Medicaid Mental Health Rates
Department of Health Care Policy and Financing

Performance Audit
November 2006

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Government Human Services Consulting

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November 22, 2006

Members of the Legislative Audit Committee:

This report contains the results of a performance audit of Medicaid Mental Health Rates. The audit was conducted pursuant to Section 2-3-103, C.R.S., which authorizes the State Auditor to conduct audits of all departments, institutions, and agencies of State government. The State Auditor contracted with Mercer Government Human Services Consulting to conduct this performance audit. The report presents our findings, conclusions, and recommendations, and the responses of the Department of Health Care Policy and Financing.

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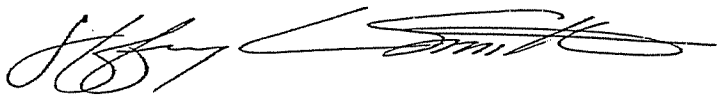

Jeff Smith, Principal

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REPORT SUMMARY

Medicaid Mental Health Rates
Department of Health Care Policy and Financing
Performance Audit
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Authority, Purpose, and Scope

This performance audit was conducted under the authority of Section 2-3-103, C.R.S., which authorizes the State Auditor to conduct performance audits of all departments, institutions, and agencies of state government. The State Auditor contracted with Mercer Government Human Services Consulting to conduct this performance audit. The audit work was conducted from June through November 2006 in accordance with generally accepted government auditing standards. The audit evaluated the current rate setting methodology used by the State to establish rates for services under Colorado's Medicaid Community Mental Health Services Program, which operates as a managed care program. The audit also reviewed processes for managing service utilization and quality and assessed the controls in place to ensure that services provided are medically necessary, access to services has not been limited inappropriately, and service data reported to the State are accurate and complete. In Fiscal Year 2006, the State paid $164.8 million to providers for services delivered under the Medicaid Community Mental Health Services Program; services are funded by approximately 50 percent federal and 50 percent state general fund monies.

Background

In 1995, in an effort to reduce costs and improve service quality and delivery, Colorado transitioned from a fee-for-service payment system to a managed care payment system for mental health services provided to Medicaid recipients. Under the managed care system the Department of Health Care Policy and Financing (Department) contracts with five managed care organizations, called Behavioral Health Organizations (BHOs), to provide Medicaid mental health services. The Department pays each BHO a capped monthly amount, or capitation rate, for each Medicaid member within the BHO's geographical service area. The rates vary depending on the Medicaid members' eligibility category (Elderly, Disabled, Children, Adults, and Foster Care). In return for the capitated payment, each BHO agrees to provide all medically necessary mental health services to any Medicaid member in the service area that needs services. In contrast, under the previous fee-for-service arrangement, the State paid each service provider for every mental health service covered by Medicaid that was provided to a Medicaid recipient.

Each BHO is required to furnish mental health services through a comprehensive network of providers and to hold all providers to the same standards and levels of oversight. The BHOs' network includes "internal" network providers consisting of Community Mental Health Centers (CMHCs) in the BHO's geographic service area and "external" network providers consisting of

residential treatment facilities, non-CMHC community-based agencies, independent physicians, and independent mental health professionals. The CMHCs within the internal networks all exercise a controlling interest in each of the BHOs (to different degrees, based on ownership and governance structures). All BHOs have sub-capitation agreements with their CMHCs for services provided through the internal provider network. These agreements require the CMHCs to provide medically necessary mental health services to all Medicaid members in need of CMHC services for a fixed payment amount, regardless of the number of members served. Each CMHC's payment amount is based on that CMHC's overall anticipated costs and is not differentiated by Medicaid eligibility category.

Summary of Audit Findings

Service Utilization and Quality

Federal regulations for managed care programs such as Colorado's Medicaid Community Mental Health Services Program include rigorous expectations for ensuring that care provided is medically necessary. Utilization management processes should encompass monitoring for both over-utilization, which occurs when a managed care organization provides more services than medically necessary or delivers services that do not provide an increased health benefit, and under-utilization, which occurs when a managed care organization does not provide the services needed to appropriately treat the member's diagnosed condition. We reviewed the Department's oversight of BHO utilization management as well as the utilization management processes currently used by the BHOs and compared these processes to 10 industry-standard utilization management practice components, as well as other aspects of the Medicaid Community Mental Health Services Program related to service utilization and quality. We found improvements are needed in the following areas:

- **Oversight of utilization management.** The Department needs to set appropriate standards for the BHOs to follow in conducting utilization management and to adequately monitor the BHOs' utilization management practices. We found BHOs use 9 of the 10 industry-standard utilization management practice components to manage their external provider networks; however, the majority of BHOs use only one of the industry-standard utilization management practices to oversee their internal or CMHC provider networks. None of the BHOs require the CMHCs to obtain prior authorization of intensive services such as residential care or intensive case management. Additionally, although the BHOs delegate utilization management functions to the CMHCs, the BHOs do not supervise CMHC staff making utilization management decisions or proactively monitor CMHCs for under-utilization by reviewing service utilization information for missed appointments, readmission rates, crisis service use, or under-utilization of specific levels of care. Insufficient utilization management could result in delivery of unnecessary or ineffective services, or inappropriate levels of services, leading to higher program costs and poor outcomes for patients.

- **Analysis of BHO data on financial and quality performance.** Although the Department works with the BHOs to improve the quality and reliability of encounter data (i.e., data on specific services provided), which is discussed below, we found the Department needs to expand its use of data analysis to assist in tracking rate parity among BHOs and identifying BHO-specific service and cost issues that may warrant further investigation or intervention. Additionally, we found that although BHOs track some industry-standard performance measures such as inpatient utilization per 1,000 members, outpatient visits per 1,000 members, and readmission rates, the BHOs do not use consistent means for calculating these performance measures or systematically reporting them to the Department. Lack of appropriate data analysis affects the Department's effectiveness in identifying and resolving issues in both the financial and quality of care performance areas of the Medicaid Community Mental Health Services Program.

- **Oversight of BHO telephone access lines.** Only two BHOs operate telephone access monitoring systems that reflect the industry standards, such as average time to answer, percent busy, call abandonment rates, and average length of calls for individual staff and clinical teams. The other three BHOs neither conduct blind monitoring nor collect call statistics for their primary access lines. As a result, the three BHOs without monitoring systems cannot ensure that individuals seeking mental health assistance through the primary access lines receive appropriate customer service.

- **Monitoring of BHO third party liability recovery efforts.** Under federal regulations, Medicaid is the payer of last resort. We found the BHOs' third party recovery efforts center on the claims they directly pay through the external provider network. However, the BHOs do not effectively monitor third party recoveries for payments made to internal network providers, which comprise between 67 and 95 percent of all expenditures for medical services made by the BHOs. Further, the Department is not adequately monitoring BHO third party recovery efforts to ensure that the BHOs comply with contractual terms, which require that BHOs implement systems and procedures to identify potential third-party payers, notify the Department's Fiscal Agent of such payers, actively pursue and collect from third party payers, and report quarterly to the Department on all recoveries made. Lack of systematic third party recovery efforts can lead to higher program costs.

Rate Setting

We assessed the Department's current rate setting methodology for Medicaid mental health capitation rates as well as the underlying components used to calculate the rates. We compared these to the current guidelines recommended by CMS for setting "actuarially sound" rates. Actuarially sound rates are defined by CMS as rates that are appropriate for the populations covered and the services furnished under a managed care contract. Although Colorado's rate setting methodology generally meets CMS guidelines and has been accepted by CMS in the past, the quality of a number of components used in Colorado's rate setting methodology need to be improved. As explained below, there are problems with the accuracy and consistency of the

underlying encounter data used as part of the basis for rate setting, the pricing strategies used to assign costs to services, and with the methodology used by the Department to calculate rates:

- **Encounter data are not reported consistently.** The audit found several problems that create a potential for encounter data reported to the State to be incomplete or inaccurate. First, four of the five BHOs do not require CMHC providers to submit encounter data using HIPAA-compliant procedure codes (i.e., codes that comply with requirements under the federal Health Insurance Portability and Accountability Act [HIPAA]). CMHCs report encounters using various self-developed procedure codes, which the BHOs then convert to HIPAA-compliant codes using individual "crosswalks" developed to report encounter data to the State. The use of crosswalks increases the risk of errors. Second, the audit found instances in which inconsistent codes were used to report the same type of encounter or service. Third, in some cases BHOs re-code encounter data reported by the CMHCs, creating a risk of errors or manipulation in reporting encounter data. Fourth, the sub-capitation agreements BHOs have in place with CMHCs provide little incentive to ensure CMHCs report all encounter data. Many other states have comprehensive encounter data reporting manuals that provide explicit instructions for BHOs and providers on the definition of services covered by the managed care contract and how to report the services in HIPAA-compliant coding formats. These manuals help to reduce inconsistencies in encounters reported and improve the validity of this data for rate setting and program evaluation purposes.

- **Methods used to price encounter data perpetuate broad discrepancies in capitation rates.** The audit identified several concerns with the Department's approach for estimating service costs and in determining actuarially sound capitation rates for the BHOs. First, in some instances the Department uses CMHC fee schedules, based on the CMHCs' cost reports, to price services provided by the CMHCs. The fee amounts in these fee schedules varied widely for the same procedure codes. For example, the lowest CMHC fee charged for group psychotherapy was $30.90 per unit, or one-fourth the highest fee of $131.84 charged by another CMHC for the same service. Second, the Department was unable to report when it had last completed a comprehensive review of the State Medicaid fee schedule used to price services provided by non-CMHC providers. The Department's practices perpetuate broad rate disparities and result in a cost-based reimbursement system that may not reflect reasonable and appropriate costs for services provided. Furthermore, these practices potentially finance provider inefficiencies and may distort the underlying cost of providing services.

- **Colorado statutes have not been amended to reflect changes in federal regulations.** Historically, federal regulations required managed care rates for mental health services to be subject to the "upper payment limit. The upper payment limit ensured that the cost of operating a Medicaid managed care program did not exceed the costs of operating an actuarially equivalent fee-for-service program. In response to the federally-required upper payment limit, Colorado enacted Section 25.5-5-408, C.R.S., which stipulates that the Department cannot pay a capitation payment to a BHO that exceeds 95 percent of the

projected fee-for-service costs to serve an equivalent Medicaid population. In effect, this statutory requirement has tied capitation rates to historical fee-for-service rates, without permitting full consideration of the actual costs of providing an appropriate mix of services in a managed care environment. Although CMS repealed the upper payment limit effective August 2003, state statute remains unchanged. Currently the Department, with assistance from its contracted actuarial firm, calculates capitation rates on the basis of data from: (1) the Historical Rate Component (comprising 70 percent of the rate) and (2) the Encounter Based Rate Component (comprising 30 percent of the rate). The Historical Rate component is primarily based on fee-for-service information that predates program start-up in 1995 (for most of the State) or 1998, projected forward. The Encounter Based Rate component is based on current encounter data priced using either the CMHC fee schedules or the State Medicaid fee schedules, as described above. The audit found that this rate setting methodology has perpetuated large discrepancies in per member rates paid to the different BHOs for services provided to the same eligibility category. The rate disparities are similar to the disparities observed at the outset of the program almost 12 years ago. For example, the audit found that for Fiscal Year 2007 in both the Disabled and Adult eligibility categories, the difference between the highest and lowest rates paid to BHOs in each category is more than 100 percent. Such disparities provide the appearance that rates are not equitable among service populations and service regions and that the cost of services in some areas may not be reasonable. Additionally, the disparities raise questions regarding whether the service encounter data reported by BHOs are accurate and complete and whether the rates for a particular eligibility category are actuarially sound. Similar disparities were identified in the Colorado Office of the State Auditor's 1998 performance audit of Medicaid Capitation for Mental Health Services.

When the federal government eliminated the upper payment limit requirement, most states revised their rate setting methodologies using encounter data and detailed financial data obtained from their managed care organizations as the primary basis for capitation rates. However, for Colorado to use encounter data to develop rates for the Medicaid mental health managed care program, the Department will need to make improvements to its utilization management program and its encounter data, as discussed previously. More specifically, the Department must ensure that all services provided are medically necessary; all necessary services are provided; encounter data are reported consistently and represent the actual procedures delivered by the providers; and encounters are priced according to a reasonable and appropriate fee schedule. Without these changes, the rate disparities that currently exist will continue to be perpetuated in the future.

Our recommendations and the responses of the Department of Health Care Policy and Financing can be found in the Recommendation Locator and in the body of the report.

RECOMMENDATION LOCATOR

Rec. No.	Page No.	Recommendation Summary	Agency Addressed	Agency Response	Implementation Date
1	28	Requiring BHOs to disclose their financial and organizational relationship with the CMHCs to the Department annually; reviewing the ownership and governance relationship between the CMHCs and BHOs to ensure oversight of utilization management is transparent and accountable; requiring formal agreements between BHOs and CMHCs when utilization management activities are delegated; and developing and monitoring standards for expected levels of care for services provided.	Department of Health Care Policy and Financing	Agree	December 2007
2	36	Improve reporting and analysis of financial and performance information related to the Medicaid Community Mental Health Services Program by reviewing data reported to ensure information is reported consistently; developing standardized financial reports and performance measures; and periodically analyzing the information reported.	Department of Health Care Policy and Financing	Agree	July 2008
3	39	Ensure adequate performance of telephone access lines maintained by BHOs by identifying performance standards and incorporating those standards into BHO contracts.	Department of Health Care Policy and Financing	Agree	January 2008
4	41	Ensure compliance with BHO contracts by reviewing and assessing the adequacy of BHO procedures for identifying and recovering from third party payers and ensuring that third party recovery efforts are adequate for services provided through both the internal and external provider networks.	Department of Health Care Policy and Financing	Agree	January 2008
5	44	Require BHOs to monitor and report on the use of allocated state mental health hospital beds by Medicaid members. The Department should monitor trends in usage over time, compare actual usage to allocations of state hospital beds among BHOs, and share this information with the Department of Human Services to assist with monitoring the sufficiency of allocated state hospital beds.	Department of Health Care Policy and Financing	Agree	July 2007

RECOMMENDATION LOCATOR

Rec. No.	Page No.	Recommendation Summary	Agency Addressed	Agency Response	Implementation Date
6	51	Ensure that encounter data for the Medicaid Community Mental Health Services Program from the BHOs and other providers are reliable and valid for rate setting purposes.	Department of Health Care Policy and Financing	Agree	July 1, 2008
7	52	Develop a standardized encounter reporting manual for the Medicaid Community Mental Health Services Program to ensure all services are coded by the service provider at the point of service in accordance with HIPAA-compliant procedure codes, and to ensure the accuracy and consistency of encounter data reported. The Department should incorporate these data reporting requirements into its contracts with the BHOs.	Department of Health Care Policy and Financing	Agree	July 2008
8	57	Initiate a cost study to assess and verify the fee schedule used to price encounters in the Medicaid Community Mental Health Services Program. The study should result in a standard mental health fee schedule that is reflective of reasonable and appropriate rates.	Department of Health Care Policy and Financing	Agree	July 2008
9	64	Work with the General Assembly to seek statutory change to align Colorado law with changes made to federal regulations, including requiring that mental health capitation rates be certified as actuarially sound and removing any reference to the outdated 95 percent fee-for-service upper payment limit for the Medicaid Community Mental Health Services Program.	Department of Health Care Policy and Financing	Partially Agree	May 2007
10	65	Work to revise its rate setting methodology for the Medicaid Community Mental Health Services Program to ensure that the methodology is based primarily on validated encounter data and that rates are reasonable and appropriate.	Department of Health Care Policy and Financing	Agree	July 2008

