

**DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
(Medicaid Mental Health Community Programs)**

-AND-

**DEPARTMENT OF HUMAN SERVICES
(Mental Health and Alcohol and Drug Abuse Services)**

FY 2012-13 JOINT BUDGET COMMITTEE HEARING AGENDA

Tuesday, January 10, 2012

3:00 pm – 5:00 pm

3:00-3:15 INTRODUCTION AND OPENING COMMENTS

3:15-3:45 PERFORMANCE-BASED GOALS AND BUDGET REQUEST

1. a. Is it an appropriate objective to increase treatment referrals to substance use disorder providers by two percent?

DHS Response: Engaging individuals with substance use disorder issues into treatment through early intervention reduces the potential for these individuals to become involved with higher cost public services, i.e. criminal justice, emergency medical care, unemployment, etc.

This performance measure is related to the Department's efforts to support the integration of primary health and behavioral health. Currently, approximately 7,000 treatment admissions to all licensed substance use disorder treatment programs are referred by self, family or other health care providers. The trend in self, family and health care provider referrals for the last two fiscal years has decreased on average by 2.5%.

The Department created the new web tool, LinkingCare.org, to fulfill one of the requirements of the Screening, Brief Intervention and Referral to Treatment (SBIRT) Grant provided through Substance Abuse Mental Health Services Administration. The LinkingCare website is a service provider directory for healthcare providers and the general public to access information on services, providers and screening tools to help identify substance use disorder issues and make informed referral decisions. The Department anticipates that the new web tool will reverse the downward trend and achieve 2% growth or 143 individuals being referred to treatment in FY 2012-13.

- b. What if other programs, such as prevention initiatives, reduce the need for treatment referrals?

DHS Response: The Department's intent is that substance use prevention initiatives will reduce the future need for substance use treatment, similar to any type of health prevention. With the State's investment in substance use prevention (\$33,649 General Fund), the Department purchases prevention services targeted towards individuals at risk of developing a substance use problem. The individuals that the Department hopes

will access substance use treatment, based on its efforts in the performance objective, are those who have a substance use disorder problem and are currently not engaged in treatment.

c. What if referral generation is successful beyond a level that the State can provide financial resources to fulfill?

DHS Response: The level of funds that the State currently provides does not fully meet the need for providing substance use disorder treatment services. The capacity to provide services is supported by multiple sources of public and private funds (State General Fund, Cash fund and Medicaid, Federal Funds, Local Funds, various private sources and consumer self-pay). The Department's position is that the incremental increase in new consumers is not significant enough to exceed the current system funding capacity. Additionally, substance use treatment in Colorado is provided primarily on an outpatient basis and there is sufficient outpatient capacity throughout the state to respond to an increase in referrals.

3:45-4:10 STRUCTURE OF STATE-SUPPORTED BEHAVIORAL HEALTH CARE

2. What is the difference between a behavioral health organization (BHO) and a managed service organization (MSO) in terms of service model? Why does the State use both models rather than one to administer State-supported behavioral health care?

DHS/HCPF Joint Response: The differentiation between the MSO model as codified under 27-80-107, C.R.S. and the BHO model as codified under 25.5-5-411 C.R.S. are detailed in the table below:

Description / Service Model	Behavioral Health Organization (BHO)	Managed Service Organization (MSO)
Administrative Agency	Department of Health Care Policy and Finance	Department of Human Services
Behavioral Health Service Provided	100% Medicaid Mental Health	100% Non-Medicaid Substance Use Disorder Treatment
Contracts	Fully Capitated, Risk-Based	Based on Available Funding
Funding	Medicaid	Six funding streams including General Fund, Federal Fund and Cash Funds
Reimbursement	Monthly “per member, per month” (PMPM) payment for each enrollee in their service areas	Based on the service and/or the funding source requirements, a combination of 1/12th, fee-for-service, project progress and incentives based on performance
Eligibility	Medicaid eligibility, medical necessity, and the presence of a covered mental health diagnosis	Open to all citizens in the State with an emphasis on federal priority populations (i.e. pregnant women, intravenous drug users and persons with HIV), and the uninsured

The State currently uses two models to administer State-supported behavioral health care. This is primarily because they serve unlike populations, with dissimilar eligibility and data reporting requirements and different funding streams.

