



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 II**

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

July 1, 2012

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EXECUTIVE SUMMARY

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 state and federal laws affecting the integrated delivery of physical and behavioral health care, as well as barriers and incentives to delivering integrated care.

The importance of integrated care, which “addresses the mental health, including substance use disorder, oral health, and physical health needs of the patient at the time of health care services,” has been acknowledged and declared by the State of Colorado via H.B. 11-1242. The purpose of this report is to determine why fully integrated care is not yet achieved by examining the perspectives of those who provide the care and implement the system: health care providers, representatives from provider associations and managed care groups, and state agency representatives. **The feedback and views presented in this report in no way represent the position of the Department or the executive branch of Colorado government. Rather, they are the views, perspectives, and feedback of a sample of providers and stakeholders.**

For this report, the approach taken was to gather responses to the questions outlined in the legislation from relevant and appropriate sources, including those required by the legislation. In January 2012, the Department contracted with an independent consultant to provide professional services in support of this effort, including a series of interviews with representatives of multiple provider groups. A total of 47 interviews were conducted, including 55 respondents, and a stakeholder meeting was held to provide an additional forum for participation.

The content of the interviews was analyzed to identify common points, which were categorized as specific issues once the interviews were completed. Each category was then tallied for how often it was mentioned by respondents in an interview. The most prevalent issues reported by respondents include the following.

1. Access to client and population data is necessary to integrated care delivery and is currently not widely available.
2. The fee-for-service reimbursement system does not support necessary functions for integrated care.
3. Systems of care and funding streams are siloed so that mental health, substance abuse, and physical health services are separated both clinically and administratively.
4. The amount and types of training currently available to providers is currently insufficient to institute integrated systems.
5. Specific services that promote integrated care are not reimbursed by Medicaid, including Health and Behavior Assessment/Intervention codes and provider-to-provider consultations.
6. Many providers still believe that same-day billing is a barrier in Medicaid. Additional messaging and education is necessary to remedy this misunderstanding.
7. Mental health and substance abuse services are fragmented by funding, administrative requirements, practitioner types, and licensing.
8. Administrative reporting requirements, including the Colorado Client Assessment Record (CCAR) and the Drug/Alcohol Coordinated Data System (DACODS) reports, are burdensome and do not align with integrated treatment approaches. These reports include information that is required by the federal government to receive block grant funds.

9. Privacy laws are both a real and a perceived barrier to sharing information between different provider types.
10. Prevention, early intervention, and wellness are necessary components of integrated care and are not currently supported by state payment systems.

Other reported barriers include societal expectations of how health care is traditionally provided and received, and the negative stigma associated with mental health and substance abuse issues.

The Accountable Care Collaborative (ACC) Program is the new Medicaid program providing a more coordinated system of care delivery for its members. Respondents generally reported that the program is a step in the right direction; however, some concerns were voiced over the current structure and policies. In addition, respondents expressed the need for additional guidance to standardize the definition of “integrated care” and a need to explore options for health homes.

The Department plans to release a policy paper by the beginning of the 2013 calendar year to 1) respond to the issues presented in this report and 2) outline the Department’s high-level strategy for integrating physical and behavioral health moving forward. The issues identified in this report are complex and will require significant effort and resources to resolve. However, the Department remains committed to the goal of effective and efficient integrated physical and behavioral health care delivery.

Disclaimer:

For the purpose of this report, the Department is presenting unfiltered input from respondents and stakeholders that was collected as a part of this process. These opinions do not in any way represent the position of the Department and sometimes do not reflect actual state policies and procedures. However, the Department believes that the first step to understanding the community needs and potential approaches to better integrate health care is to examine the experiences and perspectives of the people who provide health care services. In the next few months, the Department plans to release a policy paper that will address concerns and beliefs presented in this report. The policy paper will outline the Department’s strategy going forward to promote integrated physical and behavioral health care.

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:

- A. 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;
- B. Barriers or obstacles to the delivery of integrated physical and behavioral health care services;
- C. Any revisions to statute or regulations that would facilitate the integration of physical and behavioral health care services; and
- D. Incentives for health care providers that may increase the number of providers delivering integrated health care services.

A previous report was submitted on April 1, 2012 to address item C of the requirements. This report is now submitted to meet the remaining requirements, including the laws affecting integrated care delivery, the barriers or obstacles, and the incentives for providers to deliver integrated physical and behavioral health care services in Colorado.

BACKGROUND

The philosophy of integrated health care is based on the premise that a person is not just an assemblage of independent biological parts and functions, but rather a person represents a singular organic, social being that encompasses his or her physiology, psychology, and interactions with the surrounding environment. In other words, a whole person is more than the sum of his or her parts. The health of an individual is not isolated to a simple diagnosis, but includes the entirety of a person's functioning and experience. Therefore, integrated care seeks to treat the whole person, including diagnosis, overall functioning, and experience of well-being.

The importance of integrated care, which “addresses the mental health, including substance use disorder, oral health, and physical health needs of the patient at the time of health care services,” has been acknowledged and declared by the State of Colorado via H.B. 11-1242. Per the legislation and statute, integrated care “reduces costs, improves patient health outcomes, and creates a seamless continuum of care for the patient.”

However, despite this acknowledgement, the current Colorado health care system does not meet the standards of integrated care. The purpose of this report is to determine why fully integrated care is not yet achieved by examining the perspectives of those who provide the care and implement the system: health care providers, representatives from provider associations and managed care groups, and state agency representatives. **The feedback and views presented in this report in no way represent the position of the Department or the executive branch of Colorado government. Rather, they are the views, perspectives, and feedback of a sample of providers and stakeholders.**

Following the submission of this legislative report, the Department will be releasing a policy paper to respond to issues identified here and to summarize its approach going forward to

integrating physical and behavioral health care in the Medicaid program. The policy paper will be released by the beginning of calendar year 2013.

METHODS

For this report, the approach taken was to gather responses to the questions outlined in the legislation from relevant and appropriate sources, including those required by the legislation. In January 2012, the Department contracted with an independent consultant to provide professional services in support of this effort. As an objective third party, the consultant conducted a series of interviews with representatives of multiple provider groups. In addition, a stakeholder meeting was conducted to gather additional input, information was collected through written comments, and input was taken from the Accountable Care Collaborative (ACC) Payment Reform Subcommittee.

A total of 47 interviews were conducted, including 55 respondents. The respondents included representatives from Behavioral Health Organizations (BHOs), community mental health centers (CMHCs), primary care providers, Federally Qualified Health Centers (FQHCs), long-term supports and services providers, Regional Care Collaborative Organizations (RCCOs), provider associations, academic experts, and other state health and human services agencies. The full list of respondents is included in Appendix A. The interviews were conducted either in person or over the phone and lasted an average of one hour. The format of the interviews was unstructured; the interviewer used only the required components from Section 2, items A through D of the legislation to direct the interviews and asked clarifying questions when necessary. In order to assure confidentiality and encourage forthcoming responses, no information or statements collected through the interview process have been attributed to a specific respondent in this report.

The content of the interviews was analyzed to identify common points, which were categorized as specific issues once the interviews were completed. Each category was then tallied for how often it was mentioned by respondents in an interview. For the purpose of this analysis, the data set was based on the number of interviews rather than number of respondents. For example, several interviews included more than one respondent, so the multiple respondents are counted as one interview. Also, two respondents completed their interviews in two sessions, which are only counted as one interview each.

The stakeholder meeting was held on May 16, 2012 for an hour and a half and included 51 participants, not counting representation from the Department. Participants were prompted through discussion to respond to the April 1, 2012 report and the issues identified in the legislation: laws affecting the delivery of integrated care, barriers and obstacles, and incentives to the delivery of integrated physical and behavioral health care. This information, as well as the feedback collected via the ACC Payment Reform Subcommittee and from written comments, was not quantitatively analyzed but is included under each category in the discussion section of the report.

Some of the respondents felt comfortable speaking only to their area of specific expertise, whereas other respondents provided input based on their broader experience. The goal of this report is to present an overview of the provider and community experience and perception; however, Department clarification follows many points in the discussion section to clarify

information that may have been misunderstood by respondents. The Department is committed to capturing the perspectives of respondents in order to understand their experiences and identify any educational and messaging needs.

SUMMARY OF RESULTS

The following table displays an aggregate summary of the 15 topics most often mentioned in the interviews. A total of 51 independent issues were mentioned by more than one respondent. The complete table of results and a summary outline of the discussion section may be viewed in Appendix B. Many of the issues are interrelated or overlap in some way, and specific issues were categorized based on the common language used by respondents.

Rank	Issue or Barrier	Percentage of Respondents	Number of Respondents
1	Information sharing and data needs	74.5%	35
2	Fee-for-service reimbursement system	59.6%	28
3	Siloed systems of care and funding streams	44.7%	21
3	Provider training needs	44.7%	21
3	Health & Behavior codes, consultations and related codes	44.7%	21
6	Same-day billing and education	40.4%	19
6	Fragmentation of mental health and substance abuse	40.4%	19
8	CCAR, DACOD, other administrative requirements	38.8%	18
8	Privacy laws	38.8%	18
10	Workforce shortages	36.2%	17
10	Prevention, early intervention, and wellness needs	36.2%	17
12	ACC Program challenges	34.0%	16
13	Patient-centered approach not supported	31.9%	15
13	Licensure and certification issues	31.9%	15
13	Differences in service provision practices	31.9%	15

Respondents were not led in any particular direction and were allowed to provide input on whatever issues they had in mind related to the legislative requirements for the report. The most significant barrier to integration reported was “information sharing and availability of data” at a 75% rate of response.

Overarching Challenges

The idea that barriers to integrated care are often the result of historic fragmentation of the health care system or cultural beliefs and expectations was pervasive across the interviews. Input related to the ingrained and systemic barriers include:

- The training of providers is focused on a particular area rather than integration of disciplines and a whole-person approach.
- Organizational cultures among behavioral health provider organizations and physical health provider organizations are different.
- There is pervasive stigma against mental health and substance abuse that makes identification and treatment more challenging than for physical health needs.
- The expectation of the larger consumer and provider community is that care is fragmented, and is provided by different areas of specialty in different locations for different needs.

Another pervasive issue is the lack of integration of mental health and substance abuse treatment, together known as “behavioral health.” The need to integrate these two service categories was reflected in discussions of data needs and medical records, siloed systems of care and funding, provider training needs, CCAR/DACODS and administrative requirements, barriers in privacy laws, and licensure and certification issues, among other barriers. Several respondents stated that the integration of mental health and substance abuse services is “farther behind” than the integration of physical and behavioral health care services.

Finally, a common theme among the interviews was the structure of the health care system, including funding structures, payment mechanisms, service delivery structures, and clinical training. One respondent stated, “We need to change the fundamental economics of primary care.” Another respondent observed that “Disintegration is systemic; it starts with federal funding and comes down to how programs are implemented, which reflects the federal level of disintegration.”

DISCUSSION OF ISSUES

Information and Communication

Data Needs

Interview respondents frequently cited the need to share information about a client or a population between behavioral health and physical health providers, as well as other data from hospitals, pharmacies, laboratory results, and other specialists. The need for data was also the first barrier identified at the stakeholder meeting.

The need for client diagnosis and treatment data was described as essential to integrated practice. The information allows for “the right care and the right treatment” in the context of a whole-person approach. In addition, data are necessary for population health methods that can identify large-scale health needs as well as individual client needs in between visits. For example, providers may categorize clients using the Four Quadrant Model¹, a clinical integration model that stratifies the client population by behavioral health risk/status and by physical health risk/status. Population health data can also help to track health outcomes among a client population and support the efficacy of certain treatment strategies.

