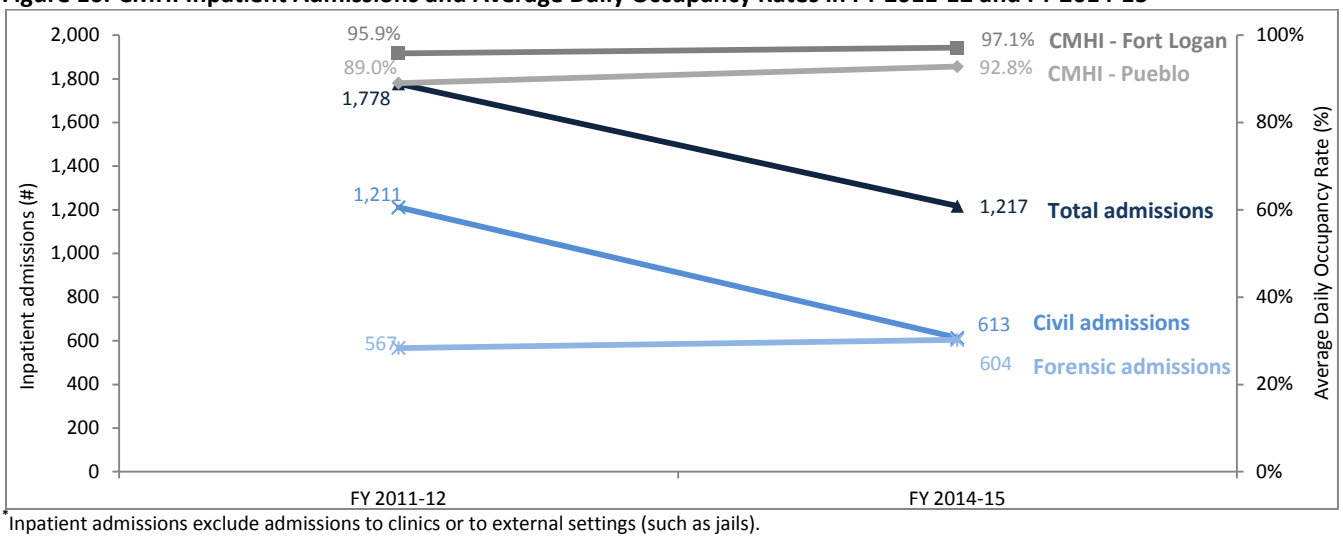


*Total hotline volume is a cumulative total of all hotline activities since the hotline's inception (August 2014). Data includes outgoing, incoming, and abandoned calls. Chat and text services were not implemented until March 2016.

Colorado Mental Health Institute Changes Since FY 2011-12

As shown in Figure 16 below, for FY 2014-15, the CMHI-Fort Logan and CMHI-Pueblo average daily occupancy rates totaled 97% and 93%, respectively, indicating that demand for inpatient hospital beds remained high and the CMHIs tended to stay near capacity. The 3% increase in the CMHI-Pueblo average daily occupancy rate reflected the increase in the proportion of forensic patients to the total patient population as forensic patients, on average, have a longer length of stay than civil patients. The decrease in the number of CMHI admissions was primarily due to a nearly 50% decrease in civil inpatient admissions at CMHI-Pueblo. Civil beds at CMHI-Pueblo have been increasingly used to meet lawsuit settlement requirements about timelines to admit forensic patients, who, on average, have longer lengths of stay than civil patients. There was a slight increase in forensic admissions (7%). Forensic admissions to CMHI-Pueblo include those committed under criminal statute, including not guilty by reason of insanity, restoration to competency to stand trial, evaluations of competency to stand trial, and transfers from the Department of Corrections for psychiatric treatment. Individuals who are admitted voluntarily or via 27-65 statutes (and not concurrently via criminal statute) are counted as civil admissions.

Figure 16. CMHI Inpatient Admissions and Average Daily Occupancy Rates in FY 2011-12 and FY 2014-15*



*Inpatient admissions exclude admissions to clinics or to external settings (such as jails).

Medicaid Expansion in Colorado

IN BRIEF

- Medicaid expansion clients represented 34% of total Medicaid capitation clients in FY 2014-15.
- The Adults without Dependent Children (AwDC) expansion category accounted for 29% of total capitation clients and 31% of capitation services in FY 2014-15.
- The Parents/Caretakers expansion category represented 5% of total capitation clients and 2% of total capitation services in FY2014-15.
- On average, both the Parents/Caretakers and AwDC populations received more substance use services than mental health services in FY 2014-15. AwDC received 34% more substance use services, while Parents/Caretakers received 65% more substance use services.
- Parents/Caretakers service costs represented 3% of total capitation services costs and 4% of total clients served.
- AwDC service costs represented both 29% of total capitation service costs and 29% of total clients served.

This section of the report examines the impact of Medicaid expansion on the capitation program. [45] Prior to the ACA, Colorado had already partially implemented expansion by adding AwDC with incomes of 0 to 10% of the FPL and Parents/Caretakers earning between 61% and 100% of the FPL. Colorado funded this initial expansion, effective April 1, 2012, with hospital provider fees.[46] The Colorado Legislature approved ACA expansion in May 2013 to be effective January 1, 2014. As a result of the ACA, Colorado added AwDC with incomes between 11% and 138% of the FPL as well as parents and caretakers earning between 101% and 138% of the FPL. Table 1 provides a high level view of the Colorado's Medicaid eligible populations and income levels before and after Medicaid expansion.

Table 1. Colorado's Medicaid Eligible Populations and Income Levels Before and After Medicaid Expansion

Population	Pre Expansion	Pre-ACA Expansion April 2012	ACA Expansion January 2014	Post Expansion
Children	0–147% of FPL	—	—	0–147% of FPL
AwDC	Not eligible	0–10% of FPL	11%–138% of FPL	0–138% of FPL
Parents/Caretakers	0–60% of FPL	61%–100% of FPL	101%–138% of FPL	0–138% of FPL
Pregnant Women	0–200% of FPL	—	—	0–200% of FPL

Medicaid Capitation Expansion Clients

Table 2 shows the number of capitation expansion clients served by BHO and by eligibility category. Overall, capitation expansion clients represented 34% of total BHO clients in FY 2014-15. The percentage of capitation expansion clients served by BHO ranges from 30% for Behavioral Healthcare Inc. (BHI) to 39% for Access Behavioral Care-Denver (ABC-D). The Parents/Caretakers population is a younger, primarily female (75%) population, with only about 3% over age 55. AwDC clients are 55% male and about 15% are aged 55 and over. (Appendix H provides data about the demographic composition of Medicaid expansion clients.)

Table 2. FY 2014-15 Medicaid Expansion Clients by Eligibility Category

	Parents/Caretakers	AwDC	All Clients	Expansion %
ABC-D	740	9,678	26,503	39.3%
ABC-NE	944	4,952	18,256	32.3%
BHI	1,507	8,111	32,427	29.7%
CHP	2,761	15,912	55,176	33.8%
FBHP	894	6,280	21,980	32.6%
Total	**6,846**	**44,933**	**154,342**	**33.5%**

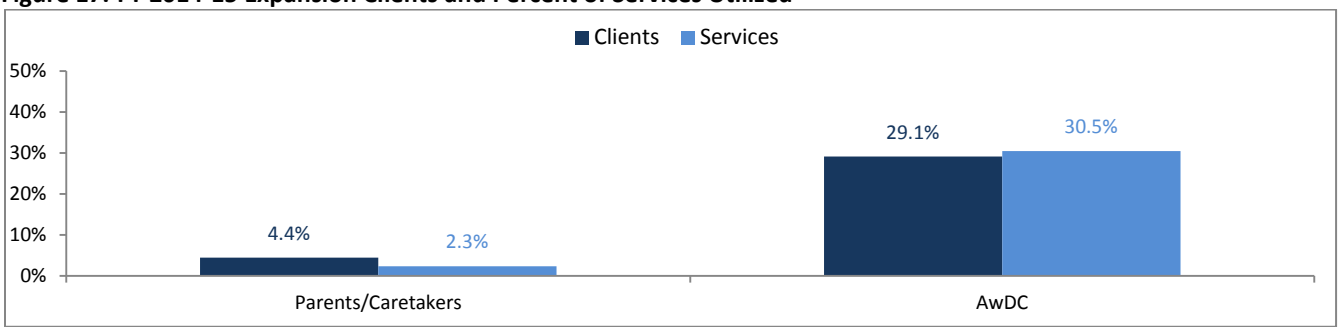
PERCENT OF SERVICES UTILIZED

As illustrated in Figure 17, Parents/Caretakers represented 4% of total BHO clients and utilized 2% of total BHO services. AwDC clients represented 29% of total BHO clients and utilized 31% of services.

[45] Information in this section from: Colorado Health Institute. *Medicaid Expansion in Colorado; An Analysis of Enrollment, Costs and Benefits – and How They Exceeded Expectations*, May 2016. Retrieved from: http://www.coloradohealthinstitute.org/uploads/postfiles/MK_Expansion_Report.pdf.

[46] The hospital provider fee is a fee paid by hospitals to the state that generates federal matching funds. These dollars are pooled in the Hospital Provider Fee Fund, which goes toward Medicaid expansion and administration as well as hospital reimbursements. Colorado Health Care Affordability Act Annual Report. (January 15, 2016). Available at: https://www.colorado.gov/pacific/sites/default/files/2016%20Annual%20Report_1.pdf

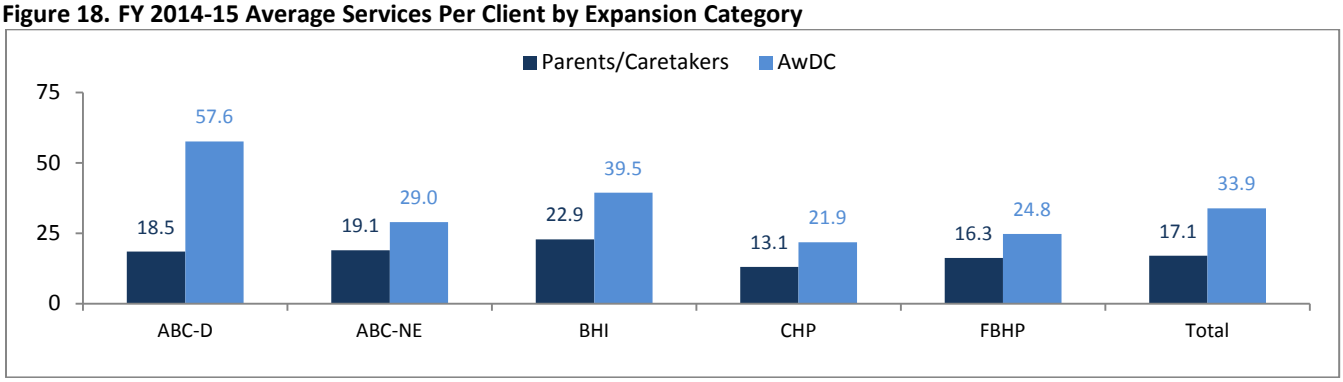
Figure 17. FY 2014-15 Expansion Clients and Percent of Services Utilized



AVERAGE SERVICES BY BHO

On average, Parents/Caretakers received 17 services while AwDC clients received 34 services, as detailed in Figure 18. Foothills Behavioral Health Partners (FBHP) provided the greatest number of services to Parents/Caretakers (25), while ABC-D provided the greatest number of AwDC services per client (58). Colorado Health Partnerships (CHP) provided the fewest Parents/Caretakers and AwDC services per client.

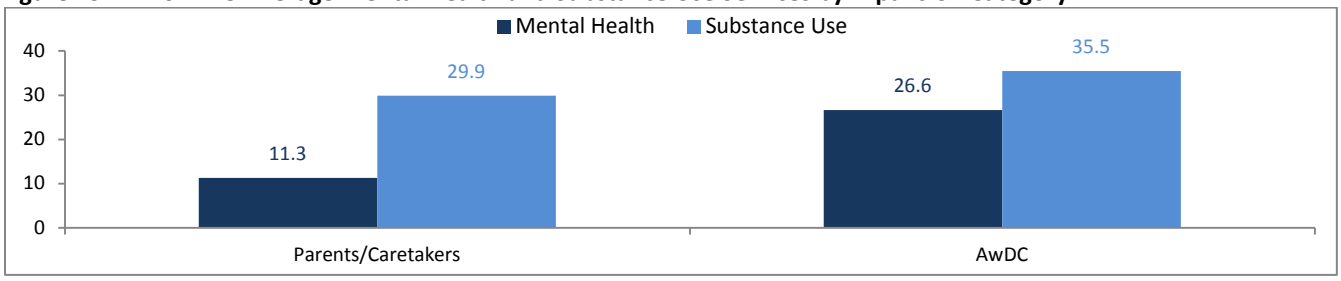
Figure 18. FY 2014-15 Average Services Per Client by Expansion Category



AVERAGE MENTAL HEALTH AND SUBSTANCE USE SERVICES

As illustrated in Figure 19, on average both Parents/Caretakers and AwDC received more substance use services than mental health services in FY 2014-15, Parents/Caretakers received 65% more substance use services, while AwDC received 34% more substance use services. A review of diagnoses of both Parents/Caretakers and AwDC indicated principal substance use diagnoses were present in 29% of AwDC and 18% of Parents/Caretakers. See Appendix H for the diagnostic composition of Medicaid expansion clients.

Figure 19. FY 2014-15 Average Mental Health and Substance Use Services by Expansion Category



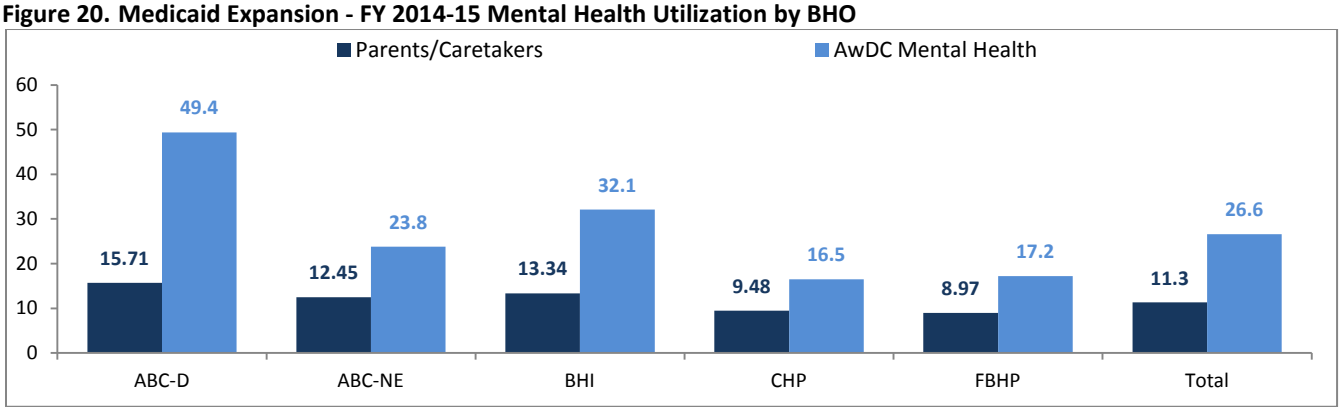
DIAGNOSTIC CATEGORIES

A review of diagnoses of both Parents/Caretakers and AwDC indicated substance use diagnoses were present in 29% of AwDC and 18% of Parents/Caretakers. The most common diagnostic categories for both AwDC and Parents/Caretakers were major depression (23% and 26%, respectively) and adjustment (16% and 24%, respectively). AwDC clients had alcohol abuse as the third most common diagnosis (15%), closely followed by anxiety (14%) and drug abuse (12%). Anxiety was the third largest category for Parents/Caretakers (19%), followed by alcohol abuse (9%) and drug abuse (8%). The diagnostic categories of expansion clients are displayed in Appendix H. (It is important to note that some clients did not have a matching CCAR and that diagnostic information was missing in some CCARs.)

MENTAL HEALTH SERVICES BY BHO

As displayed in Figure 20, ABC-D provided the greatest number of mental health services per client to both AwDC (49) and Parents/Caretakers (16). CHP provided the fewest AwDC and Parents/Caretakers services per client at 17 and 10, respectively.

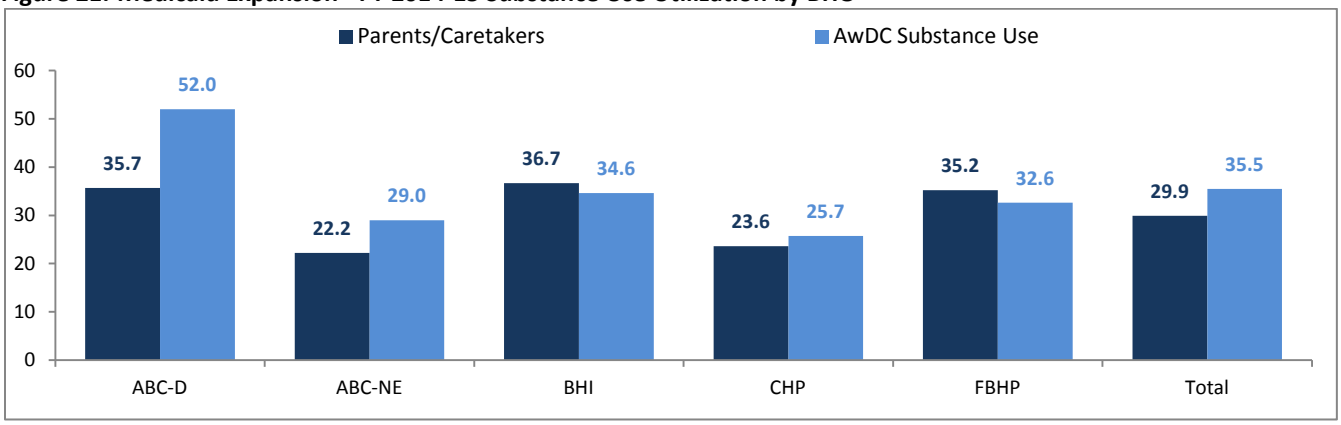
Figure 20. Medicaid Expansion - FY 2014-15 Mental Health Utilization by BHO



SUBSTANCE USE SERVICES BY BHO

As shown in Figure 21, ABC-D provided the greatest number of substance use services per client to AwDC clients (52). BHI provided the greatest number of services to Parents/Caretakers (37). Access Behavioral Care-Northeast (ABC-NE) provided the fewest services to Parents/Caretakers (22), and CHP provided the fewest services to AwDC clients (26).

Figure 21. Medicaid Expansion - FY 2014-15 Substance Use Utilization by BHO



PERCENT OF TOTAL CLIENTS AND PERCENT OF TOTAL SERVICE COSTS

Figures 22 and 23 present the percentage of clients and service costs for each of the expansion categories. The percentage of AwDC client service costs reflected approximately the same percentage as the percentage of AwDC clients receiving services (29%), while Parents/Caretakers service costs (3%) were slightly lower than the percentage of Parents/Caretakers receiving services (4%).

Figure 22. FY 2014-15 AwDC - Total Service Costs and Total Clients

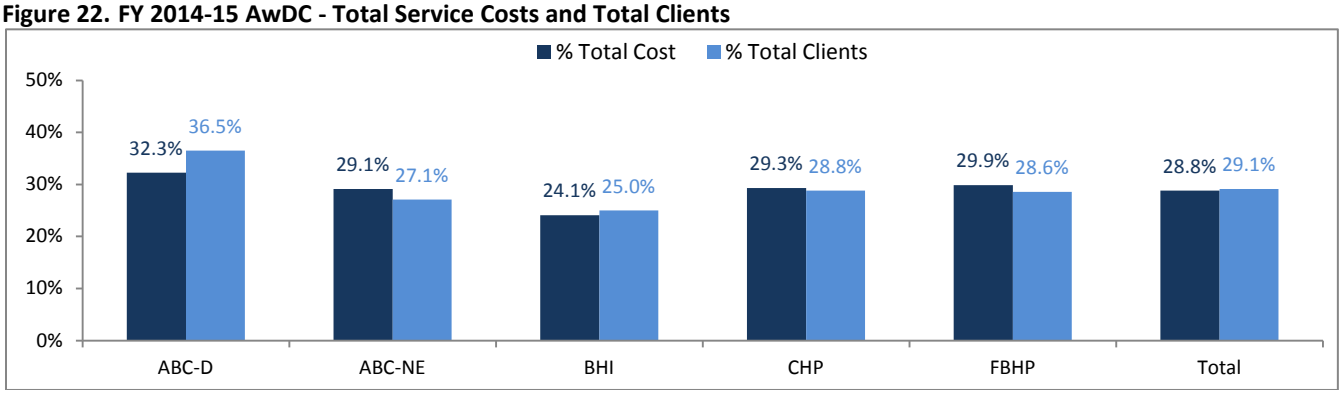
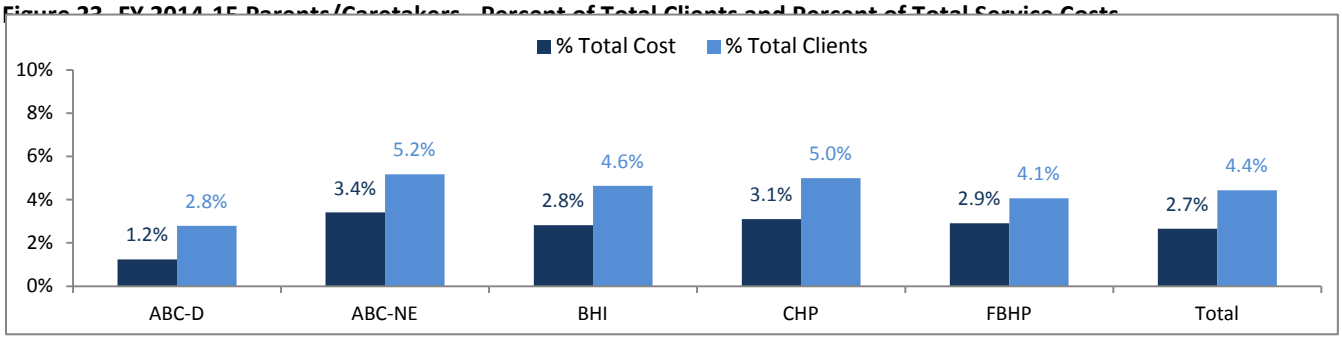


Figure 23. FY 2014-15 Parents/Caretakers - Percent of Total Clients and Percent of Total Service Costs



Other State Changes in Response to Medicaid Expansion

IN BRIEF

- States expanding Medicaid expected reductions in state general fund expenditures for uninsured individuals between $7 million and $190 million in 2015, with total savings to exceed $610 million.
- While some states chose to reinvest savings from Medicaid expansion into their state behavioral health budgets or provider networks, others chose to reduce state behavioral health budgets and appropriate funds elsewhere or offset future Medicaid expansion costs.
- Two vulnerable populations, the incarcerated and the homeless, are either ineligible or unlikely to enroll in Medicaid but will still need behavioral health treatment. For these reasons, SAMHSA's block grants will still be important as safety net funding for specialty behavioral health treatment.[47]

The purpose of this review of changes made by states in response to Medicaid expansion was to better understand how Medicaid expansion affects the delivery of public behavioral health services to inform Colorado's practices. The review addressed the following areas:

- State fiscal impact from Medicaid expansion and changes in non-Medicaid funding.
- State use of savings from Medicaid expansion.
- Continued need for safety net (state funded) services).
- Continued challenges facing the states.

The entire analysis and literature review is included as Appendix I.

Fiscal Impact

As more uninsured individuals obtain coverage, demand for health care services (including behavioral health) that serve low-income and uninsured residents declines. The number of uninsured individuals seeking care at hospitals should also decrease. As a result, all expansion states should expect to reduce state spending on programs for the uninsured.[48] An Issue Brief released by the State Health Reform Assistance Network in 2014 examines the expansion experiences of eight states (Arkansas, Colorado, Kentucky, Michigan, New Mexico, Oregon, Washington, and West Virginia). Two of these states (Arkansas and Kentucky) revealed state budgetary savings and revenue gains sufficient to offset state costs attributable to Medicaid expansion at least through state FY 2020-21. Kentucky saved $9 million in state FY 2013-14 (six months of savings) and expects to save $21 million in state FY 2014-15 in behavioral health spending. Savings from replacing state general funds with Medicaid funds totaled between $20 million in Colorado and $389 million in Michigan through 2015.[49] States expanding Medicaid expected reductions in state general fund expenditures for uninsured individuals between $7 million

[47] Woodward, A. *The CBHSQ Report: The Substance Abuse Prevention and Treatment Block Grant is still Important even with the expansion of Medicaid*, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, 2015. Retrieved from: http://www.samhsa.gov/data/sites/default/files/report_2080/ShortReport-2080.html.

[48] Bachrach, D., Boozang, P., and Glanz, D. *States expanding Medicaid see significant budget savings and revenue gains: early data shows consistent economic benefits across expansion states*, April 2015. Retrieved from: http://statenetwork.org/wp-content/uploads/2015/04/State-Network-Manatt-States-Expanding-Medicaid-See-Significant-Budget-Savings-and-Revenue-Gains-April-20152.pdf.

[49] Bachrach, D., Boozang, P., Herring, A., and Reyneri, D. G. *States expanding Medicaid see significant budget savings and revenue gains: early data shows consistent economic benefits across expansion states*, March 2016. Retrieved from http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwjf419097.

and $190 million in 2015, with total savings to exceed $610 million.[50,51,52] These programs include treatment for people with mental illness and substance use disorders, funding for hospitals to offset uncompensated care costs, and care for prisoners who have to be hospitalized outside of correctional facilities.

State Use of Savings

Medicaid expansion has given a budget boost to participating states, mostly by allowing the use of federal, rather than state funds, to care for uninsured individuals, as well as through increased tax and assessment revenues. In addition to impacts on state budgets, increased budget flexibility may also be realized in expansion states. Funds from the SAMHSA block grants, which may have been used to treat the uninsured, can now be used to meet a multitude of other needs, including workforce development, screening, prevention and early intervention programs, and the provision of the continuum of care, many of which are not covered by Medicaid. While some states chose to reinvest these savings into their state behavioral health budgets or provider networks, others chose to reduce state behavioral health budgets and appropriate funds elsewhere or offset future Medicaid expansion costs. Table 3 provides an overview of where states are allocating their new savings (data only available for 11 states and there is duplication across efforts). Please refer to Appendix I for additional detail on how states are re-allocating cost savings.

Table 3. Reallocation of State Funds[53]

	Screening and Early Intervention	Reinvest in Behavioral Health: EBPs	Reinvest in Behavioral Health: Public Awareness	Reinvest Behavioral Health: Crisis Services	Reinvest in Behavioral Health: Workforce	Reallocate Away from Behavioral Health
Number of States*	3 states	5 states	1 state	1 state	3 states	4 states

*States are not identified as the states participating in the block grant interviews were told their responses would be de-identified to encourage honest and candid feedback.

Continued Need for Safety Net Services (State-funded Services)

Although more individuals have access to expanded Medicaid and private insurance coverage through the ACA, these programs do not support many services that have been shown effective at promoting recovery. States interviewed for a Government Accountability Office report expressed concern about the adequacy of funding for wraparound services, such as peer support and supportive housing. There are concerns about having enough state behavioral health authority funding for individuals who would remain uninsured or underinsured following expansion, including individuals who are eligible but do not enroll or re-enroll in Medicaid, immigrants, and certain individuals under 65 who are enrolled in Medicare because of a disability.[54] There will continue to be uninsured and underinsured individuals. Not all eligible individuals will enroll in Medicaid; only about two-thirds of those who are eligible ultimately enroll. Two vulnerable populations, the incarcerated and the homeless, are either ineligible or unlikely to enroll in Medicaid but will still need behavioral health treatment. For these reasons, SAMHSA's block grants will still be important as safety net funding for specialty behavioral health treatment.[55]

Despite the gain in coverage for low-income adults, the majority of the remaining uninsured also falls in this low-income group in both the Medicaid expansion states and in the nonexpanding states, at 59% with family income at or below 138% of FPL in the Medicaid expansion states, and 69% in the nonexpanding states.[56] Medicaid expansion does not address the many essential services that are not Medicaid reimbursable, most notably adult inpatient psychiatric treatment, nor does it cover the many people with mental illness who do not qualify for Medicaid, either because their income is slightly higher

[50] Dey, J., Rosenoff, E., West, K., Ali, M.M., Lynch, S., McClellan, C., Mutter, R., Patton, L., Teich, J., and Woodward, A. *Benefits of Medicaid Expansion for Behavioral Health*, March 28, 2016. Retrieved from https://aspe.hhs.gov/sites/default/files/pdf/190506/BHMedicaidExpansion.pdf.
[51] U.S. Department of Health and Human Services. *New report shows Medicaid expansion can improve behavioral health care access*, March 28, 2016. Retrieved from http://www.hhs.gov/about/news/2016/03/28/new-report-shows-medicaid-expansion-can-improve-behavioral-health-care-access.html.
[52] Bachrach, D., Boozang, P., Glanz, D. *Medicaid expansion leads to economic benefits while improving access to coverage*, April 10, 2015. Retrieved from https://www.manatt.com/insights/newsletters/medicaid-update/medicaid-expansion-leads-to-economic-benefits-whil.
[53] NRI, NASADAD. *Understanding how states use the SABG and MHBG in the wake of Mental Health Parity and Addiction Equity Act and the Affordable Care Act* (Pre-publication).
[54] United States Government Accountability Office. *Behavioral Health: Options for Low- Income Adults to Receive Treatment in Selected States*, June 2015. Retrieved from: http://www.gao.gov/assets/680/670894.pdf.
[55] Woodward, A. *The CBHSQ Report: The Substance Abuse Prevention and Treatment Block Grant is still Important even with the expansion of Medicaid*, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, 2015. Retrieved from: http://www.samhsa.gov/data/sites/default/files/report_2080/ShortReport-2080.html.
[56] Shartzer, A., Long, S.K., and Zuckerman, S. "Who Are the Newly Insured as of Early March 2014?", *Health Reform Monitoring Survey*, May 22, 2014. Retrieved from: http://hrms.urban.org/briefs/Who-Are-the-Newly-Insured.html#fn5.

than the Medicaid threshold (which is well below poverty level in most states) or because they are too ill to take the steps necessary to apply and qualify for Medicaid. [57]

Some block grant funding will remain as a safety net for individuals who continue to be uninsured (e.g., enrollment in Medicaid is likely to remain low for some hard to reach individuals). The block grant funds could focus on prevention and early intervention services and "wraparound" services that are often not covered by Medicaid.[58] It is unlikely that Medicaid, which prior to full implementation covered 26% of those who were unemployed or not in the labor force, can absorb the entire 58% who were uninsured and unemployed or not in the labor force nationally.[59]

Continued Challenges Facing the States

MAINTENANCE OF EFFORT

While the ability to save general funds is an opportunity for states, it also may create some challenges for grant funds with maintenance of effort responsibilities. States may face restrictions in redirecting funding, and reprogramming within behavioral health may be a requirement in some instances, due to federal or state requirements. For example, MOE requirements, which are part of SAMHSA's block grants, require states to maintain behavioral health funding at the level of the two year period prior to receipt of the grant.[60]

SERVICE AVAILABILITY AND CAPACITY

States will need to improve the availability and quality of mental health services, which requires both additional provider capacity and better care coordination for patients with complex behavioral health needs. In terms of care coordination, one official described how the expansion "highlighted the difficulties in trying to operate a program and get services to people where you have fragmented medical, mental health, and substance abuse delivery systems."[61]

LACK OF FULL ARRAY OF COVERED SERVICES

Insurance companies still do not provide ample and equitable coverage for mental health treatment. Comprehensive treatment for mental illness includes counseling and therapy, medication, support groups, education about the illness, inpatient hospital-based treatment, and wraparound services such as mobile outreach teams and intensive case management. With effective treatment, along with supportive interpersonal relationships, access to transportation, adequate housing, adequate diet and sleep, and meaningful paid or volunteer activities, mental illness recovery is possible. Despite the effectiveness of treatments for mental illness and significant advances in effective medications and evidence-based treatments, not everyone who has a mental illness receives treatment, and not everyone who is treated receives quality care. Many population centers are still lacking basic mental health services such as crisis response and inpatient acute care. There are costs to untreated mental illness including exacerbated symptoms, high rates of emergency room visits, homelessness, incarceration, suicide, lost workdays, and family distress. [62]

States offer a variety of evidence-based practices (EBPs) for individuals with behavioral health needs. The increase in the number of individuals with private insurance has led to a major concern of advocates that these individuals will no longer have coverage for EBPs. Most private insurance companies use a more restrictive definition of medical necessity than Medicaid or state-funded plans. Medicaid and state funds also often pay for more innovative services that have shown an increase in positive outcomes, such as supported housing, supported employment, and supported education.[63]

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[57] Romine, P. *Restore Non-Medicaid Funding for Mental Health and Substance Abuse*. Retrieved from: http://www.guidedpathways.org/2015/03/restore-non-medicaid-funding/.

[58] Dey, J., et al. *Benefits of Medicaid Expansion for Behavioral Health*, March 28, 2016. Retrieved from https://aspe.hhs.gov/sites/default/files/pdf/190506/BHMedicaidExpansion.pdf.

[59] Woodward, A. *The CBHSQ Report: The Substance Abuse Prevention and Treatment Block Grant is still Important even with the expansion of Medicaid*, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, 2015. Retrieved from: http://www.samhsa.gov/data/sites/default/files/report_2080/ShortReport-2080.html.

[60] Dey, J., et al. *Benefits of Medicaid Expansion for Behavioral Health*, March 28, 2016. Retrieved from https://aspe.hhs.gov/sites/default/files/pdf/190506/BHMedicaidExpansion.pdf.

[61] Sommers, B. D., Arntson, E., Kenney, G. M., Epstien, A. M. "Lessons from Early Medicaid Expansions Under Health Reform: Interviews with Medicaid Officials," *Medicare & Medicaid Research Review*, 3(4), 2013. Retrieved from: https://www.cms.gov/mmrr/Downloads/MMRR2013_003_04_a02.pdf

[62] Signer, M.E. "Virginia's Mental Health System: How it Has Evolved and What Remains to be Improved", *The Virginia Newsletter*, 90(3), May, 2014. Retrieved from: http://www.coopercenter.org/sites/default/files/publications/Virginia%20News%20Letter%202014%20Vol.%2090%20No%203.pdf

[63] SAMHSA. *Funding and Characteristics of Single State Authorities for Substance Abuse Services and State Mental Health Agencies, 2013*, HHS Pub. No. (SMA) 15-4926. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015. Retrieved from: http://store.samhsa.gov/shin/content//SMA15-4926/SMA15-4926.pdf.

Uninsured and Underinsured Individuals

IN BRIEF

- The number of uninsured individuals declined by 58% from 2011 to 2015, while the number of underinsured individuals increased by 30%.
- An estimated 21% (or 73,015) of the total uninsured (352,664) were not within the Medicaid FPL ranges and earned less than 300% of the FPL. This population represented the uninsured indigent population (based on OBH contract definitions).
- The most common reasons cited statewide for lack of insurance coverage was high cost, followed by lack of employer-sponsored coverage and change in job/loss of job.
- The majority of the uninsured indigent population indicated receiving needed mental health care in the past twelve months (89%) and being in good mental health in the past month (88%).

This section of the report examines uninsured and underinsured individuals and changes in these populations from 2011 to 2015. Information is provided by CMHC area and by demographic category. The underinsured are defined as having health insurance but with out-of-pocket medical costs greater than 10% or more of annual income or 5% or more of income for those below 200% of the FPL.

Methodology

Data from the Colorado Health Institute's (CHI) 2015 Colorado Health Access Survey (CHAS) was retrieved from CHI's online data resource, the CHAS Regional Workbook, and was provided by CHI through specific data requests.[64] The number of uninsured and underinsured for each of the state's 21 Health Statistics Regions (HSRs), as estimated by the CHAS, was aggregated to each CMHC area. For most CMHCs, one or more HSRs compose the area. In some cases, CMHC areas and HSR boundaries do not coincide; therefore, county level estimates were reallocated to CMHC area.[65] Specifically, the number distributed to the CMHC out of an established HSR was determined by percentage of population in the area.

Uninsured and Underinsured 2011 and 2015

The number of uninsured declined by 58% from 2011 to 2015, while the number of underinsured increased by 30%, as presented in Figure 24. The significant reduction in the number of uninsured reflects the impact of Medicaid expansion and the creation of the Colorado Health Insurance Exchange. The increase in underinsured may reflect that while more individuals are insured, they are challenged by the cost of insurance and health care, including out of pocket expenses to reach annual deductable amounts and for copayments related to services.

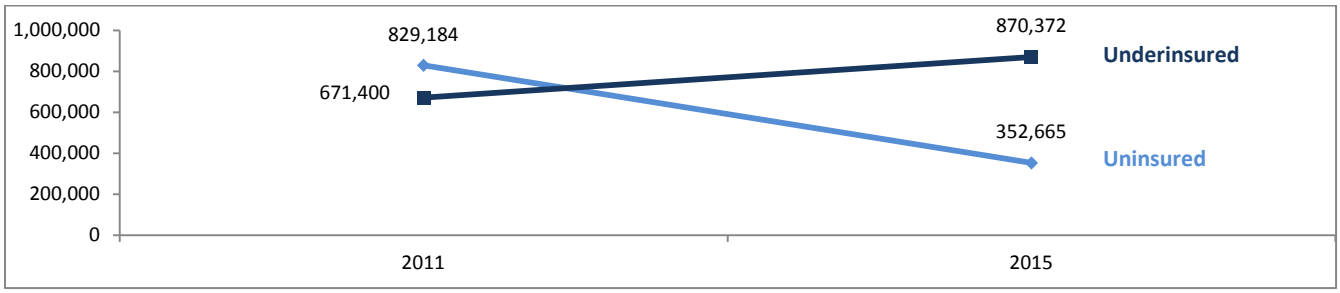


Table 4 shows the number of uninsured and underinsured by CMHC in 2011 and 2015 as well as the percent change from 2011 to 2015. Similar to the statewide trends, from 2011 to 2015, the percentage of uninsured decreased and the percentage of underinsured increased for all CMHCs. In 2015, AspenPointe, Inc. (AspenPointe), Mental Health Center of Denver (MHCD), and MindSprings accounted for over 40% of the 2015 total number of uninsured while AspenPointe, AllHealth Network (AllHealth), and Jefferson Center for Mental Health (Jefferson) accounted for 39% of the total number of underinsured.

[64] The CHAS randomly surveys more than 10,000 households, including cell phones and landlines. Survey data are weighted to accurately reflect the demographics and distribution of Colorado's population. Data are collected every two years, on odd years, so data presented are years 2011 and 2015. For more information about the survey see http://www.coloradohealthinstitute.org/key-issues/detail/health-coverage-and-the-uninsured/colorado-health-access-survey-1.

[65] Estimates of uninsured and underinsured for Aurora, AllHealth, Community Reach, Jefferson, AspenPointe, Health Solutions, and Southeast were apportioned proportionally.

Table 4. Uninsured and Underinsured by CMHC in 2011 and 2015

CMHC	Uninsured 2011	Uninsured 2015	Percent Change	Underinsured 2011	Underinsured 2015	Percent Change
AllHealth	58,155	28,793	-50.5%	74,635	117,655	57.6%
AspenPointe	80,207	50,367	-37.2%	80,331	115,615	43.9%
Aurora	42,957	23,816	-44.6%	40,103	58,939	47.0%
Axis	21,922	9,851	-55.1%	11,890	13,615	14.5%
Centennial	20,132	7,542	-62.5%	21,621	24,052	11.2%
CMH	28,088	6,223	-77.8%	15,672	22,213	41.7%
Community Reach	89,478	28,165	-68.5%	42,189	65,863	56.1%
Health Solutions	18,260	11,711	-35.9%	22,605	33,089	46.4%
Jefferson	101,329	17,586	-82.6%	77,153	107,355	39.1%
MHCD	115,844	56,670	-51.1%	63,485	71,466	12.6%
MHP	34,967	20,424	-41.6%	57,340	62,408	8.8%
Mind Springs	79,552	38,707	-51.3%	45,677	71,762	57.1%
North Range	46,024	21,915	-52.4%	31,590	32,574	3.1%
San Luis Valley	12,231	4,050	-66.9%	7,179	7,278	1.4%
Solvista	22,135	5,073	-77.1%	14,281	9,813	-31.3%
Southeast	7,510	3,967	-47.2%	14,211	10,418	-26.7%
SummitStone	50,393	17,805	-64.7%	51,438	46,257	-10.1%
Total	**829,184**	**352,665**	**-57.5%**	**671,400**	**870,372**	**29.6%**

Uninsured and Underinsured by Federal Poverty Level

Table 5 presents the numbers of uninsured and underinsured by FPL. There is a clear correlation between poverty level and likelihood of being uninsured or underinsured, which makes sense given that Table 6 shows that the most common reason for being uninsured is the cost of insurance.

Table 5. Uninsured and Underinsured in 2015 by Federal Poverty Level (FPL)

	2015 Number of Uninsured	2015 Percent of Uninsured	2015 Number of Underinsured	2015 Percent of Underinsured
0-100% FPL	135,687	38.5%	433,178	49.8%
101-200% FPL	87,636	24.8%	255,681	29.4%
201-300% FPL	44,916	12.7%	86,054	9.9%
301-400% FPL	44,956	12.7%	60,145	6.9%
More than 400% FPL	39,469	11.2%	35,313	4.1%
Total	352,664	100.0%	870,371	100.0%

Reasons for Being Uninsured

As illustrated in Table 6, cost was the most common reason cited in 2011 and 2015 by Coloradans at or below 300% FPL for being uninsured. The second most common reason cited was lack of employer sponsored coverage or not being eligible for employer coverage; this percentage decreased by 6% from 2011 to 2015.

Table 6. 2011 and 2015 Statewide Reasons for Being Uninsured - Coloradans at or Below 300% FPL

Reason	2011	2015	Percent Change
Person in family who had health insurance lost job or changed employers	38.2%	27.8%	-10.4%
Person in family who had health insurance no longer part of the family (divorce, separation or death)	7.9%	12.4%	4.6%
Family member's employer does not offer coverage or not eligible for employer's coverage	39.3%	32.7%	-6.6%
Lost eligibility for Medicaid or CHP+	18.9%	17.5%	-1.4%
Cost is too high	84.5%	84.0%	-0.5%
Don't need health insurance	13.5%	16.5%	3.0%
Don't know how to get insurance	19.2%	15.6%	-3.6%
Traded health insurance for another benefit or higher pay	2.5%	7.1%	4.6%
Can't get health insurance, have a pre-existing condition	12.6%	8.2%	-4.4%

Uninsured and Underinsured as a Percentage of the Total Population

Table 7 provides the percentage of the total 2015 population in each CMHC estimated to be uninsured and underinsured, 7% and 16% statewide, respectively. The estimated percentage of uninsured was over 10% for Axis and Mind Springs. Jefferson was estimated to have the lowest percentage of uninsured at 3%. Centennial Mental Health Center (Centennial), The Center for Mental Health (CMH), and Southeast Health Group (Southeast), which serve primarily rural and/or frontier counties, had an estimated percentage of underinsured at or over 20%.

Table 7. Uninsured and Underinsured as a Percentage of Total Population for 2015*

CMHC	County Designation	Uninsured % of Total Population	Underinsured % of Total Population
AllHealth	Urban	5.9%	19.1%
AspenPointe	Urban	6.9%	15.8%
Aurora	Urban	7.1%	17.6%
Axis	Rural/Frontier	11.1%	15.3%
Centennial	Urban/Rural/Frontier	6.5%	21.1%
CMH	Rural/Frontier	6.2%	22.2%
Community Reach	Urban	7.0%	16.3%
Health Solutions	Urban/Frontier	6.3%	17.6%
Jefferson	Urban	3.0%	17.6%
MHCD	Urban	9.5%	11.9%
MHP	Urban	5.2%	15.9%
Mind Springs	Urban/Rural/Frontier	10.7%	19.4%
North Range	Urban	8.5%	12.6%
San Luis Valley	Rural/Frontier	8.5%	17.2%
Solvista	Rural/Frontier	6.8%	13.2%
Southeast	Frontier	7.6%	20.0%
SummitStone	Urban	6.0%	15.6%
Statewide		6.7%	16.4%

*The percentages of CMHC areas that are uninsured/underinsured were calculated from percentages of uninsured/underinsured by HSR, provided by the CHAS online data resource, the CHAS Regional Workbook.

The Uninsured Who Meet the OBH Indigent Definition

Based on CHAS data, in 2015 there were an estimated 73,015 uninsured individuals who meet the OBH indigent criteria.[66] Table 8 provides demographic information about this group. Interestingly, the majority indicated receiving needed mental health care in the past twelve months (89%) and being in good mental health in the past month (88%). Almost half (44%) were aged 50-64, the majority were male (70%), over half were non-Hispanic white (59%), and approximately half were in the Denver Metro area (53%).

[66] OBH defines the indigent population as individuals earning 300% or less than the FPL without insurance (other than Medicare).

Table 8. 2015 Uninsured Population Below 300% FPL Who Are Not Eligible for Medicaid

Age	Number	Percent
0-18 years	185	0.3%
19-29 years	12,322	16.9%
30-49 years	28,060	38.4%
50-64 years	32,448	44.4%
Total	73,015	100.0%
Gender	**Number**	**Percent**
Male	50,912	69.7%
Female	22,102	30.3%
Total	73,015	100.0%
Race/Ethnicity	**Number**	**Percent**
Non-Hispanic White	40,188	58.6%
Non-Hispanic Black	830	1.2%
Hispanic	13,718	20.0%
Non-Hispanic other race	13,823	20.2%
Total	68,559	100.0%
Region	**Number**	**Percent**
Northern Colorado (Larimer, Weld, Logan, Sedgwick, Phillips, Morgan, Washington and Yuma counties)	7,504	10.3%
Southeast Colorado (Elbert, Lincoln, Kit Carson, Cheyenne, Crowley, Kiowa, Otero, Bent, Prowers, Baca, Las Animas, Huerfano, Saguache, Mineral, Rio Grande, Alamosa, Conejos, and Costilla counties)	2,858	3.9%
Denver Metro Area (Adams, Arapahoe, Boulder, Broomfield, Denver, Jefferson and Douglas counties)	38,476	52.7%
The Foothills (Gilpin, Clear Creek, Park, Teller, Lake, Chaffee, Fremont, and Custer counties)	2,975	4.1%
Southwest Colorado (Mesa, Delta, Gunnison, Montrose, San Miguel, Ouray, Hinsdale, Dolores, San Juan, Montezuma, La Plata, and Archuleta counties)	5,837	8.0%
Southern Front Range (El Paso and Pueblo counties)	6,938	9.5%
Northwest Colorado (Moffat, Routt, Jackson, Rio Blanco, Garfield, Eagle, Grand, Summit, and Pitkin counties)	8,427	11.5%
Total	73,015	100.0%
Did Not Get Needed Mental Health Care in Past 12 Months	**Number**	**Percent**
Yes	7,761	10.6%
No	65,254	89.4%
Total	73,015	100.0%
Self-Reported Mental Health Status	**Number**	**Percent**
Good mental health (less than 8 days of poor MH during past 30 days; ages 5+)	64,272	88.0%
Poor mental health (8 or more days of poor MH during past 30 days; ages 5+)	8,743	12.0%
Total	73,015	100.0%

Estimate of Uninsured and Underinsured with an SMI

THE estimated number of uninsured and underinsured with an SMI may be estimated by applying prevalence rates to CMHC population numbers.[67] These estimates by CMHC area are presented in Table 9. In 2015, there were approximately 21,865 individuals with an SMI that were uninsured and 53,963 individuals with an SMI that were underinsured. MCHD had the largest number of uninsured individuals with an SMI (3,513), followed by AspenPointe (3,123). AllHealth had the largest number of underinsured individuals with an SMI (7,294), followed by AspenPointe (7,168).

[67] Prevalence rates were taken from the National Survey on Drug Use and Health for Colorado, 2008-2011. Since the majority of uninsured fall in the age range of 19-64 (90%), the SMI prevalence rate for this age group (6.2%) was applied.

Table 9. Estimated Number of Uninsured and Underinsured Persons with SMI for 2015

CMHC	Estimated Uninsured in 2015 with SMI	Percent of Total Uninsured 2015 in with SMI	Estimated Underinsured in 2015 with SMI	Percent of Total Underinsured 2015 in with SMI
AllHealth	1,785	8.2%	7,294	13.5%
AspenPointe	3,123	14.3%	7,168	13.3%
Aurora	1,476	6.8%	3,654	6.8%
Axis	611	2.8%	844	1.6%
Centennial	468	2.1%	1,491	2.8%
CMH	386	1.8%	1,377	2.6%
Mind Springs	2,400	11.0%	4,449	8.2%
Community Reach	1,746	8.0%	4,083	7.6%
Health Solutions	726	3.3%	2,051	3.8%
Jefferson	1,090	5.0%	6,656	12.3%
MHCD	3,513	16.1%	4,431	8.2%
MHP	1,266	5.8%	3,869	7.2%
North Range	1,359	6.2%	2,019	3.7%
San Luis Valley	251	1.1%	451	0.8%
Solvista	315	1.4%	608	1.1%
Southeast	246	1.1%	646	1.2%
SummitStone	1,103	5.0%	2,868	5.3%
Statewide	21,865	100.0%	53,963	100.0%

The Underinsured and OBH Indigent Funding

The significant increase in the number of underinsured, including the number of underinsured with an SMI, suggests that individuals who would have previously met the OBH indigent income requirements (300% of the FPL or less) to receive services from a CMHC may now have health insurance, but also lack the money to meet the annual deductable, and perhaps co-payment amounts, needed to access behavioral health services. Information provided by the CBHC supports this observation, as several CMHCs report a large increase in the number of clients who do not meet the OBH indigent funding criteria as they have insurance, but do not have the funds to pay for services due to the relatively high annual deductable amounts for their insurance coverage. As a result, CMHCs report these individuals are often turned away, or prioritized for services after Medicaid clients, clients eligible for OBH indigent funding, and clients with other insurance.[68] A study conducted in 2009 indicated that 34 percent of insured people who had unmet mental health needs indicated that cost was a barrier to seeking treatment.[69]

With the enactment of the ACA and the requirement that all individuals have health insurance, OBH indicates the Office lacks authority to provide funding for individuals who have health insurance. Colorado statute prohibits health care providers from paying any required deductable or copayment of behalf of an individual. However, the statute appears to provide an exemption for mental health services purchased by OBH providers. Specifically, Section 18-13-119(5)(a) states that reimbursements made pursuant to the HCPF Colorado Indigent Care Program and the purchase of community mental health services by the Colorado Department of Human Services are exempt from this prohibition.[70] The decline in the number of individuals receiving OBH indigent services most likely reflects both the impact of Medicaid expansion and the increase in the number of underinsured.

Recommendation #2: The Governor's Office and OBH should examine the behavioral health and health insurance policy implications created as a result of the increase in the number of underinsured individuals and investigate methods to assist these individuals, particularly those with an SMI or SED, in obtaining behavioral health services.

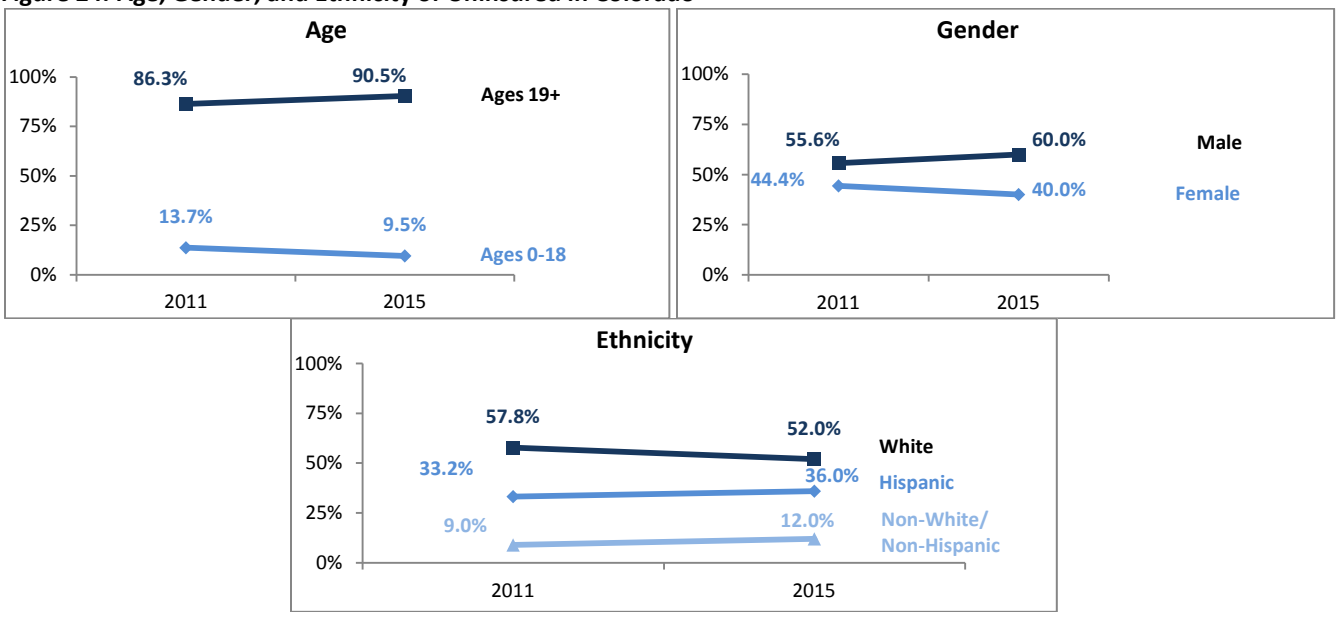
Demographic Profile of the Uninsured

Numbers of uninsured by demographics were obtained from the CHAS; the percent comprising each category are presented in Figure 25. From 2011 to 2015, the percent of uninsured youth declined by 4%, the percentage of the

[68] Focus group with Colorado Behavioral Healthcare Council members, July 20, 2016.
[69] The National Council for Community Behavioral Health Care and the National Alliance for Mental Illness. (June 2008). Coverage for All: Inclusion of Mental Illness and Substance Use Disorders in State Health Care Initiatives: Executive Summary. Retrieved October 1, 2016 at http://healthcareforuninsured.org/?p=4
[70] Ibid.

uninsured male population increased by 4%, and the proportion of uninsured who are white decreased by 6%. (Note that totals by demographics do not sum to the overall total due to missing values.)

Figure 24. Age, Gender, and Ethnicity of Uninsured in Colorado



The Estimated Population In Need of Behavioral Health Services

IN BRIEF

- The estimated number of individuals in Colorado (with incomes below 300% of the FPL) with a Serious Behavioral Health Disorder (SBHD) increased by 11% from 2007 to 2014 (from 219,112 to 242,740).
- An estimated 142,423 individuals with an SBHD (59%) received services in FY 2014-15.
- An estimated 100,316 individuals with an SBHD were not served in FY 2014-15; of these individuals, 54% were adults with an SUD, 20% were adults with an SMI, 20% were youth with an SED, and 6% were adults with a COD.
- MHCD, AspenPointe, Mind Springs, and AllHealth make up nearly half of the overall unmet need (46%).

This section of the report examines the estimated population of individuals with incomes below 300% of the FPL in need of behavioral health services by using estimates of the prevalence of an SBHD and the number of individuals receiving services.

- *Prevalence* is the number of people with an SBHD. SBHDs include adults with an SMI, an SUD, and a COD, as well as children and adolescents with an SED, which include co-occurring disorders.
- *Numbers served are* estimates of the percentage of population receiving services.
- *Unmet need* is an estimate of the persons who are in need of but not utilizing behavioral health services. Unmet need is calculated by subtracting the number of people served (or penetration rate) from the number of people with an SBHD (or prevalence). This information provides the unmet need by CMHC.

Prevalence Estimates

In 2009 WICHE conducted a Colorado Population In Need (PIN) study utilizing national consultants and extensive statistical techniques.[71] SBHD prevalence for CMHCs in 2014 were derived from applying percent change in the population age 0 – 17 and 18 and older from 2007 to 2014 to the 2007 SBHD prevalence estimates in the 2009 PIN study.[72] In comparison to the 2009 PIN study, the prevalence estimates methodology for this study is more limited in scope regarding the data sources and analytical procedures that were able to be employed. Consequently, caution should be used when comparing numbers

[71] WICHE, *Colorado Population in Need-2009*, November 2009.
[72] Population data was obtained from the State Demography Office website https://demography.dola.colorado.gov/. This data is reported by Calendar Year versus State Fiscal Year. Percent change = (2014 population – 2007 population)/2007 population).

from the 2009 PIN study to those in this study.[73] See Appendix J for additional details on the prevalence methodology for this study. Table 10 provides the estimated prevalence of SBHDs in 2014 by CMHC. (See Appendix J for 2014 prevalence estimates by age and gender.)

Table 10. Estimated Prevalence of SBHDs in 2014 by CMHC

CMHC	Youth (ages 0-17)	Adults (ages 18+)			SBHD Total
	SED	SMI Only	COD	SUD only	
AllHealth	4,219	6,309	960	4,671	16,159
AspenPointe	7,287	12,865	1,944	8,807	30,903
Aurora	3,452	5,243	837	3,874	13,406
Axis	983	2,495	383	1,754	5,615
Centennial	1,307	3,061	403	1,912	6,683
CMH	1,018	2,467	364	1,681	5,530
Community Reach	5,205	7,743	1,353	6,188	20,489
Health Solutions	2,427	5,239	711	3,175	11,552
Jefferson	3,717	7,806	1,229	5,599	18,351
MHCD	8,238	15,535	2,455	11,497	37,725
MHP	2,544	6,102	1,029	5,417	15,092
Mind Springs	3,657	7,791	1,287	5,998	18,733
North Range	3,680	5,883	979	4,877	15,419
San Luis Valley	709	1,252	169	823	2,953
Solvista	620	3,194	367	1,730	5,911
Southeast	610	1,917	243	1,118	3,888
SummitStone	2,256	5,884	997	5,194	14,331
Total	**51,929**	**100,786**	**15,710**	**74,315**	**242,740**

Estimated Number of Persons with a SBHD Served

To estimate the number persons with incomes below 300% of the FPL receiving services, persons served by any of the three systems (OBH MH indigent, publically funded OBH SUD admissions, or Medicaid capitation) were classified according to SBHD status on a matching CCAR.[74] (See Appendix J for additional details on SBHD classification methodology.) As shown in Table 11, 142,423 individuals with an SBHD were served in FY 2014-15; of those, 22% were youth. MHCD served the most individuals overall (24,921), followed by AspenPointe (19,261). Southeast served the fewest individuals (2,063), followed by Axis Health (2,353). Jefferson served the largest percentage of youth (35%), followed by Community Reach Center (Community Reach, 31%). Estimates by gender and race were not able to be calculated due to the amount of missing data for these demographic characteristics. It is important to note that number served data by CMHC may not be directly comparable as CMHCs use different methodologies to define the number of clients they serve.

[73] It is also important to note that due to methodological differences, caution should also be used when comparing numbers in this report to those in the WICHE, *Needs Analysis: Current Status, Strategic Positioning, and Future Planning*, April 2015.

[74] Indigent status does not apply to OBH SUD admissions or Medicaid capitation services thus; this PIN study includes all publically funded OBH SUD admissions and Medicaid capitation services. Individuals without matching CCAR's were classified in accordance with the known FY 2014-15 SED/SMI distribution of the relevant CMHC.

Table 11. Estimated Number of Individuals with SBHDs Served by OBH and Medicaid Capitation in FY 2014-15 by CMHC

CMHC	Youth (ages 0-17)	Adults (ages 18+)			SBHD Total
	SED	SMI Only	COD	SUD only	
AllHealth	917	2,855	512	1,343	5,627
AspenPointe	3,543	11,091	1,293	3,334	19,261
Aurora	3,506	6,839	451	1,251	12,047
Axis	434	1,324	227	368	2,353
Centennial	726	1,555	166	278	2,725
CMH	510	1,743	177	134	2,564
Community Reach	3,746	5,785	517	2,129	12,177
Health Solutions	1,831	6,904	753	1,092	10,580
Jefferson	5,998	8,228	910	1,917	17,053
MHCD	3,911	14,502	1,614	4,894	24,921
MHP	870	3,493	346	592	5,301
Mind Springs	1,658	4,770	984	639	8,051
North Range	1,583	3,766	477	590	6,416
San Luis Valley	506	1,472	255	430	2,663
Solvista	557	1,944	232	164	2,897
Southeast	368	1,251	192	252	2,063
SummitStone	1,177	3,136	556	855	5,724
Total	**31,841**	**80,658**	**9,662**	**20,262**	**142,423**

Estimated Unmet Need

Unmet need reflects the number of people with an SBHD who were not served and was calculated by subtracting the estimated number of persons served (Table 11) from the estimated prevalence of SBHDs (Table 10). See Appendix J for the estimated number of individuals needing services by CMHC. Table 12 presents the unmet need percentage for each CMHC by SBHD and age group. The unmet need percentage was calculated by dividing the unmet need by the estimated prevalence of SBHDs.

Over 40% (100,316) of individuals with a SBHD were not served in FY 2014-15. The majority of adults with an SUD (73%) were not served (54,052), while approximately 39% of adults with a COD (6,049) and youth with an SED (20,087) were not served, and 20% of adults with an SMI (20,128) were not served. Negative numbers indicate that the estimated number of individuals served was greater than the estimated prevalence of SBHDs. It is important to note that estimates of unmet need are impacted by CMHC methods for reporting number of persons served and the quality of data reported.

Most CMHCs had percentages of individuals with an SBHD who were not served that ranged from approximately 40% to 65%, while Aurora, San Luis Valley Behavioral Health Group (San Luis Valley), Health Solutions, and Jefferson had relatively small percentages (10%, 10%, 8%, and 7%, respectively). AllHealth had the largest percentage of youth with an SED who were not served (78%), followed by Mental Health Partners (MHP, 66%), while Jefferson had notably small percentage (-61%), likely due to the additional services this CMHC reports providing to youth. AllHealth had the largest percentage of adults with an SMI who were not served (55%), followed by Centennial (49%), while Health Solutions had the smallest percentage (-32%), followed by Aurora (-30%). MHP had the largest percentage of unmet need for COD (66%), followed by Community Reach (62%), while San Luis Valley had the smallest percentage (-51%), followed by Health Solutions (-6%). CMH had the largest unmet need percentage for SUD only (92%), followed by Solvista Health (Solvista, 90%), while San Luis Valley had the smallest percentage (10%), followed by MHCD (34%).

Table 12. Unmet Need Percentage by Age Group, SBHD and CMHC in FY 2014-15*

CMHC	Youth (ages 0-17)	Adults (ages 18+)			SBHD Total
	SED	SMI Only	COD	SUD only	
AllHealth	78.3%	54.7%	46.7%	71.2%	65.2%
AspenPointe	51.4%	13.8%	33.5%	62.1%	37.7%
Aurora	-1.6%	-30.4%	46.1%	67.7%	10.1%
Axis	55.8%	46.9%	40.7%	79.0%	58.1%
Centennial	44.5%	49.2%	58.8%	85.5%	59.2%
CMH	49.9%	29.3%	51.4%	92.0%	53.6%
Community Reach	28.0%	25.3%	61.8%	65.6%	40.6%
Health Solutions	24.6%	-31.8%	-5.9%	65.6%	8.4%
Jefferson	-61.4%	-5.4%	26.0%	65.8%	7.1%
MHCD	52.5%	6.6%	34.3%	57.4%	33.9%
MHP	65.8%	42.8%	66.4%	89.1%	64.9%
Mind Springs	54.7%	38.8%	23.5%	89.3%	57.0%
North Range	57.0%	36.0%	51.3%	87.9%	58.4%
San Luis Valley	28.6%	-17.6%	-50.9%	47.8%	9.8%
Solvista	10.2%	39.1%	36.8%	90.5%	51.0%
Southeast	39.7%	34.7%	21.0%	77.5%	46.9%
SummitStone	47.8%	46.7%	44.2%	83.5%	60.1%
Total	**38.7%**	**20.0%**	**38.5%**	**72.7%**	**41.3%**

*Negative numbers indicate that the estimated number of individuals served was greater than the estimated prevalence of SBHDs. County Designation source: CDPHE https://www.colorado.gov/pacific/cdphe/download-data-gis-format, data was updated to reflect the 2008-2012 Five-Year American Community Survey estimates and 2010 U.S. Census data.

3 - THE OBH INDIGENT AND MEDICAID CAPITATION SYSTEMS

The Behavioral Healthcare Needs of the OBH Indigent Population

IN BRIEF

- OBH indigent funding served a slightly more clinically severe population than the population served by Medicaid capitation. Multiple indicators of severity indicate that OBH indigent funding was critical for serving the most severe clientele. Although both funding sources served the whole range of the behavioral health population, the capitation program served more clients with less severe needs, as well as more children and youth.
- Services to reduce homelessness and unemployment were critical for the OBH indigent population. A significant proportion of the OBH indigent population was struggling with homelessness and unemployment, and homelessness, in particular, appeared to be associated with poor functioning and a higher cost of care. Similarly, recovery supports were needed to support individuals' post-acute treatment and prevent relapse.
- Nearly 80% of OBH indigent clients served in FY 2014-15 had an SMI, compared to 46% of Medicaid capitation clients. The percentage of OBH indigent and Medicaid capitation clients with an SED was more similar; nearly 20% of OBH indigent clients had an SED, compared to approximately 25% of Medicaid capitation clients.

This section of the report examines the behavioral healthcare needs of the OBH indigent population in an effort to identify priorities for OBH indigent funding. The clinical needs of the OBH indigent population are compared to the needs of the Medicaid capitation population.

Characteristics of OBH Indigent Clients Served in FY 2014-15[75]

Table 13 below shows the percent of OBH clients served in 2015 by CMHC who were homeless, unemployed, previously hospitalized and had an income below 300% of the FPL.

HOMELESSNESS[76]

Approximately 9% of the OBH indigent population was homeless, which is much higher than the 2015 statewide rate of homelessness (0.2%).[77] Homelessness is particularly high for MHP (19%), MHCD (15%), SummitStone Health Partners (SummitStone, 13%), AspenPointe (12%), and Mind Springs (12%). Southeast, Center for Mental Health (CMH), and Aurora Mental Health Center (Aurora) had the lowest rates of homelessness (1%, 2%, and 2%, respectively). See Appendix K for homelessness data by CMHC.

UNEMPLOYMENT[78]

Nearly half of the adult OBH indigent population was unemployed (49%), which was a substantially higher rate than the July 2015 statewide rate (3.8%).[79] Adult unemployment was highest for Community Reach (67%), closely followed by SummitStone (66%) and AspenPointe (61%). Solvista had the lowest unemployment rate (28%), followed by Jefferson (35%) and San Luis Valley (39%). See Appendix K for unemployment data by CMHC.

PRIOR HOSPITALIZATIONS[80]

Nearly one-half of the OBH indigent population had a prior psychiatric hospitalization (41%). Over half (58%) of MHCD clients had been previously hospitalized. SummitStone had the next highest rate (51%), closely followed by Health Solutions (50%) and Solvista (49%). Community Reach had the lowest prior hospitalization rate (14%), followed by San Luis Valley (19%) and Centennial (25%). See Appendix K for prior hospitalization data by CMHC.

[75] OBH clients were identified as indigent from the special studies code in the OBH encounter data.
[76] Homelessness for the OBH indigent population was determined from clients with a matching CCAR in FY 2014-15. The CCAR definition for homelessness is that the individual lacks a fixed, regular and adequate nighttime residence.
[77] National Alliance to End Homelessness. *The State of Homelessness in America,* 2016. Retrieved from: http://www.endhomelessness.org/page/-/files/2016%20State%20Of%20Homelessness.pdf.
[78] Unemployment for the OBH indigent population was determined from clients with a matching CCAR in FY 2014-15. The CCAR defines unemployment as the individual reporting not being employed, but may be looking for employment.
[79] State rate of unemployment retrieved from the U.S. Department of Labor, Bureau of Labor Statistics: http://beta.bls.gov/dataViewer/view/timeseries/LASST080000000000003;jsessionid=89D22CE2010F64D3E24E0C12D09EB536.tc_instance6
[80] Prior hospitalizations were determined from clients with a matching CCAR in FY 2014-15.

POVERTY RATES[81]

Need and poverty are related in that the majority of the uninsured population falls under 300% FPL. In addition, poverty rates are directly associated with the prevalence of behavioral health disorders. To assess the relative need for indigent services by CMHC, the poverty levels for each of the 17 CMHC areas were examined. Analyses showed that 10 CMHCs had poverty rates higher than the statewide average of 13.2%. The highest poverty rates were in Southeast (23.4%), San Luis Valley (22.5%), MHCD (19.1%), and Health Solutions (19.1%). The CMHCs with the lowest poverty rates were AllHealth (8.0%), Jefferson (8.7%), and Aurora (8.9%). The poverty rate in the remaining 10 CMHCs were within 1.9% of the statewide average. See Appendix K for poverty rates by CMHC.

Table 13. Percent of OBH Indigent Clients Served in 2015 who were Homelessness, Unemployed, Below Poverty, and Previously Hospitalized*

CMHC	Percent Homeless	Percent Unemployed	Percent of clients with prior hospitalization	Percent with Income Below 300% FPL
AllHealth	6.6%	40.2%	36.0%	8.0%
AspenPointe	12.3%	60.7%	57.6%	12.1%
Aurora	2.3%	47.5%	47.0%	8.9%
Axis	11.3%	56.8%	39.0%	13.5%
Centennial	4.3%	44.3%	24.6%	12.5%
CMH	2.3%	45.9%	32.9%	15.1%
Community Reach	4.0%	67.3%	14.1%	14.2%
Health Solutions	10.1%	39.5%	49.5%	19.1%
Jefferson	3.8%	35.4%	37.5%	8.7%
MHCD	14.6%	48.5%	44.8%	19.1%
MHP	19.0%	54.6%	46.7%	13.0%
Mind Springs	12.2%	52.2%	46.7%	12.8%
North Range	8.5%	53.6%	36.8%	14.7%
San Luis Valley	5.3%	39.0%	18.9%	22.5%
Solvista	3.5%	28.2%	49.4%	14.8%
Southeast	1.1%	47.0%	44.6%	23.4%
SummitStone	13.3%	66.2%	50.8%	14.1%
All CMHCs	8.9%	48.6%	40.5%	13.2%
Statewide rate	0.2%	3.8%	N/A	N/A

*OBH clients were identified as indigent from the special studies code in the OBH encounter data. Homelessness, unemployment, and prior hospitalizations were determined from clients with a matching CCAR in FY 2014-15. CCAR defines homeless as lacking a fixed, regular and adequate nighttime residence and unemployment not being employed but may be looking for employment. County poverty levels were obtained from 2009-2013 census data and combined into CMHC area via a weighted average. The state rate of homelessness was retrieved from the National Alliance to End Homelessness, *The State of Homelessness in America,* 2016 (http://www.endhomelessness.org/page/-/files/2016%20State%20Of%20Homelessness.pdf). The state rate of unemployment was retrieved from the U.S. Department of Labor, Bureau of Labor Statistics (http://beta.bls.gov/dataViewer/view/timeseries/LASST080000000000003;jsessionid=89D22CE2010F64D3E24E0C12D09EB536.tc_instance6).

Clinical Severity of OBH Indigent Clients and Medicaid Capitation Clients Admitted in FY 2014-15

The CCAR is administered to all indigent and Medicaid individuals served in the public mental health system when they enter treatment, annually, at discharge from services, and when there is a change in a client's diagnosis, employment, living arrangement, residence, or status. It contains a clinician rating of 25 domains that relate to wellbeing, mental health, and social functioning that are rated on a 1-9 point scale, with a score of 9 indicating the greatest severity, and a score greater than or equal to 5 indicating symptoms of clinical concern or an "elevated" domain score. [82]

For each CCAR domain, the percentages of OBH indigent vs. Medicaid capitation clients with clinically elevated scores (> 5) at admission were compared.[83] Detailed findings are provided in Appendix M. Analyses revealed that OBH indigent funding served a slightly more clinically severe population than Medicaid capitation. A greater proportion of OBH indigent clients had higher elevated symptom severity levels compared to Medicaid capitation clients on 22 of the 25 domains. Results indicate that OBH indigent clients were more likely to have poor social support systems and socialization skills, be in greater need of supervision, be a danger to themselves or others, as well as have more history of mental health, substance use, and

[81] Poverty levels for each of the counties were obtained from 2009-2013 U.S. census data, and combined into CMHC area via a weighted average. Poverty status is determined by comparing annual income to poverty thresholds. If a family's/individual's pre-tax income less is than the threshold the family/individual is considered to be in poverty.

[82] See Appendix L for a copy of the CCAR Outcome Section items and a description of CCAR outcome domains.

[83] CCAR admissions data was used in order to provide a representation of the clinical severity of population admitted in FY 2014-15. CCAR admission data presented is based on clients with a matching admissions CCAR in FY 2014-15.

legal issues. Of those 12 domains, depression had the greatest difference (11%), followed by legal issues (7%) and mania (5%). More than half of OBH indigent clients were likely to display symptoms warranting clinical concern related to their overall mental health (85%), depression (67%), anxiety (54%), and recovery (53%). See Appendix M for the percent difference between OBH indigent and Medicaid capitation clients.

Analyses by CMHC showed that AllHealth had a larger percentage of OBH indigent clients with elevated symptoms at admission compared to the statewide average for all 25 domains. The percentage of OBH indigent clients with elevated depression symptoms was high for Solvista (91%), North Range Behavioral Health (North Range, 77%), AspenPointe (75%), and All Health (73%). AllHealth, Solvista, and Southeast had high levels of clinical severity in overall level of functioning (90%, 86%, and 77%, respectively). Nearly all AllHealth, Solvista, Community Reach, and Aurora OBH indigent clients had elevated overall symptom severity scores (98%, 98%, 95%, and 95%, respectively). See Appendix M for detailed data by CMHC.

SED/SMI and Diagnosis Frequency - OBH Indigent vs. Medicaid Capitation

Information from the CCAR is used to capture an individuals' SED/SMI status. As shown in Table 14, nearly 80% of OBH indigent clients served in FY 2014-15 had an SMI, compared to 46% of Medicaid capitation clients. The percentage of OBH indigent and Medicaid capitation clients with an SED was more similar; nearly 20% of OBH indigent clients had an SED, compared to approximately 25% of Medicaid capitation clients. Results suggests that the need for OBH indigent funding is driven more by severe and persistent mental illness, whereas Medicaid funding may be better suited to address less persistent behavioral health challenges among the general low-income population.

Table 14. Percent of OBH Indigent and Medicaid Capitation Clients Served in FY 2014-2015 with an SED/SMI*

SMI/SED Status	OBH Indigent	Medicaid Capitation
Youth (ages 0-17) with SED	18.4%	25.3%
Adults (ages 18+) with SMI	77.6%	45.8%

*Includes data for specialty clinics (Asian Pacific Development Center and Servicios de la Raza

Analyses by CMHC showed that Aurora Mental Health Center (Aurora) had the highest percentage of OBH indigent clients with an SED (40%), followed by Axis Health (37%) and North Range (34%). AllHealth had the lowest percentage of OBH indigent clients with an SED (2%), followed by Health Solutions (6%) and Community Reach (9%). Health Solutions had the highest percentage of OBH indigent clients with an SMI (94%), followed by Mind Springs (89%) and San Luis Valley (88%). AllHealth and Aurora had the lowest percentage of OBH indigent clients with an SMI (57%), followed by Axis Health (63%). See Appendix M for detailed data by CMHC.

The CCAR also captures an individuals' primary and secondary psychiatric DSM diagnosis and substance abuse diagnosis.[84] Examining the primary and secondary diagnosis (the diagnosis frequency) for OBH indigent and Medicaid capitation clients helps delineate what, if any, differences in the relative need for services by diagnostic category exist between these two populations. Appendix M displays the diagnosis frequency for OBH indigent and Medicaid clients served in FY 2014-15. It is important to note that diagnostic information was missing for some clients with a matching CCAR. The most frequent diagnosis for both groups was major depression; OBH indigent clients had a slightly larger percentage of clients with this diagnosis (28%) compared to Medicaid capitation clients (21%). Anxiety was the second most frequent diagnosis for both groups; Medicaid capitation clients had a slightly larger percentage of clients with this diagnosis (26%) compared to Medicaid capitation clients (24%). Medicaid clients also had higher rates of conduct disorder (3%) and attention deficit disorder (5%) compared to OBH indigent clients (1% and 2%, respectively), which likely stemmed from services provided to children and youth as Medicaid is the primary funding source to address the behavioral health needs of children and youth.

[84] DSM stands for the Diagnostic and Statistical Manual of Mental Disorders, developed by the American Psychiatric Association, to serve as a guide for classifying mental disorders. The CCAR captures an individual's Primary Psychiatric Axis I, Primary Psychiatric Axis II, Secondary Psychiatric Axis I, and Substance Abuse diagnosis. Axis I includes diagnostic categories except personality disorders and intellectual disabilities. Axis II includes only personality disorders and intellectual disabilities.

Costs of the OBH Indigent Population

IN BRIEF

- Analyses were conducted to determine if the OBH indigent average service cost was related to CCAR clinical severity domains or demographic characteristics. There was no clear evidence that cost of care, as compared in two cost groups, was linked to a clinically elevated CCAR score.
- OBH indigent individuals with an SED/SMI who were homeless and unemployed were more likely to have increased cost of care.
- Overall, OBH indigent clients with an SED/SMI had a higher average service cost ($2,573) than indigent clients without an SED/SMI ($2,110). However, in 65% of the CMHCs, indigent clients without an SED/SMI had a higher average service cost than indigent clients with an SED/SMI.

