HMA

HEALTH MANAGEMENT ASSOCIATES

Supporting Children with Intellectual and Developmental Disabilities and Exceptional Behavioral Support Needs

PREPARED FOR
THE COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

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Executive Summary

Overview

The Colorado Department of Health Care Policy and Financing (HCPF) has been working toward improving services and supports provided to children in the state with both an intellectual or developmental disability (IDD) and a mental health condition. Meeting the unique needs of these children can be particularly challenging because services, programs, providers and the entities responsible for the coordination of supports are typically determined by an individual's disability type or diagnosis. However, determining whether an individual's behavioral or emotional symptoms derive from an intellectual or developmental disability, organic brain pathology, or a mental illness, is complicated.

In February 2017, HCPF issued a request for technical assistance to help identify ways it can address the issues that these children often face in getting inappropriate or ineffective interventions, as well as challenges in finding qualified providers to support them. Health Management Associates, Inc. (HMA) was contracted to conduct a brief environmental scan of programs that exist in other states, and engage community stakeholders to gather information from and solicit advice on:

- Existing service delivery gaps.
- Appropriate resources for supporting these children.
- Alternatives to inappropriate use of Residential Child Care Facility (RCCF) and Psychiatric Residential Treatment Facility (PRTF) placements or extended hospital stays.

To build on previous work done for HCPF and the Department of Human Services (CDHS) by Public Consulting Group, Inc. (PCG) and JFK Partners that took a relatively broad look at services and supports for children, as well as adults with IDD and behavioral health needs, for this project, HMA focused on those children with IDD who also have exceptional behavioral support needs. While a small population, this group of children can experience behavioral health crises that place them at imminent risk of harming themselves or those around them, and they often end up in the child welfare system and being admitted to the hospital for extended periods because there are no other alternatives for meeting their needs. The goal was to identify any new issues or specific opportunities related to this population that could be implemented in the short- and longer-term, and that the departments could use to help build toward the bigger systems changes needed to address similar issues for the larger population of children and adults with dual diagnoses.

Environmental Scan

HMA conducted a brief review of the services and approaches several other states have taken to support individuals with IDD and exceptional behavioral health needs. Based on feedback from HCPF and CDHS staff, the following states were selected for this review:

- New Jersey
- North Carolina
- Oregon

- Tennessee

HMA found that while each of these four states have very different Medicaid programs, provider capacity and capability, and fiscal and political environments, they all employ comprehensive statewide frameworks that promote coordinated approaches to community-based behavioral services and supports for individuals with dual diagnoses. There are aspects of each states' programs that could be implemented in Colorado to make improvements both for the target population of children with IDD and exceptional behavioral health needs, as well as the larger population of children and adults with dual diagnoses. These are discussed further in the report.

Stakeholder Engagement

HMA facilitated two stakeholder engagement meetings for this project - one in Denver and one in Grand Junction. Participants invited included individuals and families receiving services, and representatives from advocacy organizations, community behavioral health services providers, community-based IDD services providers, and the child welfare system. Participants at both meetings were very engaged and offered great feedback and insights. The themes identified by PCG and JFK Partners in their earlier work also were expressed by these stakeholders. There was some frustration noted by participants in feeling as though they have participated in several information-gathering meetings, though not with HCPF specifically, regarding the needs of individuals with dual diagnoses, but that it did not seem as though any changes were actually being made to improve the issues. However, both groups agreed it is useful to focus on children with IDD who have exceptional behavioral health needs, and believe that a targeted effort for this population can help to move the work forward for both them and the larger population of dual diagnosed individuals.

Stakeholders' feedback was categorized into two major areas – service coordination and access and service coverage and scope.

Service Coordination and Access

The clear message from stakeholders regarding service access and coordination was that there is not really a *system* in Colorado that is capable of or responsible for coordinating the entire array of services for children with IDD and exceptional behavioral support needs. Families of these children, and their providers do not have a single point of contact to help them navigate the complex and siloed structure that exists to piece together the supports and services they need.

Service Coverage and Scope

In terms of service coverage and scope, the top issue stakeholders noted was a lack of appropriate community-based and preventative behavioral support services. Without access to these services, children and families cannot develop necessary life skills, de-escalation techniques, and behavioral crisis prevention strategies they need. For example, virtually all stakeholders expressed dismay that for most of these children and their families, had they received these kinds of supports much earlier in their lives, they believed they would not have been as likely to land in serious crises as they got older.

Recommendations

Based on information gathered from the brief environmental scan, from the stakeholder meetings, and from previous and current work regarding individuals with dual diagnoses, as well as broader Medicaid reform efforts, HMA offers the following recommendations for consideration by HCPF and CDHS.