The major points noted from the respondents include:

¹ Proposed by the National Council for Community Behavioral Healthcare: “Behavioral Health and Primary Care Integration: The Four Quadrant Model and Evidence-Based Practices,” Revised Feb. 2006.

- Electronic health records (EHRs) are often different product systems and cannot effectively interface between systems and providers.
- Financial incentives and funding have been provided to primary care providers through the American Recovery and Reinvestment Act (ARRA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act through the meaningful use incentives. However, behavioral health providers and specialists are not eligible to apply for these resources.
- Smaller practices do not have the capacity or infrastructure to invest in elaborate records systems.
- There is no consistent mechanism to analyze the data, and common metrics across payers do not exist.
- For dual eligible clients (who have both Medicare and Medicaid benefits), not having access to the Medicare claims is a barrier to integrated care and meeting clinical needs.

The Department’s Statewide Data and Analytics Contractor (SDAC), associated with the ACC Program, was mentioned several times as a step forward. However, respondents also noted that the SDAC is only used for the ACC Program members, only includes Medicaid (and some Medicare) data, and the data are not real-time because they are claims-based (which can be delayed by up to 90 days). In addition, several respondents noted that significant education is necessary to understand and use the data in practice. Several respondents were optimistic about the All-Payer Claims Database (APCD), a secure database that will include claims data from commercial health plans, Medicare, and Medicaid.

Additional Information

The APCD was authorized by H.B. 10-1330, and will be launched in late 2012. The Center for Improving Value in Health Care (CIVHC) will administer the APCD, which will be a comprehensive source for data from all public and private payers in Colorado. There are eleven states that have implemented, or are in the process of implementing, an APCD, and 18 others expressing strong interest, according to the national APCD Council.

Two respondents pointed out that the APCD may not include claims from small group markets (private insurance). The source of this limitation is state statute CRS 10-16-104(5)(d)(I), which bars the collection of mental health claims information in the small group market because of privacy concerns. Because many small groups markets cannot pull out claims only related to mental health, it may be challenging to report any claims information.

Additional Information

The Behavioral Health Information Technology Act of 2011: Senator Sheldon Whitehouse (RI) introduced Senate Bill 539, which amends the Public Health Service Act to expand the definition of “health care provider” to include a behavioral or mental health professional, a substance abuse professional, a psychiatric hospital, a community mental health center, a residential or outpatient mental health treatment facility, and a substance abuse treatment facility. The bill has five co-sponsors and is currently in committee.

If passed and implemented, this legislation would expand eligibility for the meaningful use incentives to include behavioral health providers.

Privacy Laws

The discussion of privacy laws on either the state level or the federal level as a barrier was relatively prominent among the interviews and appeared in 18 interviews. The specific laws referenced include:

- Health Insurance Portability and Accountability Act (HIPAA),
- 42 CFR Part 2, the federal confidentiality regulations for substance abuse treatment,
- Mental Health Practice Act (Title 12, Article 43 of the Colorado Revised Statutes), and
- the state regulation requiring annual releases for the sharing of mental health treatment information in Community Mental Health Centers (2 C.C.R. 502-2-CF.2).

A common theme among these respondents was that HIPAA is often interpreted in different ways, misinterpreted, or not understood. One respondent stated that the law is intended to allow for communications between health care providers, but not all entities are comfortable entering into the necessary agreements. Another respondent noted that HIPAA is “not as restrictive as people think.”

A number of respondents identified 42 CFR Part 2, which regulates the sharing of client information related to substance abuse treatment, as a barrier to integration because it is not congruent with privacy laws for other services. Several respondents referenced the recent report by the Colorado Regional Health Information Organization (CORHIO)², which names 42 CFR Part 2 as “one identified restriction in the current policy framework” (page 30) and recommends supporting revisions to the law.

Despite the recent change in state law, several respondents referenced the state’s privacy laws for behavioral health practitioners. Only one respondent specifically named the Mental Health Practice Act. Respondents were concerned with the requirement to obtain client releases for information sharing with other treating providers because of the time required and because “in an integrated environment, if the patient will not sign a release, you can’t actually integrate treatment.” However, in 2011, the Mental Health Practice Act was amended to exempt HIPAA covered entities, their business associates, and public health entities from the state privacy law. These exempted groups include the following provider types if they transmit any transactions electronically:

- Psychologists
- Social Workers
- Marriage and Family Therapists
- Licensed Professional Counselors
- Certified Addiction Counselors

Several respondents identified the current rule for Community Mental Health Centers (CMHCs) (2 CCR 502-2-CF.2) as a barrier because CMHCs have the administrative burden of obtaining and monitoring client releases every year in order to share information with other treating

² Colorado Regional Health Information Organization. “Supporting Integration of Behavioral Health Care Through Health Information Exchange.” 2012. URL: http://www.corhio.org/media/40757/supporting_integration_of_behavioral_health_care_through_hie_april_2012-web.pdf

providers. The rule, under the Department of Human Services, requires that “the consent form shall specify that the consent is valid not longer than one year.”

Additional Information

Summary of Applicable Privacy Laws

FEDERAL LAWS:

- Health Insurance Portability and Accountability Act (HIPAA)
The HIPAA Privacy Rule was enacted in 1996 and includes federal protections for personal health information held by covered entities and business associates of covered entities. It also secures patient rights over the information. In addition, the Privacy Rule permits the disclosure of personal health information when needed for patient care and other important purposes.
- Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR Part 2)
These regulations govern the use and disclosure of alcohol and drug abuse patient records that are maintained at federally funded programs; patient consent is generally required. Patient consent must be in writing. The consent must specifically state: 1) who can disclose and receive information, 2) the purpose of disclosure (treatment, payment, disease management and/or quality improvement, etc.), 3) how much and what kind of information can be disclosed, and 4) when consent expires and must be renewed.

STATE LAWS:

- Mental Health Practice Act (Title 12, Article 43 of the Colorado Revised Statutes)
The general assembly established a state boards for each behavioral health provider type, with the authority to license, register, or certify, and take disciplinary actions and/or bring injunctive actions concerning licensed practitioners. “A licensee, registrant, or certificate holder shall not disclose, without the consent of the client, any confidential communications made by the client, or advice given to the client, in the course of professional employment.” (§ 12-43-218). ****In 2011, this law was amended to exempt HIPAA covered entities, their business associates, and public health entities. Currently, the behavioral health practitioners named in the Act who are also HIPAA covered entities may adhere to HIPAA privacy laws rather than Article 43 of Colorado Revised Statutes. (§ 12-43-218-6)**
- Community Mental Health Centers (2 C.C.R. 502-2-CF.2)
Community Mental Health Centers are required to keep information obtained and records prepared about clients confidential. Confidential information may be disclosed only after clients, parents (for clients under 15 years of age) or legal guardian give informed, written consent unless otherwise authorized by law or court order. “The consent form shall specify that the consent is valid not longer than one year and may be revoked in writing by the client, parent or legal guardian at any time.”

Other Communication Needs

A number of respondents spoke of the need for communication and collaboration among providers, separate from data needs. According to one respondent, “information does not equal

communication.” Interviewees reported that collaboration between physical health and behavioral health providers is necessary for integrated care.

Respondent Input:

- When referrals are made to behavioral health providers, there is no communication back to the primary care provider who made the referral on whether the client was engaged or treated.
- “We need meaningful communication,” and providers should “talk to each other more.”
- One underlying reason for most hospital readmissions is a lack of communication.
- For one provider, the experience of attempting to contact previous prescribers for child clients has been difficult.

Much of the input collected related to communication is interrelated with data needs and privacy laws barring the sharing of client information. The unique factor for this category is related to provider behaviors and a lack of collaboration among providers, which was described as a barrier to integration.

Payment Systems and Funding

Fee-for-Service in Medicaid

The fee-for-service payment system is the traditional model of payment that pays a fixed fee for each service allowed by the payer. Services are billed using a standard coding system. The general sentiment among respondents was that the fee-for-service system does not support integration of services and incentivizes volume of care rather than quality of care. This belief was echoed in the stakeholder meeting. In addition, the rates set for Medicaid are considered very low relative to the value of the services as well as other payer sources. Some of the responses received are below.

- One respondent described fee-for-service as “hamster health” that incentivizes running as much as possible.
- “Fee-for-service is inadequate and will always be inadequate.”
- “Going back to fee-for-service and doing integrated care is an oxymoron.”
- “Anything but fee-for-service.”

The criticism of the fee-for-service payment model was generally accompanied by the idea that a new model of payment, such as global payment system or a per-member per-month (PMPM) payment for integrated health teams, is necessary to integrate health care in Medicaid. Respondents highlighted the need to focus on the impact and outcomes of care. The observation was made several times that the payment system determines the type of clinical care provided. Global payment was seen as a way to structure a service delivery model that incentivizes quality whole-person care.

Siloed Systems and Funding

The structure of state health care systems was often identified as a barrier to integrating physical and behavioral health care, and the issue is related to several other concepts, such as the behavioral health “carve-out”, administrative burdens, and fragmentation of care for clients.

Respondent input related to siloed systems and funding:

- The nature of funding is siloed and separates physical health, mental health, and substance abuse services.

- Behavioral health funding is provided by several different state agencies – including Health Care Policy and Financing, the Division of Behavioral Health (DBH) in the Department of Human Services (DHS), the Department of Regulatory Agencies (DORA), and the Department of Education – and each agency has different expectations and requirements.
- “Mental health funding is so incredibly complex.”
- “Disintegration is systemic; it starts with federal funding and comes down to how programs are implemented. It’s a reflection of how money comes down federally.”
- “Fragmentation drives high costs” and creates an “inability to connect the dots, so we’re not good at coordination, communication, or collaboration.”
- There should be one pot of money to take care of everyone. “Show that what you do adds value to the system.”

The Structure of Behavioral Health Programs in the State

The **Division of Behavioral Health** (DBH) exists within the Colorado Department of Human Services, Office of Behavioral Health (OBH). DBH works collaboratively with the OBH Deputy Executive Director to execute the State’s federal responsibilities as the State Mental Health Authority and the Single State Substance Abuse Authority. DBH is responsible to administer, license, and regulate the provision of community-based public behavioral health system, specifically the substance use prevention, mental health promotion and early intervention, substance use disorder treatment, and mental health treatment services for the State of Colorado.

The **Department of Health Care Policy and Financing** (Department) runs the Colorado Medicaid Community Mental Health Services Program (the Mental Health Program). The Mental Health Program provides mental health care to Medicaid members in Colorado. The Mental Health Program is a managed mental health care program for all Medicaid clients. This means that Medicaid clients get mental health services through a Behavioral Health Organization (BHO). The BHO arranges for and coordinates mental health services for Medicaid members. HCPF first submitted a waiver under [Section 1915 \(b\) of Title XIX of the Social Security Act](#) to have a managed care mental health program in 1995. The waiver has been renewed every two (2) years since. The current waiver expires on June 30, 2013. In addition to State Plan services, the waiver allows the Department to offer a variety of alternative mental health services such as intensive case management, vocational services, recovery services, clubhouses and drop-in centers.

From www.colorado.gov

Behavioral Health “Carve-Out”

In the Medicaid Program, managed care organizations are paid a capitated rate for recipients to cover service costs related to a number of mental health diagnoses. These five managed care organizations, known as Behavioral Health Organizations (BHOs), are responsible for Medicaid recipients living within their region of the state. The BHOs contract with mental health providers, including Community Mental Health Centers (CMHCs), to provide services. The covered diagnoses are listed in Appendix C, and do not include substance use disorders unless they co-occur with a covered diagnosis.

