COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

1570 Grant Street, Denver, CO 80203-1818 • (303) 866-2993 • (303) 866-4411 Fax

John W. Hickenlooper, Governor • Susan E. Birch MBA, BSN, RN, Executive Director

March 30, 2012

The Honorable Ken Summers, Chair
Health and Environment Committee
200 E. Colfax Avenue, Room 271
Denver, CO 80203

Dear Representative Summers:

Enclosed please find a legislative report to the House Health and Environment Committee from the Department of Health Care Policy and Financing titled *Promoting Integrated Care in the Colorado Health Care System, Part I.*

Section 25.5-4-418 of the Colorado Revised Statutes requires the Department to report on any revisions to statute or regulations that would facilitate the integration of physical and behavioral health care services by April 1, 2012.

This report is a preliminary evaluation of legislation that may have an impact on the integration of behavioral and physical health care in Colorado and provides some initial guidance on a set of immediate and actionable steps that may be taken by the General Assembly or the Department to further facilitate integrated care. The Department has proposed five initial strategies to help advance integration of care in Medicaid and the state's health care systems:

1. Explore whether there are ways to make Health and Behavior Assessment/Intervention codes reimbursable particularly within the context of a larger payment reform initiative.
2. Assess whether behavioral health services reporting requirements may be altered to be less administratively burdensome for providers.
3. Consider whether allowing Community Mental Health Centers to obtain a one-time release for private health information is a sufficient regulation of information sharing.
4. Continue to educate the provider community on the allowance of billing physical and mental health services on the same day.
5. Implement a legislative review process for proposed health care legislation that considers the impact on integration of health services.

If you require further information or have additional questions, please contact the Department's Legislative Liaison, Carrie Cortiglio, at Carrie.Cortiglio@state.co.us or 303-866-3972.

Sincerely;

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

SEB/law

Enclosure

Cc: Representative Cindy Acree, Vice-Chair, Health and Environment Committee
Representative Laura Bradford, Health and Environment Committee
Representative J. Paul Brown, Health and Environment Committee
Representative Rhonda Fields, Health and Environment Committee
Representative Janak Joshi, Health and Environment Committee
Representative John Kefalas, Health and Environment Committee
Representative Jim Kerr, Health and Environment Committee
Representative Tom Massey, Health and Environment Committee
Representative Beth McCann, Health and Environment Committee
Representative Cherylin Peniston, Health and Environment Committee
Representative Sue Schafer, Health and Environment Committee
Representative Dave Young, Health and Environment Committee
Lorez Meinhold, Policy Director, Health, Human Services and Education, Governor's Office of Policy and Research
Susan E. Birch, MBA, BSN, RN, Executive Director
John Bartholomew, Financial & Administrative Services Office Director
Suzanne Brennan, Medical and CHP+ Program Administration Office Director
Antoinette Taranto, Client and Community Relations Office Director
Carrie Cortiglio, Legislative Liaison
Joanne Zahora, Public Information Officer

COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

REPORT TO:
Joint Budget Committee of the General Assembly,
Health and Human Services Committee of the Senate,
and
Health and Environment Committee of the House of Representatives

PROMOTING INTEGRATED CARE IN THE COLORADO HEALTH CARE SYSTEM PART I

As Required by House Bill 11-1242 of the
First Regular Session of the 68th General Assembly

April 1, 2012

INTRODUCTION

House Bill (H.B.) 11-1242 of the First Regular Session of the 68th General Assembly was passed in 2011, creating Section 25.5-4-418 of the Colorado Revised Statutes, which requires the Colorado State Department of Health Care Policy and Financing (the Department) to report on or before April 1, 2012 on "any revisions to statute or regulations that would facilitate the integration of physical and behavioral health care services." This report is submitted pursuant to the requirement.

In addition, §25.5-4-418 C.R.S. requires a subsequent report to be provided on or before June 30, 2012 to address:

1. The state and federal statutes and regulations affecting the integrated delivery of physical and behavioral health, including but not limited to statutes and regulations relating to provider reimbursement, and the time and place of delivery of health care services;
2. Barriers or obstacles to the delivery of integrated physical and behavioral health care services; and
3. Incentives for health care providers that may increase the number of providers delivering integrated health care services.

