STATE OF COLORADO

Colorado Department Health Care Policy and Financing
Susan E. Birch, MBA, BSN, RN, Executive Director

Colorado Department of Human Services
Reggie Bicha, Executive Director

John W. Hickenlooper
Governor

November 1, 2011

The Honorable Mary Hodge, Chair
Joint Budget Committee
200 East 14th Avenue, Third Floor
Denver, CO 80203

Dear Senator Hodge:

Please note that the Joint Budget Committee requested that the Department of Health Care Policy and Financing submit a total of 11 different requests for information on November 1. These reports are in addition to the Department's FY 2012-13 Budget Request, that is also due on November 1. Due to the volume of information due concurrently, the Department has not been able to submit all reports simultaneously. The Department hopes to work with the Joint Budget Committee in future years to alleviate some of the issues caused by the concurrent deadlines.

This letter is in response to the Legislative Request for Information affecting multiple departments number 2 which states:

Department of Health Care Policy and Financing, Executive Director's Office; and Department of Human Services, Division of Child Welfare and Division of Youth Corrections – The departments are requested to submit a report by November 1, 2011 on the feasibility of refinancing multi-systemic therapy, functional family therapy, and similar intensive, evidence-based therapies that support family preservation and reunification for youth involved in the child welfare and youth corrections systems. The report is specifically requested to examine whether related General Fund expenditures could be refinanced with Medicaid funds for qualifying youth and families and whether this could be done in a manner that would not drive an overall increase in Medicaid costs.

The attached response includes the issues that have been identified related to the Legislative Request for Information number 2 as well as the next steps that the Departments plan to take.

Questions regarding the attached report can be addressed to Sarah Roberts, Department of Health Care Policy and Financing, at 303-866-6255, or to Lloyd Malone, Department of Human Services, at 303-866-6480.

Sincerely,

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

Reggie Bicha
Executive Director

Cc: Representative Cheri Gerou, Vice-Chairman, Joint Budget Committee
Senator Pat Steadman, Joint Budget Committee
Senator Kent Lambert, Joint Budget Committee
Representative Jon Becker, Joint Budget Committee
Representative Mark Ferrandino, Joint Budget Committee
Senator Brandon Shaffer, President of the Senate
Senator John Morse, Senate Majority Leader
Senator Mike Kopp, Senate Minority Leader
Representative Frank McNulty, Speaker of the House
Representative Amy Stephens, House Majority Leader
Representative Sal Pace, House Minority Leader
John Ziegler, Staff Director, JBC
Eric Kurtz, JBC Analyst
Lorez Meinhold, Deputy Policy Director, Governor's Office
Henry Sobanet, Director, Office of State Planning and Budgeting
Erick Scheminske, Deputy Director, Office of State Planning and Budgeting
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Antoinette Taranto, Client & Community Relations Office Director
Phil Kalin, Center for Improving Value in Health Care (CIVHC) Director
Carrie Cortiglio, Legislative Liaison
Joanne Zahora, Public Information Officer
HCPF Budget Library, HCPF Budget Division

Attachment

Please note that the Joint Budget Committee requested that the Department of Health Care Policy and Financing submit a total of 11 different requests for information on November 1. These reports are in addition to the Department's FY 2012-13 Budget Request, that is also due on November 1. Due to the volume of information due concurrently, the Department has not been able to submit all reports simultaneously. The Department hopes to work with the Joint Budget Committee in future years to alleviate some of the issues caused by the concurrent deadlines.

This report is presented to the Joint Budget Committee of the Colorado General Assembly in response to Legislative Request for Information number 2 which states:

Department of Health Care Policy and Financing, Executive Director's Office; and Department of Human Services, Division of Child Welfare and Division of Youth Corrections – The departments are requested to submit a report by November 1, 2011 on the feasibility of refinancing multi-systemic therapy, functional family therapy, and similar intensive, evidence-based therapies that support family preservation and reunification for youth involved in the child welfare and youth corrections systems. The report is specifically requested to examine whether related General Fund expenditures could be refinanced with Medicaid funds for qualifying youth and families and whether this could be done in a manner that would not drive an overall increase in Medicaid costs.