Respondents' criticism of the BHO system as a barrier to integrated care included the following perceptions.

- BHOs are focused on treatment only and not prevention. There is little to no incentive for them to do outreach and case-finding.
- BHOs should also cover substance use disorders.
- Contracting with BHOs is challenging for providers and requires a significant amount of time and resources. In addition, if a provider is located in more than one region, the provider must separately contract with each BHO.
- BHOs do not contract with any willing provider, and will not contract with new providers once they have deemed the network to be sufficient. For providers who want to integrate and add behavioral health services, this practice is a barrier to being paid for integrated care.
- Different networks make referrals complicated.
- For integrated providers who treat 1) both physical and mental health, or 2) both mental health and substance abuse, there are two separate entities to deal with: the Department and the BHOs.
- Behavioral health disorders often co-occur with developmental disorders, dementia, and traumatic brain injury. However, these conditions are not covered diagnoses.

Two respondents believed that the BHO system is a successful model and supports good clinical care. One respondent acknowledged the BHOs as a cost-effective payment model but also that the BHO model is a barrier to integrated health care because of the separation of funds and services. In addition, several respondents were concerned about the need to keep separate funding designated solely for behavioral health needs. These respondents were concerned that an integrated funding stream would become overwhelmed by physical health care costs or promote competition for funding. One respondent pointed out that, by having behavioral health funds as a separate line item, stakeholders can trace the amount of resources being dedicated to behavioral health services and advocate as necessary.

Several respondents advised that the current covered diagnosis model should be eliminated, and instead the BHOs should be paid for covering specific services. Another respondent believed that the carve-out itself should be eliminated, and all services should be covered by one entity, under one contract. One respondent identified the future structuring of the BHOs as “the big question” in the state for integrating Medicaid, and stressed that the Department should make a decision about the next BHO procurement and message that decision to the community. According to the respondent, “Everyone is trying to make strategic plans, and the big unknown is the carve-out.”

Limited Dedicated Resources

Substance Abuse Treatment Benefit. Over twenty percent of respondents stated that they believe that the substance abuse benefit in Medicaid is insufficient. These respondents believe the low payment for substance abuse services is a barrier to integrated care. Several respondents stated that they had been “excited” when the benefit was added to Medicaid but were subsequently disappointed with the payment, which is “trickling out of the faucet.” In addition, respondents stated:

- The limited funding is not enough to attract providers, and it is difficult to get providers to participate.
- It's too expensive to get a bill out the door, and some services in the benefit, such as case management, are often provided without being billed.

- The benefit is narrow and limited only to an outpatient benefit with additional options for pregnant women.
- The way the detox benefit was set up is “crazymaking” and includes three separate services instead of a per diem amount.
- According to one respondent, many clients are court-ordered, and case management is required but not reimbursed. The associated documentation and administrative support for these clients is costly.
- One respondent claimed that the state of Colorado is ranked 49th out of 50 states for substance abuse funding³.

One respondent was frustrated by the SBIRT (Screening, Brief Intervention, Referral, and Treatment) benefit, which is used to identify substance use disorders in clients in various settings: “What do you do when you identify a need? We don’t have enough community providers to meet the need.” Several respondents stated that including substance use disorder treatment under the BHO capitation would support a continuum of care for clients and would provide access to additional resources within the BHO system.

One respondent offered a potential solution to increasing funding for substance abuse and suggested taxing liquor sales at only a few cents per purchase in order to provide additional funding for substance abuse treatment centers.

The Medicaid rates for substance abuse services are included in Appendix E.

Additional Information

Substance abuse treatment is covered through the BHO contracts when a substance use disorder is co-occurs with a covered mental health diagnosis.

Underfunded Behavioral Health Needs. According to one respondent, “The needs of my patients are not met under our current funding structure.” Another respondent pointed out that behavioral health specialists are not paid well by Medicaid, so often leave Medicaid practices to work for cash businesses supported by private funding. One provider stated: “We just need to cover the cost of providing behavioral health services. In 67 years of practice, we have not yet found it to be sustainable.”

Uncompensated Care. Over thirty percent of respondents stated health care services were being provided without any payment. Most of these respondents were providers, and several explained their reasoning behind providing non-reimbursable services is because “it’s the right thing to do.” Many practices are under-billing because of the administrative burden or confusion. Administrative burdens and same-day billing confusion are addressed elsewhere in this report. In addition, some services like wrap-around services, school contacts, and some care management, do not have treatment codes when they fall outside the case management service.

³ According to The Bell Policy Institute in its article “A Colorado Test: How do we measure up?” (*Denver Business Journal*, March 18-24, 2005), Colorado ranks 49th in the nation for per capital spending for substance abuse and treatment programs.

Administrative Structures and Burdens

State Agency Structures and Relationships

Health and human services are administered by three separate state agencies in Colorado:

- Colorado Department of Health Care Policy and Financing (HCPF)
- Colorado Department of Human Services (DHS), including the Division of Behavioral Health (DBH)
- Colorado Department of Public Health and Environment (CDPHE)

Each agency is responsible for certain components of the overall health care system in the state and administers programs that often affect the same people. Among respondents, there was a perception that the agencies do not have a strong working relationship and do not have a direct incentive to work together.

Respondent input:

- There is no perceived common vision or direction from the state agencies.
- There is a perception that the agencies do not communicate with each other and do not work together on policies that affect each other.
- The agencies have different expectations and requirements associated with funding for behavioral health. “Behavioral health funding is all over the place.”
- The agencies collect different information on clients. According to one respondent, an inter-agency workgroup that was formed to define the minimum data set for clients dissolved after two years and was unsuccessful.
- The agencies are competing for financing through the state budget.
- The state agencies do not understand the requirements for each other.
- DBH maintains different office structures and lines of communication for substance abuse and mental health service areas.
- DBH inability to keep leadership is a concern.
- “We need a true health department.”
- “Fragmentation in state government filters down to the clinical level” and is not a good model.

Respondents suggested strategies to support better functioning between the agencies, including co-location, cross-departmental teams, and mutual accountability.

A chart of agency responsibilities for behavioral health funding and programs is included as Appendix D.

Block Grant Reporting

As identified in the April 1, 2012 report, reporting requirements are considered by many respondents to be a barrier to integration. Specifically, the CCAR and the DACODS were mentioned by 13 respondents (38%). The Colorado Client Assessment Record (CCAR) is an assessment tool and data collection mechanism that fulfills a federal block grant data requirement for clients with mental health diagnoses. The Drug/Alcohol Coordinated Data System (DACODS) is the parallel assessment tool/reporting system for clients with a substance use disorder. SAMHSA requires certain data reporting for both the mental health block grant and the substance abuse block grant, and Colorado uses the CCAR and DACODS to fulfill those

requirements. The assessment tools are also used for Medicaid clients receiving mental health and substance abuse services.

The block grants are administered at the state level by DBH. A recent change in policy⁴ requires completion of the CCAR only if a client is seen more than three times in six months in FQHCs.

Respondent Input:

- The CCAR and DACODS are appropriate for clients with severe and persistent mental illness (SPMI), but are not appropriate for an integrated care setting.
- The tools are unnecessarily lengthy and time-consuming.
- Because the time requirements of the tools do not fit the model for brief treatment, behavioral health services are being provided without reimbursement, and the data for those clients are not being collected.
- The recent change in policy is a step forward but is not enough. Respondents believe that the requirement should align with the model for brief treatment, which is six visits.
- The structured interviews called for by the assessment tools are problem-focused rather than strengths-based. It is difficult to build rapport and an effective clinical relationship with clients using these interview structures.
- Providers have to get through the full assessment requirements before addressing the client's immediate issue. The requirements delay addressing client concerns, which affects the retention of clients and getting clients in for services.
- "The system is more about compliance than helping the client."
- Multiple respondents questioned the reasoning behind having more burdensome documentation standards for behavioral health providers than physical health providers.

One respondent from a mental health center stated that for clients needing substance abuse services from block grant funds, both the CCAR and the DACODS are required to be administered. The entire intake, including another 30 minutes for the center's intake process, can take as long as two or three hours. "Anything after 90 minutes dilutes our return on investment... and the costs exceed reimbursement for evaluation." This respondent calculates that the time spent on the assessment tools is doubling his costs for intake, which are reimbursed at \$150 per substance abuse intake/assessment and only cover costs for the first 90 minutes of intake.

The CCAR and DACODS tools are used for the data collection and reporting requirements associated with the SAMHSA block grants. The state is required to collect the information in order to receive block grant funds. Among respondents, there is a general understanding that the reporting tools are tied to federal requirements, but it is unclear whether these particular tools are necessary or if an integrated, more streamlined tool could be developed and used. In addition, the two SAMHSA block grants for mental health and substance abuse were recently combined into one block grant for states. It is not yet clear how this change will affect reporting requirements.

Additional Information

The CCAR and DACODS serve different purposes, and some of the data collected by each is required for federal block grants. The Division of Behavioral Health's five year strategic goals

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.*

include:

- developing a web-based, ad-hoc reporting program for providers to customize their own reports;
- integrating all DBH databases into one data warehouse and automate all routine reporting at the federal, state, and local levels by Integrating the ADDSCODS and DACODS databases, and integrating the CCAR and Encounter databases; and
- converting the system to a web-based combined system by the end of 2012.

Statement from DBH's FY11 application for the substance abuse services block grant:

“The integration project has taken considerably more time to achieve than was expected. The biggest barrier to the success of the project has been due to lack of adequate state resources to support the information technology necessary to achieve this goal in a timely fashion.”

Information on the CCAR and DACODS:

From Colorado's Uniform Application FY11 for the Substance Abuse Prevention and Treatment Block Grant:

The Drug/Alcohol Coordinated Data System (DACODS) is used to track treatment service use levels and CCAR is used to track defined geographic areas, population served, and modality. DACODS is a consumer/client-based, treatment data instrument routinely used to collect information on consumer/client demographics, alcohol and drug use patterns, history of abuse, prior treatment episodes, service utilization and outcome measures. DACODS collects information at both admission and discharge, and meets the SAMHSA data reporting requirements for the Treatment Episode Data Set (TEDS). DACODS also meets the State Outcomes Measurement and Management System (SOMMS) data reporting standards. DACODS data is the basis for reporting consumer/client activity for the block grant.

From the CCAR User Manual, produced by DBH:

The Colorado Client Assessment Record (CCAR) is a clinical instrument designed to assess the behavioral health status of a consumer in treatment. The tool can be used to identify current clinical issues facing the consumer and to measure progress during treatment. The CCAR consists of an administrative section and an outcomes section. The administrative section contains questions related to consumer characteristics/demographics (e.g., social security number, date of birth, gender, referral source, etc.). The outcomes section contains questions related to consumer clinical domains (e.g., problem severity, depressive issues, psychosis) and recovery domains (e.g., employment, housing, socialization, hope). The CCAR was developed more than 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 their reporting to the Colorado legislature. Because CCAR and service encounter data have been collected since 1978 and 1995, respectively, it is possible to examine service and outcome trends over time.

Licensure and Certification Issues

The authorities to license or certify mental health and substance abuse treatment providers are under the Department of Behavioral Health (DBH), the Colorado Department of Public Health and Environment (CDPHE), and the Department of Regulatory Agencies (DORA). In addition, mental health provider licensures are administered by various Boards for each practice type (e.g., nurses, social workers, psychologists, counselors, and therapists).