1. Establish a statewide, coordinated approach to supporting children with IDD and exceptional behavioral health needs.
2. Apply any care coordination lessons learned from the Cross-System Crisis Response Pilot and the No-Wrong Door implementation grant.
3. Continue efforts to streamline programs and processes through the waiver simplification efforts initiated by the Governor's Community Living Advisory Group.
4. Implement the new Association of Maternal and Child Health Programs (AMCHP) and the National Academy for State Health Policy (NASHP) Standards of Care for Children and Youth with Special Health Care Needs to current care coordination activities and identify opportunities to incorporate and align with these best practices.
5. Implement a statewide approach to behavioral crisis prevention and response planning.
6. Continue efforts to communicate the existing coverage options for behavioral supports and consider expansion in coverage or scope.
7. Conduct a review of provider qualifications to ensure that the requirements imposed on providers assure safe, effective, and high-quality services are provided without unnecessarily limiting the potential provider network.

Background

The Colorado Department of Health Care Policy and Financing (HCPF) contracted with Health Management Associates, Inc. (HMA) to provide technical assistance and consulting services in support of its efforts to improve its services and supports provided to children in Colorado with both an intellectual or developmental disability (IDD) and a mental health condition.

Supporting children with dual diagnoses can be particularly challenging. The available services, programs, provider network, and the entities responsible for the coordination of supports are typically determined by the individual's disability type or diagnosis. However, because it is often difficult to distinguish whether an individual's behavioral or emotional symptoms derive from an intellectual or developmental disability, organic brain pathology, or a mental illness, the specific resources and treatment options available to that individual may not be clear.

HCPF notes in its request for technical assistance that these children often have a complex diagnostic profile and that the co-occurring mental health disorder and intellectual or developmental disability could result in the use of inappropriate or ineffective interventions. Additionally, even when appropriate resources and interventions are available, challenges in identifying a qualified provider with the capacity and specialized expertise of serving children with dual diagnoses can create substantial barriers to accessing those supports.

HCPF has made significant efforts to improve the coordination and availability of appropriate mental health and behavioral support services for individuals with dual diagnoses. Still, there exists confusion among the various community partners, as well as parents and caretakers, about the resources and services available to these children.

In recognition of the challenges faced by children and families in accessing appropriate and effective services and by its partners in supporting children with IDD and exceptional behavioral support needs, HCPF issued a request for technical assistance in engaging community stakeholders to gather information from and solicit advice on:

- Existing service delivery gaps.
- Appropriate resources for supporting these children.
- Alternatives to inappropriate use of Residential Child Care Facility (RCCF) and Psychiatric Residential Treatment Facility (PRTF) placements or extended hospital stays.

For the purposes of this report, children will be defined as those individuals from birth to the age of 21. Intellectual and developmental disability will be defined using the definition established by the Colorado General Assembly at 25.5-10-202(26), C.R.S. That definition is included as Appendix A to this report.

To facilitate discussion and to build upon HCPF's efforts to ensure that individuals have access to appropriate services, irrespective of the reasons for an individual's need for treatment, HMA did not limit the discussion to those children who have a specific mental health diagnosis. Instead, HMA asked

stakeholders to focus on those children with intellectual or developmental disabilities who also have exceptional behavioral support needs. For example, children with IDD experiencing a behavioral health crisis who pose an imminent risk of harming themselves or those around them or children with IDD who exhibit problematic sexual behaviors. Without access to adequate community-based services and supports, these children often require or are at risk for placement in an RCCF, PRFT or for an extended hospital admission.

Literature Review and Environmental Scan

In preparation for stakeholder discussions, HMA conducted a brief literature review of HCPF's recent efforts to better understand and address the needs of and the services and supports currently available to these children. The findings from those efforts are summarized below.

Public Consulting Group Report

In the state fiscal year 2015-16, the HCPF and the Colorado Department of Human Services, Division of Child Welfare (CDHS-DCW) collaborated on a joint quality improvement project. The departments contracted with the firm, Public Consulting Group, Inc. (PCG), to identify strategies to improve access to behavioral health services for children and families.

PCG hosted focus groups and conducted individual interviews with child welfare case workers and supervisors, Community Mental Health Center (CMHC) case managers and clinicians, and management staff from the Regional Care Collaborative Organizations (RCCOs), Behavioral Health Organizations (BHOs), CMHCs, and private provider organizations in several counties throughout the state. A summary and recommendation report was prepared and submitted which included a three-phased approach for improving access to services for at-risk children and families, strategies for better alignment of HCPF and CDHS-DCW goals, and recommendations for streamlining program operations. Below is a summary of the recommendations from the PCG report.

Phase I (6-9 months)

- Review clinicians' reimbursement for Medicaid service provision, ensuring general consistency/equity across the state.
- Communicate an expectation and incentivize RCCO and BHO staff to report jointly to HCPF on shared plans and progress to make a "no wrong door" policy a day-to-day reality.
- Strengthen training and communication with county staff and stakeholders and identify ways to strengthen data sharing and reporting in counties.
- Identify local behaviors that HCPF, DCW, and OBH want to incentivize and explore alignment of incentives across programs to drive outcomes.
- Explore opportunities to augment local capacity, and limit the negative impact of differing regional medical necessity determinations on access and continuity of care.
- Inventory and communicate promising care coordination practices across the state.
- Leverage the COMMIT Project to identify existing business processes and the extent to which these business processes will need to change.
- Identify options for closing key gaps in service, as well as closing key gaps in timely screening and assessment.