Overview of the Medicaid Community Mental Health Services Program

Background

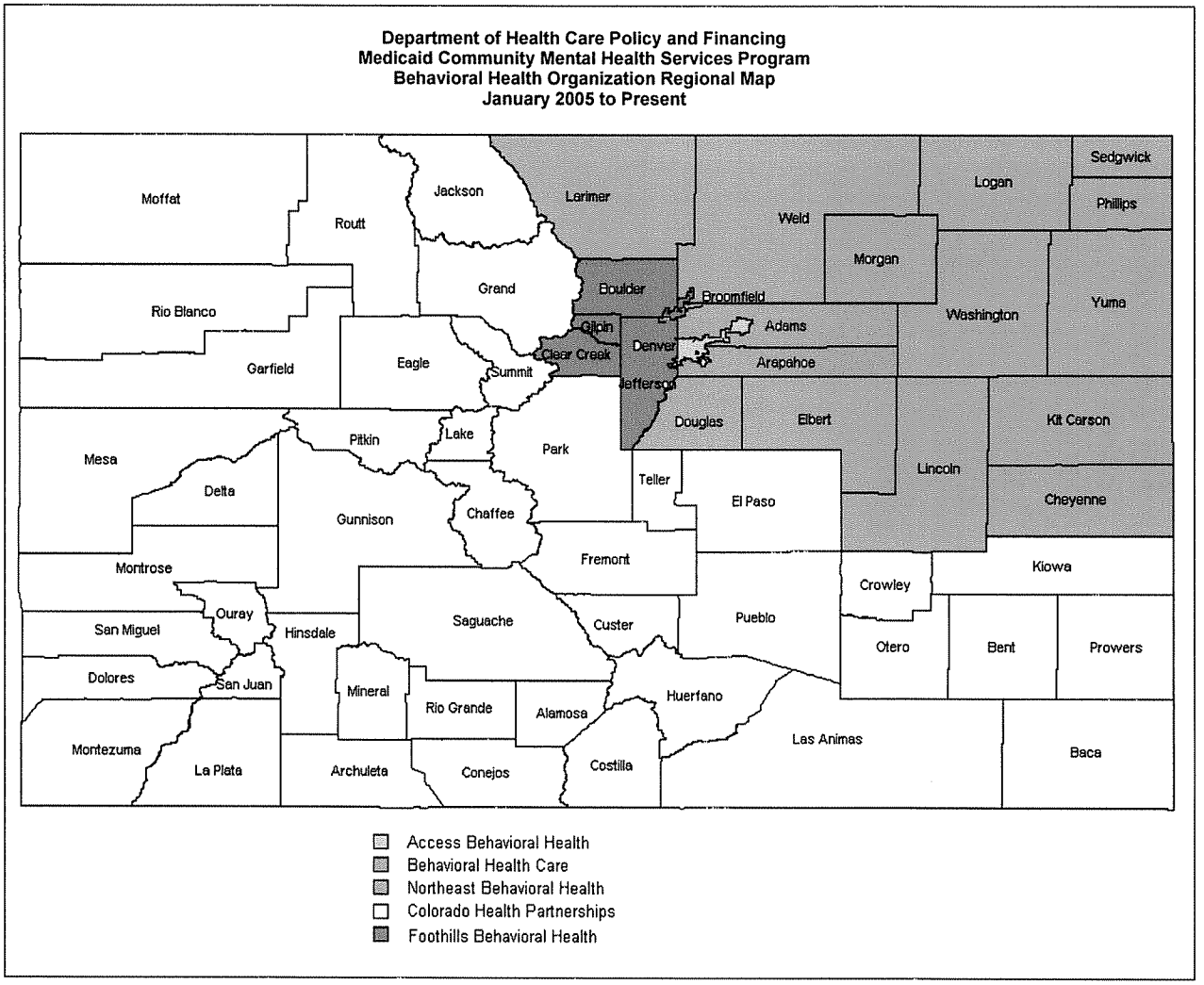
In 1995, in an effort to reduce costs and improve service quality and delivery, Colorado transitioned from a fee-for-service payment system to a managed care payment system for mental health services provided to Medicaid recipients. Initially, this transition occurred in 51 of Colorado's then 63 counties, and by 1998, it was extended to all Colorado counties. Under a managed care payment and service provision system, the State enters into an agreement to pay a managed care organization a flat monthly rate for every person eligible for Medicaid within a designated geographical area. In return, the managed care organization agrees to provide all medically necessary mental health services to any Medicaid recipient (who are referred to as members of the managed care plan) in that area needing services. In contrast, under a fee-for-service arrangement, the State pays each service provider for every mental health service covered by Medicaid that is provided to a Medicaid recipient.

Medicaid Community Mental Health Services Program

Colorado's Medicaid Mental Health Service system currently includes five managed care organizations referred to as Behavioral Health Organizations (BHOs). The Department of Health Care Policy and Financing (Department) selects BHOs through a competitive bidding process and the Department contracts with successful bidders to provide all medically necessary mental health services to covered Medicaid members living in the BHOs' geographical service area. The Department pays each BHO a capped monthly amount, or capitation rate, for each Medicaid member within the BHO's service area. These rates are differentiated based on the member's Medicaid eligibility category. In other

words, the Department pays the BHOs flat monthly rates for each of the five eligibility categories (Elderly, Disabled, Children, Adults, and Foster Care).

The BHOs provide mental health services through a provider network that includes inpatient hospitals, services purchased from "external" providers, and services purchased from "internal" providers. The internal provider network consists of the specific Community Mental Health Centers (CMHCs) in the BHO's geographic service area. The BHOs' external provider networks include residential treatment facilities, non-CMHC community-based agencies, independent physicians, and independent mental health professionals. BHOs are required by contract to provide a comprehensive network of providers and to hold all providers to the same standards and levels of oversight. The Department reports that it purposely eliminated the use of the terminology internal and external network providers from the BHO contract language in 2004 in order to discourage the BHOs from distinguishing between internal and external providers. However, BHOs must report on services provided by internal and external providers in accordance with the Mental Health Services Accounting & Auditing Guidelines and the internal and external provider service categories continue to drive the BHOs' business operations. Therefore, we refer to the providers as "internal" and "external" throughout this report. A map of the BHO service areas follows.



All of the BHOs have sub-capitation agreements with the CMHCs, which require that the CMHCs provide medically necessary mental health services for a fixed payment amount for all Medicaid members in need of CMHC services, regardless of the number served. Unlike the BHOs' monthly per member capitation rates, the BHO contracts with CMHCs to provide services to all members for a single amount. Each of the CMHC's payment amounts are based on the CMHC's overall anticipated costs, and payments are not differentiated by eligibility category. This effectively transfers much of the BHO's financial risk to the CMHCs, although from the State's perspective, the BHO remains contractually responsible for ensuring that all medically necessary mental health services are provided within the rate paid to the BHO by the State. For those services provided by external providers, BHOs typically pay on a fee-for-service basis for any mental health services obtained.

The managed care structure of the State's Medicaid Community Mental Health Services Program is somewhat unique from that seen in other states with respect to the relationships between the BHOs and the CMHCs. Depending upon the BHO, the CMHCs exercise a controlling interest in each of the BHOs (to different degrees, based on ownership and governance structures). Specifically, four of the five participating BHOs are owned by the CMHCs that provide services to their respective BHO as part of the BHO's internal network. In the case of the fifth BHO, the CMHC is directly involved as a board member of the BHO, but it is not an owner. In other words, the CMHCs that function as the internal network service providers own and/or control the operations of the BHOs or managed care organizations. At all five BHOs, the executive directors or chief executive officers of the participating CMHCs serve as board members.

As discussed later in this report, this arrangement has allowed CMHCs to function with more autonomy and less oversight by the BHO than is typically the case in states with Medicaid mental health managed care plans. In other states, including Arizona, Connecticut, Massachusetts, New Mexico, Pennsylvania, and Washington, among others, the managed care organizations are usually owned and operated by a non-provider entity that maintains a higher degree of independence from its network providers than is seen in Colorado. There are, however, other states, such as Utah and some parts of Florida, where the BHO-like entities are owned by the service providers.

Information for the last five state fiscal years on total capitation payments, eligibility, and number of services provided follows.

Department of Health Care Policy and Financing
Medicaid Community Mental Health Services Program
Capitation Payments, Number of Members, Number of Individuals Served, and Number of Services Provided
State Fiscal Years 2002 - 2006

	2002	2003	2004	2005	2006
Medicaid Mental Health Capitation Payments (In Millions)	$148.9	$144.7	$146.3	$149.3	$164.8
Number of Medicaid Members[2]	292,000	314,000	348,000	388,000	383,000
Number of Individuals Served[2]	42,000	38,000	38,000	45,000	Not Available[1]
Number of Services Provided [3]	1,200,000	1,300,000	1,100,000	1,100,000	Not Available[1]

Source: Department of Health Care Policy and Financing
Notes: [1] Fiscal Year 2006 data for the number of individuals served and number of encounters will be available in March 2007.
[2] Figures rounded to nearest thousand.
[3] Figures rounded to nearest one-hundred thousand.

Changes in the Medicaid Community Mental Health Services Program

Over the past 12 years since managed care was implemented in Colorado for Medicaid mental health services, there have been a number of federal- and state-level changes to the program. These changes are discussed below.

Evolving Federal Standards – The Centers for Medicare and Medicaid Services (CMS) has increased accountability for managed care operations in Medicaid programs over the past several years. First, in August 2002 CMS revised requirements for calculating rates in managed care programs by removing the upper payment limit requirement [42 CFR 447.361]. This limit required managed care spending to remain the same or lower than the projected fee-for-service levels. As many states moved to Medicaid managed care, the historical fee-for-service data used to project the upper payment limit became outdated. As the fee-for-service data became outdated, the validity of this limit became a concern and CMS modified federal regulations to eliminate the upper payment limit and instead require that rates be actuarially sound [42 CFR 438.6(c)]. Revisions to the federal regulations became effective in August 2003. In order for the rates to be actuarially sound, the rates paid to the managed care organization or BHO must be sufficient to cover the cost of services. Second, the Balanced Budget Act of 1997, also

implemented in August 2003 under 42 CFR 438, required states to implement External Quality Review (EQR) standards for quality, timeliness, and access of the health care services furnished to Medicaid recipients by managed care organizations. Third, as part of the new regulations governing rates, in August 2003 CMS began to require a State Medicaid Agency operating a managed care program under a 1915(b) waiver, such as Colorado's, to track and determine payment rates for services covered under the State Medicaid Plan separately from payment rates and services covered under Section 1915(b)(3) of the state's managed care waiver. Section 1915(b)(3) services are those services provided in addition to State Medicaid Plan services as a result of savings achieved from operating a managed care program, rather than a fee-for-service program. Finally, the Deficit Reduction Act of 2005 (enacted in February 2006 as P.L. 109-171) required states to more closely scrutinize specific service types, including case management and targeted case management (Section 6052). CMS expects to promulgate rules related to the Deficit Reduction Act in late 2006.

State Oversight and Program Organization – Effective July 1, 2004, Colorado moved its Medicaid Community Mental Health Services Program from the Division of Mental Health within the Department of Human Services to the Department of Health Care Policy and Financing. Additionally, Colorado's network of managed care organizations was consolidated in the last bid cycle from eight BHOs in 1998 (previously referred to as Mental Health Assessment and Service Agencies, or MHASAs) to only five as of January 1, 2005. This consolidation involved significant changes in the BHO service areas and provider networks.

Effectively, Colorado has had a managed care program for Medicaid mental health services for nearly 12 years. However, significant changes in federal regulation and the State's structure of the Medicaid Community Mental Health Services Program since 2002 have pushed BHOs to develop more formal structures and processes for oversight. As a result, the changes in BHO infrastructure and the BHOs' responses to these changed standards are relatively recent.

Medicaid Mental Health Rates

In 1998, the Colorado Office of the State Auditor released an audit of Medicaid Capitation for Mental Health Services. This audit identified a number of concerns, including concerns regarding wide variances in per member per month rates paid to different BHOs for the same categories of Medicaid members. As an

example, the Fiscal Year 1997 monthly rate paid to one BHO for members in the eligibility category of Children in Out of Home Placements (Foster Care) was $184/month while another BHO received $694/month for members in the same category, a difference of over 275 percent. Other eligibility categories demonstrated differences between the highest and lowest BHO payment rates ranging from 109 percent to 296 percent. The Department of Human Services, which was responsible for the Medicaid Community Mental Health Services Program at the time of the 1998 audit, was not able to provide justification for the wide variation in rates. Widely disparate rates provide the appearance that rates are not equitable among service populations and service regions. Additionally, these disparities could result in significant variations in the level of mental health services that Medicaid members receive. Since the 1998 audit, the Departments of Human Services and Health Care Policy and Financing have taken a number of actions in an attempt to smooth the variance among rates, including consolidating the number of BHOs and having an actuary certify the soundness of rates paid to the BHOs.

Historically, the main factor affecting the development of managed care mental health rates in the early years of the Medicaid Community Mental Health Services Program was the then-existing federal requirement regarding the upper payment limit under 42 CFR 447.361. In response to the federal requirement, Section 25.5-5-408, C.R.S. (formerly Section 26-4-119, C.R.S.), was enacted effective July 1997, which required that all managed care programs cost no more than the equivalent fee-for-service program. Section 25.5-5-408(1)(b), C.R.S., specifically states that "under no circumstances . . . shall the state department pay a capitation payment to an [Managed Care Organization] that exceeds ninety-five percent of the direct health care cost of providing these same services on an actuarially equivalent Colorado Medicaid population group . . . ."

Although CMS eliminated the upper payment limit in 2002, state statute remains unchanged. We found during the current audit that as a result of the statutory requirement, the Department continues to base 70 percent of the managed care mental health rates on historical fee-for-service data from 1998 projected forward to present. In other words, the rates currently paid to the BHOs are determined using a weighted average approach with 70 percent of the rate derived from the original 1998 capitation rates (based on fee-for-service data) projected forward and 30 percent of the rate based on more recent "encounter" or service data. Effectively this means that the rate differences identified in the 1998 audit continue to be built into the rates currently paid by the State to the BHOs, and subsequently paid by the BHOs to the Community Mental Health Centers that provide the majority of mental health services to Medicaid members. The current audit found that rates continue to reflect disparities similar to those that occurred

at the outset of the program 12 years ago, with some lessening due to the consolidation from the previous eight BHOs to the current five and the actuarial certification of the BHO rates. The implications of this continued practice of primarily basing rates on historical fee-for-service data are discussed throughout this report, most specifically in the concluding chapter focused on rate setting.

Audit Scope

The purpose of this audit was to: (1) review and assess Colorado's current rate setting methodology for the Medicaid Community Mental Health Services Program to identify limitations in the current methodology and components used in the methodology and to make recommendations for future improvements to rate setting and (2) conduct a comprehensive review of each BHO's infrastructure for managing service utilization and quality. This included assessing the controls in place at the BHOs to ensure that services provided are medically necessary, determining whether access to services has been limited inappropriately by the managed care approach to service provision, and evaluating whether services are reported accurately to the State. The State Auditor contracted with Mercer Government Human Services Consulting (Mercer) to conduct the audit. During the audit, we requested and reviewed policies and information from each BHO for an initial desk review related to utilization management practices, service encounter tracking and reporting, quality management systems and controls, and customer service. We also reviewed service utilization reports based on Fiscal Year 2005 data, since Fiscal Year 2006 data have not been fully compiled as of the time of this report. We visited each of the five BHOs and conducted interviews with staff at all levels of the BHO organization and similar interviews with the executive directors/chief executive officers of all of the participating CMHCs to augment the information obtained through the desk review. Finally, we reviewed audited financial data from each BHO.

Service Utilization and Quality
Chapter 1

Overview

Managed care is a system of delivering health care services that influences their accessibility, quality, and cost. Early attempts at managed care primarily focused on reducing costs by negotiating discounted fees with providers and conducting utilization reviews of high cost inpatient services such as inpatient hospital treatment, emergency room treatment, or residential treatment. As the managed care industry evolved, however, the focus shifted from cost containment to quality management, specifically the expectation that the right mix of services will provide the best medical outcome for the member at the most effective cost. The changes in federal regulatory oversight of Medicaid managed care organizations discussed in the Overview chapter formally initiated such a shift in the Medicaid program beginning in 2002. In response to these industry and federal regulatory changes, today's managed care programs should be designed to measure and influence program performance on the basis of critical indicators, such as individuals' access to affordable, high quality providers and improvement in the health care status of members.

In Colorado, the Department of Health Care Policy and Financing (Department) contracts with five Behavioral Health Organizations (BHOs) to "... provide or arrange for the provision of all medically necessary covered mental health services" for all individuals enrolled in Medicaid in the BHO's geographical service area. The BHO contracts also specify that the BHOs should maintain a "comprehensive provider network." The Department reports that it purposely eliminated the use of the terminology "internal" and "external" network providers from the BHO contract language in 2004 to discourage the BHOs from distinguishing between internal and external providers. The Department's intent is that each BHO develop a comprehensive provider network in which provider services are appropriately managed and available to all members needing services, and that the BHOs hold all providers to the same standards and levels of oversight. However, we found that the business practices of the five BHOs and ongoing reporting requirements (i.e., the Mental Health Services Accounting & Auditing Guidelines) continue to distinguish between internal Community Mental Health Center (CMHC) providers and external or non-CMHC providers. Differences between the two groups of providers are most apparent in the way that the BHOs pay the providers and the degree to which the BHOs oversee provider utilization. To pay for all medically necessary covered mental health services, each BHO receives a flat rate per month for each Medicaid member

living in the BHO's geographical service area, regardless of how many individuals actually seek services. These rates are differentiated based on the member's Medicaid eligibility category. In other words, the Department pays the BHOs flat monthly rates for each of the five eligibility categories (Elderly, Disabled, Children, Adults, and Foster Care). Regulations at the federal level for managed care programs such as Colorado's Medicaid Community Mental Health Services Program include rigorous expectations for ensuring the medical necessity of care provided. While the federal External Quality Review requirements under 42 CFR 438 include process measures related to medical necessity and utilization management (i.e., how a managed care organization controls an individual's access to services), compliance with these process requirements is not in and of itself sufficient to ensure that care is medically necessary. Therefore, both the integrity of state Medicaid systems and the ability of states to demonstrate medical necessity in the face of heightened federal scrutiny require managed care programs to maintain comprehensive and rigorous monitoring systems to ensure that medically necessary services are delivered and that quality care is accessible.

In our review of multiple states' managed care operations, we observed a number of components that represent industry standards and best practices and should be present in a managed care organization's utilization management program. These components include the following:

Prior authorization should be conducted for all intensive levels of care, including inpatient, residential, day treatment, intensive case management, and home-based services. Individuals generally should not receive care at these levels without a formal review by clinical care managers operating under the direction of the BHO's medical director.

Medical records should be reviewed regularly to determine whether any levels of care not subject to prior authorization are medically necessary. This should include routine review of statistically valid samples of medical records for individuals receiving services that are not prior-authorized.

Utilization data should be analyzed regularly to monitor utilization trends by level of care and across providers. Aggregate data on utilization should be reviewed regularly by clinical managers (including the medical director) to analyze and monitor utilization trends by level of care and across providers. In addition, service utilization by individual member should be monitored against specific criteria. Utilization patterns outside of established criteria ranges should trigger additional reviews of specific individual cases to protect against over- or under-utilization.