Fifteen respondents identified this licensing structure as a barrier to integration. Practices that provide both mental health and substance abuse treatment services must adhere to “two sets of everything.” There are different standards for charting and treatment plans.

Respondent Input:

- For providers who offer both detox and are acute treatment facilities, these licensures are under different agencies.
- Mental health centers and clinics are licensed by CDPHE but inspected and authorized by DBH.
- The State of Colorado does not have effective reciprocity with other states’ addiction providers credentialing. This barrier makes it difficult to attract new workforce from out of state.
- Intensive outpatient treatment is a challenge, flexible models of delivery are needed, and creativity around licensing models could be helpful. CDPHE has the authority to create new licensing types, but CDPHE is rarely included in the conversations about integration.

Licensing/Certification by Agency	
DBH	CDPHE
<ul style="list-style-type: none">• Substance use disorder treatment providers• Medical detoxification services	<ul style="list-style-type: none">• Mental Health Centers• Mental Health Clinics• Inpatient Psychiatric Facilities• Acute Treatment Units
DORA	
<ul style="list-style-type: none">• Certified Addictions Counselors (CAC I, CAC II, CAC III)	

Billing and Administrative Confusion

Many respondents were providers who brought up the challenges associated with getting reimbursed by Medicaid for services. In general, the provider community reports being confused over how to bill, what services are allowable, and how to know if a client is Medicaid eligible. This confusion is a barrier to expanding practice and integrating new services. Respondents reported that they feel that Medicaid billing is complicated, and they aren’t sure what services are billable. Others reported that it is challenging to stay current on what benefits are allowable.

Respondents were also concerned with regulatory issues, and the emphasis that is placed on regulatory issues by state agencies. Several respondents reported that they are reluctant to participate in state programs because of pressures related to compliance, and because of fears of audits and recoupment of funds.

Same-day billing. Same-day billing in Medicaid is an example of a billing issue widely misunderstood by the provider community. Same-day billing was one of the most prominent issues addressed, at 40% of respondents, and is believed to be a barrier to integrating care. As discussed in the first report, the common belief is that physical health and behavioral health services cannot be billed on the same day for the same client. However, according to both rates and program division staff at Medicaid, there have not been any validated instances of claims being denied because of same-day billing. The issue was explained and addressed in the April 1, 2012 report but continues to be a belief among providers. However, in the interviews, very little explanation accompanied most respondents' input related to same-day billing. The need for widespread communication and clarification was suggested by several respondents.

Other experiences with same-day billing barriers were also reported with other payers, including commercial insurance and Medicare. The policies of other payers, however, cannot be confirmed or clarified by the Department at this time. The Department will continue to explore the best methods of communicating that there is no same-day billing restriction in Medicaid.

Additional Information

The Department has only been able to verify one issue related to same-day billing in Medicaid, which is currently being resolved.

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 client 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.

Clinical Approaches: Wellness and Prevention

Prevention, Early Intervention, and Wellness

One of the most commonly reported barriers was the idea that prevention, early intervention, and wellness services are not currently financially supported by state programs. Respondents often stated that the state should move away from a diagnosis-based system and episodic care. Instead, the health care system should move from a "sick care system" to a "well care system."

Respondent Input:

- Exercise is the best treatment for depression, high blood pressure, and many other conditions, but no one prescribes exercise. That kind of treatment is not reimbursed.
- "To impact health, you must begin earlier than the specialty level. You don't impact heart disease in a cardiologist's office."

- Federal health care reform pushes for population-based prevention and wellness, but these services are often not reimbursed. “We need codes that can be utilized appropriately and paid for.”
- One respondent provided the statistic: “Thirty to 40 percent of health care costs are for services delivered in the last 5% of the lifespan. We need to be more concerned about the front end, with prevention, wellness, and keeping people active.”
- Identifying and treating post-partum depression can greatly benefit the family unit and potentially prevent health problems with the child. However, respondents report that post-partum depression screenings are not reimbursed by Medicaid.

Behavioral Health Prevention

According to respondents, the prevention of behavioral health conditions is not supported by reimbursement. Annual well exams for physical health are a benefit of Medicaid, and providers may bill Evaluation and Management codes at any point; however, no parallel benefit exists for behavioral health. Respondents reported a perception that behavioral health funding is focused on the treatment side, not prevention. A number of respondents claimed that behavioral health screens are just as important as health indicators as other physical health screenings like blood pressure and cholesterol checks. As one respondent stated, “Depression is an epidemic in this country.” This respondent advocated for behavioral health screenings in primary care regardless of whether a behavioral health professional is embedded in the practice. One respondent pointed out that there should be a service equivalent to SBIRT for all of behavioral health, not just substance use disorders.

Behavioral Health Statistics

Colorado Behavioral Healthcare Council

- Major Depressive Disorder is the leading cause of disability in the U.S. for ages 15-44.
- An estimated 26%, 57.7 million Americans, over the age of 18 suffer from a diagnosable mental disorder in a given year.
- About 6%, or 1 in 17, suffer from a serious mental illness (schizophrenia, bipolar disorder, and major clinical depression). People with a serious mental illness die, on average, 25 years earlier than the general population.

The Status of Mental Healthcare in Colorado

- Three in 10 Coloradans are in need of mental health or SUD care (1.5 million people). Nearly 1 in 12 has a severe need (450,000 people).
- Colorado ranks sixth among states for its rate of suicide, with the highest single-year total of deaths in the state’s recorded history reported in 2009.

Robert Wood Johnson Foundation

- More than 68% of adults with a mental disorder reported having at least one general medical disorder (2001–2003 National Comorbidity Survey Replication)
- The same survey found that 29% of those with a medical disorder had a comorbid mental health condition (2001–2003 National Comorbidity Survey Replication)

Health and Behavior Codes

Twenty-one interviews included feedback that the use of Health and Behavior Assessment/Intervention (HBAI) codes⁵ would allow them to more appropriately code and bill for their services. The topic of HBAI codes was previously discussed in the April 1, 2012 report. HBAI codes are not used to bill for treatment of 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 behavior change.

The Colorado Behavioral Healthcare Council reports that individuals with serious and persistent mental illness die on average 25 years earlier than the general population, and the deaths are more often attributed to physical health problems. As one respondent stated, “People’s behaviors lead to poor outcomes.” Many providers believe that the ability to treat behavioral health problems that do not meet the criteria for a diagnosis will greatly improve physical health outcomes.

Additional Information

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.

Discharging and Disclosures in Behavioral Health Care

Substance abuse and mental health service providers are generally required to “discharge” or close the treatment file for a client whose acute episode of treatment is completed. In contrast, primary care considers a patient to always be a patient until that person changes provider. Three of the respondents directly advocated for moving behavioral health care practices to align with the medical model. For example, one provider stated that if a client is not seen in 90 days, the requirement is that the file is closed through the completion of paperwork. However, if that same client comes back in six months later, the same series of assessments, intake, and file opening and closing must be repeated.

In addition, the informed consent and disclosures required by the Mental Health Practice Act for behavioral health providers are considered a barrier to integrated health care. One respondent called the process a “long belabored, inappropriate disclosure” that is inconsistent with brief treatment models. A behavioral health provider may only be called upon to provide community resources or education; however, the disclosure requirement still stands, including the statement that sexual relationships between the provider and client are illegal. In situations of brief contact, this statement may damage the client’s comfort level and trust, especially for a child. The

⁵ Current Procedural Terminology (CPT) codes 96150 through 96155

exceptions to the disclosure requirement are when care is provided by psychiatrists and in hospital settings.

Client-Centered Care

Over thirty percent of respondents described the current approach to health care as not client-centered. The concept of client-centered care proclaims that health care decisions should be made in partnership with the client and the client's family. Similarly, therapeutic practitioners are taught to "start where the client is," meaning the client's perspective and beliefs should be the foundation of any treatment decisions.

Respondent Input:

- "You need the time to develop the relationship and understand a person," which is not supported by the current system and reimbursement mechanisms.
- Health care is about humanity and choice, not just physical and behavioral treatments.
- Health care should "go where the patients are" and be delivered when it is needed. "We want to treat the whole person, their physical health, behavioral health, and substance abuse needs in whatever door they walk through."
- Giving out the same information to different providers for different treatment areas is a burden to the client and discourages engagement.
- Health care should be a team approach that includes the client.

Social Determinants of Health

Client-centered care considers the whole person's needs, not just a fraction or particular area of need. Interwoven with client health are his or her environmental, economic, and psychosocial needs. Nineteen percent of respondents identified the lack of psychosocial and environmental considerations in a person's treatment as a barrier to integration. The most common examples given were housing needs and poverty.

Respondent Input:

- "The boundaries of health and welfare begin to blur... child welfare, corrections, housing: every one of these pieces should be part and parcel of what we are talking about, but it's too big a bite right now."
- "This is the war on poverty." Community Mental Health Centers in Colorado are some of the best in the country because they have a whole suite of services, including job search assistance, help with utilities, and other psychosocial/environmental assistance.
- "One of the best predictors of health status is socio-economic status. You can't just beef up the medical side."
- "Poor people are sick people." Socioeconomic and illness profiles should be considered when developing reimbursement methodologies, and payments should reward effectively treating this population.

Client Education and Stigma

An important component to affecting client behaviors and providing client-centered care is client education. The lack of educational supports for clients was identified by ten respondents (21%) as posing a barrier to successful integration of health care. The main areas of educational need that were identified include de-stigmatizing behavioral health needs, parenting education, and promoting individual responsibility.

Respondent Input:

- Stigma around mental health and substance abuse is a barrier to client access and discourages information sharing. Because of issues around stigma, clients sometimes avoid acknowledging behavioral health needs and accessing appropriate care. Stigma is also cited as a reason for stricter information sharing and privacy laws around behavioral health care.
- “We need to normalize talking about behavioral health concerns.” One respondent suggested bringing SBIRT into practice as a normal part of screening verbally, rather than including a separate form.
- Physical health providers are uncomfortable working with clients with different behaviors or impaired cognition, which makes accessing services a challenge. “It’s a real discrimination and contribution to stigma, and it’s an unnecessary loss of life.”
- We should have parenting classes to end the cycle of misuse of health resources and promote healthy living from childhood.

Fragmentation of Mental Health and Substance Abuse Services

Forty percent of respondents identified the fragmentation of mental health and substance abuse services as a barrier to integrated care. Several respondents stated that the need to integrate these two areas of health care is greater or more challenging than the need to integrate physical and behavioral health care areas. According to respondents, the system-level schisms are related to three policy structures:

1. In Medicaid, substance abuse is a fee-for-service benefit, while treatment for mental health diagnoses is funded through Behavioral Health Organizations (BHOs).
2. The federal block grants have traditionally been separate and administered separately through DBH, although in this most recent year SAMHSA combined the block grants into one.
3. Licensing and credentialing for both practitioners and facilities are separate accreditations and processes.

The Medicaid reimbursement levels for services related to mental health are typically much higher than services for substance abuse. Payments for mental health services are on average twice as much as the parallel services for substance abuse. An outline of service codes and associated fees is included as Appendix E.

Respondent Input:

- “If we can’t figure out how to integrate mental health and substance abuse, it’s just not going to work.”
- Several respondents mentioned the need for dual credentialing and integrating competency to treat both mental health and substance abuse needs in one practitioner.
- Another respondent stated, “Why duplicate? Look at the continuum of services a person might need. There is an overlap that both mental health and substance abuse providers should be able to cover. It makes sense economically.”
- “Having mental health and substance abuse in different state departments is a barrier.”
- Mental health providers cannot provide the full gamut of activities done by substance abuse providers, such as methadone maintenance and detoxification. Similarly, substance use disorder treatment providers cannot provide the full array of services provided by licensed mental health providers. Additional work is necessary to be able to provide integrated services.