3. a. Have federal funding and organizational structures created barriers to integrating primary and behavioral health care?

DHS/HCPF Joint Response: The barriers to integration stem from the structure and policy of the federal government as exhibited in the form of multiple agencies that oversee different aspects of health care delivery. For example, the Centers for Medicare and Medicaid Services (CMS) administer the Medicaid program and all associated requirements related to the program. The Health Resources Services Administration (HRSA) administers and significantly funds the Federally Qualified Health Centers (FQHCs). The Substance Abuse and Mental Health Services Administration (SAMHSA) administers, collects data for all federal agencies in regards to behavioral health services, and funds a sizeable portion of behavioral health services.

Each Federal Administrative Agency promulgates its own requirements, including data collection for outcome reporting on specific performance indicators, and various funding priorities that states must comply with in order to maintain federal funding.

Health care reform has provided opportunities to eliminate some of the barriers to integration. Health care reform will shift/expand the populations and how people are covered for services in Colorado with a large shift to Medicaid and private insurance coverage that were once covered by state and other federal dollars. This will allow the state to focus more attention on directing other state and federal dollars to integration efforts, fill coverage gaps, increase focus on prevention, early intervention, and recovery focused services that enhance treatment. The required measures from SAMHSA is an example of the behavioral health data which the public-primary care system does not yet share that would help services to be integrated and funded with federal behavioral health care dollars. The federal agency must collect the data and report it to Congress each year to meet Office of Management and Budget requirements. With improvements in data collection tools eventually these data barriers will be diminished. Colorado is making strides in transforming and eliminating barriers to integration through the work of HCPF and CDHS in preparing and implementing system changes for health care reform. In addition, the work of the Behavioral Health Transformation Council is largely focused on eliminating many of these barriers to integration in the behavioral health system.

b. Have actions taken by the State, such as administering primary care in a fee-for-service model and behavioral health care in a managed care model, created barriers to integrating primary and behavioral health care?

DHS/HCPF Joint Response: The existence of the Behavioral Health Organization model and the Managed Service Organization model creates impediments to integration of services. Historically, behavioral health services and primary care services have been provided in settings that have not been well integrated, and where services have been funded differently, at the federal, state and local level. The State statutory framework, with specific requirements that dictate resource allocation to specific treatment provider systems, creates even further barriers to integrating services.

The General Assembly in collaboration with the Office of the Governor created the Behavioral Health Transformation Council (S.B. 10-153) with the charge of transforming the State public behavioral health system and emphasizing the importance of behavioral health within the health continuum of care. The Behavioral Health Transformation Council will be addressing and making recommendations on how the barriers to integration can be resolved. The Behavioral Health

Transformation Council has focused its efforts on System of Care, Criminal Justice, and Prevention and Early Intervention.

4. What methodology is used to determine the geography covered by a managed service organization (MSO)? Why is Boulder County covered by one MSO while all other MSO contracts include multiple counties?

DHS Response: The seven Sub-State Planning Areas (SSPAs) that the Department established for the purpose of contracting for substance use treatment and detoxification services through the MSOs are based on information from multiple data sources and public input. The SSPA segments currently recognized were developed in 1996 through the combination of population surveys, social indicator data (alcohol and drug related fatalities), and client oriented data system information. The concept for creating the SSPAs is based on a requirement in 1975 by the Secretary of Health, Education, and Welfare to establish health service areas throughout the U.S. as part of the implementation of the National Health Planning and resources Development Act of 1974.