- Identify options for strengthening fiscal incentives for county child welfare to use Medicaid versus State general funds to pay for reimbursable behavioral health services.

Phase II (9-18 months, building on Phase I activities)

- Investigate options for lowering the administrative burden on local Medicaid and OBH service providers.
- Update reporting requirements and performance measures with stronger incentives for desired local stakeholder alignment.
- Incentivize promising care coordination practices across the state.
- Identify and work toward opportunities for DCW-HCPF interoperability, including integrated case records for the children, adolescents, and adults in vulnerable families and reporting to support implementation of a new, integrated strategic framework.
- Explore options for incentivizing counties to use Core Services funds for services that Medicaid does not reimburse, including changes to statutory guidelines for how these funds are disbursed and administered.
- Facilitate DCW and HCPF senior leader joint working sessions to streamline strategic frameworks and set shared priorities for vulnerable children, adolescents, and families in Colorado.
- Work to influence system designs as part of the COMMIT Project to support effective administration of Medicaid-supported behavioral health programs.

Phase III (18+ months, building on Phase I and Phase II activities)

- Begin implementing and continuously improving an updated and simplified, joint DCW, HCPF, and OBH strategic framework for vulnerable children, adolescents and families with associated logic path, performance measures, and target populations.

JFK Partners Gap Analysis

During the 2013 legislative session, the Colorado General Assembly made an appropriation specifically for an analysis of access to behavioral health services for individuals with dual diagnoses of IDD and a mental health condition. The University of Colorado's JFK Partners, a designated University Center for Excellence in Developmental Disabilities, was contracted to conduct the analysis.

JFK Partners, coordinating with representatives from the Community Centered Boards (CCBs), CMHCs, and BHOs, hosted a series of 11 regional stakeholder meetings throughout the state. A web-based survey was also created to collect information from various stakeholder groups. An analysis and recommendation report was drafted based upon the information collected from the regional meetings, online survey, and a policy and regulatory review. The report included policy recommendations for improving the access to and availability of specialized supports for individuals with dual diagnoses, service coordination practices, and ensuring adequate training for service providers. JFK recommendations were:

- People with I/DD should have appropriate access to mental/behavioral health services in parity with the general population in the Colorado Medicaid Community Mental Health Services Program (CMCMHSP).
- An analysis of cost of serving the behavioral/mental health needs of individuals who are dually diagnosed should be undertaken.
- Care Coordinators should have the authority to operate across systems for I/DD services, mental health services, and primary care services.

- Supports and services should consider the holistic needs of the individual and his or her community-based support system.
- An integrated system of monitoring should be developed to ensure that desired outcomes are ultimately achieved at the individual and systems levels.
- Specialized cross-training should be provided to increase the effectiveness of assessment, prevention, intervention, and crisis response.

Both the PCG and JFK Partners reports are included as appendices to this report, and relevant recommendations have been incorporated with those for this scope of work.

IDD Cross-System Crisis Response Pilot

In response to the findings and recommendations of the JFK Partners Gap Analysis, the Colorado General Assembly passed House Bill 15-1368 in 2015. The bill directed HCPF to implement a two-year pilot program to provide individuals with IDD and a co-occurring mental health condition additional necessary services, regardless of the payer. Rocky Mountain Health Plans was awarded the contract to operate the pilot program through a competitive procurement process and has partnered with local organizations in Mesa, Montrose, Delta, Garfield, and Larimer counties.

Potential pilot program participants are identified through the Colorado Crisis Services hotline, established as a statewide access point to connect any individual experiencing a behavioral health crisis with needed services and supports, or through the walk-in crisis centers in Grand Junction or Fort Collins. Individuals are screened for a potential intellectual or developmental disability at those access points and referred to the pilot program when appropriate.

The Cross-System Crisis Response Pilot is overseen by the Division for Intellectual and Developmental Disabilities within HCPF and is authorized to operate until March of 2019. Activities for the evaluation of the program's effectiveness in closing the service gaps for individuals with dual diagnoses and for the analysis of costs for expanding the pilot's services statewide are ongoing. The first annual report to the Colorado General Assembly on HCPF's findings is due July 1, 2017.

While the full report will be released soon, anecdotal information from Western Slope counties where the program is in operation indicates the pilot has been a success in supporting individuals with IDD and behavioral health conditions in crises through the additional pilot services and through enhanced support coordination.

Supports Available in Other States

As part of this project, HMA conducted a preliminary review of the services and approaches used in other states to support individuals with intellectual and developmental services who also have exceptional behavioral support needs. In coordination with HCPF, the following states were selected for this review:

- New Jersey
- North Carolina
- Oregon
- Tennessee

Most states included in this review do not limit access to supports based on the age of the participant. Where possible, our review focused on supports tailored to children.