- “We do not provide a continuum of care. We both say we do services in each other’s realm really well, but instead we do different pieces.”
- For mental health and substance abuse treatment funded by block grants, the provider must designate a primary diagnosis and claim funding under the associated block grant.

One regulatory barrier to providing integrated care for mental health and substance abuse are the restrictions on minimum age to consent to treatment. On the mental health side, the client must be at least 15 years old, whereas substance abuse treatment can be provided at any age. Two interviews reported this barrier and stated that the age of consent should be standardized.

Oral Health

House Bill 11-1242 identified the importance of oral health as one of the three components of integrated care. In Colorado Medicaid, dental benefits are provided only for children under age 21. An emergency dental benefit is available for adults and includes extractions. As part of the stakeholder feedback process for the State Demonstration to Integrate Care for Dual Eligible Individuals, stakeholders highlighted the need for an adult dental benefit in Medicaid to cover the full spectrum of need for these individuals.

In the context of this project, six respondents brought up the need for dental services in Medicaid in order to ensure integrated whole-person care.

Respondent Input:

- One provider representing a Federally Qualified Health Center (FQHC) stated that they employ three dentists, but continued, “We do oral health care [for adults] because it’s the right thing to do, not because we get paid for it.”
- “Dental care is essential to full integrated care. Not having dental care can compromise overall health and functioning.”
- “Oral health has to do with appearance, how someone feels about themselves, and physical health conditions like mouth disease and infections.”

Workforce Issues

The combined workforce issues were the second most common barrier conveyed by respondents, and these barriers were named in 64% of the interviews. The workforce-specific barriers include shortages of providers, the need for more and better provider training, and interdisciplinary relationships.

Workforce Shortages

Seventeen respondents (36%) reported that a shortage of providers was a barrier to integrated care. Specifically, the provider types mentioned for which there are shortages include: geriatric providers including psychiatrists and dentists, child psychiatrists and other pediatric behavioral health specialists, generalist psychiatrists, substance abuse providers, masters-level behavioral health practitioners, and primary care providers.

Providers described difficulty trying to fill positions or find certain provider types. The shortage of psychiatrists was overwhelmingly the most identified problem. Two respondents advocated

for freeing psychiatric nurse practitioners and physician assistants from physician oversight and allowing them to be more independent as practitioners.

In response to the workforce shortage, several respondents mentioned that providers should be more inclusive of who they treat and work at the top of their license. One respondent stated, “We shouldn’t turn away people we can treat. Use specialists when they are necessary, but a lot can be treated within current competencies.” Another respondent suggested incentivizing new practitioners in specialty areas through student loan forgiveness.

Seven interviewees suggested that having an option to use telemedicine to assist with behavioral health integration would be helpful. Respondents pointed out that the need for specialists can be just as imperative in metro areas as rural areas of the state. Telephone access was also specified as an alternative method for access when monitoring chronic disease and some behavioral health services.

Respondents representing rural areas of the state also reported shortages and the need to attract providers to those areas. Eighty-two percent of practicing psychiatrists, 86 percent of child psychiatrists, and essentially all psychiatrists specializing in substance use disorder treatment are located in the Denver and Colorado Springs metro areas.⁶ One respondent suggested incentivizing education programs to place students in underserved communities and recruiting local residents for education programs, since they are more likely to stay in the area long-term.

Mental Health Personnel per 100,000 population		
	Colorado	National
Psychiatry (2006)	14.6	14.4
Psychology (2006)	38.7	30.9
Advanced practice psychiatric nursing (2006)	3.4	3.3
Counseling (2008)	89.5	54.4
Marriage and family therapy (2006)	10.5	16.3
Social work (2008)	79.5	82.0

From: Mental Health, United State, 2010 (SAMHSA)

Training Needs

The need to train providers in support of integrated care was identified in 21 interviews (45%) and is the largest component of workforce issues. The needs discussed by respondents included:

1. Education programs are fragmented and do not highlight integrated care models. More behavioral health providers should be taught how to work in physical health care settings using brief treatment models.
2. Providers often lack knowledge of community resources, how to “navigate the system”, and/or available providers and their competencies.
3. “Primary care doctors don’t know or understand substance abuse and we don’t understand primary care.”
4. Very little workforce development is provided to behavioral health providers.
5. Substance abuse providers should be trained in solution-focused therapies rather than traditional cognitive-behavioral modalities.

⁶ TriWest Group. “Status of Behavioral Healthcare in Colorado, 2011 Update”: http://www.coloradomentalhealth.org/sites/all/themes/acmhc/ACMHC_StatusReport.pdf

6. Motivational interviewing techniques should be taught to primary care providers as well as behavioral health providers
7. Physicians are trained in allopathic medicine that is focused on treating the symptoms rather than the cause.
8. Physicians have very little mental health training, and only minimal substance abuse training.
9. Behavioral health education programs continue to focus on building treatment plans around a diagnosis rather than behaviors or dealing of a chronic condition.
10. Both physical and behavioral health providers should have ongoing interdisciplinary training.

One respondent pointed out that many training and education barriers are related to federal-level accreditation standards for schools. However, “there’s no reason why education programs can’t get together and develop curriculum to promote the type of care we want to see, but it’s not happening.”

Interdisciplinary Relationships

Several interviewees addressed the topic of how practitioners relate to each other and practice limitations for certain practitioner types. There is a perceived hierarchy among practitioner types, with psychiatrists and physicians at the top and substance abuse providers at the bottom. This hierarchy is reflected in the reimbursement system, but does not necessarily reflect the efficacy of their interventions. Rather than have a licensing bias towards a practitioner type, physicians and other practitioners should work as a team together and recognize the strengths, abilities, and value of each member’s contributions.

One respondent made the following statement: “Master-level professionals are often better qualified for treating. You have more courage when you don’t have a medical license to engage in the kind of work that will have meaningful impact on an individual. It attracts a different kind of folk – more committed, excited, who have to work harder for the money they earn. They often surpass psychiatrists.”

In addition to the traditional provider types, three interviewees identified the need for innovative staffing models to be financially supported. Specifically, respondents identified the need for peer support, which can be done without years of training and offers an alternative solution to the workforce shortage problems. Current payment models are prescriptive and limited to licensed professionals rather than para-professionals. The inability to use non-licensed staff can also make care coordination expensive.

The Business of Clinical Practice

Physical Health Practice versus Behavioral Health Practice

The approach to running the business of clinical practice varies between physical and behavioral health care. The structure supported by Medicaid and block grants for behavioral health is a traditional model that treats clients with 50-minute sessions and traditional psychotherapies. In contrast, primary care is faster paced, generally spending 15 minutes with clients, and it is difficult to interject behavioral health treatment into that model. Some current integrated care programs use brief treatment models for behavioral health, which is generally more appropriate for the large majority of clients who do not have serious and persistent mental illness but need

behavioral interventions. As previously discussed, however, these types of interventions are often not reimbursed for clients without a mental health diagnosis, or the provider chooses not to bill for payment because the administrative requirements are considered excessive and not cost effective.

In an integrated care setting, the demand for behavioral health services is also beyond the capacity of the traditional model. In the words of one respondent: “The traditional model of mental health care, where the physician sees a problem and invites the mental health person in for an hour session, is a failed model of care. It is orders of magnitude off in terms of workload. The demand is more than the capacity. Almost half of patients will have a mental health diagnosis, whereas even more have sub-threshold issues or psychological issues.”

Although some large practices have been able to move forward with integrating care, small primary care practices and behavioral health practitioners have significantly fewer resources to support integration efforts similar to the larger endeavors. This concern was raised by several respondents who believe that all providers should be included in integration efforts – not all clients are seen in large practices and FQHCs, and the state should leverage all the available providers. One respondent pointed out that the large practices are “volume machines” and these bigger, more sophisticated practices are the “hardest to change.”

Organizational Differences

Organizational differences refers to differences in the management, policies and procedures and leadership of an organization, encompassing business and strategic planning. Respondents from physical and behavioral health organizations reported having strongly differing business practices, cycles, and cultures. Specifically, FQHCs and CMHCs have significant differences in reimbursement and governing structures. FQHCs are licensed by the federal agency, Health Resources and Services Administration (HRSA), as institutions and are paid encounter rates under the fee-for-service model. CMHCs are licensed on a state level by CDPHE and are paid through the BHOs in a capitated risk arrangement.

The following examples were provided by respondents concerning their perceptions of conflicts in governance:

1. One respondent suggested that because of the BHO managed care system, CMHCs have experience with managing risk, whereas the FQHCs have not had similar experience. In this respondent’s view, the difference in experience creates challenges in developing a risk structure model for global payment, as it is difficult to agree on the amount of financial risk each organization will take in the process.
2. State initiatives for CMHCs and federal requirements for FQHCs do not always align well. One example is site specific regulations for FQHCs. In order to be reimbursed, FQHCs must deliver services at their specific licensed site. They cannot be reimbursed for services delivered at the CMHC site. Expanding the number of FQHC sites is challenging. It can take up to a year to get a new FQHC site approved. Delivering services where it will be most beneficial to the client is an important component of client-centered care. To expand access, Colorado Valley Wide Health Systems purchased a mobile unit, licensed it as a mobile clinic site under the FQHC licensure, and now drive the unit to CMHCs and other locations of need.

3. Mentioned in several interviews is the conflict for indigent care between the FQHCs and the CMHCs. While the funding is never enough, as one interviewee put it, FQHCs receive more significant monies to provide care for the uninsured, while there are a small amount of dollars on the state level received by the community mental health centers for that care. This creates a misalignment of goals, differing expectations and conflict in providing care for indigent individuals in these two systems.

Respondents reported that joint ownership of FQHCs and CMHCs is currently being considered. Integration of organizations and boards present the easiest way to integrate, but operationalizing this goal is challenging given the conflicts in organizational management.

Provider Associations

Several respondents said provider associations are in conflict over limited resources and protecting their territory within the health care industry. These antagonistic relationships are seen as unfavorable for integrating health care. According to respondents, limited resources push their purposes into being protectionist, which prevents them from being innovative and open to change.

Additional Information

The Colorado Behavioral Healthcare Council (CBHC) is the membership organization representing Community Mental Health Centers and Behavioral Health Organizations. They recently announced that membership will now be open to Managed Service Organizations, which are regional entities contracted through DBH to provide substance use disorder treatment services.

In addition, CBHC and the Colorado Community Health Network (CCHN) have begun an integration workgroup to work more closely together. The CCHN represents safety-net community health centers, including the Federally Qualified Health Centers in the state.

Inconsistent Coverage

“The area not addressed at the policy level is the viability of any plan over time.” Specifically, several respondents stated that the “churn” of eligible Medicaid recipients as they move between eligible to ineligible status, is a barrier to providing consistent care. One respondent stated that, “When you cannot reliably count on a specific patient being part of your practice long-term, it’s very hard to do any care coordination. It will still be service visit-by-visit.” This challenge is less concerning to FQHCs, which receive funding for indigent care.

Currently, Medicaid does not allow for continuous eligibility for recipients, which has been reported as burdensome for clients with few resources to meet the requirements for re-determination, such as documentation provision and communication needs. One respondent mentioned the Colorado Health Care Affordability Act (HB 09-1293), which was passed two years ago and implements the Medicaid Buy-In program and the Adults without Dependent Children expansion. The law included a provision to implement 12-month Medicaid continuous eligibility, but this provision has not been implemented because of funding issues. This respondent suggested that implementing continuous eligibility could be helpful.