Representatives from both the Department of Health Care Policy and Financing and the Department of Human Services met several times to explore the questions contained in the Legislative Request for Information. The Departments identified several program areas that might be refinanced through Medicaid. However, determining cost neutrality and resolving issues with these refinancing strategies require more in-depth research. This report provides a review of the issues that the Departments have identified that must be researched in order to present a full picture of the benefits and costs associated with refinancing multi-systemic therapy, functional family therapy, and similar intensive, evidence-based therapies that support family preservation and reunification for youth that are involved in the child welfare and youth corrections systems.

It should be noted that part of the treatment for children and youth frequently involves behavioral health services, but research for this Legislative Request for Information has concentrated on the Division of Child Welfare and the Division of Youth Corrections, not on the Division of Behavioral Health at the Department of Human Services.

It should also be noted that child welfare services are managed by the counties with oversight from the state Department of Human Services. The counties have flexibility in using funding provided by the state, and, consequently, the counties utilize funding from several line items in the state budget for child welfare. The counties may use funding from the following budget line items: Family and Children's Programs line item, Child Welfare Services (also called the Block Grant), other funding transferred from Temporary Aid to Needy Families (also called the Colorado Works Program), and/or county-only monies.

Services for youth under the supervision of the Division of Youth Corrections are also provided from several different budgetary line items. These line items include Institutional Programs Medical Services, Institutional Personal Services, services billed directly to Medicaid when the youth is in a contract placement, or possibly by funding from the Senate Bill 91-94 line item. Since Senate Bill 91-94 is administered by the judicial districts, medical related funding is not readily known.

The information about sources of funding, as presented in the above paragraphs, illustrates some of the challenges to identifying cost neutrality of refinancing services with Medicaid.

Eligibility for Medicaid Services

The Departments make efforts to identify and to enroll all eligible youth clients in Medicaid under current state and federal regulations. However, as a result of exploring this issue, the Departments have identified a limited number of unusual circumstances in which Medicaid eligible youths are not being enrolled in Medicaid. There may be children (youth) who should be Medicaid-eligible but who have not been enrolled so far. Both Departments will be actively working to ensure that Medicaid eligible children are enrolled in Medicaid in a manner that provides the children with all necessary services in the least disruptive manner.

Functional Family Therapy applies family intervention for at-risk youth of ages 10 to 18 whose problems range from acting out to conduct disorders to alcohol and/or substance abuse. Functional Family Therapy (FFT) success has been replicated across juvenile justice, mental health settings, child welfare systems, prevention and diversion programs, aftercare and parole, drug and alcohol treatment programs, and school-based programs. Typical positive outcomes include significant and long-term reduction in youth re-offending and violent behavior, significant reductions of sibling entry into high-risk behaviors, low drop-out and high completion rates for the program, and positive impacts on family conflict, family communication, parenting, and youth problem behavior.

Multi-Systemic Therapy (MST) encompasses much of the FFT processes but goes on beyond to focus on the entire environment of chronic and violent juvenile offenders, their homes and families, schools, teachers, neighborhoods, and friends.

There may be circumstances in which Multi-systemic Therapy (MST) and Functional Family Therapy (FFT), and/or other child welfare services, could be Medicaid reimbursed. Some states, Maryland, Hawaii, North Carolina, California, and the District of Columbia, use Medicaid funding for MST by using claims codes that have not been implemented in Colorado. At this time, it is not known if Medicaid funding for MST and FFT could be implemented in Colorado. As the information in this report will make clear, both Departments continue their work to determine if it is feasible and desirable to fund these services through Medicaid. In the event that the Departments determine that such a course is advisable, it would be necessary to develop criteria for who should receive the services, how to deliver the services if Medicaid funded, and how to implement the changes. After identifying the aforementioned information, an

amendment to the State Medicaid Plan would be submitted to the federal Centers for Medicare and Medicaid Services (CMS) for approval. The Departments expect that the entire process will likely take over a year.