In the initial Request for Proposal (RFP) published by the Department in early 1997, Boulder was identified as a part of the Denver Metro area (SSPA 2a). Members of the General Assembly were approached by stakeholders of the Boulder community (Boulder County Health Department, Mental Health Center of Boulder, and others) to request that the Department break out this area into a stand-alone region. The Boulder community identified that they met the requirements through internal and external resources to qualify to bid on their own. The Department (Alcohol and Drug Abuse Division) approved the request for a separate SSPA to be part of the RFP. The Department has maintained the seven SSPAs as its contracting areas for substance use treatment and detoxification services since 1997.

4:10-4:30 COLORADO MENTAL HEALTH INSTITUTES

5. Why do adolescent beds at the Colorado Mental Health Institute at Pueblo cost almost twice that of beds in other treatment divisions, including the Institute for Forensic Psychiatry?

DHS Response: The Colorado Mental Health Institute at Pueblo (CMHIP) 20-bed inpatient adolescent unit annual average cost per bed represents the unit's annual costs (including direct and indirect costs) divided by the number of annual bed days that the unit is occupied. Since the adolescent unit occupancy rate is lower than the occupancy rates of other CMHIP treatment divisions (i.e., forensics, geriatrics), the annual cost per bed is higher than the other divisions. In addition, the adolescent unit costs are also higher because CMHIP must provide educational services to the youth residing in the adolescent unit. The General Fund impact of the \$405,168 annual cost per bed in FY

2009-10 was offset by \$209,209 in non-General Fund revenue per bed, including payments from Medicaid, BHO's and other payer sources.

When the unit adolescent census is low, nursing staff are reassigned to other CMHIP treatment units. The cost savings to the adolescent unit from reassigning these nursing staff is not reflected in the unit's \$405,168 annual cost for FY 2009-10 as no mechanism currently exists to track these adolescent unit cost savings when nursing staff are reassigned. The Institutes are currently developing a staffing database that will allow these costs to be captured and charged to other CMHIP divisions so the accuracy of the adolescent unit cost allocation is improved.

The CMHIP adolescent unit plays a critical role in the State as it is the sole provider serving both the Division of Youth Corrections and the Judicial Department in treating youth requiring assessment and stabilization (for DYC) and youth requiring competency evaluations and restorations (for the Judicial Department).

6. What is the anticipated implementation and ongoing operational expense of the electronic health record and pharmacy system proposed for a feasibility study?

DHS Response: An electronic health record (EHR) and pharmacy system will address problems identified in prescribing and monitoring medications, as well as improve clinical decision-making, reduce medical errors, and increase efficiencies. An electronic health record would enable the Institutes to improve the safe and effective delivery of quality health care to patients. With an EHR and pharmacy system, patient data is brought together in one place, continuously updated, and is immediately accessible to the patient's treatment team, offering an integrated view of patient care that is very difficult to obtain via a paper-based record. While it can never take the place of clinical judgment and experience, an EHR and pharmacy system can actively provide options and explanations that improve the clinician's efficiency and compliance with accepted practice guidelines. Also, electronic health record systems are generally believed to increase efficiencies by reducing the amount of time clinicians spend documenting patient care. Electronic health records also solve the problem of illegible handwritten notes and physician orders.

The Department obtained an estimate to implement an electronic health record and pharmacy system from the Department's current health information system vendor, NetSmart in July 2011. The estimate totaled approximately \$4.1 million for the initial purchase and installation of an EHR and pharmacy system (including the first year of vendor maintenance and support costs). Annual vendor maintenance and support costs after the first year implementation cost are estimated at approximately \$1.7 million, including \$241,000 and 3.0 FTE to maintain, support and make programming modifications to the EHR and pharmacy system.