In January 2012, the Department contracted with an independent consultant to provide professional services in support of this effort.

This report is a preliminary evaluation of potential revisions to statutes and regulations to facilitate greater integration of physical and behavioral health care ("integrated care") in Colorado and provides some initial guidance on a set of immediate and actionable steps that may be taken by the General Assembly or the Department to further facilitate integrated care. A more thorough report that will address the full extent of questions presented in §25.5-4-418 C.R.S. will be submitted by June 30, 2012.

Major Integrated Care Initiatives in Colorado

The importance of integrating specialist services such as behavioral health services into primary care has been recognized by the health care community for many years and was identified by the World Health Organization as one of their most fundamental health care recommendations in *The World Health Report 2001*. In H.B. 11-1242, the General Assembly declared that "integration of physical, oral, and behavioral health care services reduces costs, improves patient health outcomes, and creates a seamless continuum of care for the patient." A number of integrated care initiatives are being developed and implemented in various health care systems throughout Colorado. This section summarizes some of the larger initiatives in the state.

State Department Initiatives

- The Accountable Care Collaborative (ACC) Program – The Department implemented the ACC program in the spring of 2011. The goals of this initiative are to improve health outcomes through a coordinated, client-centered system while controlling costs by reducing avoidable, duplicative, variable, and inappropriate use of health care resources. Key components to the program include:

- Regional Care Collaborative Organizations (RCCOs) are responsible for developing provider networks and ensuring care coordination in each of seven regions of the state. Each RCCO is currently developing partnerships with specialist providers and mental health providers in their regions.
- The Statewide Data and Analytics Contractor (SDAC) provides data analytics, reports, and outcomes on care provided.
- Primary Care Medical Providers (PCMPs) contract with the Department and the regional RCCO to serve as the medical home for members.

- Adults without Dependent Children (AwDC) expansion – Pursuant to legislative direction in H.B. 11-1293, the Department is seeking a demonstration waiver from the Centers for Medicare and Medicaid Services (CMS) to expand services to a new eligibility category of adults without dependent children whose income is below 100% of the federal poverty level (FPL). The initial expansion phase will provide for the enrollment of 10,000 eligible applicants at or below 10% FPL who are selected through a random selection process. These individuals will be enrolled in the ACC program. Because of the expected high needs of this population, the Department is emphasizing further development of physical and behavioral health care integration for the program.

- Dual Eligible Demonstration Project – In April 2011, the Department was awarded a federal contract with CMS to develop a plan for a State Demonstration to Integrate Care for Dual Eligible Individuals. The goal is to identify and implement delivery system and payment coordination models that improve client access, quality of care, and coordination of care for individuals eligible for both Medicare and Medicaid services. The Department has engaged various stakeholders in the development of the proposal and is facilitating five stakeholder workgroups to focus on issues or services represented in the proposal. One of these workgroups is focused on behavioral health care.

- Long Term Services and Supports (LTSS) redesign - The Departments of Health Care Policy and Financing, Human Services and Public Health and Environment submitted a proposal to the Joint Budget Committee that presents a strategy to streamline the state's long term services and supports system by focusing on reducing department level fragmentation, leveraging federal health care reform dollars, and improving services to clients through better care coordination and integration of services.

Private and Other Initiatives

- The Colorado Regional Health Information Organization (CORHIO) is working on an issue brief focused on policy considerations for health information exchanges and behavioral health in Colorado. The purpose of the issue brief is to identify privacy concerns and the various federal and state laws that regulate the exchange of mental health and substance use disorder treatment information. These regulations are not consistent with those regarding physical health care and create significant challenges to ensuring quality care coordination and to providing accurate, timely information about a patient's total health.