Clinical staff making utilization management decisions should be formally supervised. This should include formal face-to-face supervision by the medical director and senior clinical staff, formal training opportunities specifically designed to improve the quality of clinical staff's utilization management activities, monitoring of inter-rater reliability for utilization management decisions (where the reliability, or consistency, of utilization decisions is measured across clinical care management staff using standardized clinical case examples), and blind monitoring to observe and document clinical care management staff's customer service skills and ability to apply the published medical necessity criteria of the BHO (blind monitoring refers to observation of staff making utilization decisions when the staff member is not aware that they are being observed). On a day-to-day basis, medical directors and their senior clinical staff should be involved in training, supervision of staff involved in utilization management, provider audits, performance management of the clinical department, and the review of complex clinical cases.

Medical directors and the medical management department of a managed care organization should be involved in strategic planning and executive oversight, as well as leadership of day-to-day clinical operations. The medical director should play a key role or chair committees overseeing utilization management, quality, and credentialing activities. In addition, the medical director should have ultimate authority over the development and oversight of clinical policies, procedures, and practice protocols; staff development and training; provider communications and training; and all medical necessity determinations.

Medical directors should be involved in fiscal planning and review of fiscal performance. Clinical decisions should not be driven by fiscal performance as the managed care operation is at its core a clinical operation. However, the medical director should have input into how clinical program needs and changes will influence fiscal performance and perform ongoing reviews of utilization trends and financial reports to monitor information about the performance of the managed care program. For example, spikes in rates of inpatient or residential care can highlight the need for the medical director to initiate additional review processes or community-based program development.

During our review of Colorado's Medicaid Community Mental Health Services Program, we evaluated the Department's oversight of the BHOs and whether the BHOs have the above components in place as part of their utilization management and monitoring for their respective provider networks.

BHO Utilization Management Practices

Utilization management is a central component of managed care. It should consist of a comprehensive approach that is based on data analysis and that targets oversight toward high cost and complex cases across levels of care more broad than just monitoring inpatient services. In addition, utilization controls should be augmented by network management, care management, medical management, case management, and other clinical programs that are focused on improving access to and quality of care. Utilization management includes monitoring for both over- and under-utilization of care. Over-utilization occurs when a managed care organization provides more services than are medically necessary or delivers services that do not provide an increased health benefit. Under-utilization occurs when a managed care organization or service provider does not provide the services needed to appropriately treat the member's diagnosed condition.

The Department manages Medicaid mental health services and associated expenditures through capitated arrangements with the BHOs in which each BHO agrees to provide all medically necessary care to Medicaid members for a fixed payment per member per month. This payment differs based on the eligibility category of the Medicaid member. In turn, the BHOs manage the services of their CMHC internal provider networks through sub-capitated arrangements in which the CMHC agrees to deliver all medically necessary services to Medicaid members in need of CMHC services for a fixed amount based on anticipated costs, not member months or rate categories. The BHOs pay providers in their non-CMHC external provider networks, including both inpatient providers and additional community-based providers, on a fee-for-service basis. Capitation arrangements, such as those between the State and the BHOs and between the BHOs and the CMHCs, are intended to limit financial risk to the State and the BHOs that result from over-utilization of services. However, capitation arrangements can provide a false sense of security that all services provided are medically necessary.

For example, three of the five BHOs stated that it was not necessary for them to conduct utilization management oversight activities over their internal provider network (i.e., the CMHCs) because all CMHCs are subject to sub-capitation arrangements, and therefore are at financial risk for their own utilization of services. Additionally, although there is some onsite evaluation of utilization management provided through the Department's External Quality Review process, this process does not encompass a review of all industry standard

utilization management procedures. Therefore, the Department does not have a comprehensive program for systematically monitoring utilization management across all BHOs.

While it is true that the BHOs and the CMHCs have a strong incentive not to over-utilize care and spend more on care than their capitated arrangements allow, this is not the same as ensuring that care provided is medically necessary or results in a beneficial outcome. Without active review of the care provided by CMHC providers, BHOs would have difficulty demonstrating that care delivered by the CMHCs is medically necessary or that services provided are efficient and effective in addressing the member's health care needs. Additionally, capitation arrangements provide strong financial incentives for BHOs and CMHCs to limit service expenditures in order to stay within their sub-capitated contracts, and as a result, there is a risk that BHOs and CMHCs may limit access to services or provide a lower level of care than is medically necessary. Therefore, it is important for the Department to monitor the BHOs' utilization management practices.

We reviewed the Department's oversight of BHO utilization management, and we conducted comprehensive reviews of BHO utilization management policies, procedures, and practices through a desk review and follow-up on-site visits with each of the five BHOs. At each BHO, we conducted interviews with BHO care managers and utilization managers, medical directors, and quality improvement staff. The results of these reviews were compared to the 10 separate utilization management practice components summarized earlier that represent the industry standards and best practices observed in our review of Medicaid mental health managed care operations in numerous states. Because the BHOs have different utilization management practices for their internal and external provider networks, we analyzed the BHOs' practices for managing each network separately. We found that the Department has not set standards or contractual requirements for the BHOs to conduct utilization management activities beyond those required by the External Quality Review process. As discussed, the utilization management aspects of the External Quality Review procedures are not adequate to ensure services provided are medically necessary. Additionally, we found that the Department needs to conduct proactive oversight and monitoring of the BHO's utilization management practices. Further, we found that although the BHOs actively monitor utilization in their *external* provider networks, generally the BHOs are not conducting adequate utilization management of the services provided by their *internal* provider networks.

It is critical that the BHOs conduct adequate utilization management reviews of internal network providers because the majority of expenditures of the Medicaid Community Mental Health Services Program are for services provided by the

CMHCs. For example, depending upon the individual BHO, the percentage of total BHO expenditures incurred through the CMHC internal provider networks was between 64 percent and 86 percent of the BHO's total expenditures for Fiscal Year 2005. When looking at BHO expenditures for medical services only, the amount of medical service expenditures incurred by internal network providers for Fiscal Year 2005 was as high as 95 percent, as demonstrated by the following table.

Department of Health Care Policy and Financing
Medicaid Community Mental Health Services Program
Behavioral Health Organization (BHO)
Comparison of Medical Spending
Internal versus External Provider Network
Fiscal Year 2005
(In Thousand's)

BHO	Internal Provider Network (CMHC) Expenditures	Internal Provider Network (CMHC) Percent of Total Medical Expense[1]	External Provider Network Expenditures	External Provider Network Percent of Total Medical Expense	Inpatient Medical Expenditures	Total Medical Expense
1	$18,400	67%	$5,300	19%	$3,800	$27,500
2	$26,600	89%	$300	1%	$3,100	$30,000
3	$9,700	95%	$200	2%	$300	$10,200
4	$11,200	84%	$1,000	7%	$1,200	$13,400
5	$20,900	89%	$1,500	6%	$1,000	$23,400
Total	**$86,800**	**83%**	**$8,300**	**8%**	**$9,400**	**$104,500**

Source: *Mercer analysis of information in BHO audited financial statements for Fiscal Year 2005.*
Notes: [1] *Based on category of spending as a percent of total Medical Expense for Fiscal Year 2005.*

Overall, our review found that although the BHOs use 9 of the 10 standard utilization management practice components to manage their non-CMHC external provider networks, the majority of BHOs use only one of the utilization management practices to oversee their internal provider networks. Therefore, BHOs generally lack adequate monitoring procedures to oversee the appropriateness of the majority of their expenditures. Specifically, we found:

- None of the five BHOs currently require that CMHCs receive prior authorization to deliver intensive services to patients such as residential, day treatment, intensive case management, or home-based services.

- None of the five BHOs regularly review CMHC service encounter data (i.e., data on actual treatments and services provided to members) to identify cases that meet criteria that should trigger additional reviews by the BHO for possible over- or under-utilization by the CMHC. One BHO is in the process of implementing a method that monitors aggregate levels of service delivery by its CMHC, but the BHO does not review individual cases identified through this process for appropriateness of care. Aggregate-level reviews will not address problems at the individual case level.

- Only one of the BHOs actively monitors and analyzes data on services delivered at an aggregate level and by different levels of care for CMHC providers.

- Three of the five BHOs limit the roles of their medical directors in terms of direct oversight of CMHC care to those instances in which CMHC providers have denied care to Medicaid patients. The medical directors of these three BHOs also serve as CMHC medical directors, and therefore they are involved more broadly in the oversight of care delivery at their CMHCs. However, because in these instances the CMHCs own the BHOs, our concern is that the medical directors perform their oversight of CMHC care delivery from the perspective of the CMHC, not the BHO. Only two BHOs employ medical directors who are not also CMHC staff. In these two cases, the BHO medical directors participate more actively in broader oversight of utilization management activities with respect to services provided by the CMHCs, including chairing the BHO utilization management committee and being involved in data-driven medical management.

- None of the BHOs perform regular, formal supervision of CMHC staff making utilization management decisions for the internal provider network. One BHO does require that the CMHC self-report on delegated utilization management activities that include inter-rater reliability reporting, but these self-reports are not audited.

- All five BHOs delegate responsibility for utilization management to the CMHCs for services provided through the internal provider network, and three BHOs also delegate prior authorization of all inpatient services to the CMHCs. While four of the five BHOs have formal delegation agreements in place with their CMHCs outlining the specific terms of the responsibilities delegated to the CMHCs, only one of these four BHOs conducts any formal monitoring of how the CMHC carries out the delegated utilization management activities. Even this BHO's efforts include only self- reported results without direct monitoring by the BHO.

> While comprehensive medical record audits are conducted as part of the required External Quality Review process, these audits do not include assessment of whether the level of care delivered is medically necessary. Without formal and direct monitoring of the medical necessity determinations made by CMHCs with delegated utilization management responsibilities, there is no mechanism in place to ensure that the CMHCs carry out their contractual obligations for managing utilization. In other words, the CMHCs are responsible for overseeing their own utilization management, with essentially no external oversight by the BHOs of these utilization management processes.

A table containing more detail on the 10 utilization management practice areas reviewed, and whether those areas are currently used by BHOs to conduct utilization management activities for external and internal provider networks, is included in Appendix A.

In addition to following the standard protocols for managing utilization discussed above, managed care organizations should specifically monitor for under-utilization. Our review found that BHOs rely on a reactive system of oversight for under-utilization. Specifically, if a Medicaid member seeks care, and the member protests either the provider's denial of care or the level of care that the provider recommends, then this action must be documented and reviewed by the BHO medical director. This process is a direct requirement of the federally-mandated External Quality Review regulations effective in August 2003, and all five BHOs have implemented such a process. The problem with relying solely on this approach is that the BHO will only identify potential instances of under-utilization if the member actively disagrees with the service provider's care decisions. If too little care is provided and the member does not know either that the level of care is inappropriate, or the member is not able or willing to tell the provider that they disagree with the care plan, then the under-utilization will not be identified. Given the vulnerability of many mental health service recipients and the technical nature of many mental health services, relying solely on the recipient to identify all instances of limited or inadequate access to care is not a reliable means of monitoring for under-utilization. This reactive approach could have implications for the adequacy of the care provided and ultimately result in high costs of care in the long-run through increased crisis intervention services, such as emergency room and inpatient treatment that result from a lack of more routine care.

As part of the development and implementation of a comprehensive system of utilization management, the BHOs should follow specific standards to proactively monitor for under-utilization. We found that neither the Department nor any of the

BHOs actively monitor for under-utilization by their CMHC providers. The Department should work with the BHOs to develop standards and practices based on the following indicators to identify potential under-utilization by providers.

- **Missed Appointments**. BHOs should have processes in place to identify members that discontinue care prematurely, with particular attention to needed outreach for members at higher risk. For example, any member missing follow-up appointments post-discharge from episodes of 24-hour care or otherwise missing three or more outpatient appointments of any type could trigger review by a BHO care manager. In addition, any active authorization for which care has not been delivered in a 60-day period could be identified for review.

- **Readmission Rates**. BHOs should identify members at the individual member level (not just in aggregate) that are readmitted to inpatient or residential care within 7 and 30 days of discharge. Any cases readmitted in these time frames could trigger a special review.

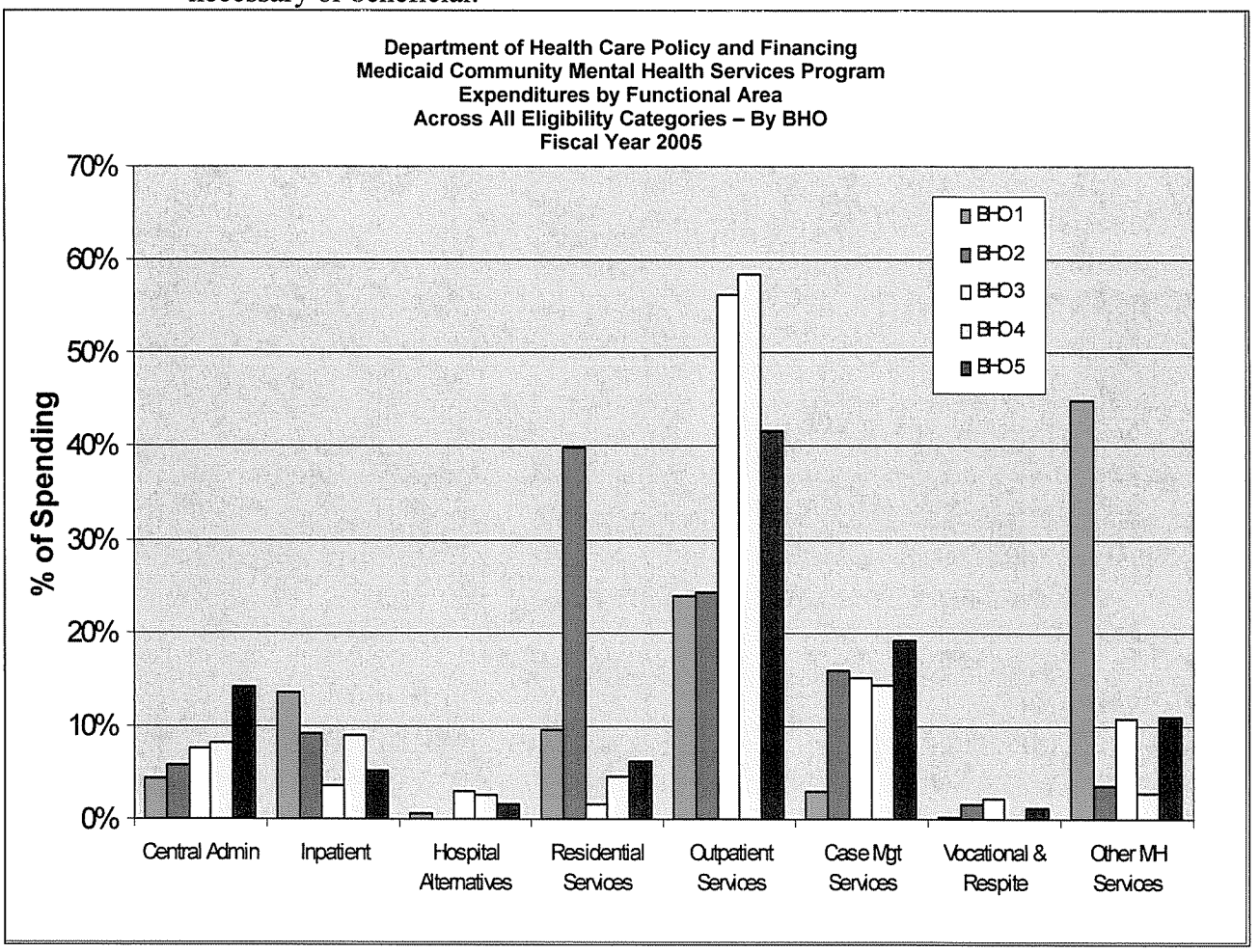
- **Crisis Service Use**. Crisis services are by their nature responses to situations that are out of control. While many people need repeated crisis support, this can also be a sign of inadequate care planning or ineffective or inadequate service availability. BHOs should have processes in place to detect and trigger a review of members using a high level of crisis services. For example, BHOs could conduct a special review of any cases where four or more crisis services are used by a member within a 30-day period.

- **Under-Utilization at Any Level of Care**. Once services across levels of care are actively monitored by BHOs, service usage can be summarized and ranked from highest to lowest, and criteria related to the expected level of service use for each defined level of care can be developed. Any individuals receiving a level of service that is significantly below the average use for a given level of care could trigger a review by the BHO. A similar standard could also be developed for over-utilization.

- **Quality of Care Concerns**. Any case involved in a sentinel event or critical incident, such as a suicide, homicide, member injury, or allegation of abuse or neglect, should be reported by network providers to the BHO and trigger additional review.

Similar to the arrangement under the fee-for-service system that existed in Colorado prior to the implementation of managed care in 1995, our audit found that for the most part CMHCs continue to make decisions about the level of care that is to be provided with very little external oversight of the appropriateness of

their care decisions by the managed care organizations, or BHOs. One of the possible effects of such a lack of oversight of utilization management by the BHOs can be seen in the graph below. The graph shows spending across functional areas by BHO, including several types of clinical levels of care. There is wide variability in the use of some types of clinical services. For example, in the case of one BHO, Residential Services represent approximately 40 percent of its total spending, while all other BHOs incurred 10 percent or less of their total spending for Residential Services. Significant ranges among BHO spending can be seen for Outpatient Services and Other Mental Health Services as well. While there may in fact be medical justification for such widely varying utilization patterns, without adequate oversight of service utilization, both the Department and the BHOs will have difficulty demonstrating that such use is medically necessary or beneficial.