The Institutes currently use a computerized health information system called Avatar (from NetSmart) to manage census, record patient diagnoses and services, and track patient legal status data. The Institutes also operate legacy pharmacy and lab systems. These systems allow the Institutes to bill medical insurers (including Medicare and Medicaid) and provide basic lab and pharmacy information, but they provide no clinical support similar to an EHR and pharmacy system. A June 2011 Office of the State Auditor performance audit recommended that the Department implement an EHR and replace a legacy pharmacy system at the Institutes.

7. Are there grants available to cover the expenses of the proposed feasibility study of an electronic health record and pharmacy system?

DHS Response: The Department is not aware of any other grants available to inpatient psychiatric hospitals to cover the expenses of the requested \$75,000 feasibility study of an electronic health record and pharmacy system. At the federal level, the American Recovery and Reinvestment Act of 2009 (ARRA) includes payment incentives to each hospital that is a meaningful user of a certified EHR; however, ARRA defines a hospital as a Medicare general, acute care, short-term hospital. Thus, psychiatric hospitals such as the Colorado Mental Health Institutes are not eligible for these federal payment incentives.

Additionally, the Colorado Regional Health Information Organization (CORHIO) provides a “Health Information Exchange (HIE)” that supports the flow of health information between physician practices, hospitals, long term care facilities, labs, radiology centers, and other health care institutions. Currently data that may be exchanged is primarily limited to lab and radiology results. Institute staff have met with CORHIO staff and will be exploring whether implementation of the HIE at the institutes would benefit patient care.

4:30-4:45 TREATMENT FOR INDIVIDUALS INVOLVED IN THE CRIMINAL JUSTICE SYSTEM

8. a. Please describe the current role of the Division of Behavioral Health in administering funds in the Drug Offender Surcharge Fund (including H.B. 10-1352 moneys).

DHS Response: The Department, along with its partner agencies that are responsible for administering the Drug Offender Surcharge Fund and the H.B. 10-1352 Drug Offender Surcharge Fund, directs the funds to programs that do the following;

- Best serve the offender-behavioral health population
- Provide local control
- Maximize available dollars

The table below details the specific responsibilities of the Department and its partner agencies:

Fund / Agency	Program Responsibility	FY 2011-12 Program Appropriation
Drug Offender Surcharge	Funding is appropriated by the General Assembly to cover the costs associated with substance use assessment, testing, education and treatment pursuant to a plan developed by the Interagency Advisory Committee on Adult and Juvenile Correctional Treatment. 16-11.5-102 (3), C.R.S. (2012)	
Colorado Department of Human Services	Outpatient offender treatment	\$837,168
	Short-term Intensive Residential Remediation and Treatment (STIRRT) - residential and outpatient treatment	\$383,316
	Provider workforce trainings (5)	\$4,000
	UCHSC-Addiction Research and Treatments Services (ARTS) - Women's residential treatment programming (Haven)	\$46,143
Colorado Department of Public Safety	Therapeutic Communities & Intensive Residential	\$1,107,813
Colorado Department of Corrections	Various Parolee Services	\$1,245,127
Judicial	Substance Abuse Treatment & Administration	\$1,745,479
Total		\$5,369,046
H.B. 10-1352 (Drug Offender Surcharge Fund Separate Allocation)	Funds are appropriated to cover costs associated with the treatment of substance use or co-occurring disorders of adult offenders who are assessed to be in need of treatment and who are on diversion, probation, parole, in community corrections, or in jail. 16-11.5-102 (3) (c) (I), C.R.S., (2012)	
Colorado Department of Human Services	Jail-Based Behavioral Health Services (JBBS) - County Sheriffs (1)	\$1,450,000
Colorado Department of Public Safety	Substance Abuse & Co-occurring Treatment and Drug Testing - Community Corrections	\$1,250,000
Colorado Department of Corrections	Treatment Accountability for Safer Communities (TASC) Programs	\$1,400,000
Judicial	Substance Abuse & Co-occurring Treatment and Drug Testing	\$2,000,000
Total		\$6,100,000

(1) The Jail-Based Behavioral Health Services program within the Department supports county sheriffs in providing screening, assessment and treatment for substance use disorders and co-occurring substance use and mental health disorders within jail settings.