- Colorado Promoting Integrated Care Sustainability (PICS) is a joint collaboration between the Colorado Health Foundation and the Collaborative Family Healthcare Association, and focuses on fiscal sustainability of integrated care services. Through an environmental scan of the state of Colorado, including an online survey and in-depth interviews, a number of barriers related to financial reimbursement structures were identified, including coding requirements and reporting mechanisms necessary for reimbursement of integrated care services on a fee for service basis. Five recommendations came forth from that study, including:
    1. Clarify current billing regulations and train integrated care sites to optimize the use of existing revenue sources to provide cost efficient, medically necessary care.
    2. Resolve confusion about same-day billing restrictions and pursue efforts to reduce administrative barriers.
    3. Examine the viability of paying for Health and Behavior Assessment codes under insurance plans.
    4. Test and analyze the viability of global funding strategies to financially sustain integrated care services.
    5. Plan and implement a standardized statewide data collection system to document financial, operational and clinical outcomes and costs of integrated care services.

Overview of Approach

For the purpose of this project, which includes this report and the subsequent report to be submitted in June 2012, the Department is conducting approximately forty interviews of key stakeholders from behavioral health organizations, community mental health centers, substance abuse treatment agencies, primary care providers, and integrated care organizations. A final list of the interviewees will be provided in the subsequent legislative report. In an effort to encourage authentic and uninhibited responses, the content of information provided by interviewees will not be attributed to any specific individual.

In addition to interviews, relevant state statutes and regulations relating to the provision of health care were reviewed and analyzed to identify barriers to integration that have arisen due to these laws. The body of laws regulating state health care services is extensive, and a comprehensive review of every law and regulation was not possible given time and resource constraints. Rather, this report focuses on certain areas that were identified through feedback from interviewees, stakeholders, and state department staff, or are known barriers identified in other reports such as the PICS report.

Achieving absolute integration of health care services may require comprehensive change to the state's health care system, including funding, reimbursement, and structure of care provision. The state agencies that provide health care services include: the Department of Health Care Policy and Financing; the Department of Human Services, which includes the Office of Child and Family Services and the Division of Behavioral Health; the Department of Public Health and Environment; and the Department of Corrections. Each of these agencies promulgates regulations that govern the way health care is provided, and most departments must adhere to

federal funding requirements[1]. Further, one person or family may be served by several or all of these agencies, and the variations across programs may cause interruptions, inconsistencies, duplication, and/or challenges to the provision of coordinated care.

This report focuses on specific items that can be distinctly and purposefully addressed by either the General Assembly or the Department via legislation or rule revision, and are items that have been prominent and recurring themes in the work of other initiatives, such as those described above. A comprehensive analysis of the barriers to integrated care and the incentives for provider participation will be included in the final report.

PROPOSED REVISIONS AND STATE STRATEGIES

Each issue identified below includes a description of the barrier to integrated care, the recommended steps towards resolution, and a chart identifying the applicable state statute, state regulation, and a note on whether legislative action is needed.

1. Procedure Codes and Reimbursement Restrictions

The current Colorado Medicaid reimbursement system focuses on a fee-for-services approach that pays a specific fee set by the Department for individual procedure codes for services that are delivered by an appropriate provider. Within a category of services, the Department creates a fee schedule that identifies which procedure codes are allowed to be billed and the amount to be paid. Within a fee-for-service environment, the Department must make decisions about what specific services can be paid. In addition, the fee-for-service system does not include a care management function for monitoring and coordinating services for clients. Without a reliable means to properly manage utilization of new services, the Department cannot project utilization and cost expectations, and therefore cannot prudently offer new services without risking uncontrolled expenditures. Inappropriate billing and over-utilization are possible issues for any new service. Some providers and stakeholders have argued that the Department should pay for certain procedure codes that could facilitate integrate care. Although the Department recognizes the value of these services, covering new services in an unmanaged FFS environment does not always result in the desired outcome of improved health.

In the interviews already conducted as part of this project, and through the work of other initiatives, providers and stakeholders have requested that Health and Behavior Assessment/Intervention (HBAI) codes[2] become procedure codes that are reimbursed by Colorado Medicaid. HBAI codes are not used to treat specific mental health diagnoses, but rather to address psychosocial and environmental factors that affect how a person can manage his or her physical health needs. These interventions can help a person adjust to chronic illness, such as asthma or diabetes, and manage the condition through behaviors.