Source: Mercer analysis of Fiscal Year End 2005 Supplemental Schedules from the BHOs' financial statements and Independent Accountants' report.

Managed care practices are evolving across the country, and Colorado is not alone in having gaps in its system for overseeing utilization and medical necessity. We found evidence that many of the BHOs have taken initial steps to redesign and increase the rigor of their utilization management processes since the start of their new contracts with the State beginning midway through Fiscal Year 2005 (January 1, 2005). Generally, these improvements have been to increase the independence of financial and managerial oversight of the BHOs from the CMHCs, separating out more formally the ownership and management structures of the BHOs. As mentioned previously, the BHOs are generally owned or operated at various degrees by the CMHCs. After the 2005 contracts were in place, one BHO spun-off its managed care functions from its CMHC to an entirely new entity in order to increase independence in the BHO's oversight of the CMHC. Two other BHOs split more formally from their CMHC owners, naming executive directors who were independent of the CMHCs and formalizing distinctions between their utilization management programs and the CMHCs' clinical management. These BHOs also restructured to have chief financial officers who are independent from the CMHCs, further formalizing boundaries between the CMHCs and the BHOs. All five BHOs had implemented targeted provider monitoring and oversight in response to federal External Quality Review requirements.

While all of these changes are movement in the right direction, additional separation of authority between the BHOs and their CMHC providers is needed in the area of utilization management. Specifically, to remove real or perceived conflicts of interest between the BHOs and the CMHCs and to improve the BHOs' ability to function as managed care organizations, the Department should require BHOs to more directly and transparently manage utilization of services by the CMHCs. Without more formal separation, the CMHCs are in effect managing themselves, and there is little assurance that the CMHCs are managing care in a way that ensures the best interests of the State or that the individuals served by the CMHCs are adequately protected.

To accomplish this, the BHOs should significantly increase their utilization management activities to ensure that the appropriate level of medically necessary care is being provided to members served through their CMHC provider networks. Furthermore, utilization management is critical to ensure the validity of encounter data upon which the new rate setting methodologies proposed later in this report are based (rate setting is discussed in Chapter 2). Without adequate utilization management and oversight of the clinical care provided by CMHCs, encounter data used in the rate setting process will not be based on the medical needs of the Medicaid populations to be served, and will likely perpetuate disparities in the services provided and rates paid to providers with different utilization practices. In addition to the utilization management procedures required by the External Quality Review process, the Department should require the BHOs to comply with additional, industry-standard utilization management

procedures and ensure consistent management of service utilization among the BHOs. As part of developing a comprehensive utilization management strategy, the Department should continue working with the BHOs to eliminate distinctions between internal and external providers. The strategy should provide the BHOs flexibility to tailor oversight approaches to high volume providers and maintain the capacity for BHOs to monitor utilization by provider.

Given the timing requirements for rate setting, it is critical that the Department take action on this immediately. For example, if the Department is able to have improved utilization management procedures in place within the current fiscal year (Fiscal Year 2007), the first full year of encounters subject to these procedures will be those in Fiscal Year 2008, which will drive rate setting activities in Fiscal Year 2009. The rates will not be implemented until Fiscal Year 2010. The Department should incorporate requirements for minimum utilization management into its contracts with all BHOs that participate in the State's Medicaid Community Mental Health Services Program, monitor the BHOs for compliance to the requirements, and take appropriate action if BHOs do not adhere to the requirements.

Recommendation No. 1:

The Department of Health Care Policy and Financing should improve utilization management in the Medicaid Community Mental Health Services Program by:

a. Requiring the BHOs to disclose the nature and extent of their financial and organizational relationship with the CMHCs to the Department annually.

b. Reviewing the ownership and governance relationship between the CMHCs and the BHOs to ensure that oversight of utilization management is sufficiently transparent and accountable given the potential for conflicts of interest between the CMHCs and BHOs.

c. Working with the BHOs to develop requirements for a minimum set of utilization management procedures and incorporating these requirements into the State's contracts with the BHOs in order to supervise the activities of all providers, whether part of the BHO's internal or external provider networks. The distinction between "internal" and "external" providers should be eliminated, although BHOs should be allowed to implement tailored oversight approaches for high volume providers, such as the CMHCs, and maintain the capacity to monitor utilization by provider. Procedures should include standard protocols that monitor for both over- and under-utilization. In addition, since industry standards for utilization

management will continue to evolve, the Department should implement a process for monitoring the adequacy of these minimum practice standards and updating them as needed over time. This process should involve BHOs, as well as periodic reviews of practices employed by other states.

d. Requiring BHOs to establish formal delegation agreements when delegating utilization management functions to any agency, especially their providers. Such agreements between the BHOs and any delegated entities (CMHCs or other organizations) should be reviewed and approved by the Department prior to the BHOs' execution of the agreement. Formal agreements to delegate utilization management should require the providers to furnish annual reports on utilization management procedures conducted and the documented results of those procedures. Delegation of utilization management functions should supplement but not replace utilization management activities conducted by the BHOs.

Department of Health Care Policy and Financing Response:

a. Agree. Implementation Date: July 2007. The Department will require the BHOs to disclose the nature and extent of their financial and organizational relationship with the CMHCs to the Department by March 2007 and annually and incorporate this requirement into the BHO contracts by July 2007.

b. Agree. Implementation Date: July 2007. The Department will review the ownership and governance relationship between the CMHCs and BHOs to ensure that oversight of utilization management is sufficiently transparent and accountable. Where BHOs do not establish or maintain oversight of utilization management functions, corrective action will be required.

c. Agree. Implementation Date: October 2007. The Department will work with the BHOs to develop requirements for a minimum set of utilization management procedures for overseeing the activities of both CMHC and non-CMHC providers and incorporate these requirements into the BHO contracts. Procedures will include standard protocols for monitoring over- and under-utilization. The Department will work with the BHOs to implement processes for monitoring the adequacy of utilization management practice standards and updating them as needed over time.

d. Agree. Implementation Date: December 2007. The Department will require BHOs to establish formal delegation agreements when delegating utilization management functions. Such agreements between a BHO and

any delegated entity will be reviewed and approved by the Department prior to the BHO's execution of the agreement. Formal delegation agreements for utilization management will require delegated providers, which may include CMHCs, to report utilization management activities and results of procedures. Delegation of utilization management functions will not replace oversight of utilization management activities by the BHOs.

Financial and Quality Performance

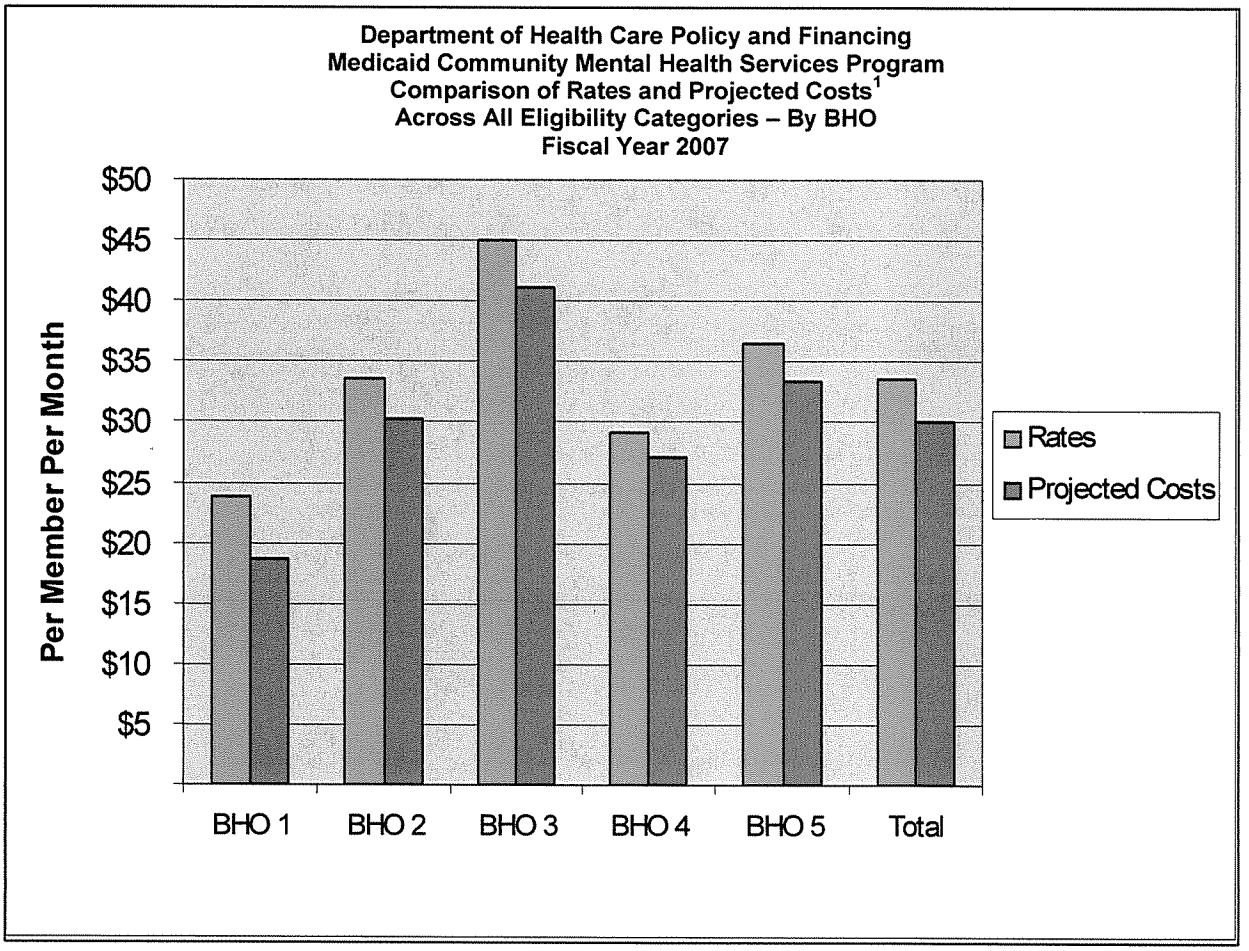
Monitoring financial reports and quality performance measures is a key component to understanding the actual cost of delivering care, the financial condition of each BHO, and the quality of care offered through the BHOs. Many states have implemented financial and quality performance measure reporting requirements for their health plans to obtain cost and financial information on a quarterly basis. Financial reports reflect data such as administrative spending and the overall profit or loss experience of a BHO, which cannot be determined simply by a review of encounter data. Analysis of cost and financial information also complements the review of encounter and utilization statistics to support the rate setting process and allows the State Medicaid Agency to conduct additional monitoring of BHO performance. Once cost data and supporting details are collected, a comparison between BHOs can be performed to identify differences in costs, including analysis of costs per person by functional area, category of spending, or eligibility category. Similarly, cost information, service encounter information, and quality performance measures can be used in tandem to identify the most cost-effective way to deliver high quality care. We found that the Department needs to improve its financial and quality performance monitoring of the Medicaid Community Mental Health Services Program by developing specific financial and quality performance indicators.

To obtain an understanding of the BHOs' financial information, we performed a desk review of the Fiscal Year 2005 audited financial statements and followed up on this review during on-site visits at each BHO. Additionally, we reviewed data supplied by the Department on the number of member months for each BHO; these data represent the number of Medicaid members in each BHO's geographical area on a monthly basis, which is useful for performing comparisons between BHOs on a per member basis. We performed a number of analyses related to the BHOs' financial performance. These types of comparisons would be useful for the Department to incorporate into its future monitoring of BHO performance and into contracts with the BHOs. In addition, this type of analysis

would assist the Department in addressing questions from stakeholders on rate parity among BHOs and in identifying BHO-specific service and cost issues that may warrant further investigation or intervention.

With respect to the graphs that follow, it is necessary to point out that these graphs are provided as examples that illustrate the types of analysis that would be beneficial for the Department to perform. Given the lack of consistency and other discrepancies described in Chapter 2 regarding how encounter data are reported by BHOs and how the Department prices encounters, information in the graphs cannot be relied upon as a basis for firm conclusions regarding BHO performance.

First, we compared Fiscal Year 2007 rates to Fiscal Year 2007 projected costs by BHO. We projected Fiscal Year 2007 expenditures by trending Fiscal Year 2005 audited BHO expense data at the 3.85 percent cost-of-living rate used by the Department's actuary, PricewaterhouseCoopers, LLC during their certification of the 2007 rates. This analysis was performed to demonstrate how the Department could use financial data and project it forward to assess whether individual BHOs would be likely to break even, make, or lose money on a per member per month basis in the year ahead. For all BHOs, this graph shows that the Medicaid mental health rates paid per person (per member month) are expected to exceed the projected cost per person of providing Medicaid mental health services. Additionally, these data show that the profit margin of BHO #1 is higher than that of the other BHOs. This type of analysis would be useful in helping the Department to identify situations where adjustments in rates may be warranted, or where rates and costs at a particular BHO require further investigation.

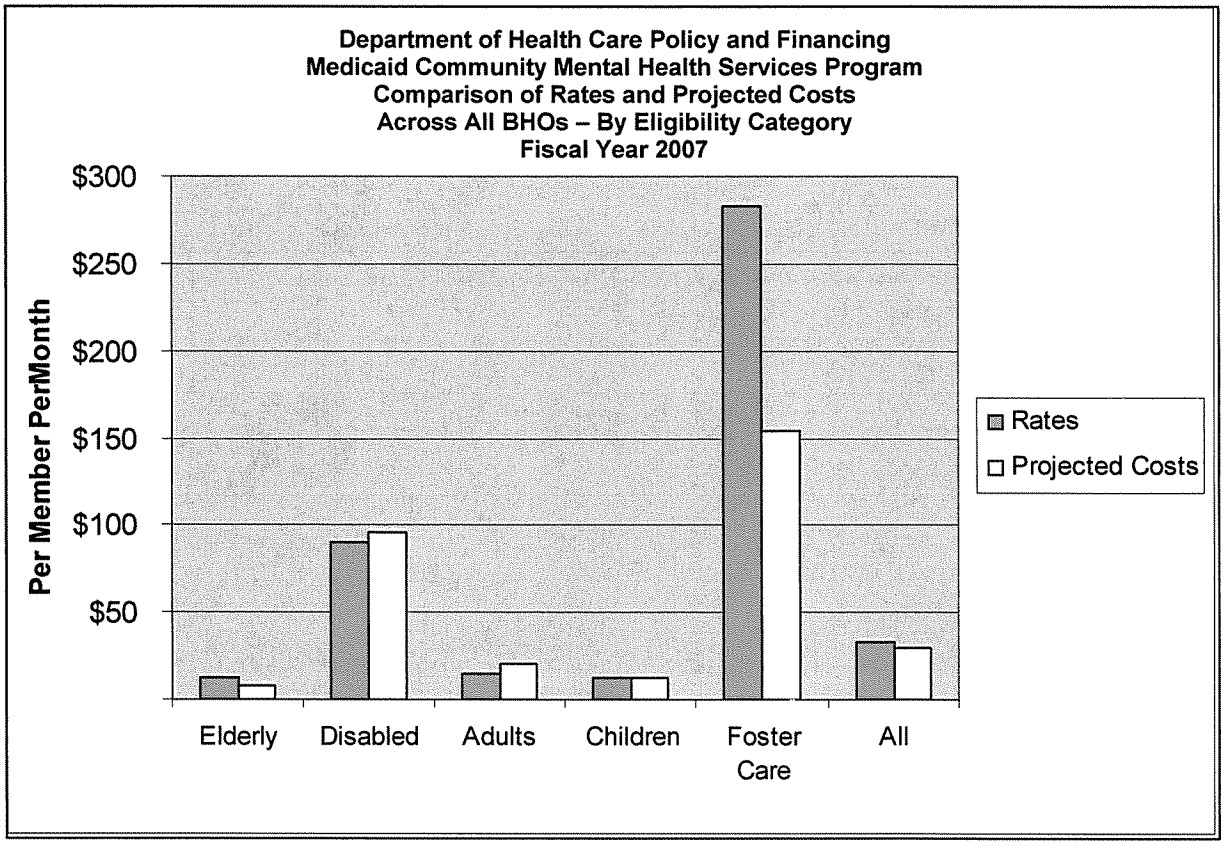


Source: Mercer analysis of Fiscal Year End 2005 Supplemental Schedules from the BHOs' financial statements and Independent Accountants' report and analysis of Final Rates for Fiscal Year 2007 and Fiscal Year 2007 Per Capita Costs from Pricewaterhouse Coopers' Actuarial Certification of Department rates.

Note: [1]Totals across all BHOs and all eligibility categories are weighted averages based on actual Fiscal Year 2005 BHO member months. Cost data by eligibility category does not include a pass-through amount of approximately $11.6 million paid to one BHO under the Goebel lawsuit settlement during Fiscal Year 2005. Projected costs are taken from Fiscal Year 2005 BHO expense data trended at the 3.85 percent cost-of-living rate; this is consistent with the method used by PricewaterhouseCoopers LLP in its certification of rates performed under contract with the Department of Health Care Policy and Financing. Cost data for BHO #3 and BHO #5 are for the second half of Fiscal Year 2005 only and are trended from that point.