New Jersey

The State of New Jersey's Department of Children and Families introduced the Children's System of Care (CSOC) in 2000. The CSOC provides individuals and families a single point of contact for behavioral health, substance abuse, and/or IDD services. A 24/7 access line is used to connect children up to the age of 21 with community-based and in-home support services, family support services, and out-of-home residential care. The CSOC is also the entity with the responsibility for determining eligibility for IDD services.

In January 2017, the New Jersey Department of Human Services initiated a public comment period on the renewal application for its Comprehensive Waiver under the Section 1115 research and demonstration waiver authority. The application was submitted to the Centers for Medicare and Medicaid Services (CMS) in March 2017, and proposes to incorporate the services for individuals with IDD into the state's managed long-term supports and services (LTSS) for other populations. The Comprehensive Waiver will be used to further integrate the delivery of physical health, behavioral health, and LTSS. Services for children with IDDs, mental illness, autism spectrum disorders, and serious emotional disturbances will remain under the CSOC's management.

North Carolina

The State of North Carolina provides behavioral supports to individuals of all ages with IDD through its NC Innovations waiver program. The NC Innovations program is a Section 1915(c) HCBS waiver that is operated concurrently with the state's Section 1915(b) Cardinal Innovations waiver. Together, the waivers offer an array of mental health, IDD, and substance abuse services under a capitated reimbursement model. The NC Innovations waiver offers an array of residential and non-residential services to individuals of all ages with IDD.

The waivers offer behavioral services which are designed to prevent crisis situations through a crisis consultation service. Included are facilitation of up to monthly team meetings, training and education for natural supports and direct support staff, and the development and implementation of crisis prevention strategies.

The state also offers a state-wide network of three Systematic, Therapeutic Assessment, Resources, and Treatment (START) community crisis supports programs. The system has been in place since 2008; but its demand currently exceeds its capacity – leading to increasing START coordinator caseloads and a potential need for service limitations. Two of the three START programs collaborate with the Developmental Centers for the purposes of reducing admissions and supporting those individuals transitioning from the centers to a community-based setting.

Oregon

The State of Oregon provides support to individuals with IDD through three Section 1915(c) waiver programs. Two of those programs, the Behavioral (ICF/IDD) model and ICF/IDD Support Services waivers, provide community-based, non-residential supports. The Behavioral (ICF/IDD) model waiver is

limited to children through the age of 17, and the ICF/IDD Support Services waiver is limited to those over 18. The third program, the ICF/IDD Comprehensive Residential waiver, offers an array of residential and non-residential services to individuals of all ages with IDD.

The Office of Developmental Disabilities also operates a network of Stabilization and Crisis Unit (SACU) homes. There are 22 SACU homes that provide 24-hour residential care and supervision to high-risk adults and children with I/DD. The SACU homes are comprised of 17 behavioral homes (79 beds), two medical comes (10 beds), one vacant medical home (5 beds), and two children's homes (10 beds). The approach is resource intensive as the model requires the SACU homes are staffed to ensure immediate access to services when needed, even if the current census does not support those staffing levels.

Although stabilization and crisis services are intended to be short term, the average length of stay currently exceeds a year. The state is undergoing efforts to transition the SACU homes to a short-term crisis model. To support these efforts, the state legislature has appropriated funds to make available one-time grant dollars of up to $50,000 per individual to community-based residential providers to support the specialized needs of individuals transitioning out of a SACU home.

Tennessee

As the State of Tennessee transitions to a managed long-term-services and supports (MLTSS) program for individuals with IDD, it is working to provide access to new behavioral health crisis prevention, intervention, and stabilization services using a model entitled "Systems of Support" (SOS). The approach includes the development of an individualized Crisis Prevention and Intervention Plan (CPIP). The CPIP identifies known vulnerabilities and potential triggers, the most effective calming/de-escalation techniques and established the individual's SOS team.

Each SOS team includes a champion for the individual receiving services; a START-certified coordinator; and other team members which may include direct support service providers, family members, psychiatrists, and other clinicians as needed. Prior authorization is required for SOS services, and access to SOS is limited to:

- Those individuals whose symptoms place him/her or others at imminent and significant risk of harm or threaten his/her current community living arrangement.
- Those individuals who have experienced multiple crisis events in a specified period (events must include involvement of law enforcement or mobile crisis services, utilization of crisis stabilization services, hospitalization in an acute psychiatric setting, and/or emergency department utilization).
- Those individuals for which other services, supports, and treatment options have been provided, but have not been effective in preventing or stabilizing crises.
- Those individuals who require comprehensive coordination of services and supports across environments and for whom that coordination is reasonably expected to achieve measurable improvements in specified outcomes.