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[1] Major federal funding streams for the provision of health care services include Title XIX of the Social Security Act (Medicaid), Title XXI of the Social Security Act (Children's Health Insurance Program, or CHIP), Title V of the Social Security Act (Maternal and Child Health Services block grants), Title X of the Public Health Service Act (family planning), and Substance Abuse and Mental Health Services Administration (SAMHSA) block grants.

[2] Current Procedural Terminology (CPT) codes 96150 through 96155

Health and behavior assessment and intervention services focus on patients whose primary diagnosis is physical in nature. The use of HBAI codes does not require a mental health diagnosis. The codes capture services addressing a wide range of physical health issues, such as patient adherence to medical treatment and medication, symptom management, health-promoting behaviors, health-related risk behaviors and overall adjustment to physical illness.

Practices interviewed for this project felt strongly that the use of Health and Behavior Assessment/Intervention codes would allow them to more appropriately code and bill for their services. For examples, children seen in a pediatric practice may be evaluated for neurodevelopment and psychosocial concerns during a clinic visit. Families are then routinely asked about that child's emotional, behavioral, and academic functioning. If there are concerns presented, the use of the health and behavior codes would allow the pediatric practice to assist with interventions and support without diagnosing a child with a mental illness. If a child does meet criteria for a mental health diagnosis, the appropriate mental health psychotherapy codes are used. Without the option to bill for HBAI codes, practitioners may be over-diagnosing patients as having a mental health disorder in order to meet their medical needs.

Providers and stakeholders have argued that the use of these codes would facilitate integration more effectively by appropriately coding for services rendered and encouraging the evaluation of the "whole person" in the process. Stakeholders have noted studies suggesting that the use of HBAI codes allows practitioners to assist in finding solutions to psychosocial determinants of health, which often result in increased well-being and compliance with care plans.

The Department has heard these questions and concerns, and believes that it would be valuable to explore whether there are ways to make these codes reimbursable within the current budget environment, or within the context of a larger payment reform initiative that would allow for examination of potential cost savings that could be realized by reimbursing for these codes. Payment and delivery system reform may be the best option for allowing sufficient flexibility to pay for necessary health services while incentivizing proper utilization and better health outcomes.

Statute:	Section 25.5, Part 4, C.R.S.
Rule:	10 CCR 2505-10 Section 8.200 allows the Department to reimburse based on a fee schedule, which is not defined in the rule. The Department may determine which codes to cover.
Legislation Needed?	Legislative authority is needed in order to change the current reimbursement system. Additionally, a budget action may be required to provide funding to the Department to explore both rate methodologies to support the use of these codes and the potential cost savings that could be generated.

2. Administrative Simplification for Reporting Requirements

Over half of the interviewees identified complex administrative and reporting requirements across the state health and human services departments as barriers to the delivery of integrated

care services. Interviewees have stated that they would like to see a new set of reporting requirements that accurately reflect integrated care needs rather than trying to make modifications to current requirements. One document that is frequently referenced as a challenge is the CCAR. The Colorado Department of Human Services website describes the CCAR:

> The Colorado Client Assessment Record (CCAR) was developed over 25 years ago and is used in Arizona, Delaware, Florida, Wyoming, and Canada. As a result of its extensive use over time, it is a well-tested instrument, with high inter-rater reliability. In Colorado, the CCAR has been required on all Admissions and Discharges to the Colorado public mental health system since 1978. Data collected in the CCAR are used to meet federal reporting requirements associated with the mental health block grant and the Uniform Reporting System (URS), and are used by state agencies in reporting to the Colorado legislature. [3]

In the interviews with stakeholders, the CCAR was identified as an administrative burden for primary care providers who have behavioral health specialists on staff either as direct employees, contractors, or through agreement with a separate mental health provider. These on-site arrangements are meant to facilitate integrated services, but often, the behavioral health services provided in this setting are brief interventions and treatment. The CCAR was described by some providers as unnecessarily long and time-consuming to complete. A recent change in policy[4] requires completion of the CCAR only if a client is seen more than three times in six months. While providers said they appreciate the intent of the streamlining policy and effort, they report that the CCAR is still an administrative barrier to integrated care services for persons with mental health needs.