This section of the report examines the relationship between OBH indigent clinical severity or demographic characteristics and the average cost of services provided to these individuals.

Service Costs and Clinical Severity

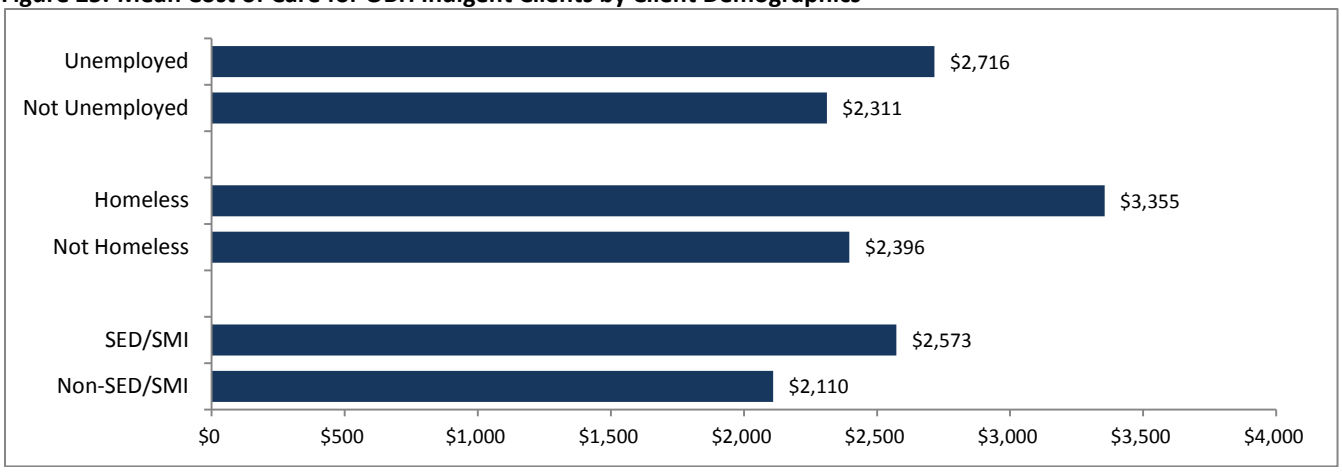
CCAR DOMAINS AND COST OF CARE

To compare cost of care with CCAR clinical severity domains, average FY 2014-15 OBH indigent client cost of care was split into two categories, a high cost (highest 25% cost of care) category and a low cost (lower 75%) category. Those in the high cost category were compared to those in the low cost category based on the frequency of having a clinically elevated domain score (> 5). The average cost for the high cost group was $7,582 (n=2,592) and $780 (n=7,776) for the low cost group. However, none of the differences between the high cost and low cost groups were statistically meaningful. Thus, there is no clear evidence that cost of care, as compared in two cost groups, is linked to a clinically elevated score in any particular domain. This does not mean, however, that severity of illness isn't linked to cost of care, only that this relationship was not captured within the CCAR data. See Appendix N for detailed results of clinically elevated CCAR rating by Cost Category.

DEMOGRAPHIC CHARACTERISTICS AND COST OF CARE

Figure 26 displays demographic characteristics that had statistically meaningful differences in cost of care. Results showed that individuals who had an SED/SMI diagnosis, were homeless, or were unemployed were more likely to have increased cost of care.[85] There were no significant differences for age, gender, or race. See Appendix N for detailed cost of care analysis.

Figure 25. Mean Cost of Care for OBH Indigent Clients by Client Demographics



Total average cost per indigent client, as well as per indigent client with and without an SED/SMI as indicated by a matching CCAR, is shown in Table 15. Using the statewide average, indigent clients with an SED/SMI had a higher average cost ($2,573) than indigent clients without an SED/SMI ($2,110). However, for 65% of the CMHCs, indigent clients without an SED/SMI had a higher average cost than indigent clients with an SED/SMI. The average cost was higher for indigent clients with an SED/SMI in six CMHCs (AllHealth, AspenPointe, Health Solutions, MHCD, Mind Springs, and Solvista). MHCD had the

[85] Analysis of Variance (ANOVA) was run. Values of $p < .05$ are considered significant.

largest average cost difference between indigent clients with an SED/SMI and without an SED/SMI ($3,683), followed by Centennial (-$1,331) and MHP (-S766).

Table 15. FY 2014-15 CMHC Average Cost Per OBH Indigent Client*

CMHC	Average Cost per Indigent Client	Average Cost per Indigent Client with a SED/SMI	Average Cost per Indigent Client without a SED/SMI
AllHealth	$1,614	$1,725	$1,551
AspenPointe	$4,413	$4,454	$4,311
Aurora	$3,284	$3,251	$3,887
Axis	$1,409	$1,378	$1,517
Centennial	$1,677	$1,574	$2,906
CMH	$1,322	$1,311	$1,742
Community Reach	$1,500	$1,491	$1,569
Health Solutions	$2,373	$2,235	$2,083
Jefferson	$984	$1,805	$1,980
MHCD	$6,146	$6,523	$2,840
MHP	$2,235	$2,053	$2,819
Mind Springs	$787	$909	$805
North Range	$599	$713	$861
San Luis Valley	$1,188	$1,088	$1,332
Solvista	$2,317	$2,441	$1,899
Southeast	$2,966	$2,148	$2,290
SummitStone	$1,656	$1,665	$1,775
Total	$1,749	$2,573	$2,110

*Total cost includes data for specialty clinics (Asian Pacific Development Center and Servicios de la Raza).

Service Utilization by Medicaid Capitation and OBH Indigent Populations

IN BRIEF

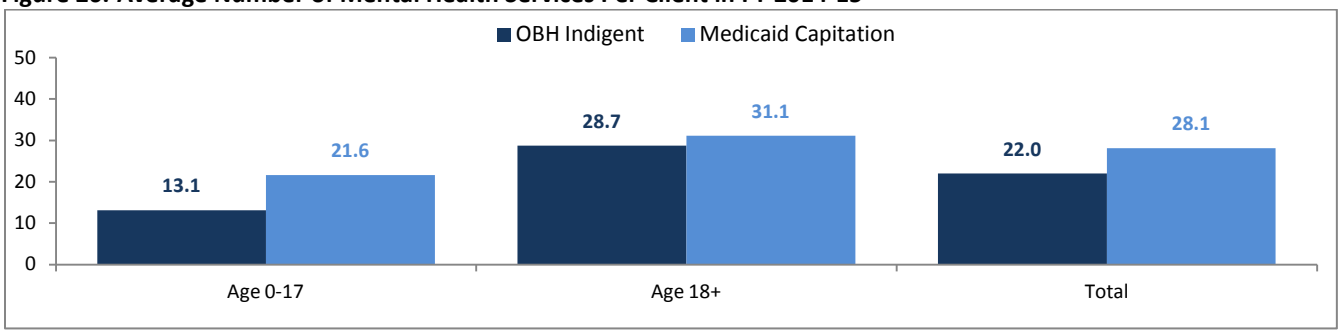
- On average, capitation clients received 28% more mental health services (28) in FY 2014-15 than OBH indigent clients (22). Adult capitation clients received 9% more mental health services (31) than adult indigent clients (29), while capitation clients under the age of 18 received 65% more mental health services (22) than indigent clients under the age of 18 (13).
- The difference in the average number of mental health services received by OBH indigent clients, in comparison to Medicaid capitation clients, may indicate that disparities exist in meeting the needs of these two populations.
- OBH SUD service data was underreported as providers began submitting substance use encounter data as of July 1, 2014 and many are still implementing data reporting to OBH. Thus, OBH substance use service data is excluded from analyses since these data were neither complete nor representative of the total number of SUD services provided.
- Significant differences existed between the average number of services provided by BHO for capitation clients (33), with ABC-D and BHI providing over the statewide average number of services (60 and 36, respectively) and the three other BHOs providing less than the average.
- Significant variation existed between the average number of services provided by CMHC for indigent clients (22), with MHCD, SummitStone, AspenPointe, and Southeast providing over the statewide average number of services (120, 45, 32, and 27, respectively).

This section of the report examines the average number of services provided to OBH indigent and Medicaid capitation clients and provides information by BHO and CMHC.

Comparison of Mental Health Services - OBH Indigent and Medicaid Capitation

As shown in Figure 27, Medicaid capitation clients, on average, received more mental health services than OBH indigent clients. The difference in the average number of mental health services received by OBH indigent clients, in comparison to Medicaid capitation clients, may indicate that disparities exist in meeting the needs of these two populations, especially given the information provided earlier that indicates OBH indigent funding served a slightly more clinically severe population than Medicaid capitation.

Figure 26. Average Number of Mental Health Services Per Client in FY 2014-15

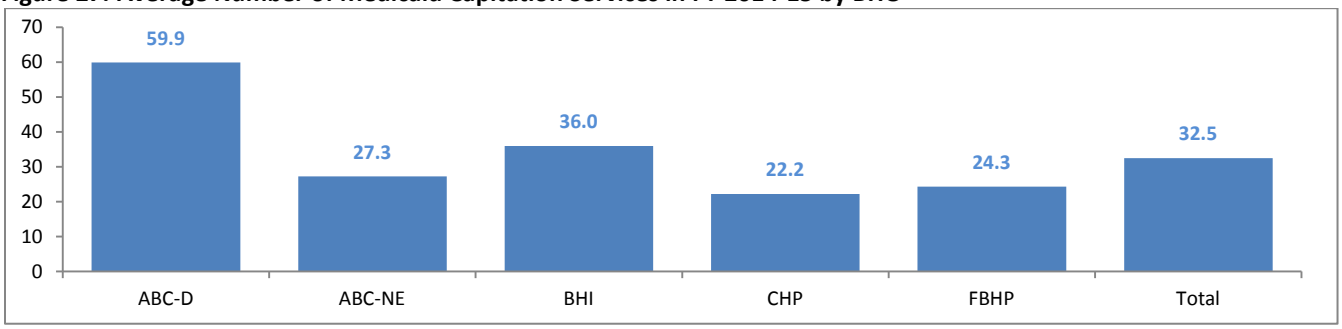


Medicaid Capitation Services Per Client [86]

UTILIZATION BY BHO

Significant variance existed between the average number of services provided by BHO. As illustrated in Figure 28 ABC-D provided the greatest number of average services per client among BHOs and almost double the average number of services statewide. CHP provided the fewest number of services per client and joined ABC-NE and FBH in providing less than the statewide average. (See Appendix O for total and average services by BHO and age group.)

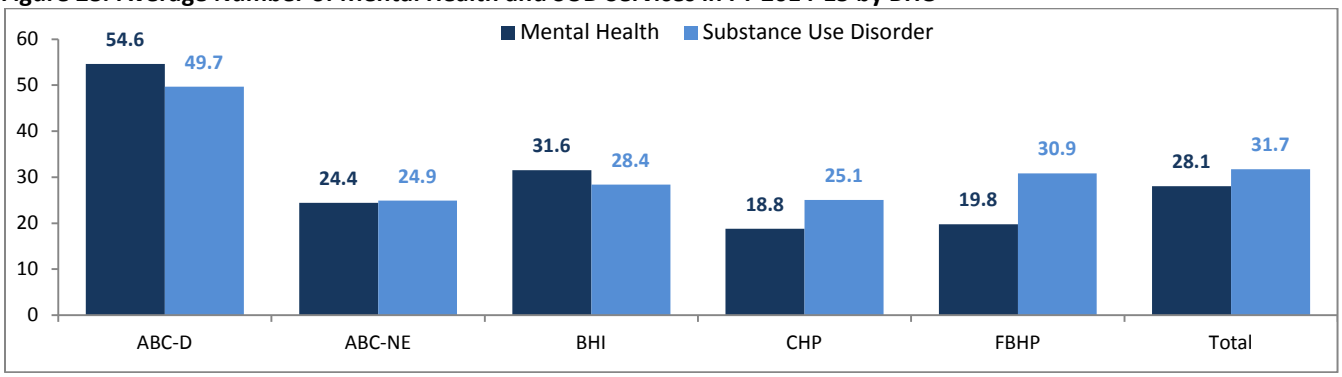
Figure 27. Average Number of Medicaid Capitation Services in FY 2014-15 by BHO



MENTAL HEALTH VS. SUBSTANCE USE UTILIZATION

As illustrated in Figure 29, on average, BHO clients received about the same number of mental health services (28) as SUD services (32). Significant variance existed in the average number of services provided by BHO. ABC-D provided the greatest number of mental health and SUD services per client and provided almost twice as many mental health services as the statewide average. Three BHOs (ABC-NE, CHP, and FBHP) provided less than the statewide average number of mental health services, while all BHOs but ABC-D provided less than the statewide average number of SUD services.

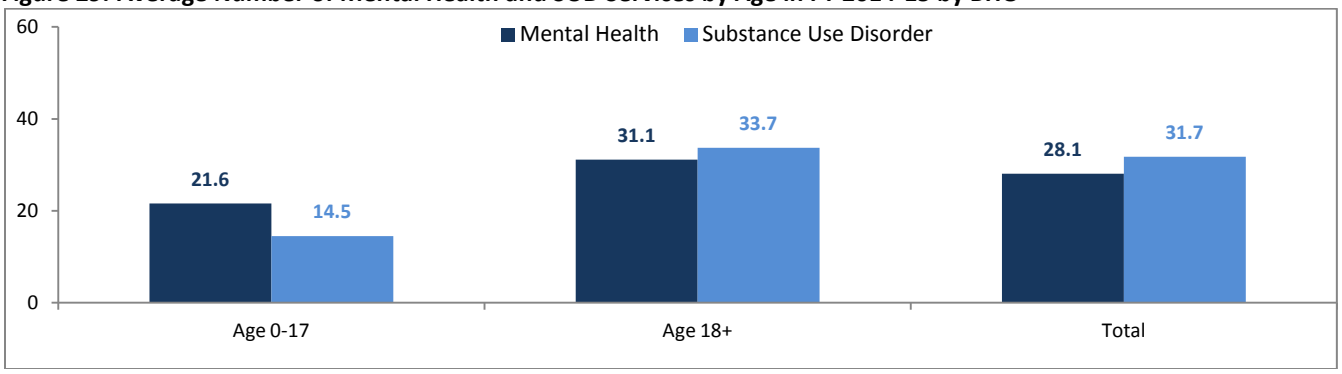
Figure 28. Average Number of Mental Health and SUD Services in FY 2014-15 by BHO



[86] Medicaid capitation utilization was calculated from all mental health encounters submitted and processed by HCPF for the Medicaid capitation program. Processed claims are those that meet the criteria for inclusion in the mental health benefit (e.g., denied claims are excluded). Clients served may differ from the total number served due to missing service cost values; not all services have assigned costs, if cost could not be determined a client was excluded from analyses.

As presented in Figure 30, adults received approximately the same number of mental health and SUD services, while youth received more mental health services than SUD services.

Figure 29. Average Number of Mental Health and SUD Services by Age in FY 2014-15 by BHO



SERVICE UTILIZATION BY SERVICE CATEGORY

Psychotherapy had the largest total number of services (926,345), followed by prevention/early intervention (747,537). Intensive treatment had the greatest mean units of service (106), followed by rehabilitation services (51), and substance use (45). Assessment and evaluation had the lowest mean units of service (2 and 3, respectively). See Appendix O for details about utilization by service category.

OBH Indigent Services Per Client[87]

UTILIZATION BY CMHC

Significant variance existed between the average number of services provided by CMHCs for indigent clients. In comparison to the statewide average number of services (22), the majority of CMHCs provided less than the average, while four (MHCD, SummitStone, AspenPointe, and Southeast) provided more than the average, and AllHealth provided approximately the average. In each CMHC, adults received the majority of services, with the exception of Jefferson where youth received 74% of services. Jefferson conducts mental health screenings within schools, which adds significantly to their reported numbers of clients served. The average number of services youth received ranged from 6 (North Range) to 32 (AspenPointe). The average number of services adults received ranged from 8 (Mind Springs) to 127 (MHCD). (See Appendix O for OBH indigent service utilization by CMHC, including by age group.)

MENTAL HEALTH VS. SUBSTANCE USE UTILIZATION

Providers, both MSOs and CMHCs, began submitting substance use encounter data to OBH as of July 1, 2014; however, data for FY 2014-15 were neither complete nor representative of the total number of SUD services provided. Therefore, data showing separate average mental health and SUD service utilization rates were not available.

SERVICE UTILIZATION BY SERVICE CATEGORY

Prevention/early intervention services were received by the largest number of clients (180,400), the majority of which were provided to youth (105,604). This finding is not unexpected, as community prevention services aim to reach a broad array of individuals. See Appendix O for FY 2014-15 utilization data by service category.

[87] Indigent status of OBH clients was identified via a matching CCAR marked as indigent in FY 2011-12 or an OBH encounter record marked as indigent in FY 2014-15.

Average Cost of Services by Medicaid Capitation and OBH Indigent Populations

IN BRIEF

- Average FY 2014-15 capitation mental health services cost per client ($2,425) was 39% higher than the average OBH indigent cost per client ($1,749).
- Average FY 2014-15 capitation SUD services cost per client equaled $1,040 in FY 2014-15, significantly below the average capitation mental health services cost per client of $2,425.
- Variations in the average cost of services between capitation clients and OBH indigent clients are not directly comparable, as Medicaid capitation includes a broader range of services, including inpatient and residential treatment, than OBH indigent funding.
- OBH indigent SUD service data was underreported as providers began submitting substance use encounter data as of July 1, 2014 and many are still implementing data reporting to OBH. Thus, OBH substance use service data is excluded from analyses since these data were neither complete nor representative of the average cost of SUD services provided.
- Variations in the average cost of services per client reflect differences in the proportion of more, or less, expensive services provided per client.
- Variations between BHOs and between CMHCs may be due to several factors, including differences in operating costs between BHOs, differences in client service needs, and differences in the resources available by BHO to meet client service needs.

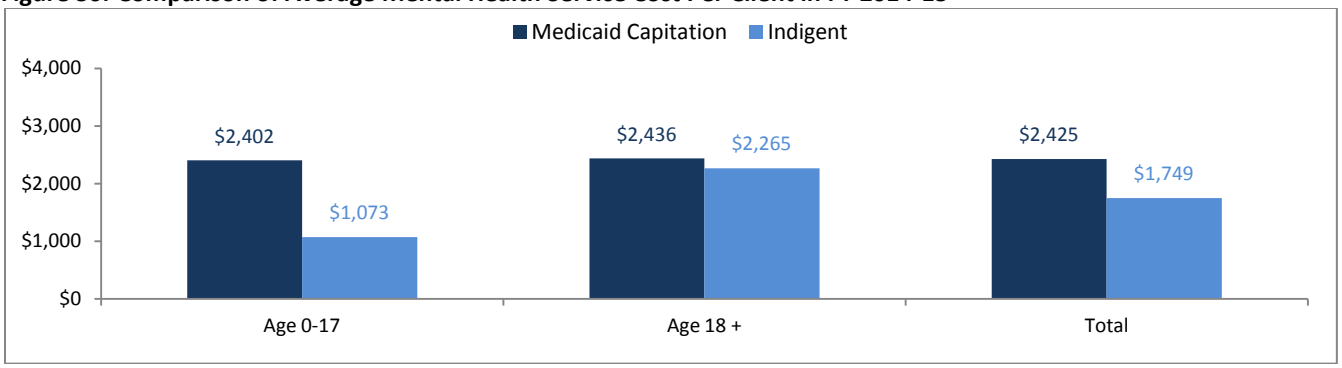
Methodology

The data in this section represents the average cost of all services provided to clients. Capitation cost of service data was aggregated from priced encounters provided by HCPF. OBH indigent average cost of service data was calculated using FY 2014-15 Relative Value Unit (RVU) costs for each service, as provided by OBH.[88] Both capitation and OBH used the same base cost per service, thus allowing cost comparisons. Costs were summed and averaged by unduplicated clients served by the BHOs and the CMHCs. Cost data for specialty clinics (Asian Pacific Development Center and Servicios de la Raza) was included in the indigent totals. Comparable cost data were not available for FY 2011-12 so only FY 2014-15 data were provided. Also, data provided in this section does not include pharmaceutical costs.

Comparison of Medicaid Capitation and OBH Indigent Costs

As shown in Figure 31, the average cost of services per Medicaid capitation client ($2,425) was 39% higher than the average OBH indigent client cost ($1,749). On average, BHO service costs for capitation youth were 139% greater than OBH service costs for indigent youth. Service costs for adults were not as disparate, with capitation costs exceeding indigent costs by 8%. Variations in the average cost of services between capitation clients and OBH indigent clients are not directly comparable, as capitation provides a broader range of services than OBH indigent funding. (Appendix P provides the average costs of services by service category for Medicaid capitation and OBH indigent.)

Figure 30. Comparison of Average Mental Health Service Cost Per Client in FY 2014-15



*Total cost includes data for specialty clinics (Asian Pacific Development Center and Servicios de la Raza).

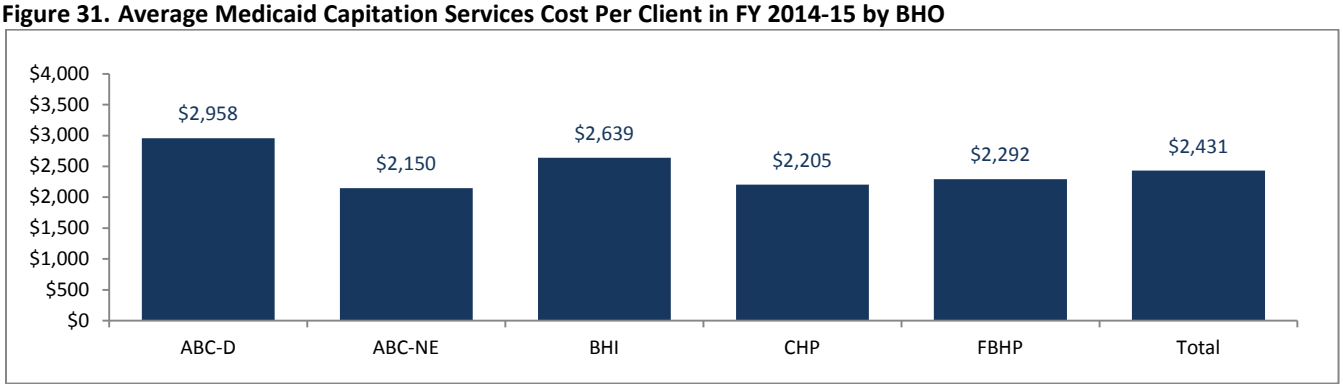
[88] OBH encounters were priced using Relative Value Units (RVUs) applied to CMHC base unit costs. RVU's are used by Medicare to determine the fee for each service. RVU rank on a common scale the resources used to provide each service. The fee is arrived at by multiplying the RVU by a cost factor. In this case, CMHC's provide a supplemental schedule with their annual audit that provides a base unit cost, the dollar conversion factor.

Medicaid Capitation Average Service Costs

BHO AVERAGE SERVICE COST PER CLIENT

As shown in Figure 32, two BHOs, ABC-D and BHI, have average service costs greater than the state average, while the remaining three BHOs (ABC-NE, CHP, and FBHP) have average costs below the state average. Variations between BHOs may be due to several factors, including differences in operating costs between BHOs, differences in client service needs, and differences in the resources available by BHO to meet client service needs.

Figure 31. Average Medicaid Capitation Services Cost Per Client in FY 2014-15 by BHO

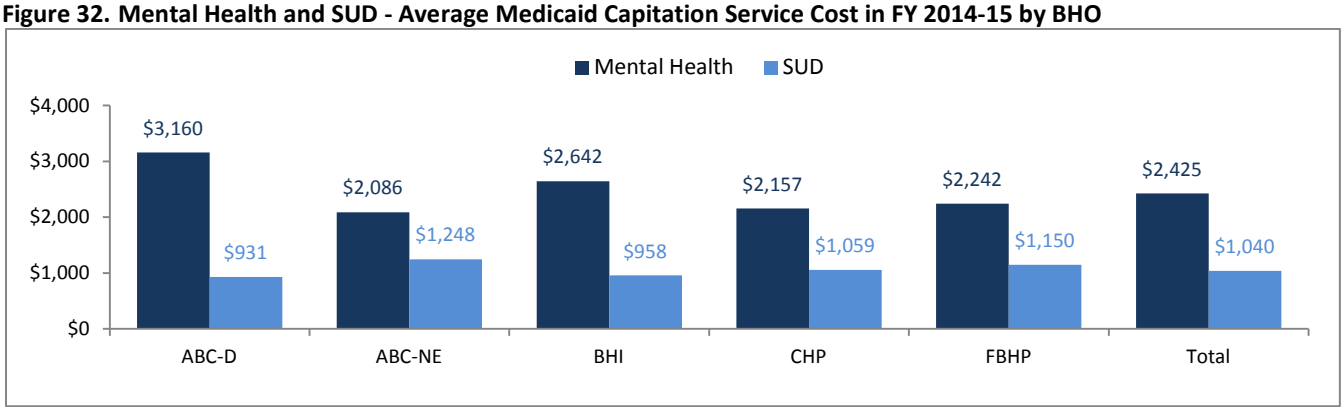


BHO AVERAGE MENTAL HEALTH AND SUD SERVICE COSTS

As illustrated in Figure 33, average services cost per Medicaid capitation client across the state for SUD services equaled $1,040 in FY 2014-15, significantly below the average mental health services cost per client of $2,425. This difference is due to the type of SUD services covered under capitation. Covered SUD services are limited to assessment, counseling and therapy, and case management, while covered mental health services include several higher cost service categories, such as residential and inpatient treatment.

More variance existed between BHOs for mental health service costs, with ABC-D having the highest average cost at $3,160, 30% greater than the statewide average ($2,425). Differences in average costs may be due to several factors, including differences in operating costs between BHOs, differences in client service needs, and differences in the resources available by BHO to meet client service needs.

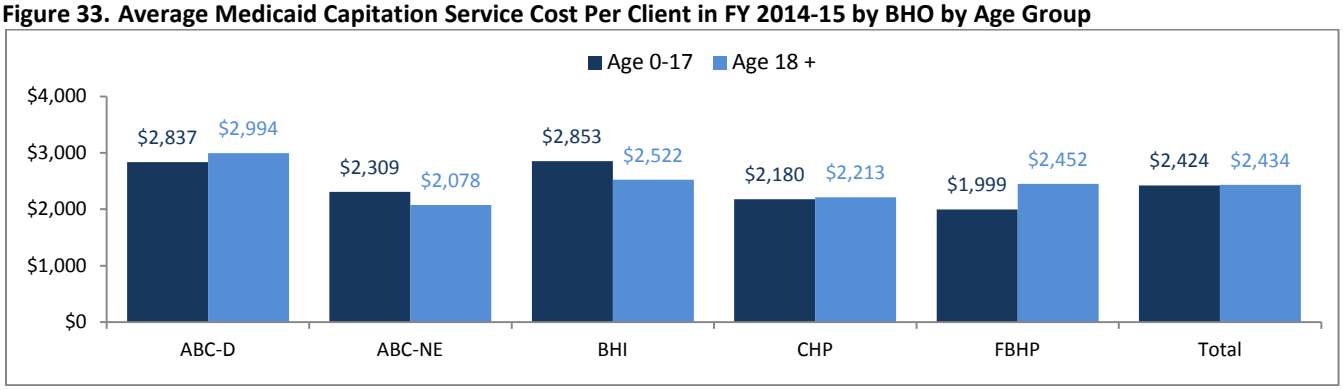
Figure 32. Mental Health and SUD - Average Medicaid Capitation Service Cost in FY 2014-15 by BHO



BHO AVERAGE SERVICE COST FOR CHILDREN AND ADULTS

As presented in Figure 34, statewide average service cost for children and adults served by the BHOs were almost identical in FY 2014-15 at $2,424 and $2,434, respectively. ABC-D, CHP, and FBHP had higher average service costs for adults; variations ranged from a difference of $453 for FBHP to a minimal $33 difference for CHP.

Figure 33. Average Medicaid Capitation Service Cost Per Client in FY 2014-15 by BHO by Age Group

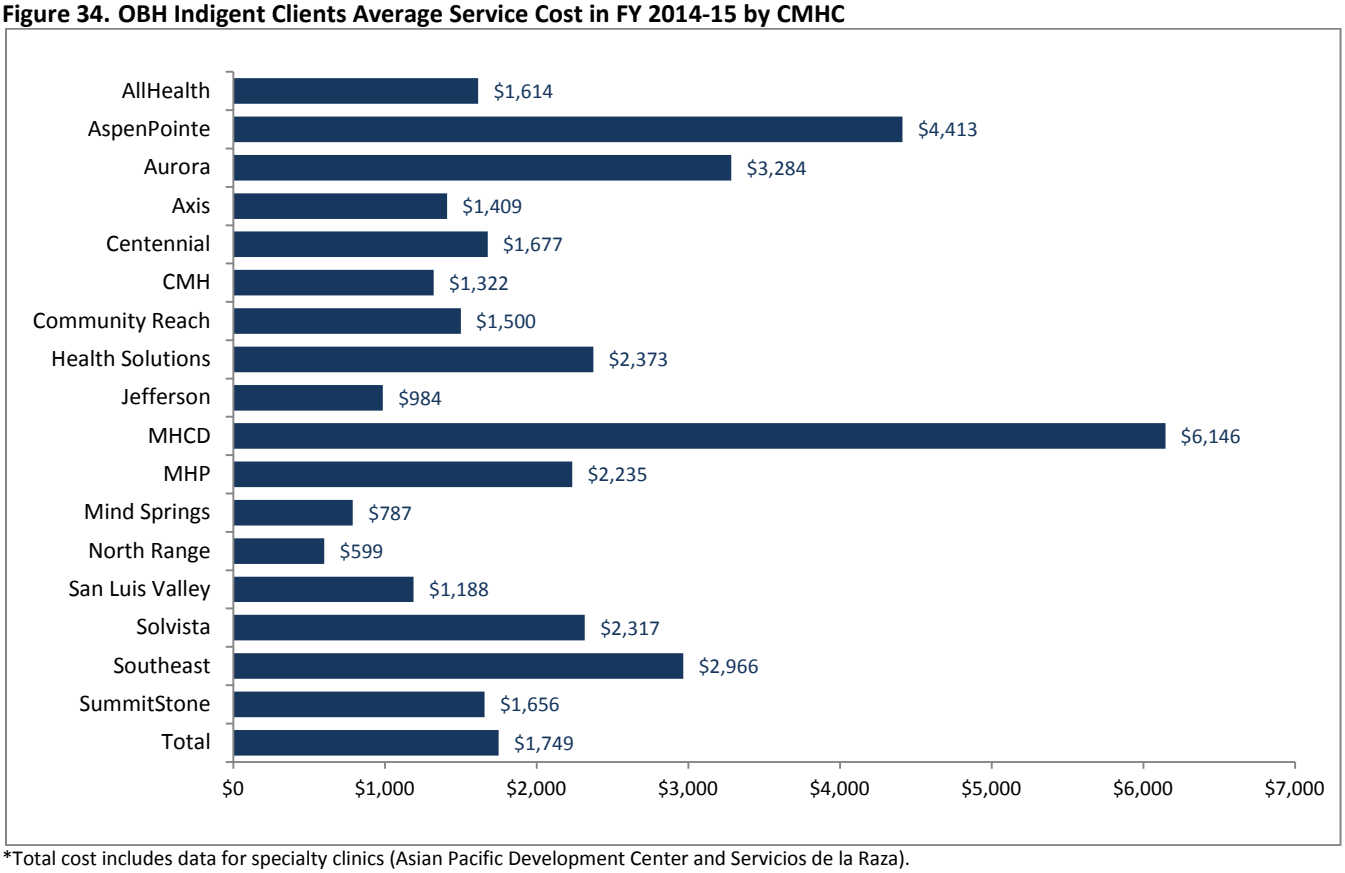


OBH Indigent Average Cost of Services

AVERAGE INDIGENT SERVICE COST BY CMHC

As displayed in Figure 35, while the statewide average service cost per client was $1,749 in FY 2014-15, cost per CMHC ranged from a high of $6,146 for MHCD to a low of $599 for North Range. Significant difference exists between the highest and lowest average service cost for indigent clients. Variations between CMHCs may be due to several factors, including differences in operating costs between CMHCs, differences in client service needs, and differences in the funds and resources available by each CMHC to meet client service needs.

Figure 34. OBH Indigent Clients Average Service Cost in FY 2014-15 by CMHC

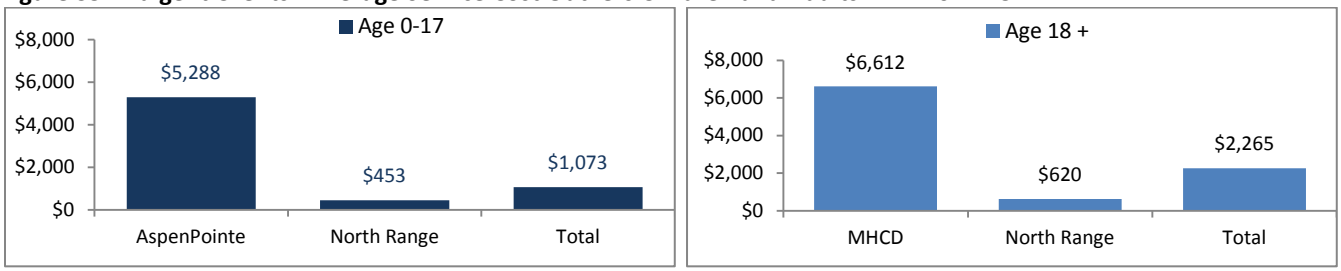


*Total cost includes data for specialty clinics (Asian Pacific Development Center and Servicios de la Raza).

INDIGENT COSTS FOR CHILDREN AND ADULTS

Unlike the BHO costs, a significant variation existed between the average indigent service cost for children and adults. The average adult cost was 63% greater than the average cost for children, as illustrated in Figure 36. In addition, the variance in average service cost between CMHCs was quite large as well, with AspenPointe having an average cost over 10 times greater than North Range for children and MHCD having an average cost over 10 times greater than North Range for adults. (Average service cost by age group by CMHC is provided in Appendix P.)

Figure 35. Indigent Clients - Average Service Cost Outliers Children and Adults in FY 2014-15



*Total cost includes data for specialty clinics (Asian Pacific Development Center and Servicios de la Raza).

OBH Indigent Funding - Prioritized Populations and Services

OBH Indigent Service Needs

An objective of this study was to examine the behavioral health needs of the OBH indigent population and also compare services and costs between the OBH indigent population and the Medicaid capitation population. As presented earlier, OBH indigent funding served a slightly more clinically severe population than Medicaid capitation. Multiple indicators of severity indicated that OBH indigent funding was critical for serving the most severe clientele. Although both funding sources served the whole range of the behavioral health population, the capitation program served more clients with less severe needs, as well as more children and youth. A significant proportion of the OBH indigent population was struggling with homelessness and unemployment, and homelessness, in particular, appeared to be associated with poor functioning and a higher cost of care. Similarly, recovery supports were needed to support individuals' post-acute treatment and prevent relapse.

Services to reduce homelessness and unemployment are critical for the indigent population, as data indicated that a significant proportion of the indigent population admitted in FY 2014-15 was homeless and/or unemployed, and being homelessness or unemployed were associated with a higher cost of care. Prevention, engagement, and support services were often the most frequently cited needs in the 2015 WICHE Colorado Statewide Behavioral Health Needs Analysis.[89] OBH indigent clients, based on their clinical profile, would benefit from these services:

- "Supportive housing" pairs affordable housing with physical health, behavioral health, and supportive services for individuals who are experiencing homelessness. Supportive housing as an intervention has been shown to significantly reduce health care expenditures.[90]
- Supported employment, implemented as an evidence-based practice, will continue to improve access to jobs. The 2015 WICHE Colorado Statewide Behavioral Health Needs Analysis identified that many agencies are already implementing this evidence-based practice for a portion of their clients.[91] Wider implementation would help alleviate the shortage of available jobs and the lack of employment services for people with disabilities. The Individual Placement and Support/Supported Employment model should be a mandatory program for all providers serving adults, and targets should be at least 10% of all adults served.
- The use of peer specialists, or other navigators or health coaches, improves patients' ability to self-manage physical and behavioral health needs, resulting in increased use of primary care.[92] OBH currently provides funding for transition specialists to support 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. Flexibility should also be allowed to fund similar services from other indigent fund allocations.

The difference in the average number of mental health services received by OBH indigent clients, in comparison to Medicaid capitation clients, may indicate that disparities exist in meeting the needs of these two populations. While the OBH indigent population served in FY 2014-15 was slightly more clinically severe than the Medicaid capitation population, on average, capitation clients received 28% more mental health services (28) in FY 2014-15 than OBH indigent clients (22). Adult capitation clients received 9% more mental health services (31) than adult indigent clients (29), while capitation clients under the age of 18 received 65% more mental health services (22) than indigent clients under the age of

[89] WICHE, *Needs Analysis: Current Status, Strategic Positioning, and Future Planning*, April 2015.
[90] Wright, B. J., Vartanian, K. B., Li, H., Royal, N., & Matson, J. K. "Formerly Homeless People Had Lower Overall Health Care Expenditures After Moving Into Supportive Housing", *Health Affairs*, 35 (1), 2016, 20-27.
[91] WICHE, *Needs Analysis: Current Status, Strategic Positioning, and Future Planning*, April 2015.
[92] Croze, C. *Healthcare integration in the era of the Affordable Care Act*, July 2015. Retrieved from: http://www.abhw.org/publications/pdf/IntegrationPaper.pdf.

18 (13). Comparisons of the number of SUD services provided between OBH indigent populations and Medicaid capitation populations are not possible given SUD providers were only required to submit encounter data beginning in FY 2014-15, and data are not complete or representative for FY 2014-15. However, the estimated population in need analysis provided earlier indicates that over half (54%) of the estimated 100,316 individuals with an SBHD that were not served in FY 2014-15 were adults with an SUD. (Data are not available to estimate how many of these individuals meet the OBH indigent definition.) These data indicate there is a proportionally greater unmet need for SUD services, and this need applies to the OBH indigent population, as well as the Medicaid population.

OBH Indigent Funding Needs

OBH currently uses a case rate payment and target number of clients to provide the majority of funding for indigent clients. (A detailed discussion of funding allocation and reimbursement methodologies is provided later in this report.)
Setting the indigent case rate payment amount based on actual services utilized by indigent clients also seems a reasonable starting point; however, the indigent population may have service needs that differ from the services they actually receive. A greater proportion of OBH indigent clients had higher elevated symptom severity levels compared to Medicaid capitation clients on 22 of the 25 domains. Results indicate that OBH indigent clients were more likely to have poor social support systems and socialization skills, be in greater need of supervision, be a danger to themselves or others, as well as have more history of mental health, substance use, and legal issues. For example, housing, employment services, and transportation needs are not reflected in the case rates; however, OBH has moved to broaden the use of indigent funding with the addition of "flexible" funding, which allows CMHCs to request specific uses for indigent funding aside from the target and non-target client funding.

RECOMMENDATION #3: OBH should continue to explore alternative payment approaches for the use indigent funds, including funding provided through the "Services for Mentally Ill Clients" appropriation for**:**

- Individuals who meet the current OBH indigent definition as Target and Non-Target clients. OBH should explore alternatives to target number requirements, including providing funding for underinsured individuals and individuals who move on and off Medicaid or remain uninsured.
- Individuals who are currently covered by Medicaid but need behavioral health services not currently covered by Medicaid to support their recovery needs.

OBH should continue to explore ways to expand support for prevention and early intervention, supportive housing, supportive employment, and peer/navigation services in coordination with the Medicaid benefit.

Intermittent Medicaid Eligibility

IN BRIEF

- During FY 2014-15 there were 48,460 out of 1,467,550 individuals (3%) with at least one gap in Medicaid eligibility. Nearly all of those with a gap in eligibility experienced just one gap (98%) and the average gap duration for these individuals was 85 days.[93]
- An identified 436 Medicaid eligible individuals received an OBH indigent service during an eligibility gap period in FY 2014-15.
- A significant relationship exists between indigent gap clients and all indigent clients and diagnosis, suggesting that individuals with more serious illnesses were less likely to experience gap periods and would consequently have less churn.[94]
- The FY 2014-15 total cost of services provided to OBH indigent clients during Medicaid eligibility gaps was $508,054, and the average service cost per client was $1,165.

What is Intermittent Eligibility, or "Churn?"

Frequent changes in eligibility for Medicaid benefits place an administrative and financial burden on HCPF, the BHOs, and other insurers. These changes, or “churn,” refer to the exit and re-entry of individuals from Medicaid eligibility. Churn is often due to fluctuations in income, loss of a job, seasonal employment, overtime or bonus pay, or changes in family

[93] The number of individuals who experienced more than one eligibility gap in FY 2014-15 cannot be reported due to HCPF data suppression requirements.
[94] Categories of diagnosis that contained fewer than 5 observations in any cell were collapsed into an “Other” category to test for independence of diagnostic distribution and population. Chi-Square test of independence results: χ^2 (12 df, n=10,814) = 937.5, p < .0001).

circumstance (e.g. pregnancy). It's estimated that within a year, over 55% of Medicaid eligible people experience churn.[95] This section focuses on the magnitude of the impact of churn on behavioral health services and spending.

Gaps in Medicaid Eligibility

Individuals who experienced at least one interruption in continuous Medicaid eligibility during the year ("gap individuals") were identified using FY 2014-15 Medicaid eligibility data for all Medicaid eligible individuals. Only individuals with an interruption in eligibility between two eligible spans were identified; lack of eligibility at the beginning or end of the fiscal year was not classified as a gap. During FY 2014-15 there were 48,460 out of 1,467,550 individuals (3%) with at least one gap in Medicaid eligibility. Nearly all of those with a gap in eligibility experienced just one gap (98%) and the average gap duration for these individuals was 85 days.[96] As shown in Table 16, the average gap length decreased as the number of gaps increased.

Table 16. Gaps in Medicaid Eligibility in FY 2014-15

Number of Eligibility Gaps	Average Length of Gap
1	85 days
2	46 days
3	43 days
4	31 days

Gap Individuals who Received Medicaid Capitation Services

In order to identify the number of gap individuals who received at least one Medicaid capitation service not during a Medicaid eligibility gap, the FY 2014-15 Medicaid eligibility file was matched to the FY 2014-15 Medicaid capitation encounter file. Of the 48,460 individuals who had intermittent eligibility, 5,585 individuals received at least one Medicaid capitation service while on Medicaid during FY 2014-15. These 5,585 individuals represent a penetration rate of 18% of all gap individuals enrolled in Medicaid capitation. The overall penetration rate for all individuals enrolled in Medicaid capitation was 15%.[97] Thus, individuals with intermittent eligibility access services more frequently than all individuals served by capitation.

Gap Individuals who Received OBH Indigent Services

To identify gap individuals who received an OBH indigent service during an eligibility gap, the Medicaid eligibility gap file was matched to clients identified as indigent in the OBH encounter file. An identified 436 Medicaid eligible individuals received an OBH indigent service during an eligibility gap period in FY 2014-15. [98] Of those, the majority experienced just one eligibility gap, and the average length of the first gap period was 98 days, as presented in Table 17.[99]

Table 17. Gaps in Medicaid Eligibility for OBH Indigent Clients in FY 2014-15

Number of Eligibility Gaps	Average Length of Gap
1	98 days
2	43 days

SERVICE COSTS

As presented in Table 18, Jefferson served the largest number of gap clients (118), followed by AspenPointe (50). The total cost of services provided to OBH indigent clients during eligibility gaps in FY 2014-15 was $508,054 and the average service cost per client was $1,165. MHCD had the highest overall cost ($188,174) and the highest per client cost ($4,590). While

[95] Sommers, B. D., Graves, J. A., Swartz, K., and Rosenbaum, S. "Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options Can Ease Impact", *Health Affairs*, 33(4), 2014. Retrieved from: http://www.nationaldisabilitynavigator.org/wp-content/uploads/resources-links/Health%20Aff-2014-Sommers-churn.pdf.

[96] The number of individuals who experienced more than one eligibility gap in FY 2014-15 cannot be reported due to HCPF data suppression requirements.

[97] The percentage of intermittent Medicaid individuals who received a service in FY 2014-15 was calculated by dividing the number served (5,585) by the number of intermittent Medicaid individuals enrolled in capitation during FY 2014-15 (30,591). The percentage of all Medicaid capitation individuals served (15%) was obtained from Appendix G (BHO penetration rates).

[98] Includes clients served by the Asian Pacific Development Center. The matching process, by nature of the identifier not being absolute, can produce erroneous matches. Likewise, name changes mean that false negatives, i.e., matches that should occur but don't, occur. This does introduce some bias in under-matching females, since name changes are more common compared to males.

[99] The number of individuals is unable to be reported in order to adhere to HCPF data suppression guidelines.

gap services costs were not directly comparable to total service costs provided earlier in this report, similarities exist.[100] For instance, MHCD had the highest average total service cost and highest average gap service cost.

Table 18. Number of Clients, Units, and Costs for Gap Services in FY 2014-15 by CMHC

CMHC	Number of Clients	Total Service Cost	Average Units/Client	Average Cost/Client
AllHealth	--	$21,406	13.3	$892
AspenPointe	50	$95,803	11.1	$1,916
Aurora	--	$12,719	5.7	$1,060
Axis	--	$11,302	8.6	$628
Centennial	--	$9,662	6.4	$966
CMH	--	$9,977	13.6	$1,425
Community Reach	--	$16,819	8.4	$801
Health Solutions	--	$8,814	5.8	$801
Jefferson	118	$29,460	3.4	$250
MHCD	41	$188,174	89.5	$4,590
MHP	31	$26,965	8.0	$870
Mind Springs	41	$24,192	7.2	$590
North Range	--	$1,481	2.4	$148
San Luis Valley	--	$2,247	3.1	$321
Solvista	--	$15,612	8.1	$1,041
Southeast	--	$8,209	8.7	$912
SummitStone	--	$9,060	48.5	$1,510
Total	**431**	**$508,054**	**15.9**	**$1,165**

*Total includes clients served by the Asian Pacific Development Center.
"--" indicates the number of individuals is less than 30 and has been suppressed per HCPF data suppression guidelines.

The services provided during gaps are described in Table 19. Note that some clients received more than one type of service; thus, the number of clients for each service category will sum to more than the total. Psychotherapy served the most gap clients (40%), while Prevention/Intervention services were the most costly overall ($158,145). Prevention/Intervention and Rehabilitation had the highest average units (29 and 26, respectively).

Table 19. Units and Costs of Gap Services by Service Category

Service Category	Number Served	Total Units	Average Units	Total Cost
Assessment	141	151	1.1	$38,651
Case Management	121	694	5.7	$36,409
Crisis/Emergency	29	133	4.6	$15,083
Evaluation/Management	108	198	1.8	$36,818
Intensive Treatment	--	--	8.0	$4,448
Other	--	--	3.5	$0
Other Professional	--	--	3.4	$190
Peer Support/Recovery	--	--	8.0	$2,262
Prevention/Early Intervention	117	3,335	28.5	$158,145
Psychiatric/Medication Management	--	--	4.8	$7,564
Psychotherapy	174	842	4.8	$147,482
Rehabilitation	44	1,139	25.9	$53,554
Residential	--	--	21.8	$589
Social Ambulatory Detox	--	--	10.6	$4,209
Substance Use	--	--	6.0	$1,821
Vocational	--	--	20.0	$828
Total	**436**	**6,951**	**8.8**	**$508,054**

*Represents the number of unduplicated individuals. Since individuals could have received more than one type of service, the number of individuals for each service category will sum to more than the total. See Appendix D for descriptions of each service category.
"--" indicates the number of individuals is less than 30 and has been suppressed per HCPF data suppression guidelines.

DIAGNOSTIC INFORMATION

Appendix Q displays detailed diagnostic information from the CCAR for OBH indigent clients with a Medicaid eligibility gap compared to all OBH indigent clients.[101] Major depression was the most common diagnosis for both groups, but indigent

[100] Service timeframes are considerably different as total service costs reflect services received throughout the entire fiscal year, while gap service costs reflect cost during gap periods which ranged from 2 days to 305 days. In addition, gap clients almost certainly received services during eligibility periods.

gap clients had a lower percentage compared to all indigent clients (28% and 40%, respectively). Bipolar disorder was the second most common diagnosis for both indigent gap clients (20%) and all indigent clients (17%). A significant relationship exists between indigent gap clients and all indigent clients and diagnosis, suggesting that individuals with more serious illnesses were less likely to experience gap periods and would consequently have less churn.[102]

DEMOGRAPHICS

Appendix Q presents the gender and age of OBH indigent clients with a Medicaid eligibility gap. Approximately 52% of OBH indigent clients with a Medicaid eligibility gap in FY 2014-15 were male, indicating males were more likely to experience disruption in eligibility since they made up less than half of the population served by OBH indigent funding. There was a significant effect of gender on length of gap, with females exhibiting longer mean first gap time (89.32 days) than males (81.49 days).[103] The majority of indigent clients with a Medicaid eligibility gap were age 18 or older (73%), which was similar to the total OBH indigent population (57%), suggesting that age was not a factor in whether a gap occurred. However, length of gap time emerged as marginally significantly different for youth (90.6 days) and adults (84.7 days).[104] Due to the lack of race/ethnicity data in the OBH encounter files, that breakout cannot be reported.

Review of OBH Encounters

IN BRIEF

- A review of a representative sample OBH indigent and Medicaid encounters) was conducted to determine if OBH indigent, Medicaid, and other third-party payers (e.g., private insurance) were appropriately utilized. Encounters were reviewed to determine if OBH indigent encounters were used to reimburse a CMHC for a Medicaid eligible individual who was enrolled with a BHO at the time of service, if duplicate/identical encounters were submitted, and if the correct payer was utilized.
- 3,674 Medicaid eligible individuals who received OBH indigent funded services during FY 2014-15 were enrolled with a BHO. Of these individuals, 664 (18%) were enrolled with a BHO on the date services were provided by the CMHC. Thus, it is assumed OBH made case rate payments of $3,186 per client (the FY 2014-15 case rate amount) to CMHC's for clients who were also funded by Medicaid capitation. The total estimated amount of these payments is approximately $2.1 million.
- Encounter data was reviewed for payer priority, checking for other payers for indigent services and third party insurance (TPI) for Medicaid encounters. Medicaid funding, followed by OBH indigent funding, should be the last two payers after all other payment sources are utilized.
- Of the 52 indigent encounters, eight had a different insurance source listed on the CCAR compared to the encounter. Of the 48 Medicaid encounters reviewed for payer priority, three listed a TPI. Since CCAR does not necessarily capture insurance coverage in real time, further investigation into whether payer priority violations occurred using chart review with insurance information is necessary.

A review of a representative sample OBH indigent and Medicaid encounters was conducted to determine if OBH indigent, Medicaid, and other third-party payers (e.g., private insurance) were appropriately utilized. Encounters were reviewed to determine if OBH indigent encounters were used to reimburse a CMHC for a Medicaid eligible individual who was enrolled with a BHO at the time of service, if duplicate/identical encounters were submitted, and if the correct payer was utilized. The goal of the review was to identify opportunities for changes or improvements in the OBH contracting and provider reimbursement process. Opportunities may include systemic and policy changes, as well as process considerations. Specifics of change depend on the root causes of these errors. Contributing factors may include the need for quality assurance at the provider or state level, and/or disparate financial systems at the state level.

[101] It is important to note that some clients did not have a matching CCAR and that diagnostic information was missing in some CCARs

[102] Categories of diagnosis that contained fewer than 5 observations in any cell were collapsed into an "Other" category to test for independence of diagnostic distribution and population. Chi-Square test of independence results: χ^2 (12 df, n=10,814) = 937.5, p < .0001).

[103] ANOVA results: $F(1,1981)=54.602$, p=.032.

[104] ANOVA results: $F(1,1981)=3.696$, p=.055.

Findings

OBH INDIGENT ENCOUNTERS USED FOR REIMBURSEMENT[105]

This analysis examines whether OBH payments to CMHCs from the "Services for Indigent Mentally Ill Clients" appropriation were made for Medicaid eligible individuals enrolled with a BHO. During FY 2014-15, CMHCs were required by contract to submit an encounter and a matching CCAR, indicating the presence of an SED or SMI, to OBH in order to receive the case rate payment for providing at least one service to an OBH indigent client. A file of 7,800 encounters identified as OBH indigent with matching CCARs was created. These 7,800 encounters and CCARs were then matched to Medicaid BHO enrollment data. This matching process resulted in 3,674 individuals who received indigent funded services who were also enrolled with a BHO during FY 2014-15. The indigent encounter service dates were then compared to the clients' Medicaid BHO enrollment dates to determine whether at least one indigent service fell outside of the enrollment window. The results indicated that 664 of the 3,674 individuals (18%) were enrolled with a BHO on the date services were provided by a CMHC. Thus, it is assumed OBH made case rate payments of $3,186 per client (the FY 2014-15 case rate amount) to CMHC's for clients who were also funded by Medicaid capitation. The total estimated amount of these payments is approximately $2.1 million. Table 20 below shows the breakout of the 664 clients by CMHC.

Table 20. OBH Indigent Reimbursements for Medicaid Capitation Clients

CMHC	Number	Percent of Total	OBH Reimbursement
AllHealth	60	9.0%	$191,160
AspenPointe	70	10.5%	$223,020
Aurora	14	2.1%	$44,604
Axis	38	5.7%	$121,068
Centennial	33	5.0%	$105,138
CMH	16	2.4%	$50,976
Community Reach	44	6.6%	$140,184
Health Solutions	21	3.2%	$66,906
Jefferson	116	17.5%	$369,576
MHCD	57	8.6%	$181,602
MHP	37	5.6%	$117,882
MindSprings	89	13.4%	$283,554
North Range	26	3.9%	$82,836
San Luis Valley	14	2.1%	$44,604
Solvista	11	1.7%	$35,046
Southeast	9	1.4%	$28,674
SummitStone	9	1.4%	$28,674
Total	**664**	**100.0%**	**$2,115,504**

DUPLICATE ENCOUNTERS

The objective of this analysis was to determine if duplicate encounters were submitted to OBH. A sample of 100 encounters submitted during FY 2014-15 was drawn from the four CMHCs that served the most OBH indigent and Medicaid clients during FY 2014-15: AspenPointe, Community Reach, Jefferson, and MHCD. The sample of 25 encounters from each of the four CMHCs was stratified to ensure that approximately one-half of the encounters from each agency were indigent (13) and one-half were Medicaid (12). The resulting sample contained 52 Indigent and 48 Medicaid encounters. The encounter sample was compared to all encounters and reviewed for duplication through the client identifier, payer, identical service, service date, procedure code, modifiers, and units. The analysis identified 20 OBH indigent encounters of the 100 encounters audited, or 20%, as duplicate encounters. Eleven were from AspenPointe, five were from Jefferson, three were from MHCD, and one was from Community Reach. Submission of duplicate indigent encounters artificially inflates utilization estimates. The total service cost for the 20 encounters was $4,073. OBH encounter submissions are not processed for duplication at the state level; therefore OBH would not have caught these duplicate encounters. HCPF's Medicaid Management Information System (MMIS) denies duplicate encounter submissions; therefore, it is not surprising that none of the Medicaid encounters were identified as duplicated.

PAYER PRIORITY

The objective of this analysis was to determine compliance to payer priority. Encounter data was reviewed for payer priority, checking for other payers for indigent services and third party insurance (TPI) for Medicaid encounters. Medicaid

[105] Included mental health and substance abuse.

funding, followed by OBH indigent funding, should be the last two payers after all other payment sources are utilized. The first completed FY 2014-15 CCAR was matched to all sample encounter records, and payers other than the payer on record for the encounter were identified via the administrative section of the CCAR. All CCARs were checked for payer and date consistency. Of the 52 indigent encounters, eight had a different insurance source listed on the CCAR compared to the encounter. Two of the eight were Medicaid encounters that had TPI identified on CCAR. Two of the eight indigent encounters listed a TPI, while the other four were listed as Medicaid enrolled. Of the 48 Medicaid encounters reviewed for payer priority, three listed a TPI. The three encounters were from the same center (Jefferson). Since CCAR does not necessarily capture insurance coverage in real time, further investigation into whether payer priority violations occurred using chart review with insurance information is necessary.

Given the findings of this review of OBH encounters, it appears that the current system for reimbursing CMHCs based on the submission of an encounter and CCAR results in payment errors to CMHCs for individuals who are Medicaid eligible and enrolled with at BHO at the time of service reimbursed by OBH. In addition, a review for duplicate encounter submission and payer priority (ensuring OBH is the payer of last resort) indicates the opportunity exists for improving data and reimbursement systems. OBH indicates it plans to implement a risk-based process for implementing standardized compliance monitoring of the highest risk contracts that includes a risk assessment based on contract size, potential for billing twice for the same service, complaints, and compliance with fiscal protocols (e.g. incorrect invoices, missing documentation). OBH also indicates it intends to conduct additional reviews or audits of contractors that appear to be in substantial contract non-compliance.[106] Thus use of the MMIS system to process indigent payments would significantly reduce, if not eliminate, duplicate payments. OBH indicates it is working with HCPF to obtain access to the new MMIS system.

RECOMMENDATION #4: OBH should take immediate action to significantly reduce or eliminate the payment of indigent client funding to CMHCs for individuals who are Medicaid eligible and enrolled in a BHO. Actions could include conducting periodic and regular comparisons of encounter data files, including the methodology used in this study, and the risk-based compliance monitoring process described by OBH. OBH may also find benefit in grouping or segregating the specific encounters and CCARs submitted by CMHCs as a basis for case rate payment.

Medicaid and OBH Indigent Allocation and Reimbursement

Funding Allocations

HCPF

HCPF employs a mix of capitation and FFS payments to pay providers. Capitation payments to the BHOs represent a pre-determined monthly amount for each Medicaid client who is eligible for behavioral health services within each respective BHO region. The "per-member-per-month" rates paid to BHOs are unique for each region and for each Medicaid eligibility category within each region. The BHO receives the payment and agrees to provide covered services to each individual requiring care. BHOs submit encounter data to HCPF for each service provided, and these data are used for capitation rate setting and analysis but are not used to directly reimburse the BHOs. In most cases, the BHOs pay the CMHCs that are their owners/partners through sub-capitation contracts. This payment arrangement results in disincentives to CMHCs to expand services or provide more costly services and incentivizes the CMHCs to seek additional funding from other sources to support the same service delivery system. In addition, since CMHCs are owners of the BHOs and are sub-capitated, the system may creates disincentives for the BHOs to establish a provider network that includes non-CMHC providers.

Under Phase II of the ACC, HCPF will move toward integration of physical and behavioral health care for Medicaid recipients by contracting with RAEs to focus on whole person care. The state will continue to be divided into seven regions to promote innovation, flexibility, and local ownership of the health care delivery system. HCPF will retain the capitation payment methodology for core behavioral health services, with the RAEs receiving the capitation payment. It is assumed the BHOs would no longer receive contracts from HCPF and will be replaced by the RAEs. The RAEs, in turn, will sub-capitate mental health services to the CMHCs. The current continuum of services provided under the capitation Program will remain, along with current medical necessity for care requirements. Requirements for use of a covered diagnosis will be limited, where possible, in an effort to improve access to care.

[106] Information provided by Dr. Nancy VanDeMark, Director, CDHS Office of Behavioral Health. October 24, 2016.

OBH

Given the large number of OBH programs and appropriations (some very specific as to the population served, the services provided, or the regions of the state receiving the services), OBH is faced with the task of allocating funding to dozens of providers and administrative entities (e.g., CMHCs, MSOs, prevention providers). OBH uses a variety of methods to allocate funding. Some funding allocations are based on historical behavior. For example, allocations for the "Services for Indigent Mentally Ill Clients" program are based on an allocation of target and non-target client counts, reimbursed at a set case rate per client. OBH uses encounter data and costs assigned to each service to calculate the case rate amount paid to the CMHCs for serving target and non target clients. The number of clients "assigned" to each CMHC is based on historical numbers and has not been reviewed or updated using data representing the relative need for these services (e.g., illness prevalence rates) by CMHC.

Other allocations are based on fixed amounts that may vary by CMHC and MSO or that may be equally distributed between CMHCs and MSOs. In many cases, these allocations have been "historical" and the same amount is allocated each fiscal year, regardless of changes in populations, the need for services, or other mitigating factors present in the CMHC or MSO catchment area. In some cases, OBH uses the RFP process to select providers and to determine annual program costs (e.g., Colorado Crisis Services).[107]

Limited funding resources, significant changes in Colorado's behavioral health system over the last several years (e.g., Medicaid expansion), as well as the continued unmet need for services suggest OBH should examine the various methods currently used to allocate funding, particularly when new funds are appropriated to OBH and require allocation. A review of allocation methodologies could result in new methods that may be simpler, more equitable, and a better reflection of current needs. OBH collects large amounts of data (encounters, CCARs, DACODS) that will assist in this effort. This study also includes data that could help inform development of new methodologies, including the updated population in need estimates. In addition, other state allocation methodologies should be reviewed, as they may serve as options for changes in Colorado. For example, Ohio allocates its mental health block grant funds using a formula that includes prevalence, population, and poverty level.[108] See Appendix R for more information about methodology options and other state allocation formulas.

It is understandable that providers, accustom to current funding allocation methodologies and amounts, would question and perhaps oppose efforts to change allocation methodologies. BH reports that CMHCs are resistant to examine modifications or adjustments to payments between CMHCs. While wholesale changes in current allocations are not recommended given provider reliance upon and need for existing funding levels, documented, defensible, and understandable allocation methodologies should be utilized for the allocation of future funding.

Recommendation #5: OBH should continue to examine the funding allocation methodologies for each of the programs and services it administers and work to refine these methodologies to incorporate and reflect current behavioral health needs and the resources of the state's communities. When examining new contract entities or new funding sources, OBH and HCPF should create a more objective allocation formula that takes into account the changing state demographics, behavioral health needs and trends, and the distribution of resources and services within and between the geographical regions used to allocate funds.

Provider Reimbursement and Payment

MEDICAID ACC PHASE II PAYMENT SYSTEM

As Colorado moves towards integration of physical and behavioral health care services, "payment reform" is a primary goal. According to HCPF, Phase II of the ACC program will incorporate value based payment strategies aimed at ensuring clients get the right care in the right setting and directly incentivizing providers to provide efficient and effective services. For the RAEs, HCPF will implement a number of quality based payments on top of the FFS system including paying for improved performance on key performance metrics related to utilization and health outcomes; sharing in the savings generated by the program; and creating an incentive pool to reward improvement in areas where opportunity exists, such as follow-up care within 30 days of discharge from the hospital or quality measures for the SIM. HCPF will retain the capitation payment methodology for core behavioral health services, with the RAEs receiving the capitation payment.[109]

[107] Conversation with Andrew Martinez, Office of Behavioral Health, August 1, 2016.
[108] State Fiscal Year 2017 Community Allocation Guidelines. Ohio Department of Mental Health and Addiction Services. Retrieved from: http://mha.ohio.gov/Default.aspx?tabid=147.
[109] Department of Human Services-Behavioral Health Services FY 2016-17 Joint Budget Committee Hearing Responses, December 16, 2015. Retrieved from: http://www.tornado.state.co.us/gov_dir/leg_dir/jbc/2015-16/hcphrg2.pdf.

OBH REIMBURSEMENT SYSTEMS

OBH payments to providers are based on a variety of payment methodologies, including:

- Per client from an encounter and a CCAR.
- Separate monthly payments (case rates) varying based on the type of programs included in the provider's contract (i.e., outpatient, residential, detox).
- Per diem rates.
- Cost reimbursement ("program cost model").
- "Capacity based" reimbursement (reimbursements that are adjusted by non-OBH revenues).
- Performance based payments.
- Flexible funding, specific to the needs of individual CMHCs.

One of OBH's primary goals for its reimbursement requirements is to ensure that providers are not spending OBH funds for services provided to individuals that have insurance (including Medicaid, Medicare, and private insurance) that would pay for the service. This challenge is compounded by the fact that CMHCs receive a sub-capitation payment from the BHOs that is not based on actual services provided (similar to FFS or case rates). The use of sub-capitation payments, coupled with OBH reimbursement requirements, creates a burden on OBH to ensure that services are not funded by two payers (HCPF and OBH). OBH is to be credited by building accountability and transparency into its reimbursement methodologies in an effort to prevent overpayments for services. However, the requirement that providers use multiple methods for obtaining reimbursement for contracted services creates an administrative burden and requires more resources be directed to these administrative and billing activities when the resource may be better allocated toward providing services to clients.

One of OBH's reimbursement requirements, referred to as the "capacity based protocol," provides an example of the complexity of the system. OBH created the capacity based contracting methodology with participation and input from CMHC and MSO representatives. A goal of capacity based contracting is to ensure that service capacity exist in communities irrespective of payer. OBH requires use of this protocol for several CMHC and MSO programs. It applies to "capacity-based facilities and programs that are funded from a variety of funding sources..." and requires providers submit detailed monthly reports itemizing program costs and revenues.[110] OBH then reimburses providers for "unfunded costs" after adjustments for revenue received from other payers (typically insurance, including Medicaid and Medicare). The OBH provider payment is limited to the provider's OBH contract amount.

From a provider perspective, the capacity based protocol presents challenges to plan for and provide services, as it creates uncertainty as to what level of revenue will be available to staff and to operate the program. This uncertainty is proportional to the percentage of non-OBH revenue (cash receipts from non-OBH payers) the program earns and the monthly or periodic variances in these non-OBH revenues. The protocol also does not allow programs to retain any excess earnings or offset expenses for capital expenditures, both critical considerations for expanding programs and maintaining or upgrading capital equipment or building new facilities. Providers indicate that, while they participated in the development of the protocol, they believe it needs to be reviewed and possibly revised.

In addition to provider concerns, the protocol raises concerns from a state budget and legislative intent perspective. The protocol could contribute to reversions of General Fund appropriations as it is applied to line items and programs that are funded with 100% General Fund appropriations. If the protocol results in underutilized General Fund spending authority, OBH either must submit a negative supplemental request to the Legislature to reduce the General Fund appropriation or revert the funds at the end of the Fiscal Year. The protocol also raises questions about whether the Legislature intended that General Fund appropriations for various OBH programs (e.g., the crisis response system) be offset or reduced by non-General Fund revenues. For example, the RFP document and contracts OBH executed with the Colorado Crisis Services providers clearly indicate that all available payer sources are to be identified and billed. However, it is not clear that when the Legislature appropriated funding for Crisis Services, it did so with the understanding it would be offset with non-General Fund revenue. Typically, when the Legislature intends for General Funds to be the "payer of last resort," it requires OSPB and state agencies to submit estimates of non-General Fund revenues, and these revenues are included in the Long Bill appropriation. OSPB and state agencies are then often required to prepare revised revenue estimates during the fiscal year and may submit supplemental requests to adjust General Fund requirements based on revised revenue estimates. (The CMHIs follow this process.)

There is a significant difference between requiring that providers not use OBH funding when other payer sources are available and adjusting provider payments as a means to enforce this requirement. OBH has created a complex system of

[110] Office of Behavioral Health (July 1, 2015). *Finance and Data Protocols, Capacity Based Protocol.* (Protocol No. 5, Amendment #1)

contract provisions and financial reporting requirements to monitor and control provider use of OBH funds. The intent is admirable; however, it may be worthwhile to examine other approaches. For example, HCPF staff indicated that, once the new MMIS is operational, there would be the option to make additional system modifications enabling the MMIS to process OBH provider claims in addition to Medicaid claims.[111]

OBH AND MEDICAID SUBSTANCE USE TREATMENT REIMBURSEMENT

OBH executes contracts with the MSOs for the provision of SUD treatment services across the seven geographic regions established by OBH. The MSOs, in turn, contract with various treatment providers across the state. The multiple OBH reimbursement methodologies outlined earlier apply to substance use treatment providers as well as mental health treatment providers. Medicaid reimbursement methodologies differ, however, for non-CMHC substance use providers. While the BHOs provide "sub-capitated" per-member-per-month payments to the CMHCs for services provided, including both mental health and SUD services, SUD providers submit FFS claims to the BHOs for SUD services.

BHOs have differing contractual, administrative, and clinical/utilization management requirements. This creates a degree of complexity and administrative workload for SUD providers, as well as hospitals as they often provide services across BHO regions and thus must contract with more than one BHO.[112] CMHCs, in comparison, typically only contract with one BHO. SUD provider challenges are also magnified as they tend to be smaller organizations than mental health providers. Thus, they have a smaller proportion of staff and resources to deal with these contract and administrative requirements. Providers commented that current substance use treatment program funding is fragmented, bundled, differential, and difficult to execute: “The costs to substance treatment programs to manage the billing associated with these variations in funding are crippling,” one provider said. “There needs to be an increased understanding of funding necessities by HCPF to effectuate full funding of necessary substance treatment services. Behavioral health organizations should provide the same contracts to providers rather than differential interpretations of HCPF regulations.”

The population in need estimates provided earlier in this report indicates that 54% of the state's estimated unmet need for services is individuals with a SUD. Colorado's Medicaid SUD benefits are fairly limited, and don't include residential or inpatient treatment, except in certain limited circumstances. Senate Bill 16-202 increases funding for SUD services by approximately $5.8 million; directs the MSOs to identify plans documenting the need for SUD services, and requires OBH to contract for an evaluation of residential SUD services. This evaluation will include recommendations about whether the Medicaid behavioral health benefit should be expanded to include intensive residential treatment for substance use disorders and will also include valuate how individuals seeking residential substance use treatment services are having these services paid for, and what entities are paying for these services. It appears this evaluation will add valuable information about reimbursement of SUD services.

Recommendation #6: OBH should continue to explore options to reduce or simplify reimbursement methods used in order to minimize payment for services that are covered by Medicaid and simplify the accounting for both the state and providers. One strategy that OBH and HCPF continue to explore is the Medicaid Management Information System (MMIS) to streamline eligibility checking and payments for applicable programs. CDHS should prioritize investment in this integration of eligibility determination and payment processing. CDHS should review the legislative intent of the various General Fund appropriations that are being offset based on the capacity-based protocol.

HCPF should examine options to simplify and align Medicaid reimbursement for SUD providers with mental health services. This may include examining sub-capitation and standardized BHO contract provisions to address the administrative and reimbursement complexities created by the need for SUD providers to contract with multiple BHOs.

Maximizing Medicaid Reimbursement

INDIVIDUALS INVOLVED IN THE CRIMINAL JUSTICE SYSTEM

The addition of the AwDC eligibility category under Medicaid expansion significantly increases the number of individuals involved in the criminal justice system who are eligible for Medicaid. States that make full use of opportunities to enroll eligible individuals in their criminal justice systems into Medicaid and appropriately leverage the program to finance eligible care have realized considerable cost savings by reducing reliance on state-funded health care services for the uninsured. Medicaid can serve as a valuable source of coverage for health care services for individuals who are mandated to treatment, on probation or parole, or who are returning to the community following incarceration. Furthermore, criminal

[111] Email correspondence with Laurel Karabotsos, HCPF. August 26, 2016.

[112] *Medicaid Behavioral Health: Health Systems Perspectives on Barriers to Care and Payment*, Colorado Hospital Association, November 2015. Retrieved from: https://cha.com/Publication-Documents/Medicaid-BH-Health-Sys-Perspectives-(BHO)-FINAL.aspx.

justice systems that identify and enroll eligible individuals in Medicaid at all points of justice system involvement, including in jails and prisons, can greatly improve access to needed health services for this population.[113]

Individuals who are on parole, probation, or have been released to the community pending trial (including those under pre-trial supervision) are not considered inmates, and thus are not subject to the prohibition on providing Medicaid covered services to inmates. In addition, in April 2016, the Centers for Medicare and Medicaid Services (CMS) provided written guidance clarifying when Medicaid-covered services are available to individuals residing in state or local, private or publicly operated, community corrections facilities. The guidance clarified that Medicaid-covered services are now available for Medicaid eligible individuals living in community corrections facilities unless residents do not have "freedom of movement and association" while living in the facility.[114]

There are numerous appropriations and programs that appear to include General Fund support for behavioral health services provided to individuals involved in the state's criminal justice system, including programs in the Department of Corrections, Department of Public Safety, Judicial Department, and CDHS Division of Youth Corrections. Based on the CMS guidance provided in April 2016, some portion of these funds may be able to be refinanced to earn Medicaid reimbursement for behavioral health services for clients served by these agencies. An examination of these refinancing possibilities should be included as part of Recommendation #1, which recommends that the behavioral health program reviews include an analysis of whether or not services currently funded entirely by General Fund are eligible for Medicaid reimbursement.

SUSPENSION VS. TERMINATION OF MEDICAID BENEFITS

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).[115] In 2008, the Colorado state legislature passed a law to require 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."[116] Colorado has not yet fully implemented this option.

As a result, CMHI and prison staff must expend additional effort in an attempt to reapply for Medicaid on the individual's behalf. Sometimes placement options are denied because the individual has not obtained Medicaid eligibility status when they are ready to leave prison or a juvenile facility or when they no longer need to be at a CMHI. For example, the CMHIs frequently place Medicaid-eligible individuals at nursing homes. The majority of these facilities will not hold a bed for the CMHI patient pending the individual's final Medicaid eligibility determination. As a result, the CMHIs and OBH must either pay for the bed until the patient's Medicaid is approved, or give up the placement, resulting in a longer length of stay at the CMHI than medically necessary.

HCPF reports the bill's implementation is in process. HCPF notes that the "Department has found no evidence that this benefits suspension will reduce the application process burden on county technicians, MA Sites or CBMS. On the contrary, implementing this policy but may actually increase the work that eligibility technicians perform by requiring that technicians transfer individuals onto their own case, rerunning Medicaid eligibility for that individual, and then suspend his or her benefits."[117]

Recommendation #7: HCPF should complete its work to implement suspension, rather than termination, of Medicaid benefits for institutionalized individuals, including DOC inmates and CMHI patients.

An Alternative Management Model

Colorado is making progress in integrating behavioral and physical health care, as evidenced by Phase II of the ACC and the State Innovation Model (SIM). HCPF plans to award contracts, effective July 1, 2018, to Regional Accountable Entities (RAEs) to provide both physical and behavioral health services to Medicaid eligible individuals. The SIM project, led by the

[113] *Medicaid and Financing Health Care for Individuals Involved with the Criminal Justice System*, The Council of State Governments Justice Center, December, 2013. Retrieved from: https://csgjusticecenter.org/wp-content/uploads/2013/12/ACA-Medicaid-Expansion-Policy-Brief.pdf.
[114] RE: To facilitate successful re-entry for individuals transitioning from incarceration to their communities, Center for Medicare and Medicaid Services State Health Official Letter #16-007, April 28, 2016.
[115] Ibid.
[116] An Act Concerning Suspension of Medicaid Benefits for Persons Confined Pursuant to a Court Order and Making an Appropriation Therefor," Senate Bill 08-006, Colorado State Legislature, 2008.
[117] Email correspondence from Lenya Robinson, Behavioral Health and Managed Care Programs Section Manager, HCPF. October 26, 2016.

Governor's Office, complements ACC Phase II as it supports integrated care delivery, data reform, and payment reform; and strengthens Colorado's Triple Aim strategy of improving the individual experience of care, improving the health of populations, and reducing the per capita costs of care for populations.[118] Implementation of the integration of behavioral and physical health services for Medicaid clients under ACC Phase II raises questions about the role OBH plays within the state's behavioral health system. OBH's current role, to fund and oversee community behavioral health services primarily for indigent individuals, is an important one. While Medicaid expansion and the creation of the Colorado Health Exchange have reduced the number of indigent clients requiring behavioral health services, they still exist. It is also important to continue to provide, and expand, non-Medicaid covered services provided to Medicaid clients, including prevention, early intervention, support, and recovery services.

The provision of behavioral health services by several state agencies, including continued segregation of the management and administration of Medicaid and non-Medicaid programs by HCPF and OBH (respectively), creates challenges, complexities and inefficiencies. OBH and HCPF are aware of the difficulties created by the current administrative structure and work together to attempt to address these challenges. The agencies have partnered to address contracting, allocation, data system, performance measure, and service definition issues. For example, during FY 2014-15, both agencies met monthly to identify opportunities to maximize Medicaid reimbursement under Medicaid expansion, and developed plans to implement an integrated management information system to manage OBH indigent eligibility and reimbursement and the development of a crosswalk of behavioral health services covered by OBH and HCPF.

Despite the efforts of the two agencies, significant challenges remain for clients and providers. As discussed earlier, the system of reimbursing providers for services provided to indigent clients results in payment errors for clients who were Medicaid eligible and enrolled in a BHO. In the absence of alignment of contractors and regions, the state relies largely on provider self-monitoring and limited audits to ensure that contractors abide by their contract terms and do not use two sources of funding to support the same service. In addition to the opportunity for double billing, having multiple administrative oversight entities (BHO, MSO, crisis contractors) involved in the delivery of the same service is inefficient. Clients who have complaints must contact OBH if they are indigent and HCPF if they are Medicaid eligible. CMHCs, the MSOs, and other SUD providers must contract with both the BHOs and OBH (in addition to other state and local government agencies) under a myriad of separate reporting and accountability, reimbursement, licensure, regulatory, and quality of care requirements. OBH is required to maintain fairly complex contractual and administrative requirements to attempt to ensure OBH funds targeted for indigent individuals are not used to provide services to Medicaid eligible individuals.