Crisis intervention and stabilization response services are available 24/7 to assist and support the individual or agency primarily responsible for supporting the individual in crisis. Response services generally last an hour, no more than two and are provided face-to-face in the home. Teleconsultation may be permitted on a case-by-case basis. Crisis respite services are also available through four agencies around the state and can only be accessed through referral by a crisis response or crisis walk-in service provider. Length of stay for crisis respite services is typically 48 hours or less.

Takeaways for Colorado

The four states HMA studied have very different Medicaid programs, provider capacity and capability, and fiscal and political environment. However, the frameworks they have implemented all include a statewide and coordinated approach to providing community-based behavioral services and supports for individuals with IDD and a behavioral health condition. HMA believes it is important for HCPF also to consider the approaches and experiences of other states in the creating its own system of support for these children.

Stakeholder Assessment of Existing Gaps and Support Needs

In early June of 2017, HMA staff hosted and facilitated two stakeholder engagement meetings in Denver and Grand Junction. Invited were individuals and families receiving services and representatives from advocacy organizations, community behavioral health services providers, community-based IDD services providers, and the child welfare system.

To kick off each stakeholder meeting, HMA and HCPF staff provided an introduction of the issue and a brief summary of recent efforts to better understand and improve the behavioral supports for children with IDD. Stakeholders were then divided into smaller focus groups based upon their perspectives. The focus groups were guided by discussion questions in conversation about the processes and challenges individuals and families encounter in identifying and accessing needed supports and their experiences in receiving or delivering those supports.

To build upon and to avoid duplication of previous endeavors, stakeholders in each group were asked to focus their discussion and input on those children with IDD and exceptional behavioral support needs who often require placement in an RCCF, PRFT or extended hospital stays due to the lack of community-based options. In this way, HMA hoped to tease out nuanced differences between the preceding stakeholder engagement efforts and this project work.

Somewhat as expected, the themes identified by PCG and JFK Partners in their previous assessments also were prominent among these stakeholders, suggesting that they are still relevant to this narrower target population.

Overall, community stakeholders appreciated the opportunity to provide input to the departments. However, several stakeholders in the Denver focus group expressed frustration at the repeated requests for their participation in similar efforts or task groups related to this topic. One individual reported that he had offered feedback and advice to the departments for over two decades, yet the recommended changes and improvements to the systems of support for these children came slowly or not at all.

Stakeholders supplied a recommendation report from February of 2010 as an example of this point. That document is included as Appendix D to this report. It was suggested by several stakeholders that a single entity within HCPF be designated as responsible for making improvements to the system of care for these children.

While the stakeholders in Grand Junction did not express such firm viewpoints as their counterparts in Denver about feeling as though they have been providing feedback to the departments, they did note that they similarly do believe there has been a significant amount of community input regarding issues related to individuals with dual diagnoses. Their hope is that the departments will move forward quickly to implement recommendations made through each of the reports over the past several years. Both groups appreciated the focus on children with IDD who have exceptional behavioral support needs, and believe that a targeted effort for this population can help to create the framework for the larger population of those with IDD and behavioral health needs.

Service Coordination and Access

The overwhelming theme from stakeholders in terms of service access and coordination is that there is not really a *system* in place that is capable of or responsible for coordinating the entire array of services for children with IDD and exceptional behavioral support needs. Without a single point of contact, families of these children, as well as their providers, are forced to navigate a complex and siloed system to piece together the supports and services they need.

As discussed earlier, the services and programs available to an individual are largely dependent upon that individual's specific disability or diagnoses. In cases where a child meets the eligibility for multiple programs or the child's need for treatment is ambiguous, that child may have access to a wider range of service alternatives. However, determining the most appropriate interventions and identifying the agency or agencies responsible for service coordination can be complicated.

Stakeholders reported that children with IDD and exceptional behavioral needs are identified from a variety of referral sources, including school districts, the Early Intervention (EI) program, the CCBs, community-based service providers, the CMHCs, hospitals, child welfare, and parents. Depending on the referral source, there were differing levels of understanding as to what resources are available to these children and their families. Additionally, stakeholders noted that there may be several case managers supporting the same child, each with their own narrow role and responsibility, and that they do not necessarily coordinate with each other, or even know about each other.

Grand Junction stakeholders reported a different, more collaborative experience among service providers and community organizations. The Cross-System Crisis Response Pilot operated by Rocky Mountain Health Plans under its contract with HCPF has shown a more coordinated response to children with exceptional behavioral support needs. The pilot program serves as a single point of contact able to coordinate resources across systems and payers. Grand Junction stakeholders also explained that, due to the nature of a small community with fewer alternatives, organizations in the area have become accustomed to collaborating on difficult cases or where the standard systems cannot meet the needs of these children. Their community underwent a significant process of learning to work together more

collaboratively some time ago, and they believe they benefit greatly from those investments of time and commitments to ongoing cooperation.

Stakeholders further noted that access to appropriate services and supports is often restricted by the narrow target criteria for certain programs. The Children's Extensive Support (CES) waiver was cited as a potential community-based solution for many of these children, yet the program's requirement for significant human intervention, even during sleeping hours, limits its accessibility.