Second, we compared Fiscal Year 2007 rates and Fiscal Year 2007 projected costs by eligibility category. This comparison shows that the rates paid on a per member per month basis by eligibility category do not appear to cover the costs per member for all categories, except for the Elderly and Foster Care eligibility categories. This could mean that rates paid for services in this category do not

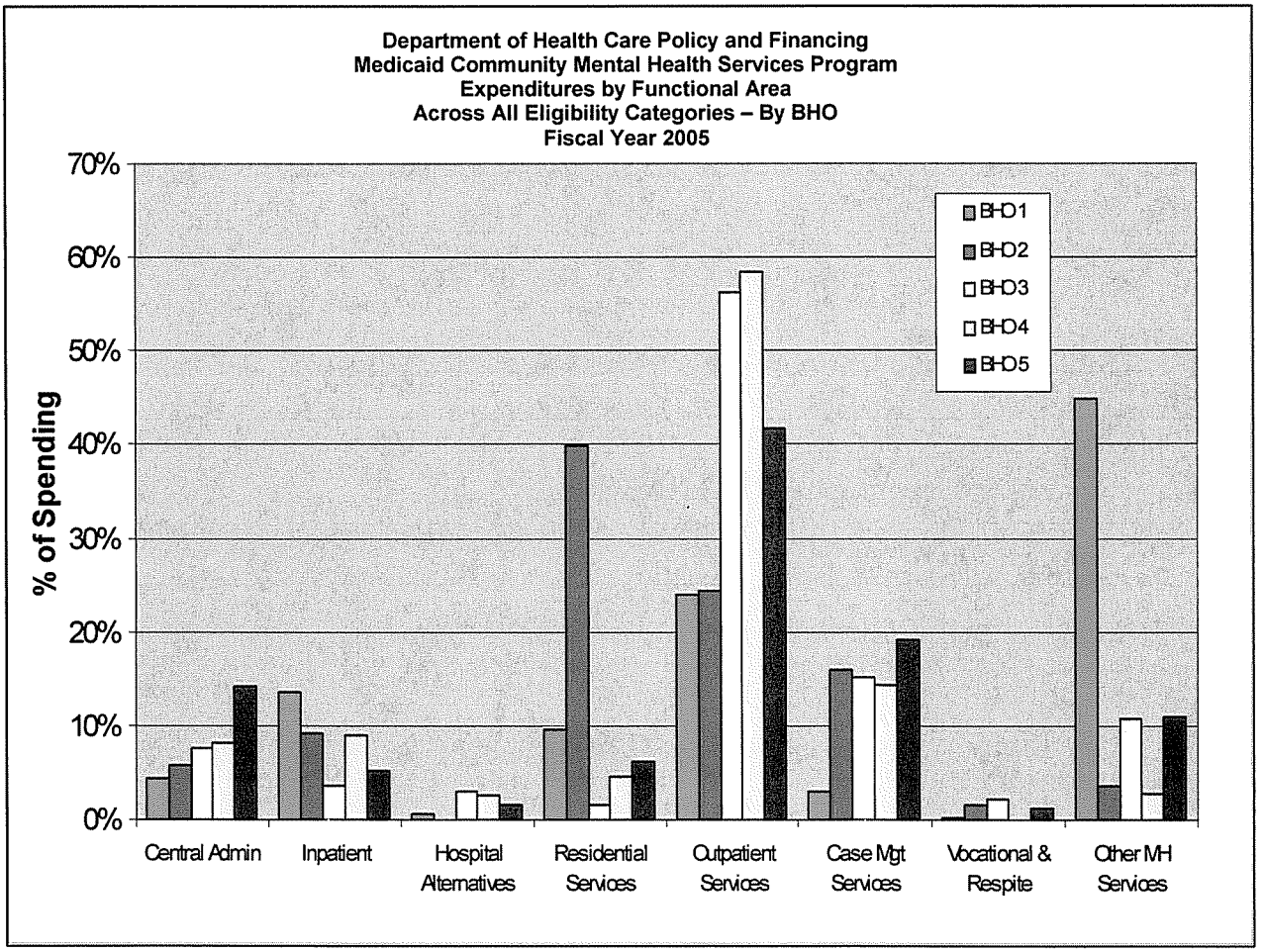
align with costs for that eligibility category, and that the Foster Care rates may be subsidizing the care for other eligibility categories. Again, this representation could be inaccurate because of the problems with reporting of encounters by the BHOs discussed in Chapter 2. However, if this analysis is substantiated with valid encounter and cost data, it could indicate a need to realign rates. These types of discrepancies warrant further investigation and monitoring because CMS requires that managed care rates be actuarially sound. This means that the rate paid must be appropriate for the specific population that the rate is intended to cover. Furthermore, one rate should not subsidize the services provided under another eligibility category.



Source: Mercer analysis of Fiscal Year End 2005 Supplemental Schedules from the BHOs' financial statements and Independent Accountants' report and analysis of Final Rates for Fiscal Year 2007 and Fiscal Year 2007 Per Capita Costs from Pricewaterhouse Coopers' Actuarial Certification of Department rates.

Third, we compared Fiscal Year 2005 spending, as a percent of total spending by functional area for each BHO. This analysis shows that BHO #2 reported significantly higher spending on Residential Services per member per month as compared to BHO #3, which had lower spending on Residential Services and higher spending on Outpatient Services. In addition, BHO #3 reported the lowest Inpatient costs when compared to the other BHOs. These types of disparities in

service protocols warrant additional follow-up by the Department to evaluate potential differences in client outcomes for different types of services, such as the use of Residential Services versus Outpatient Services. Additionally, this analysis shows that BHO #5 had the highest percent of spending (14.2 percent) for Central Administration and is the only BHO to exceed the nine percent administrative assumption factored into the rates. BHO #1 has the lowest percent of spending (4.3 percent) for Central Administration, well below the nine percent assumption. Both situations warrant further investigation. This type of reporting and analysis can be used to identify how BHOs are allocating resources and eventually to link with whether a particular type of service protocol might result in better health outcomes for members. Such analysis can be used to support continuous improvement and best practices among the BHOs through policies that reward service protocols that provide the most cost-efficient, quality outcomes.



Source: Mercer analysis of Fiscal Year End 2005 Supplemental Schedules from the BHOs' financial statements and Independent Accountants' report.

In addition to monitoring financial reports, the Department should monitor quality performance measures. Standards for measuring the quality of care provided by managed care organizations have evolved considerably since the advent of Medicaid mental health managed care in Colorado. Specifically, the National Committee for Quality Assurance (NCQA) and other states, such as Pennsylvania, have developed quality performance measures for managed care systems. Quality performance measures developed include:

- Inpatient utilization in terms of admissions per 1,000 members, days per 1,000 members, average length of stay (in aggregate and with breakdowns by standard age groups).

- Outpatient utilization in terms of visits per 1,000 members (in aggregate and with breakdowns by standard age groups).

- Readmissions to inpatient settings within 7 and 30 days.

- Follow-up appointments at 7 and 30 days after discharge from inpatient treatment.

- Emergency room use, including visits per 1,000 members and proportion of visits that result in an admission (in aggregate and with breakdowns by standard age groups).

- Target penetration rates – or targeted percentage of the Medicaid population that seeks and receives services (in aggregate and with breakdowns by standard age groups).

States and health plans that have instituted standard performance measures like these must then collect baseline data on which to base the performance standards specific to their state's Medicaid plan and system. States vary considerably in their Medicaid benefit design and provider capacities, and sometimes also vary across state regions, so performance standards must be tailored to each state's specific circumstances.

In reviewing the quality reporting systems of the BHOs, we found that BHOs were in almost all cases tracking some of the above performance measures for their own use and, in the case of three BHOs using a common subcontractor to process encounters, comparing trends across the respective BHOs. However, we found that BHOs were not systematically reporting industry-standard performance reporting measures to the Department. Furthermore, the Department has not established (1) consistent standards for BHOs to calculate these measures, or (2)

standardized statewide reporting requirements that BHOs should use to report these measures. We found that while many of these measures were included in quality indicator reports or External Quality Review findings submitted to the Department, the measures are not reported in a standardized format for comparison across BHOs. For example, all BHOs track inpatient utilization in some manner, but some perform this analysis in terms of number of visits per member and others track inpatient utilization on an aggregate basis. Additionally, four BHOs track usage of allocated adult state hospital beds at the individual level (though not in aggregate), and one BHO does not track adult use of state hospital beds at all. All BHOs track penetration rates, which are rates that measure the percentage of all members that receive services; however, some do so only in aggregate and others do so only by child and adult age groups. We did not identify any apparent barriers to reporting these types of data consistently across BHOs. However, in the absence of Department-promulgated requirements for BHOs to report on industry-standard performance measures, BHOs will naturally vary in their reporting approaches.

To develop a process for standard reporting for key financial and performance measures, the Department should perform a systematic review of existing financial reporting requirements and review financial and performance reporting standards used by leading managed care states. The Department should then discuss reporting options with representatives from the BHOs to identify a minimum set of standard financial and performance reporting requirements. The examples of analysis and reporting in this section provide information on the types of financial analysis and performance reporting measures used by the leading managed care states that we have reviewed. The measures chosen by the Department and BHOs should reflect the performance areas the State is targeting and the most reliable way to track them. Furthermore, the Department should develop processes to regularly review standard financial and performance reporting processes and regularly update those processes to ensure their reliability and relevance, as standards and systems evolve over time. As financial and performance reporting becomes more consistent and comparable among the BHOs, the Department should work to incorporate such measures into the rate setting process. Some future considerations relating to the rate setting process are discussed at the end of Chapter 2.

Recommendation No. 2:

The Department of Health Care Policy and Financing should improve reporting and analysis of financial and performance information related to the Medicaid Community Mental Health Services Program by:

a. Reviewing existing financial and clinical performance measures reported by the BHOs to ensure the data elements are reported consistently across the BHOs.

b. Developing standardized financial reports and performance measures that reflect key aspects of the Medicaid Community Mental Health Services Program and are consistent with nationally recognized measures. The Department should require all BHOs and their provider networks to submit standardized reports on a periodic basis and incorporate these requirements into the State's contract with each BHO.

c. Implementing periodic analysis of information reported by BHOs and their provider networks, including analysis of rates versus actual reported costs, detailed per member per month cost analysis by spending and eligibility category, rates by eligibility category, and clinical quality performance indicators. This analysis should be used as a basis for identifying areas in which to conduct further investigation and appropriate action, as well as to support the rate setting process.

Department of Health Care Policy and Financing Response:

a. Agree. Implementation Date: Ongoing. The Department will continue to work with the BHOs to ensure consistency in the existing clinical performance measures.

b. Agree. Implementation Date: July 2008. The Department will develop additional standardized financial reports and performance measures by July 2007 that reflect key aspects of the Medicaid mental health program and are consistent with nationally recognized measures. The BHOs will need to modify data systems for reporting additional clinical measures. This will be accomplished by September 2007. These reports will be submitted to the Department on a periodic basis and the reporting requirements will be incorporated into the BHO contracts. Additional clinical measures will be finalized for routine reporting by July 2008.

c. Agree. Implementation Date: July 7, 2007. Periodic analysis of information reported by the BHOs will begin. The Department will implement periodic analysis of information reported by the BHOs and use this analysis as a basis for identifying areas in which to conduct further investigation and appropriate action.

Telephone Access to BHOs

BHOs maintain telephone access lines that enable the Medicaid members they serve to contact a BHO at any time of day to access needed mental health services. The access lines are staffed 24 hours per day, seven days per week by either clinicians or non-clinicians with experience and training in behavioral health issues. If non-clinicians are used, federal regulations require that there be immediate access to a licensed, clinical staff member for calls to the BHO requiring clinical assistance. These standards are specific to calls made to the BHO's primary access line. Providers such as CMHCs may also provide their own access lines, but these federal standards pertain only to the primary BHO telephone line.

To ensure that member calls are answered quickly, BHOs should provide adequate staff resources to handle the volume of calls. Based on our review of Medicaid mental health managed care plans in other states, staff-to-member ratios vary depending on the plan's covered services, volume of users, managed care program requirements, and call volume. Typically, plans have one staff member answering calls for between 7,500 and 25,000 covered members depending on the Medicaid plan.

Most leading managed care organizations monitor call performance to their primary access line on a weekly basis and report call performance statistics to their state oversight agency at least quarterly. These reports assess performance on key indicators, such as average speed of answer, percent busy, call abandonment rates, and average length of calls for individual staff and clinical teams. Many states have implemented performance guarantees with associated penalties if the managed care organization is not able to meet defined performance standards on key call statistics. Based on our reviews in other states, typical performance thresholds include average time to answer of 30 seconds, less than 3 to 4 percent abandonment rates, and zero percent busy. In addition to call responsiveness statistics, well-run managed care organizations conduct blind call monitoring, where senior clinicians or managers conduct live monitoring of staff that take calls to assess the appropriateness of information provided, referrals made, and customer service. Results of the blind monitoring and call performance statistics should be reviewed with staff as part of the managed care organization's regular supervision activities.

We found that only two BHOs operate telephone access monitoring systems that reflect the industry standards described above. The other three BHOs neither conduct blind monitoring nor collect call statistics for their primary access lines. As a result, the three BHOs without monitoring systems cannot ensure that

individuals seeking mental health assistance through the primary access lines receive appropriate customer service. In the mental health services field, it is critical that a person calling his or her managed care organization for assistance be helped quickly and appropriately without having to make multiple inquiries or call back due to busy lines or dropped calls. Particularly in the area of mental health services, poor service by the managed care organization risks failure to respond adequately to an individual experiencing a serious, life-threatening crisis.

To ensure adequate responsiveness of BHO primary access lines, the Department should specify performance standards, such as abandoned or dropped call rates under 3 percent, average time to answer under 30 seconds, and no busy signals, as well as require automated systems for monitoring such performance. To ensure the quality of calls received, standards should also require that BHOs regularly conduct systematic blind monitoring of customer service staff call quality, with more frequent monitoring for new staff or staff that are not meeting performance requirements. To ensure accurate reporting, the Department should develop a standard format for BHOs to use when tracking and reporting on telephone access. These requirements would need to be incorporated into contracts with the BHOs, along with penalties for noncompliance.

Recommendation No. 3:

The Department of Health Care Policy and Financing should ensure adequate performance of telephone access lines maintained by BHOs by identifying performance standards such as those discussed above. These standards should be incorporated into BHO contracts, along with penalties for noncompliance.

Department of Health Care Policy and Financing Response:

Agree. Implementation Date: January 2008.

The Department will require BHOs to have automated systems for monitoring telephone access. Performance standards, such as those discussed in the report, will be identified by the Department and incorporated into BHO contracts. Telephone access line performance standards will be added by July 2007 to the access to care reporting currently in place. To monitor BHO performance, the Department will establish a standard format for BHOs to use in tracking and reporting key telephone call statistics to the Department. Fully operational BHO telephone monitoring systems and reporting requirements will be completed by January 2008.

The Department has existing language in the BHO contracts for remedial actions and sanctions (Section IV) and requires submission and successful completion of a corrective action plan when performance standards have not been met. These actions and sanctions will apply to telephone access standards.

Third Party Payers

Under federal regulations, Medicaid is the payer of last resort. Accordingly, State Medicaid programs are required by 42 CFR 433.135 through 433.148 to identify and recover liabilities owed by third party payers, such as private insurance companies, Medicare, or prepaid benefit plans. In other words, if a Medicaid member has private insurance that pays for mental health coverage, the private insurance benefits should be exhausted prior to services being paid for by the Medicaid mental health services program. Under Colorado's Medicaid Community Mental Health Services Program, the Department pays a capitated Medicaid mental health payment to each BHO for all Medicaid clients living in the BHO's designated service area. As part of this arrangement, the BHO agrees to provide all medically necessary mental health services to all members that seek care. As a result, the BHOs incur the actual medical costs, and therefore are responsible for third party recoveries.

For Colorado's Medicaid Community Mental Health Services Program, the BHO contracts require that the BHOs implement systems and procedures to identify potential third party payers and that, on a monthly basis, the BHOs notify the Department's Fiscal Agent (i.e., the entity the Department contracts with that is responsible for processing all Medicaid claims for payment) of any third party payers. The BHOs are required to actively pursue and collect from third party payers and provide quarterly reports to the Department on all recoveries made. The BHOs are allowed to retain all amounts recovered.

However, we found that the Department needs to improve its monitoring of BHO third party liability recovery efforts to ensure that the BHOs are complying with their contractual requirements and that recovery efforts are maximized. Additionally, the Department needs to require the BHOs to monitor the third party liability recovery efforts of all providers. Our site visits revealed that third party recovery efforts by the BHOs center only on the claims they directly pay through the external provider network (i.e., fee-for-service claims). This means that the BHOs are not monitoring third party recoveries on payments made to internal network providers. As shown earlier in this chapter, our analysis indicates that

BHOs spend between 67 percent and 95 percent of their total medical expenses on internal provider network services, or services provided by or through the CMHCs. Without adequate third party recovery efforts by the BHOs and their providers, capitation rates could be slightly higher due to increased provider costs that are not off-set by third party recoveries.

Recommendation No. 4:

The Department of Health Care Policy and Financing should work with the BHOs to improve processes for identifying third party payers and recovering payments in its Medicaid Community Mental Health Services Program by:

a. Ensuring compliance with BHO contracts by reviewing and assessing the adequacy of BHO procedures for identifying and recovering from third party payers and ensuring that third party recovery efforts are adequate for services provided through both the internal and external provider networks.

b. Requiring BHOs to actively monitor the third party recovery efforts of all providers.