Both Departments will further research the possibility of implementation in Colorado, including follow up to be sure that these services are implemented and managed uniformly across the state before going forward with a State Plan Amendment request. If implementation becomes possible for MST and FFT under Medicaid funding, there may be best practices, related to the above issue, that need to be disseminated state-wide, and the Departments will research how to accomplish that task in the best manner.

If implemented, the Departments will need to develop means to measure and track utilization by clients. This is not a simple task because of the fact that the service will be provided through the Behavioral Health Organizations, thus making the tracking and monitoring more difficult. One concern is that changing the funding source to Medicaid would make the services an entitlement, and that change might drive up the number of recipients who utilize the services that, in turn, would lead to higher costs. As a result, it is difficult to keep the services cost-neutral.

If implemented, the Departments will need to develop quality measures for the provision of these specific services and the expected outcomes. This is difficult and time consuming because HCPF has little experience in managing the provision of these specific types of services under Medicaid funding. The quality measures need to be related to the methods of provision. Since the methods of provision are still under discussion, the quality measures are a downstream product to follow after the methods of provision are determined.

Medicaid entitlement may create the necessity of serving more clients. Given the entitlement nature of Medicaid, the provision of these services under Medicaid funding would likely create additional caseload relative to the number of clients currently receiving these services. This could result in significant additional costs resulting from the funding change. Before the advisability of such a funding change can be determined the Departments must develop a reliable method of forecasting future utilization of these prospective Medicaid services. Due to the data challenges described below the Departments have been unable to make a firm projection of such utilization and whether the level of utilization will result in budget neutrality. Furthermore, if an entitlement is created, expertise in forecasting the caseload of MST and FFT services will have to be developed, as well as rate calculation studies and total appropriation trending. If the utilization of these services increases beyond the current levels, high utilization could drive significant costs, and could make cost neutrality almost impossible to maintain. In order to complete such research the Departments need more time. The Departments may find it necessary to retain the services of a contractor to do this technical research of developing forecasting methodologies and rate calculation methodologies. If so, funding would be sought through the normal budget processes.

Potentially Same Providers

Funding these services using Medicaid funds will more likely be advisable if a significant number of children's service providers are also Medicaid providers. The Departments are

researching the extent of this overlap. Medicaid Mental Health providers often work for or contract with, Behavioral Health Organizations (BHO). Claims for these Medicaid providers include only the BHO name and not the individual provider names. Preliminary research indicates that many of the existing providers are BHOs or specialty clinics that subcontract with BHOs to provide special types of mental health services to the children. There does appear to be much overlap.

MST and FFT are provided by a majority of the BHOs. But MST and FFT therapists must have rigorous education and training. Not all BHOs in all areas of the state have qualified staff. BHOs are responsible for developing and maintaining an adequate provider network, but not all BHO network providers are enrolled with Medicaid. BHOs are not required to take any willing provider.

The Department of Health Care Policy and Financing prefers that Medicaid clients be served by BHOs so that treatment can be covered by the capitation payments to BHOs. However, Medicaid children and youth who do not have a BHO-covered diagnosis are still eligible for mental health services under a fee-for-service arrangement with Medicaid funding. But fee-for-service Medicaid adds difficulty in controlling utilization and costs.

A separate issue that applies to children that receive core services and child treatment services is changing to a different individual provider can disrupt the child's treatment. Children tend to view their provider as the particular person from whom they are receiving services, rather than the organization with which the provider is associated. In the event that changing to a different individual provider becomes necessary in order to work with a Medicaid paid provider, this would present a disruption to the individual's treatment plan and would not necessarily be in the best interest of the child. This situation arises if an in-home, non-Medicaid child is receiving core services mental health treatment, but the child moves to out-of-home placement, then becoming Medicaid eligible. The Departments recognize that children in treatment are already in unstable situations, and the Departments will research how to avoid causing further instability, promote continuity of care for the child, and consider how alternative arrangements could be made.

Shifting Certain Services to Medicaid

The Departments are researching all the Core Services currently provided to determine which services are, or could be, eligible to be funded through Medicaid. The Departments will start by considering which services are better funded under the federal Temporary Aid to Needy Families grant, as well as General Fund, and local funds, and which are better funded under Medicaid. Federal regulations prevent the state from simultaneously funding any single service from both Medicaid and other federal grants.