Similarly, the residential options afforded by the Children's Habilitation Residential Program (CHRP) waiver were included as a potential option for those children who require an out-of-home placement that would be better suited to the needs of children with IDD than an RCCF or PRTF. However, access to this waiver is limited to children in the foster care system administered by CDHS-DCW. Stakeholders said that this often leads to families facing the difficult decision of relinquishing their parental rights to access the CHRP waiver supports. Some also suggested that the child welfare system, with its primary purpose to support children of families in which abuse and neglect has occurred or is suspected, is not particularly well-suited for supporting the specialized needs of children with IDD.

Universally, stakeholders emphasized the importance of early access and intervention for children with IDD and exceptional behavior support needs. Because the appropriate community-based supports are often not available or identified until a behavioral crisis occurs, individuals and families must resort to the use of emergency departments or inappropriate placements in an RCCF or PRTF. Stakeholders reported this can eventually lead to incidents involving the juvenile justice or corrections systems.

As noted in HCPF's request for technical assistance, concerns about limitations in the capacity and competency of providers were confirmed by community stakeholders. As anticipated, stakeholders reported that provider capacity was especially limited in the rural areas of the state. Also of concern was a shortage in the number of Applied Behavioral Analysis (ABA) providers.

Stakeholders also offered ideas on potential causes for the shortage in provider capacity, including inadequate reimbursement rates and the complicated requirements for enrolling as a provider across the different systems and programs. Differences in provider qualification requirements (detailed in the table below) may exacerbate challenges in accessing appropriate supports.

Summary of Colorado Medicaid's Behavioral Services Provider Qualifications

Service / Program	Basic Provider Qualifications

EPSDT Pediatric Behavioral Therapies	• Technicians must be 18 years or older, have high school education, have 20 hours of directly supervised experience, and pass background check
	• Lead/Senior Therapists must have:
	  • Doctoral degree and 400 hours training;
	  • Master's degree or higher and Board Certified Behavior Analyst (BCBA) or equivalent certification; **or**
	  • Master's degree and teacher certification and 1,000 hours supervised training or experience

HCBS-CES, HCBS-DD, & HCBS-SLS	• Line staff must be 18 years or older, have high school education, have 24 hours of directly supervised experience, and pass background check
	• Consultants and counselors must have Baccalaureate degree or higher, BCBA or equivalent certification, and two years of supervised experience
	• Plan assessors must have:
	  • Master's degree of higher, BCBA or equivalent certification, and two years of supervised experience; **or**
	  • Baccalaureate degree or higher, BCBA or equivalent certification, and work under the supervision of a licensed behavioral health professional

HCBS-CHRP	• Line staff must be 18 years or older, have high school education, have 24 hours of directly supervised experience, and pass background check
	• Lead therapists must have:
	  • Doctoral degree and one year experience; **or**
	  • Master's degree of higher and professional licensure or BCBA or equivalent certification
	• Senior therapists must have:
	  • Baccalaureate degree or higher, BCBA or equivalent certification; **or**
	  • Baccalaureate degree or higher and two years of supervised experience

Finally, it is hard to recruit providers to many rural areas; they do not have access to the same amenities as in urban areas, as well as the same levels of professional supports and colleagues.

Service Coverage and Scope

Top among the themes for service coverage and scope was the lack of appropriate community-based and preventative behavioral support services. Stakeholders reported that without access to these services, children and families lack the supports they need to develop necessary life skills, de-escalation techniques, and behavioral crisis prevention strategies. One stakeholder emphasized the importance of appropriate community-based supports by comparing the escalation of a child's behaviors over time to a volcano. Without the de-escalation and prevention tools available to families, the stresses build over

time and erupt into a behavioral crisis in which the child may become violent or pose a danger to him/herself and others.

As mentioned above, stakeholders reported that often the supports that these children exist and may be available in the communities in which they live. However, due to the siloed nature of the programs for children or the ambiguity in the particular condition, diagnosis, and circumstances driving the need for treatment, the most appropriate supports are not covered by the specific program in which that child is enrolled. The chart below illustrates the services available to children with behavior support needs.

Programs/Services Available to Children in Colorado

Mental Health & Substance Use Disorder Supports	Intellectual & Developmental Disability Supports	Child Welfare Programs & Services
•Behavioral Health Organization Services •Medicaid Fee-For-Service Mental Health •EPSDT Behavioral Therapies •Child Mental Health Treatment Act Services •Residential Child Care Facilities (RCCF) •Psychiatric Residential Treatment Facilities (PRTF) •Inpatient Psychiatric Hospital Care	•Family Support Services Program (FSSP) •EPSDT Behavioral Therapies •Children with Autism (CWA) Waiver •Children's Extensive Support (CES) Waiver •Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/ID)	•Core Services Program •Prevention & Intervention Services •Family Preservation Services •Placement Services •Children's Habilitation Residential Program (CHRP) Waiver

Stakeholders explained that the absence or inaccessibility of more appropriate community-based behavioral supports, and access to them much earlier in a child's life, often leads to children entering the system with a higher acuity of need, limiting the immediate options for treatment. At the time of a behavioral crisis, the hospital emergency department or a call to emergency response personnel may be the only alternative.