Thus, the current system is outdated. It does not serve clients or consumers well, does not lend itself to transparency, and is inefficient. CDHS and HCPF continue to implement incremental changes, including increased auditing capabilities and minimum service definitions for CMHCs and substance use disorder providers, the structure of the current system prevents any significant increases in efficiency and effectiveness. It seems inevitable that the current system requires funds and resources that could otherwise be directed to providing direct care.

Arizona's system for the management of publically funded behavioral health services provides an alternative model to Colorado's system, as it combines responsibility for eligibility determination and service delivery for both Medicaid and non-Medicaid clients with one entity in each region of the state. In addition, the state Medicaid agency, the Arizona Health Care Cost Containment System (AHCCCS), manages behavioral health services for both Medicaid eligible and non-Medicaid individuals. AHCCCS contracts with Regional Behavioral Health Authorities (RBHAs), which are similar to Colorado's BHOs. Each RBHA is responsible for managing Medicaid and non-Medicaid behavioral health services that are provided to the individuals in the region who meet eligibility requirements.

In addition to receiving funding for Medicaid clients, each RBHA receives state funding, including federal Substance Abuse Block Grant (SABG) and Mental Health Block Grant (MHBG) funds and discretionary grant funds. SABG funds are used for the priority substance use populations as identified by SAMHSA (e.g., pregnant women), and MHBG funds are used for adults with an SMI and children with an SED. Both SABG and MHBG and discretionary grant funds are used to provide services (e.g., room and board) not covered by Medicaid. FFS reimbursement is used to pay the RBHAs for services provided to non-Medicaid clients, while the RBHAs receive a per-member-per-month payment for each eligible Medicaid client in the RBHAs region.[119]

[118] *Health Transformation in Colorado: How SIM Can Leverage and Support Colorado's Healthy Spirit*, State Innovation Model Office (SIM). Retrieved from: https://www.colorado.gov/pacific/sites/default/files/Colorado%20SIM%20Powerpoint%20for%20Cost%20Commission.pdf.

[119] *Covered Behavioral Health Services Guide*, Arizona Department of Behavioral Health Services, Division of Behavioral Health Services, September 1, 2001, Version 9.3.

The Arizona model appears to provide several advantages over traditional state behavioral health service delivery systems where Medicaid and non-Medicaid, and SUD and mental health services, are often administered separately. Administration is more efficient as responsibility and authority for providing behavioral health services for all eligible individuals (including Medicaid and indigent) rests with one state agency and one managed service organization. In addition, rather than administering dozens of contracts with various providers to manage and monitor, all services are combined into two contracts per state region, one for Medicaid clients and services and another for non-Medicaid clients and services. The program has achieved minimal growth in a per-member-per-month costs, with cost decreases in calendar years 2010 - 2012 and minimal increases in 2013 (1%) and 2014 (3%). The vast majority of the decreases achieved over this time period have resulted from short-term budget saving changes made to provider reimbursement and benefits.[120]

A similar system to Arizona's may hold promise for Colorado as it implements ACC Phase II and selects new administrative entities (RAEs) to manage Medicaid service delivery. For example, OBH could contract with the RAEs to administer all indigent and non-Medicaid services and supports currently funded by the state, SAMHSA block grants, and other discretionary grants. The RAEs would then be responsible for contracting with the CMHCs, and perhaps MSOs and other providers for behavioral health services and coordinating funding and services for both the Medicaid individuals and indigent individuals with behavioral health needs within their geographic region. Placing behavioral health provider network development and payment responsibility with the RAEs could also allow for the alignment and standardization of funding allocation and reimbursement methodologies. For example, the RAEs could work with the state to develop a sub-capitated rate system to reimburse providers.

Placing this responsibility with the RAEs would potentially result in improved service coordination and reduce the potential for duplicate payments to providers for indigent and Medicaid individuals. However, appropriate safeguards, timing, and compliance processes would need to be implemented by the state to ensure success. Placing sole authority for behavioral health services with the RAEs could result in a dilution of attention and focus to the needs of indigent behavioral health clients, including populations with special needs, such as individuals transitioning from incarceration or institutionalization, who need wrap around services and supports that are not funded by Medicaid, such as housing and employment. Regulatory and compliance oversight would also be critical, as placing both OBH and HCPF behavioral health funds with a sole entity could potentially create a "too big to fail" scenario.

Another option would involve the merger of OBH and HCPF to create a single state behavioral health authority that contracts with the RAEs. This authority would then administer all state, federal grant, and Medicaid funding for behavioral health (excluding behavioral health programs reviewed under Recommendation #1 and determined to remain with another state agency. The creation of a sole state behavioral health agency needs to consider the current licensure and regulatory responsibilities provided by OBH. For example, OBH prepares and manages the periodic SAMHSA block grant applications and reviews. Also under statute,[121] CDHS is responsible for licensing SUD providers and provides several specialized substance use treatment licenses and is responsible for processing commitments for persons involuntarily committed to SUD treatment. These licensing responsibilities require specialty clinical services to ensure quality of care for individuals receiving publicly funded SUD services. OBH also makes recommendations to CDPHE about licensure of mental health providers, including nine categories of licensure designation, and administers rules related to quality of care and administrative standards for the provision of SUD and mental health services. These OBH responsibilities are not unlike the responsibilities held by CDPHE in its licensure of other providers (e.g., hospitals). OBH also currently administers the Child Mental Health Treatment Act,[122] and OBH's role in the administration of this program, and other early childhood, children, adolescents and transition-aged youth behavioral health services would need to be examined in the context of a single behavioral health authority.

Recommendation #8: OSPB, HCPF, and CDHS should examine options to place administrative responsibilities for non-Medicaid behavioral health services and supports with the RAEs, either under the state responsibility of OBH or under the responsibility of a state behavioral health authority. Making this structural change to the state's behavioral health system could strengthen the coordination and equity of care provided to individuals across the state, while also improving effectiveness and efficiency in the use of state and federal funds.

[120] *AHCCCS Strategic Plan State Fiscal Years 2015-2019*, Arizona Health Care Cost Containment System, December 2014, Page 9. Retrieved from: https://www.azahcccs.gov/AHCCCS/Downloads/Plans/StrategicPlan_15-19.pdf.
[121] Section 27-80-201, C.R.S., et. seq.
[122] Section 27-67-103, C.R.S., et. seq.

Claims Denials by Behavioral Health Organizations

IN BRIEF

- From 2010 to 2015, denied inpatient and denied outpatient authorizations increased by 7% and 20%, respectively.
- From 2010 to 2015, denied inpatient claims and denied outpatient claims decreased by 19%.
- Administrative denials, due to providers not requesting an authorization for services that were rendered pursuant to agreed-upon contractual requirements, represented 62% of inpatient authorization denial reasons and 47% of outpatient denial reasons in 2015.
- Similarly, providers not securing an authorization for services provided represent the greatest reason for 2015 inpatient claims denials at 48%.
- The greatest reason for outpatient claims denials in 2015 (41%) was due to claims being submitted without complete information or the provider not following standard billing practices.

BHOs review authorization requests and claims to assess whether rendered or requested services are covered and whether the service is medically necessary. [123] The CBHC collected data on reasons for service authorization and claims denials over time. It is important to recognize that, generally, appropriate utilization management properly determines medical necessity. There may be systemic considerations such as policies and contractual obligations for which services are denied. Criteria for covered services can also change over time. Relatedly, the Colorado Hospital Association has identified reimbursement for services provided to the co-occurring population to be problematic, often due to disagreement between the treating physician and BHO medical staff in an individual's primary diagnosis, as well as a time-consuming and expensive appeals process.[124]

Methodology

BHO data describing claim and authorization behavior was provided by the CBHC. Information included number of claims and authorizations, number of denials, and denial reasons by BHO. The results presented in this section were pulled directly from the CBHC data or were derived from those data. Service authorization and claims denial data, separated by inpatient and outpatient services, were reviewed for trends and information about reasons for denials.

Definitions

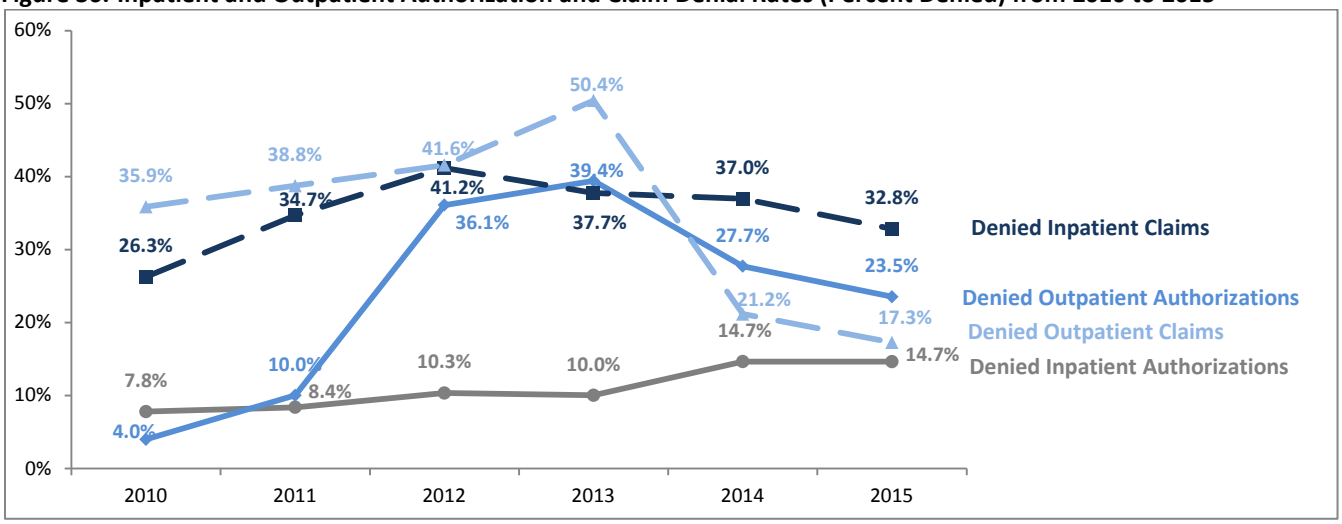
An inpatient authorization is BHO approval for inpatient hospitalization only for an overnight in an acute care psychiatric hospital. An outpatient authorization is BHO approval for services provided by a hospital, such as partial hospitalization, electro-convulsive therapy (ECT), or day treatment, to a BHO client. An authorization denial represents BHO denial of the service as a BHO covered benefit for any of a number of reasons. An inpatient claim is a request for payment for an inpatient hospital facility stay. An outpatient claim is a request for payment for non-emergency outpatient services provided by an inpatient hospital. A claim denial represents BHO denial of payment after the provider delivered the service to a client. See Appendix S for other related definitions, authorization and claim denial categories, the total number of authorizations and claims by BHO, and denial rates by BHO.

Findings

As displayed in the figure below, from 2010 to 2015, the percentage of outpatient authorizations that were denied increased by 20%, while denied inpatient authorizations and denied inpatient claims increased by 7%, and denied outpatient claims decreased by 19%. Administrative denials accounted for the majority of claim and authorization denials. Another major reason for inpatient denial was lack of authorization for service provided. Appendix S provides more detailed information about reasons for authorization and claims denials. While classifications of reasons for denials by the BHOs were not entirely consistent, these findings may indicate disagreement over co-occurring treatment for individuals with both a mental illness and a substance use disorder. Just as public admissions to SUD treatment have increased, the need for co-occurring treatment would logically increase as well, accounting for increased denials.

[123] See https://www.colorado.gov/pacific/hcpf/bho-quality-plans-and-annual-evaluations for BHO contracts, which describe service coverage.
[124] *Medicaid Behavioral Health: Health Systems Perspectives on Barriers to Care and Payment*, Colorado Hospital Association, November 2015. Retrieved from: https://cha.com/Publication-Documents/Medicaid-BH-Health-Sys-Perspectives-(BHO)-FINAL.aspx.

Figure 36. Inpatient and Outpatient Authorization and Claim Denial Rates (Percent Denied) from 2010 to 2015



CMHC Dashboards

Appendix T includes demographic and clinical data for each of the state's CMHC.

4 - Community Mental Health Center Costs and Revenue

In Brief

- Examination of available data and discussions with CMHC and CBHC representatives resulted in the conclusion that estimating CMHC costs to provide the community with a full range of expected services is not currently possible.
- Based on discussions with CMHC and CBHC representatives, there was a consensus that it is nearly impossible to project the costs of maintaining the capacity to respond to a particular community's behavioral healthcare needs in times of disaster (e.g., wildfire or flood) or significant crisis (e.g., school shooting incident).
- Total operating costs increased across all 17 of Colorado's CMHCs by 22% from FY 2013-14 and FY 2014-15 and are projected to increase by 42% from FY 2014-15 to FY 2016-17.
- FY 2014-15 revenues for all CMHCs totaled $553.8 million in FY 2014-15. Revenues for FY 2016-17 are projected to total $762.5 million, an increase of 38%.
- FY 2014-15 revenues from Medicaid averaged 64% of all CMHC revenue.
- CMHC revenues exceeded total costs for both FY 2013-14 and FY 2014-15 by $37 million and $43 million, respectively. Revenues are projected to exceed costs in FY 2016-17 by $39 million.
- The CMHCs reported using surplus revenue to fund capital improvements, expansion efforts, and other needs that arose due to the increase in clients as a result of Medicaid expansion. In FY 2014-15, this capital spending was approximately $56 million.

This section explores the costs associated with operating a CMHC, both in terms of maintaining the capacity required to serve a community with a full range of expected services, as well as the costs associated with maintaining capacity to respond to a community's behavioral health needs in times of disaster or catastrophe (e.g., natural disaster or a school shooting incident). In terms of costs associated with maintaining capacity to provide a full range of expected services, there are a number of factors that influence these costs, including geographic service area, the number of Medicaid eligible clients, the number of commercially insured clients, the number of indigent clients, local behavioral health risk factors, population health factors, stigma issues related to mental health and substance use disorders, as well as diversity within each community. Examination of available data and discussions with CMHC and CBHC representatives resulted in the conclusion that estimating CMHC costs to provide the community with a full range of expected services is not currently possible.

CMHC Operating Costs

Total operating costs

Shown in Table 21 are FY 2013-14 and FY 2014-15 actual total operating costs by CMHC as reported within each center's financial statements. Also shown are FY 2016-17 projected costs, using FY 2014-15 actual costs as a starting basis and incorporating trends for population changes by type of client served, geographic differences, unit costs, and other factors. Costs increased across all 17 of Colorado's CMHCs by 22% between FY 2013-14 and FY 2014-15 and are projected to increase annually by approximately 19% from FY 2014-15 to FY 2016-17. CMHCs in the Denver metro areas reported higher overall operating costs, both in terms of volume and in terms of average cost per client served. Centers in rural and frontier areas reported overall lower operating costs. A similar pattern emerged in analyzing the various populations each CMHC serves, with the largest concentration of Medicaid eligible clients served in the Denver metro areas and far fewer Medicaid eligible clients served in the rural and frontier areas. These increases are largely driven by Medicaid expansion and Colorado population growth.

Table 21. Total Operating Costs by CMHC

CMHC	FY 2013-14	FY 2014-15	% Change	Projected FY 2016-17	% Change
AllHealth	$27,729,147	$36,155,088	30.4%	$55,156,094	52.6%
AspenPointe	$37,159,892	$41,092,320	10.6%	$55,124,642	34.1%
Aurora	$40,505,980	$52,159,307	28.8%	$79,606,171	52.6%
Axis	$11,822,643	$13,800,556	16.7%	$18,530,721	34.3%
Centennial	$9,849,284	$11,369,829	15.4%	$16,081,206	41.4%
CMH	$7,906,877	$9,730,391	23.1%	$13,056,849	34.2%
Community Reach	$27,083,307	$33,937,582	25.3%	$51,774,715	52.6%
Health Solutions	$19,071,225	$24,424,388	28.1%	$32,785,704	34.2%
Jefferson	$39,657,077	$49,675,386	25.3%	$71,529,555	44.0%
MHCD	$68,436,014	$82,020,199	19.8%	$111,335,299	35.7%
MHP	$35,971,556	$43,241,702	20.2%	$62,325,347	44.1%
Mind Springs	$33,873,422	$39,638,109	17.0%	$53,179,311	34.2%
North Range	$21,726,848	$26,440,965	21.7%	$37,555,193	42.0%
San Luis Valley	$6,924,834	$9,139,470	32.0%	$12,278,973	34.4%
Solvista	$6,111,228	$7,986,683	30.7%	$10,744,363	34.5%
Southeast	$6,561,846	$9,063,629	38.1%	$12,183,807	34.4%
SummitStone	$17,786,821	$21,360,313	20.1%	$30,393,963	42.3%
Total	$418,178,001	$511,235,917	22.3%	$723,641,914	41.5%

AVERAGE COST PER CLIENT SERVED

As shown in Table 22, the overall average cost per client is anticipated to rise from $2,502 in FY 2013-14 to $3,239 in FY 2016-17. There are some significant differences in costs per client among CMHCs, which may be due to how each of the centers determines the numbers of clients they serve. For example, Jefferson conducts mental health screenings within schools, which adds significantly to their reported numbers of clients served. This has the effect of lowering the average cost per client served, which partially explains why Jefferson's average cost is the second lowest amongst all CMHCs at $2,208 per client in FY 2016-17. Across all three years of the analysis, MHCD reported the highest average cost per client served, which is anticipated to increase to a high of $6,672 in FY 2016-17. This is likely a result of the nature of the population that it serves. The lowest average cost per client served was reported by CMH which serves part of the Western Slope. Overall, the average costs per client served were reasonably consistent across most of the CMHCs, with many reporting in the $3,000 - $3,500 range.

Table 22. Average Cost per Client Served by CMHC

CMHC	FY 2013-14	FY 2014-15	% Change	Projected FY 2016-17	% Change
AllHealth	$2,279	$2,486	9.1%	$2,980	19.9%
AspenPointe	$2,113	$2,102	-0.5%	$2,395	13.9%
Aurora	$2,335	$2,626	12.5%	$3,150	19.9%
Axis	$2,351	$2,956	25.7%	$3,370	14.0%
Centennial	$2,620	$2,859	9.1%	$3,576	25.1%
CMH	$1,651	$1,846	11.8%	$2,103	13.9%
Community Reach	$2,317	$2,428	4.8%	$2,911	19.9%
Health Solutions	$2,587	$2,694	4.1%	$3,071	14.0%
Jefferson	$1,470	$1,807	22.9%	$2,208	22.2%
MHCD	$4,854	$5,438	12.0%	$6,672	22.7%
MHP	$4,274	$3,605	-15.7%	$4,409	22.3%
Mind Springs	$2,782	$2,910	4.6%	$3,315	13.9%
North Range	$2,203	$2,508	13.8%	$3,150	25.6%
San Luis Valley	$1,687	$1,808	7.2%	$2,062	14.1%
Solvista	$2,056	$2,846	38.4%	$3,252	14.2%
Southeast	$3,138	$3,559	13.4%	$4,062	14.2%
SummitStone	$2,665	$2,845	6.7%	$3,580	25.8%
Total	**$2,502**	**$2,726**	**8.9%**	**$3,239**	**18.8%**

ADMINISTRATIVE BILLING COSTS

There are several sources of revenues generated by the CMHCs. Considerable administrative time and effort are required to appropriately identify, bill, and meet reporting requirements of each of the payer sources. The CMHCs identified the percentage of overall CMHC administrative costs associated with appropriately identifying and billing the various payer

sources. The costs that CMHCs identified, an overall average of approximately 1% of all operating costs for FY 2014-15, are shown in Appendix U, which details FY 2013-14 and FY 2014-15 actual costs, as well as projected costs for FY 2016-17. Note that these costs are a subset of the operating costs shown in Table 21. This subset of administrative costs has increased significantly and is projected to increase in FY 2016-17 across all CMHCs. The costs associated with identifying and billing appropriate payer sources were directly related to the number and types of clients served; thus, the Denver metro areas have the highest costs for this administrative activity (as a result of the high numbers of clients served), while the rural and frontier areas of the state demonstrate the lowest costs.

CASE MANAGEMENT COSTS

In addition to the above administrative costs, there are costs associated with assisting clients with the acquisition of other essential and support services, such as housing and transportation. There was a direct correlation between the number of hours of case management time provided by each CMHC and the cost of assisting clients with other support services; thus, estimating case management costs provided a proxy measure for the cost of assisting clients with acquiring support services. Appendix U illustrates case management costs for FY 2013-14, FY 2014-15, and projected FY 2016-17. MHCD incurred more total costs than all other CMHCs providing these services. However, as a percentage of total costs, the more rural CHMCs and more geographically dispersed CMHCs incurred a greater percentage of all costs in support of these types of services. For example, the centers with the highest case management costs, as a proportion of total costs, included Solvista (11%), Centennial (9%), Southeast (7%), and San Luis Valley (6%), all serving more rural parts of the state. By comparison, the CMHCs that incurred the lowest case management costs, as a proportion of all costs, were AspenPointe (1.5%), and Aurora (2%), which serve more urban/suburban areas of the state. The other urban CMHCs, including two in the Northeast region, spend a significant amount of time providing these services.

COST TO RESPOND TO DISASTERS OR CATASTROPHES

CMHC and CBHC representatives indicated that it is nearly impossible to project the costs of maintaining the capacity to respond to a particular community's behavioral healthcare needs in times of disaster (e.g., wildfire or flood) or significant crisis (e.g., school shooting incident). The incidence and scope of a disaster or crisis cannot be predicted until the extent and scope of a traumatic event are known. According to the CMHCs, the CMHC staffs are typically diverted from their normal responsibilities to assist with a disaster or catastrophe; thus, no new staff is typically hired by CMHCs. Any new staff that may be hired as part of the response could likely be funded by the Federal Emergency Management Agency, state emergency funds, the Victims of Crime Act Crime Victims Fund, private foundations, or federal Substance Abuse and Mental Health Services Administration Emergency Response Grants. While many of the emergencies that CMHCs must respond to are more localized, they often qualify for federal aid that assists with the costs of services. According to the CMHCs, cost estimates for necessary services when responding to natural disasters or community crises over the last 20 years range from as low as $15,000 (2013 Jessica Ridgeway murder) to over $1 million (2012 Aurora theater shooting).

CMHC Revenues

CMHC revenues for FY 2014-15 are detailed in Table 23. FY 2014-15 revenues for all CMHCs totaled $553.8 million. Revenues for FY 2016-17 are projected to total $762.5 million, an increase of 38%. FY 2014-15 actual and FY 2016-17 projected revenues by funding source are included in Appendix U.

As illustrated in Table 23, as a percentage of total revenues by funding source, revenues from Medicaid averaged 64% of all CMHC revenue. In addition to Medicaid, CMHCs generated revenues from a number of sources, including Medicare, private insurance, patient-pay clients, as well as sources categorized as "All Other," which include federal grants, state and local government funding, cash contributions, donated/in-kind medications, and other miscellaneous fund sources. (Cost report data did not allow for identifying state revenues separately from other revenue sources in this category.) The next highest source of revenue after Medicaid was the "All Other" category (30%).

While overall Medicaid represented approximately 64% of all CMHC revenues, the percentages varied among CMHCs, with Health Solutions reporting the highest proportion of revenues from Medicaid (84%) and MHP reporting the lowest proportion of revenues from Medicaid (49%). Medicare accounted for less than 1% of the CMHC revenues statewide, with some rural CMHCs reporting no revenues from Medicare. Commercial payers represented a little over 2% of the CMHC revenues statewide, with most being reported by Denver metro CMHCs. Interestingly, MHCD reported no revenue from commercial payers. Patient self-pay revenues were just above 3% of total revenues statewide, and this amount varied significantly by CMHC, with a few reporting close to 0%, and Mind Springs, which is along the western slope of Colorado, reporting these revenues as over 25% of total revenues. All other revenue sources made up about 30% of total CMHC revenues, varying from the teens in rural and frontier areas to about 48% of total revenues for MHP in Boulder.

Table 23. FY 2014-15 CMHC Revenue by Fund Source

CMHC	Medicaid	Medicare	Commercial	Patient Pay	All Other	Total
AllHealth	49.7%	1.3%	14.0%	3.2%	31.7%	100%
AspenPointe	81.9%	0.8%	1.2%	0.3%	15.8%	100%
Aurora	63.9%	0.2%	2.2%	1.0%	32.8%	100%
Axis	50.0%	1.3%	3.2%	1.5%	43.9%	100%
Centennial	61.6%	0.8%	4.1%	2.3%	31.2%	100%
CMH	70.0%	1.2%	1.4%	2.2%	25.2%	100%
Community Reach	76.8%	0.6%	3.8%	0.7%	18.1%	100%
Health Solutions	83.5%	0.9%	1.0%	1.0%	13.7%	100%
Jefferson	68.6%	0.7%	1.1%	1.0%	28.6%	100%
MHCD	57.4%	1.1%	0.0%	0.5%	41.1%	100%
MHP	49.2%	0.6%	1.5%	0.8%	47.9%	100%
Mind Springs	55.4%	0.0%	0.0%	25.8%	18.8%	100%
North Range	59.3%	0.2%	3.3%	5.5%	31.7%	100%
San Luis Valley	80.7%	0.0%	1.2%	2.5%	15.6%	100%
Solvista	74.1%	1.6%	0.7%	0.6%	23.1%	100%
Southeast	81.5%	0.0%	0.0%	0.1%	18.4%	100%
SummitStone	68.2%	0.4%	0.7%	1.1%	29.6%	100%
Total	64.0%	0.7%	2.2%	3.3%	29.8%	100%

Table 24 displays CMHC revenue less expenses for FY 2013-14, FY 2014-15, and FY 2016-17 (projected). Statewide, CMHC revenues exceeded total costs for both FY 2013-14 and FY 2014-15 by $37 million and $43 million, respectively. Revenues are projected to exceed costs in FY 2016-17 by $39 million. According to the CMHCs and HCPF, when Colorado expanded its Medicaid program under the ACA, it was not known the extent to which the expansion provisions would impact the operations of CMHCs, nor the behavioral healthcare morbidity levels of the new expansion populations. Very little historical cost data existed within Colorado for these new groups, so the rates were developed based on data from other states that had made similar expansion decisions and using actuarial judgment. The Medicaid reimbursement rates for BHOs and CMHCs were calculated using favorable client growth assumptions, which in turn generated significantly higher revenues as compared to costs that were incurred during the first years of implementation of the ACA.

Table 24. CMHC Revenue Less Expenses

CMHC	FY 2013-14	FY 2014-15	Projected FY 2016-17
AllHealth	$1,659,104	-$75,721	-$2,381,478
AspenPointe	$4,227	$907,177	$107,651
Aurora	$2,096,396	-$195,563	-$2,011,503
Axis	$669,104	$2,407,677	$2,082,449
Centennial	$509,845	$1,064,603	-$75,381
CMH	$918,896	$2,531,290	$2,931,094
Community Reach	$5,719,558	$5,993,548	$7,641,017
Health Solutions	$2,503,150	$1,485,218	$1,384,722
Jefferson	$5,228,311	$8,372,976	$3,723,261
MHCD	$8,535,683	$2,175,045	$12,789,870
MHP	$1,563,853	$8,117,363	$8,541,864
Mind Springs	$2,161,592	$5,253,065	$5,705,889
North Range	$2,265,927	$1,354,629	-$1,815,186
San Luis Valley	$863,165	$389,747	$206,672
Solvista	$649,366	$913,664	$939,013
Southeast	$763,793	$75,792	-$192,188
SummitStone	$800,150	$1,811,666	-$763,752
Total	**$36,912,120**	**$42,582,176**	**$38,813,746**

The increase in the number of individuals eligible for Medicaid resulted in a significant increase in CMHC revenues. In turn, this resulted in many more people coming to the CMHCs for services, necessitating a large increase in staff and physical facilities needed to serve the additional clients. However, CMHCs were unable to expend all these funds during the fiscal years in which they were paid. This was primarily due to the fact that, at the peak of the hiring, it was taking between five and six months to bring on qualified staff. In addition, the CMHCs' strategy to handle the increased demand was to purchase new facilities and to renovate existing facilities; however, there is a "lag time" associated with expensing building

acquisitions and renovations. Because purchasing a building and the cost to renovate is capitalized, the amortized cost (depreciation) will be stated on the income and expense statement over the next 20 to 30 years, thus showing a larger profit in the short term.

The CMHCs reported they were able to use some of the revenue to fund capital improvements, expansion efforts, and other needs that arose due to the additional covered population; costs not normally funded by any of the revenue sources.[125] In FY 2014-15, approximately $56 million of the revenue was used towards capital improvement; nearly all of this revenue was used to add staff and improve facilities in order to better serve the large increase in Coloradans eligible for Medicaid.[126] Going forward into FY18, no capital spending will be allowed to be included in the rate setting process for Medicaid. All CMHC costs will be based on encounters or other operating expenses as allowed by provider contracts. CBHC indicated that removing this support will make it difficult for CMHCs to fund and complete capital improvements when needed in the future.

CMHCs surveyed by CBHC provided the following more detailed explanation of the reasons for the large increase in net assets:

- 74% cited Medicaid expansion funding as the single biggest reason.
- 7% received unexpected grant awards.
- 6% had one time property sales.
- 5% received very large donations, which are most unusual in this system.
- 8% cited a variety of miscellaneous reasons that accounted for increases in net assets.

In terms of how these monies were used by the Centers, here, again, are the details reported by the CMHCs:

- 49% of the funds was spent for building improvements and the purchase of real property ($29.3 million).
- 40% was used to hire additional staff and to increase wages and benefits to aid in staff retention ($23.9 million).
- 3% was set aside to purchase new electronic medical record systems ($2.1 million).
- 1% was employed to expand services in areas not covered in the past ($800,000).
- 7% cited a variety of other uses of the funding ($3.9 million).

[125] Information in this paragraph and the following paragraph compiled from written Information provided by Doyle Forrestal, CBHC, August 16, 2016.
[126] This amount exceeds the surplus revenue amount in Table 24 because the CMHCs had access to other revenue, in addition to the amounts shown in the table.

5 - Conclusions and Recommendations

This study examined behavioral health funding in Colorado, including the impact of the Affordable Care Act and Medicaid expansion on the state's primary behavioral health safety net populations (individuals served by the Medicaid capitation program and indigent individuals who lack insurance served by state and federal funds). The study also reviewed the state systems for providing public behavioral health services to safety net populations, including the funding allocation and reimbursement methodologies utilized by state agencies and behavioral health service providers. An in-depth examination of the Medicaid capitation and Office of Behavioral Health indigent populations, including clinical and funding needs, attempted to identify any unique or distinct service needs of the indigent population in an effort to inform the allocation of state funds for this population.

Colorado has Increased Behavioral Health Services and Funding for Safety Net Populations

As a result of Medicaid expansion, more individuals are receiving behavioral health services than ever before. While Colorado's population increased by 5% from 2012 to 2015, the total number of persons served in the public behavioral health system increased by 50%. State spending for behavioral health services across all state programs totaled nearly $1 billion in FY 2014-15, increasing by 63% from FY 2011-12, primarily due to Medicaid expansion. The ACA and the creation of the Colorado Health Insurance Exchange has served to reduce the number of uninsured Coloradoans by 58% from 2011 to 2015; however, the number of underinsured has increased by 30% during this same time. The increase in underinsured may reflect that while more individuals are insured, they are challenged by the cost of insurance and health care, including out of pocket expenses to reach annual deductable amounts and for copayments related to services.

A significant number of safety net individuals with serious behavioral health needs have not received services, particularly those with Substance Use Disorder needs. An estimated 100,316 individuals with a Serious Behavioral Health Disorder were not served in FY 2014-15; 54% of these individuals have a Substance Use Disorder, 20% have a Serious Mental Illness, 20% have a Serious Emotional Disorder and 6% have a Co-Occurring Disorder.

The significant increase in the number of underinsured and the estimated number of underinsured with an SMI indicates a significant number of individuals may have the need for behavioral health services but lack the resources to obtain these services. Information provided by the CBHC supports this observation, as several CMHCs report a large increase in the number of clients who do not meet the OBH indigent funding criteria as they have insurance, but do not have the funds to pay for services due to the relatively high annual deductable amounts for their insurance coverage. As a result, CMHCs may have to prioritize serving these clients after serving Medicaid clients, clients eligible for OBH indigent funding, and clients with other insurance.[127]

The difference in the average number of mental health services received by OBH indigent clients, in comparison to Medicaid capitation clients, may indicate that disparities exist in meeting the needs of these two populations. On average, capitation clients received 28% more mental health services (28) in FY 2014-15 than OBH indigent clients (22). Adult capitation clients received 9% more mental health services (31) than adult indigent clients (29), while capitation clients under the age of 18 received 65% more mental health services (22) than indigent clients under the age of 18 (13).

Variations in the average cost of services between capitation clients and OBH indigent clients are not directly comparable, as Medicaid capitation includes a broader range of services, including inpatient and residential treatment, than OBH indigent funding. The average FY 2014-15 capitation mental health services cost per client ($2,425) was 39% higher than the average OBH indigent cost per client ($1,749). The average FY 2014-15 capitation SUD services cost per client equaled $1,040 in FY 2014-15, significantly below the average capitation mental health services cost per client of $2,425.

The analysis of the OBH indigent population may help target service and funding needs. OBH indigent funding served a slightly more clinically severe population than Medicaid capitation. Multiple indicators of severity indicated that OBH indigent funding was critical for serving the most severe clientele. Although both funding sources served the whole range of the behavioral health population, the capitation program served more clients with less severe needs, as well as more children and youth. A significant proportion of the OBH indigent population was struggling with homelessness and unemployment, and homelessness, in particular, appeared to be associated with poor functioning and a higher cost of care. Similarly, recovery supports were needed to support individuals' post-acute treatment and prevent relapse.

[127] Focus group with Colorado Behavioral Healthcare Council members, July 20, 2016.

OBH should continue to explore alternative payment approaches for the use indigent funds, including funding provided through the "Services for Mentally Ill Clients" appropriation for:

- *Individuals who meet the current OBH indigent definition as Target and Non-Target clients. OBH should explore alternatives to target number requirements, including providing funding for underinsured individuals and individuals who move on and off Medicaid or remain uninsured.*
- *Individuals who are currently covered by Medicaid but need behavioral health services not currently covered by Medicaid to support their recovery needs.*

OBH should continue to explore ways to expand support for prevention and early intervention, supportive housing, supportive employment, and peer/navigation services in coordination with the Medicaid benefit.

The Governor's Office and OBH should examine the behavioral health and health insurance policy implications created as a result of the increase in the number of underinsured individuals and investigate methods to assist these individuals, particularly those with an SMI or SED, in obtaining behavioral health services.

Despite Stronger State Agency Partnerships, the System is Still Fragmented and Complex

Given the numerous state agencies providing services at many points along the behavioral health continuum from prevention to inpatient treatment, there is no simple solution to improving the efficiency and effectiveness of the state's behavioral health organizational structure. Unilaterally moving the authority and control of all behavioral health funding, planning, programs, and regulations into a single department and agency would not necessarily improve the situation and could create increased inefficiencies. For example, authority over behavioral health services delivered to adult and juvenile corrections populations while incarcerated should most likely remain with the agencies legally responsible for their care. On the other hand, centralizing the authority and funding for behavioral health prevention programs, which is currently dispersed over several agencies, could lead to increased efficiencies, and perhaps effectiveness.

The Governor's Office of State Planning and Budgeting should conduct a detailed review of each state behavioral health program administered outside of HCPF and OBH. The review should examine the each program's cost and benefits, including the costs and benefits of relocating the program to a centralized behavioral health agency such as HCPF or OBH. The review should include qualitative input from agency and program staff, along with input from individuals receiving services and providers and other identified stakeholders. The program reviews should include an analysis of whether or not services currently funded entirely by General Fund are eligible for Medicaid reimbursement.

The continued segregation of the management and administration of Medicaid and non-Medicaid behavioral health programs by HCPF and OBH (respectively), creates challenges, complexities and inefficiencies. OBH and HCPF are aware of the difficulties created by the current administrative structure and work together to attempt to address these challenges. The agencies have partnered to address contracting, allocation, data system, performance measure, and service definition issues. For example, during FY 2014-15, both agencies met monthly to identify opportunities to maximize Medicaid reimbursement under Medicaid expansion, and developed plans to implement an integrated management information system to manage OBH indigent eligibility and reimbursement and the development of a crosswalk of behavioral health services covered by OBH and HCPF.

Despite the efforts of the two agencies, significant challenges remain for clients and providers. As discussed earlier, the system of reimbursing providers for services provided to indigent clients results in payment errors for clients who were Medicaid eligible and enrolled in a BHO. The current system is outdated. It does not serve clients or consumers well, does not lend itself to transparency, and is inefficient. CDHS and HCPF continue to implement incremental changes, including increased auditing capabilities and minimum service definitions for CMHCs and substance use disorder providers, the structure of the current system prevents any significant increases in efficiency and effectiveness. It seems inevitable that the current system requires funds and resources that could otherwise be directed to providing direct care.

OSPB, HCPF, and CDHS should examine options to place administrative responsibilities for non-Medicaid behavioral health services and supports with the Regional Accountable Entities that will administer Medicaid behavioral health services under Phase II of the Accountable Care Collaborative, either under the state responsibility of OBH or under the responsibility of a state behavioral health authority. Making this structural change to the state's behavioral health system could strengthen the coordination and equity of care provided to individuals across the state, while also improving effectiveness and efficiency in the use of state and federal funds.

Funding Allocation and Reimbursement Methodologies are Complicated and Error Prone

Given the large number of OBH programs and appropriations (some very specific as to the population served, the services provided, or the regions of the state receiving the services), OBH is faced with the task of allocating funding to dozens of

providers and administrative entities (e.g., CMHCs, MSOs, prevention providers). OBH uses a variety of methods to allocate funding. One of OBH's primary goals for its reimbursement requirements is to ensure that providers are not spending OBH funds for services provided to individuals that have insurance (including Medicaid, Medicare, and private insurance) that would pay for the service. This challenge is compounded by the fact that CMHCs receive a sub-capitation payment from the BHOs that is not based on actual services provided (similar to FFS or case rates). The use of sub-capitation payments, coupled with OBH reimbursement requirements, creates a burden on OBH to ensure that services are not funded by two payers (HCPF and OBH).

- OBH is to be credited by building accountability and transparency into its reimbursement methodologies in an effort to prevent overpayments for services. However, the requirement that providers use multiple methods for obtaining reimbursement for contracted services creates an administrative burden and requires more resources be directed to these administrative and billing activities when the resource may be better allocated toward providing services to clients. The complexity of reimbursement requirements has led to payment errors. A comparison of the encounter files from 7,800 individuals indicated that 664 clients of the 3,674 individuals matched (18%) were enrolled with a BHO on the date services were provided with OBH indigent funding. Thus, it is assumed OBH made case rate payments of $3,186 per client (the FY 2014-15 case rate amount) per individual to CMHC's for clients who were also funded by Medicaid capitation. The total estimated amount of these payments is approximately $2.1 million.

OBH should take immediate action to significantly reduce or eliminate the payment of indigent client funding to CMHCs for individuals who are Medicaid eligible and enrolled in a BHO. Actions could include conducting periodic and regular comparisons of encounter data files, including the methodology used in this study, and the risk-based compliance monitoring process described by OBH. OBH may also find benefit in grouping or segregating the specific encounters and CCARs submitted by CMHCs as a basis for case rate payment.

OBH should continue to explore options to reduce or simplify reimbursement methods used in order to minimize payment for services that are covered by Medicaid and simplify the accounting for both the state and providers. One strategy that OBH and HCPF continue to explore is the Medicaid Management Information System (MMIS) to streamline eligibility checking and payments for applicable programs. CDHS should prioritize investment in this integration of eligibility determination and payment processing. CDHS should review the legislative intent of the various General Fund appropriations that are being offset based on the capacity-based protocol.

HCPF should examine options to simplify and align Medicaid reimbursement for SUD providers with mental health services. This may include examining sub-capitation and standardized BHO contract provisions to address the administrative and reimbursement complexities created by the need for SUD providers to contract with multiple BHOs.

Appendix A - State Agencies and the Services they Provide

Service	Program Description	FY 2011-12 Expenditures	FY 2011-12 Clients Served	FY 2014-15 Expenditures	FY 2014-15 Clients Served
Colorado Department of Human Services					
Office of Behavioral Health					
Services for Indigent Mentally Ill Clients	Community-based mental health services for indigent adults and youth who are not eligible for Medicaid are provided through the State's 17 Community Mental Health Centers (CMHC). The medically indigent individual (income less than 300 percent of the federal poverty level) is not eligible for Medicaid, and does not receive mental health care from any other source or service. Each CMHC is responsible for providing a set of core services, including: residential; inpatient; vocational; psychiatric/medication management; interagency consultation; public education; early intervention; consumer advocacy and family support. Each CMHC has access to a certain number of inpatient beds at one of the Mental Health Institutes, and is responsible for managing admissions to the allotted beds for adults within their respective service areas. Unlike services provided under the Medicaid capitation program, services for indigent clients are not an entitlement; thus, the number of individuals receiving services is directly correlated with the level of available funding.	$37,628,712	9,468	$36,629,154	10,203
Medications for Indigent Mentally Ill Clients	This funding is used by the community mental health centers for direct purchase of medications or to employ an individual to negotiate the purchase of medications.	$1,688,283	N/A	$1,521,855	N/A
School-based Mental Health Services	Each CMHC supports a school-based mental health specialist through this program. The specialists serve as a liaison between the schools and the Centers.	$1,098,670	N/A	$1,188,380	N/A
Assertive Community Treatment Programs	Assertive Community Treatment (ACT) is a systematic, evidence-based treatment and case management service delivery model for adults with serious and persistent mental illness who are at a heightened risk of homelessness, psychiatric hospitalization, and institutional recidivism. The ACT model includes a mobile mental health team with members that function interchangeably to provide the treatment, rehabilitation and support services that adults with serious mental illnesses need to live successfully in the community.	$645,200	N/A	$674,557	N/A
Alternatives to Inpatient Hospitalization at a Mental Health Institute	This program provides services to individuals who would otherwise require hospitalization at one of the mental health institutes. Funding is allocated among CMHCs to provide: acute treatment unit and residential treatment capacity; medication administration education and practice; intensive therapy and case management; mentoring; and other services to improve the patient's level of functioning in the community.	$3,138,615	N/A	$3,261,625	N/A
Mental Health Services for Juvenile and Adult Offenders	This program provides services for juvenile and adult offenders who have mental health problems and are involved with the criminal justice system. Eleven Community Mental Health Centers employ staff who provides case management, wrap-around services, medications, and treatment services that are not covered by Medicaid. This program is supported by tobacco litigation settlement moneys that are annually transferred to the Offender Mental Health Services Fund.	$3,453,338	N/A	$3,088,993	N/A
Mental Health Treatment Services for Youth	In 1999, the Colorado General Assembly adopted HB 1116, the Child Mental Health Treatment Act (CMHTA), which provides funding for mental health treatment services for children under the age of 18, without the need for county department of human services involvement. Services may include in-home family mental health treatment, other family preservation services, residential treatment, or post-residential follow-up services. Services for children who are Medicaid-eligible may be provided by the local Behavioral Health Organization, while local Community Mental Health Centers may provide services for non Medicaid-eligible children. Parents are also responsible for paying a portion of the cost of care based on a sliding scale.	$1,018,777	N/A	$716,654	N/A
Mental Health First Aid	Mental Health First Aid is a public education program designed to provide training to adults to help identify mental health and substance abuse problems, to connect individuals to care, and to safely de-escalate crisis situations when needed. The program is intended to teach lay persons methods of identifying and assisting young people and adults who may be developing a behavioral health problem, and encouraging them to seek appropriate support and services as early as possible.	N/A	N/A	$750,000	N/A

Service	Program Description	FY 2011-12 Expenditures	FY 2011-12 Clients Served	FY 2014-15 Expenditures	FY 2014-15 Clients Served
Substance Use Treatment and Prevention					
Treatment and Detoxification	The Office of Behavioral Health contracts with four managed service organizations (MSO) for the provision of substance use disorder treatment and detoxification services in seven catchment areas of the State for indigent individuals who are not eligible for Medicaid and to provide services not covered by Medicaid. The MSOs subcontract with local treatment providers with locations around the state to deliver these services. The providers are required to place and emphasis on providing services to: persons involuntarily committed by the courts; pregnant women and women with dependent children; adult and adolescent intravenous drug users; drug-dependent adults and adolescents with human immunodeficiency virus (HIV) or tuberculosis; and uninsured individuals.	$22,800,002	N/A	$30,743,690	N/A
Case Management for Chronic Detoxification Clients	Treatment and detoxification are two different levels of care that have separate and distinct contract admission requirements. 1) *Non-hospital detoxification services*: Individuals who are intoxicated by alcohol or drugs are evaluated and provided services necessary to protect client and public health and safety until the blood level of the intoxicating substance(s) is zero. Detoxification services are critical for law enforcement and community protection, but do not constitute treatment for substance abuse. 2) *Treatment*: Basic treatment services include: outpatient opioid replacement treatment; individual, group, and family outpatient therapy; intensive outpatient therapy; transitional residential treatment; therapeutic community, and intensive residential treatment.	$369,311	N/A	$411,673	N/A
Short-term Intensive Residential Remediation and Treatment (STIRRT)	This is the Project to Reduce Over-Utilization of Detoxification (PROUD), a program designed to address the overuse of detoxification facilities and associated emergency services by chronic alcohol and substance users. In addition to substance abuse problems, most PROUD clients are homeless, have co-occurring mental and/or physical health problems, and face significant barriers to employment. Case managers help clients navigate the behavioral and physical health care systems, and provide linkages to food assistance, housing, transportation, vocational, and other services designed to reduce detox episodes and support long-term recovery.	$3,240,091	N/A	$3,447,833	N/A
High Risk Pregnant Women Program	The goal of the Short-term Intensive Residential Remediation and Treatment (STIRRT) program is to reduce recidivism among adult male and female offenders who are at high risk of incarceration (either in a county jail or the Department of Corrections) resulting from continued substance abuse. STIRRT includes two weeks of intensive residential treatment, followed by continuing care in an outpatient setting for at least eight months, based on individual need. Clients are primarily referred from Probation or drug courts, the Department of Corrections Parole, and community corrections.	$1,126,309	N/A	$843,895	N/A
Prevention Contracts	These prevention programs provide youth, families and communities with the resources and skills to increase protective factors and decrease risk factors linked to substance abuse. The Office of Behavioral Health contracts with statewide and local prevention programs by providing partial funding for services designed to prevent the illegal and inappropriate use of alcohol, tobacco, and other drugs. Services include: mentoring, tutoring, life skills training, parenting training, creative arts, education/resource centers, DUI prevention programs, and employee assistance programs. The prevention strategies are largely focused on providing communities with information and prevention education, which involves a structured, formal research-based curriculum and problem identification and assessment, which determines whether substance abusing behavior can be reversed through education.	$3,829,412	N/A	$5,398,574	N/A
Persistent Drunk Driver Programs	These programs are funded through the Persistent Drunk Driver Cash Fund, which consists of a surcharge of $100 - $500 for persons convicted of DUI, DUI per se, or DWAI. Moneys in the Persistent Drunk Driver Cash Fund are used to pay for the following:• To support programs that are intended to deter persistent drunk driving or intended to educate the public regarding the dangers of drunk driving;• To pay a portion of the costs for intervention or treatment services statutorily required for a persistent drunk driver who is unable to pay for the required intervention and treatment services;• To assist in providing ignition interlock devices for indigent offenders;• To assist in providing continuous monitoring technology or devices for indigent offenders; and,• To support costs incurred by the Department of Revenue concerning persistent drunk drivers, including costs associated with the revocation of a driver's license.	$1,439,436	N/A	$1,890,919	N/A
Law Enforcement Assistance Fund	The Law Enforcement Assistance Fund (LEAF) consists of revenues from a $75 surcharge on drunk and drugged driving convictions to help pay for enforcement, laboratory charges, and prevention programs. The funding is used to establish a statewide program for the prevention of driving after drinking, including:	$135,633	N/A	$255,000	N/A

Service	Program Description	FY 2011-12 Expenditures	FY 2011-12 Clients Served	FY 2014-15 Expenditures	FY 2014-15 Clients Served
Contracts	• Educating the public in the problems of driving after drinking; • Training of teachers, health professionals, and law enforcement in the dangers of driving after drinking; • Preparing and disseminating educational materials dealing with the effects of alcohol and other drugs on driving behavior; and, • Preparing and disseminating education curriculum materials for use at all levels of school, specifically to establish impaired driving prevention programs.				
Federal Grants	The Office of Behavioral Health receives a variety of federal alcohol and substance use discretionary grants, which are included in this line.	$3,403,072	N/A	$3,220,975	N/A
Balance of Substance Abuse Block Grant Programs	This line item includes federal Substance Abuse Prevention and Treatment Block Grant allocations. The Office of Behavioral Health has the flexibility to allocate funds in this line item to the Treatment and Detoxification Contracts and Prevention Contracts line items. The Department is required to use 35 percent of block grant funds for alcohol abuse programs, 35 percent for drug abuse programs, and 20 percent for prevention. The remaining 10 percent may be used for any of these three areas. This flexibility is essential for the Department to meet the five earmarked requirements of each block grant award (administration, drug/alcohol treatment, prevention, women's services, and HIV early intervention).	$8,774,622	N/A	$216,466	N/A
Community Prevention and Treatment	These funds are used to purchase community services designed to prevent and treat alcohol and drug abuse. This line item is supported by tobacco settlement moneys that are annually transferred to the Alcohol and Drug Abuse Community Prevention and Treatment Fund.	$813,771	N/A	$692,659	N/A
Rural Substance Abuse Prevention and Treatment	In the 2009 Legislative Session, House Bill 09-1119 created the Rural Alcohol and Substance Abuse Prevention and Treatment Program. A "rural area" is defined as a county with a population of less than 30,000. The program consists of two components: 1) Half of the available funds support the Rural Youth Alcohol and Substance Abuse Prevention and Treatment Project, which provides prevention and treatment services to children ages eight to 17 in rural areas. 2) The remaining half of the funds support treatment services for persons addicted to alcohol or drugs. These funds are allocated to six of the seven MSO regions to support detoxification facilities in rural counties.	$88,436	N/A	$124,829	N/A
Gambling Addiction Counseling Services	This program, which is supported by 2.0 percent of the gaming tax revenues that are annually transferred to the Local Government Limited Gaming Impact Fund, provides gambling addition counseling services to Colorado residents. Moneys in the Fund may be used to provide grants to state or local public or private entities and programs that provide gambling additional counseling services and that have, or are seeking nationally accredited gambling addiction counselors.	$68,417	N/A	$82,343	N/A
Crisis Response System- Walk-in, Stabilization, Mobile, Residential, and Respite Services	The State's Crisis Response System was authorized through SB 13-266. The Act defined "crisis intervention services" to mean an array of integrated services that are available 24 hours per day, seven days per week, to respond to and assist individuals who are experiencing a behavioral health emergency. This line item supports walk-in crisis services and crisis stabilization units with the capacity for immediate clinical intervention, triage, and stabilization. Mobile crisis services are units that are linked to the walk-in crisis services and crisis respite services, and have the ability to initiate a response in a timely fashion to a behavioral health crisis. Residential and respite crisis services are linked to the walk-in crisis services, and include a range of short-term crisis residential services, including but not limited to community living arrangements.	N/A	N/A	$22,007,161	N/A
Crisis Response System – Telephone Hotline	The crisis response telephone hotline (1-844-493-TALK) supports a 24-hour telephone crisis service that is staffed by skilled professionals who are capable of assessing anyone who may be affected by a mental health, substance abuse, or emotional crisis, and making the appropriate referrals.	N/A	N/A	$2,355,865	N/A
Crisis Response System – Marketing	This appropriation supports a contract with a marketing firm for a Statewide public information campaign regarding the crisis response telephone hotline.	N/A	N/A	$615,000	N/A
Community Transition Services	These funds provide 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. Currently, the Office of Behavioral Health contracts with	N/A	N/A	$4,801,597	N/A

Service	Program Description	FY 2011-12 Expenditures	FY 2011-12 Clients Served	FY 2014-15 Expenditures	FY 2014-15 Clients Served
	Behavioral Health Inc. (BHI), which in turn works with the mental health institutes and community organizations and agencies to provide a client-centered continuum of services for clients who are difficult to discharge from the institutes as well as clients who have a history of behavioral health-related hospitalizations. BHI staff work with transitioning individuals 30 days prior to discharge from the institutes and up to 60 days after they return to their communities.				
Jail-based Behavioral Health Services	This program provides jail-based behavioral health services to offenders residing within county jails. The Office of Behavioral Health contracts with county sheriffs' departments to administer the funds; in turn, sheriff departments work with local community providers to provide screenings, assessment, and treatment within jails, as well as case management for transitional care and a seamless re-entry in treatment services in the community. Treatment providers screen all inmates for presence of substance use disorders, mental health disorders, trauma, and traumatic brain injury, and identify inmates with active duty or veteran military status.	$1,118,134	N/A	$4,580,539	N/A
Rural Co-occurring Disorder Services	The Rural Co-occurring Disorder Program provides for a full continuum of co-occurring behavioral health services to adolescents and adults in southern Colorado and the Arkansas Valley. These funds were appropriated based on data that demonstrated a gap in the service delivery system for southern Colorado relating to services for the co-occurring, dually diagnosed population, including primary substance use and secondary mental health (Axis I) anxiety and depression. Services include residential and outpatient services with a combination of individual and group mental health therapies, individual and group substance use treatment, case management, medication assisted therapy, substance use testing, and other similar services.	N/A	N/A	$512,500	N/A
	Subtotals - Office of Behavioral Health	**$95,878,241**	**9,468**	**$130,032,736**	**10,203**
Mental Health Institutes					
Ft. Logan	The funding shown here includes support for employee salaries and benefits, operating costs, and pharmaceutical expenses for the Colorado Mental Health Institute at Ft. Logan. Also included here is funding for contracted medical services and the medical staff employed through an interagency agreement with the University of Colorado - Denver School of Medicine.	$19,254,908	465	$21,091,200	418
Pueblo[2]	The funding shown here includes support for employee salaries and benefits, operating costs, and pharmaceutical expenses for the Colorado Mental Health Institute at Pueblo. Also included here is funding for contracted medical services and the medical staff employed through an interagency agreement with the University of Colorado - Denver School of Medicine.	$71,020,056	2,693	$83,876,685	2,536
	Subtotals - Mental Health Institutes	**$90,274,964**	**3,158**	**$104,967,885**	**2,954**
Division of Child Welfare					
Family and Children's Programs[3]	This line item, also referred to as the "Core Services Program," was established largely as a result of the Child Welfare Settlement Agreement, which was finalized in February 1994. The Settlement Agreement required a number of improvements in the child welfare system, including the provision of core services to children and families. The Core Services Program is a specific set of services that must be made available to prevent the out-of-home placement of children, promote the safe return of children to the home, and/or to promote care in the least restrictive setting. Counties must have the eight basic core services accessible to children and their families who meet the eligibility criteria for the program. These services include home-based intervention, intensive family therapy, life skills, day treatment, sexual abuse treatment, special economic assistance, mental health services, and substance abuse. Responding to the complexity and variability in the needs of children, youth, and families across the diverse regions of Colorado, the Core Services Program combines the consistency of centralized state administrative oversight with the flexibility and accountability of a county-run system. Only a portion of these funds are used to provide behavioral health services.	$27,270,478	27,070	$29,342,630	25,747
*Performance-based Collaborative Management Incentives**	This program was originally authorized by H.B. 04-1451, and represents incentives to counties to promote a collaborative system of services to multi-system involved children and families, or to those at risk for multi-system involvement. If a county department elects to enter into a memorandum of understanding (MOU) for the program, participation by local representatives from the following agencies is required: • local judicial districts, including probation services; • health department, whether a county, district, or regional health department;	$3,216,580	N/A	$24,885	N/A

Service	Program Description	FY 2011-12 Expenditures	FY 2011-12 Clients Served	FY 2014-15 Expenditures	FY 2014-15 Clients Served
	• local school district or school districts; • each community mental health center; • each Behavioral Health Organization (BHO); • Division of Youth Corrections; • a designated managed service organization for the provision of treatment services for alcohol and drug abuse; and • a domestic abuse program, if representation from such a program is available. Parties to each MOU are required to establish collaborative management processes that are designed to reduce duplication and eliminate fragmentation of services; increase the quality, appropriateness, and effectiveness of services; integrate services for multisystem involved children and families; and encourage cost sharing among service providers.				
	Subtotals - Division of Child Welfare	**$30,487,058**	**27,070**	**$29,367,515**	**25,747**
Division of Youth Corrections					
Institutional Programs[4]	This appropriation supports ten state-operated detention and commitment facilities, including diagnostic, education, and program services for juvenile while they are in an institution. Six of these facilities serve committed youth, with programs that are designed to treat the highest risk, highest need committed males and females. Thus, a portion of the monies in this line fund behavioral health therapists, as well as Certified Additions Counselors.	$4,303,939	1,645	$3,933,078	1,368
Medical Services[4]	This appropriation funds the personnel, operating, and contractual costs associated with providing medical services to youth who are in a State facility, including two State-owned and privately-operated facilities. A portion of the funding pays for State and contracted behavioral health staff, including psychiatrists, psychologists and Certified Addictions Counselors. The Division provides comprehensive individual, group and family counseling services, primarily to committed youth within State facilities.	$1,595,972	N/A	$634,571	N/A
Prevention/Intervention Services	This appropriation funds an intra-agency agreement between the Division of Youth Corrections and the Department's Office of Behavioral Health (OBH). These funds support drug and alcohol assessments, as well as training for substance abuse counselors in the Division's facilities. These are federal funds that are transferred to the Division from OBH.	$49,500	N/A	$46,501	N/A
Purchase of Contract Placements	All funds in this line item support the purchase of residential placement for detained and committed youth within private for profit and non-profit organizations. A portion of these funds are federal Medicaid funds that are initially appropriated to the Department of Health Care Policy and Financing, and are shown here for informational purposes only. The Medicaid funds are used to provide individual, group and family mental health counseling on a fee-for-service basis.	$1,506,706	360	$1,303,119	441
S.B. 91-94 Programs	Senate Bill 91-94 authorized the creation of local, judicial district-based programs designed to provide community-based detention services for pre-adjudicated and adjudicated youth. These programs work to reduce the incarcerated population by reducing the number of admissions into the Division of Youth Corrections (DYC) facilities, or by reducing the length of stay for youth placed in DYC facilities. SB 94 funds are also used in each judicial district to implement a uniform intake screening and assessment of all youth taken into custody by law enforcement. In many cases, youth can be served and monitored through non-secure, community-based services such as day reporting, electronic home monitoring, and/or enhanced community supervision. Only the portion of this funding that is used to provide mental health and substance abuse services are shown here.	$1,925,074	550	$2,719,846	562
*Parole Program Services**	This line item funds activities that are designed to assist youth in a successful transition from commitment to parole, and aid in successful completion of parole. Client manager/Juvenile Parole Officers are responsible for the supervision of committed youth released to parole including the development, implementation, and monitoring of a parole plan. The services purchased for transition and parole services are almost wholly spent with private providers. Services may be provided to youth while still in a State facility or contracted placement in advance of parole. Services include educational, vocational, and employment support, as well as behavioral health services, including substance abuse treatment services. Only the behavioral health portion of these funds is represented here.	$1,925,074	550	$2,719,846	562

Service	Program Description	FY 2011-12 Expenditures	FY 2011-12 Clients Served	FY 2014-15 Expenditures	FY 2014-15 Clients Served
	Subtotals - Division of Youth Corrections	**$11,306,265**	**3,105**	**$11,356,961**	**2,933**
Division of Vocational Rehabilitation					
Vocational Rehabilitation Mental Health Services	This Division of Vocational Rehabilitation (DVR) uses these funds to contract with mental health providers to assist DVR in the provision of mental health services to DVR clients. Matching local funds are from the Office of Behavioral Health. Effective July 1, 2016, S.B. 15-130 transfers this line item within DVR to the Colorado Department of Labor and Employment.	$0	552	$1,748,180	663
Office of Community Access and Independence					
Regional Centers for People with Developmental Disabilities					
Wheat Ridge, Grand Junction and Pueblo Regional Centers	Historically, the Regional Centers have provided mental health services to both the Intermediate Care Facility (ICF) residents and Home and Community Based Services for Individuals with Developmental Disabilities (HCBS-DD) waiver-funded residents through Regional Center FTE who are licensed psychiatrists or through contracts with licensed psychiatrists. Psychiatric services for the ICF/IID residents are funded through the Regional Center's cost based daily reimbursement rate. Psychiatric services provided to residents in HCBS-DD waiver homes were historically paid for by the Regional Centers out of their total reimbursements for services covered by the waiver program. However, effective July 1, 2014, all mental health services are provided on a fee-for-service basis under the State Medicaid Plan. All Regional Center residents are assessed for the need for psychiatric services and the vast majority of residents receive psychiatric services.	$117,981	298	$157,643	268
SUBTOTALS - CO DEPARTMENT OF HUMAN SERVICES		**$228,064,509**	**43,651**	**$277,630,920**	**42,768**
Colorado Department of Health Care Policy and Financing					
Behavioral Health Capitation Payments[5]	The Behavioral Health Capitation program funds mental health and substance abuse services for Medicaid-eligible clients throughout Colorado. The Department contracts with five managed-care providers called Behavioral Health Organizations (BHOs), which are responsible for providing or arranging all medically necessary behavioral health services to Medicaid-eligible clients within a specified geographic location for a pre-determined capitation rate. The Department pays actuarially certified rates to each behavioral health organization for each Medicaid client in each Medicaid eligibility category that is covered by the BHO contract.	$271,506,613	74,557	$567,778,001	154,342
Medicaid Behavioral Health Fee-For-Service Payments[5]	The Medicaid Behavioral Health Fee-for-Service Payments allows Medicaid clients not enrolled in a Behavioral Health Organization to receive mental health or substance abuse services, and allows enrolled Medicaid clients to receive mental health or substance abuse services not covered by the Behavioral Health Organizations.	$3,892,397	17,957	$7,525,424	40,572
SUBTOTALS - CO DEPT. OF HEALTH CARE POLICY & FINANCING		**$275,399,010**	**92,514**	**$575,303,425**	**194,914**
Colorado Department of Corrections					
Mental Health Subprogram	This subprogram provides a full range of professional psychiatric, psychological, social work, and other mental health services to offenders housed within Department of Corrections facilities. Three broad categories of mental health services are provided: clinical mental health services, rehabilitative services, and services for offenders who are mentally ill and/or developmentally disabled. The funds support State staff as well as contract psychiatrists and psychologists who supplement services provided by DOC mental health staff.	$10,143,487	4,062	$14,294,908	5,527
Drug and Alcohol Treatment Subprogram	The subprogram is responsible for providing substance abuse services to offenders, such as: 1) intake evaluation, assessment, and orientation; 2) self-help meetings; 3) facility-based education and treatment services; 4) drug testing; 5) intensive treatment; and, 6) community/parole services.	$7,422,139	10,126	$9,523,342	11,453
Parole Subprogram					
Contract Services	In February 2016 the DOC transitioned to a contract with First Alliance Treatment Services, which provides full case management services, mental health assessment and referrals, sex offender assessment and referrals, urinalysis testing, and alcohol/substance abuse evaluation and referrals. Some of the General Fund appropriation pays for fugitive returns.	$4,725,109	N/A	$6,877,449	N/A
Wrap-Around Services	This program provides funds for comprehensive assistance (such as substance abuse treatment and job placement) through local community-based service providers. Service components may include mental health	$1,199,728	N/A	$1,539,243	N/A

Service	Program Description	FY 2011-12 Expenditures	FY 2011-12 Clients Served	FY 2014-15 Expenditures	FY 2014-15 Clients Served
Program	services, substance abuse treatment, housing, and vocational assistance.				
Non-Residential Services	The funds in this line item support services such as drug screens, Antabuse monitoring, medication management, and daily call-ins to a day reporting center for inmates who have transitioned to parole and intensive supervision parole status in the community.	$1,156,580	N/A	$1,203,437	N/A
Community Services Subprogram					
Community Mental Health Services	The Community Supervision subprogram is responsible for the community supervision of transitional offenders who are released from a prison to a community corrections facility, including daily monitoring and close supervision for up to six months for transition offenders who are living in their own home or in an approved private residence. The Community Mental Health Services line item provides contract mental health services to offenders primarily residing within community corrections facilities.	$449,185	N/A	$629,363	N/A
Psychotropic Medication	This line item provides psychotropic medications for offenders with mental health treatment needs in community transition programs and community return to custody facilities. Upon transition from prison to the community, offenders routinely receive a 30-day supply of appropriate medications and become eligible for the psychotropic medication program after the supply of these medications has been exhausted. Participating offenders receives a voucher for their prescribed psychotropic medications that is honored by participating pharmacies.	$131,760	N/A	$59,842	N/A
Contract Services	This line item provides funding for drug screens, substance abuse monitoring, medication management, daily call-ins to a day reporting center, etc. for offenders on intensive supervision inmate status.	$3,103,366	N/A	$2,811,799	N/A
Community Re-entry Subprogram	The Community Re-entry Subprogram consists of pre- and post-release components. The prerelease component includes activities that screen inmates to identify the individual skill requirements necessary to increase the probability of success following release, and the development of personal life and pre-employment skills critical to transition from an institutional setting to the community. The post-release component consists of assistance and support to the offender in the transition process, in accessing community services, and in securing employment and/or training. Support services are also available to those offenders for whom limited financial support in areas such as housing, clothing, and tools will increase the opportunity of success.	$2,954,903	N/A	$3,531,872	N/A
Youthful Offender System Aftercare					
Contract Services	This line item provides funding for contract services for youth who are transitioning to the community-based aftercare portion of the Youthful Offender System (YOS) program. Services include housing, food, alcohol and drug intervention, and mental health counseling. The purpose of Phase III is to prepare youth to live independently or to return to their families.	$985,676	47	$881,277	37
SUBTOTALS - CO DEPARTMENT OF CORRECTIONS		**$32,271,933**	**14,235**	**$41,352,532**	**17,017**
Colorado Department of Public Safety					
Division of Criminal Justice					
Community Corrections Placements[6] *(Note: In FY 2012-13, funding for nearly all Community Corrections placements were consolidated into a single line item)**	Colorado's community corrections programs, also known as halfway houses, provide offenders with supervision and structure in both residential and nonresidential settings. They are operated by local governments, private providers, and non-profit entities. Residential offenders live in local residential facilities and go out during the day to work or seek work. On a controlled basis they also go out to visit family, receive medical care, or receive treatment for behavioral problems. These placements can be either for Diversion clients who are placed in Community Corrections as an alternative to a sentence to the Department of Corrections, or for Transition clients who are Department of Corrections' inmates who are approved for placement in a Community Corrections facility prior to release on parole. Some community corrections programs provide more specialized and extensive treatment, including two substance abuse programs (Intensive Residential Treatment – IRT, and Therapeutic Communities – TC), and combined mental health and substance abuse programs (Residential Dual Diagnosis Treatment – RDDT), which typically last 6 months or more, addressing co-occurring mental health and substance use problems. Included in the FY 2011-12 funding are previous Long Bill line items for Transition Programs, Diversion Programs, Mental Health Bed Differential, and the John Eachon Re-entry Program.	$50,076,852	7,191	$53,173,366	8,102
Services for Substance	This appropriation pays for outpatient treatment for offenders in standard community corrections programs who have problems with substance abuse and co-occurring disorders. Funding comes from the Correctional Treatment	$1,076,071	871	$2,313,132	4,393

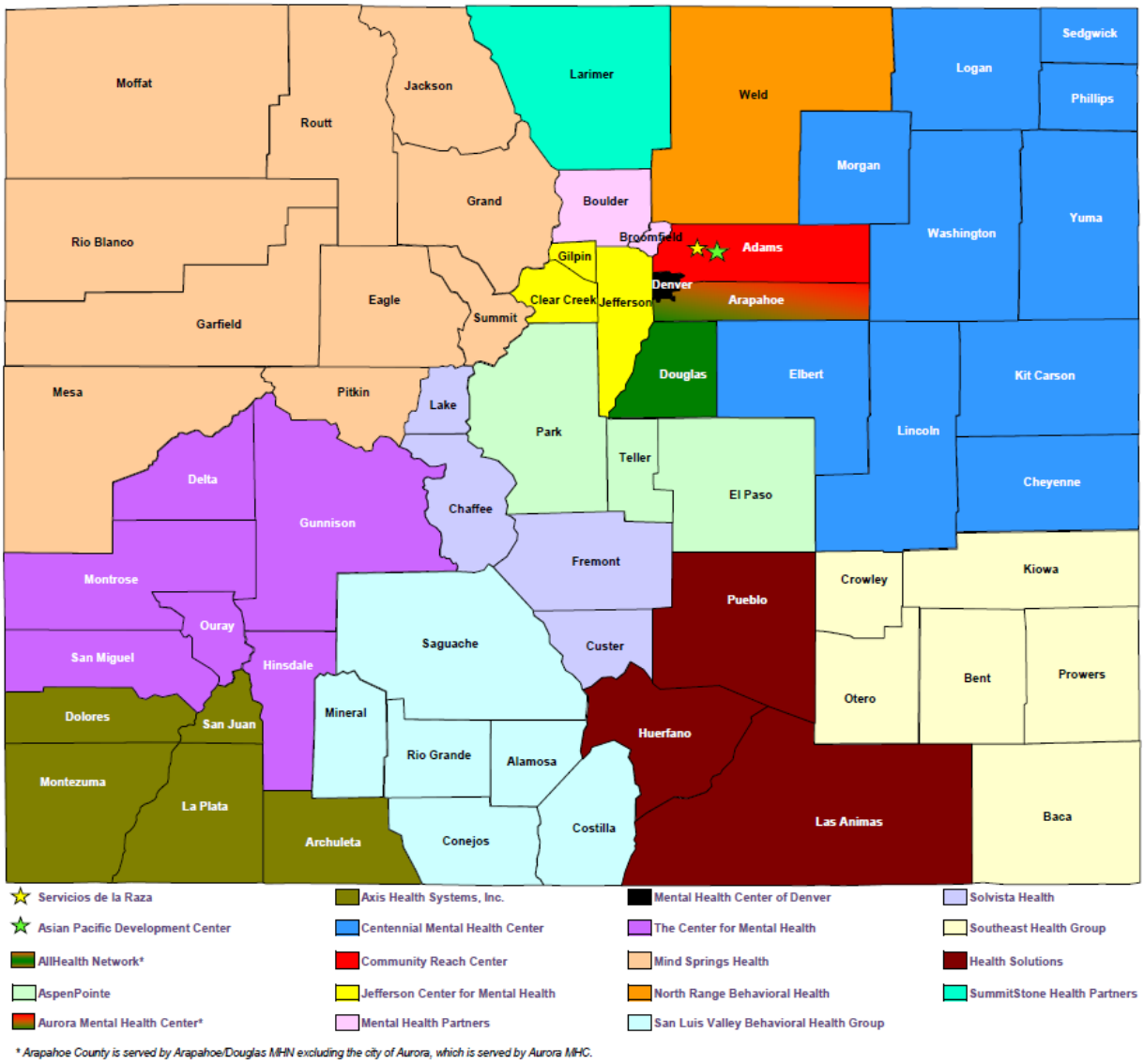
Service	Program Description	FY 2011-12 Expenditures	FY 2011-12 Clients Served	FY 2014-15 Expenditures	FY 2014-15 Clients Served
Abuse and Co-occurring Disorders	Cash Fund and can be spent for substance abuse screening, assessment, evaluation, testing, education, training, treatment, and recovery support. The appropriation can also be spent for treatment of co-occurring mental health problems. Included in the FY 2011-12 funding are previous line items for Substance Abuse Treatment Programs, Outpatient Therapeutic Community Programs, and the Intensive Residential Treatment Pilot Program.				
Specialized Offender Services	This line item, sometimes referred to as the "SOS" appropriation, supports the purchase of mental health treatment, cognitive training, therapists, counselors, medications, sex offender treatment, and other specialized outpatient services that are not typically provided by standard community corrections programs.	$61,490	115	$51,976	86
SUBTOTALS - CO DEPARTMENT OF PUBLIC SAFETY		**$51,214,413**	**8,177**	**$55,538,474**	**12,581**
Colorado Department of Public Health & Environment					
Prevention Services Division					
Suicide Prevention[7]	The Office of Suicide Prevention provides coordination for suicide prevention activities statewide. It includes initiatives in three areas: 1) development and implementation of a statewide public information campaign, including resource and assistance lists for people in crisis; 2) training on the recognition and response to signs of suicide; and, 3) local suicide prevention and education service development.	$281,614	25,000	$441,226	27,000
Marijuana Education Campaign	This line item funds the Retail Marijuana Education Program (RMEP) to ensure that Colorado residents and visitors understand the parameters of safe, legal, and responsible use of retail marijuana. The RMEP is also charged with creating educational messages that target high risk populations such as youth and pregnant or breastfeeding women.	N/A	N/A	$5,665,002	106,951,464
School-based Health Centers	House Bill 06-1396 created the School-Based Health Centers Grant Program to provide State support of school-based health centers (SBHCs). SBHCs provide medical and behavioral health care to school-aged children during the school day, and are operated by the school districts in cooperation with other health service providers such as hospitals, medical providers, and community health centers.	$998,204	N/A	$4,675,229	N/A
SUBTOTALS - CO DEPT. OF PUBLIC HEALTH & ENVIRONMENT		**$1,279,818**	**25,000**	**$10,781,457**	**106,978,464**
Colorado Judicial Department					
Probation Services					
Offender Treatment and Services	This line funds the following treatment and services for Adult and Juvenile offenders throughout the state: electronic home monitoring, drug testing, polygraph, UA's, pre-sentence sex offender evaluations, sex offender treatment, substance abuse, domestic violence, medical and mental health treatment, education and vocational training, emergency housing and interpreter services.	$9,411,265	N/A	$15,702,945	N/A
*SB 91-94**	This funding is transferred from the Colorado Department of Human Services, Division of Youth Corrections to provide community-based services designed to reduce juvenile admissions and decrease the length of stay in State funded facilities.	$1,502,621	N/A	$2,002,479	N/A
SUBTOTALS - COLORADO JUDICIAL DEPARTMENT		**$10,913,886**	**0**	**$17,705,424**	**0**
Colorado Department of Local Affairs					
Community Services					
Low Income Rental Subsidies[10]	This line funds the federal Section 8 vouchers to assist low income families to obtain affordable rental housing units for workforce needs and lower income families. A portion of this funding is used to support behavioral health vouchers for participants in the Assertive Community Treatment (ACT) program, Adult Resources for Care and Help (ARCH) vouchers, and Colorado Choice Transitions (CCT) program vouchers. Shown here is the amount used to support mental health housing vouchers.	$462,223	148	$943,395	136
SUBTOTALS - COLORADO DEPARTMENT OF LOCAL AFFAIRS		**$462,223**	**148**	**$943,395**	**136**
TOTALS - BEHAVIORAL HEALTH (OFFICE OF BEHAVIORAL HEALTH AND HEALTH CARE POLICY)		**$371,277,251**	**101,982**	**$705,336,161**	**205,117**
TOTALS - CORRECTIONAL (YOUTH CORRECTIONS, CORRECTIONS, PUBLIC SAFETY, JUDICIAL)		**$105,706,497**	**25,517**	**$125,953,391**	**32,531**
TOTALS - ALL OTHER DEPARTMENTS AND AGENCIES		**$122,622,044**	**56,226**	**$147,966,075**	**107,008,232**
GRAND TOTAL - STATE OF COLORADO		**$599,605,792**	**183,725**	**$979,255,627**	**107,245,880**

Footnotes:

[1] In FY 2014-15, the Department expended a majority of the balance of Substance Abuse Block Grant funding in other lines, with a majority in the Treatment and Detoxification Contracts line item. In subsequent years, the General Assembly has appropriated these funds within the various program line items where the funds are expended.
[2] Clients served data include both inpatient and outpatient clients; however, individuals served as both inpatient and outpatient in the same fiscal year are counted as only inpatient to avoid duplication. Outpatients include those committed Not Guilty by Reason of Insanity that are living in the community, Department of Corrections inmates receiving outpatient medical clinic services, persons receiving court-ordered evaluations that are performed in jails and in the community, patients receiving electroshock treatments, and individuals being restored to competency to stand trial in community or jail settings.
[3] The CDHS is not able to break out clients who received only behavioral health services. The clients served figures reflect all clients who were served in the Family and Children's Programs line; however, the expenditure figures reflect spending only on behavioral health services.
[4] Funding for behavioral health services for youth residing within DYC State-operated facilities is split between the Institutional Programs and Medical Services line items. Thus, the clients served data is shown only in the Institutional Programs line.
[5] Clients served data reflects the number of distinct clients that utilized a service through a Behavioral Health Organization.
[6] The Department was not able to access actual FY 12 expenditure and clients served data; thus, the amounts shown were extrapolated by the Department based on FY 13 expenditures and clients served data.
[7] Number served includes training participants, educational materials disseminated, CO visits to Mantherapy.org, conference and presentation attendees, and emergency departments.
[8] Clients served data represents the number of low income families that received mental health housing vouchers.
* Denotes line items where expenditures and clients served data do not exclusively reflect only behavioral health services. These amounts were provided by each respective State agency.
Source: Amounts other than those indicated in line items with an * from JBC Figure Setting documents and CDHS FY 2016-17 Budget Request Sched. #3

Appendix B - Colorado Public Behavioral Health System Geographic Catchment and Service Areas Maps