Related to the above issue, both Departments continue to research the challenges to implementing Medicaid funding for these existing services; for example, if MST is transferred to Medicaid funding (see prior discussion above), there will be a need to implement currently unused claims coding in the Medicaid Management Information System (MMIS), as well as to handle other challenges not yet identified.

The Departments believe there will be implementation costs associated with converting these services to Medicaid funding, but estimates for the implementation costs have not yet been obtained from the vendor(s) of affected databases or systems because the Departments have not yet defined all of the processes that would be affected. The complexity of these processes affects the programming changes that have yet to be identified. The Departments need to continue to research estimated implementation costs as well as potential ongoing costs for affected systems that would have to be paid through Medicaid. Both Departments are aware of the need to achieve cost neutrality with any changes that are made in the future.

In the event that these services are moved under the Medicaid funding umbrella, changes will be needed to the Long Bill appropriations for both Departments. In addition, there may also be a need for statutory changes, although it is too early to make that determination with the information available at this time. The Departments will work with the General Assembly to identify any necessary statutory revisions to accomplish the transition if Medicaid funding is determined to be the preferred direction.

In addition to services and programs already mentioned, there may be other services that currently are paid through General Fund that could be paid through Medicaid. Both Departments will continue to work to identify any other programs that might best be funded through Medicaid.

Youth Corrections Programs and Considering Alternatives

The population of youth who may be eligible for Medicaid payment of services for treatment, and who are receiving these services under General Fund, is limited to youth who are on parole and youth who participate in Senate Bill 91-94 services described below. Medicaid regulations, 42 C.F.R. §435.1009, prohibit Medicaid funding for anyone who is "incarcerated". Correct identification of eligible individuals is important, and both Departments are working to identify and implement procedures for accurately determining which youth are eligible for Medicaid funded health services.

As a part of the research for this report, the Departments have determined that it may be possible to treat youthful sex offenders in a community setting with Medicaid funding under the MST program. Currently, the diagnosis codes associated with sex offenses are not covered under the Colorado Medicaid Behavioral Health Organizations' contract. Some Community Mental Health Centers have paid to train staff in offender-specific treatment to provide some level of information to other staff and clients/families. One mental health center has developed a comprehensive offender-specific treatment program, but the center contracts directly with the Division of Youth Corrections, and the services are not offered as a part of the regular Medicaid Mental Health capitation program. Medicaid Behavioral Health Organizations in Colorado do provide mental health treatment for co-existing covered diagnoses to children/youth who also happen to be sex offenders, but generally do not specifically address the sex offense.

In the states that fund MST through Medicaid, juvenile sex offender treatment is typically included in MST. This inclusion suggests that juvenile sex offender treatment might be possible under Medicaid funding in Colorado, but further research is needed on feasibility and regulations as well as any potential additional costs. Offense-specific treatment models are highly specific, and training is both extensive and costly. Some research indicates that MST provided to Medicaid youth involved in the criminal justice system provides better outcomes, but the improved outcomes are not specific to sexual offense behaviors or recidivism related specifically to sexually related offenses. Both Departments need to research how contracts with Medicaid Behavioral Health Organizations might be modified to require inclusion of treatment for juvenile sex offenders and whether the Medicaid Behavioral Health Organizations are receptive to this change.

Providers who currently treat youth that are not currently eligible for Medicaid, may not wish to provide services if the Medicaid rates are lower than the current rates paid through the Department of Human Services. The possible result of switching to Medicaid providers might be that some youth go without treatment if there is a shortage of willing Medicaid providers. Any evaluation of the feasibility of funding these services through Medicaid will require an analysis of projected impacts to the availability of the services to clients based on expected reimbursement rates. Such a study would be involved and require additional time, and possibly additional funding to retain the services of a contractor. If such a contractor is determined to be necessary, the Departments will seek the funding through the regular budget processes.