When asked about the recent expansion of behavioral therapies offered by the Medicaid State Plan under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) coverage provisions, stakeholders reported that it has not yet made a significant impact on these children. As a relatively new service option, the provider network was reported to be inadequate and that more information and education was needed to ensure case managers and families are aware of this resource.

Again, the Cross-System Crisis Response Pilot serves as an area of best practice in the state. Grand Junction Stakeholders report that the pilot's additional services offer a safety net of support that has reduced reliance on hospitals and other, more intensive treatment options. Rocky Mountain Health

Plans has implemented the START model and has established cooperative agreements with key community partners. Stakeholders stated that key to the program's success is the provision of a short-term therapeutic support service. The program operates four stabilization and therapeutic support homes – two in Grand Junction and two in Larimer County. These homes allow for individuals in crisis to receive supports in a community-based setting and by providers specifically trained to serve individuals with IDD and behavioral health conditions. A representative from the pilot program estimated that more than 60 children in the roughly nine months since the program was operationalized.

While available to the children enrolled in the CHRP waiver, long-term residential supports are largely unavailable to children with IDD and exceptional behavioral support needs. Stakeholders stressed the need for such services when in-home services are insufficient in meeting the child's needs or when the child's behaviors put other family members at risk. As a result, children may be placed in an RCCF or PRTF. Stakeholders explained that the RCCFs and PRFTs are not designed to serve children with IDD and that they often cannot meet their specialized needs. Many expressed concerns that their inappropriate use may result in additional trauma or do more harm than good for children with IDD.

As discussed above, the complexity of the multiple systems of support also contribute to variations in the service design and administration. For example, the table below includes brief descriptions of the service coverage and limitations for the behavioral services available in several waiver programs.

Colorado Medicaid Behavioral Services Scope and Limitations

Service / Program	Brief Coverage Description	Limitations
EPSDT Pediatric Behavioral Therapies	Adaptive behavior treatment, conducted by either a technician or BCBA. Behavior identification assessments through testing, observation, caregiver interview, results interpretation, report preparation and discussion of findings. Behavior identification re-assessments.	All services subject to utilization management vendor review. Behavior identification re-assessments limited to 1 hour per six months.

HCBS-CES, HCBS-CHRP, HCBS-DD, & HCBS-SLS	Behavioral consultation and recommendations for development behavioral support plans. Behavioral plan assessment through observation, interviews, analysis, evaluations, and report preparation. Individual and group counseling services. Line services including direct implementation of the behavioral support plan.	• HCBS-DD and HCBS-SLS unit limits:
		  • Line staff 960 units/year
		  • Consultation 80 units/year
		  Counseling 280 units/year
		  • Plan assessment 40 units/year
		• HCBS-SLS also limited by support level dollar limits and overall service plan limit of $37,944/year
		• HCBS-CES overall service plan limit of $37,310/year and plan assessment limit of 40 units/year

HCBS-CWA	Behavioral therapies including the development of a treatment plan, supervision and implementation of the treatment plan. Therapies may include training, modeling, conditioning, and biofeedback or reinforcement techniques.	• Overall service plan limited to $25,000/year • Ongoing and post service evaluations limited to 90 minutes/year, each

Stakeholders expressed frustration with the slight variations that made it difficult for an agency to provide services in multiple programs. They note that better and more thoughtful alignment of provider requirements, covered services and supports, and reimbursements that support such alignment could significantly improve options for families and children with IDD and exceptional behavioral needs.

Recommendations

Based on the work previously done by both PCG and JFK Partners, as well as the information gathered from stakeholders and a brief environmental scan through this project, as well as an understanding of the larger context of Medicaid reform efforts in Colorado and nationally, HMA proposes the following recommendations for HCPF's consideration.

1. **A clear, overwhelming need is the creation of a statewide, coordinated approach to serving children with IDD and exceptional behavioral health needs.** Today there exists no statewide system immediately capable of or responsible for navigating the entire array of options available. The complexity of the network of programs and funding sources contributes to a structure that is difficult to navigate and understand for individuals, families, providers, and administrators. To address this issue in the short term, HCPF should designate a single point of contact as the individual or division responsible for supporting all stakeholders in ensuring all feasible community-based alternatives are made available to these children.