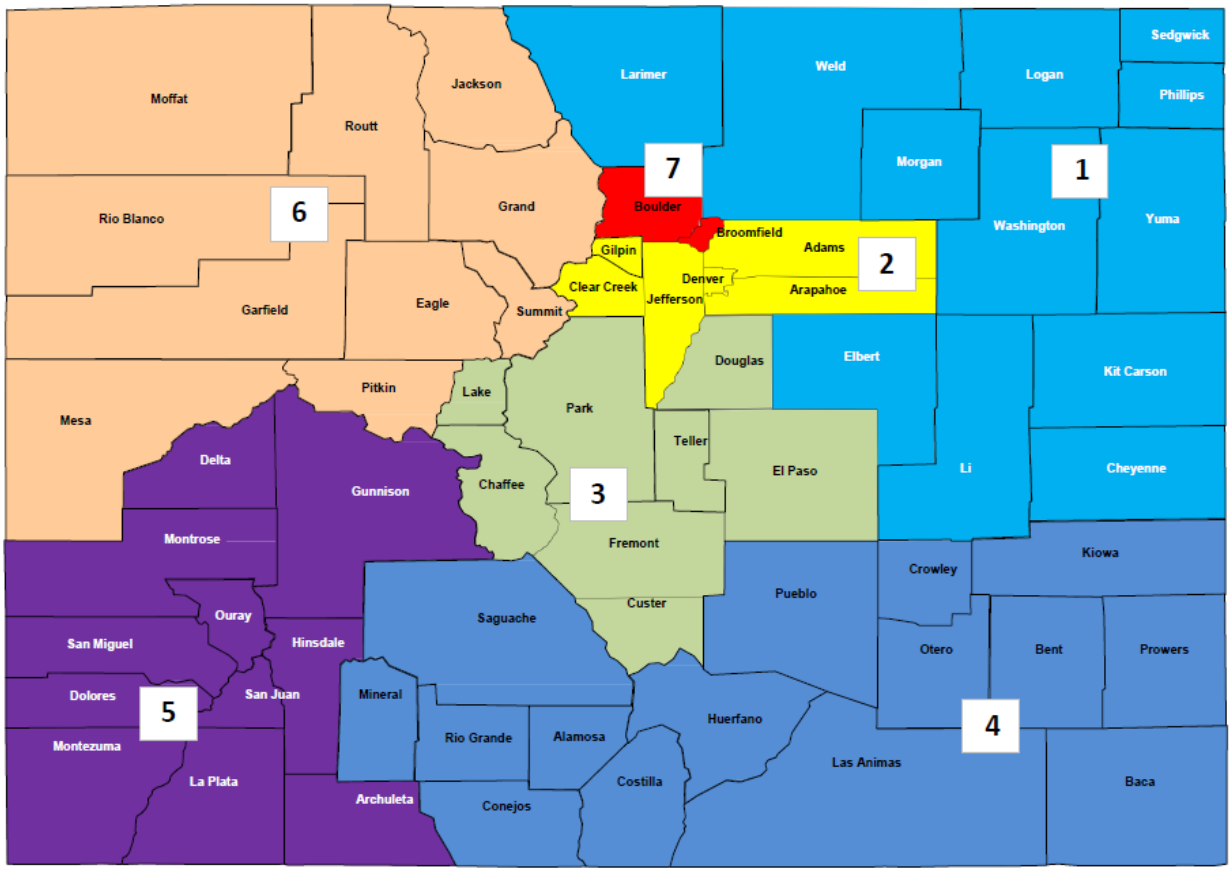
Colorado Community Mental Health Centers (CMHCs) by County Served



Colorado Community Mental Health Centers by County Served

Source: Colorado Behavioral Health Care Council

Colorado Managed Service Organizations (MSOs) Catchment Areas by Sub-State Planning Areas (SSPA)



Colorado Managed Service Organizations
Catchment Areas by Sub-State Planning Areas (SSPA)

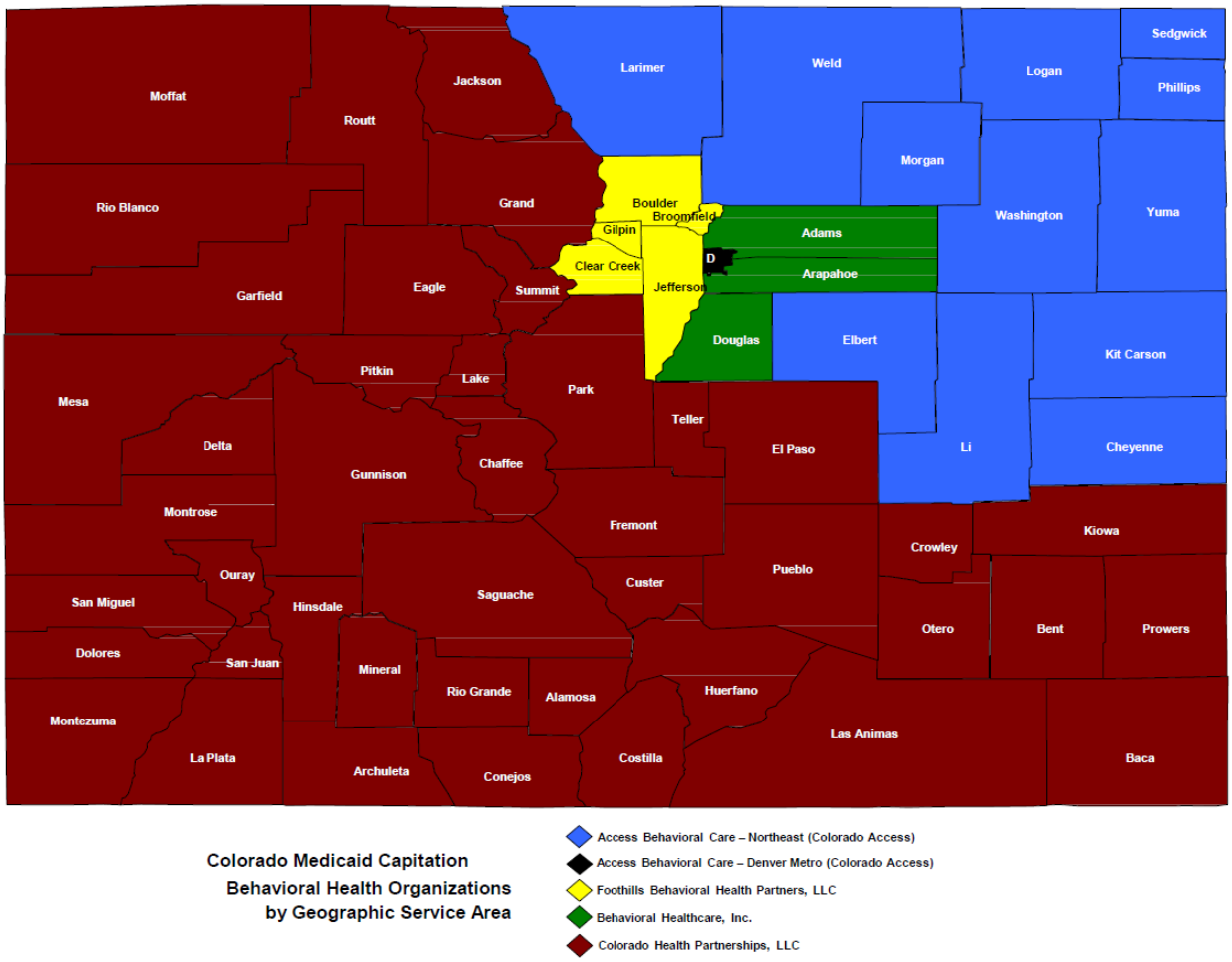
MSO	SSPA
Mental Health Partners	7
AspenPointe	3
Signal Behavioral Health Network, Inc.	1, 2, 4
West Slope Casa, LLC	5, 6

Source: Colorado Behavioral Health Care Council

Colorado Crisis Services Regions

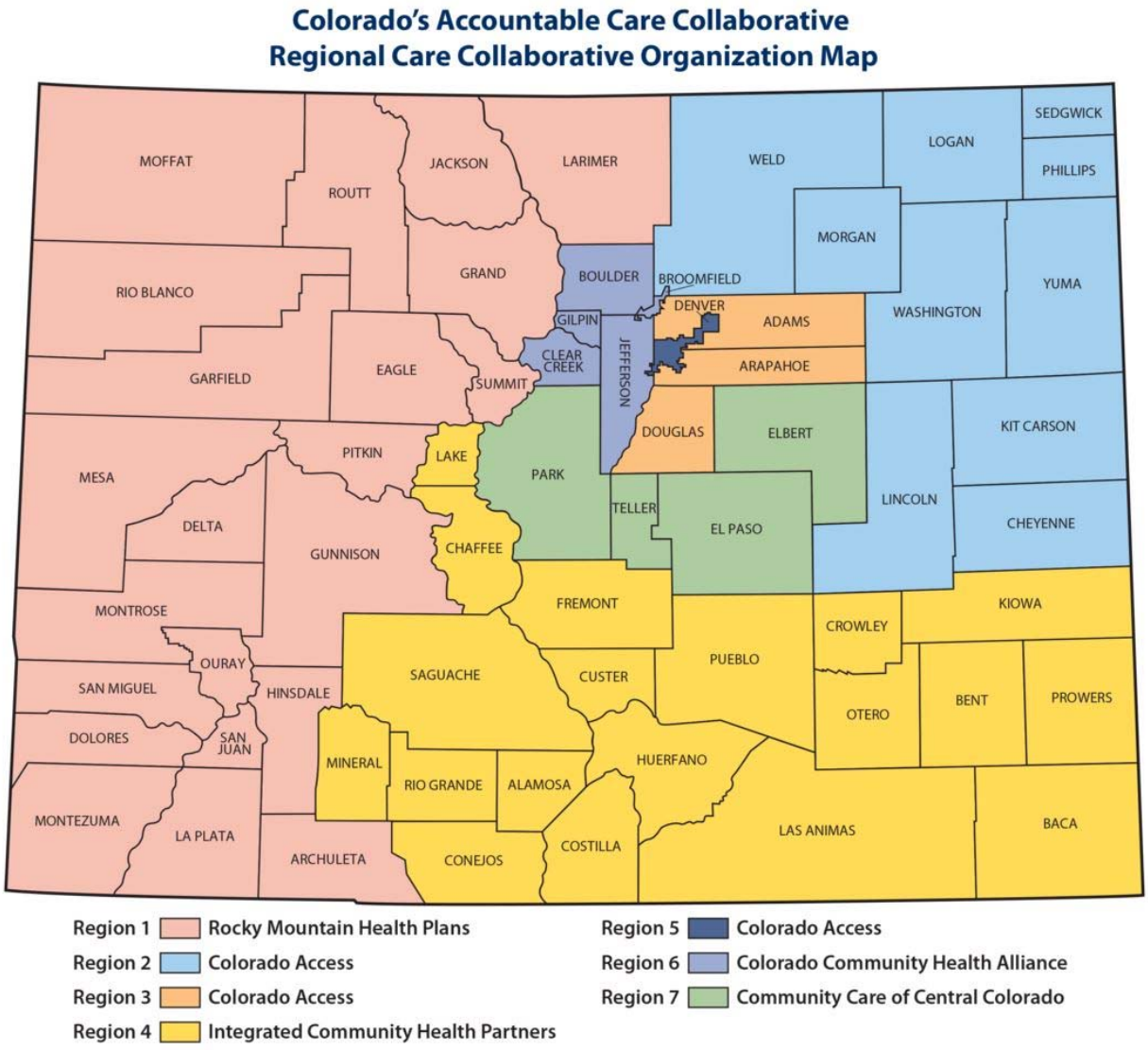
Source: Colorado Office of Behavioral Health

Colorado Behavioral Health Organizations (BHOs) by Geographic Service Area



Source: Colorado Behavioral Health Care Council

Regional Care Collaborative Organization (RCCO) Regions



Source: Colorado Department of Health Care Policy and Financing (HCPF)
https://www.colorado.gov/pacific/hcpf/regional-care-collaborative-organization-map

Appendix C - State Agency Service Area Crosswalk

County	County Designation	CMHC	BHO	Crisis Services Region	MSO	SSPA	RCCO
Adams	Urban	Community Reach Center (Community Reach)	Behavioral Healthcare, Inc. (BHI)	Community Crisis Connection	Signal Behavioral Health Network, Inc.	2 (Metro Denver)	Region 3-Colorado Access
Alamosa	Rural	San Luis Valley	Colorado Health Partnerships, LLC (CHP)	AspenPointe	Signal Behavioral Health Network, Inc.	4 (Southeast)	Region 4-Integrated Community Health Partners
Arapahoe	Urban	AllHealth	Behavioral Healthcare, Inc. (BHI)	Community Crisis Connection	Signal Behavioral Health Network, Inc.	2 (Metro Denver)	Region 3-Colorado Access
Archuleta	Rural	Axis Health	Colorado Health Partnerships, LLC (CHP)	West Slope Casa	West Slope Casa, LLC	5 (Southwest)	Region 1-Rocky Mountain Health Plans
Baca	Frontier	Southeast	Colorado Health Partnerships, LLC (CHP)	AspenPointe	Signal Behavioral Health Network, Inc.	4 (Southeast)	Region 4-Integrated Community Health Partners
Bent	Frontier	Southeast	Colorado Health Partnerships, LLC (CHP)	AspenPointe	Signal Behavioral Health Network, Inc.	4 (Southeast)	Region 4-Integrated Community Health Partners
Boulder	Urban	Mental Health Partners (MHP)	Foothills Behavioral Health Partners, LLC (FBHP)	Community Crisis Connection	Mental Health Partners	7	Region 6-Colorado Community Health Alliance
Broomfield	Urban	Mental Health Partners (MHP)	Foothills Behavioral Health Partners, LLC (FBHP)	Community Crisis Connection	Mental Health Partners	7	Region 6-Colorado Community Health Alliance
Chaffee	Rural	SolVista Health (Solvista)	Colorado Health Partnerships, LLC (CHP)	AspenPointe	AspenPointe	3	Region 4-Integrated Community Health Partners
Cheyenne	Frontier	Centennial	Access Behavioral Care - Northeast (Colorado Access; ABC-NE)	Northeast Behavioral Health	Signal Behavioral Health Network, Inc.	1 (Northeast)	Region 2-Colorado Access
Clear Creek	Urban	Jefferson	Foothills Behavioral Health Partners, LLC (FBHP)	Community Crisis Connection	Signal Behavioral Health Network, Inc.	2 (Metro Denver)	Region 6-Colorado Community Health Alliance
Conejos	Rural	San Luis Valley	Colorado Health Partnerships, LLC (CHP)	AspenPointe	Signal Behavioral Health Network, Inc.	4 (Southeast)	Region 4-Integrated Community Health Partners
Costilla	Frontier	San Luis Valley	Colorado Health Partnerships, LLC (CHP)	AspenPointe	Signal Behavioral Health Network, Inc.	4 (Southeast)	Region 4-Integrated Community Health Partners
Crowley	Rural	Southeast	Colorado Health Partnerships, LLC (CHP)	AspenPointe	Signal Behavioral Health Network, Inc.	4 (Southeast)	Region 4-Integrated Community Health Partners
Custer	Frontier	SolVista Health (Solvista)	Colorado Health Partnerships, LLC (CHP)	AspenPointe	AspenPointe	3	Region 4-Integrated Community Health Partners
Delta	Rural	The Center for Mental Health (CMH)	Colorado Health Partnerships, LLC (CHP)	West Slope Casa	West Slope Casa, LLC	5 (Southwest)	Region 1-Rocky Mountain Health Plans
Denver	Urban	Mental Health Center of Denver (MHCD)	Access Behavioral Care - Denver Metro (Colorado Access; ABC-Denver	Community Crisis Connection	Signal Behavioral Health Network, Inc.	2 (Metro Denver)	Region 5: Colorado Access
Dolores	Frontier	Axis Health	Colorado Health Partnerships, LLC (CHP)	West Slope Casa	West Slope Casa, LLC	5 (Southwest)	Region 1-Rocky Mountain Health Plans
Douglas	Urban	AllHealth	Behavioral Healthcare, Inc. (BHI)	Community Crisis Connection	AspenPointe	3	Region 3-Colorado Access
Eagle	Rural	Mind Springs	Colorado Health Partnerships, LLC (CHP)	West Slope Casa	West Slope Casa, LLC	6 (Northwest)	Region 1-Rocky Mountain Health Plans
El Paso	Urban	AspenPointe	Colorado Health Partnerships, LLC (CHP)	AspenPointe	AspenPointe	3	Region 7-Community Care of Central Colorado
Elbert	Urban	Centennial	Access Behavioral Care - Northeast (Colorado Access; ABC-NE)	Northeast Behavioral Health	Signal Behavioral Health Network, Inc.	1 (Northeast)	Region 7-Community Care of Central Colorado

County	County Designation	CMHC	BHO	Crisis Services Region	MSO	SSPA	RCCO
Fremont	Rural	SolVista Health (Solvista)	Colorado Health Partnerships, LLC (CHP)	AspenPointe	AspenPointe	3	Region 4-Integrated Community Health Partners
Garfield	Rural	Mind Springs	Colorado Health Partnerships, LLC (CHP)	West Slope Casa	West Slope Casa, LLC	6 (Northwest)	Region 1-Rocky Mountain Health Plans
Gilpin	Urban	Jefferson	Foothills Behavioral Health Partners, LLC (FBHP)	Community Crisis Connection	Signal Behavioral Health Network, Inc.	2 (Metro Denver)	Region 6-Colorado Community Health Alliance
Grand	Rural	Mind Springs	Colorado Health Partnerships, LLC (CHP)	West Slope Casa	West Slope Casa, LLC	6 (Northwest)	Region 1-Rocky Mountain Health Plans
Gunnison	Frontier	The Center for Mental Health (CMH)	Colorado Health Partnerships, LLC (CHP)	West Slope Casa	West Slope Casa, LLC	5 (Southwest)	Region 1-Rocky Mountain Health Plans
Hinsdale	Frontier	The Center for Mental Health (CMH)	Colorado Health Partnerships, LLC (CHP)	West Slope Casa	West Slope Casa, LLC	5 (Southwest)	Region 1-Rocky Mountain Health Plans
Huerfano	Frontier	Health Solutions	Colorado Health Partnerships, LLC (CHP)	AspenPointe	Signal Behavioral Health Network, Inc.	4 (Southeast)	Region 4-Integrated Community Health Partners
Jackson	Frontier	Mind Springs	Colorado Health Partnerships, LLC (CHP)	West Slope Casa	West Slope Casa, LLC	6 (Northwest)	Region 1-Rocky Mountain Health Plans
Jefferson	Urban	Jefferson	Foothills Behavioral Health Partners, LLC (FBHP)	Community Crisis Connection	Signal Behavioral Health Network, Inc.	2 (Metro Denver)	Region 6-Colorado Community Health Alliance
Kiowa	Frontier	Southeast	Colorado Health Partnerships, LLC (CHP)	AspenPointe	Signal Behavioral Health Network, Inc.	4 (Southeast)	Region 4-Integrated Community Health Partners
Kit Carson	Frontier	Centennial	Access Behavioral Care - Northeast (Colorado Access; ABC-NE)	Northeast Behavioral Health	Signal Behavioral Health Network, Inc.	1 (Northeast)	Region 2-Colorado Access
La Plata	Rural	Axis Health	Colorado Health Partnerships, LLC (CHP)	West Slope Casa	West Slope Casa, LLC	5 (Southwest)	Region 1-Rocky Mountain Health Plans
Lake	Rural	SolVista Health (Solvista)	Colorado Health Partnerships, LLC (CHP)	AspenPointe	AspenPointe	3	Region 4-Integrated Community Health Partners
Larimer	Urban	SummitStone	Access Behavioral Care - Northeast (Colorado Access; ABC-NE)	Northeast Behavioral Health	Signal Behavioral Health Network, Inc.	1 (Northeast)	Region 1-Rocky Mountain Health Plans
Las Animas	Frontier	Health Solutions	Colorado Health Partnerships, LLC (CHP)	AspenPointe	Signal Behavioral Health Network, Inc.	4 (Southeast)	Region 4-Integrated Community Health Partners
Lincoln	Frontier	Centennial	Access Behavioral Care - Northeast (Colorado Access; ABC-NE)	Northeast Behavioral Health	Signal Behavioral Health Network, Inc.	1 (Northeast)	Region 2-Colorado Access
Logan	Rural	Centennial	Access Behavioral Care - Northeast (Colorado Access; ABC-NE)	Northeast Behavioral Health	Signal Behavioral Health Network, Inc.	1 (Northeast)	Region 2-Colorado Access
Mesa	Urban	Mind Springs	Colorado Health Partnerships, LLC (CHP)	West Slope Casa	West Slope Casa, LLC	6 (Northwest)	Region 1-Rocky Mountain Health Plans
Mineral	Frontier	San Luis Valley	Colorado Health Partnerships, LLC (CHP)	AspenPointe	Signal Behavioral Health Network, Inc.	4 (Southeast)	Region 4-Integrated Community Health Partners
Moffat	Frontier	Mind Springs	Colorado Health Partnerships, LLC (CHP)	West Slope Casa	West Slope Casa, LLC	6 (Northwest)	Region 1-Rocky Mountain Health Plans
Montezuma	Rural	Axis Health	Colorado Health Partnerships, LLC (CHP)	West Slope Casa	West Slope Casa, LLC	5 (Southwest)	Region 1-Rocky Mountain Health Plans
Montrose	Rural	The Center for Mental Health (CMH)	Colorado Health Partnerships, LLC (CHP)	West Slope Casa	West Slope Casa, LLC	5 (Southwest)	Region 1-Rocky Mountain Health Plans
Morgan	Rural	Centennial	Access Behavioral Care - Northeast (Colorado Access; ABC-NE)	Northeast Behavioral Health	Signal Behavioral Health Network, Inc.	1 (Northeast)	Region 2-Colorado Access
Otero	Rural	Southeast	Colorado Health Partnerships, LLC (CHP)	AspenPointe	Signal Behavioral Health Network, Inc.	4 (Southeast)	Region 4-Integrated Community Health Partners

County	County Designation	CMHC	BHO	Crisis Services Region	MSO	SSPA	RCCO
Ouray	Rural	The Center for Mental Health (CMH)	Colorado Health Partnerships, LLC (CHP)	West Slope Casa	West Slope Casa, LLC	5 (Southwest)	Region 1-Rocky Mountain Health Plans
Park	Urban	AspenPointe	Colorado Health Partnerships, LLC (CHP)	AspenPointe	AspenPointe	3	Region 7-Community Care of Central Colorado
Phillips	Rural	Centennial	Access Behavioral Care - Northeast (Colorado Access; ABC-NE)	Northeast Behavioral Health	Signal Behavioral Health Network, Inc.	1 (Northeast)	Region 2-Colorado Access
Pitkin	Rural	Mind Springs	Colorado Health Partnerships, LLC (CHP)	West Slope Casa	West Slope Casa, LLC	6 (Northwest)	Region 1-Rocky Mountain Health Plans
Prowers	Rural	Southeast	Colorado Health Partnerships, LLC (CHP)	AspenPointe	Signal Behavioral Health Network, Inc.	4 (Southeast)	Region 4-Integrated Community Health Partners
Pueblo	Urban	Health Solutions	Colorado Health Partnerships, LLC (CHP)	AspenPointe	Signal Behavioral Health Network, Inc.	4 (Southeast)	Region 4-Integrated Community Health Partners
Rio Blanco	Frontier	Mind Springs	Colorado Health Partnerships, LLC (CHP)	West Slope Casa	West Slope Casa, LLC	6 (Northwest)	Region 1-Rocky Mountain Health Plans
Rio Grande	Rural	San Luis Valley	Colorado Health Partnerships, LLC (CHP)	AspenPointe	Signal Behavioral Health Network, Inc.	4 (Southeast)	Region 4-Integrated Community Health Partners
Routt	Rural	Mind Springs	Colorado Health Partnerships, LLC (CHP)	West Slope Casa	West Slope Casa, LLC	6 (Northwest)	Region 1-Rocky Mountain Health Plans
Saguache	Frontier	San Luis Valley	Colorado Health Partnerships, LLC (CHP)	AspenPointe	Signal Behavioral Health Network, Inc.	4 (Southeast)	Region 4-Integrated Community Health Partners
San Juan	Frontier	Axis Health	Colorado Health Partnerships, LLC (CHP)	West Slope Casa	West Slope Casa, LLC	5 (Southwest)	Region 1-Rocky Mountain Health Plans
San Miguel	Frontier	The Center for Mental Health (CMH)	Colorado Health Partnerships, LLC (CHP)	West Slope Casa	West Slope Casa, LLC	5 (Southwest)	Region 1-Rocky Mountain Health Plans
Sedgwick	Frontier	Centennial	Access Behavioral Care - Northeast (Colorado Access; ABC-NE)	Northeast Behavioral Health	Signal Behavioral Health Network, Inc.	1 (Northeast)	Region 2-Colorado Access
Summit	Rural	Mind Springs	Colorado Health Partnerships, LLC (CHP)	West Slope Casa	West Slope Casa, LLC	6 (Northwest)	Region 1-Rocky Mountain Health Plans
Teller	Urban	AspenPointe	Colorado Health Partnerships, LLC (CHP)	AspenPointe	AspenPointe	3	Region 7-Community Care of Central Colorado
Washington	Frontier	Centennial	Access Behavioral Care - Northeast (Colorado Access; ABC-NE)	Northeast Behavioral Health	Signal Behavioral Health Network, Inc.	1 (Northeast)	Region 2-Colorado Access
Weld	Urban	North Range Behavioral Health (North Range)	Access Behavioral Care - Northeast (Colorado Access; ABC-NE)	Northeast Behavioral Health	Signal Behavioral Health Network, Inc.	1 (Northeast)	Region 2-Colorado Access
Yuma	Frontier	Centennial	Access Behavioral Care - Northeast (Colorado Access; ABC-NE)	Northeast Behavioral Health	Signal Behavioral Health Network, Inc.	1 (Northeast)	Region 2-Colorado Access
Adams/ Arapahoe		Aurora Mental Health Center (Aurora)	Behavioral Healthcare, Inc. (BHI)	Community Crisis Connection	Signal Behavioral Health Network, Inc.	2 (Metro Denver)	Region 3-Colorado Access

County Designation source: Colorado Department of Public Health and Environment (CDPHE) **https://www.colorado.gov/pacific/cdphe/download-data-gis-format**. Data was updated to reflect the 2008-2012 Five-Year American Community Survey estimates and 2010 U.S. Census data.

Appendix D - Covered Medicaid Behavioral Health Procedures Codes and Service Categories

Proc Code	Full description of the procedure codes
104	Anesthesia for electroconvulsive therapy
90785	Interactive complexity (This code is an add-on. Please see the USGS or 2013 CPT for coding guidelines).
90791	Psychiatric diagnostic evaluation
90792	Psychiatric diagnostic evaluation with medical services
90832	Psychotherapy, 30 minutes with patient and/or family member
90833	Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service (This code is an add-on. Please see the USGS or 2013 CPT for coding guidelines).
90834	Psychotherapy, 45 minutes with patient and/or family member
90836	Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service (This code is an add-on. Please see the USGS or 2013 CPT for coding guidelines).
90837	Psychotherapy, 60 minutes with patient and/or family
90838	Psychotherapy, 60 minutes with patient and/or family member when performed with an evaluation and management service (This code is an add-on. Please see the USGS or 2013 CPT for coding guidelines).
90839	Psychotherapy for crisis, first 60 minutes
90840	Psychotherapy for crisis, each additional 30 minutes (This code is an add-on. Please see the USGS or 2013 CPT for coding guidelines).
90846	Family psychotherapy (without the patient present)
90847	Family psychotherapy (conjoint psychotherapy) (with patient present)
90849	Multiple-family group psychotherapy
90853	Group psychotherapy (other than of a multiple-family group)
90870	Electroconvulsive therapy (includes necessary monitoring)
90875	Individual psycho-physiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavior modifying or supportive psychotherapy); 30 minutes
90876	Individual psycho-physiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavior modifying or supportive psychotherapy); 45 minutes
90887	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient
96101	Psychological testing (includes psycho-diagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report
96102	Psychological testing (includes psycho-diagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI and WAIS), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face
96103	Psychological testing administered by a computer, with qualified health care professional interpretation and report.
96116	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report
96118	Neuropsychological testing (e.g., Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report
96119	Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face
96120	Neuropsychological testing by a computer, with qualified health care professional interpretation and report.
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug) subcutaneous or intramuscular
97535	Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes
97537	Community/work reintegration training (e.g., shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact, each 15 minutes
98966	Telephone evaluation and management service provided by a qualified non- physician health care professional to an established patient, parent, or guardian not originating from a related EIM service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
98967	Telephone evaluation and management service provided by a qualified non- physician health care professional to an established patient, parent, or guardian not originating from a related ElM service provided within the previous 7 days nor leading to an ElM service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion
98968	Telephone evaluation and management service provided by a qualified non- physician health care professional to an established patient, parent, or guardian not originating from a related ElM service provided within the previous 7 days nor leading to an ElM service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion
99221	Initial Hospital Care Low Complexity
99222	Initial Hospital Care Moderate Complexity
99223	Initial Hospital Care High Complexity
99231	Subsequent Hospital Care Low Complexity

Proc Code	Full description of the procedure codes
99232	Subsequent Hospital Care Moderate Complexity
99233	Subsequent Hospital Care High Complexity
99238	Hospital Discharge Day Management/3D minutes
99239	Discharge day management; more than 30 minutes
99251	Initial Inpatient Consultation/20 minutes
99252	Initial Inpatient Consultation/40 minutes
99253	Initial Inpatient Consultation/55 minutes
99254	Initial Inpatient Consultation/SO minutes
99366	Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more, participation by non- physician qualified health care professional.
99367	Medical team conference, with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician.
99368	Medical team conference with interdisciplinary team, patient and/or family not present, 30 minutes or more, participation by non-physician qualified health care professional
99441	Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment: 5-10 minutes of medical discussion
99442	Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment: 11-20 minutes of medical discussion
99443	Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related EIM service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment: 21-30 minutes of medical discussion
G0176	Activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more)
G0177	Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more).
*H0001	Alcohol and/or drug assessment
H0002	Behavioral health screening to determine eligibility for admission to treatment program
*H0004	Behavioral health counseling and therapy, per 15 minutes
*HOO05	Alcohol and/or drug services; group counseling by a clinician
*H0006	Alcohol and/or drug services; case management (targeted)
H0017	Behavioral health; residential (hospital residential treatment program), without room and board, per diem
H0018	Behavioral health; short-term residential (nonhospital residential treatment program), without room and board, per diem
H0019	Behavioral health; long-term residential (nonmedical, non-acute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem
*H0020	Medication Assisted Treatment
H0023	Behavioral health outreach service (planned approach to reach a targeted population)
H0025	Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude and/or behavior)
H0031	Mental health assessment, by non-physician
H0032	Mental health service plan development by non-physician
H0033	Oral medication administration, direct observation
H0034	Medication training and support, per 15 minutes
H0035	Mental health partial hospitalization, treatment, less than 24 hours
H0036	Community psychiatric supportive treatment, face-to-face, per 15 minutes
H0037	Community psychiatric supportive treatment program, per diem
H0038	Self-help/peer services, per 15 minutes
H0039	Assertive community treatment, face-to-face, per 15 minutes
H0040	Assertive community treatment program, per diem
H0043	Supported housing, per diem
H0044	Supported housing, per month
H0045	Respite care services, not in the home, per diem
H1011	Family assessment by licensed behavioral health professional for state defined purposes
H2000	Comprehensive multidisciplinary evaluation
H2001	Rehabilitation program, per 1/2 day
H2011	Crisis intervention service, per 15 minutes
H2012	Behavioral health day treatment, per hour
H2014	Skills training and development, per 15 minutes
H2015	Comprehensive community support services, per 15 minutes. Long definition: The purpose of Comprehensive Community Support Services is to coordinate and provide services and resources to individuals/families necessary to promote recovery, rehabilitation and resiliency. Comprehensive Community Support Services identifies and addresses the barriers that impede the development of skills necessary for independent functioning in the community; as well as strengths, which may aid the individual or family in the recovery or resiliency process. Community support activities address goals specifically in the following areas: independent living; learning; working; socializing and recreation. Comprehensive Community Support Services also include supporting an individual and family in crisis situations; and providing individual interventions to develop or enhance an individual's ability to make informed and independent choices.

Proc Code	Full description of the procedure codes
H2016	Comprehensive community support services, per diem
H2017	Psychosocial rehabilitation services, per 15 minutes
H2018	Psychosocial rehabilitation services, per diem
H2021	Community-based wrap-around services, per 15 minutes
H2022	Community-based wrap-around services, per diem
H2023	Supported employment, per 15 minutes
H2024	Supported employment, per diem
H2025	Ongoing support to maintain employment, per 15 minutes
H2026	Ongoing support to maintain employment, per diem
H2027	Psycho educational service, per 15 minutes
H2030	Mental health clubhouse services, per 15 minutes
H2031	Mental health clubhouse services, per diem
H2032	Activity therapy, per 15 minutes
H2033	Multi-systemic therapy for juveniles, per 15 minutes
M0064	Brief office visit for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental, psychoneurotic, and personality disorders
*S3005	Safety assessment including suicidal ideation and other behavioral health issues
S5150	Unskilled respite care, not hospice; per 15 minutes
S5151	Unskilled respite care, not hospice; per diem
*S9445	Drug screening and monitoring
S9453	Smoking cessation classes, non-physician provider, per session
S9454	Stress management classes, non-physician provider, per session
S9480	Intensive outpatient psychiatric services, per diem
S9485	Crisis intervention mental health services, per diem
T1005	Respite care services, up to 15 minutes
*T1007	Physical assessment of detoxification progression including vital signs monitoring
T1016	Case management, each 15 minutes
T1017	Targeted case management, each 15 minutes
*T1019	Provision of daily living needs including hydration, nutrition, cleanliness and toiletry for clients
*T1023	Level of motivation assessment for treatment evaluation

*Denotes SUD services covered under the Medicaid substance use disorder benefit.

Please note: The Department and its Contractors will continue to refine and update the covered procedures list on an ongoing basis.

The below list of Evaluation and Management codes are covered by the BHOs when they are billed in conjunction with a psychotherapy add-on from the above list or when used for the purposes of medication management with minimal psychotherapy provided by a prescriber from the BHO network.

99201	Office or other outpatient visit, new patient/10 minutes
99202	Office or other outpatient visit, new patient/20 minutes
99203	Office or other outpatient visit, new patient/ 30 minutes
99204	Office or other outpatient visit, new patient/45 minutes
99205	Office or other outpatient visit, new patient/60 minutes
99211	Office or other outpatient visit, established patient/ 5 minutes
99212	Office or other outpatient visit, established patient/10 minutes
99213	Office or other outpatient visit, established patient/15 minutes
99214	Office or other outpatient visit, established patient/25 minutes
99215	Office or other outpatient visit, established patient/ 40 minutes
99217	Observation care discharge day management
99218	Initial observation / 30 minutes
99219	Initial observation care/50 minutes
99220	Initial observation care/ 70 minutes
99224	Subsequent observation care/15 minutes
99225	Subsequent observation care/25 minutes
99226	Subsequent observation care/35 minutes
99234	Observation or inpatient hospital care, patient admitted and discharged on same date of service, 40 minutes
99235	Observation or inpatient hospital care, patient admitted and discharged on same date of service/50 minutes
99236	Observation or inpatient hospital care, patient admitted and discharged on same date of service/ 55 minutes
99241	Office consultation/15 minutes
99242	Office consultation/ 30 minutes
99243	Office consultation/ 40 minutes
99244	Office consultation/50 minutes
99245	Office consultation/SO minutes
99255	Initial inpatient consultation/110 minutes.
99304	Initial nursing facility care/per day/25 minutes spent at bedside or on patient floor/unit
99305	Initial nursing facility care/per day/ 35 minutes spent at bedside or on patient floor/unit

Proc Code	Full description of the procedure codes
99306	Initial nursing facility care/per day/45 minutes spent at bedside or on patient floor/unit
99307	Subsequent nursing facility care/per day/10 minutes spent at bedside or on patient floor/unit
99308	Subsequent nursing facility care/per day/15 minutes spent at bedside or on patient floor/unit
99309	Subsequent nursing facility care/per day/25 minutes spent at bedside or on patient floor/unit
99310	Subsequent nursing facility care/per day/35 minutes spent at bedside or on patient floor/unit
99315	Nursing facility discharge day management; 30 minutes or less
99316	Nursing facility discharge day management; more than 30 minutes
99318	Annual nursing facility assessment 30 minutes spent at bedside or on patient floor/unit
99324	Domiciliary or rest home visit, new patient/20 minutes
99325	Domiciliary or rest home visit, new patient 30 minutes
99326	Domiciliary or rest home visit, new patient 45 minutes
99327	Domiciliary or rest home visit, new patient 60 minutes
99328	Domiciliary or rest home visit, new patient 75 minutes
99334	Domiciliary or rest home visit, established patient/15 minutes
99335	Domiciliary or rest home visit, established patient/25 minutes
99336	Domiciliary or rest home visit, established patient 40 minutes
99337	Domiciliary or rest home visit, established patient 60 minutes
99341	Home visit, new patient/20 minutes
99342	Home visit, new patient/30 minutes
99343	Home visit, new patient/45 minutes
99344	Home visit, new patient/60 minutes
99345	Home visit, new patient/75 minutes
99347	Home visit, established patient/15 minutes
99348	Home visit, established patient/25 minutes
99349	Home visit, established patient/40 minutes
99350	Home visit, established patient/60 minutes

Service Category	Service Components
Assessment	Alcohol/Drug Assessment, Alcohol/Drug Screening, Multidisciplinary Evaluation, Family Consult/Assessment, Healthcare Prof Phone Call, MH Assessment, Service Plan Development, Neurobehavioral Status, Neuropsych Testing, Psych Diagnostic Evaluation, Psych Testing
Case Management	Alcohol/Drug Services, Case Management, Targeted Case Management
Crisis/Emergency	Crisis Intervention
Evaluation/Management	Nursing Facility Assessment, Dom Rest Custodial, Home Care, Initial Nursing Facility, Nursing Facility Discharge, Observational Care, Inpatient Consultation, Office or Outpatient, Same Day Admit/Discharge, Subsequent Hospital or Nursing facility care
Inpatient	Initial Hospital Care, Hospital Discharge, Inpatient Consultation, Subsequent Hospital Care
Intensive Treatment	Behavioral Health Day Treatment, Intensive Outpatient, MH Partial Hospitalization, OPPS/PHP
Other Professional	Community Wraparound, MST juvenile, Psycho education, Psycho physiological therapy, Team Conference
Other	Education, Evaluation/Management, Lab Testing, Drug Screen, Room and Board, Pharmacy Services, Lab, Psych Services in Hospital
Peer Support/Recovery	Community Support Service, Self-help/Peer Service
Prevention/Early Intervention	Alcohol/Drug Outreach, Alcohol/Drug Prevention/EI, Skills Training, Smoking Cessation
Psychiatric/Medication Management	Office visit for Medication Management, Medication Training/Support, Oral Medication Administration, Phone Evaluation/Management by MD, Medication Injection
Psychotherapy	Family Psychotherapy, Group Psychotherapy, Multi-family Group, Psychological Crisis, Psychological Treatment,
Rehabilitation	Activity Therapy, ACT, MH Clubhouse, Psychosocial Rehab, Rehab Program, Self-care Training, Skills training
Residential	Supported Housing, ATU, and Residential Units
Respite Care	Respite Care Service, Respite Not-in-home, Unskilled Respite Care
Social Ambulatory Detox	Self-Assess Depression, Program Intake Assessment, Treatment Plan Development
Substance Use	Alcohol/Drug Screening
Vocational	Support/Maintain Employment, Supported Employment

Appendix E - Data Obtained for this Study and Data Processing Methodology

The primary data sources for this study were obtained from two state agencies: the Department of Health Care Policy and Financing (HCPF), which is the State Authority for Medicaid and Medicare, and the Office of Behavioral Health (OBH), which is within the Department of Human Services.

HCPF provided data for all mental health capitation processed claims in state FY 2011-12 and FY 2014-15 and substance use processed claims for FY 2014-15 (Medicaid Capitation data file). On January 1, 2015, substance use services provided by Medicaid were added to the Capitation program. Prior to this date, the services were reimbursed through the Medicaid FFS program. Encounter claim files included pricing of each encounter. The file did not contain claims that occurred outside of enrollment eligibility due to any reason (e.g., Medicaid eligibility lapse, ineligible procedure code).

OBH provided FY 2011-12 and FY 2014-15 substance use (SUD) admissions data from the Drug/Alcohol Coordinated Data System (DACODS) data file. These data were comprised of all admissions (first face-to-face therapeutic contact with a clinician) to any OBH-licensed substance use provider in the respective FY. This file provided an administrative record for each treatment episode. A person with multiple episodes had repeated records. Numbers reported represent admissions in each year rather than total served due to the nature of the data provided. Detailed service information was not part of these records. SUD Admissions did not identify indigent status. Primary payer of services was identified for each episode.

OBH provided data for all persons served for whom an encounter record had been submitted in FY 2011-12 and FY 2014-15 (OBH encounters). It is important to note that the encounter data only included encounters submitted by CMHCs and MSOs, which represent a portion of the programs and services funded by OBH. FY 2011-12 included only mental health encounters, whereas FY 2014-15 data reflected the updated business requirement to submit substance use encounters. FY 2014-15 substance use encounters were excluded from analyses since these data are neither complete nor representative of the total number of SUD services as providers are still working to comply with the recent requirements to submit this data. Both years of data included adjustment records, some of which required additional processing.

OBH provided FY 2011-12 and FY 2014-15 data from the Colorado Client Assessment Record (CCAR), the clinical instrument used to assess the behavioral health status of a client in treatment. If more than one CCAR was present for an individual, typically the first CCAR was used in analyses.

Indigent status of OBH clients was identified via a matching CCAR marked as indigent in FY 2011-12 or an OBH encounter record marked as indigent in FY 2014-15.

CCAR data were used to determine the severity of illness/presence of a SED/SMI in FY 2011-12 and FY 2014-15. For more information on how SED/SMI presence and severity is determined, please refer to the CCAR Manual, available at: https://sites.google.com/a/state.co.us/cdhs-behavioral-health/home/community-behavioral-health/reports-and-presentations/ccar-and-encounter-documentation.

OBH encounters were priced using Relative Value Units (RVUs) applied to CMHC base unit costs. RVU's are used by Medicare to determine the fee for each service. RVU rank on a common scale the resources used to provide each service. The fee is arrived at by multiplying the RVU by a cost factor. In this case, CMHC's provide a supplemental schedule with their annual audit that provides a base unit cost, the dollar conversion factor.

Numbers of persons served in each system were computed based on a constructed identifier with elements common to all data systems. Elements of the identifier included date of birth, gender, and first three letters of the last name. Numbers of persons served within each system enumerate unduplicated numbers served by each agency/provider; that is, files were aggregated by agency and identifier. Numbers of persons served across systems enumerate unduplicated numbers served across all agencies, and across systems, i.e., unduplicated by identifier.

When data at the county level was presented by CMHC, we arrived at the CMHC values by combining county level estimates using a weighted averaging to account for population differences across counties. For each county within a CMHC area we developed a weight that represented the proportion of county population that comprises the makeup of the total CMHC area population (e.g., county A in a CMHC area comprises 51% of the CMHC area total population). County values were multiplied by the corresponding population weight and summed to arrive at the CMHC value.

Appendix F - Number of Persons Served by the Office of Behavioral Health (OBH) and the Department of Health Care Policy and Financing (HCPF) in FY 2011-12 and FY 2014-15

Total Number of Indigent Persons Served by OBH in FY 2011-12 and FY 2014-15, Percent of Total Served, and Percent Change

CMHC	FY 2011-12		FY 2014-15		Percent change
	Number of Indigent	Percent of all Served	Number of Indigent	Percent of all Served	
AllHealth	917	21.7%	712	9.6%	-12.1%
AspenPointe	1,479	13.3%	875	4.5%	-8.8%
Aurora	1,434	19.9%	533	8.1%	-11.8%
Axis	769	20.1%	367	11.8%	-8.3%
Centennial	723	28.6%	326	9.4%	-19.2%
CMH	693	19.5%	370	8.0%	-11.5%
Community Reach	939	12.3%	577	4.6%	-7.7%
Health Solutions	937	19.9%	580	5.4%	-14.5%
Jefferson	13,801	69.7%	8,867	31.1%	-38.6%
MHCD	2,096	24.0%	1,229	10.4%	-13.6%
MHP	1,779	27.4%	873	11.1%	-16.3%
Mind Springs	1,943	20.8%	1,123	8.7%	-12.1%
North Range	2,010	33.3%	847	8.1%	-25.2%
San Luis Valley	431	23.8%	222	6.1%	-17.7%
Solvista	523	28.9%	250	9.3%	-19.6%
Southeast	472	26.3%	124	6.2%	-20.1%
SummitStone	1,055	24.3%	301	4.2%	-20.1%
Total	32,001	30.5%	18,176	11.7%	-18.8%

Source: Office of Behavioral Health (OBH) encounter data file. FY 2011-12 does not include data for substance use encounters (only includes mental health encounters).

Total Number of Indigent Persons Served by OBH in FY 2011-12 and FY 2014-15 and Percent Change by Age

CMHC	Age 0-17			Age 18+		
	FY 2011-12 Number Served	FY 2014-15 Number Served	Percent Change	FY 2011-12 Number Served	FY 2014-15 Number Served	Percent Change
AllHealth	213	56	-73.7%	704	656	-6.8%
AspenPointe	394	144	-63.5%	1,085	731	-32.6%
Aurora	364	135	-62.9%	1,070	387	-63.8%
Axis	107	76	-29.0%	662	290	-56.2%
Centennial	144	61	-57.6%	579	264	-54.4%
CMH	99	34	-65.7%	594	331	-44.3%
Community Reach	237	52	-78.1%	702	523	-25.5%
Health Solutions	112	35	-68.8%	825	540	-34.5%
Jefferson	6,004	6,568	9.4%	7,797	2,291	-70.6%
MHCD	349	178	-49.0%	1,747	1,033	-40.9%
MHP	193	78	-59.6%	1,586	789	-50.3%
Mind Springs	273	140	-48.7%	1,670	983	-41.1%
North Range	320	105	-67.2%	1,690	742	-56.1%
San Luis Valley	125	27	-78.4%	306	193	-36.9%
Solvista	53	24	-54.7%	470	226	-51.9%
Southeast	85	14	-83.5%	387	110	-71.6%
SummitStone	168	19	-88.7%	887	277	-68.8%
Total	9,240	7,746	-16.2%	22,761	10,366	-54.5%

Source: Office of Behavioral Health (OBH) encounter data file. FY 2011-12 does not include data for substance use encounters (only includes mental health encounters). Due to missing data for age, total by age is not the same as the total number served.

Total Number of Indigent Persons Served by OBH in FY 2011-12 and FY 2014-15 and Percent Change by Gender

CMHC	Female			Male		
	FY 2011-12 Number Served	FY 2014-15 Number Served	Percent Change	FY 2011-12 Number Served	FY 2014-15 Number Served	Percent Change
AllHealth	487	348	-28.5%	429	361	-15.9%
AspenPointe	796	461	-42.1%	677	414	-38.8%
Aurora	859	292	-66.0%	575	229	-60.2%
Axis	449	191	-57.5%	320	175	-45.3%
Centennial	421	169	-59.9%	302	156	-48.3%
CMH	360	188	-47.8%	333	177	-46.8%
Community Reach	521	295	-43.4%	418	280	-33.0%
Health Solutions	504	156	-69.0%	433	190	-56.1%
Jefferson	7,683	4,497	-41.5%	6,066	4,362	-28.1%
MHCD	1,150	650	-43.5%	946	560	-40.8%
MHP	945	440	-53.4%	834	427	-48.8%
Mind Springs	991	558	-43.7%	952	565	-40.7%
North Range	1,173	511	-56.4%	837	336	-59.9%
San Luis Valley	231	103	-55.4%	200	117	-41.5%
Solvista	305	148	-51.5%	218	102	-53.2%
Southeast	260	59	-77.3%	212	65	-69.3%
SummitStone	565	147	-74.0%	490	148	-69.8%
Total	17,700	9,213	-47.9%	14,242	8,664	-39.2%

Source: Office of Behavioral Health (OBH) encounter data file. FY 2011-12 does not include data for substance use encounters (only includes mental health encounters). Due to missing data for gender, total by gender is not the same as the total number served.

Total Number of OBH Publically Funded Substance Use Disorder (SUD) Admissions in FY 2011-12 and FY 2014-15 and Percent Change

MSO	FY 2011-12 Number Served	FY 2014-15 Number Served	Percent Change
AspenPointe	4,308	5,200	20.7%
MHP	749	919	22.7%
Signal Denver	16,724	16,072	-3.9%
Signal NE	1,657	3,191	92.6%
Signal SE	2,838	3,096	9.1%
Westslope NW	638	1,669	161.6%
Westslope SW	953	875	-8.2%
Total	27,867	31,022	11.3%

Source: Office of Behavioral Health (OBH) Drug/Alcohol Coordinated Data System (DACODs) data file.

Total Number of OBH Publically Funded Substance Use Disorder (SUD) Admissions in FY 2011-12 and FY 2014-15 and Percent Change by Age

MSO	Age 0-17			Age 18+		
	FY 2011-12 Number Served	FY 2014-15 Number Served	Percent Change	FY 2011-12 Number Served	FY 2014-15 Number Served	Percent Change
AspenPointe	135	189	40.0%	4,173	5,011	20.1%
MHP	25	23	-8.0%	723	896	23.9%
Signal Denver	526	419	-20.3%	16,198	15,653	-3.4%
Signal NE	234	266	13.7%	1,423	2,925	105.6%
Signal SE	200	143	-28.5%	2,638	2,953	11.9%
Westslope NW	51	69	35.3%	587	1,600	172.6%
Westslope SW	45	30	-33.3%	906	845	-6.7%
Total	1,216	1,139	-6.3%	26,648	29,883	12.1%

Source: Office of Behavioral Health (OBH) Drug/Alcohol Coordinated Data System (DACODs) data file. Due to missing data for age, total by age is not the same as the total number served.

Total Number of OBH Publically Funded Substance Use Disorder (SUD) Admissions in FY 2011-12 and FY 2014-15 and Percent Change by Gender

MSO	Female			Male		
	FY 2011-12 Number Served	FY 2014-15 Number Served	Percent Change	FY 2011-12 Number Served	FY 2014-15 Number Served	Percent Change
AspenPointe	1,617	1,909	18.1%	2,691	3,291	22.3%
MHP	233	360	54.5%	516	559	8.3%
Signal Denver	4,814	5,354	11.2%	11,910	10,718	-10.0%
Signal NE	702	1,349	92.2%	955	1,842	92.9%
Signal SE	1,030	1,268	23.1%	1,808	1,828	1.1%
Westslope NW	310	675	117.7%	328	994	203.0%
Westslope SW	297	324	9.1%	656	551	-16.0%
Total	9,003	11,239	24.8%	18,864	19,783	4.9%

Source: Office of Behavioral Health (OBH) Drug/Alcohol Coordinated Data System (DACODs) data file. Due to missing data for gender, total by gender is not the same as the total number served.

Total Number of Persons Served by Medicaid Capitation in FY 2011-12 and FY 2014-15 and Percent Change

BHO	FY 2011-12 Number Served	FY 2014-15 Number Served	Percent Change
ABC-D	10,042	22,677	125.8%
ABC-NE	9,816	16,583	68.9%
BHI	15,635	29,462	88.4%
CHP	27,360	51,319	87.6%
FBHP	12,456	20,192	62.1%
Total	75,309	140,233	86.2%

Source: The Department of Health Care Policy and Financing (HCPF) processed claims file.

Total Number of Persons Served by Medicaid Capitation in FY 2011-12 and FY 2014-15 and Percent Change by Age

BHO	Age 0-17			Age 18+		
	FY 2011-12 Number Served	FY 2014-15 Number Served	Percent Change	FY 2011-12 Number Served	FY 2014-15 Number Served	Percent Change
ABC-D	3,814	6,040	58.4%	6,228	16,637	167.1%
ABC-NE	4,486	5,601	24.9%	5,330	10,982	106.0%
BHI	7,498	11,385	51.8%	8,137	18,077	122.2%
CHP	11,382	14,209	24.8%	15,978	37,110	132.3%
FBHP	6,172	7,734	25.3%	6,284	12,458	98.2%
Total	33,352	44,969	34.8%	41,957	95,264	127.1%

Source: The Department of Health Care Policy and Financing (HCPF) processed claims file.

Total Number of Persons Served by Medicaid Capitation in FY 2011-12 and FY 2014-15 and Percent Change by Gender

BHO	Female			Male		
	FY 2011-12 Number Served	FY 2014-15 Number Served	Percent Change	FY 2011-12 Number Served	FY 2014-15 Number Served	Percent Change
ABC-D	5,535	12,552	126.8%	4,439	10,098	127.5%
ABC-NE	5,741	9,583	66.9%	4,049	6,999	72.9%
BHI	8,854	16,886	90.7%	6,377	12,542	96.7%
CHP	16,360	29,400	79.7%	10,859	21,689	99.7%
FBHP	7,113	11,294	58.8%	5,263	8,850	68.2%
Total	43,603	79,715	82.8%	30,987	60,178	94.2%

Source: The Department of Health Care Policy and Financing (HCPF) processed claims file. Due to missing data for gender, total by gender is not the same as the total number served.

Total Number of Unduplicated Persons Served by OBH MH-Indigent, OBH SUD, and HCPF Medicaid Capitation in FY 2011-12 and FY 2014-15*

CMHC Area	FY 2011-12	FY 2014-15	Percent Change
AllHealth	6,405	8,573	33.8%
AspenPointe	15,852	24,305	53.3%
Aurora	8,454	13,240	56.6%
Axis	2,715	2,924	7.7%
Centennial	2,343	2,919	24.6%
CMH	2,283	3,398	48.8%
Community Reach	9,051	13,616	50.4%
Health Solutions	6,648	11,685	75.8%
Jefferson	20,360	25,197	23.8%
MHCD	16,237	27,941	72.1%
MHP	5,559	6,868	23.5%
Mind Springs	5,550	9,438	70.1%
North Range	6,761	8,774	29.8%
San Luis Valley	2,457	3,526	43.5%
Solvista	2,048	3,123	52.5%
Southeast	2,296	2,501	8.9%
SummitStone	5,010	7,826	56.2%
Unknown CMHC Area	309	0	--
Total	120,338	175,854	46.1%

*CMHC area was not able to be determined for 309 cases in FY 2011-12.

Source: Office of Behavioral Health (OBH) encounter data file (Note: FY 2011-12 does not include data for substance use encounters; only includes mental health encounters), Office of Behavioral Health (OBH) Drug/Alcohol Coordinated Data System (DACODs) data file, and The Department of Health Care Policy and Financing (HCPF) processed claims file.

Appendix G - Number of Persons Enrolled in and Served by Behavioral Health Organizations (BHOs) and BHO Penetration Rates in FY 2011-12 and FY 2014-15

Total (Colorado)	FY 2011-12			FY 2014-15		
	Enrollment	Members Served	Penetration Rate	Enrollment	Members Served	Penetration Rate
Youth 0-17	359,349	34,391	9.57%	497,333	48,976	9.85%
Adults 18+	259,891	46,290	17.81%	637,310	117,418	18.42%
Total	619,240	80,681	13.03%	1,134,643	166,394	14.66%

ABD-D	FY 2011-12			FY 2014-15		
	Enrollment	Members Served	Penetration Rate	Enrollment	Members Served	Penetration Rate
Youth 0-17	61,476	4,736	7.70%	77,481	7,217	9.31%
Adults 18+	43,730	7,366	16.84%	105,142	22,844	21.73%
Total	105,206	12,102	11.50%	182,623	30,061	16.46%

ABC-NE	FY 2011-12			FY 2014-15		
	Enrollment	Members Served	Penetration Rate	Enrollment	Members Served	Penetration Rate
Youth 0-17	45,768	4,348	9.50%	64,383	6,571	10.21%
Adults 18+	32,944	5,677	17.23%	78,029	13,038	16.71%
Total	78,712	10,025	12.74%	142,412	19,609	13.77%

BHI	FY 2011-12			FY 2014-15		
	Enrollment	Members Served	Penetration Rate	Enrollment	Members Served	Penetration Rate
Youth 0-17	94,460	7,806	8.26%	135,722	12,352	9.10%
Adults 18+	56,292	9,199	16.34%	140,786	23,019	16.35%
Total	150,753	17,005	11.28%	276,508	35,371	12.79%

CHP	FY 2011-12			FY 2014-15		
	Enrollment	Members Served	Penetration Rate	Enrollment	Members Served	Penetration Rate
Youth 0-17	117,711	11,298	9.60%	163,298	14,876	9.11%
Adults 18+	95,065	17,208	18.10%	229,017	43,286	18.90%
Total	212,776	28,506	13.40%	392,315	58,162	14.83%

FBHP	FY 2011-12			FY 2014-15		
	Enrollment	Members Served	Penetration Rate	Enrollment	Members Served	Penetration Rate
Youth 0-17	39,934	6,203	15.53%	56,449	7,960	14.10%
Adults 18+	31,860	6,840	21.47%	84,336	15,231	18.06%
Total	71,795	13,043	18.17%	140,785	23,191	16.47%

Data Source: BHO's annual performance measure validation reports (https://www.colorado.gov/pacific/hcpf/performance-measures-encounter-data-validation). Penetration rates represent the number of members who received at least one service (paid or denied claim) divided by the number of FTE enrolled in the Medicaid mental health managed care program. Statewide penetration rates were calculated by the summing total number served and the total number enrolled by each BHO.

Appendix H - Demographic and Diagnostic Composition of Medicaid Expansion Clients in FY 2014-15

FY 2014-15 Demographic Composition of Medicaid Expansion Clients

FY 2014-15	AwDC					Parents/Caretakers				
BHO	Number Served	Female	Male	Age 18-54	Age 55 +	Number Served	Female	Male	Age 18-54	Age 55 +
ABC-D	9,678	40.1%	59.9%	84.2%	15.8%	740	75.1%	24.9%	95.1%	4.9%
ABC-NE	4,952	47.0%	53.0%	85.8%	14.2%	944	75.7%	24.3%	98.1%	1.9%
BHI	8,111	48.3%	51.7%	85.5%	14.5%	1,507	76.8%	23.2%	97.7%	2.3%
CHP	15,912	46.0%	54.0%	84.7%	15.3%	2,761	74.0%	26.0%	96.7%	3.3%
FBHP	6,280	47.5%	52.5%	83.9%	16.1%	894	75.7%	24.3%	95.9%	4.1%
Total	44,933	45.5%	54.5%	84.7%	15.2%	6,846	75.2%	24.8%	96.8%	3.2%

FY 2014-15 Diagnostic Information for Medicaid Expansion Clients*

Diagnostic Category	AwDC		Parents/Caretakers	
	Number	Percent of Total	Number	Percent of Total
Major Depression	10,101	22.7%	1,754	25.8%
Adjustment	7,159	16.1%	1,654	24.3%
Alcohol Abuse	6,798	15.3%	639	9.4%
Anxiety	5,993	13.5%	1,310	19.3%
Drug Abuse	5,325	12.0%	525	7.7%
Bipolar	4,291	9.6%	504	7.4%
Attention Deficit Disorder	1,029	2.3%	140	2.1%
Schizophrenia	864	1.9%	31	0.5%
Schizoaffective	735	1.7%	--	--
Alcohol Related Mental Disorder	731	1.6%	63	0.9%
Other Psychotic Disorder	723	1.6%	34	0.5%
Personality Impulse	211	0.5%	--	--
Conduct Disorder	118	0.3%	--	--
Delusion	98	0.2%	--	--
Eating/Sleeping Disorder	91	0.2%	--	--
Other Medical Ment Disorder	87	0.2%	--	--
Somatoform	77	0.2%	45	0.7%
Other Childhood Disorder	35	0.1%	--	--
Autism	--	--	--	--
Schizophreniform	--	--	--	--
Mental Retardation	--	--	--	--
Dissociative	--	--	--	--
Other NonPsychotic	--	--	--	--
Sexual	--	--	--	--
Med Induced Disorder	--	--	--	--
Vascular Dementia	--	--	--	--
Total	44,531	100.0%	6,802	100.0%

*Diagnostic information is based on the primary diagnosis on a matching CCAR. A small percentage of clients did not have diagnostic information: AwDC= 0.9%; Parents/Caretakers=1.3%. Diagnoses for which there are 30 or fewer clients have been suppressed, which is indicated by "--".

Appendix I - Other State Practices Literature Review

Impact of Medicaid Expansion on Behavioral Health Services: A Literature Review

August 10, 2016

National Association of State Mental Health Program Directors Research Institute, Inc.

Contents

Introduction and Methodology

Status and Impact of Medicaid Expansion:

- Medicaid Expansion and the Public Behavioral Health System
- Fiscal Impact
- Use of New Revenue and Savings
- Implementation Results

Types of Individuals Covered by Medically Indigent Programs

Prioritization of Services and Supports

Overcoming Barriers the Prevent Individuals from Obtaining Health Insurance Coverage

Continued Challenges

Introduction and Methodology:

The Patient Protection and Affordable Care Act (ACA), passed in 2010, affords states the option to expand Medicaid coverage to include individuals at or below 138% of the federal poverty level (FPL). States that elect to expand Medicaid may realize an increase in demand for behavioral health services, which will place new demands on the public system that states must learn to navigate.

The purpose of this literature review is to better understand how Medicaid expansion affects the delivery of public behavioral health services to inform the State of Colorado's practices. This literature review specifically addresses the following areas:

- Status and Impact of Medicaid expansion;
- Types of individuals covered under medically indigent programs;
- Prioritization of services and supports;
- Strategies to overcome barriers that keep medically needy individuals from obtaining health insurance coverage;

Between March and July of 2016, researchers conducted Internet and database searches to inform this literature review, focusing primarily on documents and grey literature found through Google Scholar, government websites, and professional websites. In addition, references from found documents were searched for additional resources. Material was identified through a combination of key word, phrases, and topical searches, including:

- Medicaid expansion
    - and behavioral health impact
    - and budget impact
    - and reports
    - and safety net
    - and state experiences
    - and uninsured mental health
    - and adult group profile
- Indigent care
    - and definition of
    - and population

In the spring of 2016, under a Substance Abuse and Mental Health Services Administration (SAMHSA) subcontract with Truven Health Analytics, NRI and NASADAD staff interviewed nine state behavioral health authorities (SBHAs) to better understand how state authorities change their use of the SAMHSA block grants in response to the implementation of the ACA and the implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA). Information from these interviews was developed into a report, *Determining How States Use the Substance Abuse Prevention and Treatment Block Grant (SABG) and the Community Mental Health Services Block Grant (MHBG) in the Wake of the Mental Health Parity and Addiction Equity Act and the Affordable Care Act,* for SAMHSA's Center for Financing Reform and Innovation. The report is currently in pre-publication; however, relevant information from the report is included in this literature review.

In addition to information gleaned from the Internet searches and interviews with states about their use of the block grants, information from NRI's State Profiling System is included to provide context to the findings. The State Profiling System is a database of information that describes the organization, funding, operation, services, policies, statutes, and clients of state behavioral health authorities. Information from the State Profiling System is cited accordingly.

When possible, examples from Western states are included to provide additional relevance to Colorado's decision-making. For the purposes of this literature review, Western states are defined as those belonging to the WICHE region, and include: Alaska*, Arizona*, California*, Colorado*, Idaho, Montana*, Nevada*, New Mexico*, North Dakota*, Oregon*, South Dakota, Utah, Washington*, and Wyoming (states marked with an asterisk have expanded Medicaid).[1]

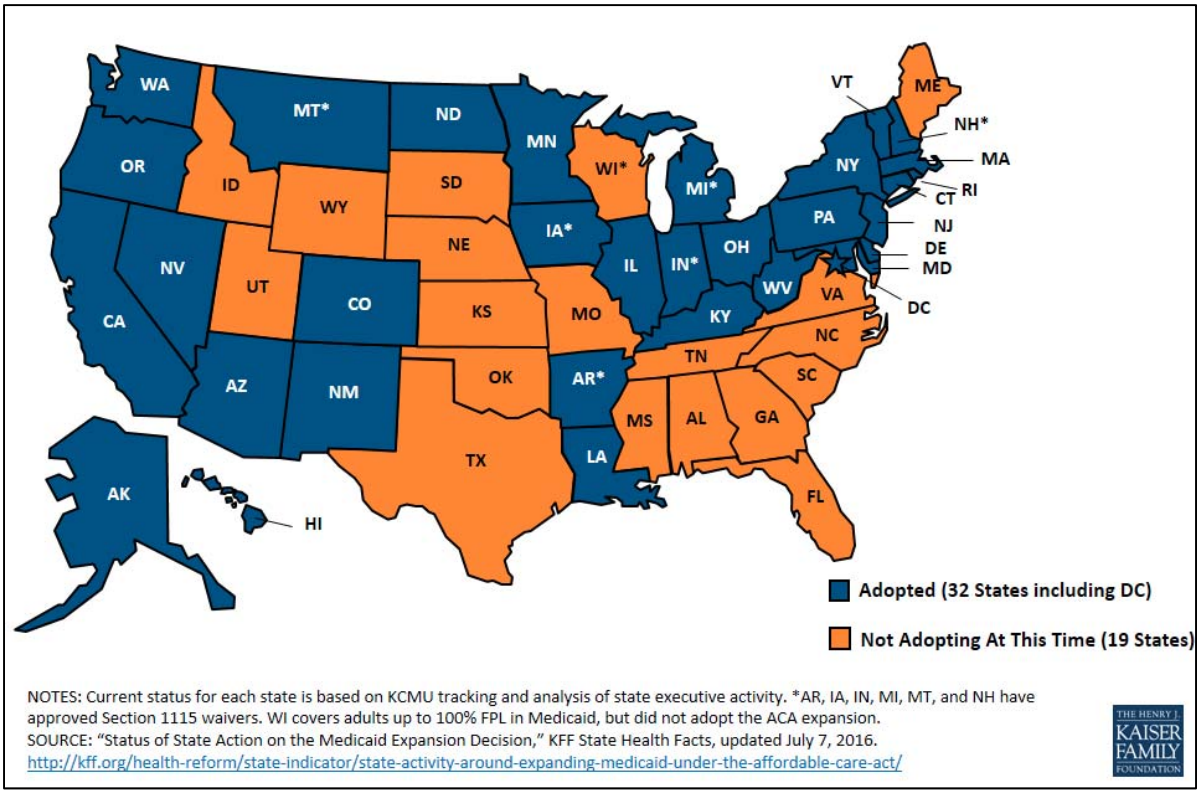
EndNote was used to manage citations and references, and NVivo was used to code and identify themes and relationships amongst articles. Citations to resources are referenced throughout the document in the form of footnotes at the bottom of each page.

[1] Western Interstate Commission for Higher Education. (2015). *WICHE region.* Retrieved from http://www.wiche.edu/states.

Status and Impact of Medicaid Expansion:

As of July 7, 2016, 32 states, including the District of Columbia, have expanded their Medicaid programs, including 10 states in the West (Alaska, Arizona, California, Colorado, Montana, Nevada, New Mexico, North Dakota, Oregon, and Washington; See Figure 1).[2]

Figure 1: Status of State Medicaid Expansion Decisions (as of July 7, 2016)[3]



Between the summer of 2013 and January 2016, Medicaid enrollment expanded to include 15.5 million additional adults. Of these additional enrollees, "82% of the net enrollment in growth occurred in expansion states."[4] Information on individual states' increased Medicaid enrollment, and decreased uninsured populations shows dramatic impact.[5] Nationwide, for states that expanded Medicaid (with available data), increases in enrollment ranged from 8% in Delaware, to 87% in Kentucky between Fall 2013 through June 2015.[6] Table 1 highlights changes in Medicaid enrollment during the same period for Western states that elected to expand Medicaid.

[2] Kaiser Family Foundation (2016, Jul 7). *Current status of state Medicaid expansion decisions.* Retrieved from: http://kff.org/health-reform/slide/current-status-of-the-medicaid-expansion-decision/
[3] Ibid.
[4] Gates, A., Rudowtz, R., and Artiga, S. (2016, Jun 24). *Two year trends in Medicaid and CHIP enrollment data: findings from the CMS performance indicator project..* Retrieved from http://kff.org/report-section/two-year-trends-in-medicaid-and-chip-enrollment-data-key-findings/
[5] Searing, A., and Hoadley, J. (2016, June). *Beyond the reduction in uncompensated care: Medicaid expansion is having a positive impact on safety net hospitals and clinics.* Retrieved from http://ccf.georgetown.edu/wp-content/uploads/2016/05/Medicaid_hospitals-clinics-June-2016.pdf
[6] Norris, L. (2015, Dec 26). *Medicaid coverage in your state.* Retrieved from https://www.healthinsurance.org/medicaid/.

Table 1: Changes in Medicaid Enrollment in Western Expansion States, 2013-2015[7]

State	Date Expanded Medicaid (MM/YY)	Covered by Medicaid as of May 2015	Newly Eligible with Expansion (Est.)	Change in Medicaid Enrollment Since 2013	Change in Uninsured 2013 to 2014	Change in Medicaid/CHIP Coverage Fall 2013-May 2015
AK	09/15	122,521	42,000	N/A	-46%	N/A
AZ	07/13*	1,557,193	463,000	N/A	-14%	355,423
CA	06/13	12,549,540	2,875,000	38%	-27%	3,392,540
CO	01/14	1,253,040	351,000	62%	-34%	469,620
MT	01/16	178,846	70,000	N/A	N/A	N/A
NV	12/12*	559,165	266,000	69%	-22%	226,605
NM	01/14	705,730	187,000	N/A	-24%	248,052
ND	01/14	89,001	35,000	27%	-24%	19,021
OR	01/14	1,098,508	325,000	72%	-40%	472,152
WA	06/13*	1,710,356	419,000	55%	-62%	592,780
**Signed into law*						

While some increases would have resulted even without Medicaid expansion due other ACA features, such as the streamlining and simplifying of the Medicaid enrollment process, the states' newly-eligible Medicaid enrollment figures far exceeded expectations.[8] The figures listed in table 1 above reflect the total number of newly insured recipients, and not only those with behavioral health needs. It is important to be aware of the profile of the Medicaid expansion group and the extent of their behavioral health needs as they provide insight into the impact on states' behavioral health systems.

Medicaid Expansion and the Public Behavioral Health System

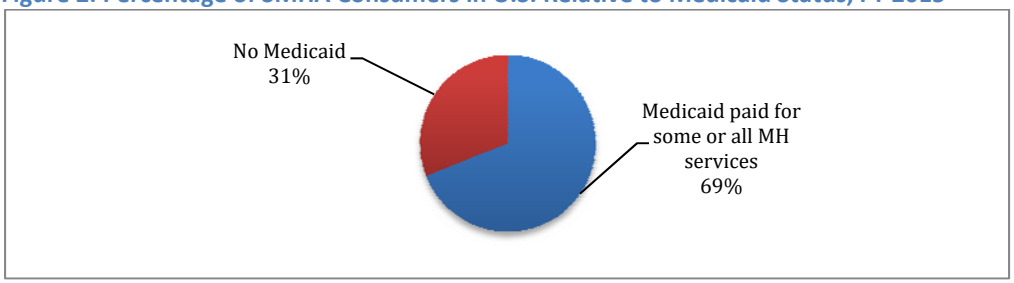
Medicaid is the largest single funder of mental health services in the public mental health system, representing 49% ($19.7 billion) of all SBHA funds in fiscal year 2014; many people in the Medicaid expansion group have behavioral health needs.[9,10] Due to data infrastructure limitations, most SBHAs are unable to identify whether Medicaid clients are part of the expanded Medicaid population or are part of the traditional Medicaid population. During the development of the report, *Funding and Characteristics of Single State Agencies for Substance Abuse Services and State Mental Health Agencies: 2015* (herein referred to as the "2015 Profiles Report"), NRI only identified five state mental health authorities (SMHAs) and five single state agencies for substance abuse services (SSAs) that could determine which clients were covered under expanded Medicaid, and which clients were covered under the traditional Medicaid structure.

Of the five SMHAs that could identify clients' Medicaid classifications, slightly more than half (51%) of the clients covered by expanded Medicaid were new clients who entered service during FY 2013-14, and 49% were continuing clients from prior years of service.[11] Similarly, the five SSAs that were able to identify clients' Medicaid status found that, of individuals covered under expanded Medicaid, 54% were new clients (not served in the prior year), and 46% were continuing clients who had been served in prior years.[12]

According to 2015 Uniform Reporting System (URS) data, there was a significant increase in the number (and percent) of SMHA consumers served who had Medicaid covering some or all of their care. A crosstab analysis revealed that the increase was from states with Medicaid expansion, with the greatest increase coming from early adopters of expansion. In the 26 states that expanded Medicaid in 2014, there was a net increase of 674,071 individuals served with Medicaid paying for care, and a decrease of 470,180 individuals with no Medicaid coverage. During this time, Colorado realized an increase of 37,370 clients served by the SMHA with Medicaid, and a decrease of 11,089 served with no Medicaid.[13] The figure below shows the percentage of all SMHA consumers in the U.S. in 2015 relative to Medicaid status.

[7] Ibid.
[8] Dorn, S., and Francis, N., Urban Institute, Snyder, L., and Rudowitz, R. (2015, Mar 11). *The effects of the Medicaid expansion on budgets: an early look in select states.* Retrieved from http://kff.org/medicaid/issue-brief/the-effects-of-the-medicaid-expansion-on-state-budgets-an-early-look-in-select-states/.
[9] NRI. (Pre-publication). *Funding and characteristics of single state agencies for substance abuse services and state mental health agencies: 2015.*
[10] Dey, J., Rosenoff, E., West, K., Ali, M., Lynch, S., McClellan, C., Mutter, et al. (2016, Mar 28). *Benefits of Medicaid expansion for behavioral health*. Retrieved from https://aspe.hhs.gov/sites/default/files/pdf/190506/BHMedicaidExpansion.pdf
[11] NRI. (Pre-publication). *Funding and characteristics of single state agencies for substance abuse services and state mental health agencies: 2015.*
[12] Ibid.
[13] SAMHSA. (2015). *2015 URS Data.*

Figure 2: Percentage of SMHA Consumers in U.S. Relative to Medicaid Status, FY 2015[14]



There was speculation before Medicaid expansion that the group of individuals newly eligible for Medicaid would present with increased health needs; this prediction became reality. According to Eric Lloyd, chief executive of Amerigroup in Nevada, "many of [the] new enrollees have far greater health needs than the mothers and children who dominated the Medicaid rolls in the past."[15] CMS interviewed six states that adopted the Medicaid expansion early (California, Connecticut, the District of Columbia, Minnesota, New Jersey, and Washington), and found that the expansion population utilized behavioral health services beyond projections in each of the states. The states also reported that high demand overwhelmed the available services. Two of the six states (not identified) shared estimates on prevalence of substance abuse disorders for the newly eligible population, ranging from 9% to 13%. Meanwhile, one other state reported that an estimated 60% of those with mental illnesses also had a concurrent substance use disorder.[16,17] Between January 2014 and April 2015, Arizona's Medicaid program gained 270,507 eligible members classified as having a serious mental illness (SMI), a 52% increase over the 16-month period. The total eligible SMI population in Arizona at the end of the period was 784,920.[18]

Fiscal Impact

Although expansion states have realized an increase in the number of Medicaid enrollees, these states have also experienced an increase in cost savings and revenue gains associated with expanded Medicaid. Examples of cost savings found in the literature include:

- An Issue Brief, released by The State Health Reform Assistance Network in 2014, examines the expansion experiences of eight states (Arkansas, Colorado, Kentucky, Michigan, New Mexico, Oregon, Washington, and West Virginia). Two of these states (Arkansas and Kentucky) revealed state budgetary savings and revenue gains sufficient to offset state costs attributable to Medicaid expansion at least through State FY21. Kentucky saved $9 million in State FY 2013-14 (six months of savings), and expects to save $21 million in State FY 2014-15 in behavioral health spending. Savings totaled between $20 million in Colorado, and $389 million in Michigan through 2015.[19]
- The Center on Budget and Policy Priorities, in an April 2015 article, noted that Medicaid expansion saved the State of Washington $105.5 million in FY 2013-14. Washington expects to realize an additional savings of $286.6 million in FY 2014-15.[20]

These savings are attributed to reduced state general fund (SGF) expenditures on uninsured and Supplemental Security Income (SSI) populations; revenue gains from existing insurer and provider taxes; an enhanced Medicaid match rate; and broader economic benefits associated with job growth.[21] Table 2 provides an overview of the available data on these

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[14] Ibid.

[15] Galewitz, P. (2014, Oct 28). *Reno finds Medicaid expansion is easier said than done.* Retrieved from http://www.governing.com/topics/health-human-services/reno-finds-medicaid-expansion-is-easier-said-than-done.html

[16] Sommers, B.D., Arntson, E., Kenney, G.M., and Epstein, A.M. (2013). *Lessons from early Medicaid expansions under health reform: interviews with Medicaid officials.* Retrieved from https://www.cms.gov/mmrr/Downloads/MMRR2013_003_04_a02.pdf.