As is true with children who receive child welfare services, treatment for youth moving to parole may be disrupted if a provider change is necessary in order to work with a Medicaid paid provider. In the event that this becomes necessary in order to work with a Medicaid paid provider this change would not necessarily be in the best interest of the youth. The Departments recognize that children and youth in treatment are already in unstable situations, and the Departments will research how to avoid causing further instability for the youth and consider how alternative arrangements could be made.

The current eligibility determination systems related to the DYC are Colorado Trails and the Colorado Benefits Management System. If there are changes in funding sources and service provisions, system changes may be necessary. The Departments recognize that any cost increase related to system changes needs to be offset to maintain overall cost neutrality.

In the course of research, the Departments have identified an additional program that may have Medicaid eligible youth. The Senate Bill Programs, as established by SB 91-94, provide community alternatives to institutionalization of youth, either when pre-adjudicated or after adjudication. The youths may be in community group houses, or the youth may remain in the family home, depending on what is determined to be the best arrangement for the particular youth. These alternative programs are managed by the Colorado Judicial Districts rather than by the communities or counties. It is possible that a fairly high percentage of youth in the Senate Bill Programs may be Medicaid eligible and may already be enrolled in Medicaid. However, it is difficult to determine in advance how many youth in the Senate Bill Programs, or on parole, are eligible. Prescreening of the participating youth for Medicaid eligibility in each judicial district might disclose an estimate, but a formal study might need to be done, and a formal study

will take extra time and extra funding. Prescreening of the youth for Medicaid should not be confused with the prescreening that currently occurs to determine eligibility for participation in the SB 91-94 Programs.

Adding to Medicaid enrollment in the judicial district services might necessitate more Medicaid-funded providers. Both Departments need to research what additional capacity there may be in the communities, particularly in rural communities, for rendering these services to determine if there are willing, able, and available providers. The search for additional providers may be done concurrently with the above mentioned prescreening of youth for potential Medicaid eligibility, or depending on the number of youth found with potential Medicaid eligibility, the search for available providers may continue sequentially to the prescreening estimates.

Currently, the Department of Health Care Policy and Financing receives no funding for any programs related to the judicial districts, and, consequently has no current, ongoing working relationships with the judicial districts, but the Department of Health Care Policy and Financing will make every effort to establish working relationships, should it be determined that Medicaid-funded medical care is possible for participants in the community programs under SB 91-94.

Next Steps

- The Departments will work to ensure federal compliance by applying for Medicaid State Plan amendment(s) as needed.
- The Departments will work to amend State Medicaid Rules as needed.
- The Departments will work to identify the number of children and youth who are receiving the services described in this response and determine which ones are not already receiving Medicaid but who should be prescreened for Medicaid enrollment.
- The Departments will review and revise the BHO contracts as needed, to include diagnosis codes, treatment services, and quality measures required. The BHOs might object to changes in their contracts, but any objections will be addressed.
- The Departments will research available providers in the geographic areas of the state to determine where scarcity of qualified providers exists.
- The Departments will reach out to qualified providers to ask them to enroll or to contract with a BHO if they are agreeable to do so.
- The Departments will identify current costs for services and projected costs for services to be refinanced by Medicaid.
- The Departments will compare rates paid to service providers by DHS to rates paid by HCPF to service providers to identify any need for adjustments.
- The Departments will identify administrative costs and computer system costs to determine how much offsets need to be for cost neutrality.
- The Departments will sum all projected costs to verify is cost neutrality has been achieved.
- The Departments will pursue any other issues that arise as a result of the above mentioned steps.

Summary

The Departments have explored the feasibility of refinancing multi-systemic therapy, functional family therapy, and similar intensive evidence-based therapies that support family preservation and reunification for youth involved in the child welfare and youth corrections systems. However, due to the complexities associated with the request, more research is needed. Both Departments are open to further discussion with the Joint Budget Committee and its staff about going forward with additional research and the future findings of the research. It is also possible that the federal regulations may change the Medicaid landscape of the future related to additional eligibility of children and/or parents, so the Departments will keep the Joint Budget Committee informed if changes arise.

Please note that the Departments will work with the Governor's Office on any potential legislation or budgetary changes if any such changes become necessary.