   Additionally, and over the longer term, HCPF should build on the Accountable Care Collaborative (ACC) Phase II infrastructure and continue to fully integrate LTSS into that structure. With likely inclusion of brokerage responsibilities for LTSS case management incorporated into the ACC Phase II responsibilities for the Regional Accountable Entities (RAEs), this establishes a logical pathway for further integration, including in the shorter-term, for children with IDD and exceptional behavioral health needs. The RAEs could serve as the statewide network of centralized authority and responsibility for coordinating their care across systems and providers, ensuring they have access to all needed services without duplication of effort from multiple case managers, and helping to document gaps in appropriate behavioral service alternatives, as well as identifying solutions. Again, as the RAEs already will be responsible for communicating with providers in their Health Neighborhoods and across the state, they will be able to educate local IDD/behavioral health agencies and providers on how to determine eligibility for children with IDD and exceptional behavioral health needs and coordinate services for them across systems and payers.

2. Until such a statewide system can be designated and operationalized, **apply any lessons learned from the Cross-System Crisis Response Pilot and the No-Wrong Door (NWD) implementation grant** to ensure that those entities currently responsible for determining eligibility and coordinating services have a complete understanding of the resources and programs available to these children. The frontline experiences and relationships established through the Cross-System Crisis Response pilot should provide HCPF with a new understanding of how existing resources can be leveraged and where gaps exist. The toolkit and action plans to be developed based upon the experiences of the four NWD pilot sites may provide an operational structure for improved interagency cooperation and cross-system service coordination. Colorado should also review and consider for implementation the best practices in service coordination from the State of New Jersey.

3. **Continue efforts to streamline programs and processes through the waiver simplification efforts initiated by the Governor's Community Living Advisory Group.** As detailed in the group's Waiver Simplification Concept Paper (Appendix E), the consolidation of services and supports for children with IDD into a single waiver program would help to eliminate many of the access issues related to program targeting criteria. In doing so, Colorado should consider entire array of services currently available to children who meet the narrower target populations for current programs and ensure the continuity of critical community-based services. HCPF should consider expansion of a residential service beyond those children in the foster care system, such as those services available to children with IDD in North Carolina and Oregon.

4. **Implement the new Association of Maternal and Child Health Programs (AMCHP) and the National Academy for State Health Policy (NASHP) Standards of Care for Children and Youth with Special Health Care Needs to current care coordination activities and identify opportunities to incorporate and align with these best practices**. The attached document (Appendix F) describes key elements and functions of a high-performing care coordination framework as well as a 10-step process for implementing an effective plan of care. The standards are well-aligned with HCPF's commitment to a person-centered culture and improved member experience and should be incorporated into the foundation of a statewide system of care.

5. In addition to a more comprehensive and coordinated approach to the traditional participant service planning process, **implement a statewide approach to behavioral crisis prevention and response planning** similar to the models used in North Carolina and Tennessee. HCPF should adopt a statewide approach to behavioral support services such as the Start Model used in North Carolina, Tennessee, and by the Cross-System Crisis Response Pilot. This approach should emphasize the importance of and make available preventative behavioral supports. The use of individualized crisis prevention plans such as those in Tennessee should be used to identify known vulnerabilities and potential triggers, document the most effective calming/de-escalation techniques, and potentially prevent inappropriate use of RCCF, PRFT, or hospital services.

6. **Continue efforts to communicate the existing coverage options for behavioral supports and consider expansion in coverage or scope.** HCPF should work with the BHOs and case

management agencies to send additional communications to providers, host webinars, or make targeted calls to high-volume providers to make sure they understand the full range of services and supports available to these children, especially those therapies recently added under the EPSDT coverage provisions. HCPF should conduct a review of the service coverage standards and limitations for behavioral supports and therapies available under the waivers and through EPSDT. As the results of the Cross-System Crisis Response Pilot evaluation become available, HCPF should consider the expansion of pilot services which demonstrate a reduced reliance on RCCF and PRFT placements and extended hospital stays.

7. **Conduct a review of provider qualifications to ensure that the requirements imposed on providers assure safe, effective, and high-quality services are provided without unnecessarily limiting the potential provider network.** The qualifications and provider enrollment processes should be standardized across programs and services to the greatest extent possible. HCPF should cross-reference provider networks for each program to identify those providers who have not also been enrolled to provide comparable services in all other programs. Those providers should be encouraged and supported to enroll as providers and support children enrolled in those other programs.

Conclusion

In consideration of the extensive body of work predating this stakeholder engagement process, it was expected that many of the same themes and experiences would emerge. While that is true, some interesting nuances and insights were uncovered by narrowing the focus of this project to those children with IDD and exceptional behavioral support needs – including stakeholder requests for a more coordinated approach across payers and programs and the critical importance of earlier access to community-based services in avoiding inappropriate placements in an RCCF or PRTF and extended hospital stays. Stakeholders also hope that by starting with a narrower focus, the lessons learned can be applied to a system that better meets the needs of all children with IDD and behavioral health conditions.

Recent developments in service and program administration, such as the expansion of behavioral therapies coverage under EPSDT and the implementation of the ACC Phase II, provide great possibility and opportunity for the implementation of a system of care for these children. Additionally, the implementation of a solution for this specific population can serve as the footing for and initiate improvements in the systems of support for other populations as well.