Several respondents also described the difficulty of interacting with many different payers for their client populations. Although not noted by any of the interviewees, the Department anticipates this will not be a challenge when the Health Insurance Exchange is implemented.

Standards for Integration and Health Homes

What is Integrated Care?

No common definition of integration is currently agreed upon by the provider community, and several respondents stated that a uniform definition should be promulgated by the Department. Several respondents argued that one standard would not be appropriate for every community setting, and there is no “one size fits all.” Whether a model works is “personality-driven,” so payers should work with providers on what is comfortable and incrementally move in the direction of better outcomes and an integrated model.

Respondent Input:

- How do you measure integration when there are different definitions?
- “Integrated care means a lot of things to a lot of people.” The models include embedded practitioners, co-location of providers, or a coordinated “warm” referral process.
- “[Integration] has so many meanings, there is almost no meaning.”

Health Home Standards

Similarly, several respondents were interested in the Department providing direction on what types of practices and models can be designated as a health home. Currently, Medicaid has two medical home programs: the Children’s Medical Home and the Accountable Care Collaborative (ACC) Program. The Children’s Medical Home program has a process to certify Medicaid providers as medical homes. The ACC Program contracts with current providers to serve as Primary Care Medical Providers (PCMPs) for the program; however, the standards to become a PCMP only require that the practice provides primary care and works towards certain goals. The model is considered a “come as you are” approach to recruiting providers to be PCMPs. The standards for each program are included in Appendix F.

Currently in the ACC Program, only primary care providers can be designated as PCMPs and receive the per-member per-month (PMPM) payments. A number of respondents believe that behavioral health providers may be the most appropriate venue as a health home for some clients.

Respondent Input:

- The definition of a medical home in the ACC Program has not been clearly communicated, including how behavioral health services are incorporated.
- Health homes should include primary care, behavioral health care, and oral health care.
- The ACA Section 2703⁷ option would generate more revenue to care for high-risk clients with chronic conditions. “We’d be interested in participating.”
- Medical homes need to fund all the issues that are meant to be addressed, and “pay-for-performance should only pay for things we have control over.”

⁷ Section 2703 of the ACA provides enhanced federal funding for two years for “health homes” serving Medicaid beneficiaries with chronic conditions. According to CMS, the goal of health homes is “to expand the traditional medical home models to build linkages to other community and social supports, and to enhance coordination of medical and behavioral health care, in keeping with the needs of persons with multiple chronic illnesses.” For more information visit: <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf>

- “The SPMI population is much more comfortable seeing a Community Mental Health Center. It’s much more conducive to have primary care within a behavioral health setting. There is a different mindset.”
- The state should “get serious” about the health home model and “do everything they can to support NCQA practices and other existing things that work.”

Long-Term Services and Supports

Very few of the respondents interviewed represented the perspective of geriatrics and long-term services. However, a significant amount of information was provided which offers a unique and important perspective on the barriers to integrated physical and behavioral health care for this population.

Population Needs

As stated by respondents, clients of long-term services and supports generally have complicated needs that require specialized care. For older adults, dementia is a large factor in those needs. As one respondent stated, “Dementia holds a very unique place; it’s different than other behavioral health issues.” Dementia spans both the physical and behavioral health arenas, including neurologic, geriatric, and internal medicine. Dementia often manifests as memory loss, but can also manifest through other behavior changes, such as temper changes, linguistic changes, or anger.⁸

One respondent reported a significant need to integrate behavioral health into long-term care. Clients with dementia in long-term services and supports programs are rarely treated by behavioral health providers. A respondent providing services to the older adult population estimated that 50% of the population they serve has mental illness and another 50% has dementia, and these are not mutually exclusive conditions. Depression is known to commonly co-occur with the onset of dementia. One respondent reported a belief that ageism continues to present as a barrier to integrated care because providers are not willing to treat older adults with complex conditions and needs.

Provider Shortages

Respondents communicated frustration with the need for more geriatricians, geriatric psychiatrists, and geriatric dentists, including for home care settings. One respondent reported that there is a huge need for geropsychiatric nurse practitioners with prescriptive authority in Colorado, and although a number of nurses trained at the University of Colorado, School of Nursing have completed their education requirements, no geriatric psychiatrists are available to provide supervision. Under the licensure specifications, supervision and mentorship are required for prescriptive authority.

In addition to workforce shortages, additional training was reported as a need for geriatric service providers. Treatment methods for this population are unique and require specialized skill. One example given is that frontal lobe disinhibition is often preset with the beginning moderate stage of dementia, and the education needed to identify, assess, and intervene in these cases is not common. Further, overmedication is very common in long-term care facilities, and more training is necessary in non-pharmacological interventions.

⁸ U.S. National Library of Medicine: <http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0001748/>

Program Structures for Long-Term Services and Supports

Clients generally access home and community-based waiver services via three types of agencies: Community Centered Boards (CCBs), Single Entry Point (SEP) agencies and County Departments of Human or Social Services (CDH/SS). State statutes and regulations have formed separate programmatic structures for long-term services and supports that one respondent believes is a significant barrier to integrating with other health services.

State Laws Related to Long-term Care

- Single Entry Point Designation: 10 CCR 2505-10 8.391
- Community Centered Board: CRS 27-10.5-105
- Managed Care Carve Out: CRS 25.5-5-402.2 (b)
- Nursing Facility Reimbursement: CRS 25.5-6-204 (2)(a)
- Medicaid 100.2 Assessment Tool: 10 CCR 2505-10 8.401.15D
- Affordable Care Act Case Management Section 10202

Moving Forward with Integration

Accountable Care Collaborative (ACC) Program

The Accountable Care Collaborative (ACC) was implemented in May 2011 and is a new Medicaid program to improve clients' health and reduce costs. Members are enrolled into a Regional Care Collaborative Organization (RCCO) and linked with a Primary Care Medical Provider (PCMP). The seven RCCOs are tasked with building a provider network, ensuring care coordination, and impacting health outcomes. The PCMPs serve as the medical home for members. Both the RCCOs and the PCMPs are paid a per-member per-month amount, and beginning fiscal year 2012-2013, they will be able to earn an incentive payment based on performance metrics.

Sixteen respondents presented challenges within the ACC Program as being barriers to integration; however, the overall sentiment reflected the belief that the ACC Program is “a step in the right direction.” Several other respondents mentioned the ACC Program as being helpful in working towards integrated care.

Respondent Input:

- The RCCOs have made referrals to behavior health much simpler, and appointments can be made quickly.
- The program incentivizes coordination but focuses more on controlling costs.
- Coordination between the BHOs and the RCCOs is essential for success of the program.
- ACC is an opportunity for FQHCs and CMHCs to work together in new ways.
- Behavioral health providers are currently not allowed to be PCMPs, although they may be the more appropriate health home for certain members.
- This new delivery system is receiving national attention on its promotion of integration in health care.
- Behavioral health is not currently a priority, and the ACC Program has not yet defined how behavioral health services are incorporated.

The ACC Program is still in an early phase, and the Department's goal is to continue to develop a more efficient and effective program through experience.

The Need for Research and Best Practices

A number of respondents shared the need for evidence on best practices as guidance for what works in integration. The concept of integrated care is relatively new and peer-reviewed academic studies are sparse. A number of publications describe the experience and outcomes of certain initiatives and programs across the country; however, the strategies of integration vary, and anecdotally, the provider community believes there is no one right way to integrate care. One respondent stated, "Whether a model works is very personality-driven."

The Policy-Making Process

Ten of the respondents identified the process in which laws are created as a barrier. One respondent stated: "The instinct is that there is no problem we can't legislate." Respondents believed that the state legislature should not "micromanage" state programs, allow flexibility within statutes, and should promote the capacity to solve the problems addressed. One respondent stated that the legislature should avoid "unfunded mandates" and be mindful of the costs associated with integration initiatives.

Another concern identified is the need to show cost-savings in the short term when providing integrated care requires up-front investment for long-term health promotion. One respondent stated: "It looks like a significant amount of money on the front end because of the way we budget. However, any economist will tell you that is unrealistic because long-term you will see savings." The expectation is that integrated, whole-person care will promote better health throughout the lifespan and avoid future chronic conditions and costs.

Ownership and Overall State Strategy for Integration

In addition to standard definitions for integration and health homes, several respondents communicated that one barrier to integrated care is the lack of clear direction at the state level: "We don't have clear direction of where to go."

One respondent stated that there is "misalignment" between the public policies being promoted and the current statutes and regulations in the state. While prevention and wellness are being highlighted as valuable services through federal health reform and growing understanding amongst providers, the current payment structure does not support these efforts.

Another respondent from a managed care organization suggested that not all of the burden should be put on the state government, but rather public-private partnerships are necessary for success because the private sector has more resources. "The state cannot make the investment for practices to integrate, and we shouldn't expect it to. The money has to come from elsewhere. The state just needs to set up conditions so that integration can be successful."

A number of respondents and stakeholders emphasized the need to make changes quickly. At the stakeholder meeting, one participant stated that "the time is slipping through our fingers."

INCENTIVES

When respondents were prompted to identify “incentives for health care providers that may increase the number of providers delivering integrated health care” (H.B. 11-1242), the two most prominent responses were: 1) to resolve the barriers that have been identified, and 2) to cover the costs of providing integrated care.

Some stakeholders communicated that incentives are not necessary; providers are ready and willing to provide integrated care. These providers are either barred by the issues presented in this report, or they are making efforts towards integration at a net loss of funds. To quote one participant in the stakeholder meeting:

“I would like to suggest that you replace the word ‘incentive’ to something else. The people in this room don’t have to be incented, they are dying to do it. We don’t need to incentivize, we just need to cover their cost. We just need the providers to be able to recover the cost of providing proper care. Pay for the cost. That’s it.”

Nineteen respondents and participants at the stakeholder meeting advocated for payment reform, with many suggesting a global payment methodology. Twelve respondents emphasized the need for outcome and quality measures as part of any payment methodology. However, two respondents clarified that any incentives or pay for performance metrics should focus on “things we actually have control over.”

Other responses to incentives included:

- Incentivize specialists to work in rural communities by emphasizing quality of life in those areas.
- Create an enhanced licensing or dual licensing of mental health and substance abuse qualifications for facilities and provider types.
- Allow for an expanded telemedicine benefit in Medicaid.
- Incentivize successful referrals when a client gets appropriate treatment from behavioral health or specialist providers.
- Provide additional assistance for individuals trying to apply for Medicaid.
- An oral health benefit for all ages in Medicaid is necessary to fully integrate care.
- Provide additional population and client data or subsidize investments for electronic health records.

Some respondents and stakeholders advocated for small, incremental changes whereas others believe a large-scale re-structuring of health care systems is needed soon.

NEXT STEPS

As one respondent stated, “We need to create the system that the Colorado community deserves.” This report is a first step in that direction.

The Department will be developing a policy paper in response to the major issues addressed in this report. The goal of the policy paper will be to identify a high-level strategy for integrated care moving forward in the Department. The Department plans to have this paper completed and available by the beginning of calendar year 2013. The issues identified in this report are complex

and will require significant effort and resources to resolve. However, the Department remains committed to the goal of effective and efficient integrated physical and behavioral health care delivery.