The advantage of the CCAR is that it is a well-established tool that has been in use for decades, and data have been collected over a long period of time, so trends in services provided and outcomes can be examined. However, this tool was developed many years ago, long before the idea of integrated care became a mainstream health system concern. If a client is referred to specialty care in mental health, it is considered appropriate to complete the assessment. Currently, in order to obtain payment through the publicly funded mental health system, the CCAR must be administered.

The federal SAMHSA block grant requires[5] certain data reporting that is currently collected through the CCAR. However, it might be worth exploring whether a more simplified tool could collect the required information while reducing administrative burdens that could impact integration of care. Exploration of data needs and the best ways to meet those needs may be a helpful next step.

In addition to the CCAR, federal SAMHSA block grants require parallel data reporting on substance abuse treatment services, which is collected in Colorado through the Drug/Alcohol Coordinated Data System (DACODS) instrument. Other federal reporting requirements for health services are met through the state's use of other administrative tools and reports. However, the CCAR was most often singled out by interviewees as an administrative barrier to integrated care.

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[3] http://www.colorado.gov/cs/Satellite/CDHS-BehavioralHealth/CBON/1251581450335

[4] This policy is contained in the document titled: *Colorado Department of Human Services, Division of Behavioral Health and Department of Health Care Policy and Financing Paperwork Streamlining Policy.*

[5] 42 CFR Part 92 states the Uniform Administrative Requirements that apply to state and local governments.

Health system changes at the federal level may also have an impact on reporting requirements in the near future. For example, the two SAMHSA block grants for mental health and substance abuse were recently combined into one block grant for states. As reporting instruments and administrative requirements are being evaluated, the potential impact of federal health care reforms should remain an element of consideration.

Statute:	Not applicable
Rule:	None known.
Legislation Needed?	Further evaluation of data needs may need to be done, which may require a budget action to provide funding to explore these needs.

3. Information Sharing

The sharing of individual health care information is a complex issue governed by multiple state and federal laws. Requirements for mental health and substance abuse treatment providers differ from physical health providers and even differ from one another. Some of the major laws regulating personal health information include:

- **42 CFR, Part 2** (Federal Rules on Confidentiality of Alcohol and Drug Abuse Patient Records) cover substance use disorder treatment.
- **Health Insurance Portability and Accountability Act (HIPAA)** Privacy and Security Rules govern all health care, including physical and mental health.
- The state statutes at **C.R.S. 12-43-218**: Disclosure of Confidential Communication, Mental Health Practice Act, governs psychologists, social workers, professional counselors, marriage and family therapists, school psychologists practicing outside the school setting, licensed or certified addiction counselors, and unlicensed individuals who practice psychotherapy in Colorado.

Community Mental Health Centers

Providers report that they are often challenged by the more stringent requirements for sharing information related to behavioral health care. One of the reported barriers is specific to community mental health centers (CMHCs), which are required to have a release signed by patients every year in order to share personal health information with the patient's other providers, such as a primary care doctor. This requirement would also apply in a co-location scenario where a physician was stationed at a CMHC. The requirement to obtain an updated annual release, rather than a one-time release, is a state regulation and not present for any other health providers, including other types of behavioral health providers like independent psychologists.

The Mental Health Practice Act was amended by the General Assembly in 2011 to correct some of the unnecessary information sharing hurdles for providers. The update was successful in accomplishing some needed fixes for individual behavioral healthcare providers, but did not address the CMHCs' organizational requirements. Providers and clients question why this yearly requirement applies to the community mental health centers and not with other healthcare

providers. The tracking of updated annual releases for every patient has been identified as an additional administrative burden that impairs the coordination of care.