Beginning in FY 2011-12, ten awards totaling \$1,450,000 were made to the following counties based on a competitive bid process:

Alamosa	\$ 69,403	El Paso	\$196,720
Arapahoe	\$148,765	Jefferson	\$107,100
Boulder	\$208,334	Larimer	\$ 62,217
Denver	\$145,500	La Plata	\$ 62,217
Delta*	\$209,603	Logan**	\$240,141

***Also includes Gunnison, Hinsdale, Montrose, and Ouray counties**

****Also includes Cheyenne, Elbert, Kit Carson, Lincoln, Morgan, Phillips, Sedgwick, Washington and Yuma counties**

b. Please address data collection, data reporting, and performance measurement.

DHS Response: The Department was not appropriated funding for data collection, data reporting, and performance measurement functions in the Drug Offender Surcharge Fund or the H.B. 10-1352 Drug Offender Surcharge Fund.

The data and performance management functions for the population served by these funds are aggregated with all treatment services that are monitored administratively by the Department. All licensed substance use disorder treatment providers are required to submit Drug/Alcohol Coordinated Data System (DACODS) data to the Department. The DACODS collects demographic data, social indicators, and referral information, plus assessment and evaluation information at time of consumer admission and at time of discharge.

The Department is currently processing a purchase order to develop a web-based client management database to track critical information on consumers served through the Department's Jail-Based Behavioral Health Services (H.B. 10-1352) Program (06/30/2012 system completion date). The budget for this project is \$5,000 that will be paid out of program savings from a late start date of the Jefferson County program.

c. How could this administration be improved?

DHS Response: The Department's position is that improvements to the current data collection system are necessary in order to improve the consistency, quality and effectiveness of data collected and reported. The improvements include the development of the ability to collect service level data on all consumers (all providers) and the addition of data variables to identify service funding by source (Department appropriated and other agencies). These items would allow for improved tracking of expenditures (by provider and by service) to individual consumers, resulting in increased accountability, improved coordination between agencies, and enhanced effectiveness in the use of funds.

9. Please describe the proposed role of the Division of Behavioral Health in administering funds in the proposed Correctional Treatment Cash Fund. Please address data collection, data reporting, and performance measurement.

DHS Response: The Colorado Criminal and Juvenile Justice Commission (CCJJ) shared general information regarding this topic at a committee meeting held on October 14, 2011. The CCJJ recommends the consolidation of the Drug Offender Surcharge Cash Fund, the H.B. 10-1352 General Fund appropriation, and the Drug Treatment Fund (created in S.B. 03-318) into a single fund, as well as combining the oversight bodies of each of three funds into a single decision making body.

The purpose of this consolidation is to increase efficiency, foster cross-agency collaboration in the delivery of treatment to people under the supervision of the criminal justice system and enhance reporting requirements on specific treatment outcomes and programs.

Examples of the recommendations by the CCJJ include the following:

- The newly created fund would retain interest earned and all unexpended monies would remain in the fund as Re-appropriated Funds at year end.
- The new eight member oversight body would have one voting representative from each of the following:
 - Department of Corrections
 - Judicial Department (Division of Probation Services)
 - Department of Public Safety
 - Department of Human Services
 - Office of the State Public Defender
 - Colorado District Attorneys Council
 - Colorado Sheriff's Association
 - Colorado Counties Association
- Enhance the data collection and reporting of treatment outcomes for people in the criminal justice system. The recommendations of the CCJJ would require the Department to create reports by treatment program to include numerous new

variables with the desired outcome to achieve efficiency and cross-system accountability of the funds.