APPENDICES

Appendix A: List of Interviewees

Michael Allen, LCSW, CAC III, MBA

Vice President -Health Network and
TeleCare
AspenPointe
Colorado Springs, CO

Ford Allison, MBA

Director of Long Term Care Solutions
Colorado Access
Denver, CO

Polly Anderson

Chief Policy Officer
Colorado Community Health Network
Denver, CO

**Donald Bechtold, MD, DFAPA,
DFAACAP**

Vice President and Medical Director
Jefferson Center for Mental Health
Wheat Ridge, CO

Barbara Becker, PhD, LPC

Manager, Integrated Care Services
Arapahoe/Douglas Mental Health Network
Englewood, CO

Robert W. Bremer, MA, LPC, PhD

Executive Director
Access Behavioral Care - Colorado Access
Denver, CO

John L Bender, M.D., FAAFP

President and CEO
Miramont Family Medicine
Fort Collins, CO

David Brody, MD

Medical Director
Denver Health Managed Care Plans
Denver, CO

Jay Brooke, MSW

Executive Director
High Plains Community Health Center
Lamar, CO

Joseph C. Carrica III, MA, CAC III

Chief Operations Officer/Assistant
Executive Director
Southeast Mental Health Services
La Junta, CO

Debbie Chandler

Executive Vice President/CEO
Colorado Springs Health Partners
Colorado Springs, CO

Marc S. Condojani, LCSW, CAC III

Director of Community Treatment and
Recovery Programs
Division of Behavioral Health
Colorado Department of Human Services
Denver, CO

Beverley Dahan

Vice President of Regulatory Affairs
innovAge (Colorado PACE)
Denver, CO

George DelGrosso

CEO/Executive Director
Colorado Behavioral Healthcare Council
Denver, CO

Tillman Farley, MD

Executive Vice President of Medical
Services
Salud Family Health Centers
Fort Lupton, CO

Steven G. Federico, MD, FAAP

President of CO American Academy of
Pediatrics

Gail Finley
Vice President of Rural Health & Hospitals
Colorado Hospital Association
Greenwood Village, CO

Liza Fox-Wylie
Policy Director
Colorado Regional Health Information
Organization (CORHIO)
Denver, CO

Angie Goodger, MPH, MHA
Quality Improvement Coach
Colorado Children's Healthcare Access
Program (CCHAP)
Children's Hospital
Aurora, CO

Patrick Gordon, MPA
Director
Rocky Mountain Health Plans
Denver, CO

Roger Gunter
Chief Executive Officer
Behavioral Healthcare, Inc. (BHI)
Englewood, CO

Chris Habgood
Director of Planning and Policy
Office/Division of Behavioral Health
Colorado Department of Human Services
Denver, CO

Bern Heath, Jr., PhD
Chief Executive Officer
Axis Health System
Durango, CO (serving SW Colorado)

Thomas Hill, JD
Director of Regulatory Policy
Colorado Hospital Association
Greenwood Village, CO

Julie Holtz, MS
Deputy Director of Medicaid
RCCO Region 5 Contract Manager
Colorado Access
Denver, CO

Jacki Kennedy, LPC
Deputy Director
North Range Behavioral Health
Greeley, CO

Pete Leibig
President/CEO
Clinica Family Health Services
Lafayette, CO

Tamara McCoy, Ph.D.
Administrative Director
North Range Behavioral Health
Greeley, CO

Benjamin F Miller, PsyD
Assistant Professor
Department of Family Medicine
University of Colorado Denver School of
Medicine
Denver, CO

Karen Mooney, LCSW, CAC III
Manager, Women's Substance Use Disorder
Programs
Division of Behavioral Health
Colorado Department of Human Services
Denver, CO

Donald Moore, MHA
Chief Executive Officer
Pueblo Community Health Center
Pueblo, CO

Carmelita Muniz
Executive Director
Colorado Providers Association
Denver, CO

David Murphy, MA
Chief Executive Officer
Arapahoe House
Thornton, CO

Jenny Nate, MSW
Director of Policy and Planning
Center for Improving Value in Health Care
(CIVHC)
Denver, CO

Joan Nelson, DNP, ANP-BC
Associate Professor
University of Colorado School of Nursing
Aurora, CO &
Geriatric Nurse Practitioner
Physician Housecalls
Denver, CO

Ann C Noonan, MA, LPC, CAC III
Manager
Boulder County Public Health
Boulder, CO

Kelly Philips-Henry, PsyD
Chief Operating Officer
AspenPointe
Colorado Springs, CO

Steve Poole, MD
Professor and Vice Chair
Department of Pediatrics
Division Head, Community Pediatrics
UC Denver School of Medicine & the
Children's Hospital Colorado &
Executive Director
Colorado Children's Healthcare Access
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Children's Hospital
Aurora, CO

Larry Pottorff, LCSW
Executive Director
North Range Behavioral Health
Greeley, CO

Michael Pramenko, MD
Previous Colorado Medical Society
President &
Executive Director
Primary Care Partners
Grand Junction, CO

Genie Pritchett, MD
Vice President of Medical Services
Colorado Access
Denver, CO &
Geriatrician
Senior Care of Colorado
Englewood, CO

Sharon Raggio, LPC, LMFT, MBA
President and CEO
Colorado West Regional Mental Health, Inc.
Glenwood Springs, CO

Randy Ratliff
Chief Executive Officer
Touchstone Health Partners
(Larimer Center for Mental Health)
Fort Collins, CO

Anita Rich, MSW
Director of Community Outreach
Colorado Children's Healthcare Access
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Children's Hospital
Aurora, CO

Jim Rowan, CAC III, LAC
Manager, Intervention Programs and
Medicaid Access
Division of Behavioral Health
Colorado Department of Human Services
Denver, CO

Barbara Ryan, PhD
Chief Executive Officer
Mental Health Partners
Boulder/Broomfield, CO

Arnold Salazar

Executive Director
Colorado Health Partnerships, LLC
Alamosa, CO

Erica Schwartz, DNP, MSN, CNM

Executive Director
Sheridan Health Services
UC Denver College of Nursing
Denver, CO (nurse managed low income clinic) &
Director of Midwifery Services
Co-Director PROMISE, OB/GYN
UC Denver College of Nursing

Eddie Sonn

Vice President of Strategic Initiatives
Center for Improving Value in Health Care (CIVHC)
Denver, CO

Randy Stith, PhD

Chief Executive Officer
Aurora Mental Health Center
Aurora, CO

Erik Stone, MS, CAC III

Director of Compliance & Quality Assurance
Signal Behavioral Health Network
Denver, CO

Scott Thoenke, MEd, CAC III

Executive Director/CEO
Arapahoe/Douglas Mental Health Network
Englewood, CO

Elizabeth Whitmore, Ph.D.

Associate Professor of Psychiatry
Deputy Executive Director
Addiction Research and Treatment Services (ARTS)
University of Colorado School of Medicine
Denver, CO

Patrice G. Whistler, MD, MPH, FAAP

Pediatrician
Western Colorado Pediatric Associates,
a division of Primary Care Partners
Grand Junction, CO

Larry Wolk, MD, MSPH

Founder and Executive Director
The Rocky Mountain Youth Clinics
Thornton, CO

Appendix B: Full Results Table

Rank	Issue or Barrier	Percentage of Respondents	Number of Respondents
1	Information sharing and data needs	74.5%	35
2	Fee-for-service reimbursement system	59.6%	28
3	Siloed systems of care and funding streams	44.7%	21
3	Provider training needs	44.7%	21
3	Health & Behavior codes, consultations and related codes	44.7%	21
6	Same-day billing and education	40.4%	19
6	Fragmentation of mental health and substance abuse	40.4%	19
8	CCAR, DACOD, other administrative requirements	38.8%	18
8	Privacy laws	38.8%	18
10	Workforce shortages	36.2%	17
10	Prevention, early intervention, and wellness needs	36.2%	17
12	ACC Program challenges	34.0%	16
13	Client-centered approach not supported	31.9%	15
13	Licensure and certification issues	31.9%	15
13	Differences in service provision practices	31.9%	15
13	Uncompensated Care	31.9%	15
17	Behavioral Health Carve-out	29.8%	14
17	Medical Home Standards/ Definition of Integration	29.8%	14
19	Medicaid billing and administrative confusion	25.5%	12
19	Access to care and/or awareness of where to go	25.5%	12
21	Scope of BHO coverage	23.4%	11
21	Substance abuse treatment benefits	23.4%	11
23	HCPF/DHS/CDPHE relationship	21.3%	10
23	Client education and destigmatizing BH	21.3%	10
23	Policy Process	21.3%	10
26	Interdisciplinary relationships and scope	19.1%	9
27	Psychosocial needs are unmet	19.1%	9

27	Need research and best practices	19.1%	9
27	Need for behavioral health prevention services	19.1%	9
30	Communication between practitioners	17.0%	8
30	Contracting process with BHOs	17.0%	8
30	Competition for resources	17.0%	8
33	Expectations and cultural outlook	14.9%	7
33	Telemedicine	14.9%	7
33	Underfunded BH	14.9%	7
36	Oral health	12.8%	6
37	Ownership/ overall plan for integration	10.6%	5
37	Rural areas	10.6%	5
39	"Discharging" in BH	8.5%	4
40	Governance (FQHCs and CMHCs)	6.4%	3
40	Need Innovative staffing models	6.4%	3
40	Fragmentation of long-term care services	6.4%	3
40	Home health requirements	6.4%	3
40	Provider associations conflict	6.4%	3
45	CMHCs - releases must be done annually	4.3%	2
45	Age of consent for services	4.3%	2
45	Churn of Medicaid eligibility	4.3%	2
45	Consumer accountability	4.3%	2

Appendix C: BHO Covered Diagnoses

Colorado Medicaid Community Mental Health Services Program Covered Diagnoses			
ICD-9-CM		DSM-4-TR	
295	Schizophrenic disorders	295	Schizophrenia & other psychotic disorders
296	Affective psychoses	296	Mood disorders
297	Paranoid states	297	Schizophrenic & other psychotic disorders
298	Other nonorganic psychoses		
300	Neurotic disorders	300	Anxiety, somatoform, factitious disorders
301	Personality disorders	301	Personality disorders
308	Acute reaction to stress	308	Anxiety disorders
309	Adjustment reaction	309	Adjustment disorders
311	Depressive disorder, not elsewhere classified	311	Depressive disorders NOS
312	Disturbance of conduct, not elsewhere classified	312	Attention-deficit & disruptive behavior disorders
313	Disturbance of emotions specific to childhood and adolescence	313	Attention-deficit & disruptive behavior disorders
314	Hyperkinetic syndrome of childhood		
<i>USCSM 2012, Revised 5/16/2012, Effective 7/1/2012</i>			

Appendix D: Behavioral Health Funding by Agency

Overview of Colorado’s Behavioral Health Financing System

Program	Funding Source	Type of Funding	Eligibility	Delivery System
Administered through the Department of Health Care Policy and Financing (HCPF)				
Medicaid Community Mental Health Program	State General Fund and federal Medicaid matching funds from CMS	Entitlement program Behavioral Health Organizations (BHOs) receive a monthly capitation payment for each covered member. Mental health services for people with diagnoses not covered in the BHO contract are billed directly to Medicaid on a fee-for-service basis	Medicaid eligible	HCPF contracts with five regional Behavioral Health Organizations (BHOs) for delivery of services
Medicaid Outpatient Substance Abuse Program	State General Fund and federal Medicaid matching funds from CMS	Entitlement program Fee-for-service	Medicaid eligible	HCPF approves Department of Human Services (DHS)-licensed practitioners/sites to bill Medicaid fee-for-service; DHS manages provider contracts
Child Health Plan Plus (CHP+) Mental Health and Substance Abuse Program	State General Fund and federal Children’s Health Insurance Program matching funds from CMS	Non-entitlement Contracted managed care organizations receive a monthly capitation payment for each covered member; fee-for-service for individual providers in the State Managed Care Network	CHP+ eligible (non Medicaid eligible)	HCPF contracts with individual providers who participate in the State Managed Care Network and with managed care organizations for the delivery of services