Department of Health Care Policy and Financing Response:

a. Agree. Implementation Date: January 2008. The Department will review and assess the adequacy of the BHOs' third party recovery procedures for both the CMHC and non-CMHC providers within their networks. Where the Department finds BHO processes and procedures to be inadequate, corrective action will be required.

b. Agree. Implementation Date: January 2008. The Department will require the BHOs to actively monitor the third party recovery efforts of all providers. The Department will monitor BHO third party recovery activities on a quarterly basis and revise reports as needed to ensure that BHOs are monitoring both CMHC and non-CMHC provider third party recovery activities.

State Hospital Beds

In total, the CMHCs manage the use of 155 adult inpatient beds at the Colorado Mental Health Institutes at Fort Logan and Pueblo. The State General Fund pays for beds managed by the CMHCs. There are also children, adolescent, and geriatric inpatient beds at the Colorado Mental Health Institutes that are not allocated for the use of the CMHCs, but are instead purchased by the Department's Medicaid program (including the Medicaid Community Mental Health Services Program), or otherwise used on an as-needed basis. The allocated adult inpatient resources are available for all Colorado residents in need of them, whether or not they have Medicaid coverage. In turn, CMHCs are responsible for managing this resource for all populations of individuals needing service, whether individuals are Medicaid recipients or not. The CMHCs' use of these beds must be maintained within the allocated levels. For adults ages 21 to 64, Medicaid cannot pay for inpatient stays in state-allocated hospital beds because of Medicaid program restrictions on paying for adult hospital care in what are termed "Institutes of Mental Disease" or IMDs. While state hospital resources can be purchased by Medicaid for children and older adults, they cannot be purchased for adults ages 21 to 64. However, it is allowable for the BHOs to use Medicaid funds to pay for inpatient mental health treatment in community or in general hospital settings, such as Denver Health Medical Center, the University of Colorado Hospital, and other general hospitals offering inpatient mental health treatment across the State.

Currently, BHOs differ dramatically in their use of allocated adult state hospital resources for Medicaid recipients within the Medicaid Community Mental Health Services Program. One BHO does not track use of these resources and relies fully on CMHCs to manage their use. On the other hand, another BHO currently provides nearly all of its inpatient care for adults using its CMHCs' allocated adult beds. Other BHOs fall in between. One BHO has formally divided its allocation based on historical use patterns, with the CMHC managing a portion and the BHO managing a portion.

There are two competing primary interests governing the use of these allocated state hospital resources that the State must balance. On the one hand, allocated adult state hospital beds are an important resource for the State's non-Medicaid individuals. Therefore, excess use by the BHOs for its Medicaid members may reduce the availability of these resources to non-Medicaid populations. On the other hand, under-use by the BHOs of the state hospital beds for their Medicaid members could result in higher costs to Medicaid. This could occur because BHOs that use non-state hospitals to provide inpatient services must pay for the costs of this care out of their Medicaid rates.

For example, a BHO that uses primarily non-state beds would show greater overall inpatient costs related to its Medicaid population because the BHO is paying for these services out of its capitation payment, while another BHO that uses primarily state hospital beds would show a lower level of costs for inpatient services because the State, and not the BHO, pays for inpatient stays in these state-allocated beds. This would tend to increase Medicaid rates for BHO areas that did not use state allocated hospital resources, relative to rates in those areas that did make use of them. Current data on adult bed allocations and their use by BHOs is not available because BHOs do not consistently track this information. Past analyses of Colorado Mental Health Institute utilization by BHOs has suggested that many BHOs increased their use of allocated adult beds for Medicaid recipients post-capitation.[1]

Each region of the state has developed its own system for managing its allocation of state hospital resources. Some CMHCs agreed in past years to reduce their state hospital adult inpatient allocation to shift funding from closed state hospital units to acute treatment units and inpatient resources within their geographical service areas. Others responded to the build up or loss of community inpatient resources by adjusting the proportion of allocated state hospital resources used by their Medicaid and non-Medicaid populations. However, accountability for changes and variability in the use of state hospital resources over time remains an important area regarding quality of care and access to services for Medicaid and non-Medicaid populations alike.

In addition to the minimum set of standards for utilization monitoring discussed earlier, the Department should require BHOs to track their use of allocated state hospital beds for adults. Such data are important for managing the care of individual Medicaid recipient members using these resources. The data can also be used to track the amount of adult state hospital bed usage by each BHO. The Department of Health Care Policy and Financing should compare state hospital bed usage over time and across BHOs to monitor for differential use. Based on this information, the Department should consider whether BHOs are making appropriate use of adult state hospital bed allocations for Medicaid members. The Department should also share this information with the Department of Human Services for broader monitoring of the overall adequacy of adult state hospital allocations. It should be noted that differential use is not necessarily problematic, but the Department of Health Care Policy and Financing should ensure that such

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[1] *Triwest Group. (4/2001). Colorado Mental Health Institute (CMHI) operational plan: Appendix 1, Recommendations for the Mental Health Institutes in Colorado. Denver, CO: State of Colorado, Department of Human Services.*

variation in use is justified by the BHOs and that the BHOs' approaches fit with the overall goals and expected outcomes for the Medicaid Community Mental Health Services Program.

Recommendation No. 5:

The Department of Health Care Policy and Financing should require BHOs to monitor and report on the use of allocated state mental health hospital beds by Medicaid members. The Department should monitor trends in usage over time, determine whether BHOs are making appropriate use of adult state hospital bed allocations for Medicaid members, and share this information with the Department of Human Services for broader monitoring of the overall adequacy of adult state hospital allocations.

Department of Health Care Policy and Financing Response:

Agree. Implementation Date: July 2007.

The Department will require BHOs to monitor and report their utilization of allocated state mental health hospital beds by Medicaid members using a standardized format developed by the Department and the BHOs. The Department will utilize BHO reports to monitor trends in usage of state bed allocations. The Department will share the obtained information with the Department of Human Services Division of Mental Health for broader monitoring of the overall adequacy of adult state hospital bed allocations.

Rate Setting
Chapter 2

Overview

Under a Medicaid managed care program, states must develop monthly capitation rates (i.e., flat payment rates) on a per member basis that are used to make payments to managed care organizations. In turn, managed care organizations are responsible for providing medically necessary care to Medicaid members within their designated areas. In the case of Colorado's Medicaid Community Mental Health Services Program, the Department of Health Care Policy and Financing (Department), along with its contracted actuarial firm, develops capitation rates that are used to make payments to participating managed care organizations, referred to as Behavioral Health Organizations (BHOs). These rates are differentiated based on the member's Medicaid eligibility category. In other words, the Department pays a flat monthly rate to the BHOs for each of the five eligibility categories (Elderly, Disabled, Children, Adults, and Foster Care). To operate a Medicaid managed care system, the State of Colorado must comply with federal regulations on rate setting as well as any applicable state statutes.

Prior to 2002, the federal Centers for Medicare and Medicaid Services (CMS) imposed an upper payment limit on all Medicaid managed care programs which required that managed care programs cost no more than an actuarially equivalent fee-for-service program. As such, Colorado statute, Section 25.5-5-408, C.R.S., was enacted to comply with this federal requirement by stipulating that under no circumstances, including competitive bidding, shall the state department pay a capitation payment to a BHO that exceeds 95 percent of the direct health care cost of providing these same services to an actuarially equivalent Colorado Medicaid population group. In effect, this requirement has tied capitation rates to historical fee-for-service rates, without permitting full consideration of the actual costs of providing an appropriate mix of services in a managed care environment.

Effective August 2003 CMS repealed the upper payment limit regulation [42 CFR 447.461], replacing it with a requirement that all managed care rates be actuarially sound [42 CFR 438.6(c)]. One of the contributing factors to the change in regulation was CMS' concern that fee-for-service utilization data were outdated and no longer meaningful for states with long-standing managed care programs, such as Colorado's Program. This effectively removed the requirement that rates be based on historical fee-for-service data and gave states flexibility to use alternative data sources, including BHO service encounters (i.e., data that tracks services or treatments provided by the BHO). However, the State has not changed

its laws to reflect the removal of the federal upper payment limit requirement. Since 2003, the Department has based between 70 and 100 percent of its Medicaid mental health capitation rates on projected fee-for-service data. Fee-for-service data used in rate setting are based on projections of fee-for-service information from 1995 or 1998, depending on when the region converted from a fee-for-service to managed care system of providing services.

The Office of the State Auditor conducted the Medicaid Capitation for Mental Health Services Performance Audit dated October 1998 in response to questions about capitation rates. The 1998 audit raised significant concerns about the Department's use of historical fee-for-service data in its rate setting process. The basis for these concerns is that once all mental health services are provided through a managed care system, fee-for-service data for the mental health population no longer exists, and therefore the assumptions used to project the historical fee-for-service data forward cannot be validated. Furthermore, basing managed care rates solely on fee-for service data perpetuates the differing service protocols that existed in a fee-for-service environment and incorporates them into the capitated rates.

Our current audit found that many of the same concerns identified in 1998 continue to exist, including the disparities among rates paid to BHOs. For example, in both the Disabled and Adult eligibility categories the difference between the highest and lowest rates paid to BHOs in Fiscal Year 2007 is more than 100 percent. While these disparities are an improvement from the more than 200 percent disparities seen in the 1997 rates during the prior audit, such disparities provide the appearance that rates are not equitable among service populations and service regions, that the cost of service in some areas may not be reasonable, and that there could be problems with the accuracy and completeness of service encounter data reported by the BHOs. These disparities also raise concerns that rates for a given eligibility category may not be actuarially sound. If these disparities are not addressed, CMS could question the rates or disallow certain Medicaid expenditures for federal reimbursement in the future.

The Office of the State Auditor contracted with Mercer Government Human Services Consulting to review the Department's current rate setting methodology and its underlying components, including service encounter data, and utilization management at the BHOs to determine if Colorado's current rates are based on valid encounter data and appropriate controls are in place at the BHOs to ensure that services provided are medically necessary. Additionally, the Office of the State Auditor asked Mercer to provide information on improvements Colorado could make in its future rate setting processes to ensure rates are equitable.

In the prior chapter, we discussed significant problems with the utilization management practices and monitoring of the BHOs that raise concerns about whether all care provided is medically necessary, and additionally, about whether all medically necessary care is provided. In this chapter, we discuss general guidelines for rate setting which describe the components of an appropriate rate setting process. Additionally, we discuss problems we identified with encounter data and the fee schedules the Department uses to price those encounters. We also describe problems identified with Colorado's current rate setting methodology and provide some information on future improvements Colorado should consider in its rate setting process. If Colorado's future managed care rates are to be equitable and acceptable to CMS, the Department will need to ensure that services provided are medically necessary and provide an appropriate level of care. Additionally, service encounter data and the fee schedules used to price that data must be validated and based on reasonable and appropriate rates for service.

General Guidelines for Rate Setting

Federal regulation requires rates for Medicaid managed care programs to be certified as actuarially sound. Actuarially sound rates are defined by CMS as rates that are appropriate for the populations covered and the services furnished under a managed care contract. To assist states and actuaries, CMS has produced a rate setting guideline, which outlines key considerations in the development of actuarially sound Medicaid managed care rates. The general guidelines for the underlying components of an actuarially sound rate setting methodology include the following concepts.

- **Utilization data should be specific to the Medicaid population and services covered under the managed care program.** Utilization data should contain information on the actual services delivered to the Medicaid population. These data can serve as the base information to perform the rate calculations. Utilization data may be from a state's fee-for-service system or the BHO managed care encounter data system. Regardless of the source, the data should be recent and free from material omissions.

- **Service cost assumptions should be appropriate for the Medicaid population.** Service cost assumptions are necessary to assign a fee to each encounter collected for rate setting. The service costs should represent a reasonable, attainable Medicaid fee for each type of service delivered. The fees should be consistently developed across the state and reflect a reasonable and appropriate rate for each procedure delivered.

- **Rating categories should consider differences in cost related to age, gender, Medicaid eligibility category, and locality or region.** Rating categories must be designed to calculate differential rates for populations with differences in service utilization and per capita costs. For example, children in foster care may need a greater volume of services and be more expensive per person to serve than individuals in the elderly age category. This increases the predictability of the rates and allows for adjustments in the overall payments to the BHO, when there are changes in the enrolled population served by the BHO.

- **Projection assumptions should be reasonable and consistent with generally accepted actuarial principles and practices.** After summarizing the historical utilization and cost data into rating categories, the data must be projected into the contract period to reflect medical inflation, any changes to the covered services or populations, and an appropriate factor for the cost of BHO administration. Managed care rate adjustments may be necessary to ensure the underlying utilization data represent efficient service delivery under managed care. In other words, inefficient service practices and resulting costs should not be built into the rate setting structure. The application of these assumptions results in a projection of an actuarially sound rate range for each rating category.

Although Colorado's rate setting methodology generally meets these guidelines and has been accepted by CMS in the past, there are a number of the above components that need to be improved. Areas for improvement include the validity of the encounter data, the service cost assumptions or fee schedules used to price the encounter data, and development of a rate setting methodology based on validated and appropriately priced encounter data.

Encounter Data

In a statewide managed care system that has been in place for over 10 years, such as Colorado's, recent historical fee-for-service data for mental health services are not available. As a result, encounter data should be used to assess the actual Medicaid reimbursable services provided to the individuals covered under the managed care program. CMS recommends using encounter data to set capitated rates for managed care programs in Medicaid where recent fee-for-service data are not available. Therefore, the encounter data reported must be accurate, consistent, and complete to provide a valid basis for determining appropriate capitation rates.

In addition, valid encounter data allow the Department to perform meaningful analysis and comparison of service utilization and costs among BHOs and provider groups.

Encounter data should contain records with the specific details of the services provided to Medicaid members. An encounter should identify the type of service delivered (e.g., individual therapy) using standard procedure codes required by the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), the date and duration of the service, the provider of the service, the Medicaid recipient, and other details. The information contained in the encounter records should originate at the individual provider level to ensure validity. The provider submits the record with the information outlined above to the BHO and the BHO in turn submits a copy of the record to the Department in the form of an encounter. Recording the service at the provider level ensures that the encounter is an accurate representation of the service delivered.

The Department reports that it has developed a list of covered services and associated HIPAA-compliant procedure codes and service definitions. This list provides instructions on how BHOs are to code and report State Medicaid Plan services, as well as 1915(b)(3) services. (The 1915(b)(3) services are services offered in addition to the services provided through the State Medicaid Plan, such as assertive community treatment, respite care, and drop-in centers.) However, the BHOs determine service reporting procedures for their providers. We reviewed the service encounter reporting procedures that the BHOs require their providers to adhere to and found that four of the five BHOs do not currently require their Community Mental Health Center (CMHC) providers to submit encounter data using HIPAA-compliant codes. These four BHOs allow the CMHCs to report encounters using various self-developed procedure codes. The BHOs then convert these procedure codes to HIPAA compliant codes using individual "crosswalks" they have developed in order for encounter data to be reported to the State. Additionally, while the Department, through its External Quality Review process, requires BHOs to perform chart reviews to verify the accuracy of services reported, these reviews do not sufficiently ensure that (1) the crosswalks used by the BHOs correctly convert CMHC-specific service codes to the HIPAA-compliant codes required by the State, or (2) the different crosswalks used by the CMHCs convert service codes in a consistent manner. As a result, the CMHCs that provide the vast majority of the services within the Medicaid Community Mental Health Services Program likely do not report encounter data consistently to the BHOs or the Department. Consequently, it is difficult to conduct meaningful analysis of service utilization on a statewide basis. Specific examples of problems BHOs and CMHCs reported with encounters include:

- **Inconsistent coding.** The BHOs' processes of converting CMHC procedure codes to HIPAA-compliant codes raise significant concerns regarding the validity of the data received by the Department, and nearly all of the stakeholders interviewed during the audit cited service encounter coding inconsistencies as a major limitation in the usefulness of Colorado's encounter data. For example, we found that a 45-minute individual therapy encounter at one BHO is reported as a single encounter, whereas at another BHO it is reported as three separate 15-minute encounters. Another BHO reported tracking such encounters and reporting them to the State using both approaches. That is, some individual therapy encounters were reported as single encounters regardless of the duration of the encounter and others were reported as multiple encounters.

- **Incomplete data.** Due to sub-capitation arrangements between the BHOs and CMHCs, the encounter data submitted to the Department may not reflect all services provided. This is due to the financial nature of these contracts between the BHOs and CMHCs. Under sub-capitation arrangements, the CMHCs are paid a fixed amount to provide CMHC services in their respective regions, based on overall anticipated costs, which are not differentiated by eligibility category. This rate is not dependent upon the actual number of services the CMHCs provide. While this is an acceptable reimbursement arrangement under managed care, sub-capitated providers do not have strong incentives to submit complete encounter data to the BHO because the encounters do not impact the CMHCs' immediate reimbursement. Without strong monitoring, these arrangements can lead to underreporting of actual services delivered and potentially erroneous conclusions about service delivery. Also, as mentioned previously, Colorado offers services in addition to its State Medicaid Plan services through Section 1915(b)(3) of its Medicaid managed care waiver program, such as assertive community treatment, respite care, and drop-in centers. Throughout this report these services are referred to as 1915(b)(3) services. For rates set through Fiscal Year 2007, adequate encounter data for 1915(b)(3) services were not available. However, the Department reports that encounter data for 1915(b)(3) services will be available for the calculation of Fiscal Year 2008 rates.