[17] Kardish, C. (2013, Dec 2). *New Medicaid enrollees come with mental health needs, uncertain costs.* Retrieved from http://www.governing.com/topics/health-human-services/Report-New-Medicaid-Enrollees-Come-With-Mental-Health-Needs-Uncertain-Costs.html

[18] Landry, V.L. (2015, Sept 14). *The relationship between Medicaid expansion and the utilization of behavioral health care services by severely mentally ill patients in Arizona.* https://research.phoenix.edu/publication/relationship-between-medicaid-expansion-and-utilization-behavioral-health-care-services

[19] Bachrach, D., Boozang, P., Herring, A., and Glanz Reyneri, D. (2016 Mar). *States expanding Medicaid see significant budget savings and revenue gains: early data shows consistent economic benefits across expansion states.* Retrieved from http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwjf419097

[20] Cross-Call, J. (2015, Apr 28). *Medicaid expansion is producing large gains in health coverage and saving states money.* Retrieved from http://www.cbpp.org/research/health/medicaid-expansion-is-producing-large-gains-in-health-coverage-and-saving-states

[21] Bachrach, D., Boozang, P., and Glanz, D. (2015 Mar). *Medicaid expansion states see significant budget savings and revenue gains: early data from two states shows more than $1 billion in savings.* Retrieved from http://statenetwork.org/wp-content/uploads/2015/03/Medicaid-Expansion-States-See-Significant-Budget-Savings-and-Revenue-Gai....pdf

savings for 2015 only; the subsections below provide further explanations about where these savings were realized, including savings across multiple years (when available).

Table 2: Savings Realized in State FY 2015 Related to Medicaid Expansion (in millions)[22]

State	Uninsured/ SGF Savings	SSI	Inpatient Costs of Prisoners	Behavioral Health	Gains from Taxes/ Assessments	Gains from Enhanced Match Rate
AR	$33.4	N/A	$2.75	$7.1	$29.7	$67.97
CA	$750.0	N/A	N/A	N/A	$615.43	$250.0
CO	$10.0	N/A	$5.0	N/A	N/A	$149.9
DC	N/A	N/A	N/A	N/A	N/A	$41.3
KY	$49.9	N/A	$11.0	$21.0	N/A	$33.3
MD	$13.61	N/A	N/A	N/A	$26.6	$110.11
MI	$209.0	N/A	$19.0	$190.0	$26.0	$35.4
NM	N/A	N/A	N/A	N/A	$30.0	N/A
OR	$137.5	N/A	N/A	N/A	N/A	$137.5
PA	$108.0	N/A	N/A	N/A	N/A	$0.59
WA	$68.1	$109.8	$1.4	$51.2	$33.9	$250.5

Reduced State General Fund Expenditures on Uninsured Populations

As more uninsured individuals obtain coverage, demand for health care services (including behavioral health) that serve low-income and uninsured residents declines. The number of uninsured individuals seeking care at hospitals should also decrease. Because of this, all expansion states should expect to reduce state spending on programs for the uninsured.[23] States expanding Medicaid expected reductions in SGF expenditures for uninsured individuals between $7 million and $190 million in 2015, with total savings expected to exceed $610 million.[24,25,26] These programs include treatment for people with mental illness and substance use disorders, funding for hospitals to offset uncompensated care costs, and care for prisoners who have to be hospitalized outside of correctional facilities.

Farah Hanley, Deputy Director for Central Operations for the Michigan Department of Health and Human Services, indicated that the majority of those served by state-funded programs became eligible for Medicaid after expansion and the state was able to cut funding for the programs by two-thirds. In FY 2014-15, Michigan expects to reap $190 million in savings by transitioning individuals with serious mental illness (SMI) in state-funded programs into the new adult group under Medicaid expansion.[27] Similarly, Kentucky expects to save $30 million in mental health spending by July 1, 2015 by transitioning individuals into the new adult group.[28]

The State of Washington also experienced savings to its behavioral health budget through Medicaid expansion. Washington saved $105.5 million in FY 2013-14, including $64.6 million in behavioral health spending.[29]

New Mexico saved $15.3 million in 2015 because of lower demand for state-funded behavioral health services.[30] Kentucky saved $9 million in 2014 as recipients of state-funded behavioral health programs became fully covered by Medicaid.[31]

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[22] Bachrach, D., Boozang, P., Herring, A., and Glanz Reyneri, D. (2016 Mar). *States expanding Medicaid see significant budget savings and revenue gains: early data shows consistent economic benefits across expansion states.* Retrieved from http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwjf419097

[23] Bachrach, D., Boozang, P., and Glanz, D. (2015, Apr). *States expanding Medicaid see significant budget savings and revenue gains: early data shows consistent economic benefits across expansion states.* Retrieved from: http://statenetwork.org/wp-content/uploads/2015/04/State-Network-Manatt-States-Expanding-Medicaid-See-Significant-Budget-Savings-and-Revenue-Gains-April-20152.pdf

[24] Dey, J., Rosenoff, E., West, K., Ali, M.M., Lynch, S., McClellan, C., Mutter, R., Patton, L., Teich, J., and Woodward, A. (2016, Mar 28). *Benefits of Medicaid Expansion for Behavioral Health.* Retrieved from https://aspe.hhs.gov/sites/default/files/pdf/190506/BHMedicaidExpansion.pdf

[25] HHS. (2016, Mar 28). *New report shows Medicaid expansion can improve behavioral health care access.* Retrieved from http://www.hhs.gov/about/news/2016/03/28/new-report-shows-medicaid-expansion-can-improve-behavioral-health-care-access.html

[26] Bachrach, D., Boozang, P., Glanz, D. (2015, Apr 10). *Medicaid expansion leads to economic benefits while improving access to coverage.* Retrieved from https://www.manatt.com/insights/newsletters/medicaid-update/medicaid-expansion-leads-to-economic-benefits-whil

[27] Bachrach, D., Boozang, P., and Glanz, D. (2015, Apr). *States expanding Medicaid see significant budget savings and revenue gains: early data shows consistent economic benefits across expansion states.* Retrieved from: http://statenetwork.org/wp-content/uploads/2015/04/State-Network-Manatt-States-Expanding-Medicaid-See-Significant-Budget-Savings-and-Revenue-Gains-April-20152.pdf

[28] Ollove, M. (2015, Apr 29). *States find savings through Medicaid expansion.* Retrieved from http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/4/29/states-find-savings-through-medicaid-expansion

[29] Cross-Call, J. (2015, Apr 28). *Medicaid expansion is producing large gains in health coverage and saving states money.* Retrieved from http://www.cbpp.org/research/health/medicaid-expansion-is-producing-large-gains-in-health-coverage-and-saving-states

[30] Ibid.

In 2014, compared to non-expansion states, states that elected to expand Medicaid began to show a significant increase in the number of inpatient stays for Medicaid patients, and a sharp decline in the number of uninsured inpatient stays. Data show that while inpatient stays declined by 3.4% for a typical expansion state from 2013 to 2014, Medicaid inpatient stays increased by 16.3%, and uninsured stays decreased by 36.9%.[32]

Expansion states experienced significant increases in Medicaid discharges, and declines in uninsured discharges from hospitals. One report found that "mental health stays accounted for 5.8% of adult hospital stays in the second quarter of 2014. A typical expansion state experienced a decrease of 1.5% in mental health inpatient stays, but saw a 36.5% increase in Medicaid mental health inpatient stays, and a 44.4% decline in uninsured stays for mental health," whereas non-expansion states realized a slight increase of 1.6% in overall mental health stays across public payers.[33] Although hospitals are realizing a decline in uninsured hospital stays, the number of hospital admissions and emergency room visits in expansion states have increased.

Oregon example of where hospital admissions and emergency room visits have increased with expansion. In Oregon, Medicaid expansion has increased the likelihood that individuals will seek out hospital care, with admissions increasing from 6.7% to 8.8% since expanding Medicaid.[34] Oregon also realized a 40% increase in the use of emergency services during the same time.[35] North Dakota also noticed an increase in inpatient stays in their Medicaid population.

North Dakota's Medicaid expansion provider, Sanford Health, compared the expansion group to individuals covered by private insurance and found that the total number of inpatient days was 4.6 times higher among individuals covered under Medicaid expansion.[36] On average, individuals covered under Medicaid expansion in North Dakota stayed 5.75 days, compared to 3.95 days for those covered by private insurance.[37] North Dakota also realized an increase in emergency room visits among the Medicaid population compared to the private group. For individuals covered by Medicaid, the state realized 1,212 emergency room visits per every 1,000 members compared to 244 visits per 1,000 of commercially insured.[38]

These statistics indicate that individuals covered by Medicaid tend to have more complicated and adverse health conditions than those covered by private insurance. The increased use of emergency rooms may also reflect the habits of newly covered Medicaid recipients who traditionally sought care in acute settings.

Reduced Expenditures on the Supplemental Security Income Population

Washington realized declining enrollment in an optional eligibility pathway that provides coverage for those awaiting a Supplemental Security Income (SSI) disability determination. Adults who would have enrolled under these optional eligibility pathways were instead enrolling under the new Medicaid expansion group, qualifying for a higher matching rate.[39] This saved Washington $147.9 million.[40]

In State FY 2014-15, Kansas spent approximately $348 million on the blind and disabled SSI population. With Medicaid expansion, some low-income individuals who previously would have pursued disability determinations to qualify for Medicaid are now able to enroll in the new adult group based on income alone. As a result, early expansion states are reporting sharp drops in the number of individuals seeking disability determinations.[41]

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[31] Bachrach, D., Boozang, P., and Glanz, D. (2015, Apr). *States expanding Medicaid see significant budget savings and revenue gains: early data shows consistent economic benefits across expansion states.* Retrieved from: http://statenetwork.org/wp-content/uploads/2015/04/State-Network-Manatt-States-Expanding-Medicaid-See-Significant-Budget-Savings-and-Revenue-Gains-April-20152.pdf

[32] Rudowitz, R., and Garfield, R. (2015, Sept 17). *New analysis shows states with Medicaid expansion experienced declines in uninsured hospital discharges.* Retrieved from http://kff.org/health-reform/issue-brief/new-analysis-shows-states-with-medicaid-expansion-experienced-declines-in-uninsured-hospital-discharges/

[33] Ibid.

[34] DeLeire, T., Joynt, K., and McDonald, R. (2014, Sept 24). *Impact of insurance expansion on hospital uncompensated care costs in 2014.* Retrieved from https://aspe.hhs.gov/sites/default/files/pdf/77061/ib_UncompensatedCare.pdf.

[35] Ibid.

[36] North Dakota. (2016, Jan 19). *North Dakota Medicaid expansion: Health Care Reform Review Committee: January 19, 2016.* Retrieved from http://www.legis.nd.gov/assembly/64-2015/committees/interim/health-care-reform-review-committee

[37] Ibid.

[38] Ibid.

[39] Dorn, S., Francis, N., Snyder, L., and Rudowitz, R. (2015, Mar 11). *The effects of the Medicaid expansion on state budgets: an early look in select states.* Retrieved from http://kff.org/medicaid/issue-brief/the-effects-of-the-medicaid-expansion-on-state-budgets-an-early-look-in-select-states/.

[40] Cross-Call, J. (2015, Apr 28). *Medicaid expansion is producing large gains in health coverage and saving states money.* Retrieved from http://www.cbpp.org/research/health/medicaid-expansion-is-producing-large-gains-in-health-coverage-and-saving-states

[41] Bachrach, D., Mann, C., and Wallis, K. (2015, Dec). *Impact of Medicaid expansion on the Kansas State budget.* Retrieved from http://www.sunflowerfoundation.org/transfer/manatt/budgetimpact-kancareexpansion.pdf

Reduction in State General Fund Expenditures for State Behavioral Health

States rely on State General Funds to support the public safety net of behavioral health services for indigent populations. With more individuals eligible for, and covered by Medicaid, some states have realized significant savings in this area. According to a Robert Wood Johnson Foundation study, at least four expansion states have documented savings in this area, totaling $269.3 million in FY 2015: Arkansas, Kentucky, Michigan, and Washington.

Table 3: State General Fund Savings for Behavioral Health Services[42]

State	FY 2014	FY 2015
AR	N/A	$7,100,000
KY	$9,000,000	$21,000,000
MI	$180,000,000	$190,000,000
WA	$13,400,000	$51,200,000

Reductions in Costs for Inpatient Hospital Stays for Prisoners

Criminal justice systems in expansion states may also realize cost savings, as the population served by this system is more likely to be covered by Medicaid under expansion. The Bureau of Justice Statistics estimates that 45% of federal prisoners, 56% of state prisoners, and 64% of jail inmates are affected by a mental illness.[43] It is also estimated that 50% of state prisoners, and 68% of jail inmates have diagnosable substance use disorders.[44] Data indicate that state and local spending are reduced when Medicaid and behavioral health coverage is offered to the criminal justice population. In addition, states that provide behavioral health services in the community, as opposed to inside correctional facilities, are eligible to receive federal matching dollars for providing community-based care.

Since Washington expanded funding for substance use treatment to low-income individuals frequently involved with the criminal justice system, arrests declined significantly across three different study groups (ranging from a 17% reduction to a 33% reduction).[45] The decline in arrests resulted in $3.00 of savings for the criminal justice system for every $1.00 spent on treatment.[46] Simultaneously, medical expenditures for this population also decreased. The reduction in arrests equaled savings ranging from $9,000 to $18,000 for each person treated, for a total savings of $275 million across the three study sites.[47]

Another study examined the coverage of inpatient hospitalization stays for inmates, and identified significant cost savings for states implementing expanded Medicaid. Table 4 shows the savings these six states experienced associated with Medicaid coverage of inmates' inpatient care.

Table 4: Savings Associated with Medicaid Coverage of Inmates' Inpatient Care[48]

State	Savings	Time Period
AR	$2.75 million	FY 2014-15
CO	$10 million	FY 2013-14-15
KY	$16.4 million	FY 2013-14-15
MI	$19.2 million	FY 2013-14-15
OH	$10.3 million	FY 2013-14
WA	$2.1 million	FY 2013-14-15

To recognize these savings, and improve individuals' ability to obtain services and reduce recidivism rates, states can facilitate criminal justice-involved individuals' enrollment into Medicaid while incarcerated, and provide support for community-based services following incarceration.[49]

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[42] Bachrach, D., Boozang, P., Herring, A., and Glanz Reyneri, D. (2016 Mar). *States expanding Medicaid see significant budget savings and revenue gains: early data shows consistent economic benefits across expansion states.* Retrieved from http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwjf419097

[43] James, D.J., and Glaze, L.E. (2006, Dec 14). *Mental health problems of prison and jail inmates.* Retrieved from http://www.bjs.gov/content/pub/pdf/mhppji.pdf

[44] Dey, J., Rosenoff, E., West, K., Ali, M.M., Lynch, S., McClellan, C., Mutter, R., Patton, L., Teich, J., and Woodward, J. (2016, Mar 28). *Benefits of Medicaid expansion for behavioral health.* Retrieved from https://aspe.hhs.gov/pdf-report/benefits-medicaid-expansion-behavioral-health

[45] Ibid.

[46] Ibid.

[47] Dey, J., Rosenoff, E., West, K., Ali, M.M., Lynch, S., McClellan, C., Mutter, R., Patton, L., Teich, J., and Woodward, J. (2016, Mar 28). *Benefits of Medicaid expansion for behavioral health.* Retrieved from https://aspe.hhs.gov/pdf-report/benefits-medicaid-expansion-behavioral-health

[48] Guyer, J., Bachrach, D., and Shine, N. (2015, Nov). *Medicaid expansion and criminal justice costs: pre-expansion studies and emerging practices point toward opportunities for states.* Retrieved from http://statenetwork.org/wp-content/uploads/2015/11/State-Network-Manatt-Medicaid-Expansion-and-Criminal-Justice-Costs-November-2015.pdf

Additional Revenue from Taxes and Fees

As provider and health plan revenues increase with Medicaid expansion, additional revenue for states that raise assessments or fees on providers and health plans is realized. According to a Robert Wood Johnson 2015 Issue Brief that examined the experience of eight states (Arkansas, Colorado, Kentucky, Michigan, New Mexico, Oregon, Washington, and West Virginia), four states had already experienced gains from provider assessments and fees. Although not yet realized, Colorado "can expect to see revenue gains [from increased insurer and provider assessments and taxes] because of expansion."[50] Table 5 below shows the additional amount each of the four states realized in FYs 2014 and 2015.[51]

Table 5: Estimated Revenue Gains from Insurer Assessments, 2014 and 2015

State	Estimated Revenue Gains from Insurer Assessment 2014	Estimated Revenue Gains from Insurer Assessment 2015	Total '14/'15
AR	$4,700,000	$29,700,000	$34,400,000
MI	$0	$26,000,000	$26,000,000
NM	$30,000,000	$30,000,000	$60,000,000
WA	N/A	$33,900,000	$33,900,000

Enhanced Match Rate

States have typically been responsible for between 30% and 50% of the cost of covering individuals in the Medicaid program, referred to as the Federal Medical Assistance Percentages (FMAP). "For states that implement the [Medicaid] expansion, the federal government will finance 100% of the costs of those made newly eligible for Medicaid from 2014 to 2016 and the federal contribution phases down to 90% by 2020 and beyond. States would continue to pay the traditional Medicaid match rate for increased participation among those currently eligible."[52] With Medicaid expansion, many individuals previously eligible for Medicaid in eligibility groups approved through waivers or specialized eligibility categories can be transferred to the expansion group. This means that these states will receive enhanced federal funding for providing Medicaid benefits.

Seven out of eight states highlighted in a Robert Wood Johnson study projected savings in this category. Savings totaled between $4 million in West Virginia, and $342 million in Washington through 2015. Arkansas saved $17.5 million in 2014 by accessing the 100% federal match for adults previously enrolled in waiver programs, and targeted categorical eligibility groups that transitioned to the new adult group.[53] Table 6 summarizes the results from this study.

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[49] Dey, J., Rosenoff, E., West, K., Ali, M.M., Lynch, S., McClellan, C., Mutter, R., Patton, L., Teich, J., and Woodward, J. (2016, Mar 28). *Benefits of Medicaid expansion for behavioral health.* Retrieved from https://aspe.hhs.gov/pdf-report/benefits-medicaid-expansion-behavioral-health

[50] Ibid

[51] Bachrach, D., Boozang, P., Herring, A., and Glanz Reyneri, D. (2016 Mar). *States expanding Medicaid see significant budget savings and revenue gains: early data shows consistent economic benefits across expansion states.* Retrieved from http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwjf419097

[52] Rudowitz, R. (2014, Sept 29). *Understanding how states access the enhanced Medicaid match rates.* Retrieved from http://kff.org/medicaid/issue-brief/understanding-how-states-access-the-aca-enhanced-medicaid-match-rates/.

[53] Bachrach, D., Boozang, P., Herring, A., and Glanz Reyneri, D. (2016 Mar). *States expanding Medicaid see significant budget savings and revenue gains: early data shows consistent economic benefits across expansion states.* Retrieved from http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwjf419097

Table 6: State Savings from Enhanced Federal Medicaid Matching Funds, SFY 2014 and SFY 2015[54]

State	Savings in State FY 2014	Savings in State FY 2015	Notes
AR	$17,500,000	$67,970,000	Savings realized from the following programs: ARHealthNetwork, Medically Needy, Disabled Adults, Pregnant Women, Family Planning, Breast & Cervical Treatment, and Tuberculosis
CA	$0	$250,000,000	Savings realized from the Low Income Health Program
CO	$137,900,000	$149,900,000	Savings realized from the following programs: Childless Adults Early Expansion Waiver, Breast & Cervical Cancer Treatment, Early Expansion for Parents, and Pregnant Women
KY	$7,400,000	$33,300,000	Savings realized from the following programs: Medically Needy, Disabled Adults, Breast & Cervical Cancer Treatment, State Technical Assistance
MD	$50,402,887	$110,106,816	Savings realized from the following programs: Primary Adult Care, Breast & Cervical Cancer Treatment, Pregnant Women
MI	$17,700,000	$35,400,000	Savings realized from the following programs: Adult Benefits Waiver, Family Planning
NM	N/A	N/A	N/A
OR	N/A	N/A	N/A
PA	N/A	$588,000	Savings realized from the Select Plan for Women
WA	$91,500,000	$250,500,000	Savings realized from the following programs: Medically Needy, Breast & Cervical Cancer Treatment, Family Planning, Pregnant Women, Adult Waiver Populations, Presumptive Supplemental Security Income (SSI) – Expansion State Designation
Total:	**$322,402,887**	**$867,794,816**	

According to a Kaiser Family Foundation study, New Mexico will save $60 million between 2014 and 2016 by transitioning low-income adults who, prior to expansion, received Medicaid coverage through a waiver into the expansion eligibility group.[55]

Eight states highlighted in a State Health Reform Network report (Arkansas, Colorado, Kentucky, Michigan, New Mexico, Oregon, Washington, and West Virginia) expected total savings related to enhanced Medicaid match to exceed $1 billion through 2015. In addition, these states expect to save a combined $71 million through 2015 as high-need and high-cost individuals who previously would have only qualified for Medicaid by "spending down" to the medically needy eligibility group instead were able to enroll in the new adult group, where the federal government provides enhanced match rates for their services. This is a significant area of savings for states with medically needy programs given the high per-beneficiary cost of this population. These savings occur without any reductions in medically needy eligibility levels.[56]

The conclusion is that every expansion state should expect to see savings as individuals who were previously eligible for limited Medicaid benefits under pre-ACA eligibility categories are now eligible for full Medicaid coverage in the new adult group with enhanced federal funding.[57]

Economic Benefits due to Job Growth and Productivity

In addition to reduced expenditures on uninsured populations, and increased revenues from taxes and fees, expansion states are also realizing broader economic benefits. During 2014, states that expanded Medicaid realized a growth in jobs by 2.4%, while states that did not expand Medicaid only realized an increase in jobs of 1.8%. Most of the new jobs in the expansion states were added in the health care sector.[58] An analysis conducted by the Urban Studies Institute at the University of Kentucky, Louisville estimated that Medicaid expansion led to an increase of 12,000 jobs in State FY 2013-14 alone, with more than 40,000 additional jobs expected through 2021. This increase in jobs also results in additional tax revenue to the state and localities.

In addition to job creation, states can also expect to have a more productive workforce as more individuals seek care for behavioral health issues. Expanding behavioral health treatment encourages a reduction in adverse workforce outcomes

[54] Ibid
[55] Dorn, S., Francis, N., Snyder, L., and Rudowitz, R. (2015, Mar 11). *The effects of the Medicaid expansion on state budgets: an early look in select states.* Retrieved from http://kff.org/medicaid/issue-brief/the-effects-of-the-medicaid-expansion-on-state-budgets-an-early-look-in-select-states/.
[56] Bachrach, D., Boozang, P., Herring, A., and Glanz Reyneri, D. (2016 Mar). *States expanding Medicaid see significant budget savings and revenue gains: early data shows consistent economic benefits across expansion states.* Retrieved from http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwjf419097
[57] Ibid.
[58] Ibid.

stemming from mental health and substance use issues. Research shows that employees with depression incur significantly more disability days than do otherwise similar employees. Substance use disorder treatment is associated with $5,366 in employer savings from reduced absenteeism alone.[59]

Use of New Revenue and Savings

Medicaid expansion has given a budget boost to participating states, mostly by allowing them to use federal money instead of state dollars to care for uninsured individuals, as well as through increased tax and assessment revenues. States are now faced with determining where to allocate these savings.

Some states have chosen to reinvest these funds into their behavioral health service systems to bring budgets up to pre-recession levels and enhance the continuum of care for behavioral health. States have specifically reallocated funds toward peer support services and supported employment. [60] Kentucky expanded the types of behavioral health providers that were eligible for Medicaid reimbursement, both for the traditional Medicaid program as well as for the Medicaid expansion group, increasing access to behavioral health services.[61]

In addition to impacts on state budgets, increased budget flexibility may also be realized in expansion states. Funds from the SAMHSA block grants, which may have been used to treat the uninsured, can now be used to meet a multitude of other needs, including workforce development, screening, prevention and early intervention programs, and the provision of the continuum of care, many of which are not covered by Medicaid. One expansion state (not identified) indicated "Medicaid expansion allowed them to free-up $5.7 million for services in FY 2015-16. With these funds, the SBHA has filled gaps in the system, expanded a contract for a public awareness campaign for the crisis service line, and increased provider rates by 12.5%."[62] Another state (not identified), in anticipation of Medicaid expansion, "planned to allocate newly available block grant funds that were previously dedicated to indigent care to implement supported employment and supported housing evidence-based practices."[63] However, when the Supreme Court ruled that expansion was optional, the state elected not to expand Medicaid. As a result, this state's block grant and state general funds are used primarily for indigent care, with very few funds remaining for other activities.

As mentioned above, some states have elected to use expansion savings to increase provider rates. Inland Empire, a Medi-Cal managed care plan in California, is using savings to pay providers higher rates. The CEO of the Inland Empire Health Plan, Dr. Bradley Gilbert, stated that he has "to create a network while meeting demands for adequate reimbursement."[64] This health plan has added approximately 300 mental health providers to its network in the past 18 months.[65]

While some states chose to reinvest these savings into their state behavioral health budgets or provider networks, others chose to reduce SBHA budgets and appropriate funds elsewhere, or offset future Medicaid expansion costs.

Some states have reduced the amount of tax revenues dedicated to providing care to the uninsured, most of which now qualify for Medicaid, and invest the funds toward other initiatives or lower taxes. In FY 2014-15, legislatures reduced the budget for behavioral health agencies by $25.5 million in Connecticut, $21 million in Kentucky, and $33 million in Nevada.[66] The State of Washington also reduced funds to the SBHA by $64.6 million; an additional $147.9 million was transferred away from adults awaiting a disability determination for SSI to help fund the Medicaid program.[6768]

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[59] HHS. (2016, Mar 28). *New report shows Medicaid expansion can improve behavioral health care access.* Retrieved from http://www.hhs.gov/about/news/2016/03/28/new-report-shows-medicaid-expansion-can-improve-behavioral-health-care-access.html

[60] Dey, J., Rosenoff, E., West, K., Ali, M., Lynch, S., McClellan, C., Mutter, R., Patton, L., Teich, J., and Woodward, A. (2016, Mar 28). *Benefits of Medicaid expansion for behavioral health*. Retrieved from https://aspe.hhs.gov/sites/default/files/pdf/190506/BHMedicaidExpansion.pdf

[61] Dorn, D., Francis, N., Snyder, L., and Rudowitz, R. (2015, Mar 11). *The effects of the Medicaid expansion on state budgets: an early look in select states.* Retrieved from http://kff.org/medicaid/issue-brief/the-effects-of-the-medicaid-expansion-on-state-budgets-an-early-look-in-select-states/.

[62] NRI, NASADAD. (Pre-publication). *Understanding how states use the SABG and MHBG in the wake of Mental Health Parity and Addiction Equity Act and the Affordable Care Act.*

[63] Ibid.

[64] Dickson, V. (2015, July 4). *Medicaid plans struggle to provide mental health services.* Retrieved from http://www.modernhealthcare.com/article/20150704/MAGAZINE/307049979.

[65] Ibid.

[66] Karamanakis, K. (2015, Aug 3). *GAO: States with expanded Medicaid can better treat mental illness.* Retrieved from http://www.governing.com/topics/health-human-services/gov-gao-report-medicaid-mental-health.html

[67] Dey, J., Rosenoff, E., West, K., Ali, M., Lynch, S., McClellan, C., Mutter, R., Patton, L., Teich, J., and Woodward, A. (2016, Mar 28). *Benefits of Medicaid expansion for behavioral health*. Retrieved from https://aspe.hhs.gov/sites/default/files/pdf/190506/BHMedicaidExpansion.pdf

[68] Cross-Call, J. (2015, Apr 28). *Medicaid expansion is producing large gains in health coverage and saving states money.* Retrieved from http://www.cbpp.org/research/health/medicaid-expansion-is-producing-large-gains-in-health-coverage-and-saving-states

States may also elect to divert the savings associated with Medicaid expansion to offset the cost of covering new enrollees, which will increase beginning in 2017, when the federal government no longer covers the expansion population at 100%.[69] Table 7 provides an overview of where states are allocating their new savings (data only available for 11 states (note there may be duplication across efforts).

Table 7: Reallocation of State Funds[70]

	Screening and Early Intervention	Reinvest in Behavioral Health: EBPs	Reinvest in Behavioral Health: Public Awareness	Reinvest Behavioral Health: Crisis Services	Reinvest in Behavioral Health: Workforce	Reallocate Away from Behavioral Health
Number of States	3 States	5 States	1 State	1 State	3 States	4 States

Implementation Results

States that expanded Medicaid have experienced a variety of consequences, both positive and negative, associated with Medicaid expansion. States have recognized benefits and challenges in the availability of services, quality and quantity of the state's behavioral health workforce, providers' ability to bill Medicaid, ability for clients to enroll in Medicaid and access care, and outcomes of Medicaid participants.

Availability of Services

People enrolled in Medicaid who reside in expansion states have more behavioral health service options and greater availability than those living in non-expansion states.[71] According to a report by the Government Accountability Office, expansion states tend to have an increased availability of behavioral health service options:[72]

- Kentucky realized a substantial increase in the availability of behavioral health services for Medicaid enrollees, as individuals were no longer restricted to services provided by state-funded community mental health services.
- Prior to Medicaid expansion, uninsured individuals often "experienced long delays in receiving care" because their options for treatment were so limited. Medicaid expansion has contributed to a decrease in wait times.
- Medicaid enrollees in West Virginia have increased availability to prescription drugs, as the state's SMHA did not typically cover prescription drugs for the uninsured population. Newly eligible enrollees "gained access to the full array of covered drugs under the state's Medicaid program."

Although the array of services has increased in expansion states, expansion states have expressed some concerns:[73]

- Officials in Nevada conducted a "secret shopper" study of psychiatrists participating in the state's Medicaid program and "found that only 22%... were accepting new Medicaid patients."
- Medicaid enrollees in Maryland and Connecticut have had difficulty accessing certain prescription drugs used for Medication-Assisted Therapies for substance use "due to a lack of physicians willing to prescribe these drugs for Medicaid enrollees."

Contrasting the findings in Maryland and Connecticut, one recent study focused on the relationship between a state's Medicaid expansion status and the growth in supply of physicians waivered to prescribe buprenorphine for opioid dependence found that expansion states had a higher growth in the supply of buprenorphine-waivered physicians than non-expansion states. This finding may bode well for the impact of Medicaid expansion on meeting the treatment needs of those with opioid-use disorders.[74]

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[69] Bannow, T. (2016, Apr 28). *Oregon saving big from Medicaid expansion.* Retrieved from http://www.bendbulletin.com/health/4224305-151/oregon-saving-big-from-medicaid-expansion.

[70] NRI, NASADAD. (Pre-publication). *Understanding how states use the SABG and MHBG in the wake of Mental Health Parity and Addiction Equity Act and the Affordable Care Act.*

[71] DiPietro, B., Artiga, S., and Gates, S. (2014, Nov 13). *Early impacts of the Medicaid expansion for the homeless population.* Retrieved from http://kff.org/uninsured/issue-brief/early-impacts-of-the-medicaid-expansion-for-the-homeless-population/.

[72] GAO. (2015, Jun). *Options for low-income adults to receive treatment in selected states.* Retrieved from http://www.gao.gov/assets/680/670894.pdf.

[73] Ibid.

[74] Dey, J., Rosenoff, E., West, K., Ali, M., Lynch, S., McClellan, C., Mutter, R., Patton, L., Teich, J., and Woodward, A. (2016, Mar 28). *Benefits of Medicaid expansion for behavioral health*. Retrieved from https://aspe.hhs.gov/sites/default/files/pdf/190506/BHMedicaidExpansion.pdf

Workforce Impact

Although states have benefitted economically from job growth in the health care sector due to Medicaid expansion, the supply of behavioral health professionals to meet the increased service need continues to be a concern for states. According to 2015 Profiles Data, nearly every SSA and SMHA reported that their state does not have a sufficient behavioral health workforce to meet current demand. States cited a shortage of psychiatrists, nurse practitioners, psychiatric nurses, consumer and peer specialists, and substance abuse counselors. Over half of SBHAs identified workforce shortages in rural and frontier areas. In an effort to curb this effect, states are pursuing a variety of activities, including training behavioral health workers, collaborating with universities to support training, and increasing the use of telemedicine to provide behavioral health services.[75]

In the spring of 2016, through a SAMHSA contract, NRI and NASADAD conducted interviews with 17 states to learn how the use of their federal funds has changed since the implementation of the ACA (states remained anonymous). During these interviews, it was recognized by one expansion state that due to the "woodwork effect," which refers to individuals who were previously eligible for Medicaid coverage but were not aware of their eligibility who now seek services, demand increased for public behavioral health services. This phenomenon has exacerbated the behavioral health workforce shortages already felt by many states. This state noted that since January 2014, when the number of adults seeking care from the state's public behavioral health system, one-third of which had co-occurring disorders, has doubled. While this does not directly affect the delivery of SMHA-funded services, it does strain the state's workforce. The state is experiencing a shortage of nursing staff and physicians, and the population of psychiatrists is aging. To alleviate the pressure on the state's behavioral health workforce, this SMHA is training its providers to deliver more group-based therapies, and is advocating the use of peer support specialists.[76]

Providers' Ability to Bill for Services

Many expansion states have experienced challenges and delays in transitioning behavioral health providers from billing grants to billing Medicaid. Data from NRI's State Profiling System for 2015 indicate that, on average, 33% of substance use providers are not certified to bill Medicaid, resulting in individuals accessing Medicaid-covered services supported with other public dollars.[77] Although many providers are uninterested in becoming Medicaid-certified, states are making efforts to encourage and facilitate provider certification through education and technical assistance initiatives:[78]

- Texas's SBHA makes training available to help rehab and targeted case management providers meet managed care organization (MCO) requirements for delivery of Medicaid-funded behavioral health services. Texas's SMHA is also working with the state's Regulatory Division to address licensing barriers to local mental health authorities delivering substance use services.
- SSAs in Hawai'i, Illinois, Tennessee, and Wisconsin offer trainings to substance use providers on how to become Medicaid certified.
- Indiana's SSA collaborates with its Medicaid authority to develop webinars and oversee the Behavioral Health Business Program.

Table 8 provides a summary of information about the number of SSAs and SMHAs engaged in partnerships to increase provider enrollment and facilitate Medicaid billing.

Table 8: SSA and SMHA Activities with State Medicaid Authorities[79]

Activity	Number of SSAs		Number of SMHAs	
	Yes	No	Yes	No
Working with state Medicaid authority on mental health and substance use disorder benefits in Alternative Benefit Plan	26	10	24	13
All substance use disorder and mental health providers are certified Medicaid providers	13	23	21	16
All private practitioners and individual counselors/clinicians certified to bill Medicaid for behavioral health services	5	27	8	23

Client Outcomes

[75] NRI. (Pre-publication). *Funding and characteristics of single state agencies for substance abuse services and state mental health agencies: 2015.*
[76] NRI, NASADAD. (Pre-publication). *Understanding how states use the SABG and MHBG in the wake of Mental Health Parity and Addiction Equity Act and the Affordable Care Act.*
[77] NRI. (2015). *State profiling system.* Retrieved from http://www.nri-incdata.org/.
[78] Ibid.
[79] Ibid.

Improvements in health outcomes for Medicaid enrollees have been recognized by many expansion states, particularly in individuals who are homeless. Providers have noted improvements in individuals' ability to work and maintain stable housing due to better management of behavioral health conditions. In addition, Medicaid enrollees have reduced financial stressors and improved access to services, programs, and supports, including disability benefits.[80] "Among low-income adults, Medicaid expansion is [also] associated with a reduction in the unmet need for mental health and substance use disorder treatment."[81]

Types of Individuals Covered by Medically Indigent Programs

"Medically indigent" is the term used to describe individuals who do not have access to health care due to financial or other barriers.[82] Each state determines what criteria individuals must meet to be classified as medically indigent to receive safety-net services. A review of the literature did not reveal much information about how states define medically indigent populations; however, California does provide some information on how its counties classify medically indigent populations for healthcare services (including behavioral health). It is important to note that information available about California's indigent services is dated 2009, prior to the state adopting Medicaid expansion.

California

Each of California's 58 counties is responsible for providing "safety-net" healthcare services to "low-income uninsured adults with no other source of care."[83] As of 2009, 34 of the counties, primarily rural, offer a standard benefit package through Anthem Blue Cross Life and Health Insurance Company's County Medical Services Program. The remaining counties develop their own service packages and make their own determinations about funding levels and eligibility requirements.

Counties that subscribe to the County Medical Services Program (CMSP) limit eligibility to county residents between the ages of 21 and 64 with income at or below 200% FPL. Beneficiaries of this program do not need to demonstrate a medical need to receive coverage. Beneficiaries must show proof of residency to receive the full array of service coverage; without documentation, individuals are only able to access emergency services through this program. Fees are charged on a sliding scale based on income, and the length of coverage is dependent on the share of cost and residency status. "Documented residents with no share of cost" are eligible for six months of coverage, whereas individuals who cost share are eligible for three months of coverage. Undocumented beneficiaries are only eligible for two months of emergency service coverage.[84]

The remaining counties, referred to as Medically Indigent Service Program (MISP) Counties, develop their own service mix and determine eligibility requirements. Nine of these counties provide safety net services to any county resident regardless of age. Sixteen counties serve adults between the ages of 21 and 64. The remaining ten counties serve individuals from age 18 or 19 to 64. Most of the counties serve residents who earn up to 200% of the FPL, "with 10 programs serving higher-income residents, and seven serving those with incomes below 200% of the FPL."[85] Sixteen of these counties require medical need (19 do not), and 21 offer services only to documented legal residents (14 serve undocumented residents as well). Just over half of these counties provide services to eligible residents for up to one year, while the remaining counties offer services up to six months, maximum. Patients may be charged on a sliding scale, depending on income level.[86]

Table 9 below provides a breakdown of how many counties under each type of program scheme defines medically indigent.

[80] DiPietro, B., Artiga, S., and Gates, S. (2014, Nov 13). *Early impacts of the Medicaid expansion for the homeless population.* Retrieved from http://kff.org/uninsured/issue-brief/early-impacts-of-the-medicaid-expansion-for-the-homeless-population/.
[81] Dey, J., Rosenoff, E., West, K., Ali, M., Lynch, S., McClellan, C., Mutter, R., Patton, L., Teich, J., and Woodward, A. (2016, Mar 28). *Benefits of Medicaid expansion for behavioral health*. Retrieved from https://aspe.hhs.gov/sites/default/files/pdf/190506/BHMedicaidExpansion.pdf
[82] Akin, B.V., Rucker, L., Hubbell, F.A., Cygan, R.W, and Waitzkin, H. (1989, May). *Access to medical care in a medically indigent population.* Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/2723834
[83] Blue Sky Consulting Group. (2009, Oct). *County programs for the medically indigent in California.* Retrieved from http://www.chcf.org/publications/2009/10/county-programs-for-the-medically-indigent-in-california.
[84] California Healthcare Foundation. (2009, Oct). *County programs for the medically indigent in California.* Retrieved from http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20C/PDF%20CountyIndigentPrograms.pdf.
[85] Ibid.
[86] Ibid.

Table 9: Criteria for Medically Indigent in California's Counties, 2009[87]

Criteria	MISP (n=35)	CMSP (n=34)
FPL Covered		
Up to 63%	1 county	
Up to 100%	2 counties	
Up to 133%	3 counties	
Up to 200%	17 counties	34 counties
Up to 250%	2 counties	
More than 250%	2 counties	
Not based on FPL	2 counties	
Maximum Coverage Duration		
Between 1 and 6 months	11 counties	34 counties
6 months	5 counties	
12 months	19 counties	
Medical Need Required		
Yes	16 counties	
No	19 counties	34 counties
County Residency Requirement		
Undocumented Not Covered	21 counties	
Undocumented Receive Emergency Services Only	1 county	34 counties
Undocumented Receive Clinic and Non-Emergency Services Only	1 county	
Undocumented Receive Full Services	12 counties	
Share of Cost		
One Rate for All Enrollees	1 county	
Amount Dependent on FPL, Could be None	19 counties	34 counties
None	15 counties	
Copay for Services		
Same Amounts for All Enrollees	9 counties	
Amounts Depend on FPL, Could be None	11 counties	
None	13 counties	34 counties

Prioritization of Services and Supports

Although more individuals have access to expanded Medicaid and private insurance coverage through the ACA, these programs do not support many services that have shown effective at promoting recovery. States interviewed for a Government Accountability Office report expressed concern about the adequacy of funding for wraparound services, such as peer support and supportive housing.[88]

Peer Support Services

Peer support provides a cost-efficient alternative to specialty practices. A licensed professional, such as a psychiatrist, may consult on a case or see a client a few times a year, whereas peer support specialists can meet with clients on a regular basis. Tom Lutzow, CEO of iCare in Milwaukee, Minnesota indicates "there's a real friendship bond that forms, where there's a feeling that they've been in your shoes and know what you're going through… There's a real trust there."[89] The use of peer support specialists has been associated with a reduction in emergency room visits, and is much less costly than a psychiatrist. Lutzow indicated, "a peer counselor may earn $22.00 per hour, much less than a psychiatrist."[90]

Supportive Housing

The State of Washington is pursuing the use of its Medicaid funds on the subset of people who need supportive housing, and intends to pay for supportive housing services. Implementing supportive housing services under the Medicaid benefit

[87] Ibid.
[88] GAO. (2015, Jun). *Options for low-income adults to receive treatment in selected states.* Retrieved from http://www.gao.gov/assets/680/670894.pdf.
[89] Dickson, V. (2015, Jul 4). *Medicaid plans struggle to provide mental health services.* Retrieved from http://www.modernhealthcare.com/article/20150704/MAGAZINE/307049979
[90] Ibid.

requires four key considerations on the part of policy makers, state agencies, advocates, managed care organizations, and providers of supportive housing services:[91]

1. Eligibility: criteria should be considered within three categories of need – health conditions, housing status, and system costs – to ensure the benefit serves those who need it most.
2. Services: the package of services covered by the benefit should be distinguished by their focus on housing retention and housing-based case management.
3. System plan changes: the 1915(i) State Plan Amendment offers the opportunity to implement home and community-based services statewide without limits on the population to be served, so long as they meet needs-based criteria. The 1115 Waiver offers significant flexibility to implement the benefit, so long as implementation is cost-neutral to the federal government and evaluations are performed to demonstrate outcomes. Any state plan changes will require companion changes to the state's managed care plan amendments and/or waivers and CMS approval.
4. Financing and reinvestment strategies: an upfront investment in the benefit will use state dollars more efficiently and likely produce a return on investment. An important next step will be to conduct an in-depth financial analysis that takes into account the population to be served, parameters of state plan changes, and a reinvestment strategy that takes the state's efforts to end chronic homelessness to scale.

Overcoming Barriers that Prevent Individuals from Obtaining Health Insurance Coverage

Medicaid Enrollment

Medicaid expansion has led to an increase in demand for behavioral health services. Many of these new individuals seeking care have little to no experience with Medicaid or private insurance, and now face unique challenges in enrolling in Medicaid and accessing services.[92]

To encourage enrollment in expanded Medicaid, states implemented a variety of strategies:

- Oregon received a waiver from CMS that allowed for "fast tracked" enrollment, through which the Oregon Health Authority (OHA) pre-screened and recruited Medicaid-qualified participants of the Supplemental Nutrition Assistance Program, and parents of children enrolled in the Oregon Health Plan. This enhanced enrollment effort complemented other outreach efforts, and by the second quarter of 2014, Oregon had enrolled an additional 360,000 individuals over the prior year. This process also serves the purpose of allowing the OHA to identify Medicaid-eligible individuals based on their participation in other state-run programs. Because their income and immigration statuses are already verified through other programs, the individuals identified as "fast-track eligible" are not required to go through the full application process for Medicaid. The state has distributed approximately 300,000 notifications, alerting residents of their eligibility. If an individual receives a letter, he/she simply needs to fill out both sides of the included form, return it to OHA, and he/she will be automatically enrolled.[93]
- Washington's Health Plan Finder is a specialized program to improve Medicaid enrollment in the state. This tool provides an online portal, and utilizes volunteers and community partners to facilitate awareness.[94]

Access to Care

In a separate initiative, Oregon sought to understand clients' perception of care three years after gaining Medicaid coverage. The state found that 40% of new enrollees sought care infrequently due to one or more of the following barriers: confusion around coverage, difficulty accessing treatment, bad interactions with providers, and/or that care was unnecessary. The remaining 60% that had multiple interactions with health care providers cited continuity of care and positive provider-client relationships as critical to satisfaction and improved health outcomes. Although some newly insured enrollees experienced rapid improvements in health, most reported that gains were realized after months or years of working closely and systematically with a provider. These findings suggest that improved communication with beneficiaries and increased coordination of care across multiple settings help reduce the barriers that new enrollees are likely to experience.[95]

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[91] Thiele, D.C. (2014, Aug). *Creating a Medicaid supportive housing services benefit.* Retrieved from http://www.csh.org/wp-content/uploads/2014/08/Creating_Medicaid_Supportive_Housing_Servcies_Benefit_WashingtonState.pdf

[92] Albright, B. (2014, Mar 18). *The ACA and behavioral health: a look ahead.* Retrieved from http://www.behavioral.net/article/aca-and-behavioral-health-look-ahead

[93] Norris, L. (2016, Jul 1). *Oregon Medicaid.* Retrieved from https://www.healthinsurance.org/oregon-medicaid/

[94] Washington State Healthcare Authority. (2016). *Stakeholder training and education.* Retrieved from http://www.hca.wa.gov/hcr/me/pages/training_education.aspx.

[95] Allen, H., Wright, B.J., and Baicker, K. (2014, Feb). *New Medicaid enrollees in Oregon report health care successes and challenges.* Retrieved from http://content.healthaffairs.org/content/33/2/292.abstract

Client Engagement

Engagement strategies are also crucial to reducing barriers to care and improving clients' experiences. "Improving engagement results in greater medication adherence; reduced medical costs; and improved health status, both physical and mental."[96] To improve engagement efforts, Washington developed the Patient Activation Measure (PAM), "which quantifies a patient's confidence and ability to manage his or her health."[97] The use of the PAM, in conjunction with health coaching, has been identified as a promising practice. Studies have fond that "patients who score high on the PAM are significantly more likely to have regular checkups, screenings, and immunizations, [and are] more likely to engage in healthy behaviors."[98] Health homes in Washington that contract with the state's Medicaid plan are required to implement the PAM. Studies of the health homes have demonstrated that "employing peer specialists as navigators and health coaches improves patients' [PAM scores] and their ability to self-manage physical and behavioral health needs, resulting in increased use of primary care."[99]

The Unreachable

Several officials said that culturally- and linguistically competent outreach conducted through community-based providers was one important means of overcoming Medicaid access barriers. Even after enrollment, officials in three states described reports of beneficiaries encountering challenges in obtaining care. Care coordination in fee-for-service Medicaid was one area of concern and several officials lamented the shortage of providers in rural areas.[100]

Many homeless individuals are disengaged from and distrustful of public systems. Some may be willing to apply, other are distrustful and reluctant. Overcoming these challenges takes time and effort. It can sometimes take months or years of relationship-building. Some of the barriers to enrollment are language and literacy barriers, lack of transportation, lack of housing, stable contact information, and required eligibility documentation. Often the condition they need medical care for creates the challenge for enrollment. These individuals also lack a secure place to store eligibility documentation once they obtain it. Individuals experiencing homelessness primarily rely on safety-net providers for their care and are heavily reliant on emergency room care. Front-line workers find it essential to educate individuals about other available sources of care and to collaborate with hospitals to create diversion programs.[101]

New Mexico still has more than 109,000 uninsured residents who are eligible for Medicaid, accounting for 47% of the state's total uninsured population.[102] Colorado's Medicaid program enrollments increased by 62%, but 225,000 of the remaining uninsured are Medicaid-eligible.[103]

Coordination of Care and Integration of Services

Several states expressed concern about the ability of patients with SMI to coordinate their own care without the structure of a managed care plan. To facilitate care management, these states use a managed care carve-out for behavioral health.[104] States are increasingly relying on managed care organizations to oversee physical and behavioral health services, rather than "having a behavioral health organization provide fee-for-service benefits."[105] Arizona, California, and New York have pursued this strategy.[106]

According to a GAO report, "providers have [also] raised concerns about managing behavioral health benefits separately from medical benefits, and some states reported making efforts to make sure care is coordinated."[107] Providers find it

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[96] Croze, C. (2015, Jul). *Healthcare integration in the era of the Affordable Care Act.* Retrieved from http://www.abhw.org/publications/pdf/IntegrationPaper.pdf

[97] Ibid.

[98] Ibid.

[99] Ibid.

[100] Sommers, B. D., Arntson, E., Kenney, G. M., et al., "Lessons from Early Medicaid Expansions Under Health Reform: Interviews with Medicaid Officials," n.d.: E12, *cms.gov*, accessed May 30, 2016. https://www.cms.gov/mmrr/Downloads/MMRR2013_003_04_a02.pdf

[101] DiPietro, B., Knopfs, S., Artiga, S., and Arguello, R., "Medicaid Coverage and Care for the Homeless," (2012): 2, *kff.org*, accessed June 20, 2016, http://kff.org/health-reform/report/medicaid-coverage-and-care-for-the-homeless/

[102] Louise Norris. New Mexico Medicaid," (2015): n.pag., *healthinsurance.org*, accessed June 21, 2016https://www.healthinsurance.org/new-mexico-medicaid/

[103] Louise Norris. Colorado Medicaid," (2015): n.pag., *healthinsurance.org*, accessed June 21, 2016. https://www.healthinsurance.org/colorado-medicaid/

[104] Dey, J., Rosenoff, E., West, K., Ali, M., Lynch, S., McClellan, C., Mutter, R., Patton, L., Teich, J., and Woodward, A. (2016, Mar 28). *Benefits of Medicaid expansion for behavioral health*. Retrieved from https://aspe.hhs.gov/sites/default/files/pdf/190506/BHMedicaidExpansion.pdf

[105] Dickson, V. (2015, Jul 4). *Medicaid plans struggle to provide mental health services.* Retrieved from http://www.modernhealthcare.com/article/20150704/MAGAZINE/307049979?template=print

[106] Ibid.

[107] GAO. (2015, Jun). *Options for low-income adults to receive treatment in selected states.* Retrieved from http://www.gao.gov/assets/680/670894.pdf.

"difficult to assess the total cost of care for individuals with behavioral health conditions" when payment streams for physical and behavioral health are separate.[108] This siloing of funds also does not allow"adequate incentives to make investments in one type of care that may reduce costs for another type of care" (e.g., a lack of investment in substance use services could lead to additional costs for emergency medical care).[109]

More than 68% of adults with a mental illness are reported to have at least one general medical disorder, which is substantially higher than the rate for those without a mental illness.[110] Integrating behavioral health and medical health care provides better outcomes for clients and is cost efficient for providers; a lack of coordination leads to sicker patients and higher costs.[111]

Innovations in Health Homes and Data Analytics

To improve the coordination of care, the ACA authorized the development of health homes under Medicaid. "A health home is a model of service delivery that coordinates and integrates all types of care required by an enrollee, combining physical health care, behavioral health care, and long-term care services and supports."[112] Individuals with two or more chronic conditions, inclusive of behavioral health issues, are eligible for care in health homes. Health homes are mandated to provide the following services: comprehensive case management; care coordination and health promotion; comprehensive transitional care from inpatient to other settings, including appropriate follow-up; individual and family support; referral to the community and social support services; and linkages of services using health information technology.[113]

According to 2015 State Profiles data, eight SSAs (Idaho, Kansas, Maine, Michigan, Oregon, Vermont, Washington, and West Virginia) have approved plans to provide substance use services via Medicaid health homes, and another 28 SSAs are in the process of establishing Medicaid health homes for substance use services. Only nine responding SSAs (Connecticut, Delaware, Florida, North Carolina, Nebraska, North Dakota, South Dakota, Texas, and Wisconsin) had no plans to use health homes to provide substance use services.[114]

Similarly, seven SMHAs (Idaho, Kansas, Maine, Michigan, Missouri, Oklahoma, and Washington) have approved plans to provide mental health services through Medicaid health homes, and an additional 27 SMHAs are in the process of establishing Medicaid health homes for mental health services. As with SSAs, only nine SMHAs (Delaware, Florida, North Carolina, Nebraska, North Dakota, New Hampshire, South Dakota, Texas, and Wisconsin) had no plans to use health homes to provide mental health services. [115]

Since Medicaid health homes are a relatively new approach to care, data are limited to the early adopters of health homes. According to 2015 State Profiles data, 124 health homes in six states provided mental health services, and 98 health homes in five states provided substance use services in 2015. Table 10 below provides greater detail about the number of clients receiving behavioral health services through health homes.

[108] Ibid.
[109] Ibid.
[110] Dey, J., Rosenoff, E., West, K., Ali, M., Lynch, S., McClellan, C., Mutter, R., Patton, L., Teich, J., and Woodward, A. (2016, Mar 28). *Benefits of Medicaid expansion for behavioral health*. Retrieved from https://aspe.hhs.gov/sites/default/files/pdf/190506/BHMedicaidExpansion.pdf
[111] Dickson, V. (2015, Jul 4). *Medicaid plans struggle to provide mental health services.* Retrieved from http://www.modernhealthcare.com/article/20150704/MAGAZINE/307049979?template=print
[112] NRI. (Pre-publication). *Funding and characteristics of single state agencies for substance abuse services and state mental health agencies: 2015.*
[113] Ibid.
[114] Ibid.
[115] Ibid.

Table 10: Clients Receiving Behavioral Health Services in Health Homes[116]

Health Homes	SMHA		SSA	
	N	Number of States	N	Number of States
Number of Health Homes Providing Mental Health/ Substance Use Services	98	5	124	6
Number of Consumers that Received Mental Health/ Substance User Services in Health Homes (2014)	6,243	3	24,243	1
Number of Consumers Receiving Mental Health/ Substance Use Services in Health Homes (Since 2014)	5,006	3	28,498	3

Connecticut, Michigan, Maryland, and West Virginia have established Medicaid health homes to coordinate care for individuals with chronic conditions, including behavioral health conditions. The following are a few examples of these states' efforts:[117]

- As of January 2015, Connecticut was in the process of developing Medicaid health homes for individuals with behavioral health conditions.
- Michigan chose to address the behavioral health needs of its new Medicaid enrollees by leveraging its primary care workforce. The state used a health assessment tool as part of its enrollment process for its alternative benefit plan that included questions about potential behavioral health conditions. Health assessment information was conveyed to each enrollee's primary care provider, who could then address any behavioral health needs, or refer for specialty care as needed.
- Maryland includes financial incentives related to physical health, such as the number of patients who have an annual primary care visit, in the contract with its behavioral health benefits manager.
- West Virginia officials are creating a comprehensive managed care plan for newly eligible Medicaid enrollees that would offer both physical and behavioral health benefits, including prescription drugs, under the same plan in order to better coordinate care.

States that adopted health homes early are already realizing improved health outcomes and/or cost savings for behavioral health clients. Among improved outcomes are reduced emergency department visits, increased use of primary care, improved functioning following substance use treatment, and improved health outcomes around diabetes and hypertension.[118]

States that have implemented health homes longer than the two years during which the federal government enhanced Medicaid payments to cover costs of health homes are relying on other sources of funding to cover the costs. Missouri and Michigan rely on state general funds and SAMHSA block grant funds to cover health home costs beyond the two-year enhanced federal funding. In addition, Michigan also plans to use physical health cost savings to offset decreased federal funding for health homes.[119]

To encourage physical and behavioral health care integration, an Association for Behavioral Health and Wellness member promoted the use of the Health and Behavior Assessment and Intervention procedure codes. These codes were added to the behavioral health provider fee schedules, and the claim system was set up such that the codes could be submitted with a medical diagnosis. Primary care physicians can refer patients with physical illnesses and ailments that either were being provoked by a behavioral health condition or can assist in providing psychoeducational consultation/intervention to assist members to manage and adhere to their medical condition treatment plans. In Maine, where the provider community engaged quickly with these codes, a study was done looking at members who were eligible for benefits over a three-year period, and compared the baseline to year one for members with diagnoses of sleep disorders, headaches, chronic pain, and morbid obesity. While behavioral health costs increased, Medical and pharmacy costs decreased with a net overall healthcare cost reduction of 3.2%.[120]

[116] Ibid.
[117] GAO. (2015, Jun). *Options for low-income adults to receive treatment in selected states.* Retrieved from http://www.gao.gov/assets/680/670894.pdf.
[118] Ibid.
[119] NRI. (Pre-publication). *Funding and characteristics of single state agencies for substance abuse services and state mental health agencies: 2015.*
[120] Searing, A., and Hoadley, J. (2016, Jun 1). *Beyond the reduction in uncompensated care: Medicaid expansion is having a positive impact on safety net hospitals and clinics.* Retrieved from http://ccf.georgetown.edu/wp-content/uploads/2016/05/Medicaid_hospitals-clinics-June-2016.pdf.

North Dakota's plan implemented several quality improvement projects that provide a whole health approach. The state has implemented a follow-up contact for mental health services, hospitalization for mental illness, and screening for clinical depression and follow-up plan.[121]

For persons with serious behavioral health conditions whose behavioral health provider serves as a health home, the providers are in a strong position to assist the behavioral health specialists to perform health home functions through specialized training. In addition, data analytics and population health management interventions to support care management and health promotion activities can be included. In Washington, one plan serves as the "lead health home organization" and contracts with 24 Coordinated Care Organizations (CCOs) that provide health home services. Since there are patients with behavioral health conditions who prefer to remain in medical settings for treatment, partnerships with primary care physicians are critical to improving health outcomes. Based on the recognition that over 75% of all psychotropic medications are prescribed by primary care physicians, their Psychotropic Drug Intervention Program uses aggregate data and scaled clinical insight to promote integration of care at the provider level. Analyzing integrated behavioral health, medical, and pharmacy claims data, the health organization identifies target events and intervenes with members and prescribers to educate them on best practices and changes on pharmacological treatment. Evidence-based practices drive the algorithms in the technology platform that identifies prescription-related problems. Peer-to-peer consultation staffed by psychiatrists utilizes the best available clinical guidelines to coach physicians on practice improvement while health coaches educate members and provide care coordination. As a result of this program, hospital admissions and emergency room visits decreased by 30%, and inpatient spending was reduced by $90 per member per month.[122]

Continued Challenges

Maintenance of Effort in the SAMHSA Block Grants

While the ability to save general funds is an opportunity for states, it also may create some challenges with grant funds with maintenance of effort (MOE) responsibilities. States may face restrictions in redirecting funding, and reprogramming within behavioral health may be a requirement in some instances, due to federal or state requirements. For example, MOE requirements, which are part of SAMHSA's block grants, require states to maintain behavioral health funding at the level of the two year period prior to receipt of the grant.[123]

Nevada indicated in a legislative hearing that they might not meet the MOE requirement in FY 2015 because of decreased State General Fund appropriations. The 2013 Legislature approved a reduction of 31.3 percent in General Fund appropriations in FY 2014. It was anticipated they would be $1.5 million short of meeting the MOE for FY 2015. Division staff concluded that Nevada would not meet the waiver requirements. The agency was seeking authority from the SAMHSA to use General Fund contributions from divisions within the Department of Health and Human Services as a potential match.[124] It is important to work with SAMHSA and gain technical assistance if states anticipate a MOE problem.

Institutions of Mental Diseases

The Medicaid Institutions for Mental Diseases (IMD) exclusion prohibits the use of federal Medicaid financing for care provided to most patients in mental health and substance use disorder residential treatment facilities larger than 16 beds.[125]

Kentucky officials said that they were working to expand capacity for residential treatment programs for substance use. Officials said that given Medicaid's exclusion of payment for treatment for adults at "institutions for mental disease", they were encouraging providers to design any new residential substance use programs to be under that limit. However, the state noted that doing so can prevent providers from taking advantage of economies of scale and may make it more

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[121] North Dakota. (2016, Jan 19). *North Dakota Medicaid expansion: Health Care Reform Review Committee: January 19, 2016.* Retrieved from http://www.legis.nd.gov/assembly/64-2015/committees/interim/health-care-reform-review-committee

[122] Croze, C. (2015, Jul). *Healthcare integration in the era of the Affordable Care Act.* Retrieved from http://www.abhw.org/publications/pdf/IntegrationPaper.pdf

[123] Judith Dey, Emily Rosenoff and Kristina West (ASPE) Mir M. Ali, Sean Lynch, Chandler McClellan, Ryan Mutter, Lisa Patton, Judith Teich and Albert Woodward (SAMHSA). "Benefits of Medicaid Expansion for Behavioral Health," (2016): 10, *aspe.hhs.gov*, accessed June 16, 2016. https://aspe.hhs.gov/sites/default/files/pdf/190506/BHMedicaidExpansion.pdf

[124] "Minutes Of The Meeting Of The Assembly Committee On Ways And Means And Senate Committee On Finance Subcommittees On Human Services," (2015): 7, *leg.state.nv.us*, accessed June 21, 2016, https://www.leg.state.nv.us/Session/78th2015/Minutes/Assembly/WM/Final/1104.pdf

[125] "The Medicaid IMD Exclusion: An Overview and Opportunities for Reform," (2016): 1, *lac.org*, accessed July 10, 2016, http://lac.org/wp-content/uploads/2014/07/IMD_exclusion_fact_sheet.pdf
http://mentalillnesspolicy.org/imd/imd-medicaid-mentally-ill.html

difficult to operate some residential treatment programs shown to be effective for substance use conditions. Officials said that the state was working to develop alternatives to inpatient care for Medicaid enrollees, such as transitional housing combined with an intensive outpatient program.[126] The CMS IMD final rule was issued in April 2016 and says in part, "…to permit FFP for a full monthly capitation payment on behalf of an enrollee aged 21 to 64 who is a patient in an IMD for part of that month to cases in which: (1) the enrollee elects such services in an IMD as an alternative to otherwise covered settings for such services; (2) the IMD is a hospital providing psychiatric or substance use disorder (SUD) inpatient care or a sub-acute facility providing psychiatric or SUD crisis residential services; and (3) the stay in the IMD is for no more than 15 days in that month." If a facility that would be considered an IMD under the statute is providing psychiatric or substance abuse care to an adult ages 21 to 64 for a Medicaid-covered individual in a managed care plan, the facility can treat that patient for 15 days and be paid by the state Medicaid program with the state receiving the federal matching payment for the service."[127] This may provide some relief but each state will need to determine impact due to state system differences.

Increased Costs Due to High Needs

North Dakota's expansion costs have been higher than expected. Sanford Health, the insurer who received the project award, reported that the cost of claims among the Medicaid expansion group in 2014 averaged $1,215 per member, per month, far higher than the $352 average for their commercially-insured members.

Although the federal government is currently covering the entire cost of providing coverage for the newly eligible population, the state will have to begin paying five percent of the cost starting in 2017. Originally, the North Dakota Department of Human Services modeled their expansion plans on projections that the state would pay $2.9 million in Medicaid expansion costs during the first half of 2017. But that projection now stands at $8.2 million.[128]

Quality and Availability of Services

States will need to improve the availability and quality of mental health services, which requires both additional provider capacity and better care coordination for patients with complex behavioral health needs. In terms of care coordination, one official described how the expansion "highlighted the difficulties in trying to operate a program and get services to people where you have fragmented medical, mental health, and substance abuse delivery systems."[129]

System Capacity

Other continuing access problems mentioned by state officials related to inpatient behavioral health treatment. Nevada lacks psychiatric inpatient capacity, which has led to patients who were considered a risk to themselves or others being kept in emergency rooms for up to several days before they could secure a bed in a psychiatric hospital. Officials said that an average of 90 to 110 patients per day, predominately Medicaid enrollees, were waiting in emergency rooms. Nevada has made efforts to address the problem, for example, by sending teams of psychiatrists to emergency rooms to assess psychiatric patients to determine whether they could be discharged and treated on an outpatient basis. However, officials noted that discharging such patients carries risks and has led to poor outcomes in the past.[130] Nevada officials stated that while the SBHA and the state's Medicaid program provide the same array of behavioral health treatments, some uninsured individuals experienced long delays in receiving care prior to enrolling in Medicaid coverage under the expansion.[131]

Providers not accepting Medicaid

As mentioned earlier in this report, Nevada officials reported conducting a secret shopper study of psychiatrists in the state's Medicaid program in 2014 that found only 22 percent of Medicaid-enrolled psychiatrists were accepting new Medicaid patients. Maryland and Connecticut officials reported difficulties providing Medicaid enrollees with access to certain prescription drugs used for medication-assisted treatment for substance use conditions due to a lack of physicians willing to prescribe these drugs for Medicaid enrollees.[132]

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[126] GAO, "BEHAVIORAL HEALTH: Options for Low- Income Adults to Receive Treatment in Selected States," (2015): 31, *gao.gov*, accessed June 12, 2016, http://www.gao.gov/assets/680/670894.pdf

[127] Rodney Whitlock, "The IMD Exclusion: Changes Now and Changes to Come," (2016): n.pag., *healthlawpolicymatters.com*, accessed June 21, 2016, https://www.healthlawpolicymatters.com/2016/04/27/the-imd-exclusion-changes-now-and-changes-to-come/

[128] Louise Norris. North Dakota Medicaid," (2015): *healthinsurance.org*, accessed June 21, 2016. https://www.healthinsurance.org/north-dakota-medicaid/

[129] Sommers, B. D., Arntson, E., Kenney, G. M., et al. "Lessons from Early Medicaid Expansions Under Health Reform: Interviews with Medicaid Officials," n.d.: n.pag., *cms.gov*, accessed May 30, 2016. https://www.cms.gov/mmrr/Downloads/MMRR2013_003_04_a02.pdf

[130] GAO, "BEHAVIORAL HEALTH: Options for Low- Income Adults to Receive Treatment in Selected States," (2015): 30, *gao.gov*, accessed June 12, 2016, http://www.gao.gov/assets/680/670894.pdf

[131] Ibid 28.

[132] Ibid 29.

The top roadblock to recruiting providers remains Medicaid's low rates, although many also complain about restrictive rules imposed by state agencies. “We work primarily with a population that has the resources to seek private treatment for their mental health,” said Douglas Bodin, CEO of a Los Altos, Calif.-based therapeutic consulting firm. “The public sector is riddled with waste, fraud and bureaucratic inertia that render appropriate interventions specifically tailored to each individual nearly impossible.” Low-income patients often take longer to treat because they have other issues that must be addressed, including poor housing, transportation and nutrition. It often falls to mental health professionals to deal with these issues.[133]

Medicaid not accepting some professions

Many mental health practices are willing to take on interns or postdoctoral fellows to serve Medicaid beneficiaries, but many states decline to reimburse them. The APA is noticing that financing internships is difficult, making it harder to recruit and train the next generation of psychologists willing to work with low-income populations.[134]

Retroactive Medicaid

A significant number of uninsured patients become eligible for insurance benefits subsequent to registration. Hospitals should consider periodically checking state and federal payers for retroactive eligibility for uninsured patients over a defined period of time. Services provided for those patients identified as having retroactive coverage, can then be billed to Medicaid or Medicare. Revenue360 can automatically identify and report on retroactive insurance coverage. Retroactive eligibility verification is especially important for collection efforts when a patient has Medicaid. With Medicaid dramatically expanding in many states and paying up to three months prior to the date of application, providers can increase collections by re-submitting eligibility checks on self-pay patients.[135]

Lack of full array of covered services

Insurance companies still do not provide ample and equitable coverage for mental health treatment. Comprehensive treatment for mental illness includes counseling and therapy, medication, support groups, education about the illness, inpatient hospital-based treatment, and wrap-around services such as mobile outreach teams and intensive case management. With effective treatment, along with supportive interpersonal relationships, access to transportation, adequate housing, adequate diet and sleep, and meaningful paid or volunteer activities, mental illness recovery is possible. Despite the effectiveness of treatments for mental illness and significant advances in effective medications and evidence-based treatments, not everyone who has a mental illness receives treatment, and not everyone who is treated receives quality care. Many population centers are still lacking basic mental health services such as crisis response and inpatient acute care. There are costs to untreated mental illness including exacerbated symptoms, high rates of emergency room visits, homelessness, incarceration, suicide, lost workdays, and family distress. [136]

States offer a variety of evidence-based practices (EBPs) for individuals with behavioral health needs. The increase in the number of individuals with private insurance has led to a major concern of advocates that these individuals will no longer have coverage for EBPs. Most private insurance companies use a more restrictive definition of medical necessity than Medicaid or state-funded plans. Medicaid and state funds also often pay for more innovative services that have shown an increase in positive outcomes, such as supported housing, supported employment, and supported education.[137]

Continued Need for Safety Net Services (State-funded Services)

There will continue to be uninsured and underinsured individuals. Not all eligible individuals will enroll in Medicaid, only about two-thirds of those who are eligible ultimately enroll; therefore, treatment facilities will likely depend on the SABG and MHBG funding. Two vulnerable populations, the incarcerated and the homeless, are either ineligible or unlikely to enroll in Medicaid but will still need behavioral health treatment. For these reasons, SAMHSA’s Block Grants will still be important as safety net funding for specialty behavioral health treatment.[138] There are concerns about having enough state behavioral health authority funding for individuals who would remain uninsured or underinsured following expansion,

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[133] Virgil Dickson, “Medicaid plans struggle to provide mental health services,” (2015), *modernhealthcare.com*, accessed June 13, 2016, http://www.modernhealthcare.com/article/20150704/MAGAZINE/307049979

[134] Ibid.

[135] “Retroactive Medicaid,” accessed June 21, 2016, http://revenue360.net/tag/retroactive-medicaid/

[136] Mira E. Signer, “Virginia’s Mental Health System”, (2014): 2, http://www.coopercenter.org/sites/default/files/publications/Virginia%20News%20Letter%202014%20Vol.%2090%20No%203.pdf

[137] Funding and Characteristics of Single State Authorities for Substance Abuse Services and State Mental Health Agencies, 2015.

[138] Albert Woodward, Ph.D., M.B.A., “The CBHSQ Report: The Substance Abuse Prevention and Treatment Block Grant is still Important even with the Expansion of Medicaid,” (2015), *samhsa.gov*, accessed June 10, 2016, http://www.samhsa.gov/data/sites/default/files/report_2080/ShortReport-2080.html

including individuals who are eligible but do not enroll or re-enroll in Medicaid, immigrants, and certain individuals under 65 who are enrolled in Medicare because of a disability.[139]

The GAO report highlighted six expansion states (Connecticut, Kentucky, Maryland, Michigan, West Virginia, and Nevada). Officials expressed concerns about the adequacy of funding for wraparound services—services that are not covered by their states' Medicaid programs, such as supportive housing—for Medicaid enrollees. Some states have made adjustments for example, Michigan's BHA received an additional $25 million for fiscal year 2015 to address behavioral health needs in certain populations that remain ineligible for Medicaid. Despite concerns about specific behavioral health budget reductions, when additional Medicaid funds from the expansion were considered as part of the behavioral health budget, much more funding was available overall.[140]

Despite the gain in coverage for low-income adults, however, the majority of the remaining uninsured also falls in this low-income group in both the Medicaid expansion states and in the nonexpanding states, at 58.7 percent with family income at or below 138 percent of FPL in the Medicaid expansion states, and 68.9 percent in the nonexpanding states.[141]

During the last two Washington State legislative sessions, it became apparent that there is a common misconception that Medicaid expansion under the ACA would greatly reduce or eliminate the need for state general funds in the mental health and substance abuse budgets. However, Medicaid's expansion does not address the many essential services that are not Medicaid Reimbursable, most notably inpatient psychiatric treatment, nor does it cover the many people with mental illness who do not qualify for Medicaid, either because their income is slightly higher than the Medicaid threshold (which is well below poverty level in most states) or because they are too ill to take the steps necessary to apply and qualify for Medicaid. [142]

Some block grant funding will remain as a safety net for individuals who continue to be uninsured (for example, enrollment in Medicaid is likely to remain low for some hard-to reach individuals). The block grant funds could focus on prevention and early intervention services, and "wraparound" services that are often not covered by Medicaid.[143]

It is unlikely that Medicaid—which prior to full implementation covered 25.7% of those who were unemployed or not in the labor force— can absorb the entire 58.3% who were uninsured and unemployed or not in the labor force.[144]

[139] GAO, "BEHAVIORAL HEALTH: Options for Low- Income Adults to Receive Treatment in Selected States," (2015), *gao.gov*, accessed June 12, 2016, http://www.gao.gov/assets/680/670894.pdf

[140] Ibid.

[141] Adele Shartzer, Sharon K. Long, and Stephen Zuckerman, "Who Are the Newly Insured as of Early March 2014?," (2014), *hrms.urban.org*, accessed June 12, 2016, http://hrms.urban.org/briefs/Who-Are-the-Newly-Insured.html#fn5

[142] Pam Romine, "Restore Non-Medicaid Funding for Mental Health and Substance Abuse," *guidedpathways.org*, accessed June 12, 2016, http://www.guidedpathways.org/2015/03/restore-non-medicaid-funding/

[143] Judith Dey, Emily Rosenoff and Kristina West (ASPE) Mir M. Ali, Sean Lynch, Chandler McClellan, Ryan Mutter, Lisa Patton, Judith Teich and Albert Woodward (SAMHSA). "Benefits of Medicaid Expansion for Behavioral Health," (2016), *aspe.hhs.gov*, accessed June 16, 2016. https://aspe.hhs.gov/sites/default/files/pdf/190506/BHMedicaidExpansion.pdf

[144] Albert Woodward, Ph.D., M.B.A., "The CBHSQ Report: The Substance Abuse Prevention and Treatment Block Grant is still Important even with the Expansion of Medicaid," (2015), *samhsa.gov*, accessed June 10, 2016, http://www.samhsa.gov/data/sites/default/files/report_2080/ShortReport-2080.html

Appendix J - Serious Behavioral Health Disorder Prevalence, Penetration Rates, and Unmet Need

Methodology

The 2009 Colorado Population in Need (PIN) study calculated 2007 prevalence estimates of people with a serious behavioral health disorder (SBHD) in Colorado under 300% Federal Poverty Level (FPL) by taking national prevalence rates from epidemiological studies and applying these rates to Colorado census data. Since Colorado residents were not directly surveyed to assess prevalence rates, this methodology produces what is referred to as 'synthetic' prevalence estimates. The epidemiological data used were from the Collaborative Psychiatric Epidemiology Surveys (CPES), which merged three nationally representative datasets: the National Co-morbidity Survey Replication (NCS-R), the National Survey of American Life (NSAL), and the National Latino and Asian American Study (NLAAS). CPES prevalence estimates are relatively conservative compared to other national surveys, such as the National Survey of Drug Use and Health (NSDHU), since the methodology calls for the respondent to be screened prior to probing for specific disorders.

Since the CPES dataset does not include data for youth who only have a substance use disorders (SUD), a limitation of the synthetic prevalence estimates used in the report is the lack of prevalence data on youth with SUD. Thus, SED refers to youth with a Serious Emotional Disorder (SED) only and to youth with co-occurring SED and SUD.

Rates from these national surveys were applied to census data from Colorado at a very detailed level producing synthetic prevalence estimates for each county by poverty level, age group, gender, race/ethnicity, marital status, education, and group quarters. Data from the following agencies was used to determine the number of people who received behavioral health services in FY07: the Department of Health Care Policy and Financing (HCPF), the Colorado Office of Behavioral Health (OBH), the Division of Vocational Rehabilitation (DVR), and the Division of Child Welfare (DCW). All individuals who received a behavioral health service using public funds were included thus; individuals without a SBHD were not excluded. This approach was taken in order to ensure that estimates of unmet need would be conservative. Penetration rates were calculated by dividing the SBHD prevalence estimates by the number of individuals served. Unmet need was calculated by subtracting numbers served from the SBHD prevalence estimates.

Given the sophistication of the 2009 PIN study, the methodology could not be replicated for this study. Instead, analyses were conducted to update the 2009 PIN study SBHD prevalence estimates, numbers served, and unmet need numbers, applying extrapolation and assumptions to do so. Consequently, caution should be used when comparing numbers from the 2009 PIN study to those in this study.

Estimated SBHD prevalence for CMHC's in 2014 was derived from the prevalence estimates in the 2009 PIN study, which were based on 2007 census figures. Percent change in the population aged 0 – 17 and 18 and older from 2007 to 2014 in each Colorado county was calculated using estimated population figures obtained from the State Demography Office website[145]. The percent change for each CMHC was obtained through a weighted average of county population differences applied to 2009 PIN study SED/SMI prevalence figures. It was assumed that changes in the prevalence of SBHDs would follow the same general trend as changes in the population and that the demographic characteristics used to calculate prevalence in the 2009 study have remained the same in the service areas. There were likely population changes that would result in different numbers. We assumed those changes would not be drastic.

The estimated number of individuals with SBHDs who received a publicly funded behavioral health service in FY 2014-15 was determined through combining the numbers served by OBH indigent mental health funds (OBH encounters data), the numbers served by HCPF's Medicaid Capitation program (Medicaid Capitation data), and the number of publicly funded OBH SUD admissions (DACODs data). Matching the three files by the constructed identifier and unduplicating across each data file allowed for classification of the type of services received: SUD only, Mental Health only, or Both. Individuals who were only present in the DACODs data were classified as being served by SUD only, individuals who were present in the OBH encounters data and/or Medicaid Capitation data were classified as being served by Mental Health (MH) only, individuals who were present in the DACODs data and the OBH encounters and/or Medicaid Capitation data file were classified as being served by both SUD and MH.