Administered through the Department of Human Services (DHS)

Community-based Mental Health Program	State General Fund and federal funds through Substance Abuse and Mental Health Services Administration's (SAMHSA) Mental Health Block Grant	Non-entitlement Cost reimbursement and fixed price	Individuals with incomes less than 300% Federal Poverty Level (FPL) who are not eligible for Medicaid, not insured, and not receiving mental health services through another system; Individuals must meet strict criteria of problem severity and diagnosis	DHS contracts with Community Mental Health Centers (CMHCs) for delivery of services
Community-based Substance Abuse Program	State General Fund and federal funds through SAMHSA's Substance Abuse Prevention and Treatment Block Grant	Non-entitlement Fixed price	Individuals with incomes less than 300% FPL who are not eligible for Medicaid, not insured and who are not receiving substance abuse services through another system	DHS contracts with four Managed Service Organizations (MSOs) for substance abuse prevention and treatment

Colorado Association for School-Based Health Care, Sept. 2011

**Appendix E:
Mental Health versus Substance Abuse Fees in Medicaid**

Substance Abuse Services			Mental Health Services		
Service Code	Rate	Unit	Service Code	Rate	Unit
H0001 (Assessment)	\$95.70	Each	90801 (Assessment)	\$200.57	Max Allowable
H0005 (Group Counseling)	\$28.17	Per session (up to 3 hours)	90805 (Group)	\$43.63	Each
H0004 (Individual Counseling)	\$13.14	Per 15 min	90804 (Individual Counseling)	\$38.51	20-30 min
Intensive Outpatient	\$28.17	3 hour session	90806 (Individual Counseling)	\$58.26	45-50 min

Appendix F: Medical Home Standards for the ACC and the Children’s Medical Home Programs in Medicaid

Children’s Medical Home Program

In order to become certified as a Medical Home by the Department, a practice should contact and work with Colorado Children’s Healthcare Access Program (CCHAP) and Family Voices Colorado, including a Quality Improvement Coach and a Medical Home Navigator. Practices are assessed using the Center for Medical Home Improvement Medical Home Measurement Tools: ***The Medical Home Index*** and ***The Medical Home Family Index*** and are assisted with ongoing quality improvement projects, which must be child centric. Under SB 07-130, any willing provider may become a medical home for children, and a medical home includes physical health, behavioral health and oral health.

The Colorado Medical Home Initiative developed the Colorado Medical Home Standards – a list of eleven guiding principles that describe the characteristics of a medical home approach. The care delivered is accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally competent. These practice-level standards are a framework for continuous quality improvement and are a way to acknowledge good practice while providing a shared vision and common language for a quality system of care for all children in Colorado.

The Eleven Guiding Principles:

1. Provides 24 hour 7 day access to a provider or trained triage service.
2. Child/family has a personal provider or team familiar with their child’s health history.
3. Appointments are based on condition (acute, chronic, well or diagnostic) and provider can accommodate same day scheduling when needed.
4. A system is in place for children and families to obtain information and referrals about insurance, community resources, non-medical services, education and transition to adult providers.
5. Provider and office staff communicates in a way that is family centered and encourages the family to be a partner in health care decision making.
6. Provider and office staff demonstrate cultural competency.
7. The designated Medical Home takes the primary responsibility for care coordination.
8. Age appropriate preventive care and screening are provided or coordinated by the provider on a timely basis.
9. The designated Medical Home adopts and implements evidence-based diagnosis and treatment guidelines.
10. The child’s medical records are up to date and comprehensive, and upon the family’s authorization, records may be shared with other providers or agencies.
11. The Medical Home has a continuous quality improvement plan that references Medical Home standards and elements.

ACC Program

In order to enroll as a PCMP in the ACC Program, a practice must be an enrolled Medicaid provider that meets any one of these criteria:

- Certified by the Department as a provider in the Medicaid and CHP+ Medical Homes for Children program; OR
- A Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC) or a clinic or other group practice with a focus on primary care, general practice, internal medicine, pediatrics, geriatrics, or obstetrics and gynecology; OR
- An individual physician, advanced practice nurse or physician assistant with a focus on primary care, general practice, internal medicine, pediatrics, geriatrics, or obstetrics and gynecology.

In addition, PCMP contracts outline the following requirements for the program.

The PCMP is:

- Accessible, aiming to meet high access-to-care standards, such as:
 - 24/7 phone coverage with access to a clinician that can triage;
 - Extended daytime and weekend hours;
 - Appointment scheduling within 48 hours for urgent care, 10 days for symptomatic, non-urgent care and 45 days for non-symptomatic routine care; and
 - Short waiting times in the Contractor's reception area;
- Committed to operational and fiscal efficiency;
- Able and willing to coordinate with the Contractor's RCCO on medical management, care coordination, and case management of Members;
- Committed to initiating and tracking continuous performance and process improvement activities, such as improving tracking and follow-up on diagnostic tests, improving care transitions, and improving care coordination with specialists and other Medicaid providers, etc;
- Willing to use proven practice and process improvement tools, such as assessments, visit agendas, screenings, Member self-management tools and plans;
- Willing to spend the time to teach Members about their health conditions and the appropriate use of the health care system as well as inspire confidence and empowerment in Members' health care ownership;
- Focused on fostering a culture of constant improvement and continuous learning;
- Willing to accept accountability for outcomes and the Member/family experience;
- Able to give Members and designated family members easy access to their medical records when requested; and
- Committed to working as a partner with the region's RCCO in providing the highest level of care to Members. This commitment includes data-sharing, access to medical records when requested, cooperation on referrals, participation in performance improvement activities and initiatives, willingness to give feedback and potentially participate on committees and provide clinical expertise, and use the data available to the practice to better manage Members and their health needs.

Appendix G: Federal and State Statutes and Regulations Affecting the Integration of Physical and Behavioral Health

FEDERAL

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The HIPAA Privacy Rule provides federal protections for personal health information held by covered entities and gives patients an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of personal health information needed for patient care and other important purposes.

Confidentiality of Alcohol and Drug Abuse Patient Records of 1975 (42 CFR Part 2)

This federal act governs the use and disclosure of alcohol and drug abuse patient records that are maintained at federally funded programs; such consent is required in most cases. Patient consent must be in writing and include information regarding who can disclose and receive information, the purpose of disclosure (treatment, payment, disease management and/or quality improvement, etc.), how much and what kind of information can be disclosed and when consent must be renewed.

Health Homes in Affordable Care Act of 2010 (Sec. 2703 & Sec. 19459(e))

Creates a new Medicaid benefit for eligible individuals with chronic conditions. If states chose to implement the new health home benefit, the federal medical assistance percentage (FMAP) is increased to 90% for the first eight (8) federal fiscal quarters. Encourages states to develop person-centered health home that results in improved outcomes for beneficiaries and better services and value for state Medicaid and other programs, including mental health and substance abuse agencies.

Wellstone-Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

To help end discriminatory insurance coverage of mental health and substance use services, Congress passed the Wellstone-Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) in 2008. The Act, which went into effect in 2010, requires private health insurance plans to provide equal coverage for mental and physical health services. The law applies to all group health insurance plans for more than 50 employees that provide mental health or substance use disorder benefits as part of the plan.

Excellence in Mental Health Act (S. 2257)

Introduced 3/29/2012: Excellence in Mental Health Act - Amends the Public Health Service Act (PHSA) to set forth criteria for the certification of federally-qualified community behavioral health centers. Amends title XIX (Medicaid) of the Social Security Act to make such centers eligible for payments for services under Medicaid. Authorizes the Secretary of Health and Human Services (HHS) to award matching grants to states or Indian tribes to expend funds for the construction or modernization of facilities used to provide mental health and substance

abuse services to individuals. Amends the Public Health Service Act to expand the 340B drug discount program (a program limiting the cost of covered outpatient drugs to certain federal grantees) to allow participation by entities providing community mental health services or providing treatment services for substance abuse.

STATE

Integration of Physical and Behavioral Health Services (HB 11-1242)

This bill requires HCPF to review certain issues that relate to the provision of both physical and mental health care services as part of an integrated system of patient care, and any barriers to the integration of care. The department shall report to certain committees of the general assembly concerning the issues reviewed pursuant to the bill.

Mental Health Practice Act (Title 12, Article 43 of the Colorado Revised Statutes)

The general assembly established a state board of psychologist examiners, a state board of social work examiners, a state board of marriage and family therapist examiners, a state board of licensed professional counselor examiners, a state board of registered psychotherapists, and a state board of addiction counselor examiners with the authority to license, register, or certify, and take disciplinary actions or bring injunctive actions, or both, concerning licensed practitioners. A licensee, registrant, or certificate holder shall not disclose, without the consent of the client, any confidential communications made by the client, or advice given to the client, in the course of professional employment.

Community Mental Health Centers (2 C.C.R. 502-2-CF.2)

State rules for approving mental health centers, clinics, and other agencies to protect the public, promote high quality care in the least restrictive setting, and assure clients' dignity. The organization shall keep information obtained and records prepared about clients confidential.

House Joint Resolution (HJR 07-1050)

In 2007, this Joint Resolution created a task force to study behavioral health funding and treatment and to study mental health and substance abuse services in order to coordinate the efforts of state agencies and streamline the services provided and to maximize federal and other funding sources.

HJR-07-1050 Task Force

In 2009, the TTI Grant funded a year-long planning process to engage a broad coalition of stakeholders to (1) develop the Behavioral Health Transformation Council as an ongoing process for meaningful input from people receiving mental health and SUD services, as well as other stakeholders, to guide system transformation; (2) develop work plans to further implement system integration based on the HJR-1050 recommendations; and (3) identify ongoing funding for system transformation efforts.

Senate Bill 10-153

In 2010, the Transformation Council was established in statute through SB 10-153 with representatives of the executive, judicial and legislative branches.

Colorado Medical Home Initiative (SB 07-130)

In 2008 the Colorado General Assembly passed SB 07-130 designating HCPF to collaborate with CDPHE's Colorado Medical Home Initiative (which began its work in 2001) to increase the number of medical homes for children eligible for Medicaid and CHP+.

Relocation of Provisions Related to Behavioral Health (SB 10-175)

Senate Bill 10-175 was signed into law in 2010 and recodified all the State substance abuse and mental health statutes under one Colorado Revised Statute section- Title 27. This set the stage for further evaluation and integration of Behavioral Health regulations.

Medicaid Payment Reform Pilot Program of 2012 (HB 12-1281)

This bill directs HCPF to facilitate collaboration among Medicaid providers, clients, advocates, and payors to improve health outcomes and patient satisfaction and support the financial sustainability of the Medicaid program. The executive director of the state department may promulgate rules relating to the collaborative process.

The bill creates the Medicaid payment reform and innovation pilot program within the framework of Medicaid's current coordinated care system. The Department will solicit payment reform proposals which may include but are not limited to global payments, risk adjustment, risk sharing, and aligned payment incentives. The pilot projects chosen by the Department will be implemented for at least two years but not to extend beyond June 30, 2016

Rural Substance Abuse Programs (HB 09-1119)

Establishes the rural youth alcohol and substance use disorders prevention and treatment project and the rural detoxification project within the Division of Behavioral Health within the Department of Human Services to provide an additional funding mechanism to entities that provide alcohol and substance use disorders services to youth and for detoxification services to all ages.