- **Potential miscoding.** In the case of the four BHOs that re-code CMHC-reported encounters from local codes to HIPAA-compliant codes, there is a risk that codes could be manipulated; which could affect rates. This includes both the risk of unintentional changes that lead costs to be computed incorrectly, as well as the risk of intentional up-coding to claim that more expensive services were delivered than was the case. While our

audit did not identify any instances of intentional up-coding, it remains a risk in any system that converts the original procedure codes assigned by the service provider at the point of service delivery.

Allowing the BHOs to convert data submitted by providers raises the risk that reported data are inaccurate and inconsistent and greatly increases the need for monitoring by the State. Specifically, if the State continues to allow BHOs to use crosswalks to convert service encounter data reported by CMHCs and other providers, the Department will need to expand its current review program to ensure that converted data are accurate and complete, and that various crosswalks used by the CMHCs convert service data to HIPAA-compliant codes in a consistent manner. This review would need to verify service encounter coding against member medical files through chart reviews and trace information on the services provided through each of the reporting and conversion processes until the data reach the State.

Many other states have gone beyond the development of basic lists of covered services and procedure code definitions and have created comprehensive encounter data reporting manuals. These manuals provide explicit instructions for BHOs and providers on the definition of services covered under the managed care contract and how to report services in HIPAA-compliant coding formats. In order to move forward with recommendations discussed later in this report and eliminate some of the disparities in Medicaid mental health managed care rates, the Department should address problems with encounter data by (1) performing a detailed review of current encounter data to determine its validity and to correct errors identified, and (2) developing and implementing a standard encounter reporting process that requires providers to code future encounters at the point of service delivery using HIPAA-compliant procedure codes. These manuals may be developed by internal state staff if resources are available, or contracted vendors with encounter data reporting expertise. The detailed instructions provided by the manual can provide states a standard against which to direct and monitor providers to ensure that service delivery is consistently tracked and reported statewide.

Recommendation No. 6:

The Department of Health Care Policy and Financing should ensure that encounter data for the Medicaid Community Mental Health Services Program from the BHOs and other providers are reliable and valid for rate setting purposes by:

a. Conducting data analysis to determine the validity of current BHO and other provider encounter data.

b. Implementing a process for monitoring encounters reported by service providers and BHOs to ensure that encounters are reported consistently and accurately. This process should include review and comparison of service encounter information in members' medical files with service encounter information reported to the BHOs and, subsequently, to the State.

c. Establishing a process to address and resolve discrepancies identified in the BHOs' tracking and reporting of encounter data as a result of these activities. This process should include, but not be limited to, correcting the data so that it can be used in the rate setting process.

Department of Health Care Policy and Financing Response:

a. Agree. Implementation Date: July 1, 2008. The Department will modify the External Quality Review Organization Request for Proposal to include an encounter data validation study for each BHO. The study will include a statistically valid sample of data submitted by each BHO and include medical records from all provider groups.

b. Agree. Implementation Date: January 30, 2007. The Department will implement a process to ensure that encounters are reported consistently and accurately by comparing encounter data reported to the Department with members' medical records on a periodic basis.

c. Agree. Implementation Date: December 30, 2007. The Department will use its current corrective action process to address encounter data discrepancies identified as a result of the encounter monitoring in 6a and 6b above.

Recommendation No. 7:

The Department of Health Care Policy and Financing should develop a standardized encounter reporting manual for the Medicaid Community Mental Health Services Program to ensure all services are coded by the service provider, at the point of service, in accordance with HIPAA-compliant procedure codes and to ensure the accuracy and consistency of encounter data reported. This manual

should provide detailed instructions on the submission of encounter data by BHOs, as well as reporting requirements for the BHOs' internal and external network providers. Once the manual is complete, all service providers should be required to report encounters to BHOs using HIPAA-compliant codes. The use of crosswalks by BHOs to recode local CMHC coding should be eliminated. The Department should incorporate these data reporting requirements for BHOs and their providers into its contracts with the BHOs.

Department of Health Care Policy and Financing Response:

Agree. Implementation Date: July 2008, assuming the necessary resources are made available in Fiscal Year 07-08.

The Department of Health Care Policy and Financing continues to work with the BHOs on the submission of HIPAA-compliant encounter data to the Medicaid Management Information System (MMIS). The Department does not have the resources to develop a standardized encounter reporting manual to ensure all services are properly coded by the service provider. To fully implement this recommendation, the Department would need additional resources from the General Assembly, which would be used to hire a contractor to develop the standardized encounter reporting manual. Implementation of this recommendation will require additional funding. Therefore, the request for funding will go through the standard budgeting process.

The earliest the Department would expect legislative action would be the 2007 session of the General Assembly. Assuming the necessary resources are made available in Fiscal Year 07-08, the Department will incorporate in its contracts with the Behavior Health Organizations effective July 2008 these data reporting requirements, including the use of HIPAA-compliant codes at the point of service and the elimination of any crosswalks used to recode local Community Mental Health Centers' services.

Fee-for-Service Pricing Schedule

Federal regulations in 42 CFR 438.6(c) require State Medicaid Agencies to establish capitation rates that use fully documented actuarial methods. When relying on encounter data to set capitation rates, the State must determine the appropriate fee to attach to each service delivered to estimate the cost of providing

services. The intent of the encounter pricing is to assign a reasonable and appropriate fee for each procedure delivered, and to use this information to determine an actuarially sound capitation rate. Several sources of fee information are available for the Department to use for pricing encounter services, and these sources are briefly discussed below.

- **State Medicaid Fee Schedule.** This schedule is developed and maintained by the Department and is used to pay claims through the fee-for-service system. These schedules can become outdated as programs move to managed care and the volume of fee-for-service claims decreases. The validity of these fee schedules may diminish if the fee-for-service claims represent a very low proportion of expenses to the mental health budget, as well as a low revenue amount to contracted providers. The Department could not report when the last comprehensive review of the State Medicaid Fee Schedule for mental health services was completed.

- **Medicare Fee Schedule.** Medicare also publishes a fee schedule for the services covered under that program. Many commercial insurers negotiate provider fees as a percentage of Medicare fees. The Medicare program does not cover many mental health services; therefore, many of the procedures provided by the Colorado Medicaid Community Mental Health Services Program are not contained in this fee schedule.

- **Provider Cost Report.** For CMHC services, the Department collects cost report information from the CMHC providers. These reports outline the providers' cost for each service delivered; however, these costs do not necessarily reflect the cost of efficient service delivery.

- **Hospital Rate Schedule.** Similar to the Medicaid fee schedule, the Department also maintains a fee schedule for hospitals. Since the Department pays a significant amount to hospitals annually, these schedules are updated frequently.

- **BHO Fee Schedules.** For external providers, each BHO has negotiated fees with its external provider network. These schedules provide an additional source of mental health costs for individual services provided in each Medicaid region.

- **Other States' Medicaid Fee Schedules**. These schedules would provide comparative information on fees paid in other state programs. With the implementation of standard coding under HIPAA, the services should be more comparable across states.

For rate setting purposes, the Department uses several approaches to price the encounter data received from the BHOs. First, the Department determines if the service was provided by a CMHC. If so, the Department prices the encounter using information from the most recent CMHC cost report. The CMHCs provide annual audited financial statements and supplemental schedules, including a cost report that demonstrates the cost to that CMHC of providing various types of mental health services. Second, for services not provided by the CMHCs or not on the CMHC fee schedule, the Department prices the encounters according to the State Medicaid fee schedule. Third, for inpatient services, the encounters are priced according to the State's hospital rate schedule. Finally, for the additional 1915(b)(3) services provided by the BHOs, the Department did not have sufficient encounter data to assign fees to the individual services for rates calculated through Fiscal Year 2007. Instead, the Department relied on the actual BHO expenses for these services as reported annually by the BHOs in their audited financial statements and supplemental reports. The Department reports that encounter data for 1915(b)(3) services will be available for the Fiscal Year 2008 rate setting cycle. For future rates, the Department will need to assign fees for each of the 1915(b)(3) services reported in the encounter data.

Of particular concern in the pricing methodology is the Department's direct incorporation of the CMHC cost reports into the pricing of encounter services. The CMHCs' unit cost data are based on the CMHCs' audited financial statements and state-designed supplemental schedules. Although these data are audited, this does not ensure the reported unit cost represents a reasonable and efficient rate for the service delivered. The Department of Human Services uses these cost reports to develop separate fee schedules for each CMHC. The Department of Human Services then provides the CMHC fee schedules to the Department of Health Care Policy and Financing. This results in up to 17 different rates for the same type of service across the 17 CMHCs. As illustrated below, the fees for the most frequently used CMHC procedures vary widely across the State.

Department of Health Care Policy and Financing Medicaid Community Mental Health Services Program Fee Schedule Fiscal Year 2007							
Service Description	**Procedure Code**	**Lowest CMHC Fee**	**25th Percentile**	**50th Percentile**	**75th Percentile**	**Highest CMHC Fee**	**Medicaid Fee Schedule**
Individual Psychotherapy (20-30 Minutes)	90804	$35.93	$86.00	$113.21	$129.10	$157.69	$39.19
Individual Psychotherapy (45-50 minutes)	90806	$113.73	$142.43	$164.18	$181.84	$190.45	$59.29
Group Psychotherapy	90853	$30.90	$51.09	$81.97	$119.13	$131.84	$4.20
Case Management	T1016	$36.17	$51.45	$71.34	$82.41	$98.95	$8.03
Source: Mercer analysis of Community Mental Health Fee Schedule provided by the Department of Health Care Policy and Financing.							

This table outlines the range of fees currently paid to the CMHCs. To illustrate the differences, we selected four highly used procedure codes: individual psychotherapy (20–30 minutes), individual psychotherapy (45–50 minutes), group psychotherapy, and case management. We have included percentiles to help aggregate the comparison across the 17 CMHCs. For instance, the 25th percentile indicates that 25 percent of the CMHCs have a fee below this value for a particular procedure. For each of the top procedures included in the table, differences between the CMHCs' fees are dramatic. For group psychotherapy, the lowest CMHC fee is $30.90 per unit, which is about one-fourth the fee of the highest CMHC. These differences are not isolated to a single outlier highest or lowest CMHC. For example, for group psychotherapy, 25 percent of the CMHCs have fees below $51.09 and another 25 percent have fees above $119.13. This analysis suggests the fee differences by CMHC contribute significantly to the overall capitation rate disparity among the BHOs.

The Department's current pricing methodology perpetuates broad rate disparities and possible inefficiencies across the State of Colorado. Relying on each CMHC fee schedule creates a cost-based reimbursement system that may not reflect reasonable costs for services provided. Furthermore, these practices potentially finance provider inefficiencies and may distort the underlying costs of providing services. In addition, the Department was unable to report when the last comprehensive review of the State Medicaid fee schedule for mental health services was completed. As a result, it is very likely that the State's Medicaid mental health fee schedule does not reflect the current costs of care.

For the State to develop a future rate setting methodology based entirely on encounter data, as discussed later in this report, it is critical that encounters be priced on the basis of current fee schedules that represent reasonable and

appropriate rates for services that are provided. Such a fee schedule would assign a reasonable fee to each encounter and not necessarily reimburse providers for their full cost of care. This would drive providers to be more efficient and create more equitable financing of mental health care in Colorado.

Recommendation No. 8:

The Department of Health Care Policy and Financing should initiate a cost study to assess and verify the fee schedule used to price encounters in the Medicaid Community Mental Health Services Program. The evaluation should be based on HIPAA-compliant coding to allow for more accurate comparison to other states' fee schedules. If the study incorporates provider cost report data, the Department should analyze additional fee information to ensure the fees reasonably reflect the best value for services. The study should result in a standard mental health fee schedule that is reflective of reasonable and appropriate rates.

The Department should also implement a process to ensure that the fee schedule is updated periodically to reflect changes in the rates over time.

Department of Health Care Policy and Financing Response:

Agree. Implementation Date: July 2008, assuming the necessary resources are made available in Fiscal Year 07-08.

The Department does not have the resources to initiate a cost study to assess and verify the fee schedule used to price encounters in the Medicaid Community Mental Health Services Program. To fully implement this recommendation, the Department would need additional resources from the General Assembly, which would be used to hire a contractor to perform the cost study and develop a standard mental health fee schedule. Implementation of this recommendation will require additional funding. Therefore, the request for funding will go through the standard budgeting process.

The earliest the Department would expect legislative action would be the 2007 session of the General Assembly. Assuming the necessary resources are made available in Fiscal Year 07-08, the Department will incorporate the resultant standard mental health fee schedule into the rate setting methodology and implement a process to ensure that the fee schedule is updated periodically to reflect changes in the rates over time.

Current Rate Setting Methodology

To obtain an understanding of the current rate setting methodology, we reviewed actuarial certifications prepared by independent actuarial firms under contract with the Department. These certifications support capitation rate development over the past two years. In addition, we conducted a survey of the five BHOs as well as the Department to gain a better understanding of rate setting and any limitations of the current methodology. Finally, we analyzed recent financial information submitted by the BHOs to understand current rates, and we interviewed the executive directors and chief executive officers of the five BHOs and their 17 sub-contracted CMHC providers to understand the historical basis underlying the rates. Relevant findings discussed earlier in this report, such as the lack of standardized encounter reporting in HIPAA-compliant formats and the broad-based failure to ensure the medical necessity of services delivered by CMHC providers, were also incorporated into our analysis of the methodology.

Currently the Department, along with its contracted actuarial firm, calculates capitation rates based on data from two primary sources of information. These sources consist of the Historical Rate Component (comprising 70 percent of the rate) and the Encounter Based Rate Component (comprising 30 percent of the rate). Each data source is described below in terms of the general rate setting guidelines discussed earlier in this chapter.

Historical Rate Component

- **Utilization Data Source.** Originally, capitated rates were based on either 1995 or 1998 fee-for-service data, depending on when the mental health managed care program began in each region. The fee-for-service data was priced using the State's Medicaid Fee Schedule to arrive at a capitated rate. Medicaid mental health capitation rates since that time have been based on these original rates, projected forward and adjusted for cost-of-living, programmatic changes, and an implicit administrative load for the BHO (meaning during the fee-for-service payment system, the BHOs had to finance administration out of the fee-for-service payments received). Therefore, the historical rate component does not reflect current service utilization.

- **Service Cost Assumptions**. By using the 1995 or 1998 Medicaid fee schedule, the service cost assumptions from those time periods are reflected in the underlying data. These cost assumptions have not been updated since the initial rate setting. This is one of the limitations of the Historical Rate Component.

- **Rating Categories.** The historical rates by eligibility category and region are used for this data source. Essentially, when managed care was implemented for the Medicaid Community Mental Health Services Program in 1995 or 1998, different rates were developed for different categories of Medicaid eligibility, including Elderly, Disabled, Children, Adults, and Foster Care. Differences in the rates were primarily driven by differences in historical costs. Differences in rates paid by rating category have also been projected forward since managed care was first implemented.

- **Projection Assumptions**. The State incorporates adjustments for cost-of-living, programmatic changes, and an implicit administrative load for the BHO.

Encounter Based Rate Component

- **Utilization Data Source.** This includes State Medicaid Plan service encounter information reported by the BHOs in 2005. For those services offered in addition to the State Plan, or 1915(b)(3) services, the Department did not have adequate encounter data available for Fiscal Year 2007 rate setting. According to the Department, data for 1915(b)(3) services are now available and will be incorporated into the rate setting process in Fiscal Year 2008 for the first time. For rates set through Fiscal Year 2007, the Department has relied on total BHO-reported expenses to set capitated rates for the 1915(b)(3) services. In other words, the Department divided a BHO's total 1915(b)(3) expenses by the appropriate number of member months to determine each BHO's capitated rate for 1915(b)(3) services.

- **Service Cost Assumptions.** For the State Plan service encounters, the State uses the pricing methodology described in the previous section on the fee-for-service pricing schedules, which relies on CMHC cost reports and the current Medicaid fee schedule.

- **Rating Categories.** Consistent with the Historical Rate Component, the historical eligibility categories are used for this data source.

- **Projection Assumptions.** The State incorporates adjustments for cost-of-living, programmatic changes, and an administrative load for the BHOs.

CMS requires separate rate calculations for State Plan and 1915(b)(3) services. Both calculations must be based on encounter data and must be actuarially sound. Colorado's rates for State Plan services (i.e., services listed in the Colorado Medicaid State Plan) are based on encounter data, as well as the prior year's capitation rate, which continues to be primarily based on historical fee-for-service data from the early 1990s. As we discussed, the rate setting methodology for 1915(b)(3) services relies on reported expenses. To complicate this calculation further, the historical fee-for-service rate component is based solely on State Plan services and does not contain any costs for 1915(b)(3) services. This is because 1915(b)(3) services were not available prior to capitated managed care. Thus, the Department's 70/30 weighting scheme does not in fact create a specific rate for 1915(b)(3) services. Since rates calculated for 1915(b)(3) services through Fiscal Year 2007 have not been developed from encounter data, the 1915(b)(3) rate setting methodology is currently inconsistent with CMS rate setting guidelines. Again, encounter data should be available for 1915(b)(3) services for the next rate setting cycle.

As discussed previously, Section 25.5-5-408(1)(b), C.R.S., requires that the cost of Medicaid managed care programs not exceed 95 percent of the cost of providing the same services under a fee-for-service program. The Department believes the current statute requires a rate setting methodology based primarily on historical fee-for-service data and precludes the Department from placing greater reliance on the encounter data. As a result of this statute, the Department has established a rate setting methodology in which capitation rates are based on no less than 70 percent historical fee-for-service rate information. The remaining 30 percent of the capitation rates are based on recent service encounter data. Since this methodology places greater weight on historical fee-for-service-based information, the disparity in costs that existed under the fee-for-service system continues to be reflected in the BHO capitation rates.