After classifying based on type of services received, individuals were categorized into SBHD categories of Adult-SMI Only, Adult-SUD only, Adult-COD (co-occurring SMI and SUD), and Youth-SED. All youth receiving an SUD admission were categorized as Youth-SED. Youth classified as being served by Mental Health only or both who had a matching CCAR that indicated the presence of an SED were categorized as SED. For youth served by MH only or both who did not have a CCAR to indicate SED status, the percent of known SED prevalence was applied to the unknown population. For example, if a CMHC had 50% known SED, that percent was applied to the number without a CCAR (unknown SED status). Adults classified

[145] https://demography.dola.colorado.gov/. This data is reported by Calendar Year versus State Fiscal Year.

as being served by SUD only were categorized as Adult-SUD only. Adults classified as being served by Both were categorized as Adult-COD. Adults classified as being served by Mental Health only, who had a matching CCAR that indicated the presence of an SMI were categorized as SMI Only. For adults classified as being served by Mental Health only who did not have a matching CCAR, the percent of known SMI prevalence was applied to the unknown population.

Penetration rates were calculated by dividing the prevalence estimates by the number of individuals served.

Unmet need was calculated by subtracting numbers served from the prevalence estimates.

Estimated Prevalence of SBHDs in 2014 by CMHC by Age and Gender*

	Youth (ages 0-17) with SED			Adults (ages 18+) with SMI			Adults (ages 18+) with COD			Adults (ages 18+) with SUD			
CMHC	Male	Female	SED Total	Male	Female	SMI Total	Male	Female	COD Total	Male	Female	SUD Total	SBHD Total
AllHealth	2,159	2,060	4,219	3,064	3,245	6,309	466	494	960	2,268	2,403	4,671	16,159
AspenPointe	3,694	3,593	7,287	6,329	6,536	12,865	956	988	1,944	4,333	4,474	8,807	30,903
Aurora	1,769	1,683	3,452	2,548	2,695	5,243	407	430	837	1,883	1,991	3,874	13,406
Axis	510	473	983	1,247	1,248	2,495	191	192	383	876	878	1,754	5,615
Centennial	661	646	1,307	1,607	1,454	3,061	212	191	403	1,003	909	1,912	6,683
CMH	522	496	1,018	1,246	1,221	2,467	184	180	364	849	832	1,681	5,530
Community Reach	2,662	2,543	5,205	3,865	3,878	7,743	675	678	1,353	3,089	3,099	6,188	20,489
Health Solutions	1,246	1,181	2,427	2,558	2,681	5,239	347	364	711	1,550	1,625	3,175	11,552
Jefferson	1,902	1,815	3,717	3,846	3,960	7,806	606	623	1,229	2,759	2,840	5,599	18,351
MHCD	4,186	4,052	8,238	7,728	7,807	15,535	1,221	1,234	2,455	5,719	5,778	11,497	37,725
MHP	1,295	1,249	2,544	3,044	3,058	6,102	513	516	1,029	2,702	2,715	5,417	15,092
Mind Springs	1,870	1,787	3,657	4,015	3,776	7,791	663	624	1,287	3,091	2,907	5,998	18,733
North Range	1,877	1,803	3,680	2,921	2,962	5,883	486	493	979	2,421	2,456	4,877	15,419
San Luis Valley	356	353	709	626	626	1,252	85	84	169	412	411	823	2,953
Solvista	310	310	620	1,812	1,382	3,194	208	159	367	982	748	1,730	5,911
Southeast	314	296	610	1,057	860	1,917	134	109	243	617	501	1,118	3,888
SummitStone	1,152	1,104	2,256	2,898	2,986	5,884	491	506	997	2,559	2,635	5,194	14,331
Total	26,485	25,444	51,929	50,411	50,375	100,786	7,845	7,865	15,710	37,113	37,202	74,315	242,740

Estimated Unmet Need by Age Group, SBHD, and CMHC in FY 2014-15*

CMHC	Youth (ages 0-17)	Adults (ages 18+)			SBHD Total
	SED	SMI Only	COD	SUD only	
AllHealth	3,302	3,454	448	3,328	10,532
AspenPointe	3,744	1,774	651	5,473	11,642
Aurora	-54	-1,596	386	2,623	1,360
Axis	549	1,171	156	1,386	3,263
Centennial	581	1,506	237	1,634	3,958
CMH	508	724	187	1,547	2,965
Community Reach	1,459	1,958	836	4,059	8,312
Health Solutions	596	-1,665	-42	2,083	972
Jefferson	-2,281	-422	319	3,682	1,298
MHCD	4,327	1,033	841	6,603	12,803
MHP	1,674	2,609	683	4,825	9,791
Mind Springs	1,999	3,021	303	5,359	10,681
North Range	2,097	2,117	502	4,287	9,002
San Luis Valley	203	-220	-86	393	290
Solvista	63	1,250	135	1,566	3,013
Southeast	242	666	51	866	1,825
SummitStone	1,079	2,748	441	4,339	8,608
Total	20,087	20,128	6,049	54,052	100,316

*Negative numbers indicate that the estimated number of individuals served was greater than the estimated prevalence of SBHDs.

Appendix K - OBH Indigent Client Characteristics in FY 2014-15[146]

OBH Indigent Clients-Number and Percent Homeless by CMHC in FY 2014-15[147]

CMHC	Number of Homeless	Percent Homeless
AllHealth	44	6.6%
AspenPointe	107	12.3%
Aurora	12	2.3%
Axis	41	11.3%
Centennial	14	4.3%
CMH	--	2.3%
Community Reach	23	4.0%
Health Solutions	28	10.1%
Jefferson	80	3.8%
MHCD	177	14.6%
MHP	163	19.0%
Mind Springs	110	12.2%
North Range	50	8.5%
San Luis Valley	--	5.3%
Solvista	--	3.5%
Southeast	--	1.1%
SummitStone	39	13.3%
All CMHCs	911	8.9%
Statewide rate (2015)[148]		0.2%

"--" indicates the number has been suppressed per OBH data suppression guidelines.

OBH Indigent Clients-Number and Percent Unemployed by CMHC in FY 2014-15[149]

CMHC	Number Unemployed	Percent Unemployed
AllHealth	247	40.2%
AspenPointe	441	60.7%
Aurora	187	47.5%
Axis	163	56.8%
Centennial	116	44.3%
CMH	130	45.9%
Community Reach	352	67.3%
Health Solutions	102	39.5%
Jefferson	572	35.4%
MHCD	502	48.5%
MHP	424	54.6%
Mind Springs	413	52.2%
North Range	279	53.6%
San Luis Valley	57	39.0%
Solvista	42	28.2%
Southeast	39	47.0%
SummitStone	182	66.2%
All CMHCs	4,248	48.6%
Statewide rate (July 2015)[150]		3.8%

[146] OBH clients were identified as indigent from the special studies code in the OBH encounter data.
[147] Homelessness for the OBH indigent population was determined from FY 2014-15 CCAR data. The CCAR definition for homeless is that the individual lacks a fixed, regular and adequate nighttime residence.
[148] *The State of Homelessness in America,* Washington, DC: National Alliance to End Homelessness, 2016. Retrieved from: http://www.endhomelessness.org/page/-/files/2016%20State%20Of%20Homelessness.pdf.
[149] Unemployment for the OBH indigent population was determined from FY 2014-15 CCAR data. The CCAR defines unemployment as the individual reporting not being employed, but may be looking for employment.
[150] State rate of unemployment retrieved from United States Department of Labor, Bureau of Labor Statistics: http://beta.bls.gov/dataViewer/view/timeseries/LASST080000000000003;jsessionid=89D22CE2010F64D3E24E0C12D09EB536.tc_instance6

OBH Indigent Clients-Poverty Rates (Percent Under 300% FPL) by CMHC in FY 2014-15[151]

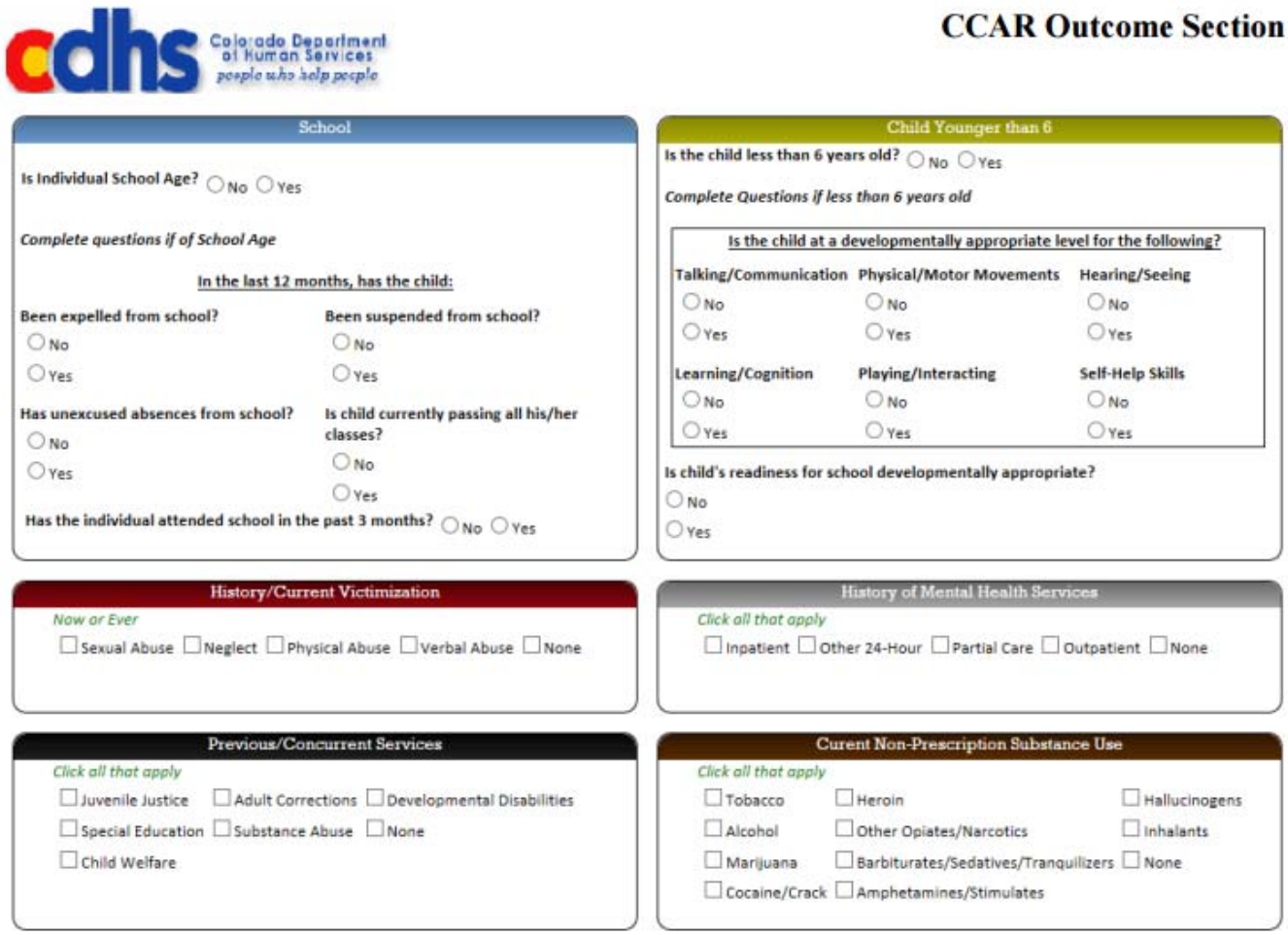
CMHC	Percent with Income Below Poverty
AllHealth	8.0%
AspenPointe	12.1%
Aurora	8.9%
Axis	13.5%
Centennial	12.5%
CMH	15.1%
Community Reach	14.2%
Health Solutions	19.1%
Jefferson	8.7%
MHCD	19.1%
MHP	13.0%
Mind Springs	12.8%
North Range	14.7%
San Luis Valley	22.5%
Solvista	14.8%
Southeast	23.4%
SummitStone	14.1%
Colorado	13.2%

OBH Indigent Clients-Number and Percent with Prior Hospitalizations by CMHC in FY 2014-15[152]

CMHC	Number of clients with prior hospitalization	Percent of clients with prior hospitalization
AllHealth	85	36.0%
AspenPointe	465	57.6%
Aurora	341	47.0%
Axis	127	39.0%
Centennial	76	24.6%
CMH	161	32.9%
Community Reach	89	14.1%
Health Solutions	164	49.5%
Jefferson	493	37.5%
MHCD	269	44.8%
MHP	247	46.7%
Mind Springs	323	46.7%
North Range	228	36.8%
San Luis Valley	55	18.9%
Solvista	118	49.4%
Southeast	54	44.6%
SummitStone	259	50.8%
All CMHCs	31,293	40.5%

[151] Poverty levels for each of the counties were obtained from 2009-2013 census data, and combined into CMHC area via a weighted average.
[152] Prior hospitalizations were determined from FY 2014-15 CCAR data.

Appendix L - CCAR Outcome Section Items and Outcome Domains Description



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CCAR Outcome Section

School

Is Individual School Age? ○ No ○ Yes

Complete questions if of School Age

In the last 12 months, has the child:

Been expelled from school? ○ No ○ Yes

Been suspended from school? ○ No ○ Yes

Has unexcused absences from school? ○ No ○ Yes

Is child currently passing all his/her classes? ○ No ○ Yes

Has the individual attended school in the past 3 months? ○ No ○ Yes

Child Younger than 6

Is the child less than 6 years old? ○ No ○ Yes

Complete Questions if less than 6 years old

Is the child at a developmentally appropriate level for the following?

Talking/Communication	Physical/Motor Movements	Hearing/Seeing
○ No ○ Yes	○ No ○ Yes	○ No ○ Yes
Learning/Cognition	**Playing/Interacting**	**Self-Help Skills**
○ No ○ Yes	○ No ○ Yes	○ No ○ Yes

Is child's readiness for school developmentally appropriate? ○ No ○ Yes

History/Current Victimization

Now or Ever

☐ Sexual Abuse ☐ Neglect ☐ Physical Abuse ☐ Verbal Abuse ☐ None

History of Mental Health Services

Click all that apply

☐ Inpatient ☐ Other 24-Hour ☐ Partial Care ☐ Outpatient ☐ None

Previous/Concurrent Services

Click all that apply

☐ Juvenile Justice ☐ Adult Corrections ☐ Developmental Disabilities
☐ Special Education ☐ Substance Abuse ☐ None
☐ Child Welfare

Curent Non-Prescription Substance Use

Click all that apply

☐ Tobacco	☐ Heroin	☐ Hallucinogens
☐ Alcohol	☐ Other Opiates/Narcotics	☐ Inhalants
☐ Marijuana	☐ Barbiturates/Sedatives/Tranquilizers	☐ None
☐ Cocaine/Crack	☐ Amphetamines/Stimulates	

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CCAR Outcome Section
Domain Scales

Physical Health Rating

Extent to which a person's physical health or condition is a source of concern.

- ○1. No physical problems that interfere with daily living.
- ○2
- ○3. Presence of occasional or mild physical problems that may interfere with daily living.
- ○4
- ○5. Frequent or chronic physical health problems.
- ○6
- ○7. Incapacitated due to medical/physical health, and likely to require inpatient or residential health care.
- ○8
- ○9. Presence of critical medical condition requiring immediate inpatient or residential health care treatment.

Self Care/Basic Needs Rating

Extent to which mental health symptoms impact a person's ability to care for self and provide for needs.

- ○1. Able to care for self and provide for own needs.
- ○2
- ○3. Occasional assistance required in caring for self and obtaining basic needs.
- ○4
- ○5. High levels of assistance needed in caring for self and obtaining basic needs.
- ○6
- ○7. Unable to care for self and obtain basic needs in safe and sanitary manner.
- ○8
- ○9. Gravely disabled and in extreme need of complete supportive care.

Legal Rating

Extent to which a person is involved in the criminal justice system.

- ○1. No legal difficulties.
- ○2
- ○3. Occasional legal difficulties.
- ○4
- ○5. Frequent legal difficulties.
- ○6
- ○7. May be in confinement or at risk of confinement due to illegal activity.
- ○8
- ○9. Continuously at risk for illegal behavior. Likely to be in confinement or with current serious charges pending.

Security/Supervision Rating

Extent to which the person is in need of increased supervision.

- ○1. No special security or supervision precautions needed.
- ○2
- ○3. Occasional behavior problems are present and require low levels of security and supervision.
- ○4
- ○5. Requires moderate levels of security and supervision due to intermittent high-risk and/or dangerous behaviors.
- ○6
- ○7. Close supervision, seclusion, suicide watch, or controlled medication administration may be necessary due to severe behavioral problems. Walkaway/escape potential may be high.
- ○8
- ○9. Requires constant supervision or secure environment due to behaviors that are likely to result in injury to self or others.

Suicide/Danger to Self Rating

Extent to which a person experiences self-harming thoughts and/or behaviors.

- ○1. No indication of self-destructiveness or self-endangerment.
- ○2
- ○3. Self-harmful tendencies are evident from speech and/or previous behavior, and person may experience harmful thoughts with minimal danger to self.
- ○4
- ○5. Self-harmful thoughts and/or actions are present and are of serious concern.
- ○6
- ○7. Self-harmful thoughts and/or actions are persistent, affecting most aspects of daily functioning.
- ○8
- ○9. Requires immediate intervention to prevent suicide or physical self-injury.

Aggression/Danger to Others Rating

Extent of aggressivness in interactions with others.

- ○1. Exhibits no aggressiveness towards others.
- ○2
- ○3. Occasional low-level aggressive behavior toward others.
- ○4
- ○5. Occasional major or frequent minor aggressive behavior which is perceived as dangerous.
- ○6
- ○7. Repeated major aggressive behavior that is problematic and is hostile, threatening and dangerous.
- ○8
- ○9. Continuously aggressive behavior that is intended to inflict injury or pain, verbal attacks and/or demonstrates imminent danger to others.

Psychosis Rating

Extent to which a person experiences delusional, disorganized and irrational thought processes.

- ○1. No evidence of thought difficulties.
- ○2
- ○3. Occasional odd thought processes.
- ○4
- ○5. Frequent substitution of fantasy for reality, isolated delusions or infrequent hallucinations.
- ○6
- ○7. Persistent thought disturbance, frequent hallucinations or delusions. Communication is highly impaired.
- ○8
- ○9. Thought processes are disorganized and tangential, resulting in persistent disruption in communication. Extreme disconnection from reality.

Cognition Rating

Extent to which a person performs cognitive tasks and experiences symtoms such as, but not limited to, confusion, poor problem solving, and impaired judgment.

- ○1. No evidence of impaired cognitive capacity.
- ○2
- ○3. Occasional incidences of poor judgment or memory loss may occur.
- ○4
- ○5. Cognitive process are persistently impaired and may exhibit impaired functioning.
- ○6
- ○7. Person may be unable to function independently due to significantly impaired cognitive processes.
- ○8
- ○9. Impaired cognitive processes result in inability to care for self.

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CCAR Outcome Section
Domain Scales

Attention Rating

Extent to which a person experiences attention issues such as, but not limited to, distractability, inability to concentrate, and restlessness.

- ○ 1. No disruption of daily activities. Issues are temporary, appropriate and do not impact functioning.
- ○ 2
- ○ 3. May persist beyond situational event, but not debilitating.
- ○ 4
- ○ 5. Persistent, low-level or occasionally moderate, impacts daily functioning.
- ○ 6
- ○ 7. Persistent and incapacitating, affecting most aspects of daily functioning.
- ○ 8
- ○ 9. Person is completely incapacitated by and is seemingly incapable of responding appropriately.

Manic Issues Rating

Extent to which a person experiences manic symptoms such as, but not limited to, excessive activity level, elevated mood, and decreased need for sleep.

- ○ 1. No disruption of daily activities. Issues are temporary, appropriate and do not impact functioning.
- ○ 2
- ○ 3. May persist beyond situational event, but not debilitating.
- ○ 4
- ○ 5. Persistent, low-level or occasionally moderate, impacts daily functioning.
- ○ 6
- ○ 7. Persistent and incapacitating, affecting most aspects of daily functioning.
- ○ 8
- ○ 9. Person is completely incapacitated by and is seemingly incapable of responding appropriately.

Anxiety Issues Rating

Extent to which a person experiences anxiety symptoms such as, but not limited to, nervousness, fearfulness and tension.

- ○ 1. No disruption of daily activities. Issues are temporary, appropriate and do not impact functioning.
- ○ 2
- ○ 3. May persist beyond situational event, but not debilitating.
- ○ 4
- ○ 5. Persistent, low-level or occasionally moderate, impacts daily functioning.
- ○ 6
- ○ 7. Persistent and incapacitating, affecting most aspects of daily functioning.
- ○ 8
- ○ 9. Person is completely incapacitated by and is seemingly incapable of responding appropriately.

Depressive Issues Rating

Extent to which a person experiences depressive symptoms such as, but not limited to, sadness, worrying, irritability and agitation.

- ○ 1. No disruption of daily activities. Issues are temporary, appropriate and do not impact functioning.
- ○ 2
- ○ 3. May persist beyond situational event, but not debilitating.
- ○ 4
- ○ 5. Persistent, low-level or occasionally moderate, impacts daily functioning.
- ○ 6
- ○ 7. Persistent and incapacitating, affecting most aspects of daily functioning.
- ○ 8
- ○ 9. Person is completely incapacitated by and is seemingly incapable of responding appropriately. Impaired functioning and requires immediate treatment.

Alcohol Use Rating

Extent to which a person's use of alcohol impairs daily functioning.

- ○ 1. No impairment of general functioning due to alcohol use.
- ○ 2
- ○ 3. Occasional difficulties in functioning due to alcohol use.
- ○ 4
- ○ 5. Frequent difficulties in functioning due to alcohol use.
- ○ 6
- ○ 7. Significantly impaired functioning due to alcohol use. Alcohol use dominates life to the exclusion of other activities.
- ○ 8
- ○ 9. Constantly debilitated due to alcohol use, with no regard for basic needs or safety of self and others.

Drug Use Rating

Extent to which a person's use of legal or illegal drugs impairs daily functioning.

- ○ 1. No impairment of general functioning due to drug use.
- ○ 2
- ○ 3. Occasional difficulties in functioning due to drug use.
- ○ 4
- ○ 5. Frequent difficulties in functioning due to drug use.
- ○ 6
- ○ 7. Significantly impaired functioning due to drug use. Drug use dominates life to the exclusion of other activities.
- ○ 8
- ○ 9. Constantly debilitated due to drug use, with no regard for basic needs or safety of self and others.

Family Rating

Extent to which issues within the individual's identified family and family relationships are problematic.

- ○ 1. Family relationships are not of current concern.
- ○ 2
- ○ 3. Occasional friction or discord in family relationships.
- ○ 4
- ○ 5. Frequent disagreements or turbulence with family members.
- ○ 6
- ○ 7. Extensive disruption in family functioning which has resulted in out of home placement or estrangement.
- ○ 8
- ○ 9. Family members are at considerable personal risk and require formal external supportive services.

Interpersonal Rating

Extent to which a person establishes and maintains relationships with others.

- ○ 1. Demonstrates healthy relationships with others.
- ○ 2
- ○ 3. Some difficulty developing or maintaining healthy interpersonal relationships.
- ○ 4
- ○ 5. Inadequate relational skills resulting in tenuous and strained relationships.
- ○ 6
- ○ 7. Markedly impaired relational skills resulting in poor relationship formation and maintenance.
- ○ 8
- ○ 9. Interpersonal relationships are virtually nonexistent.

Socialization Rating

Extent to which a person's conduct deviates cultural and social norms.

- ○ 1. Generally conforms to social norms and rules.
- ○ 2
- ○ 3. Occasionally violates rights of others, social norms, and/or rules.
- ○ 4
- ○ 5. Frequently violates rights of others, social norms, and/or rules.
- ○ 6
- ○ 7. No regard for rules, rights of others and seriously disruptive to others.
- ○ 8
- ○ 9. Complete disregard for rights of others, social norms, and/or rules resulting in social destructiveness and dangerousness to others.

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CCAR Outcome Section
Domain Scales

Role Performance Rating

Extent to which a person adequately performs his/her occupational role. NOTE: Rate individual's current primary role (e.g. worker, caregiver, student) as marked on the Administrative Section

- 1. Performs comfortably and completely in role.
- 2
- 3. Occasional disruption of role performance.
- 4
- 5. Frequent disruption of role performance.
- 6
- 7. Severe disruption of role performance. Attempts at functioning are ineffective.
- 8
- 9. Productive functioning is absent and currently inconceivable.

Overall Symptom Severity Rating

Rate the severity of the person's mental health symptoms.

- 1. No symptoms are present for this person.
- 2
- 3. Symptoms may be intermittent of may persist at a low level.
- 4
- 5. Symptoms are present which require formal professional mental health intervention.
- 6
- 7. Significant symptoms affecting multiple domains exist, often requiring external intervention.
- 8
- 9. Symptoms are profound and potentially live-threatening.

Social Support Rating

Extent to which a person has relationships with supportive people who contribute to recovery.

- 1. Supportive relationships outside of service providers AND actively particiates in maintaining them.
- 2
- 3. Supportive relationships ouside of service providers.
- 4
- 5. Only meaningful relationships with service providers AND other receiving services.
- 6
- 7. Only meaningful relationships are with service providers.
- 8
- 9. No meaningful relationships (or relationships that are not constructive) AND person wants or could clearly benefit from them.

Hope Rating

Extent to which a person is optimistic about future outcomes.

- 1. Openly expresses hope for the future AND is making efforts to achieve better outcomes.
- 2
- 3. Openly expresses hope for the future, but is not currently making efforts that would lead to better outcomes.
- 4
- 5. Expresses both positive and negative attitudes with regards to future outcomes.
- 6
- 7. Does not express hope for the future, but may be convinced that there is opportunity for better outcomes.
- 8
- 9. Actively expresses hopelessness about future change.

Empowerment Rating (mark 1 if less than 12 years old)

Extent to which a person uses available resources that contribute to personal health, welfare and recovery. This includes knowledge and understanding of symptoms, treatment options and resource alternatives.

- 1. Actively engages in planning and activities to assure optimal personal health, welfare and recovery.
- 2
- 3. Is aware of some available resources and generally acts to access them to assure personal health, welfare and recover.
- 4
- 5. Does not respond to signs and symptoms that may reduce personal health, welfare and recovery.
- 6
- 7. Ignores or rejects offers of resources or assistance to assure personal health, welfare and recovery.
- 8
- 9. Requires intervention to assure recovery.

Activity Involvement Rating

Extent to which a person participates in positive activities.

- 1. High involvement in a variety of positive activites that are self, other and community focused.
- 2
- 3. Involvement in a variety of positive activites that includes others.
- 4
- 5. Involvement in a variety of positive activities, but rarely includes others.
- 6
- 7. Engages in few, in any, positive activities and none with others.
- 8
- 9. No identified positive activities.

Overall Recovery Rating

Extent to which a person is involved in the process of getting better and developing/restoring /maintaining a positive and meaningful sense of self.

- 1. Views self positively with the knowledge that setbacks may occur AND is able to actively pursue and access resources to support recovery with a sense of empowerment and hopefulness about future outcomes.
- 2
- 3. Hopeful about future outcomes AND is actively participating and using resources to promote recovery.
- 4
- 5. Expresses hopefulness about future outcomes AND is willing to begin to engage in using available resources to promote recovery.
- 6
- 7. Expresses a mixture of hopefulness and hopelessness about future outcomes and is interested in discussing available options and resources to aid in recovery.
- 8
- 9. Entrenched in symptoms, expresses hopelessness about future outcomes AND does not actively engage in using available resources that might promote recovery.

Overall Level of Functioning Rating

Extent to which a person is able to carry out activities of daily living, despite the presence of mental health symptoms.

- 1. Functioning well in most activities of daily living.
- 2
- 3. Adequate functioning in activities of daily living.
- 4
- 5. Limited functioning in activities of daily living.
- 6
- 7. Impaired functioning that interferes with most activities of daily living.
- 8
- 9. Significantly impaired functioning, may be life threatening.

Source: Colorado Department of Human Services, CCAR and Encounter Documentation https://sites.google.com/a/state.co.us/cdhs-behavioral-health/home/community-behavioral-health/reports-and-presentations/ccar-and-encounter-documentation

CCAR Domain	CCAR Domain Description
Physical Health	Extent to which a person's physical health or condition is a source of concern
Self-Care	Extent to which mental health symptoms impact a person's ability to care for self and provide for needs
Legal	Extent to which a person is involved in the criminal justice system
Need for Supervision	Extent to which the person is in need of increased supervision
Suicide/Self Harm	Extent to which a person experiences self-harming thoughts and/or behaviors
Aggression	Extent of aggressiveness in interactions with others
Psychosis	Extent to which a person experiences delusional, disorganized and irrational thought processes
Cognition	Extent to which a person performs cognitive tasks and experiences symptoms such as, but not limited to, confusion, poor problem solving, and impaired judgment
Attention	Extent to which a person experiences attention issues such as, but not limited to, distractibility, inability to concentrate, and restlessness
Mania	Extent to which a person experiences manic symptoms such as, but not limited to, excessive activity level, elevated mood, and decreased need for sleep
Anxiety	Extent to which a person experiences anxiety symptoms such as, but not limited to, nervousness, fearfulness, and tension
Depression	Extent to which a person experiences depressive symptoms such as, but not limited to, sadness, worrying, irritability and agitation
Alcohol Use	Extent to which a person's use of alcohol impairs daily functioning
Drug Use	Extent to which a person's use of legal or illegal drugs impairs daily functioning
Problematic Family Relationships	Extent to which issues within the individuals identified family and family relationships are problematic
Interpersonal Relationships	Extent to which a person establishes and maintains relationships with others
Socialization	Extent to which a person's conduct deviates cultural and social norms
Role Performance	Extent to which a person adequately performs his/her occupational role
Overall Symptom Severity	Rate the severity of the persons mental health symptoms
Empowerment	Extent to which a person uses available resources that contribute to personal health, welfare, and recovery
Activity Involvement	Extent to which a person participates in positive activities
Social Supports	Extent to which a person has relationships with supportive people that contribute to recovery
Hope	Extent to which a person is optimistic about future outcomes
Recovery	Extent to which a person is involved in the process of getting better and developing restoring/maintaining a positive and meaningful sense of self
Overall Level of Functioning	Extent to which a person is able to carry out activities of daily living despite the presence of mental health symptoms

Appendix M - Clinical Severity of OBH Indigent and Medicaid Capitation Clients as Measured by CCAR Outcome Domains in FY 2014-15

The CCAR is administered to all individuals served in the public mental health system when they enter treatment, annually, at discharge from services, and when there is a change in a client's diagnosis, employment, living arrangement, residence, or status. It contains a clinician rating of 25 domains that relate to wellbeing, mental health, and social functioning that are rated on a 1-9 point scale. A score of 9 indicates the greatest severity, and a score that is greater than or equal to 5 indicates symptoms of clinical concern, or an "elevated" domain score.

FY 2014-15 Percent of OBH Indigent and Medicaid Capitation Clients Admitted in FY 2014-15 with Clinically Elevated CCAR Outcome Domains*

CCAR Outcome Domain	OBH Indigent Percent with Elevated Score	Medicaid Capitation Percent with Elevated Score	Percent Different
Overall Symptom Severity	**85.4%**	82.5%	2.8%
Depressive Issues	**67.4%**	56.9%	10.5%
Anxiety Issues	**54.2%**	53.7%	0.5%
Overall Recovery	**53.8%**	51.1%	2.7%
Overall Level of Functioning	**47.0%**	44.4%	2.6%
Activity Involvement	**46.7%**	39.6%	7.1%
Role Performance	**42.8%**	40.2%	2.6%
Family	38.7%	**40.0%**	-1.3%
Hope	**36.7%**	32.5%	4.2%
Interpersonal	**26.6%**	24.2%	2.3%
Attention	23.9%	**25.4%**	-1.5%
Physical Health	18.4%	**19.0%**	-0.6%
Social Support	**16.0%**	12.9%	3.1%
Empowerment	**15.4%**	14.5%	0.9%
Legal	**14.5%**	7.7%	6.8%
Manic Issues	**13.1%**	7.8%	5.3%
Socialization	**12.1%**	10.3%	1.8%
Drug Use	**11.4%**	7.1%	4.3%
Psychosis	**11.1%**	6.0%	5.1%
Security/Supervision	**11.0%**	8.8%	2.2%
Self Care/Basic Needs	**10.8%**	9.4%	1.4%
Aggression/Danger to others	**9.8%**	9.5%	0.3%
Alcohol Use	**9.7%**	5.9%	3.8%
Cognition	**7.9%**	7.7%	0.2%
Suicide/Danger to Self	**5.8%**	4.5%	1.3%

*Includes data for specialty clinics (Asian Pacific Development Center and Servicios de la Raza).

FY 2014-15 Frequency of Clinically Elevated (<5) CCAR Rating at Admission for OBH Indigent Clients for each CCAR Outcome Domain by CMHC

CMHC	Activity Involvement	Aggression / Danger to Others	Alcohol Use	Anxiety Issues	Attention	Cognition	Depressive Issues	Drug use	Empower-ment	Family	Hope	Inter-personal	Legal
AllHealth	56.8%	27.3%	40.9%	72.7%	40.9%	27.3%	72.7%	36.4%	44.3%	62.5%	47.7%	54.5%	43.2%
AspenPointe	57.8%	7.8%	4.9%	60.8%	31.4%	13.7%	74.5%	1.0%	22.5%	40.2%	38.2%	32.4%	2.9%
Aurora	40.3%	5.6%	0.7%	48.6%	23.6%	2.8%	62.5%	2.8%	8.3%	26.4%	31.9%	15.3%	2.8%
Axis	41.2%	11.8%	5.9%	60.3%	25.0%	10.3%	61.8%	10.3%	10.3%	50.0%	35.3%	35.3%	8.8%
Centennial	37.7%	11.6%	4.8%	52.7%	13.7%	4.1%	54.1%	6.8%	13.0%	34.9%	24.7%	24.0%	15.8%
CMH	49.5%	5.7%	6.7%	47.6%	21.0%	1.9%	70.5%	7.6%	14.3%	35.2%	46.7%	27.6%	14.3%
Community Reach	43.1%	10.8%	7.7%	49.2%	15.4%	4.6%	66.2%	9.2%	13.8%	38.5%	16.9%	15.4%	9.2%
Health Solutions	47.7%	7.0%	4.7%	40.7%	19.8%	10.5%	64.0%	15.1%	16.3%	37.2%	25.6%	27.9%	11.6%
Jefferson	44.6%	5.5%	9.8%	46.7%	22.4%	5.8%	64.6%	12.1%	15.8%	38.5%	41.7%	23.2%	17.4%
MHCD	42.2%	11.3%	7.4%	48.8%	20.7%	9.0%	62.5%	7.4%	14.5%	40.6%	26.6%	27.3%	9.0%
MHP	45.5%	6.7%	11.8%	58.2%	24.2%	1.3%	69.7%	9.4%	10.4%	33.3%	34.3%	32.0%	14.1%
Mind Springs	52.5%	14.2%	19.9%	51.1%	24.8%	19.1%	63.1%	17.0%	24.1%	36.9%	38.3%	25.5%	18.4%
North Range	49.6%	13.9%	8.3%	67.1%	33.7%	8.7%	77.4%	15.1%	12.3%	34.9%	47.2%	25.8%	14.7%
San Luis Valley	46.7%	6.7%	4.0%	46.7%	13.3%	5.3%	62.7%	21.3%	12.0%	29.3%	28.0%	16.0%	37.3%
Solvista	69.8%	11.6%	16.3%	72.1%	25.6%	11.6%	90.7%	11.6%	51.2%	72.1%	69.8%	44.2%	9.3%
Southeast	52.9%	0.0%	11.8%	23.5%	17.6%	0.0%	58.8%	17.6%	11.8%	58.8%	23.5%	41.2%	23.5%
SummitStone	40.8%	10.3%	10.3%	56.9%	17.8%	5.7%	66.7%	12.6%	7.5%	41.4%	31.6%	13.8%	14.4%
Statewide*	46.7%	9.8%	9.7%	54.2%	23.9%	7.9%	67.4%	11.4%	15.4%	38.7%	36.7%	26.6%	14.5%

*Includes data for specialty clinics (Asian Pacific Development Center and Servicios de la Raza).

FY 2014-15 Frequency of Clinically Elevated (<5) CCAR Rating at Admission for OBH Indigent Clients for each CCAR Outcome Domain by CMHC

CMHC	Manic Issues	Overall Level of Functioning	Overall Recovery	Overall Symptom Severity	Physical Health	Psychosis	Role Performance	Security/ Supervision	Self care/ Basic Needs	Socialization	Social Support	Suicide/ Danger to Self
AllHealth	26.1%	89.8%	67.0%	97.7%	31.8%	14.8%	71.6%	35.2%	34.1%	40.9%	40.9%	12.5%
AspenPointe	14.7%	64.7%	63.7%	89.2%	16.7%	8.8%	57.8%	9.8%	11.8%	8.8%	19.6%	8.8%
Aurora	15.3%	32.6%	44.4%	95.1%	13.2%	9.0%	22.9%	10.4%	5.6%	5.6%	8.3%	4.9%
Axis	13.2%	42.6%	39.7%	82.4%	19.1%	5.9%	36.8%	13.2%	17.6%	16.2%	11.8%	11.8%
Centennial	6.8%	28.8%	50.0%	77.4%	18.5%	11.6%	24.0%	4.1%	4.1%	6.8%	12.3%	2.7%
CMH	7.6%	37.1%	65.7%	88.6%	23.8%	7.6%	52.4%	9.5%	6.7%	8.6%	17.1%	7.6%
Community Reach	7.7%	50.8%	55.4%	95.4%	7.7%	7.7%	32.3%	3.1%	1.5%	4.6%	6.2%	7.7%
Health Solutions	11.6%	33.7%	40.7%	77.9%	24.4%	15.1%	43.0%	9.3%	7.0%	12.8%	19.8%	8.1%
Jefferson	10.0%	34.6%	58.8%	82.8%	14.0%	7.7%	36.4%	9.2%	5.8%	12.1%	12.4%	4.0%
MHCD	14.8%	43.4%	39.8%	77.7%	26.6%	16.4%	38.3%	10.5%	10.5%	8.6%	18.8%	7.8%
MHP	13.8%	52.2%	45.8%	91.9%	17.2%	11.8%	54.5%	3.0%	17.2%	9.1%	18.5%	1.7%
Mind Springs	17.0%	34.0%	61.7%	85.1%	23.4%	20.6%	37.6%	20.6%	20.6%	19.1%	21.3%	11.3%
North Range	13.1%	65.5%	64.3%	91.3%	11.1%	11.9%	55.6%	19.4%	9.1%	16.3%	13.1%	7.5%
San Luis Valley	5.3%	46.7%	46.7%	65.3%	24.0%	1.3%	37.3%	12.0%	5.3%	18.7%	14.7%	2.7%
Solvista	18.6%	86.0%	86.0%	97.7%	27.9%	9.3%	83.7%	9.3%	11.6%	25.6%	30.2%	7.0%
Southeast	11.8%	76.5%	41.2%	94.1%	41.2%	5.9%	47.1%	11.8%	5.9%	5.9%	23.5%	0.0%
SummitStone	14.4%	51.1%	51.1%	75.9%	14.4%	9.2%	36.2%	8.6%	6.9%	6.9%	8.6%	1.1%
*Statewide	13.1%	47.0%	53.8%	85.4%	18.4%	11.1%	42.8%	11.0%	10.8%	12.1%	16.0%	5.8%

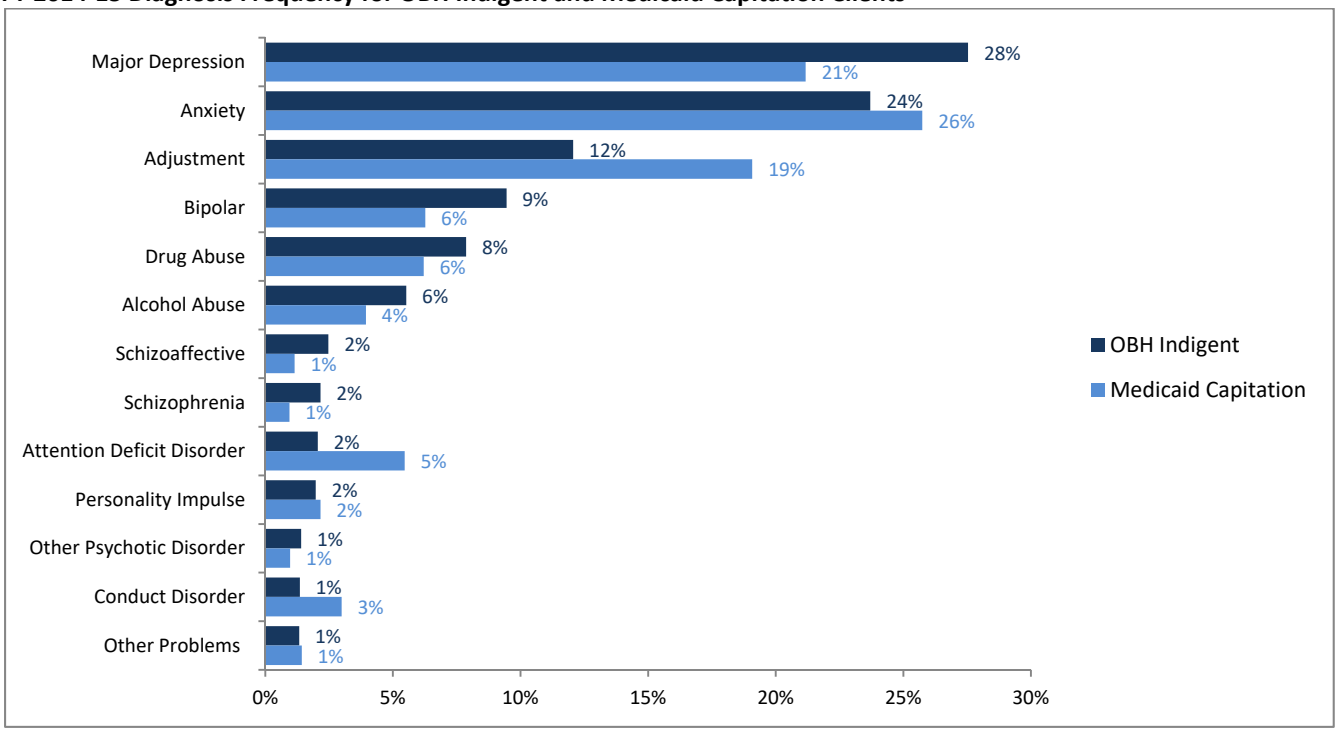
*Includes data for specialty clinics (Asian Pacific Development Center and Servicios de la Raza).

FY 2014-15 Percent of OBH Indigent Clients Admitted in FY 2014-15 with an SED/SMI by CMHC*

CMHC	% of OBH Indigent Youth (ages 0-17) with SED	% of OBH Indigent Adults (ages 18+) with SMI
AllHealth	2.3%	56.8%
AspenPointe	17.6%	81.4%
Aurora	39.6%	56.9%
Axis	36.8%	63.2%
Centennial	20.5%	78.8%
CMH	13.3%	85.7%
Community Reach	9.2%	72.3%
Health Solutions	5.8%	94.2%
Jefferson	19.3%	70.7%
MHCD	17.2%	82.8%
MHP	11.4%	87.2%
Mind Springs	11.3%	88.7%
North Range	34.1%	65.9%
San Luis Valley	12.0%	88.0%
Solvista	18.6%	81.4%
Southeast	17.6%	82.4%
SummitStone	13.8%	86.2%
Total	18.4%	77.6%

*Includes data for specialty clinics (Asian Pacific Development Center and Servicios de la Raza).

FY 2014-15 Diagnosis Frequency for OBH Indigent and Medicaid Capitation Clients*



*Includes data for specialty clinics (Asian Pacific Development Center and Servicios de la Raza).

Appendix N - Factors Related to Cost of Care for OBH Indigent Clients in FY 2014-15

FY 2014-15 Frequency of Clinically Elevated (<5) CCAR Rating at Admission for OBH Indigent Clients by Cost Category for each CCAR Outcome Domain*

CCAR Domain	High Cost (top 25%)	Low Cost (bottom 75%)	Percent Difference Between High Cost and Low Cost
Activity Involvement	37.2%	35.6%	1.6%
Aggression/Danger to Others	6.2%	7.2%	-1.0%
Alcohol Use	5.2%	7.6%	-2.5%
Anxiety Issues	44.6%	39.4%	5.2%
Attention	20.2%	18.3%	1.9%
Cognition	10.2%	7.9%	2.2%
Depressive Issues	53.2%	48.9%	4.3%
Drug Use	6.2%	7.8%	-1.6%
Empowerment	12.5%	13.5%	-0.9%
Family	30.5%	29.0%	1.5%
Hope	29.6%	26.9%	2.8%
Interpersonal	23.9%	21.2%	2.7%
Legal	7.6%	10.8%	-3.2%
Mania	10.1%	9.3%	0.8%
Overall Level of Functioning	35.5%	34.2%	1.3%
Overall Recovery	41.5%	39.7%	1.8%
Overall Symptom Severity	70.0%	62.0%	8.0%
Physical Health	21.1%	17.8%	3.2%
Psychoses	13.7%	9.8%	3.9%
Role Performance	31.9%	30.4%	1.6%
Security/Supervision	8.7%	9.1%	-0.4%
Self Care/Basic Needs	9.0%	9.4%	-0.4%
Social Support	12.5%	12.9%	-0.4%
Socialization	8.7%	9.2%	-0.5%
Suicide/Danger to Self	5.3%	5.8%	-0.5%

FY 2014-15 Mean Cost of Care for OBH Indigent Clients by Demographics

Factor	Mean Cost	Significance (p-value)*
Age 0-17	$2,527	0.803
Age 18+	$2,473	
Male	$2,548	0.414
Female	$2,422	
Non-White	$2,585	0.742
White	$2,528	
Non-SED/SMI	$2,110	0.017
SED/SMI	$2,573	
Not Homeless	$2,396	0.0001
Homeless	$3,355	
Not Unemployed	$2,311	0.01
Unemployed	$2,716	

* Analysis of Variance (ANOVA) was run. p-values < .05 are considered significant.

Appendix O - Service Utilization in FY 2014-15

Medicaid Capitation Service Utilization in FY 2014-15 by BHO and Age Group

CMHC	Age 0-17			Age 18+			Total	
	Total Services	% of Total Services	Avg. # Services/ Client	Total Services	% of Total Services	Avg. # Services/ Client	Total Services	Avg. # Services/ Client
ABC-D	165,360	10.4%	27.0	1,422,248	89.6%	69.8	1,587,608	59.9
ABC-NE	123,596	24.8%	21.8	374,441	75.2%	29.8	498,037	27.3
BHI	308,628	26.5%	26.8	857,909	73.5%	41.0	1,166,537	36.0
CHP	283,128	23.1%	19.7	940,654	76.9%	23.0	1,223,782	22.2
FBHP	140,763	26.3%	18.1	393,533	73.7%	27.7	534,296	24.3
Total	1,021,475	20.4%	22.5	3,988,785	79.6%	36.6	5,010,260	32.5

Medicaid Capitation Service Utilization in FY 2014-15 by Service Category and Age Group*

Service Category	Age 0-17		Age 18+		Total	
	Total Services	Avg. # Services/ Client	Total Services	Avg. # Services/ Client	Total Services	Avg. # Services/ Client
Assessment	51,121	1.9	108,495	1.7	159,616	1.8
Case Management	89,773	8.0	296,691	10.5	386,464	9.8
Crisis/Emergency	23,741	6.7	82,936	7.4	106,677	7.2
Evaluation/Management	38,567	3.5	126,626	3.1	165,193	3.2
Inpatient	3,407	5.7	18,557	7.1	21,964	6.8
Intensive Treatment	68,869	274.4	8,677	18.1	77,546	106.2
Other	92,519	19.4	500,677	27.0	593,196	25.4
Other Professional	89,873	37.3	28,789	11.3	118,662	24.0
Peer Support/Recovery	7,003	32.6	50,944	22.1	57,947	23.0
Prevention/Early Intervention	82,784	7.7	664,753	33.5	747,537	24.4
Psychiatric/Medication Management	1,821	2.3	92,969	14.4	94,790	13.1
Psychotherapy	352,521	12.2	573,824	10.0	926,345	10.7
Rehabilitation	80,132	35.7	592,180	53.7	672,312	50.7
Residential	19,746	13.2	71,279	21.6	91,025	19.0
Respite Care	7,477	48.2	2,032	13.9	9,509	31.6
Social Ambulatory Detox	--	12.0	238,090	27.7	238,365	27.6
Substance Use	4,716	12.4	494,556	46.3	499,272	45.1
Vocational	--	11.5	43,771	29.0	43,840	29.0
Total	1,014,414	9.6	3,995,846	13.9	5,010,260	12.7

"--" indicates the number has been suppressed per HCPF data suppression guidelines.

OBH Indigent Utilization in FY 2014-15 by CMHC and Age Group

CMHC	Age 0-17			Age 18+			Total	
	Total Services	% of Total Services	Avg. # Services / Client	Total Services	% of Total Services	Avg. # Services / Client	Total Services	Avg. # Services / Client
AllHealth	503	3.3%	9.5	14,828	96.7%	23.4	15,331	22.3
AspenPointe	4,575	16.6%	31.8	22,977	83.4%	31.6	27,552	31.6
Aurora	3,056	27.2%	22.5	8,186	72.8%	20.6	11,242	21.1
Axis	1,347	24.7%	18.0	4,105	75.3%	14.3	5,452	15.0
Centennial	693	11.8%	11.4	5,201	88.2%	19.6	5,894	18.1
CMH	250	5.7%	7.4	4,105	94.3%	12.3	4,355	11.9
Community Reach	557	5.7%	10.5	9,176	94.3%	17.5	9,733	16.9
Health Solutions	301	4.6%	13.1	6,231	95.4%	18.8	6,532	18.5
Jefferson	81,853	74.0%	12.3	28,737	26.0%	12.5	110,590	12.4
MHCD	4,694	3.4%	26.5	131,881	96.6%	127.2	136,575	112.5
MHP	2,108	11.4%	26.7	16,383	88.6%	20.7	18,491	21.2
Mind Springs	1,129	11.8%	8.0	8,400	88.2%	8.4	9,529	8.4
North Range	602	6.3%	5.8	8,990	93.7%	12.7	9,592	11.8
San Luis Valley	217	10.7%	8.0	1,811	89.3%	9.3	2,028	9.2
Solvista	162	3.5%	6.8	4,521	96.5%	20.1	4,683	18.8
Southeast	230	6.8%	16.4	3,142	93.2%	28.6	3,372	27.2
SummitStone	221	1.6%	11.6	13,457	98.4%	47.7	13,678	45.4
Total	102,542	25.9%	13.1	293,460	74.1%	28.7	396,002	22.0

OBH Indigent Service Utilization in FY 2014-15 by CMHC*

CMHC	FY 2014-15		
	Total Services	Clients Served	Avg. # Services / Client
AllHealth	15,331	688	22.3
AspenPointe	27,552	872	31.6
Aurora	11,242	533	21.1
Axis	5,452	363	15.0
Centennial	5,894	326	18.1
CMH	4,355	367	11.9
Community Reach	9,733	577	16.9
Health Solutions	6,532	354	18.5
Jefferson	110,590	8,933	12.4
MHCD	136,575	1,214	112.5
MHP	18,491	871	21.2
Mind Springs	9,529	1,136	8.4
North Range	9,592	812	11.8
San Luis Valley	2,028	221	9.2
Solvista	4,683	249	18.8
Southeast	3,372	124	27.2
SummitStone	13,678	301	45.4
Total	396,002	18,032	22.0

*Total includes Asian Pacific Development Center and Servicios de la Raza.

OBH Mental Health Service Utilization in FY 2014-15 by Service Category and Age Group*

Service Category	Age 0-17		Age 18+		Total	
	Total Services	Avg. # Services/ Client	Total Services	Avg. # Services/ Client	Total Services	Avg. # Services/ Client
Assessment	1,519	1.7	7,218	1.6	8,737	1.7
Case Management	3,842	6.6	25,682	8.0	29,524	7.8
Crisis/Emergency	1,410	6.8	8,565	6.3	9,975	6.3
Evaluation/Management	906	3.6	16,083	3.4	16,989	3.5
Inpatient	--	4.3	128	4.0	141	4.0
Intensive Treatment	--	347.6	370	12.3	2,108	60.2
Other	1,598	3.7	408	6.4	2,006	4.1
Other Professional	640	9.8	4,145	19.0	4,785	16.9
Peer Support/Recovery	--	13.3	4,581	21.4	4,621	21.3
Prevention/Early Intervention	74,796	12.3	105,604	60.6	180,400	23.1
Psychiatric/Medication Management	28	2.2	11,255	14.9	11,283	14.7
Psychotherapy	12,133	10.7	40,240	7.8	52,373	8.3
Rehabilitation	3,670	36.0	56,425	48.3	60,095	47.3
Residential	0	0.0	4,305	22.3	4,305	22.3
Respite Care	--	12.0	10	3.3	22	5.5
Substance Use	--	2.5	1,307	11.6	1,312	11.4
Treatment	0	0.0	120	24.0	120	24.0
Vocational	--	2.5	7,201	42.6	7,206	42.1
Total	102,355	10.5	293,647	12.5	396,002	11.9

"--" indicates the number has been suppressed per OBH data suppression guidelines.

Appendix P - Average Cost of Services in FY 2014-15

Medicaid Capitation - Average Service Cost by Service Category FY 2014-15

	Age 0-17	Age 18+	Total
Assessment	$336	$311	$319
Case Management	$346	$546	$489
Crisis/Emergency	$666	$751	$730
Evaluation/Management	$630	$540	$560
Inpatient	$600	$682	$667
Intensive Treatment	$16,603	$4,762	$8,833
Other	$2,460	$2,005	$2,097
Other Prof	$909	$156	$523
Peer Support/Recovery	$591	$838	$817
Prevention/Early Intervention	$369	$643	$546
Psychiatric/Medication Management	$170	$786	$718
Psychotherapy	$1,791	$1,293	$1,459
Rehabilitation	$1,620	$2,168	$2,076
Residential	$5,857	$6,767	$6,484
Respite Care	$2,264	$2,178	$2,222
Social Ambulatory Detox	$231	$818	$816
Substance Use	$427	$1,044	$1,022
Vocational	$167	$359	$358

OBH Indigent - Average Service Cost by Service Category FY 2014-15

	Age 0-17	Age 18+	Total
Assessment	$463	$397	$408
Case Management	$355	$423	$412
Crisis/Emergency	$639	$635	$636
Evaluation/Management	$709	$575	$582
Inpatient	$759	$670	$678
Intensive Treatment	$24,727	$5,282	$8,060
Other	$0	$518	$14
Other Professional	$160	$221	$207
Peer Support/Recovery	$325	$931	$922
Prevention/Early Intervention	$729	$2,773	$1,184
Psychiatric/Medication Management	$164	$879	$867
Psychotherapy	$2,221	$1,489	$1,622
Rehabilitation	$3,067	$2,337	$2,396
Residential	$0	$232	$232
Respite Care	$3,854	$1,161	$1,834
Substance Use	$140	$686	$677
Treatment	$0	$2,496	$2,496
Vocational	$27	$465	$459

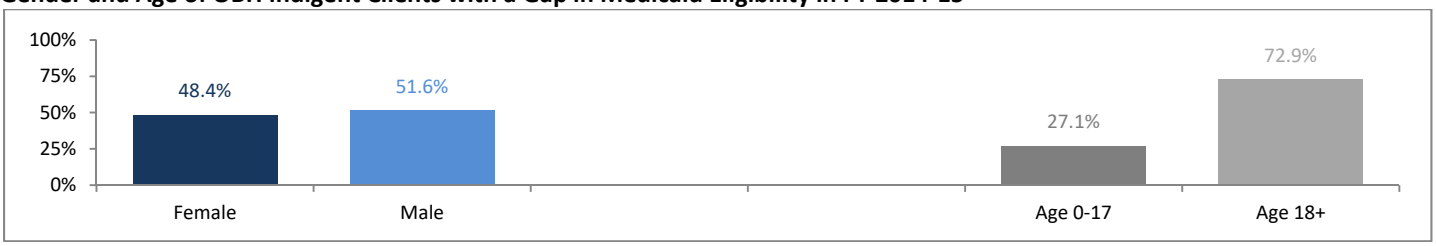
OBH Indigent Average Cost of Services in FY 2014-15 by CMHC by Age Group*

CMHC	Age 0-17	Age 18+	Total
AllHealth	$1,331	$1,638	$1,614
AspenPointe	$5,288	$4,240	$4,413
Aurora	$4,004	$3,037	$3,284
Axis	$2,438	$1,141	$1,409
Centennial	$1,647	$1,683	$1,677
CMH	$1,370	$1,513	$1,500
Community Reach	$822	$1,453	$984
Health Solutions	$2,875	$2,171	$2,235
Jefferson	$3,416	$6,612	$6,146
MHCD	$832	$1,372	$1,322
MHP	$756	$791	$787
Mind Springs	$453	$620	$599
North Range	$901	$1,228	$1,188
San Luis Valley	$1,583	$3,142	$2,966
Solvista	$2,174	$2,386	$2,373
Southeast	$1,821	$1,645	$1,656
SummitStone	$1,212	$2,435	$2,317
Total	$1,073	$2,265	$1,749

*Total cost includes data for specialty clinics (Asian Pacific Development Center and Servicios de la Raza).

Appendix Q - OBH Indigent Gap Clients and OBH Indigent Clients in FY 2014-15*

Gender and Age of OBH Indigent Clients with a Gap in Medicaid Eligibility in FY 2014-15



Diagnostic Information for OBH Indigent Gap Clients and OBH Indigent Clients in FY15*

Diagnosis	OBH Indigent Gap clients		OBH Indigent Clients	
Major Depression	91	27.7%	3554	40.1%
Bipolar	65	19.8%	1534	17.3%
Anxiety	52	15.9%	1179	13.3%
Adjustment	47	14.3%	1186	13.4%
Schizoaffective	--	6.1%	423	4.8%
Schizophrenia	--	--	440	5.0%
Alcohol Abuse	--	--	--	--
Drug Abuse	--	--	27	0.3%
Other Psychotic Disorder	--	--	183	2.1%
Conduct Disorder	--	--	125	1.4%
Attention Deficit Disorder	--	--	119	1.3%
Delusion	--	--	--	--
Alcohol Related Mental Disorder	--	--	--	--
Personality Impulse	--	--	--	--
Other Medical Mental Disorder	--	--	--	--
Autism	--	--	--	--
Dissociative	--	--	--	--
Eating/Sleeping Disorder	--	--	--	--
Mental Retardation	--	--	--	--
No Mental Disorder	--	--	--	--
Other Problems Non Ment	--	--	--	--
Schizophreniform	--	--	--	--
Somatoform	--	--	--	--
Total	--	100.0%	8865	100.0%

*Diagnostic information is based on the primary diagnosis on a matching CCAR. It is important to note that not all OBH Indigent gap client or OBH indigent clients with matching CCARs had diagnostic information.

"--" indicates the number has been suppressed per OBH and HCPF data suppression guidelines.

Appendix R - Methodology Options and Other State Allocation Formulas[153]

In the past several years many states have worked to develop allocation formulas with the stated goal of more equitably distributing public funds. Although distributing public funds using a formula is not new, the development of more sophisticated formulas at the state and local levels has only recently become a priority. Many older formulas are considered to be out-of-date as new technologies emerge and state sponsored data or epidemiology workgroups are making more community level data available. Considering the new types of data available to administrators at the state level there are four primary methodologies that can be considered in allocating funds (Burgess et al, 2002):

- *Uniform or flat-rate models*: These models assume that there is no difference across geographically-defined populations in terms of mental health need. Implicitly or explicitly, they therefore recommend that funding should be distributed equally across areas.
- *Social Indicator models using synthetic information*: These models take individual- level demographic data drawn from previous population-based, individual-level surveys, and examine given levels of need for particular population subgroups (e.g. based on age/sex groupings) from that survey. The overall population structure of the area under consideration is then divided on the basis of the same sub groupings. They then model the needs for the given area, assuming that the patterns of need within area-based subgroups will be the same as those found in the survey for the population subgroups.
- *Social Indicator models based on service utilization and prevalence*: These models take indirect social indicator variables at an area-level (e.g. emergency room visits), and examine their association with a given measure of need from the same area, using regression analysis. These models can be sub classified in terms of the type of measure of need they use. Need is typically related to: service utilization (e.g. admissions to acute psychiatric wards); or prevalence (e.g. levels of psychiatric morbidity).
- *Social Indicator models based on expert judgment*: These models use expert judgment to determine the social factors likely to have an influence on need. Typically, these models are only used in the absence of more objective measures of need or are a combination of above mentioned methods.

Stakeholder dissatisfaction. Any changes to an allocation funding formula should be completed with input from regional health boards and all other stakeholders associated with healthcare services. Regardless of the formula adopted, any changes to the funding levels of individual organizations and Regional Behavioral Health Authorities (RBHAs) should be thoroughly examined. The Ohio Department of Mental Health advices all states implementing changes to a funding formula implement the revised funding formula in annual increments during the first few years of the new plan, to smooth out the transitional effects for local boards (Seiber et al, 2012).

Funding Factors Used By Other States

Throughout October and November of 2012 LeCroy & Milligan Associates gathered allocation formula information from the key contact states. Of these Nebraska, Colorado, Ohio, and Michigan provided material that was helpful in examining funding factors and their inherent strengths and weaknesses in representing prevention and treatment need in a region. The formulas utilized across these states to distribute SAPT and CMHS block grant funds varied in their approach. However there were a few formula variables that were regularly used.

- Most common variables used:
  - Population
  - Poverty Level
  - Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED) Prevalence
- Others variables used:
  - Medicaid caseloads
  - Emergency room admittance with drug related codes
  - Treatment admissions
  - Drug-related crimes
  - Homelessness
  - A rural differential

Nebraska

Nebraska opted to keep things very simple and have only added one variable to population. The formula for distributing SAPT grant funds in Nebraska, which is structured in a similar way to Arizona with Regional Behavioral Health Authorities receiving money to serve a designated population, is “three parts population, one part poverty” (Adams, S., personal communication, 2012). The rationale behind adding poverty to the allocation formula is that poverty has been found to be a significant predictor of

[153] Appendix excerpted from LeCroy & Milligan Associates, Inc. "Arizona Department of Health Services, Needs Assessment Allocation Formula Recommendations," 2013. Retrieved from: http://www.lecroymilligan.com/data/resources/allocation-formula-reportfinal-1.pdf

mental illness hospitalization rates across states (Bye and Partridge, 2003). This is a simple formula and easy to explain and justify to stakeholders.

Colorado

Colorado chose to employ more layers of data to their formula, requiring more intricate data collection techniques. In 2009, the Colorado Division of Behavioral Health contracted with the Western Interstate Commission for Higher Education (WICHE) Mental Health Program to produce a comprehensive Population in Need study that demonstrated not only prevalence of certain mental health illnesses in a region but also projected numbers of people with SMI and SED with unmet need in a region (WICHE, 2009). The "unmet need," calculated into a penetration rate (by dividing the number of individuals utilizing behavioral health services by the number of individuals with a serious behavioral health disorder), is used as the primary funding metric in Colorado's formula. The unmet need and penetration rate figures also include a measure of poverty, as only people with a serious behavioral health disorder under 300% of the FPL are included in the study. This method is only feasible when state or other funding exists to complete a comprehensive need assessment of this level. The prevalence rates will need to be recalculated regularly to adjust for changes in population over time.

Ohio

Mental Health Community Based Funding: Ohio's Experience in Revising Its Funding Allocation Methodology provides a brief historical perspective to funding formulas used in Ohio over the past 25 years. Ohio's funding formula has changed multiple times during this period as old funding variables were found to be inadequate and others became viable through new data collecting priorities. In the early 1990s, the formula was shifting from historical hospital use data from each catchment area to a 50/50 split between a count of Severely Mentally Disabled (SMD) adult cases for each board and an Unmet Need (prevalence) factor (Seiber et al, 2012). Hospital utilization patterns were being shown to significantly fluctuate from year to year. This was precipitated by the closure of many of the state hospitals. From 1988 to 2008, Ohio reduced the number of free-standing inpatient mental health hospitals from 17 to 7, reallocating over $500 million from hospital costs to community care. As hospitals closed, the weighting on past hospital utilization was reduced, and less funding was produced for boards that had previously had a public hospital in their service area. This reallocation from some boards with high public mental health utilization to others with lower utilization proved contentious. (Seiber et al, 2012).

By the mid-1990s only 20% of catchment area funding was allocated based on hospitalization utilization, with the remaining 40% on SMD count and 40% on Unmet Need. From 1998, the states mental health board introduced a "hold harmless" provision to the allocation formula so that area health boards would not experience a reduction in funding. State population demographic shifts along with financial stressors to the mental health system in the state made the "hold harmless" clause untenable by 2006.

Ohio's most recent examination and overhaul of the mental health allocation formula began in early 2008 when Ohio Department of Mental Health (ODMH) staff began meeting with an advisory committee comprised of representatives from the local boards to establish system finance principles to be considered in the new funding formula. The formula advisory committee sought insight from a variety of stakeholders and were given ample feedback in regards to what factors should be incorporated into the formula. Proposed factors included board expenditure and revenue data, local poverty measures, a cost-of-doing business index, unemployment levels, proportion of minority population, Medicaid enrollment, total square miles in the board catchment area, presence of a prison or state mental hospital, and other considerations (Seiber et al, 2012). Faced with competing factors to include in the revised formula, ODMH staff developed a conceptual framework to evaluate the merits of each proposed factor. To be included in the funding formula, factors had to meet the following conceptual criteria (Seiber et al, 2012):

1. Do these factors meet the system financing principles?
2. Can data be gathered so that ODMH staff can compute the factor for each board?
3. Are data associated with the factor verifiable?
4. Does the factor accurately reflect what is currently happening in the board area?
5. Does the formula include the SMD factor?
6. Does the formula include a total population factor?

One important insight garnered from Ohio is that relying heavily on national data sets to inform county and community variables can be dubious. Often national data gathered on substance abuse risk behaviors is not sufficient for small-level populations within a state (Seiber et al, 2012). Prior to 2007 Ohio utilized the US Census Bureau's American Community Survey data to determine SMD prevalence numbers for each of the 50 local board areas. The ACS micro data proved insufficient since the Census Bureau limits the release of geographic identification for areas with populations of less than 100,000 to ensure confidentiality for survey respondents (Seiber et al, 2012). Beyond national restrictions to disseminating rural area survey results to ensure confidentiality national survey data rarely serves local data needs because of insufficient sample size and a lack of flexibility to address local health issues and system structures (Simon et al, 2001). Members of the funding formula team in the Ohio Department of Mental Health ended up using data from the Ohio Family Health Survey, conducted every five years by the State of Ohio, to determine local area

SMD prevalence numbers for the formula. After much deliberation the funding formula team chose to use population, poverty and the prevalence of SMD individuals based on the Ohio state conducted survey.

Michigan

In 2007 with the passing of appropriations bill (Act 330 of the Public Acts of 2006) for the Michigan Department of Community Health (MDCH) a funding equity workgroup was created to examine the funding formula used to distribute funds to all Community Mental Health Service Providers (CMHSP). The workgroup, made up of CMHSP leaders, state health department representatives, and other stakeholders in the mental health community, in their initial report outlined many statutory and practical difficulties to achieving "recipient equity" in the system based off a formula (Michigan Department of Community Mental Health, 2007).

The workgroup highlighted how enigmatic equity was to achieve. Community need and capacity for mental health treatment services was easily understood but difficult to quantify based on any specific formula variables. The workgroup examined various utilization data, and researched the connection of social indicators to mental health illnesses. Nevertheless, workgroup stakeholders were unable to come to a consensus on which variables should be included in the formula. Despite disagreement among workgroup members, the funding formula was modified to include three main variables of need:

1. Population;
2. Poverty rates;
3. SMI prevalence.

The Michigan *Workgroup Plan to Achieve Funding Equity for All CMHSPS* also provided a good discussion on the concept of equity in determining factors for inclusion in a behavioral health funding formula. There were clear differences among stakeholders regarding what is meant by the concept of equity (e.g., recipient equity, taxpayer equity, organizational fiscal-capacity equity, etc.). Additionally there were:

- Concerns regarding the complexities in determining and weighting variables of need;
- Disagreements on how to measure and incorporate differences in cost of services (COS) as a formula component;
- Data source and data quality issues;
- And questions regarding whether improving "equity" in one funding strand (general fund) might potentially increase overall fiscal disparities (total organizational fiscal-capacity) within the current, very complex and intricate, multiple source funding environment (Michigan Department of Community Mental Health, 2007).

One interesting option the workgroup examined, in exploring the concept of organizational fiscal-capacity equity, was to try to incorporate each CMHSP's carry- forward and retained earnings, earned contract revenues, and the size of an organization's unrestricted fund balance, either into the formula equation or as secondary info to distribute additional funds to those CMHSPs with high "expenditure needs." Although the option was not adopted, some workgroup members thought some general funds should be reserved and allocated to organizations to reduce "expenditure need," the gap between what other entities have through an assortment of funding arrangements and retained earnings, and what the more disadvantaged organizations need to sustain and provide a certain standard level of service provision (Michigan Department of Community Mental Health, 2007).

Appendix S - Denied Authorizations and Claims

BHO data describing claim and authorization behavior was provided by the CBHC. Information included number of claims and authorizations, number of denials, and denial reasons by BHO. Information presented in this Appendix is pulled directly from the CBHC data or were derived from those data. Service authorization and claims denial data, separated by inpatient and outpatient services, were reviewed for trends and information about reasons for denials.