An alternative perspective voiced by the Division of Behavioral Health is that the annual release is an important protective check and balance for the most vulnerable clients to ensure that their rights and confidentiality are periodically reviewed. The Department will be conducting further discussion with stakeholders and client advocates related to this concern.
The regulation governing the requirement for annual releases by CMHC is located at 2 C.C.R. 502-2. Legislation is not required to change the regulation, and the regulation falls under the authority of the Department of Human Services, Division of Mental Health. A review of this requirement, including benefits and burdens of the yearly release, may help to resolve the issue as a barrier to integrating behavioral and physical health care.

Statute:	None.
Rule:	2 C.C.R. 502-2
Legislation Needed?	None needed at this time. Additional research will be done as part of the current project to determine whether and how this issue could be resolved.

In addition, confusion related to the interplay of the various laws regulating personal health information remains a barrier to integration in the provider community. The Department will continue to research this issue and will address it more in the June 2012 report.

4. Same-Day Billing for Physical and Behavioral Health Services in Medicaid

Many organizations and practices have indicated that they believe same-day billing for physical and behavioral health services in Medicaid is not allowed. Confusion and uncertainty over same-day billing are pervasive in the provider community, and the common belief is that services cannot be billed on the same day by different provider types who work in the same site. However, only one same-day billing issue has been validated by the Department, which relates to services provided by Federally Qualified Health Centers (FQHCs).

The Department contracts with regional Behavioral Health Organizations (BHOs) to provide capitated managed care for services provided to treat specific mental health disorders. When a provider delivers behavioral health care for a covered diagnosis, the provider bills the BHO in that region to receive payment.

Federally Qualified Health Centers receive a rate set to cover 100% of their reasonable costs based on an annual cost report and paid per visit, or "encounter". Currently, the regulation states that an FQHC may only bill one encounter per patient per day. An encounter may include physical health services and behavioral health services, but a claim for behavioral health services only must be submitted to the BHO in that region. FQHC providers have reported confusion over whether they are allowed to bill both the Department for the encounter *and* the BHO for behavioral health services in one day. The billing of both is currently allowable, but the regulation does not specifically address the possibility. The Department is working internally and with the provider community to modify this regulation, located at 10 CCR 2505-10-8.700.7.A, to directly address the matter.

In addition, comprehensive provider education is needed to clarify what is allowable for all organizations and providers. The Department will be providing education and information throughout several of the integrated care initiatives and also with the development of a state wide coding sheet to be developed as part of the final report for this legislation.

Statute:	None known.
Rule:	10 CCR 2505-10-8.700
Legislation Needed?	No legislative action is required. A coding sheet, which will provide additional details about which codes may be billed by different providers within different settings, is being developed as part of this project, which will further clarify this issue.

5. Legislative Review and Integrated Care

Legislation is generally proposed with the intent to improve or advance the state's health care system. As new legislation is proposed, consistent review of proposed legislation to analyze the degree of support for integration, or potential new barriers to integration would allow the General Assembly to maintain a focus on moving systems more towards integrated, cost-effective, and capable health care. For example, legislatively-directed pilot projects may mandate services offered through a particular provider type without considering other innovative methods of integrating service delivery.

Statute:	Not applicable
Rule:	Not applicable.
Legislation Needed?	A legislative review process could help assembly members evaluate whether health care legislation and pilot projects would support the continued progression towards an integrated health care system.

CONCLUSION

The effective integration of physical and behavioral health care services has been shown to significantly reduce costs and improve health outcomes. The Department has proposed five initial strategies related to the legislative or rule-making processes to help advance integration of care in Medicaid and the state's health care systems:

1. Explore whether there are ways to make Health and Behavior Assessment/Intervention codes reimbursable within current budget constraints, or within the context of a larger payment reform initiative.
2. Assess whether behavioral health services reporting requirements may be altered to be less administratively burdensome for providers.

3. Consider whether allowing CMHCs to obtain a one-time release for private health information is a sufficient regulation of information sharing.
4. The Department should continue to educate the provider community on the allowance of billing physical and mental health services on the same day.
5. Implement a legislative review process for proposed health care legislation that considers the impact on integration of health services.

These items are potential first steps toward achieving a more integrated and coordinated state health system in Colorado. A more comprehensive analysis of the barriers to integration and proposed incentives for providers to participate in integration activities will be submitted by the Department by June 30, 2012.