2007 Capitation Rate Comparisons

The rate disparities are demonstrated in the following comparisons of the 2007 Medicaid mental health capitation rates. The following tables illustrate the 2007 rates calculated by the Department and its actuary. The first table shows rates calculated using historical fee-for-service information only. The second table shows rates calculated based only on current encounter and service cost assumptions. The third table represents the actual 2007 rates paid to the BHOs for both State Plan and 1915(b)(3) services and is the result of the Department's rate setting methodology based 70 percent on the historical fee-for-service rates and 30 percent on rates derived from current encounter data.

Table 1
Department of Health Care Policy and Financing
Colorado Medicaid Community Mental Health Services Program
Fiscal Year 2007 Rates based on Historical Fee-For-Service Data

	Elderly	Disabled	Adults	Children	Foster Care	Weighted Average
BHO 1	$ 15.32	$ 54.80	$ 7.00	$ 10.39	$ 174.76	$ 22.18
BHO 2	$ 7.96	$ 92.96	$ 11.43	$ 12.63	$ 338.10	$ 32.46
BHO 3	$ 11.71	$ 107.95	$ 15.57	$ 18.52	$ 353.21	$ 45.48
BHO 4	$ 9.28	$ 53.89	$ 12.13	$ 8.66	$ 301.69	$ 27.44
BHO 5	$ 17.75	$ 76.60	$ 15.91	$ 14.08	$ 344.38	$ 35.86
Weighted Average	$ 13.68	$ 76.47	$ 12.98	$ 12.88	$ 312.23	$ 32.72
Percent Difference Between the Lowest and Highest Rate	123%	100%	127%	114%	102%	105%

Source: Mercer analysis of Exhibit 3: Historical Rates; Development of Fiscal Year 2007 Per Capita Costs – from PricewaterhouseCoopers Actuarial Certification of Department rates.

Table 2
Department of Health Care Policy and Financing
Colorado Medicaid Community Mental Health Services Program
Fiscal Year 2007 Rates based on Current Encounter Data

	Elderly	Disabled	Adults	Children	Foster Care	Weighted Average
BHO 1	$ 13.17	$ 78.94	$ 12.42	$ 10.31	$ 205.40	$ 27.32
BHO 2	$ 7.15	$ 154.34	$ 19.17	$ 13.69	$ 207.70	$ 35.94
BHO 3	$ 13.34	$ 196.05	$ 19.62	$ 12.16	$ 98.27	$ 43.81
BHO 4	$ 7.59	$ 131.41	$ 17.58	$ 14.48	$ 112.23	$ 32.86
BHO 5	$ 9.28	$ 105.29	$ 21.44	$ 12.92	$ 306.98	$ 38.16
Weighted Average	$ 9.91	$ 122.57	$ 18.83	$ 12.73	$ 214.43	$ 35.71
Percent Difference Between the Lowest and Highest Rate	87%	148%	73%	40%	212%	60%

Source: Mercer analysis of Exhibit 4: Encounter Data; Development of Fiscal Year 2007 Per Capita Costs – from PricewaterhouseCoopers Actuarial Certification of Department rates.

Table 3
Department of Health Care Policy and Financing
Colorado Medicaid Community Mental Health Services Program
Fiscal Year 2007 Final Rates

	Elderly	Disabled	Adults	Children	Foster Care	Weighted Average
BHO 1	$ 14.67	$ 62.05	$ 8.62	$ 10.36	$ 183.95	$ 23.72
BHO 2	$ 7.72	$ 111.37	$ 13.75	$ 12.95	$ 298.98	$ 33.50
BHO 3	$ 12.20	$ 134.38	$ 16.79	$ 16.62	$ 276.73	$ 44.98
BHO 4	$ 8.77	$ 77.15	$ 13.77	$ 10.41	$ 244.85	$ 29.07
BHO 5	$ 15.21	$ 85.21	$ 17.57	$ 13.73	$ 333.16	$ 36.55
Weighted Average	$ 12.55	$ 90.31	$ 14.74	$ 12.84	$ 282.89	$ 33.62
Percent Difference Between the Lowest and Highest Rate	97%	117%	104%	60%	81%	90%

Source: Mercer analysis of Exhibit 2: Final Rates; Development of Fiscal Year 2007 Per Capita Costs – from PricewaterhouseCoopers Actuarial Certification of Department rates.

We calculated comparisons within each eligibility category as well as overall to analyze the disparity of the rates. In general, the percent difference between the lowest and highest weighted average rate paid to the various BHOs suggests the rates paid per Medicaid member (Per Member Per Month - PMPM) among the BHOs becomes more consistent when rates are based on the encounter data (see Table 2). The Historical Rate component (Table 1) illustrates a disparity between the highest and lowest rates of 105 percent versus 60 percent for the encounter based calculation. Although the disparities by eligibility category have slightly diminished since the initial rates were set and reported on in the 1998 audit, the disparities in rates paid to the BHOs remain significant. Interestingly, BHO #3 has the highest Foster Care rate ($353 per member) based on the historical rate component, but the lowest rate ($98 per member) based on the encounter data. In other words, based on pre-capitation trends, BHO #3 provided the highest number of services to Foster Care members. Since then, either the number of services or cost per service provided by BHO #3 to Foster Care members has decreased significantly, resulting in a lower rate per member when rates are based on encounter data as opposed to historical fee-for-service data.

Although the encounter data supporting this analysis needs to be validated as discussed earlier in this chapter, it appears that using historical capitation rates no longer represents a valid picture of actual service provision or costs. This is also clear when considering the differences between the rates paid and the cost of services, which was discussed in Chapter 1. That chapter noted that for the Foster Care eligibility category, the Fiscal Year 2007 average rates paid on a per member basis to the BHOs were significantly higher than the costs of serving that population, although in other categories, such as the Disabled and Adult categories, rates paid were insufficient to cover costs on a per member basis. CMS requires each individual rate by eligibility category to be actuarially sound. While the overall weighted average rate paid to each BHO is similar for the historical and encounter-based rates, the differences in rates paid within each eligibility category raise concerns with the actuarial soundness of the final rates paid to the BHOs.

In addition to the above analysis, which demonstrates that fee-for-service data are no longer appropriate for use in setting rates, there are other factors that impact the validity of the historical fee-for service data. These factors include differences in the distribution of service expenditures and the varying administrative approaches taken by the BHOs and CMHCs under managed care. Additionally, the demographics of the individuals served and impact of the Goebel lawsuit, which required the State to provide specific mental health services to a subset of the Medicaid population in the Denver area, have also changed the cost and delivery of services since implementation of the managed care program and the initial rate setting process. With all of these changes, the fee-for-service information from the early 1990s is no longer relevant in setting the current rates for the Medicaid Community Mental Health Services Program.

Alternative Rate Setting Methodology

As discussed, CMS' repeal of the upper payment limit requirement in federal regulations means that states no longer have to base rates on fee-for-service equivalent costs. As a result of the federal regulatory change, most states have revised their rate setting methodologies to incorporate data from their managed care organizations (BHOs in the case of Colorado) as the primary basis for rate setting. These alternative methodologies focus on encounter data and detailed financial data as the primary sources for capitation rate development. These sources reflect current cost and utilization under managed care based on the current medical needs of the population, rather than projecting historical fee-for-service utilization patterns forward from the pre-managed care environment.

CMS published a guideline or checklist to assist states in developing rates under the new managed care regulations. These guidelines urge states to use recent utilization and cost data in the development of the capitation rates. Based on Colorado's existing statute and resultant rate setting methodology, limiting the use of encounter data to 30 percent for rate setting could jeopardize CMS approval of future BHO capitation rates. We understand CMS has approved the current rate setting methodology; however, nationally, CMS has recommended that states increase the use of encounter data in Medicaid managed care rate setting. Without making such changes, there is a risk that CMS could fail to approve future rates, and federal matching funds could be suspended for Medicaid mental health services until CMS determines that the rate setting methodology is in compliance with federal requirements. In Fiscal Year 2006, the State spent $164.8 million on capitation payments for the Medicaid Community Mental Health Services Program. Of this, about $82 million was federal Medicaid funding which may be at risk in the absence of reform.

A key component that the Department must address in making a transition to using encounter data as the basis for rate setting is the need for improvements in the encounter data reporting. Encounter data must be reported consistently and represent the actual, valid procedures delivered by the providers. In addition, the encounter data must be priced according to a reliable, reasonable, and appropriate fee schedule to help ensure an equitable rate setting methodology. It is important to note that the Department must address recommendations contained in this report related to ensuring the medical necessity of provided services, validating encounters, and setting reasonable and appropriate fees for individual procedures, or many of the same disparity issues that affect current rates will continue to be perpetuated in future rates.

If the recommendations in this report are followed, the Department should be well positioned to satisfy CMS regulations regarding actuarial soundness in the State's rate setting methodology in the future, and the methodology will provide more consistency in rates across regions. In addition, the enhancements to the managed care practices discussed earlier in the report will help ensure the services delivered are medically necessary and meet the individual member needs, thus ensuring that the services provided adequately reflect the differential populations and manifest differing clinical needs across the five BHO regions.

Recommendation No. 9:

The Department of Health Care Policy and Financing should work with the General Assembly to seek change in statutes related to Medicaid mental health capitation payments [Section 25.5-5-408, C.R.S.] to align Colorado law with changes made to federal regulations contained in 42 CFR 438.6(c). These changes should include revising statutes to require that mental health capitation rates be certified as actuarially sound and removing any reference to the outdated 95 percent fee-for-service upper payment limit for the Medicaid Community Mental Health Services Program.

Department of Health Care Policy and Financing Response:

Partially Agree. Implementation Date: May 2007, if approved by the General Assembly and enacted by the Governor.

Although the Department does support funding rates solely on actuarial soundness, the Department does not agree that it is against federal regulations to base a portion of the rates on a percent of fee-for-service. The recommendation regarding the 95 percent fee-for-service and upper payment limit is a policy decision for the General Assembly, not a compliance or audit issue. The Department of Health Care Policy and Financing will work with the General Assembly to examine opportunities for legislative change related to Medicaid mental health capitation payments (Section 25.5-5-408, C.R.S.) and to clarify that the rates should not be based solely on fee-for-service experience. The earliest the Department would expect any legislative action would be during the 2007 session of the General Assembly.

Auditor's Addendum

The concern raised in the audit is that as managed care programs mature, no source exists for obtaining valid fee-for-service cost data to use in evaluating managed care program costs. For this reason, CMS removed the upper payment limit, which uses fee-for-service data to evaluate managed care cost-effectiveness, for all Medicaid programs in 2003. The Department's fee-for-service data dates back to 1995 and can no longer be used as a basis for setting rates or evaluating managed care program costs. Therefore, it is important that the Department work with the General Assembly to eliminate the upper payment limit requirement from Colorado statutes.

Recommendation No. 10:

Once the Department has implemented the recommendations in this report necessary to address rate disparities, the Department of Health Care Policy and Financing should work with its actuaries to revise its rate setting methodology for the Medicaid Community Mental Health Services Program. These revisions should ensure that the methodology is primarily based on validated encounters and rates that are reasonable and appropriate, as outlined in the previous recommendations contained in this report. In the future, the Department should consider the addition of factors discussed in the following section to enhance the Medicaid mental health rate setting process.

Department of Health Care Policy and Financing Response:

Agree. Implementation Date: July 2008, assuming the completion of related recommendations and if the appropriate statutory change is approved by the General Assembly and enacted by the Governor during the 2007 session of the General Assembly.

The implementation of this recommendation requires the completed implementation of many of the other recommendations contained in this audit. Several of these other recommendations require both statutory changes and the funding for additional resources. However, upon the release of this audit report, the Department will start a planning process, in conjunction with the Department's contracted actuaries, using current resources, to review the current rate setting methodology for the Medicaid Community Mental Health

Services Program to incorporate the factors, as appropriate, to enhance the rate setting methodology. As an ongoing process, the Department always seeks to ensure that the rate setting methodology is based on validated data and that rates are reasonable and appropriate.

Considerations for Future Rate Setting Activities

Over the last two rate setting cycles, the Department has been moving the rate setting methodology in the right direction-- that is, moving toward a rate setting methodology based on valid encounter data and related costs. Progress has been made to move away from a rate setting methodology based entirely on fee-for-service data to a methodology that incorporates encounter data, although presently the Department limits the use of encounter data. If the Department is successful in implementing the recommendations made throughout this report, and Section 25.5-5-408, C.R.S., is modified to provide greater flexibility, the rate setting methodology could eventually be based on the cost of an efficient managed mental health care system in Colorado. The additional improvements discussed below can be used to create such an enhanced rate setting methodology.

Managed Care Best Practices. With clear definitions of medical necessity and good encounter data, the Department could perform detailed data analyses to identify potential issues of over- or under-utilization at the BHOs. Through targeted, statistically-valid chart reviews and data analysis, managed care adjustments can be made to the rates to reflect managed care best practices and influence service provision at the provider level. These types of adjustments will ensure rate setting is not merely a cost-based reimbursement system and instead focuses on setting a rate that considers the appropriate mix of services for a given population of individuals, such as the seriously mentally ill or severely emotionally disturbed populations that are traditionally high-volume users of behavioral health services. Other states such as Pennsylvania currently perform these analyses to assist in rate setting and program management for severely disabled populations.

Pay for Performance. With better encounter data, the Department has the ability to monitor BHO performance on standard managed care indicators such as readmissions within 7 or 30 days from psychiatric inpatient discharge, outpatient follow-up within 7 days following discharge, and penetration rates, among others. Standardized data will allow for comparisons among BHOs and potentially for developing targets for improvement in BHO performance.

Achieving performance targets could eventually be factored into BHO contracts to trigger incentives. This would allow Colorado to develop a performance-based contracting approach that creates incentives for improvement toward the State's goals for its capitated Medicaid mental health system. Pay for performance programs are currently under consideration by many states nationally and are a mechanism to reward good performance among contractors. States such as Iowa and Massachusetts have implemented pay for performance in their Medicaid mental health programs.

Risk Assessment. Risk assessment is a process of creating risk profiles of the members of a BHO and allows for comparisons among the BHOs for similar populations. While similar to risk adjustment, risk assessment does not result in a specific rate adjustment, but rather, over time creates baseline indicators for a given population or risk profile that could identify appropriate levels of service, cost, or outcomes for that population. Risk assessment could be a valuable tool for managing the Medicaid Community Mental Health Services Program in the future. In contrast, risk adjustment is the process of adjusting BHO capitation payments for treating a higher risk population and is typically used in situations where there are multiple health plans serving the same region or population. In Colorado, regions are covered by single BHOs and there is no competition for member enrollment. Therefore, once the rate setting process is realigned on the basis of valid encounters and reasonable rates, risk adjustment would likely not be necessary under the current BHO-specific rate setting methodology.

Accurate encounter data provide valuable information for rate setting in the form of providing a basis for detailed analyses as well as program monitoring. The considerations listed above would further enhance the Colorado mental health rate setting methodology and ensure the rates are reasonable and equitable for efficient operation by the BHOs. These enhancements are consistent with the current trends in the industry to pay providers for high-quality performance. Since these are longer-term initiatives, we have not made a specific recommendation in this area. Rather, the Department should consider these initiatives after implementing the other changes recommended in this report.

Appendix

Appendix A

Medicaid Community Mental Health Services Program Utilization Best Practice Standards Number of BHOs Using Standards/Practices						
Utilization Practice Activity Industry Standard/Best Practice	**External Provider Network (non-CMHC)**			**Internal Provider Network (CMHC)**		
	Full	**Partial**	**Not at All**	**Full**	**Partial**	**Not at All**
1. BHO medical directors are actively involved in overseeing denials of care.	5	--	--	5	--	--
2. BHO medical directors are actively involved in direction of the broader utilization management program, data-driven medical management, and quality oversight of staff making utilization decisions.	3	1	1	1	1	3
3. BHOs conduct inter-rater reliability studies across multiple levels of care (not just inpatient) to ensure staff making utilization management decisions use the BHO's published medical necessity standards reliably to manage care.	5	--	--	1	--	4
4. BHOs conduct formal face-to-face supervision by the Medical Director and senior clinical staff of staff making utilization management decisions.	2	3	--	--	--	5
5. BHOs perform formal blind monitoring of staff making utilization management decisions to observe and document their customer service skills and ability to apply medical necessity criteria.	--	1	4	--	--	5
6. BHOs prior-authorize intensive levels of care, such as inpatient, residential, day treatment, intensive case management, and home-based services.	3	2	--	--	1[1]	4
7. BHOs monitor specific criteria (including service encounter data trends) to trigger additional review of individual cases for over- or under-utilization.	2	1	2	--	1	4
8. BHOs review statistically-valid samples of medical records for all levels of care not subject to prior authorization to ensure care provided is medically necessary.	1	--	1[2]	--	--	5
9. BHOs review and analyze data on utilization trends, by provider, for all levels of care.	2	3	--	1	--	4
10. BHOs have a formal training curriculum for staff making utilization management decisions.	2	3	--	--	4	1
Source: *Mercer compilation of information obtained from desk reviews and onsite visits at BHOs.*						

[1] *After prior authorizing CMHC care for multiple years, for Fiscal Year 2007 this BHO now no longer prior authorizes CMHC levels of care and instead monitors utilization against benchmarks based on when care was prior authorized.*

[2] *This standard does not apply to 3 BHOs who prior authorize all external provider network cases.*

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