Authorization and Claim Denial Categories and Definitions

Category	Definition
Inpatient Authorization	An authorization by the BHO requested for inpatient hospitalization only for an overnight in an Acute Care Psychiatric Hospital
Outpatient Authorization	An authorization by the BHO for outpatient services provided by a hospital, such as partial hospitalization, ECT, Day Treatment
Inpatient Claim	A request for payment for an inpatient hospital facility stay
Outpatient Claim	A request for payment for non-emergency outpatient services provided by an inpatient hospital
Administrative Denial	Provider did not request an authorization for services that were rendered pursuant to agreed-upon contractual requirements
Clinical Denial	No authorization was given due to a lack of clinical justification; member symptoms not approved for medical necessity by a physician
Non-Covered Diagnosis	Focus of treatment was not for a BHO-covered diagnosis as prescribed by HCPF
Member Not Eligible	Medicaid coverage was not in effect on the date of service
Service Not Covered	Service billed is not included in the BHO contract with HCPF, such as for medical claims
Billing/Admin Issue	Bill was not submitted with complete information; provider not following standard billing practices, such as missing/incorrect information
Claim Not Authorized	Provider did not secure an authorization for services provided. (*Note: also includes denied authorizations*)

Detailed Authorization Denial Categories and Descriptions

Category	Description
Admin Denial	Admit type requires 450 revcode
Admin Denial	AUTH REQ DENIED - MEMBER NOT ELIG ON DOS
Admin Denial	AUTH REQ DENIED - NOT A COVERED BENEFIT
Admin Denial	AUTH REQ DENIED - SUFFICIENT INFO NOT REC'D
Admin Denial	AUTH REQ DENIED DUE LATE NOTIFICATION
Admin Denial	Coinsurance days exceeds covered days
Admin Denial	Coinsurance days missing associated value codes
Admin Denial	Covered days and coinsured days exceed maximum for hospital
Admin Denial	Covered days and coinsured days exceed maximum for SNF
Admin Denial	Covered days exceed maximum for SNF
Admin Denial	Covered days exceeds maximum for hospital
Admin Denial	Invalid Admit Hour (0 -- 23)
Admin Denial	Invalid coinsurance days for 11x bill type
Admin Denial	Invalid Discharge Hour (0 -- 23)
Admin Denial	Invalid Lifetime Reserve Days
Admin Denial	Invalid or missing admission date
Admin Denial	Life reserve days exceed maximum
Admin Denial	Non-covered days exceed statement-covered period
Admin Denial	Non-covered days less than leave of absence days
Clinical Denial	AUTH REQ DENIED - SERVICES NOT MED NECESSARY
Non-Covered Diagnosis	AUTH REQ DENIED - NOT A COVERED DIAGNOSIS

Detailed Claim Denial Categories and Descriptions

Category	Description
Billing/Admin Issue	Primary carrier's EOB missing. Resubmit within 30 days or claim may be denied.
Billing/Admin Issue	GROUP NOT EFFECTIVE FOR DATE OF SERVICE
Billing/Admin Issue	MEDICARE IS THE PRIMARY PAYOR
Billing/Admin Issue	Interim Claims Not Accepted by Colorado Access
Billing/Admin Issue	Duplicate charge(s) previously processed
Billing/Admin Issue	Invalid accommodation days
Billing/Admin Issue	Contract Term Requires Manual Review
Billing/Admin Issue	Submission Window Exceeded for Claim Start Date
Billing/Admin Issue	Payment is being made in accordance with IHG/HPO discount rate agreement.
Billing/Admin Issue	Claim has been manually denied
Billing/Admin Issue	Contract Price on Service Line Manually Overridden to Zero
Billing/Admin Issue	Missing Claim Information
Billing/Admin Issue	Claim appeal request has been processed
Billing/Admin Issue	Claim adjusted per provider request
Billing/Admin Issue	POSITIVE FOR SUBSTANCE ABUSE
Billing/Admin Issue	PROCEDURE CODE NOT CONSISTENT W/DIAG CODE
Billing/Admin Issue	SERVICES NOT CONSISTENT WITH DIAGNOSIS

Category	Description
Billing/Admin Issue	CLAIM MUST BE SUBMITTED ON A UB92 CLAIM FORM
Billing/Admin Issue	PLEASE SUBMIT CLAIM TO MEDICAL CARRIER
Billing/Admin Issue	BILL AS FEE-FOR-SERVICE TO MEDICAID
Billing/Admin Issue	SEND MEDICAL RECORDS
Billing/Admin Issue	SUBMIT OTHER CARRIER EOB
Billing/Admin Issue	Resubmit claim and EOB with the same billed charges
Billing/Admin Issue	RESUBMIT CLAIM W/CORRECT TAX ID#
Billing/Admin Issue	Resubmit claim on CMS 1500 form
Billing/Admin Issue	Resubmit claim with itemized bill
Billing/Admin Issue	INVALID PLACE OF SERVICE
Billing/Admin Issue	SUBMIT MEDICAL RECORDS
Billing/Admin Issue	Resubmit claim and EOB with the same codes
Billing/Admin Issue	Resubmit with primary EOB.
Billing/Admin Issue	PHYS NOT CONTRACTED WITH BILLED VENDOR
Billing/Admin Issue	Authorization number invalid for DOS.
Billing/Admin Issue	Prior authorization is not for same provider.
Billing/Admin Issue	PLEASE SUBMIT TO PROPER CARRIER
Billing/Admin Issue	Original claim decision upheld upon appeal
Billing/Admin Issue	Resubmit ER services with inpatient claim
Billing/Admin Issue	ER Processed on separate claim
Billing/Admin Issue	Code not covered in provider's contract
Billing/Admin Issue	INVALID OR MISSING REVENUE CODE
Billing/Admin Issue	Invalid or Deleted Service Code
Billing/Admin Issue	Invalid or Deleted Diagnosis Code
Billing/Admin Issue	Claim denied. Invalid type of bill.
Billing/Admin Issue	Bill type is inconsistent with services rendered
Billing/Admin Issue	REBILL LATE CHG W/ORIG CLM CHG ON CORRECTED BILL
Billing/Admin Issue	Invalid CPT/HCPCS
Billing/Admin Issue	Invalid Revenue Code
Billing/Admin Issue	Claim denied. Incorrect admit date.
Billing/Admin Issue	BILL MEDICARE / MEDICAID CROSSOVER
Billing/Admin Issue	NEWBORN CHARGES INCL W/MOM'S PER DIEM
Billing/Admin Issue	NO PAY INPT CROSS-OVER CLAIM
Billing/Admin Issue	Place of service is inappropriate with service code
Billing/Admin Issue	Resubmit claim and EOB with EOB paid date
Billing/Admin Issue	Resubmit claim and EOB with same DOS
Billing/Admin Issue	Other insurance did not finalize their consideration
Billing/Admin Issue	Resubmit claim with copy of finalized EOB
Billing/Admin Issue	Payment on claim does not match EOB
Billing/Admin Issue	Claim denied. Requested information not received within 30 days.
Billing/Admin Issue	Included in DRG rate
Billing/Admin Issue	Resubmit claim with HCPCS/CPT codes for pricing
Billing/Admin Issue	Included in per diem
Billing/Admin Issue	Missing POA Indicator
Billing/Admin Issue	Appeal not filed within 60 days of EOP
Billing/Admin Issue	Claim not filed within timely filing guidelines
Billing/Admin Issue	Inappropriate units for date span
Billing/Admin Issue	BILL MEDICAID / MEDICARE CROSS-OVER
Billing/Admin Issue	CLM DENIED/SERVICE DATE DOES NOT MATCH BILLED DATE
Clinical Denied	SERVICE NOT MEDICALLY NECESSARY
Clinical Denied	Medical review denial.
Clinical Denied	Medical necessity not established for services rendered.
Clinical Denied	APPEAL DENIED; SEE LETTER FOR DETAILS
Diagnosis Not Covered	Claim denied. Not a covered diagnosis for service.
Diagnosis Not Covered	Not a covered BHO diagnosis. Please submit to Medicaid Physical Health Payer.
Diagnosis Not Covered	DIAGNOSIS AND/OR PROCEDURE NOT COVERED
Diagnosis Not Covered	NOT A COVERED BHO DIAGNOSIS
Member Not Eligible	Date of Service prior to effective date or after termination date
Member Not Eligible	Member lost eligibility during date span
Member Not Eligible	MEMBER NOT ELIG W/ BHI ON DOS
Member Not Eligible	Patient not eligible with Health Plan on date of service
Member Not Eligible	MEMBER NOT ELIG W/ABC ON DOS
Member Not Eligible	MEMBER NOT ELIG W/CHP ON DOS
Not Authorized	AUTH REQ DENIED - SUFFICIENT INFO NOT REC'D
Not Authorized	AUTH REQ DENIED - SERVICES NOT MED NECESSARY
Not Authorized	AUTH REQ DENIED DUE LATE NOTIFICATION

Category	Description
Not Authorized	AUTH REQ DENIED - NOT A COVERED DIAGNOSIS
Not Authorized	AUTH REQ DENIED - NOT A COVERED BENEFIT
Not Authorized	MAXIMUM NUMBER OF VISITS MET
Not Authorized	Visits exceed the number authorized
Not Authorized	Service denied. No prior authorization obtained.
Not Authorized	Prior authorization is denied.
Service Not Covered	Not a covered benefit under Health Plan
Service Not Covered	SERVICE OR DIAGNOSIS EXCLUDED BY PLAN
Service Not Covered	INPT DAYS EXCEED 45 DAY LIMIT
Service Not Covered	SERVICES NOT COVERED PER CONTRACT
Service Not Covered	Not a covered BHO service. Please submit to Medicaid Physical Health Payer.
Service Not Covered	Annual visit limit has been exceeded

Total Inpatient Claims and Percent Denied 2010-2015 by BHO

	Total Inpatient Claims						% Denied Inpatient Claims					
BHO	2010	2011	2012	2013	2014	2015	2010	2011	2012	2013	2014	2015
ABC-D	1,053	892	1,028	1,016	1,666	1,808	22.0%	23.7%	30.4%	31.9%	26.8%	17.5%
ABC-NE	1,125	886	795	726	750	1,448	27.7%	37.7%	51.2%	46.4%	33.9%	33.9%
BHI	933	871	953	1,063	1,715	1,530	29.7%	33.0%	39.9%	32.3%	30.7%	26.9%
CHP	2,713	2,280	1,830	2,296	3,663	4,372	24.8%	36.0%	39.3%	33.4%	39.2%	37.2%
FBHP	934	756	760	959	1,640	1,789	30.1%	42.3%	51.6%	53.7%	50.2%	42.0%
Total	6,758	5,685	5,366	6,060	9,434	10,947	26.3%	34.7%	41.2%	37.7%	37.0%	32.8%

Total Outpatient Claims and Percent Denied 2010-2015 by BHO

	Total Outpatient Claims						% Denied Outpatient Claims					
BHO	2010	2011	2012	2013	2014	2015	2010	2011	2012	2013	2014	2015
ABC-D	7,619	4,824	4,851	8,246	12,396	13,704	32.6%	31.0%	28.3%	51.6%	12.1%	6.3%
ABC-NE	546	964	2,419	2,324	897	2,408	46.5%	31.5%	37.3%	48.5%	45.6%	48.4%
BHI	1,644	3,028	3,819	4,406	4,147	4,693	59.6%	56.7%	50.2%	45.5%	37.7%	27.4%
CHP	2,688	2,700	3,284	3,560	5,719	6,438	22.5%	28.9%	46.4%	47.1%	48.9%	39.3%
FBHP	1,076	1,414	2,565	2,797	20,730	22,340	50.3%	50.6%	51.8%	60.6%	14.6%	12.2%
Total	13,573	12,930	16,938	21,333	43,889	49,583	35.9%	38.8%	41.6%	50.4%	21.2%	17.3%

Total Inpatient Claims and Percent Denied 2010-2015 by Denial Category by BHO

BHO	Denial Category	# of Inpatient Claims Denied						% of Denied Inpatient Claims					
		2010	2011	2012	2013	2014	2015	2010	2011	2012	2013	2014	2015
ABC-D	Member Not Eligible	16	14	13	9	0	0	6.9%	6.6%	4.2%	2.8%	0.0%	0.0%
	Service Not Covered	1	0	5	6	17	6	0.4%	0.0%	1.6%	1.9%	3.8%	1.9%
	Clinical Denial	1	1	0	0	7	2	0.4%	0.5%	0.0%	0.0%	1.6%	0.6%
	Non-Covered Diagnosis	48	46	70	89	50	12	20.7%	21.8%	22.4%	27.5%	11.2%	3.8%
	Not Authorized	133	124	179	181	282	263	57.3%	58.8%	57.4%	55.9%	63.1%	83.2%
	Billing/Admin Issue	33	26	45	39	91	33	14.2%	12.3%	14.4%	12.0%	20.4%	10.4%
ABC-NE	Member Not Eligible	21	25	38	30	1	0	6.7%	7.5%	9.3%	8.9%	0.4%	0.0%
	Service Not Covered	7	0	2	6	15	125	2.2%	0.0%	0.5%	1.8%	5.9%	25.5%
	Clinical Denial	35	94	149	90	1	7	11.2%	28.1%	36.6%	26.7%	0.4%	1.4%
	Non-Covered Diagnosis	45	42	39	21	49	40	14.4%	12.6%	9.6%	6.2%	19.3%	8.1%
	Not Authorized	85	94	71	79	140	277	27.2%	28.1%	17.4%	23.4%	55.1%	56.4%
	Billing/Admin Issue	119	79	108	111	48	42	38.1%	23.7%	26.5%	32.9%	18.9%	8.6%
BHI	Member Not Eligible	20	21	25	19	2	0	7.2%	7.3%	6.6%	5.5%	0.4%	0.0%
	Service Not Covered	1	3	3	2	19	7	0.4%	1.0%	0.8%	0.6%	3.6%	1.7%
	Clinical Denial	0	4	52	51	8	8	0.0%	1.4%	13.7%	14.9%	1.5%	1.9%
	Non-Covered Diagnosis	22	30	31	35	32	20	7.9%	10.5%	8.2%	10.2%	6.1%	4.9%
	Not Authorized	96	102	184	150	258	231	34.7%	35.5%	48.4%	43.7%	49.0%	56.2%
	Billing/Admin Issue	138	127	85	86	208	145	49.8%	44.3%	22.4%	25.1%	39.5%	35.3%
CHP	Member Not Eligible	89	100	72	66	147	82	13.2%	12.2%	10.0%	8.6%	10.2%	5.0%
	Service Not Covered	2	34	9	21	252	345	0.3%	4.1%	1.3%	2.7%	17.5%	21.2%
	Clinical Denial	56	162	214	196	260	183	8.3%	19.8%	29.8%	25.5%	18.1%	11.3%
	Non-Covered Diagnosis	52	84	43	56	60	59	7.7%	10.2%	6.0%	7.3%	4.2%	3.6%
	Not Authorized	154	85	107	133	451	629	22.9%	10.4%	14.9%	17.3%	31.4%	38.7%
	Billing/Admin Issue	319	355	274	296	267	328	47.5%	43.3%	38.1%	38.5%	18.6%	20.2%
FBHP	Member Not Eligible	18	36	49	53	51	24	6.4%	11.3%	12.5%	10.3%	6.2%	3.2%
	Service Not Covered	2	2	1	15	119	103	0.7%	0.6%	0.3%	2.9%	14.5%	13.7%
	Clinical Denial	35	95	127	145	139	148	12.5%	29.7%	32.4%	28.2%	16.9%	19.7%
	Non-Covered Diagnosis	23	31	31	28	36	22	8.2%	9.7%	7.9%	5.4%	4.4%	2.9%
	Not Authorized	91	93	96	120	366	315	32.4%	29.1%	24.5%	23.3%	44.5%	41.9%
	Billing/Admin Issue	112	63	88	154	112	140	39.9%	19.7%	22.4%	29.9%	13.6%	18.6%

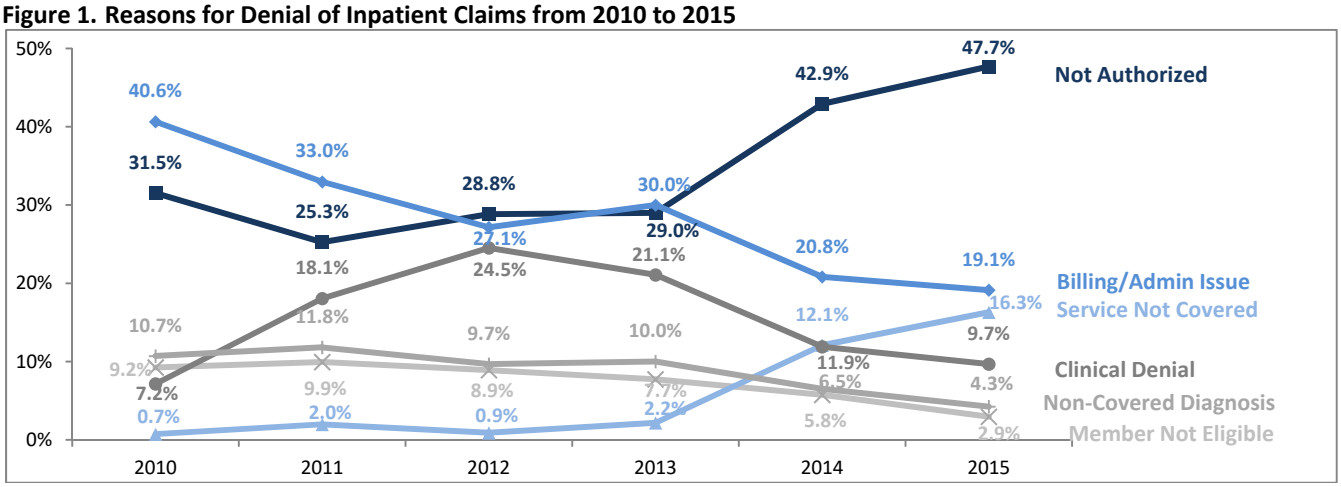
Total Outpatient Claims and Percent Denied 2010-2015 by Denial Category by BHO

BHO	Denial Category	# of Inpatient Claims Denied						% of Denied Inpatient Claims					
		2010	2011	2012	2013	2014	2015	2010	2011	2012	2013	2014	2015
ABC-D	Member Not Eligible	159	129	106	73	1	0	6.4%	8.6%	7.7%	1.7%	0.1%	0.0%
	Service Not Covered	1,077	367	261	2,747	213	144	43.3%	24.6%	19.0%	64.5%	14.2%	16.7%
	Clinical Denial	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Non-Covered Diagnosis	1,042	722	852	1,113	774	369	41.9%	48.3%	62.1%	26.2%	51.5%	42.9%
	Not Authorized	6	11	28	2	78	57	0.2%	0.7%	2.0%	0.0%	5.2%	6.6%
	Billing/Admin Issue	203	265	126	321	438	291	8.2%	17.7%	9.2%	7.5%	29.1%	33.8%
ABC-NE	Total	2,487	1,494	1,373	4,256	1,504	861	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	Member Not Eligible	48	29	64	92	0	0	18.9%	9.5%	7.1%	8.2%	0.0%	0.0%
	Service Not Covered	19	13	61	252	4	13	7.5%	4.3%	6.8%	22.4%	1.0%	1.1%
	Clinical Denial		4	2	20	0	0	0.0%	1.3%	0.2%	1.8%	0.0%	0.0%
	Non-Covered Diagnosis	82	66	310	80	169	349	32.3%	21.7%	34.4%	7.1%	41.3%	29.9%
	Not Authorized	36	59	226	144	205	739	14.2%	19.4%	25.1%	12.8%	50.1%	63.4%
BHI	Billing/Admin Issue	69	133	239	538	31	65	27.2%	43.8%	26.5%	47.8%	7.6%	5.6%
	Total	254	304	902	1,126	409	1,166	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	Member Not Eligible	44	66	67	92	0	0	4.5%	3.8%	3.5%	4.6%	0.0%	0.0%
	Service Not Covered	14	42	206	143	203	124	1.4%	2.4%	10.7%	7.1%	13.0%	9.6%
	Clinical Denial	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Non-Covered Diagnosis	78	166	165	307	342	282	8.0%	9.7%	8.6%	15.3%	21.9%	21.9%
CHP	Not Authorized	601	991	1,193	771	63	107	61.3%	57.7%	62.2%	38.5%	4.0%	8.3%
	Billing/Admin Issue	243	452	286	692	954	773	24.8%	26.3%	14.9%	34.5%	61.1%	60.1%
	Total	980	1,717	1,917	2,005	1,562	1,286	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	Member Not Eligible	115	149	160	165	628	169	19.0%	19.1%	10.5%	9.8%	22.4%	6.7%
	Service Not Covered	78	89	109	226	532	386	12.9%	11.4%	7.1%	13.5%	19.0%	15.3%
	Clinical Denial	5	0	22	24	71	38	0.8%	0.0%	1.4%	1.4%	2.5%	1.5%
FBHP	Non-Covered Diagnosis	149	145	206	234	61	191	24.6%	18.6%	13.5%	14.0%	2.2%	7.5%
	Not Authorized	54	159	394	277	355	582	8.9%	20.4%	25.8%	16.5%	12.7%	23.0%
	Billing/Admin Issue	205	238	634	750	1,151	1,165	33.8%	30.5%	41.6%	44.7%	41.1%	46.0%
	Total	606	780	1,525	1,676	2,798	2,531	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	Member Not Eligible	65	54	139	114	597	196	12.0%	7.5%	10.5%	6.7%	19.8%	7.2%
	Service Not Covered	72	61	98	283	764	657	13.3%	8.5%	7.4%	16.7%	25.3%	24.1%

Reasons for Authorization and Claim Denials

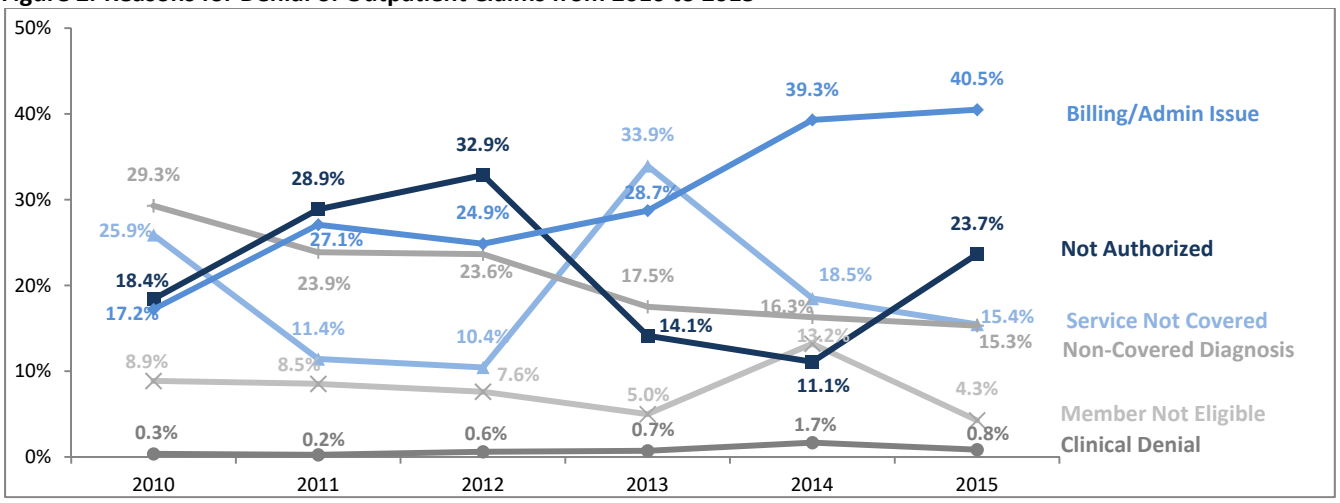
- The percentage of inpatient claims denied due to a prior authorizations being denied or a provider not securing an authorization (Not Authorized) generally increased, accounting for nearly half of claims denials in 2014 and 2015. The percentage inpatient claims denied due to billing/administrative issues decreased by 22% from 2010 to 2015. There was a consistent increase in the percentage of inpatient claims denied as a result of the service not being BHO-covered. The percentage of denials due to a non-covered diagnosis and non-eligibility was been relatively small and generally decreased from 2010 to 2015.

Figure 1. Reasons for Denial of Inpatient Claims from 2010 to 2015

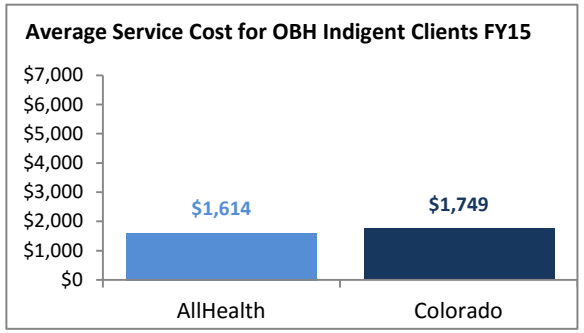


- For the most part, the percentage of denials of outpatient claims for billing/administrative issues steadily increased, accounting for nearly half of denials in 2014 and 2015. The pattern of denials due to not securing an authorization varied, increasing from 2010 to 2012, decreasing from 2012 to 2014, and increasing from 2014 to 2015. Denials due to non-covered diagnoses steadily decreased. Denials to due non eligibility generally hovered around 10%, with a slight uptick in 2014 and a slight downtick in 2015. A consistently small percentage of denials were due to a lack of clinical justification.

Figure 2. Reasons for Denial of Outpatient Claims from 2010 to 2015



CMHC: AllHealth Network



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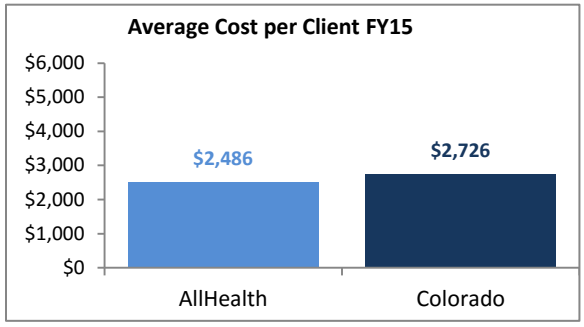

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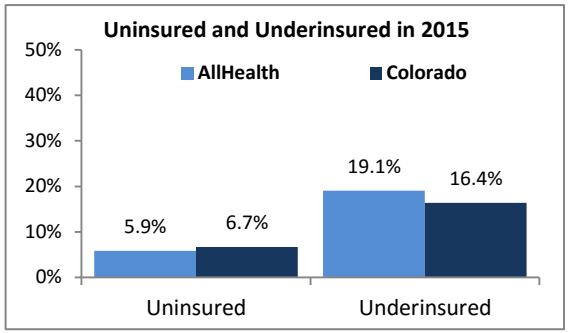

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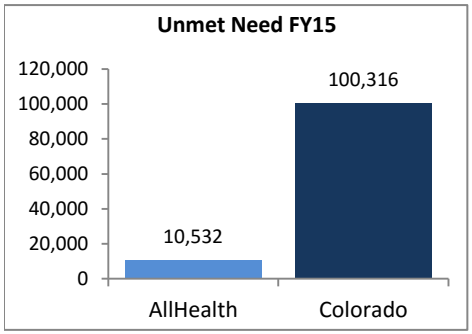

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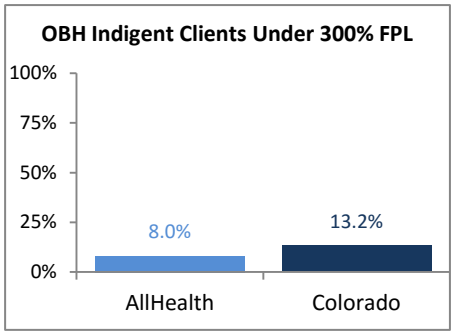

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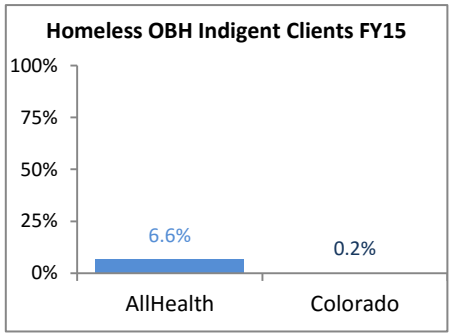

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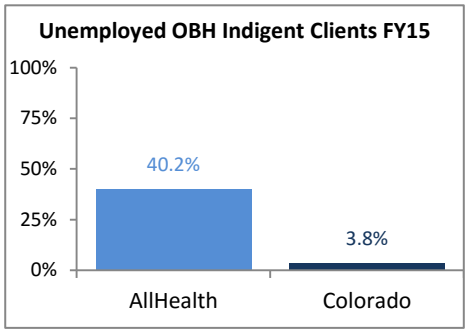

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[3]State rate of unemployment retrieved from US Department of Labor, Bureau of Labor Statistics: http://beta.bls.gov/dataViewer/view/timeseries/LASST080000000000003;jsessionid=89D22CE2010F64D3E24E0C12D09EB536.tc_instance6

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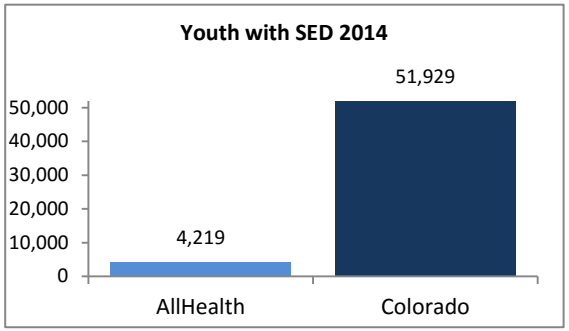

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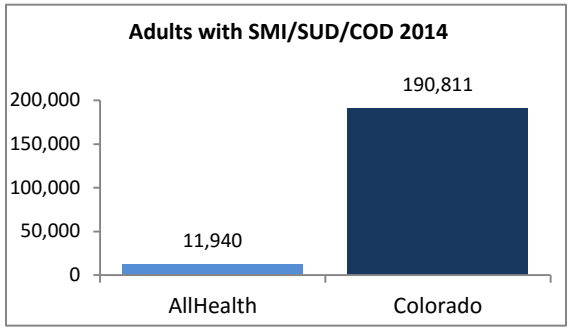

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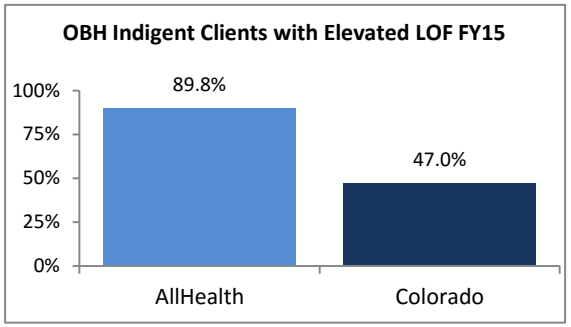

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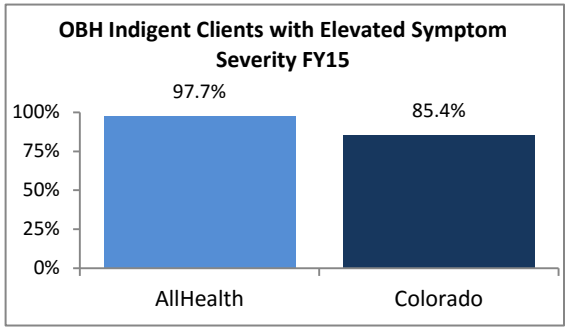

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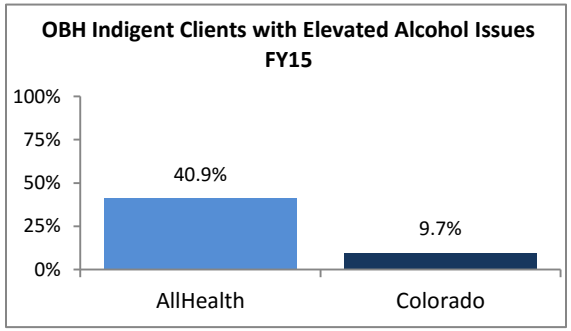

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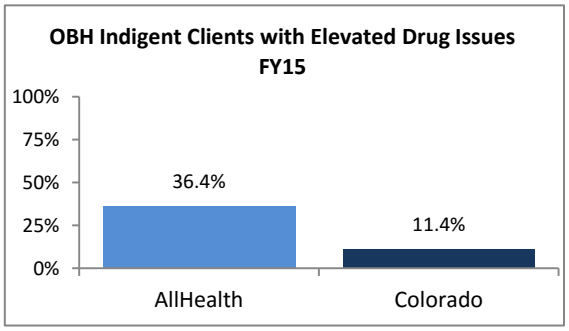

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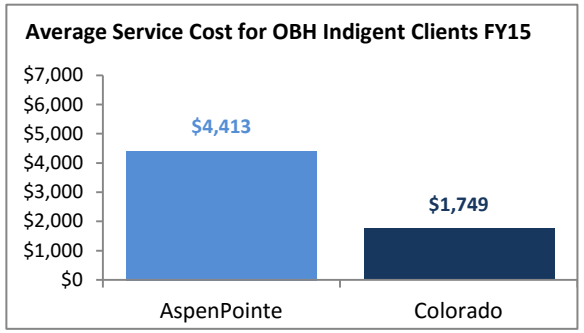

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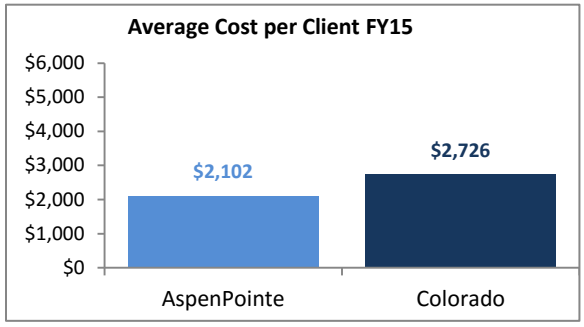

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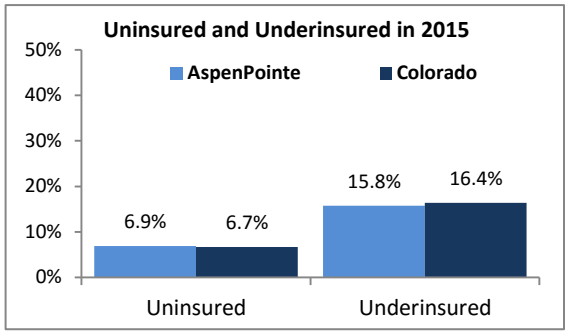

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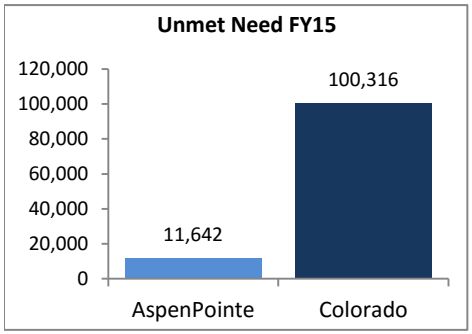

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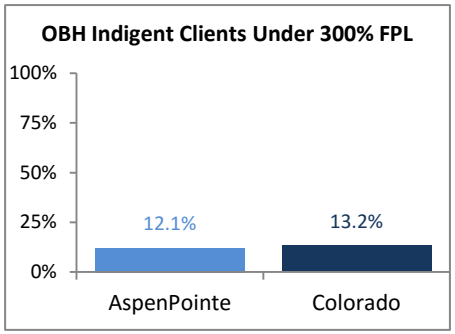

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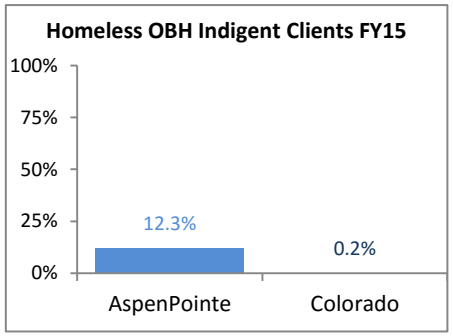

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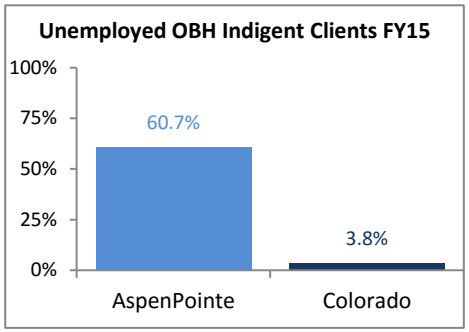

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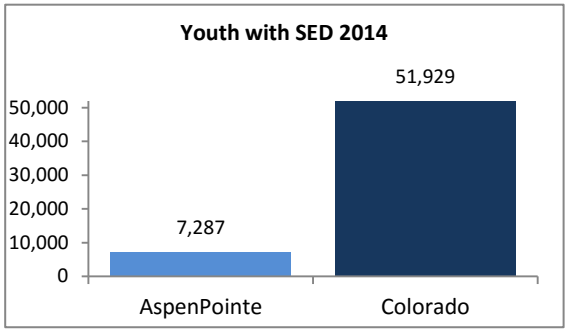

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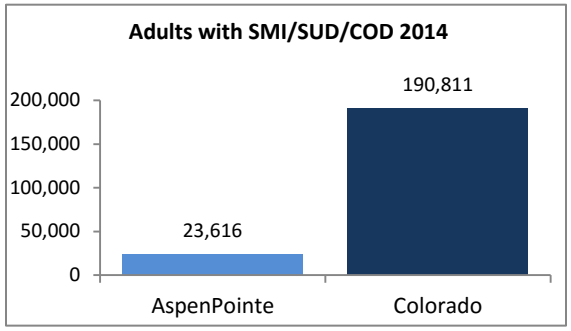

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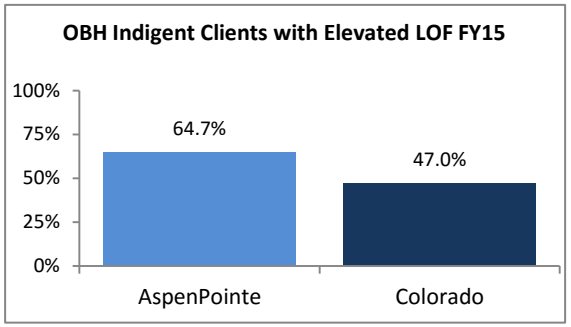

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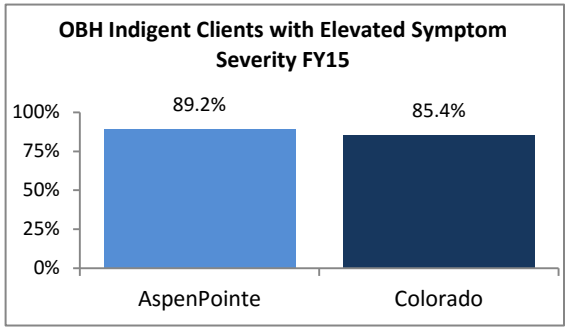

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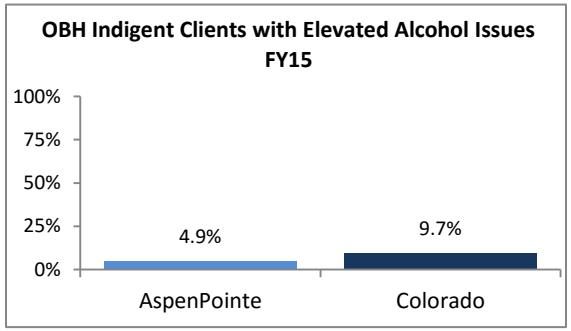

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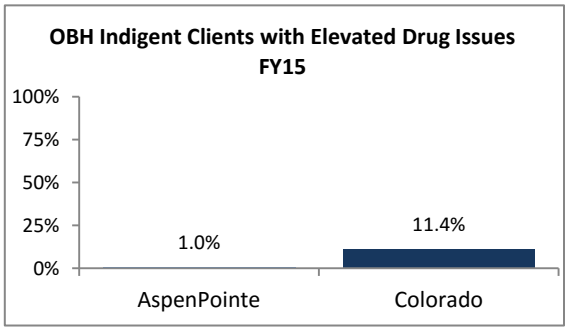

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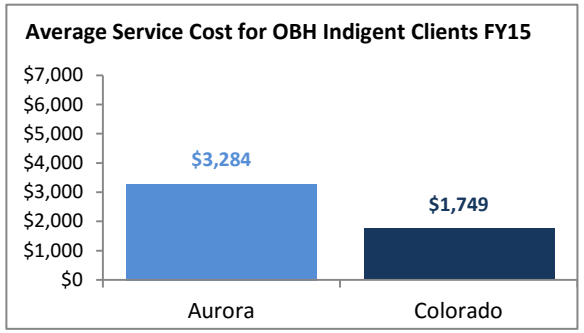

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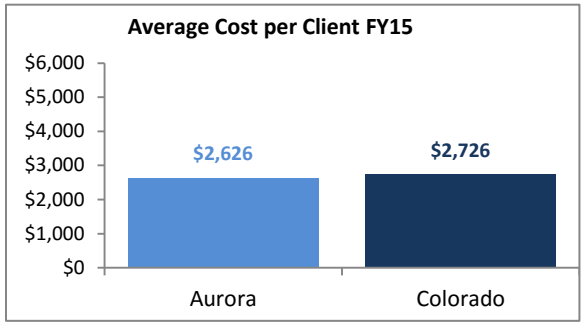

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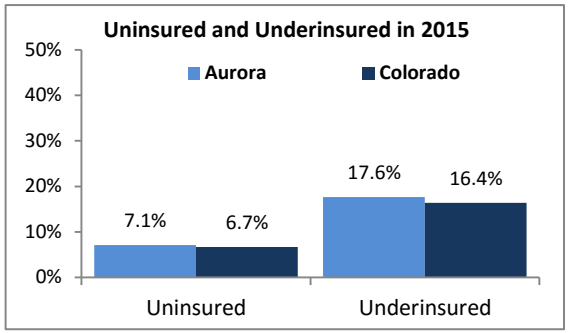

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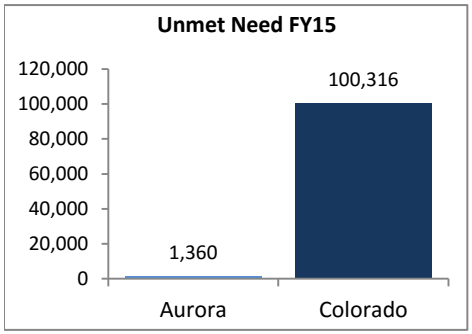

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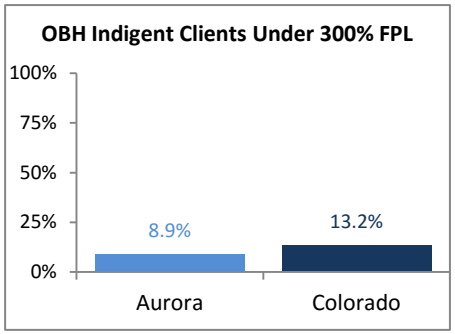

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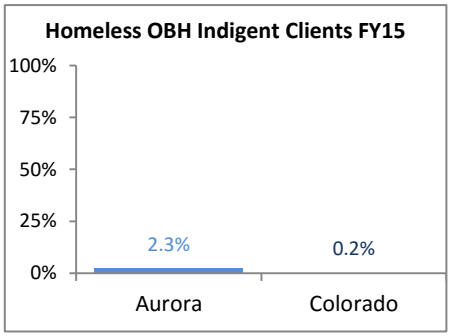

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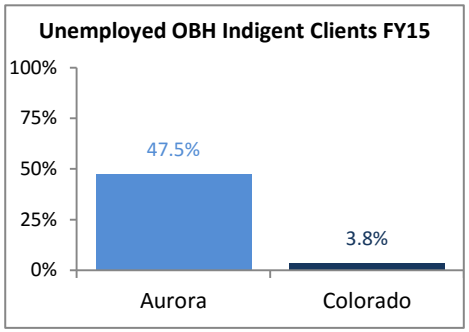

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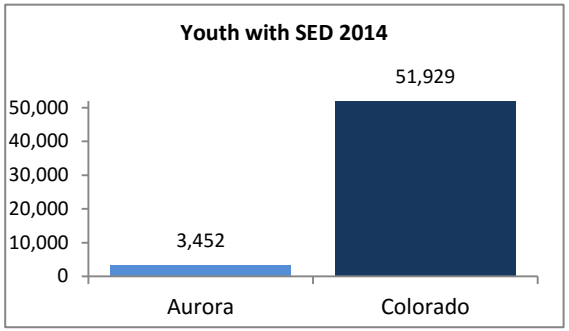

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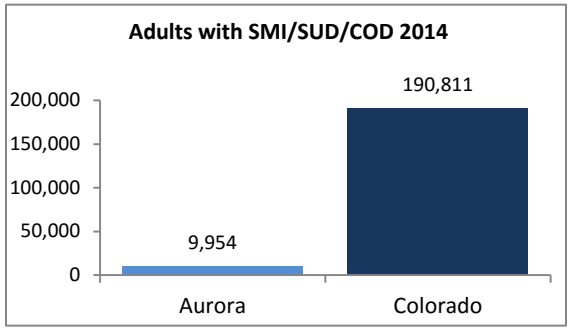

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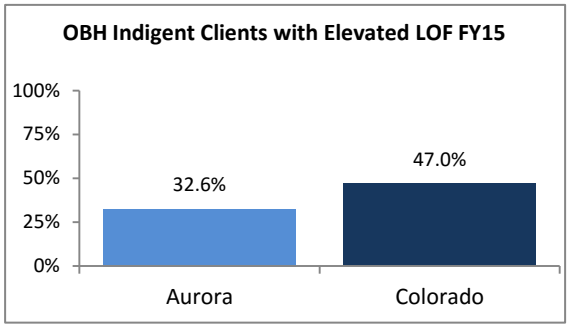

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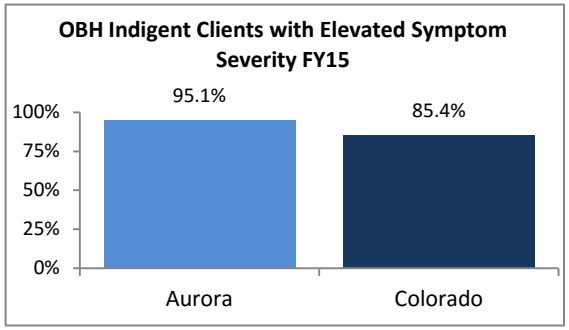

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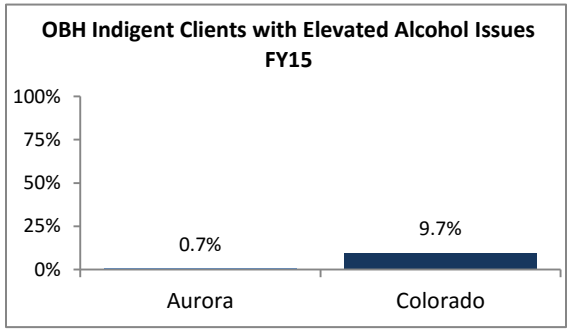

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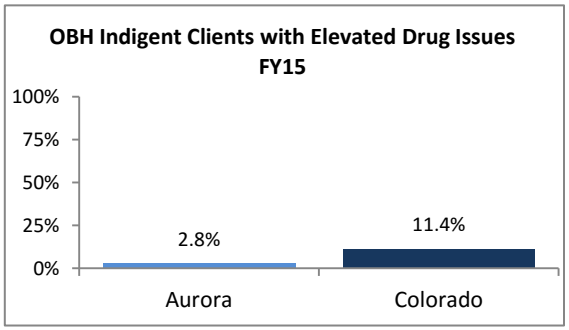

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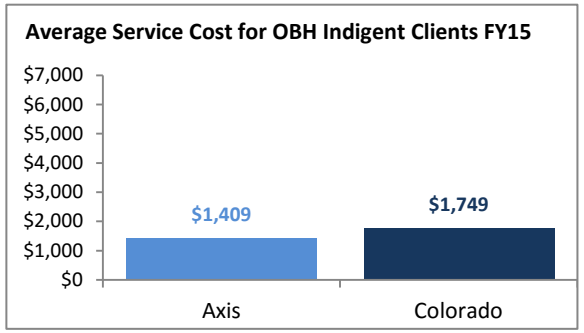
CMHC: Axis Health System, Inc.



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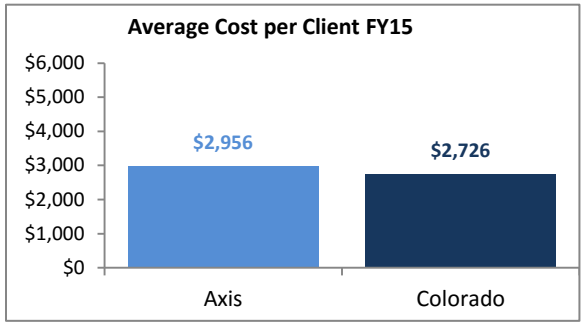

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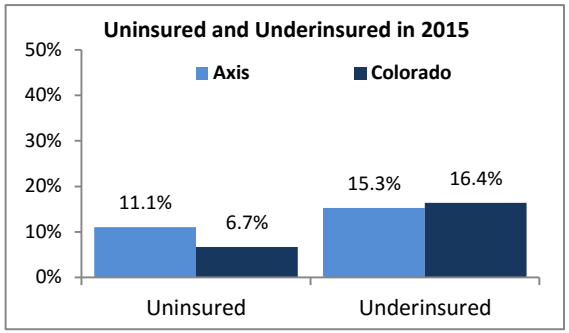

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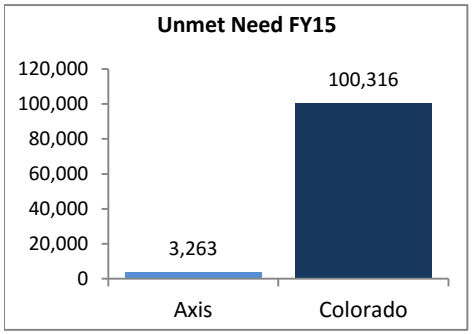

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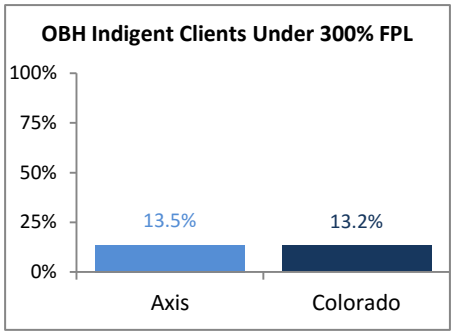

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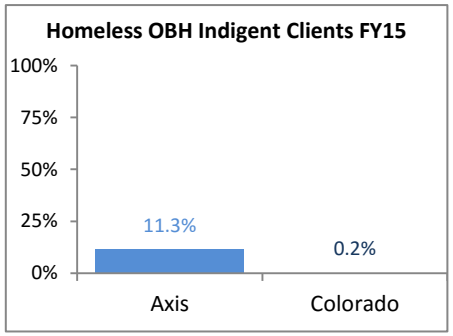

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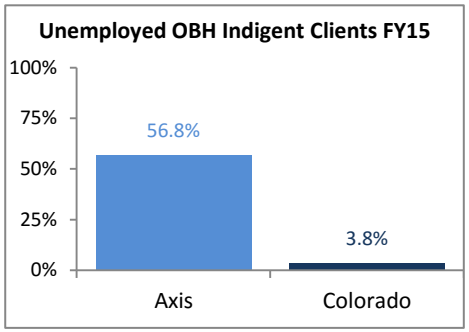

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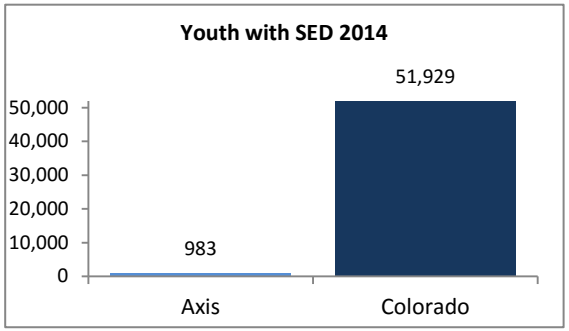

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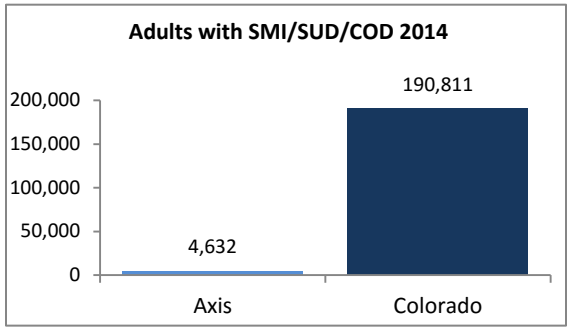

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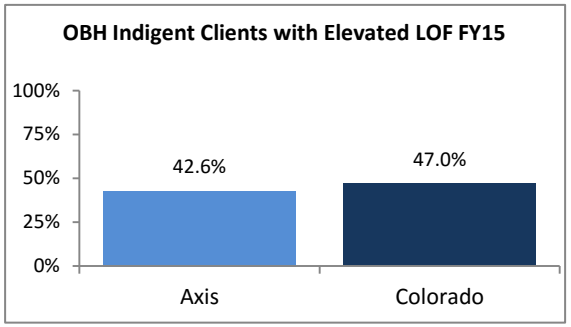

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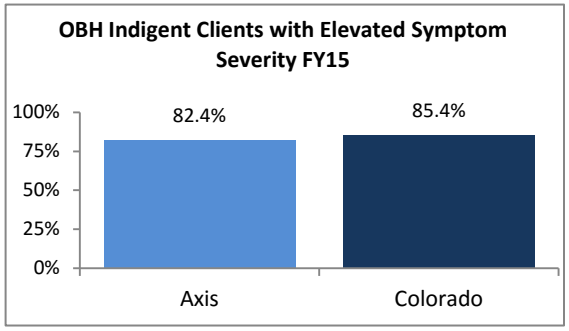

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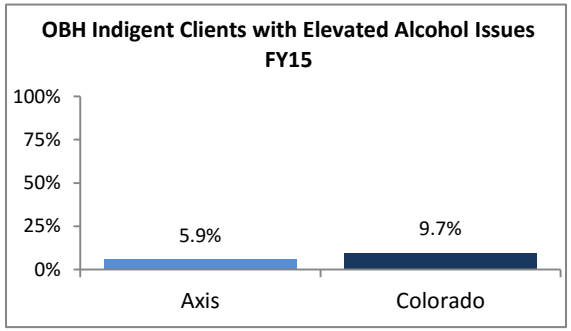

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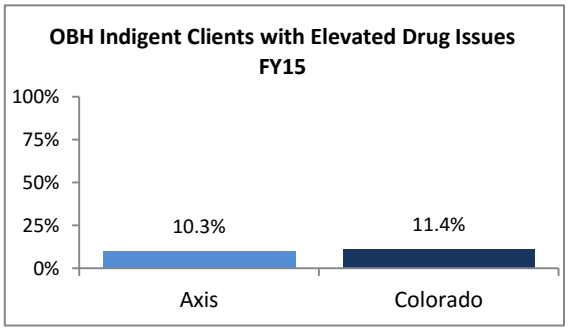

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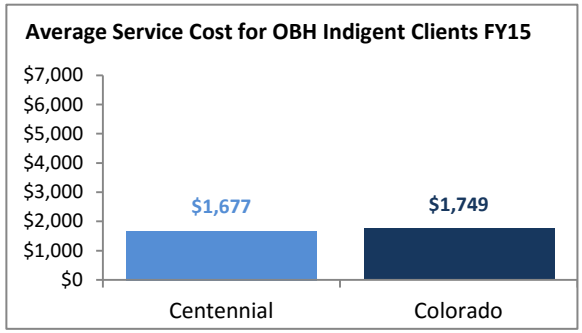

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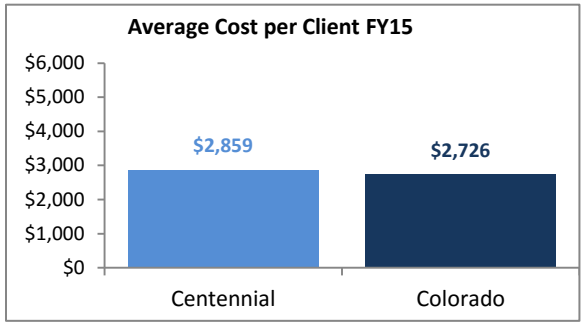

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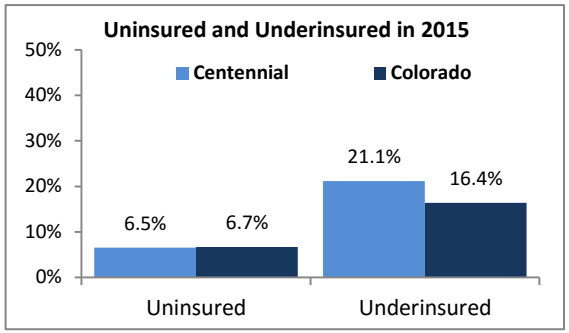

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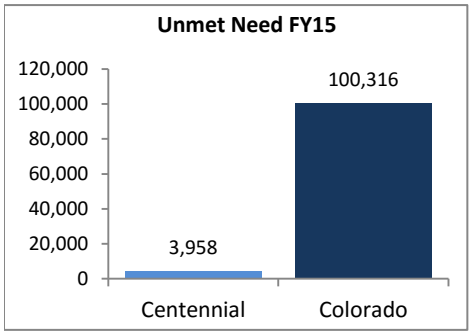

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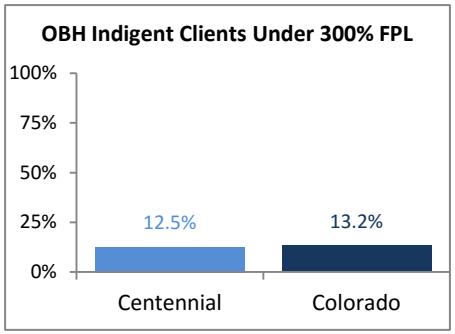

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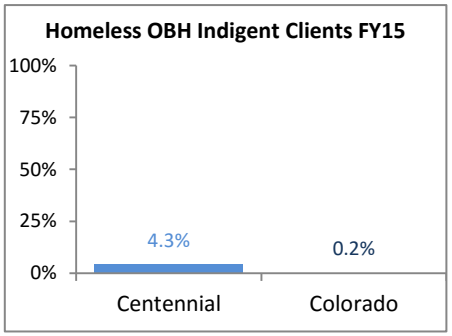

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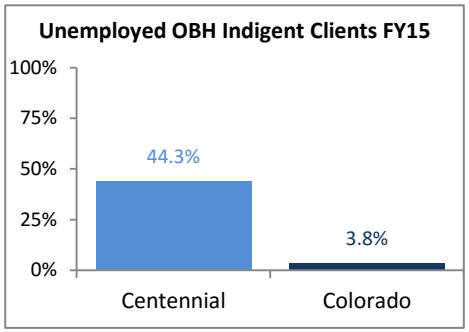

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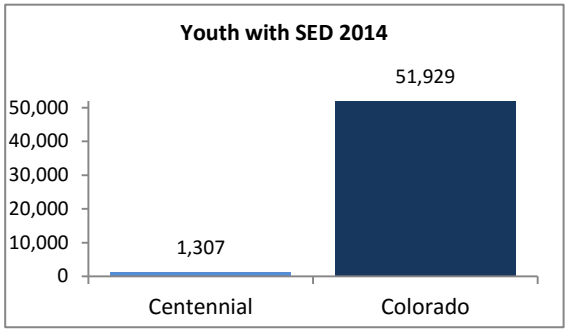

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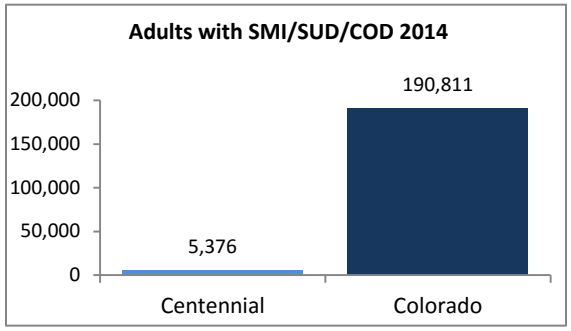

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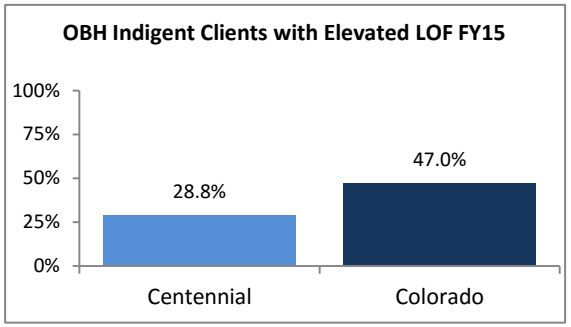

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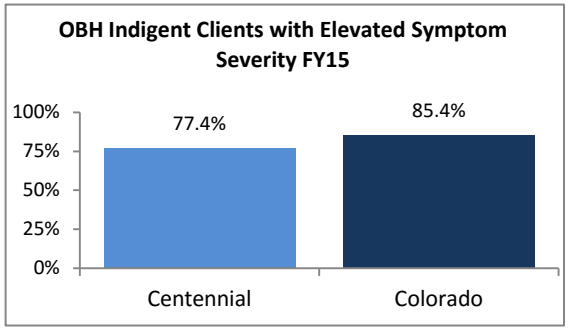

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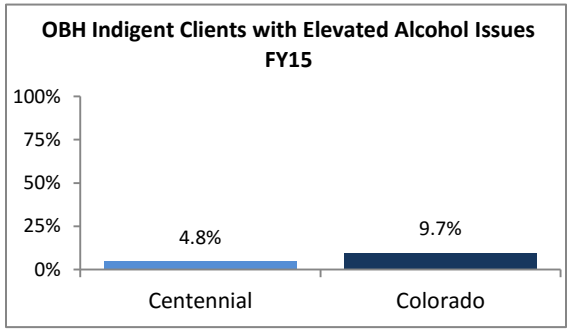

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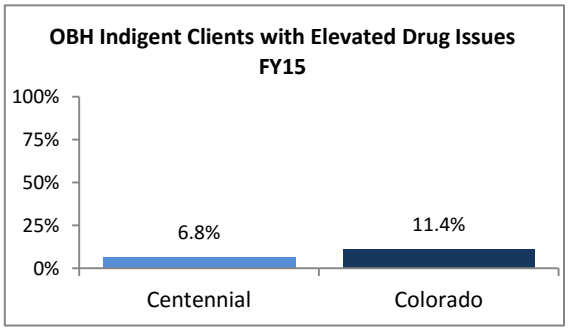

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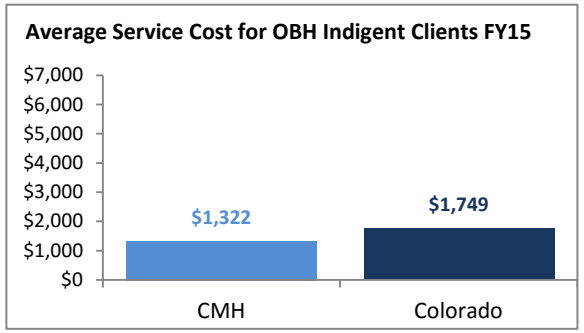

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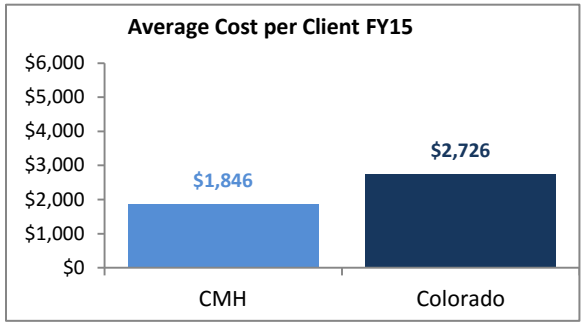

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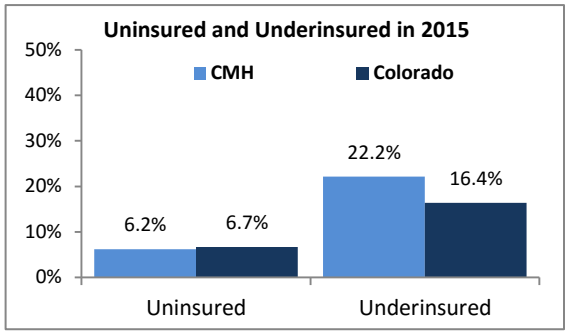

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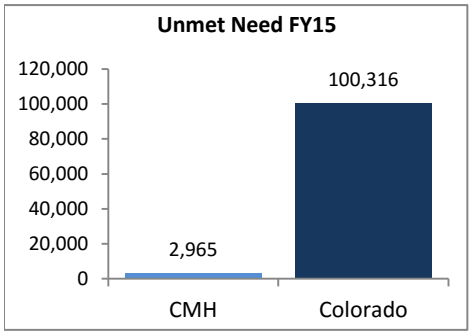

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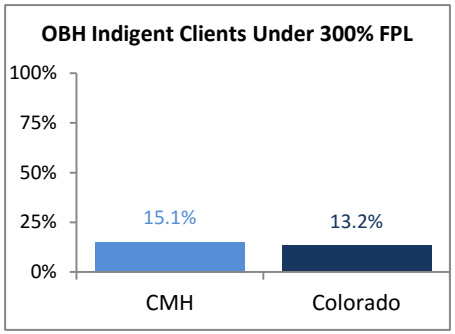

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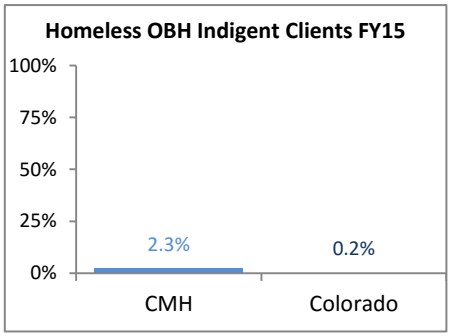

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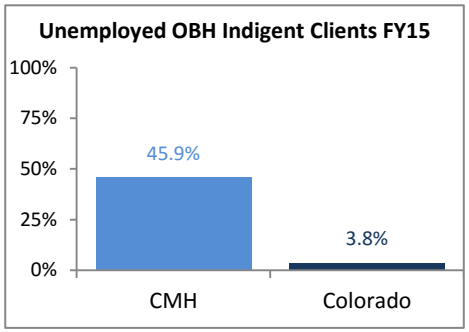

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[3]State rate of unemployment retrieved from US Department of Labor, Bureau of Labor Statistics: http://beta.bls.gov/dataViewer/view/timeseries/LASST080000000000003;jsessionid=89D22CE2010F64D3E24E0C12D09EB536.tc_instance6

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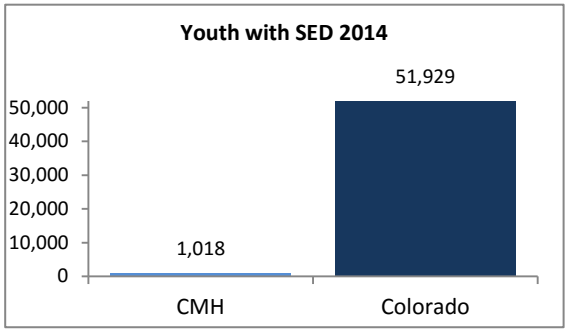

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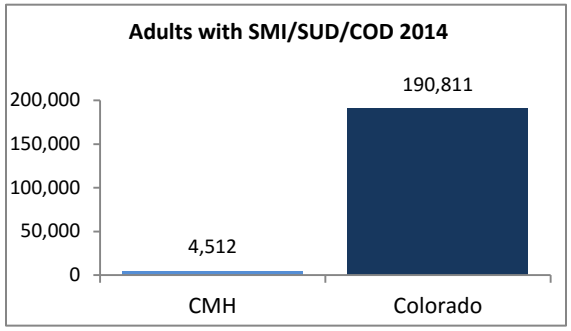

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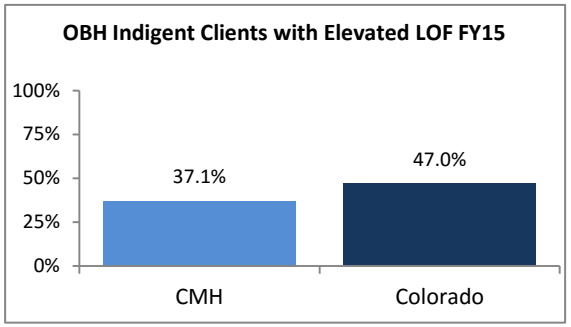

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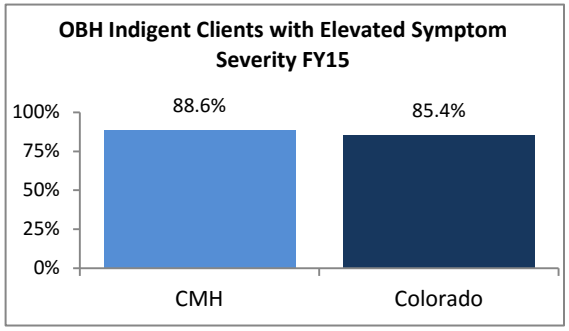

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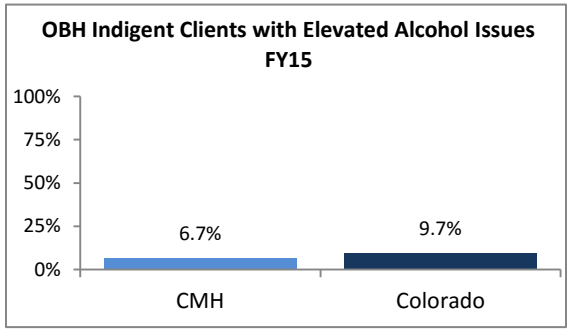

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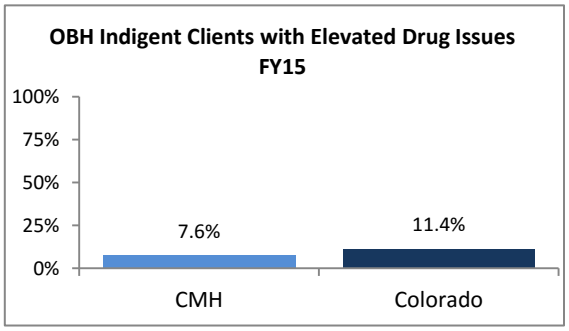

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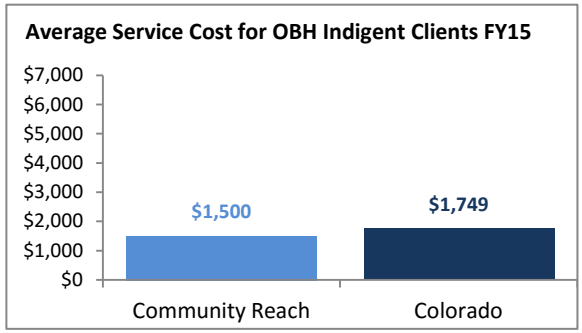
CMHC: Community Reach Center



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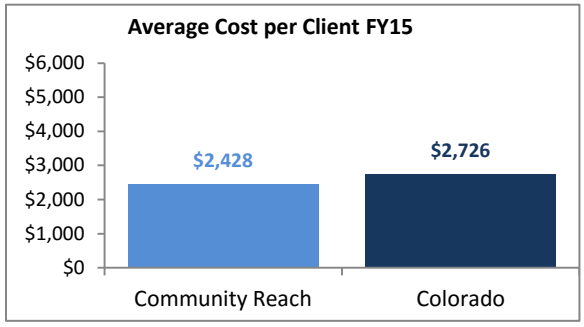

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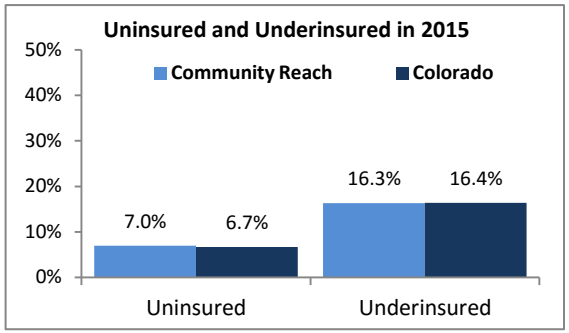

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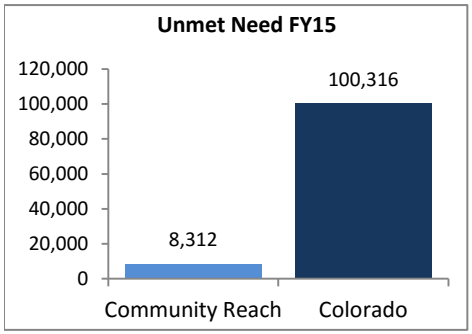

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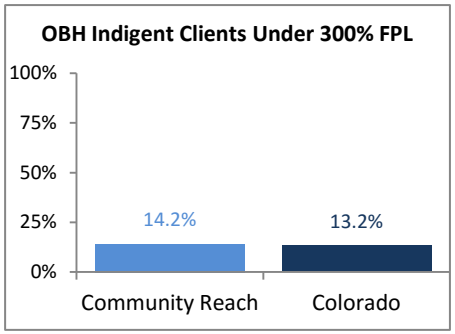

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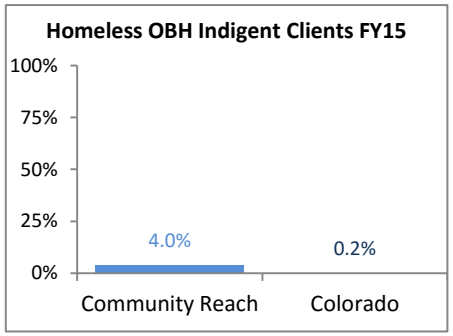

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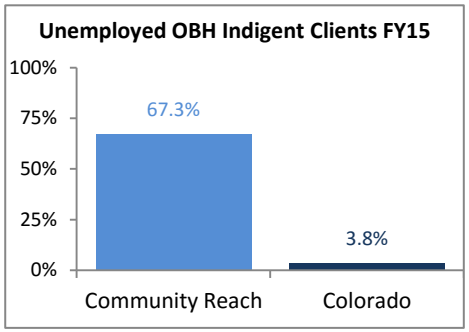

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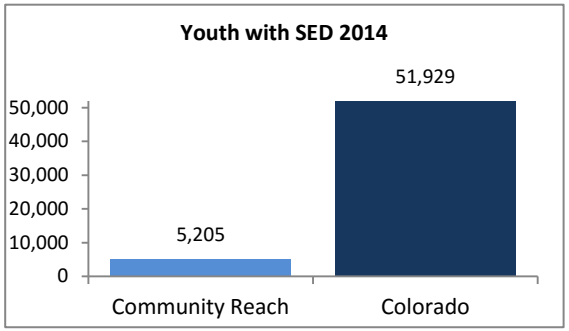

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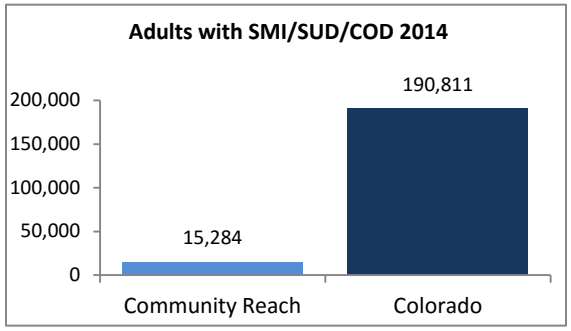

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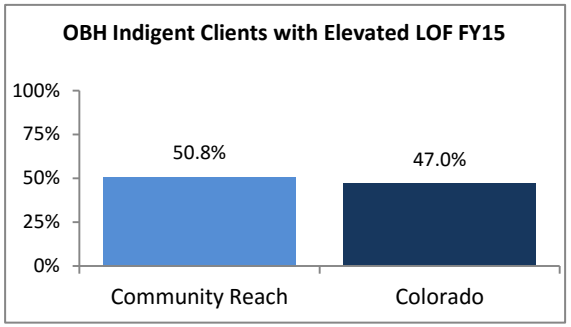

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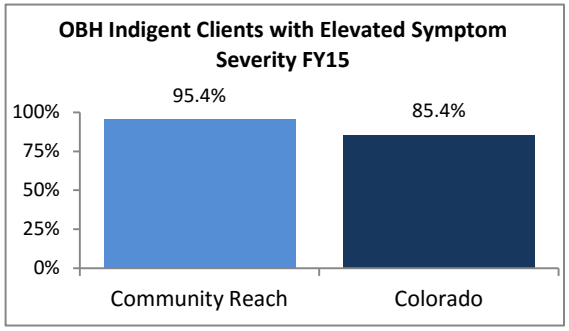

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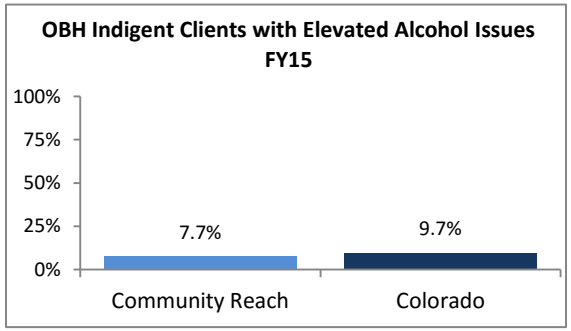

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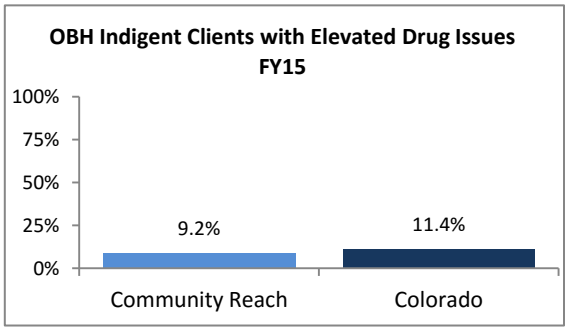

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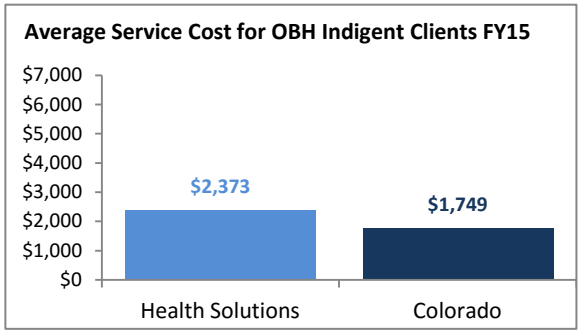

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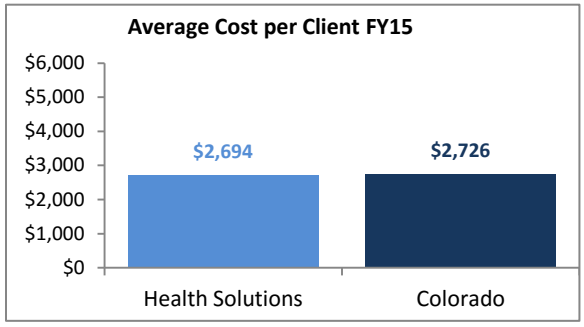

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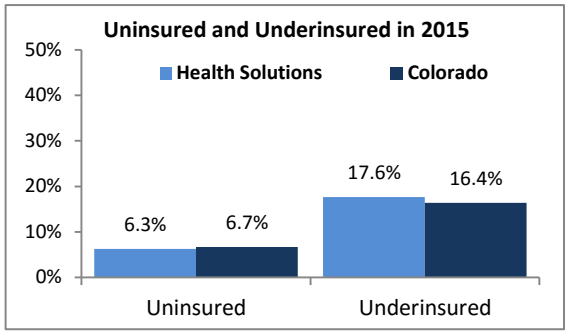

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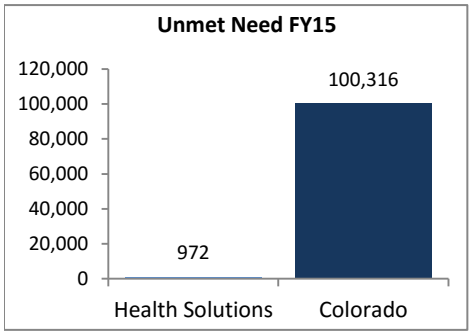

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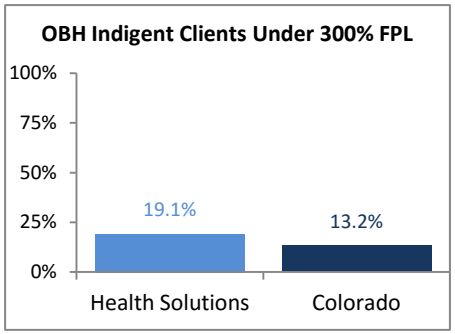

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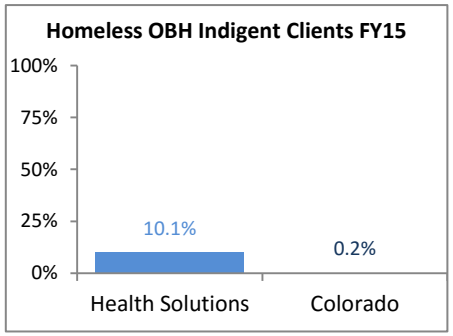

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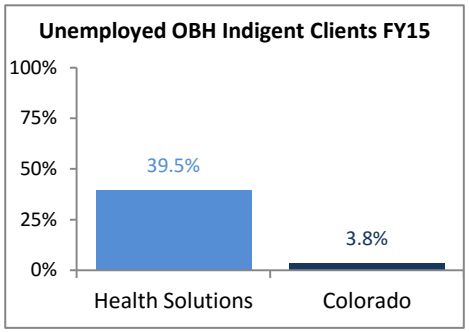

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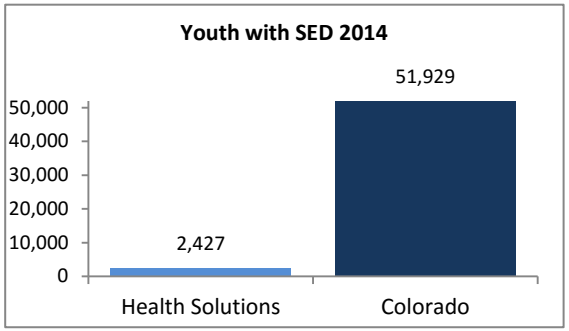
CMHC: Health Solutions



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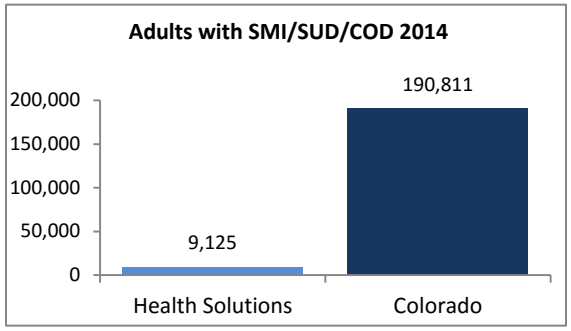

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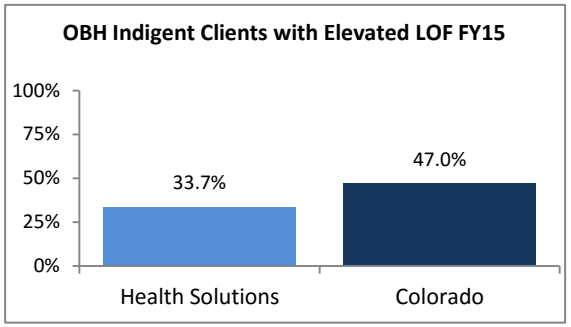

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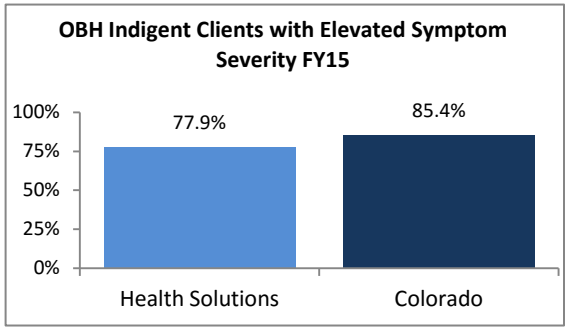

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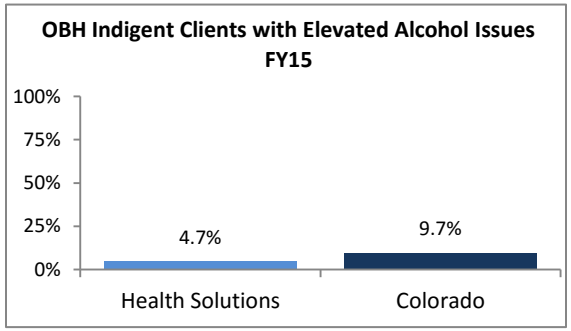

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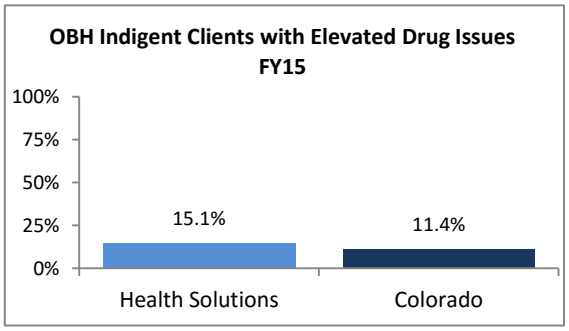

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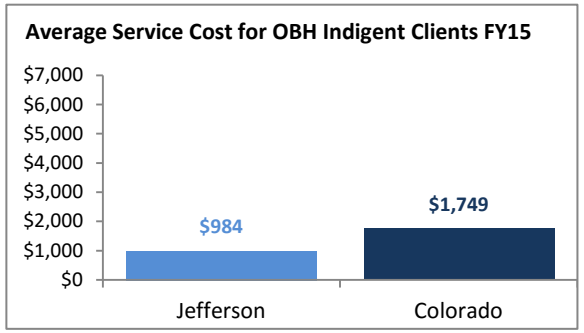

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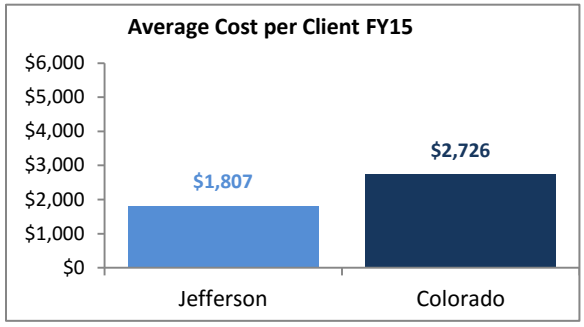

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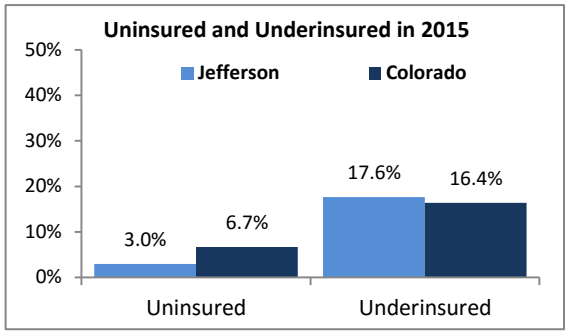

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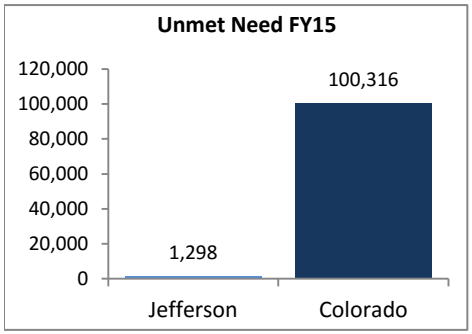

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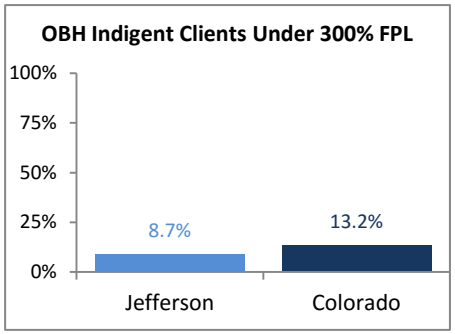

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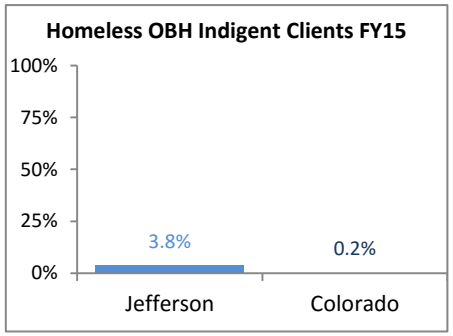

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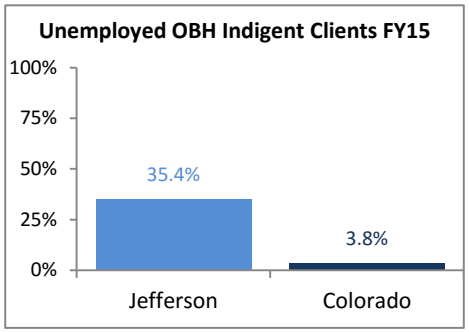

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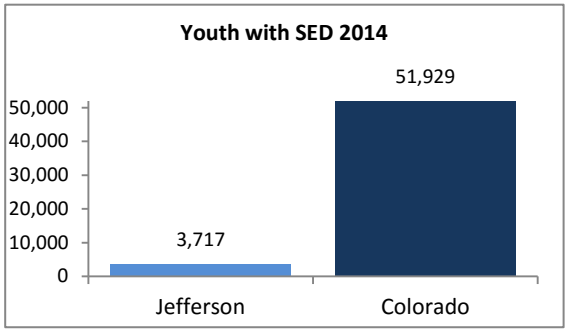

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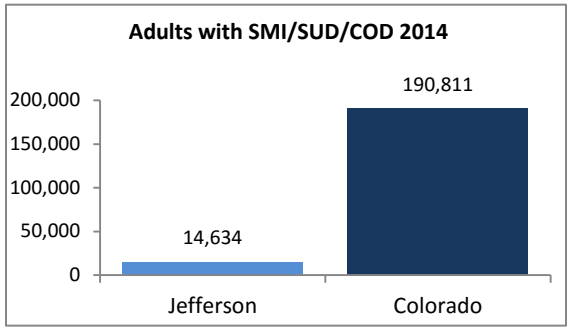

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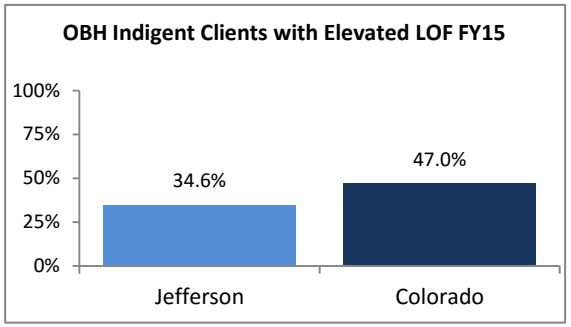

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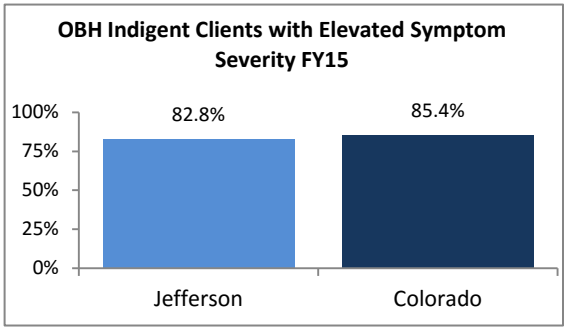

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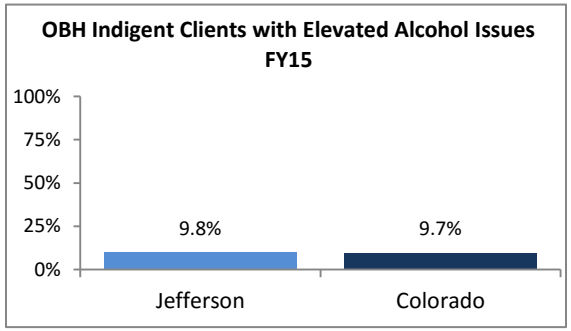

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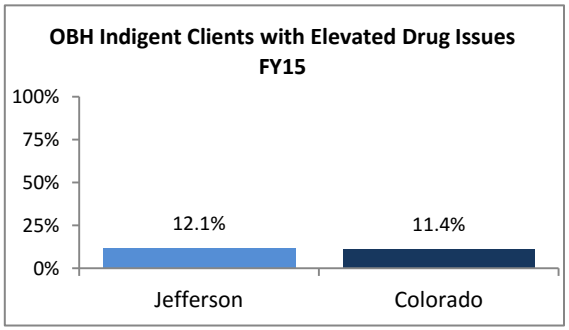

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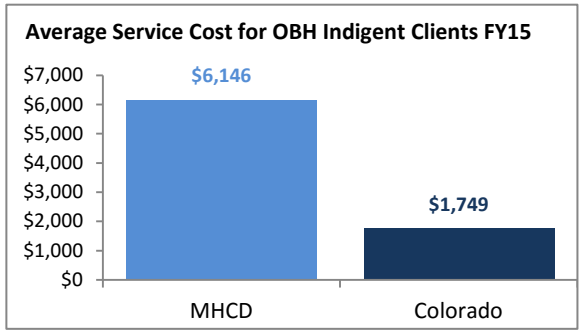

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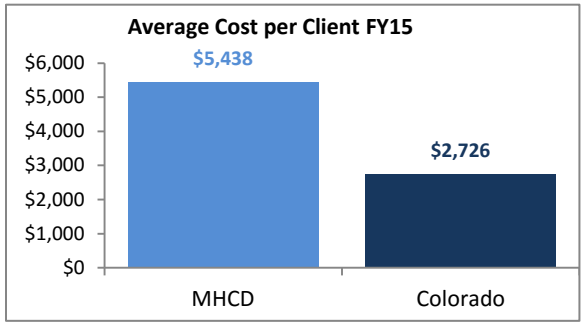

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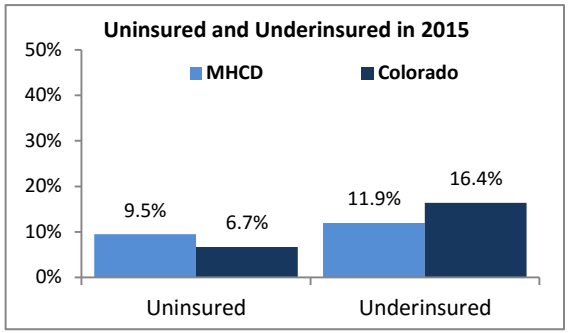

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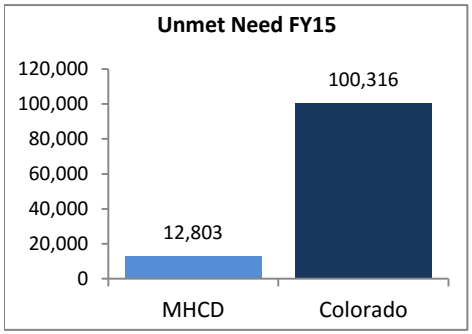

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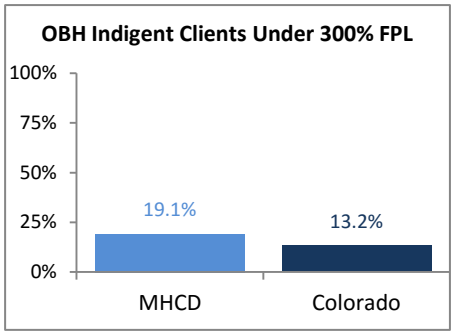

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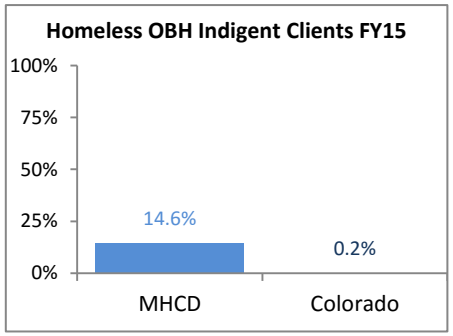

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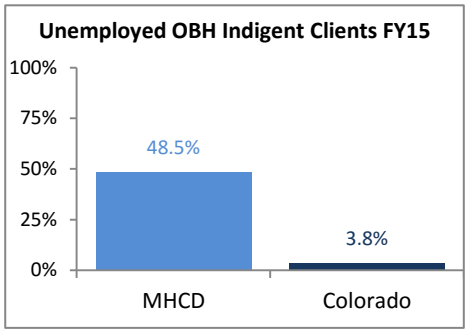

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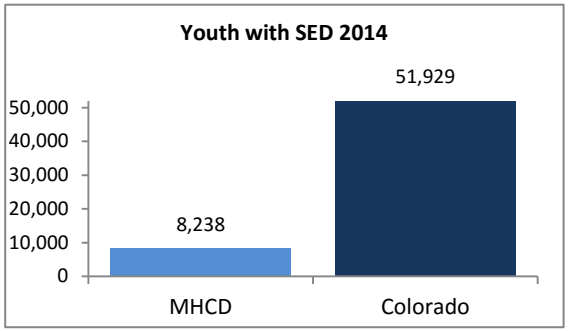

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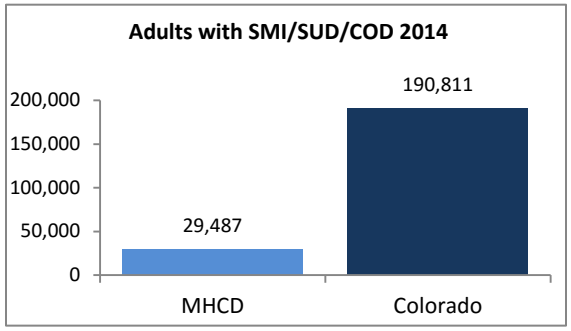

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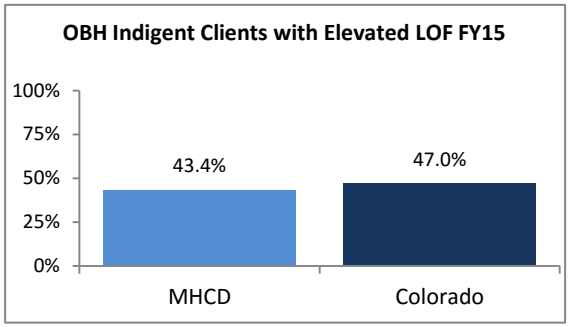

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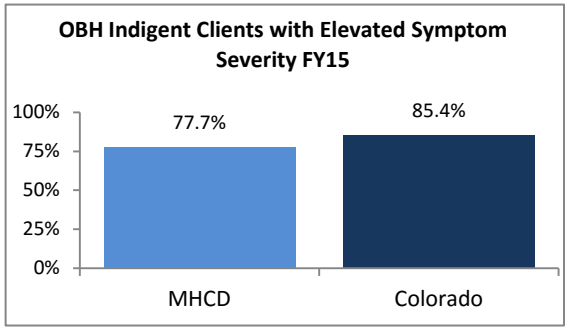

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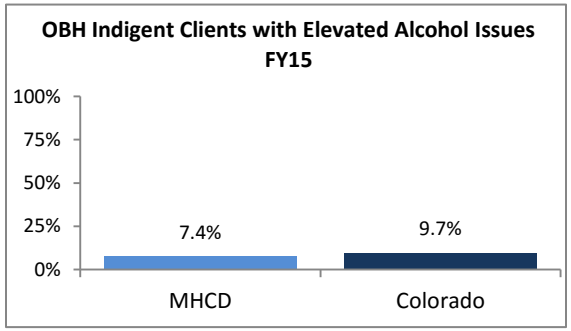

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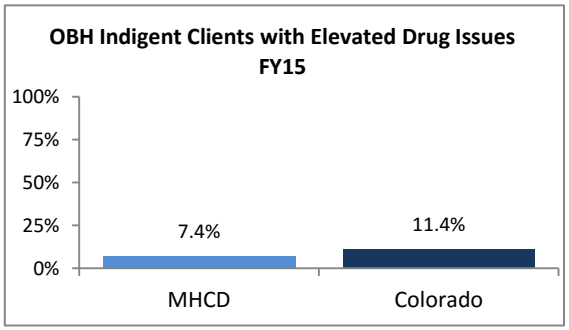

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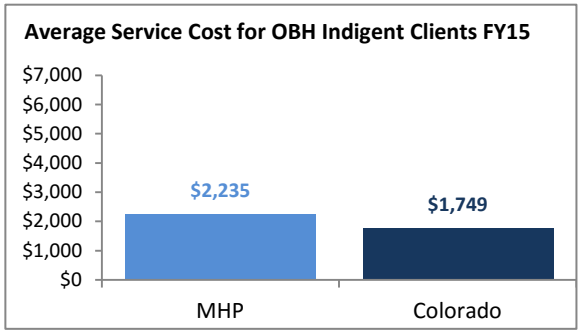
[4]WICHE, *Colorado Population in Need-2009* , November 2009.
[5]Population data is reported by Calendar Year versus State Fiscal Year and was obtained from the State Demography Office website: https://demography.dola.colorado.gov/

CMHC: Mental Health Partners



Data source: OBH encounters.
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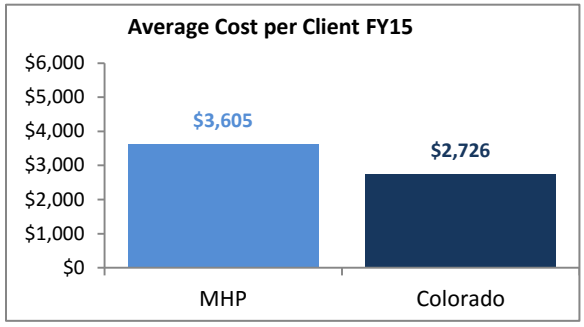
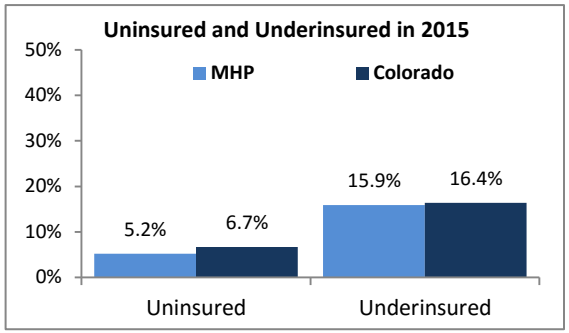
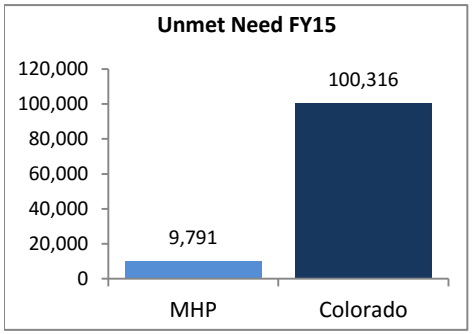


Data source: Milliman.
Includes all clients served by CMHCs.



Data source: Colorado Health Institute, Colorado Health Access Survey (CHAS)[1].
Underinsured have health insurance but their out-of-pocket medical costs represent 10% or more of their annual income (or 5% of income for those below 200% of the federal poverty level). Data for the State's Health Statistics Regions were aggregated to the CMHC area based on population percentages. Data represents uninsured/underinsured as a percentage of the total population.



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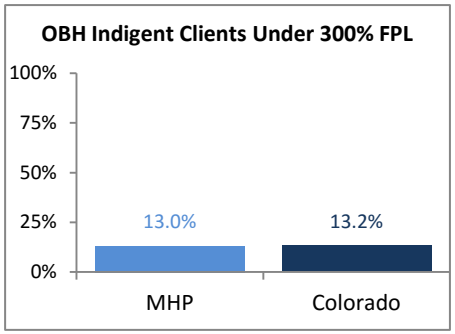

Data source: US Census Bureau.
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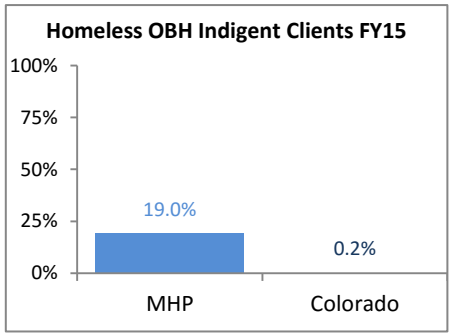

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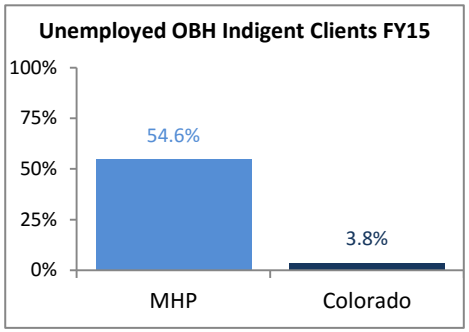


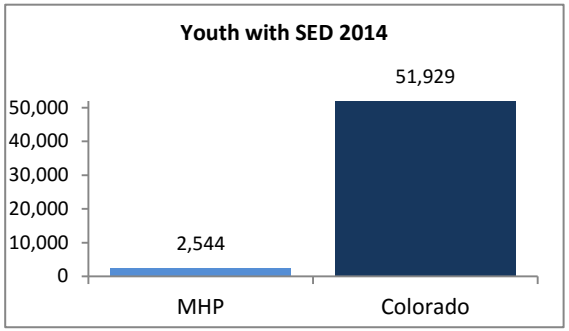
Data source: CMHC-Colorado Client Assessment Record (CCAR); Colorado-US Department of Labor[3].
Colorado data represents the statewide rate in July 2015. CMHC data represents the percentage of OBH indigent adult clients served during FY15 who had a matching CCAR which indicated that the client reported not being employed, but may be looking for employment.

[1]Data were obtained from the Colorado Health Institute's CHAS Online and Interactive analysis section and data section: www.coloradohealthinstitute.org/key-issues/detail/health-coverage-and-the-uninsured/colorado-health-access-survey-1

[2]The State of Homelessness in America, Washington, DC: National Alliance to End Homelessness, 2016. Retrieved from: www.endhomelessness.org/page/-/files/2016%20State%20Of%20Homelessness.pdf

[3]State rate of unemployment retrieved from US Department of Labor, Bureau of Labor Statistics: http://beta.bls.gov/dataViewer/view/timeseries/LASST080000000000003;jsessionid=89D22CE2010F64D3E24E0C12D09EB536.tc_instance6

CMHC: Mental Health Partners



Data source: 2009 Colorado Population (PIN) study[5] and the State Demography Office[6].
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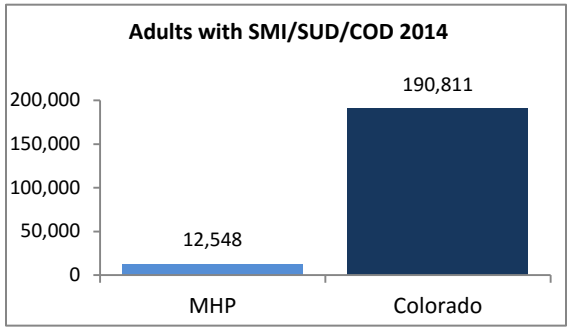

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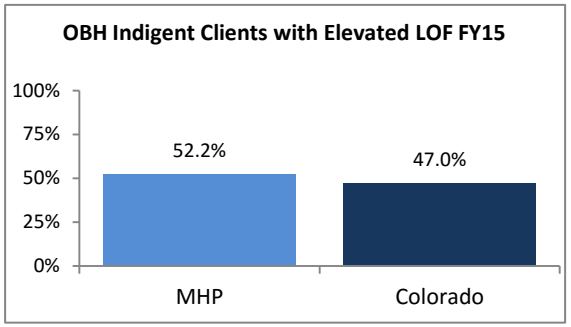

Data source: Colorado Client Assessment Record (CCAR).
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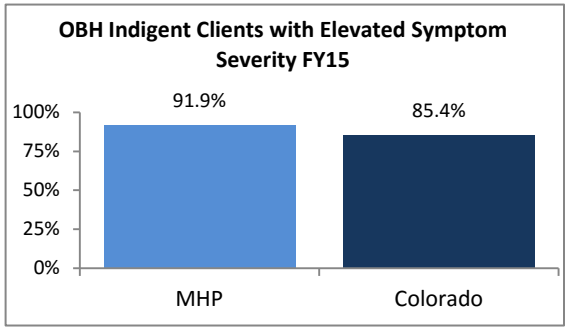

Data source: Colorado Client Assessment Record (CCAR)
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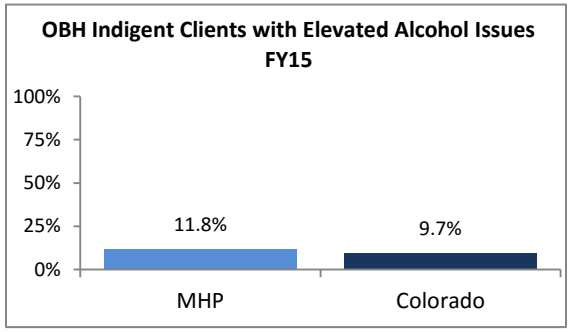

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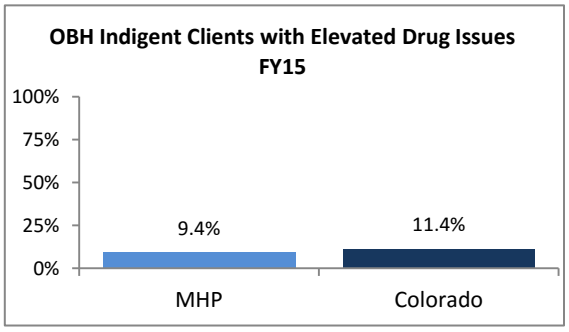

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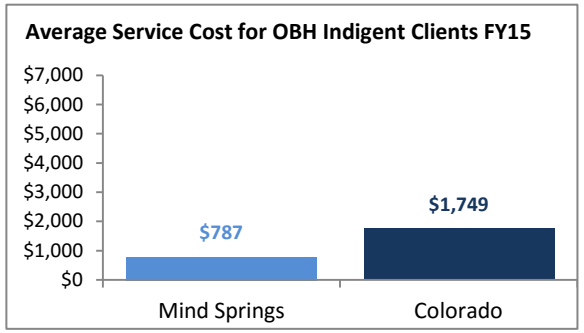
CMHC: Mind Springs Health



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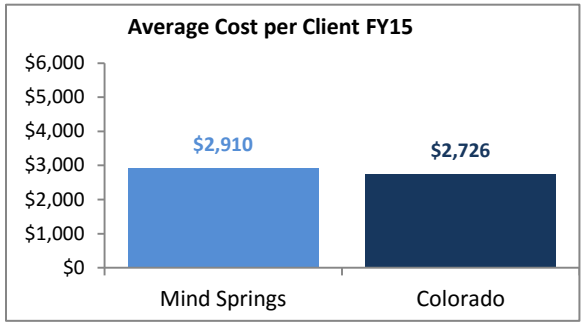

Data source: Milliman.
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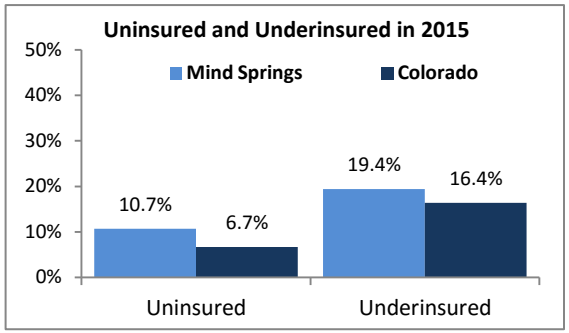

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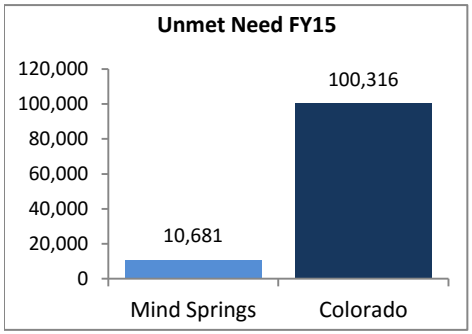

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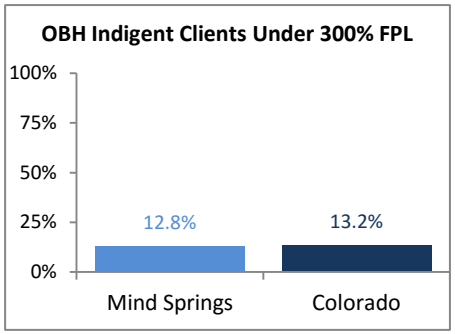

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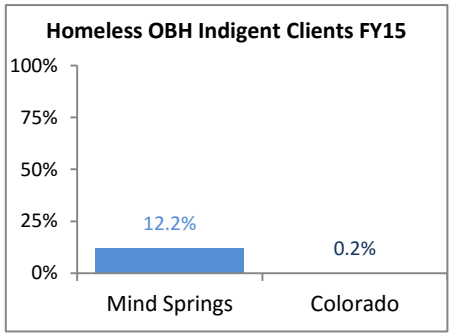

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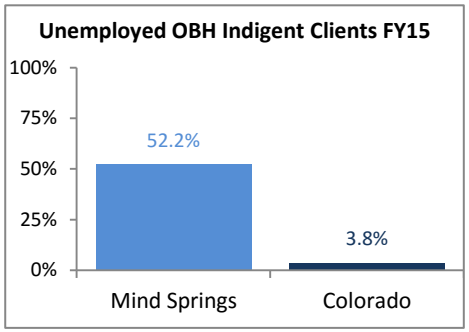

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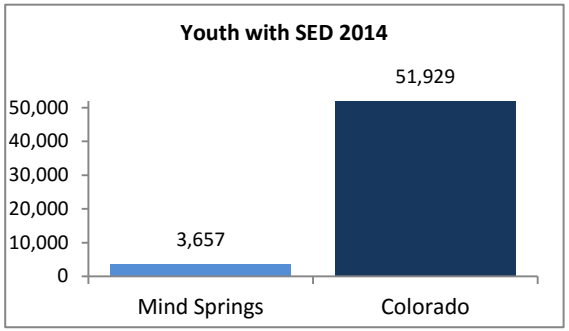

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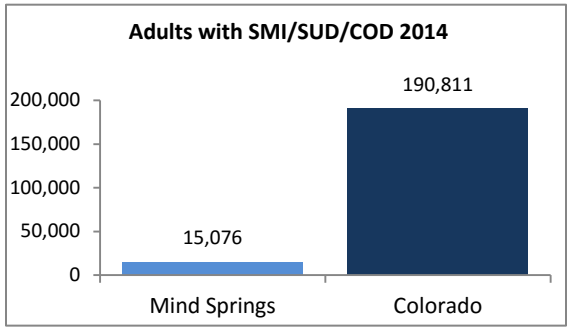

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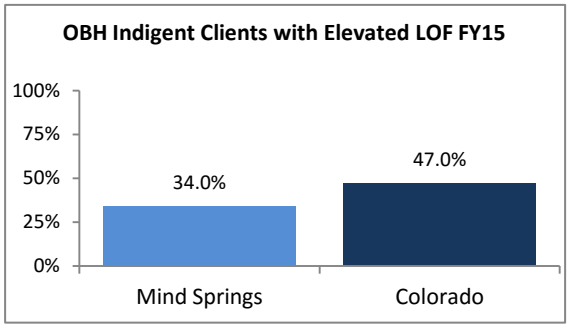

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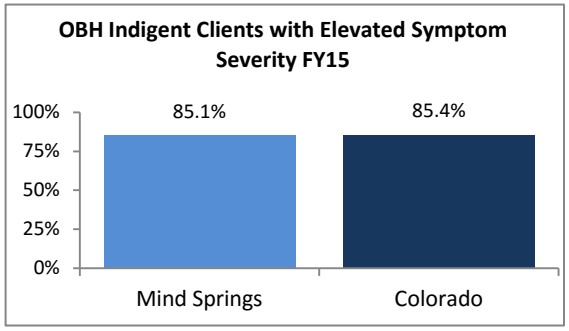

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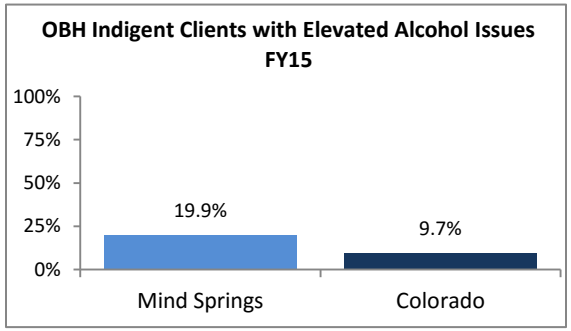

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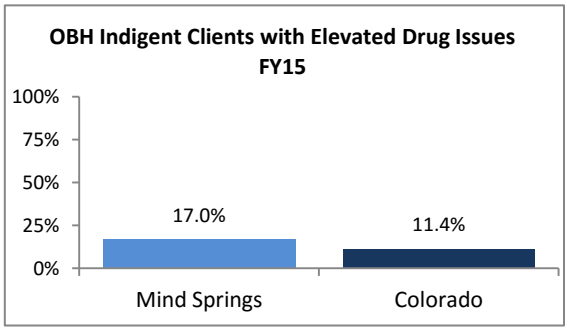

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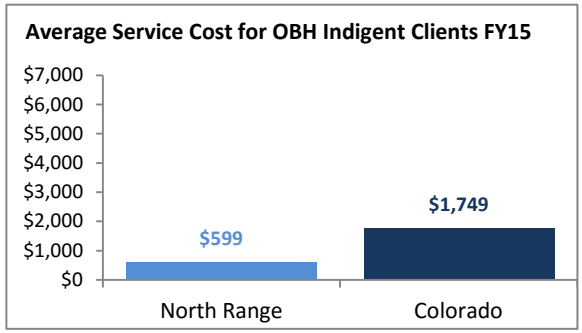
CMHC: North Range Behavioral Health



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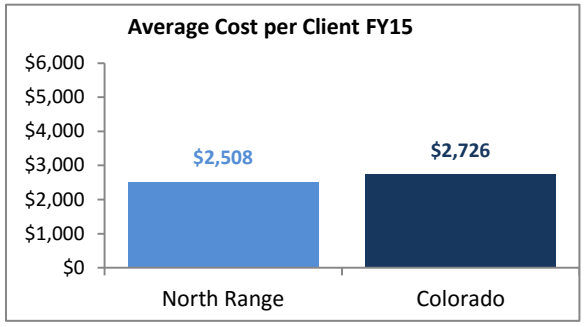

Data source: Milliman.
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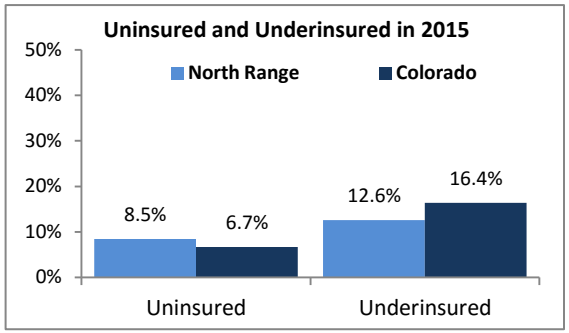

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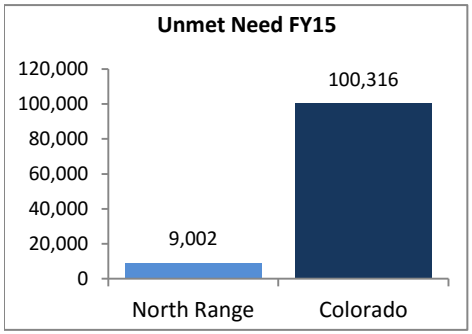

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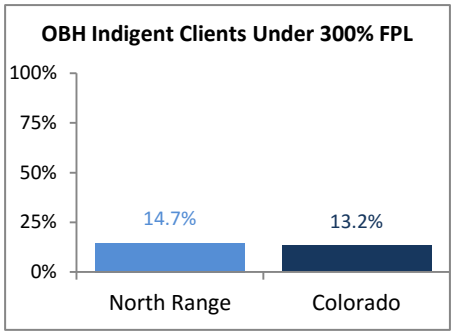

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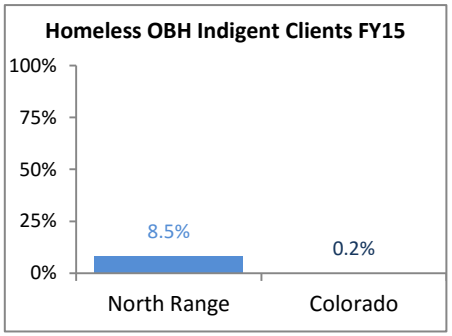

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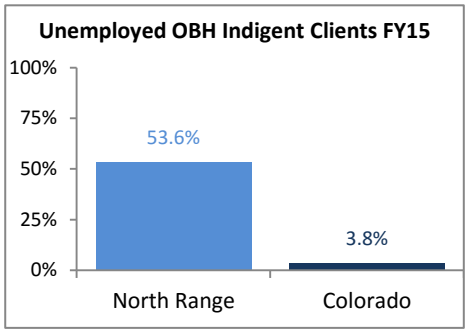

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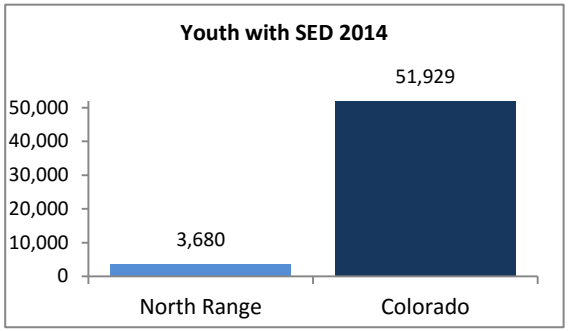
CMHC: North Range Behavioral Health



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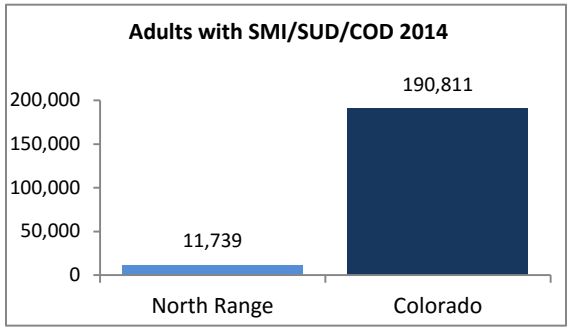

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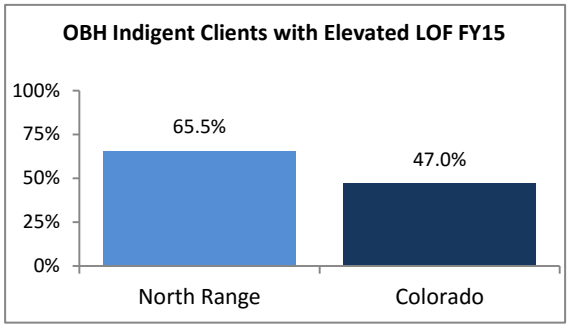

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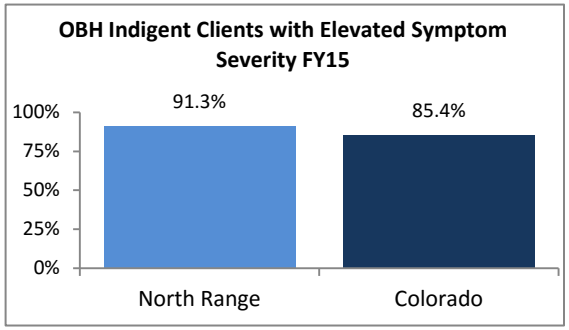

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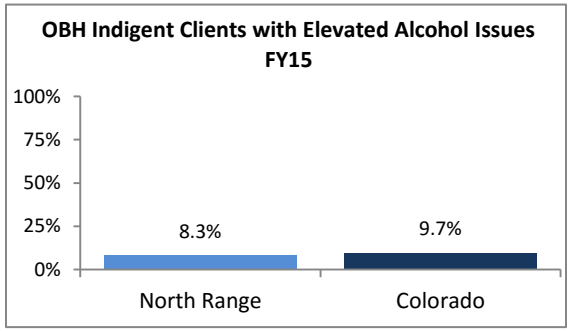

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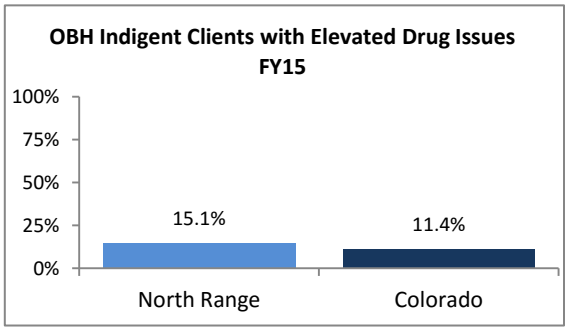

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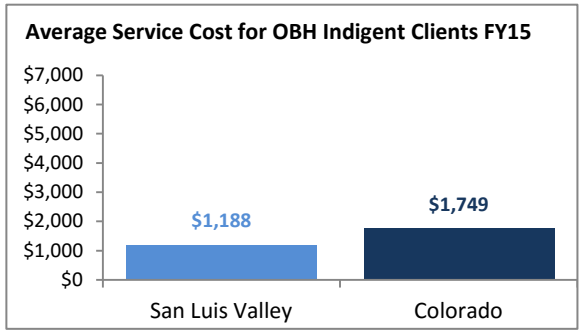
CMHC: San Luis Valley Behavioral Health Group



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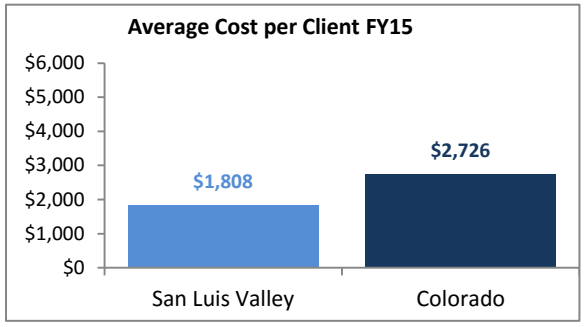

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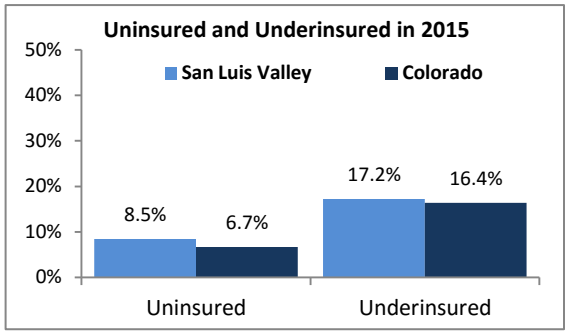

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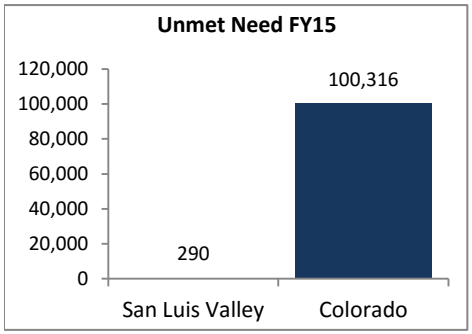

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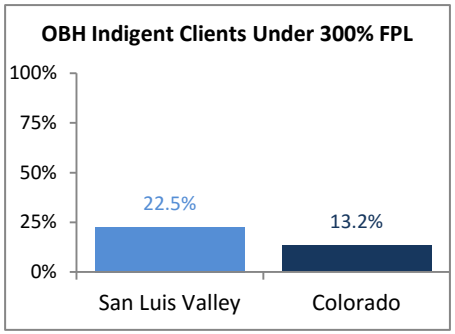

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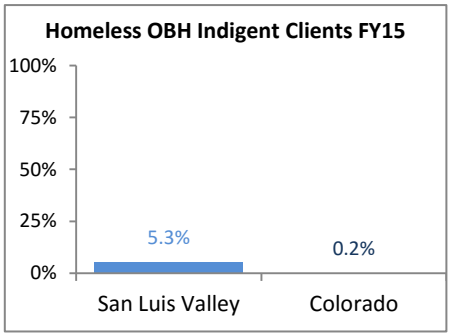

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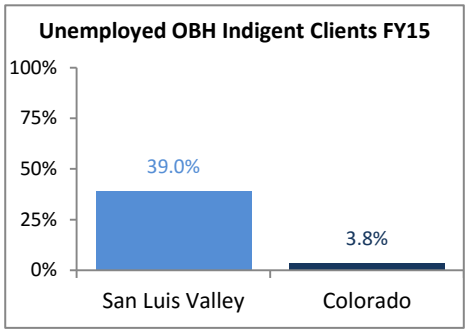

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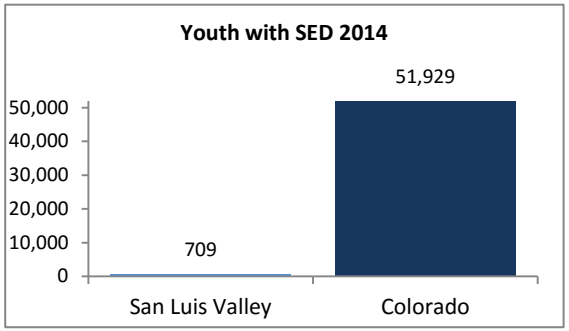

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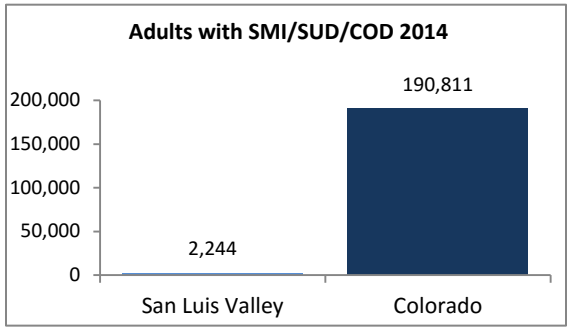

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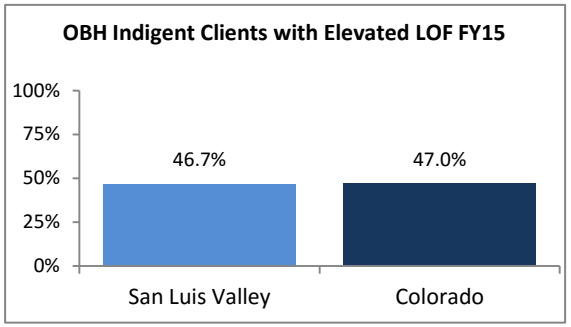

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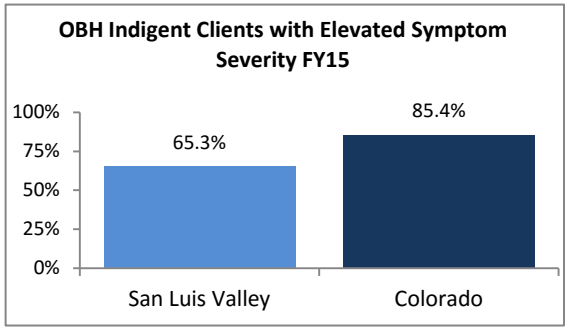

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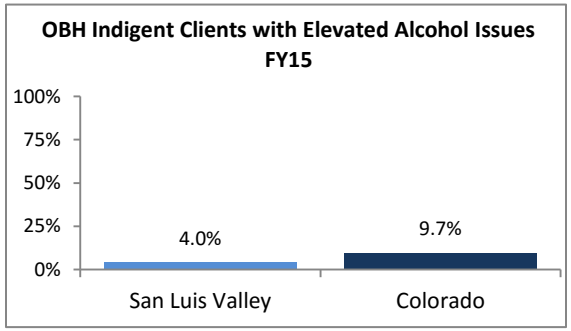

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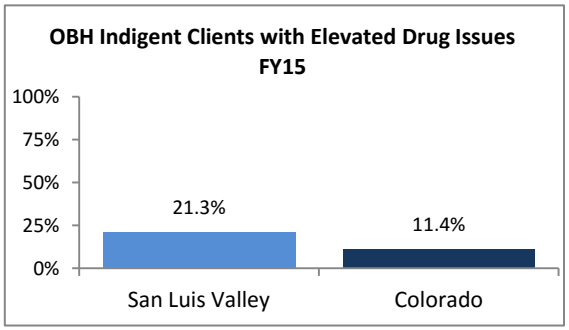

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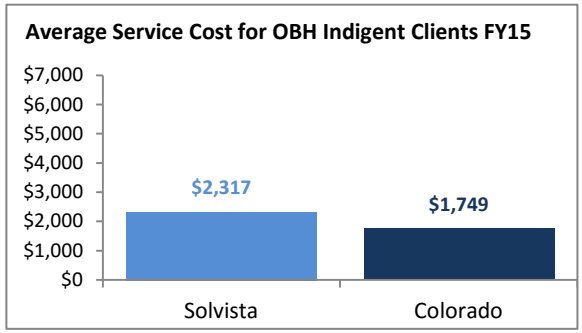

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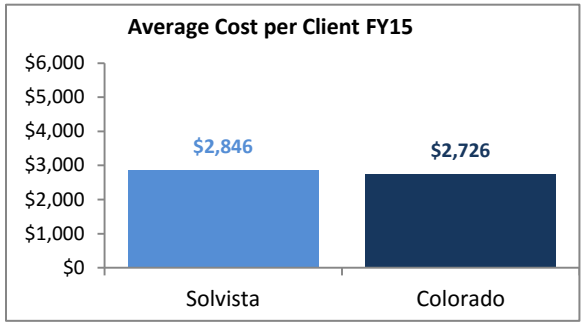

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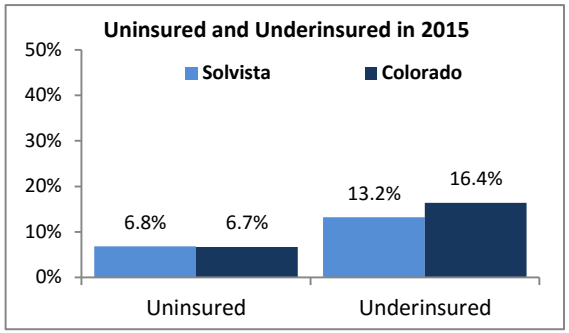

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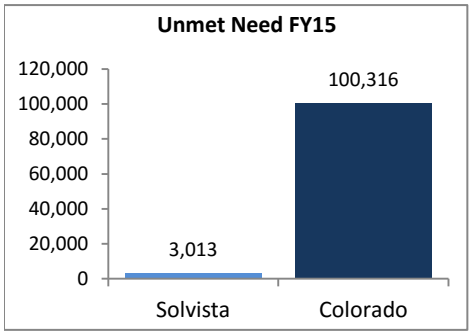

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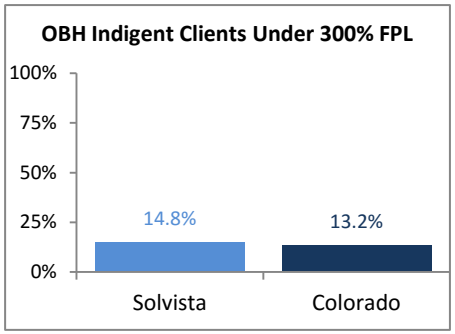

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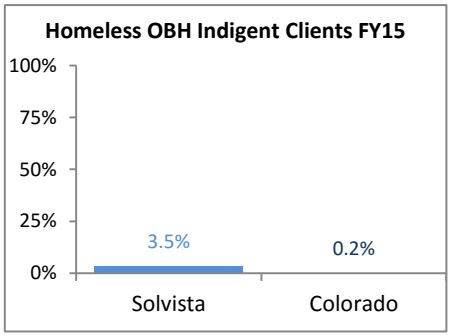

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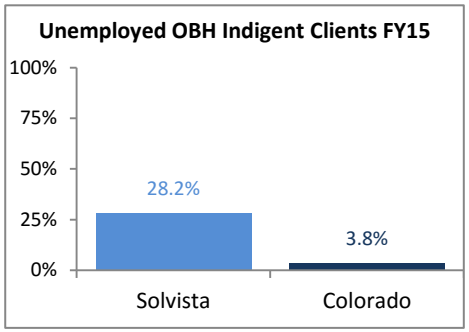

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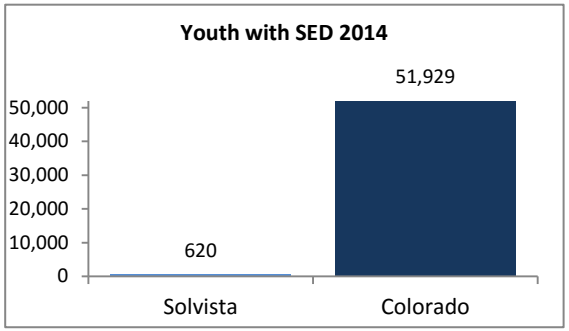

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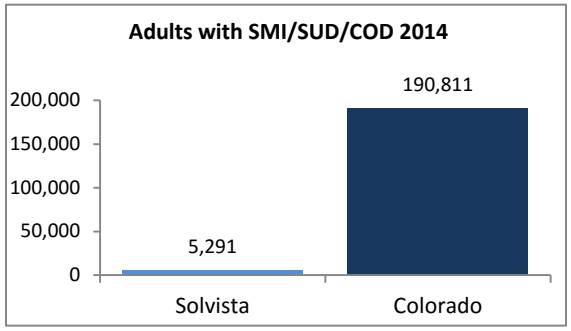

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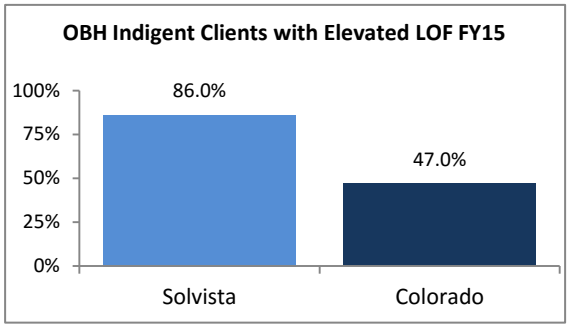

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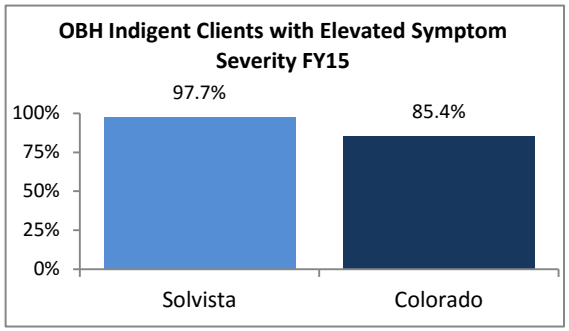

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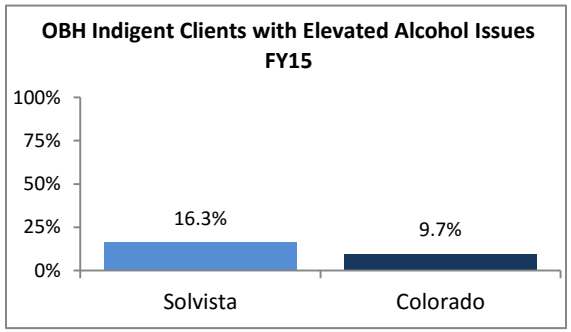

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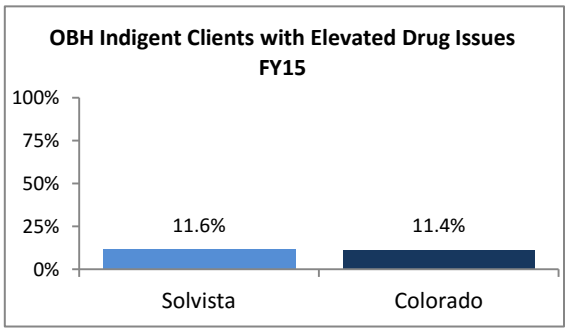

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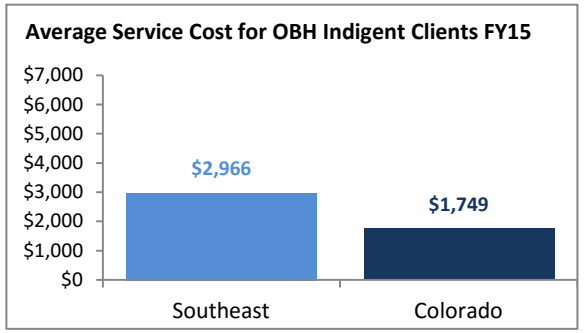
CMHC: Southeast Health Group



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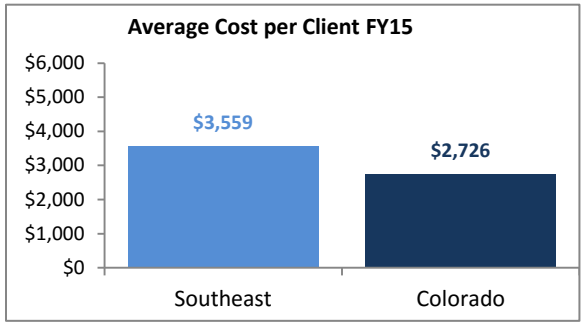

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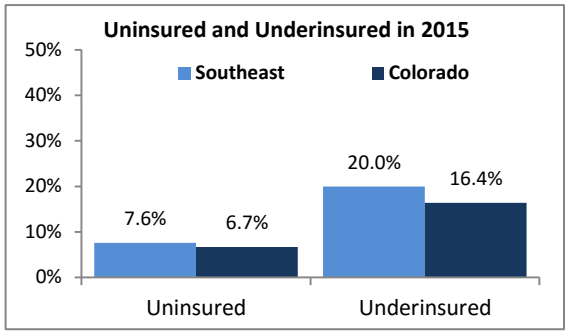

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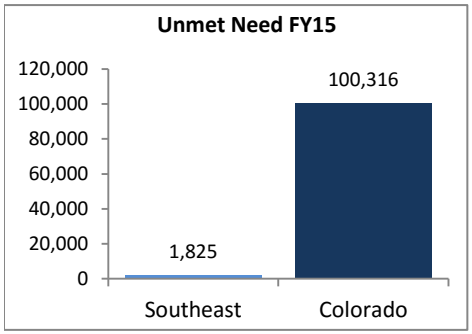

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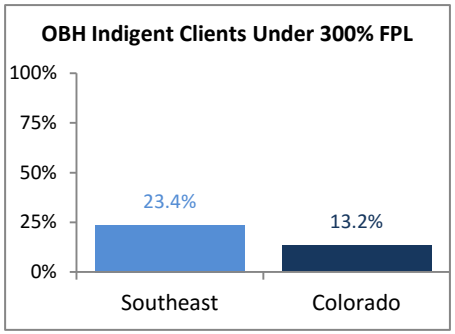

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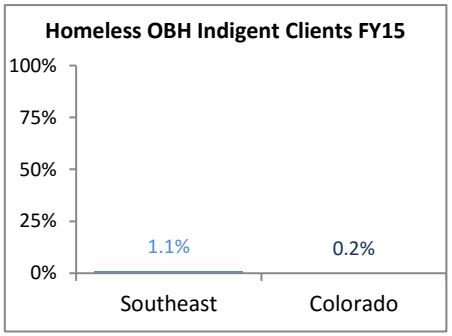

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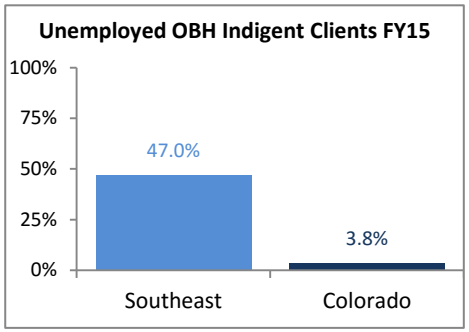

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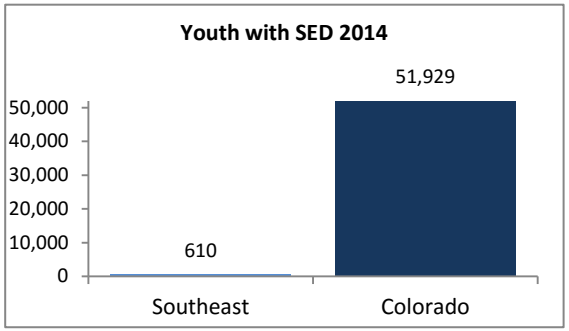

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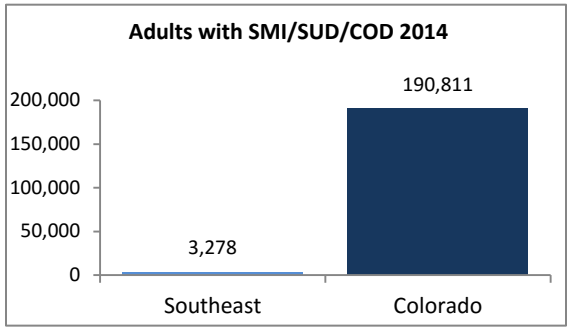

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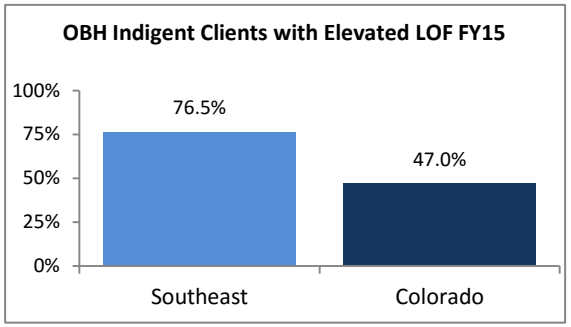

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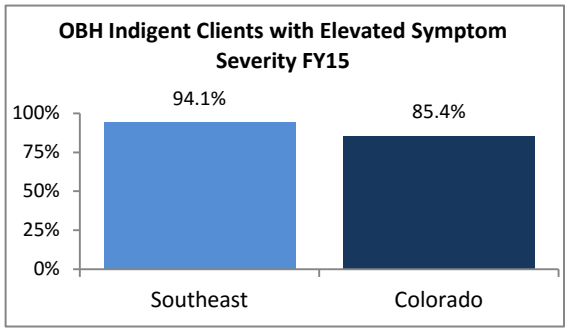

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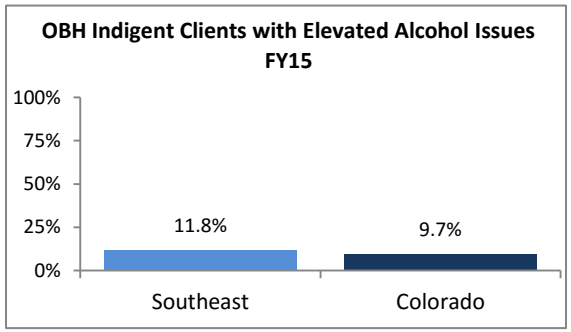

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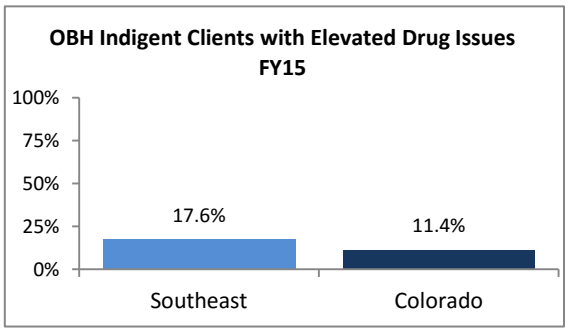

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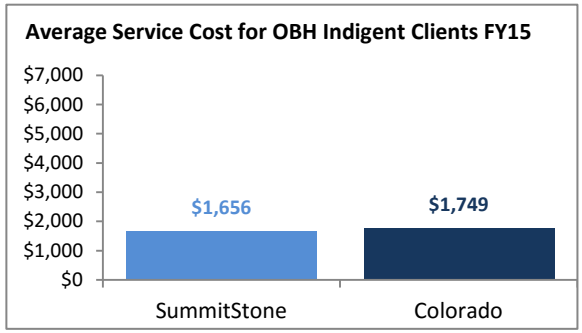
CMHC: SummitStone Health Partners



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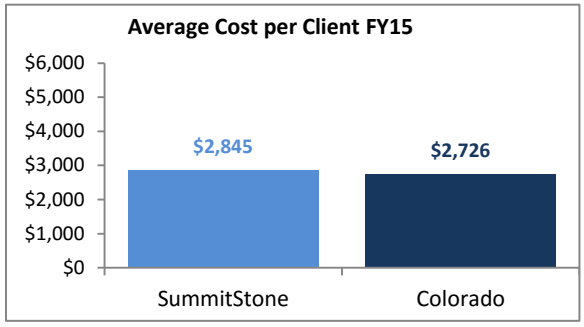

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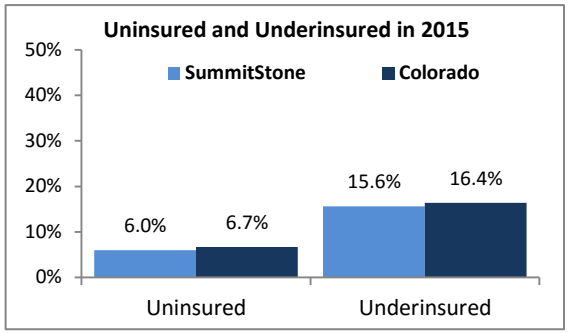

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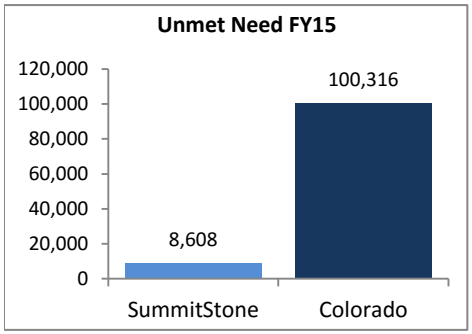

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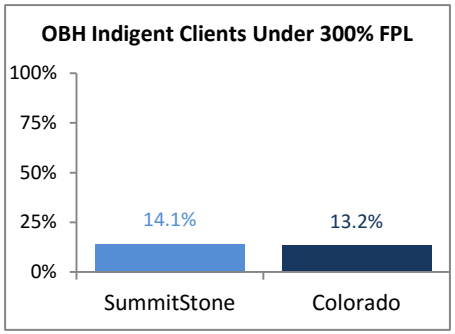

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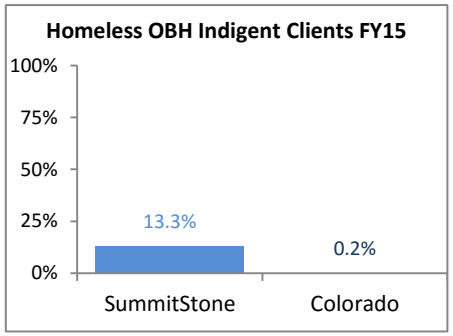

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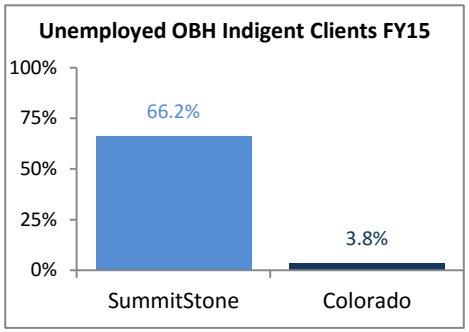

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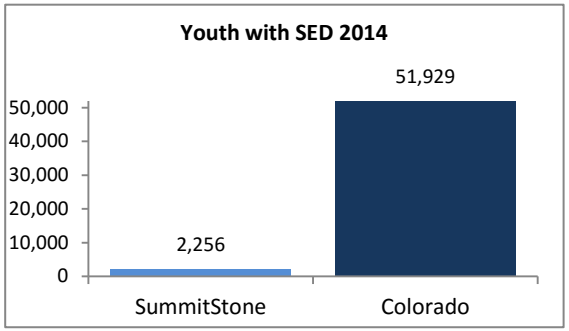

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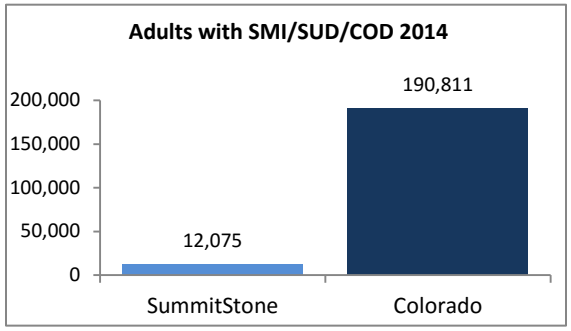

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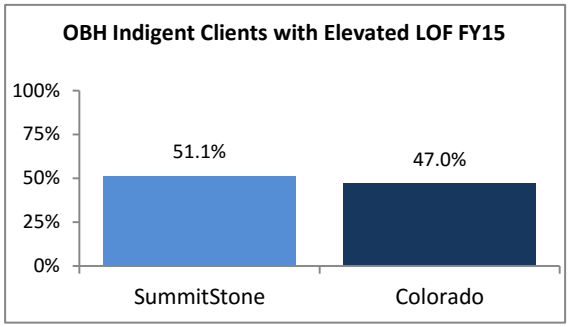

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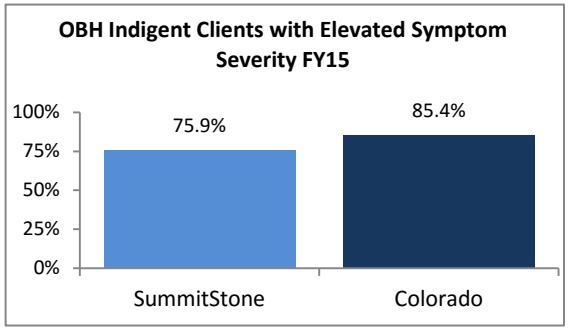

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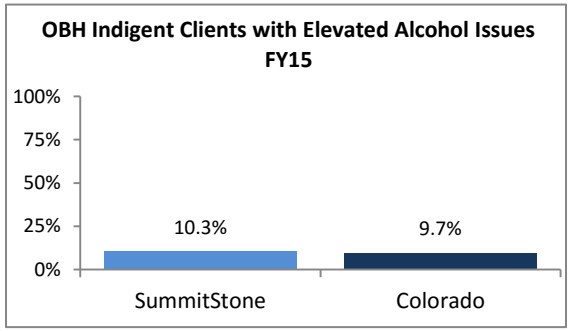

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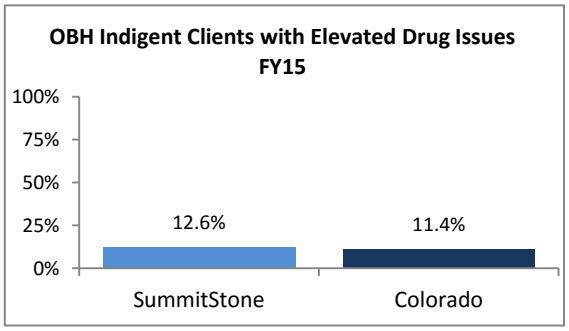

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Appendix U - Community Mental Health Center Costs and Revenue

Administrative Billing Costs by CMHC

CMHC	FY 2013-14	FY 2014-15	% Change	Projected FY 2016-17	% Change	% of Total Costs
AllHealth	$1,113,591	$1,380,523	24.0%	$2,063,451	49.5%	3.7%
AspenPointe	$429,497	$616,697	43.6%	$853,019	38.3%	1.5%
Aurora	$878,378	$1,140,020	29.8%	$1,703,975	49.5%	2.1%
Axis	$604,231	$593,600	-1.8%	$821,070	38.3%	4.4%
Centennial	$1,055,102	$1,143,762	8.4%	$1,519,169	32.8%	9.4%
CMH	$65,490	$228,357	248.7%	$315,865	38.3%	2.4%
Community Reach	$973,438	$1,239,324	27.3%	$1,852,403	49.5%	3.6%
Health Solutions	$737,165	$897,024	21.7%	$1,240,769	38.3%	3.8%
Jefferson	$2,844,520	$3,032,291	6.6%	$4,196,648	38.4%	5.9%
MHCD	$2,796,700	$4,182,147	49.5%	$5,434,925	30.0%	4.9%
MHP	$1,100,378	$1,502,880	36.6%	$2,079,965	38.4%	3.3%
Mind Springs	$692,057	$837,980	21.1%	$1,159,098	38.3%	2.2%
North Range	$1,724,216	$1,492,373	-13.4%	$1,982,200	32.8%	5.3%
San Luis Valley	$522,319	$571,904	9.5%	$791,060	38.3%	6.4%
Solvista	$459,763	$815,973	77.5%	$1,128,658	38.3%	10.5%
Southeast	$528,686	$630,392	19.2%	$871,961	38.3%	7.2%
SummitStone	$674,238	$616,739	-8.5%	$819,165	32.8%	2.7%
Total	**$17,199,769**	**$20,921,986**	**21.6%**	**$28,833,402**	**37.8%**	**4.0%**

Case Management Costs by CMHC

CMHC	FY 2013-14	FY 2014-15	% Change	Projected FY 2016-17	% Change	% of Total Costs
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MHP	$1,100,378	$1,502,880	36.6%	$2,079,965	38.4%	3.3%
Mind Springs	$692,057	$837,980	21.1%	$1,159,098	38.3%	2.2%
North Range	$1,724,216	$1,492,373	-13.4%	$1,982,200	32.8%	5.3%
San Luis Valley	$522,319	$571,904	9.5%	$791,060	38.3%	6.4%
Solvista	$459,763	$815,973	77.5%	$1,128,658	38.3%	10.5%
Southeast	$528,686	$630,392	19.2%	$871,961	38.3%	7.2%
SummitStone	$674,238	$616,739	-8.5%	$819,165	32.8%	2.7%
Total	**$17,199,769**	**$20,921,986**	**21.6%**	**$28,833,402**	**37.8%**	**4.0%**

FY 2014-15 CMHC Revenues by Fund Source

CMHC	Medicaid	Medicare	Commercial	Patient Pay	All Other	Total
AllHealth	$17,931,845	$479,928	$5,061,573	$1,172,269	$11,433,752	$36,079,367
AspenPointe	$34,397,438	$351,243	$492,054	$116,308	$6,642,454	$41,999,497
Aurora	$33,180,571	$84,774	$1,124,576	$544,737	$17,029,086	$51,963,744
Axis	$8,106,972	$213,074	$521,715	$247,268	$7,119,204	$16,208,233
Centennial	$7,657,684	$96,680	$515,310	$288,743	$3,876,015	$12,434,432
CMH	$8,584,728	$144,099	$170,757	$273,379	$3,088,718	$12,261,681
Community Reach	$30,659,035	$236,848	$1,524,695	$266,152	$7,244,400	$39,931,130
Health Solutions	$21,630,034	$224,074	$261,331	$257,095	$3,537,072	$25,909,606
Jefferson	$39,823,337	$428,662	$648,807	$565,592	$16,581,964	$58,048,362
MHCD	$48,341,141	$890,756	$0	$379,216	$34,584,131	$84,195,244
MHP	$25,274,909	$315,979	$772,211	$419,892	$24,576,074	$51,359,065
Mind Springs	$24,868,315	$0	$0	$11,562,903	$8,459,956	$44,891,174
North Range	$16,472,229	$64,112	$920,402	$1,540,315	$8,798,536	$27,795,594
San Luis Valley	$7,689,393	$0	$111,416	$238,204	$1,490,204	$9,529,217
Solvista	$6,593,669	$143,323	$58,718	$49,039	$2,055,598	$8,900,347
Southeast	$7,447,820	$0	$0	$7,646	$1,683,955	$9,139,421
SummitStone	$15,808,173	$83,749	$158,429	$257,202	$6,864,426	$23,171,979
Total	**$354,467,293**	**$3,757,301**	**$12,341,994**	**$18,185,960**	**$165,065,545**	**$553,818,093**

Projected FY 2016-17 CMHC Revenues by Fund Source

CMHC	Medicaid	Medicare	Commercial	Patient Pay	All Other	Total
AllHealth	$26,836,743	$359,854	$7,062,309	$1,241,623	$17,273,817	$52,774,347
AspenPointe	$45,957,823	$682,701	$426,888	$155,489	$8,009,392	$55,232,294
Aurora	$49,657,938	$63,564	$1,569,098	$576,965	$25,727,103	$77,594,668
Axis	$10,831,585	$414,146	$452,621	$330,566	$8,584,252	$20,613,170
Centennial	$9,669,991	$140,977	$748,986	$373,888	$5,071,983	$16,005,824
CMH	$11,469,907	$280,081	$148,143	$365,474	$3,724,340	$15,987,944
Community Reach	$45,884,215	$177,591	$2,127,376	$281,898	$10,944,652	$59,415,732
Health Solutions	$28,899,515	$435,526	$226,721	$343,704	$4,264,959	$34,170,426
Jefferson	$46,604,951	$724,087	$91,490	$817,361	$27,014,927	$75,252,817
MHCD	$83,401,565	$1,298,887	$0	$491,039	$38,933,678	$124,125,169
MHP	$29,579,035	$533,745	$108,892	$606,804	$40,038,735	$70,867,211
Mind Springs	$33,226,126	$0	$0	$15,458,159	$10,200,915	$58,885,200
North Range	$20,800,845	$93,487	$1,337,774	$1,994,524	$11,513,377	$35,740,007
San Luis Valley	$10,273,665	$0	$96,660	$318,449	$1,796,870	$12,485,645
Solvista	$8,809,687	$278,573	$50,942	$65,559	$2,478,616	$11,683,376
Southeast	$9,950,904	$0	$0	$10,222	$2,030,493	$11,991,618
SummitStone	$19,962,287	$122,122	$230,271	$333,046	$8,982,486	$29,630,211
Total	$491,816,781	$5,605,341	$14,678,173	$23,764,771	$226,590,595	$762,455,660