- The recommendations reference some data system improvements that would need to be made.
- The recommendations of the CCJJ also discuss how local communities would continue to play a role in managing some of the funds, as they do with the current Drug Treatment Fund created by S.B. 03-318; requires the newly created oversight body to prepare an annual funding plan; specifies that additional stakeholders may attend, but not vote at meetings of the oversight body.

4:45-4:50 PRIOR YEAR LEGISLATION

10. Is the implementation of S.B. 11-008 (concerning aligning Medicaid eligibility for children) going to be delayed one year?

HCPF Response: S.B. 11-008 requires computer programming changes in CBMS to implement the bill. Per the fiscal note associated with the bill, funding for that implementation will become available in FY 2012-13, and implementation is anticipated to occur in FY 2012-13.

4:50-5:00 Treatment Services for Youth Involved in the Child Welfare and Youth Corrections Systems *(note, this agenda section was added per Committee request during the December 13, 2011 hearing with the Department of Human Services on the Division of Child Welfare and the Division of Youth Corrections)*

11. Provide your perspective on the current multiple funding streams that support treatment services for youth involved in the child welfare and youth corrections systems.
- a. How does the current system affect what services are available?

DHS Response: The vast majority of children who receive child welfare or youth correction services get the services that they need. Only a small number of children and youth with multiple mental health presentations and complex needs challenge the current system.

The current funding system for child welfare treatment services has several positive attributes, including providing the county the ability to use Core and Block funding flexibility. Public agencies and their service systems provide the most appropriate and least restrictive services at the right time whenever possible. The Colorado Department of Human Services (CDHS) ensures that dollars are spent to address the immediate needs of a child or youth based on the presentation of risk and other treatment needs. Services may also be impacted in the following ways:

- **Conflicting attitudes and values of the various systems regarding treatment approaches – including differences in policy, practice, availability of services, and openness to collaboration;**

- Services can sometimes be limited based on funding limitations;
- For Division of Youth Corrections' (DYC) youth, services can be impacted based on a youth's status; e.g., detention (physical custody) versus commitment (legal custody); and
- Services can also be impacted based on geographic considerations; e.g., some services are either not available or are in short supply – particularly in rural areas of the State.

Constraints have been identified in two areas: one, with Medicaid-funded mental health services in terms of service accessibility and coordination; and, two, from federal restrictions on Title IV-E maintenance funds for early intervention services to prevent a child or family's involvement with child welfare.

Many counties report easier accessibility to mental health services in those communities where there is history of a close working relationship between the county department and local behavioral health organization (BHO). BHO representatives and Health Care Policy and Financing (HCPF) program staff are now participating in quarterly Core Services Coordinator meetings with the goal of improving these working relationships and providing additional education to county staff about how to resolve access issues quickly when they arise.

b. How does it affect how youth are placed (e.g., hospital, therapeutic residential facility, DYC)?

DHS/HCPF Joint Response: Youth in Child Welfare and Youth Corrections are provided the right services at the right time in the most appropriate setting. Local agencies have worked diligently over the last few years to improve coordinated access and expand the array of community-based services and supports for families.

Inpatient psychiatric treatment and residential mental health treatment for children with Medicaid must have prior authorization by the BHO. Authorization criteria include medical necessity, the presence of a covered mental health diagnosis, and confirmation that the child is being served in the least restrictive environment. BHOs are obligated to deny youth in the custody of the CDHS, either in the Division of Child Welfare (DCW) or DYC, who are placed by those agencies in a Psychiatric Residential Treatment Facility (PRTF). Mental health services for these youth are billed to fee-for-service Medicaid and are excluded from the Community Mental Health Services Program.

The DYC has a comprehensive continuum of placement options, ranging from intensive mental health services (both state-operated and Residential Child Care Facility (RCCF)), to non-secure community-based transition services. Youth are placed in the most appropriate setting and provided services as necessary. While there are budgetary ramifications for the types of placements and services provided for DYC youth, a youth's treatment and security needs remain a priority when determining placement.

Ultimately, local courts have the final authority to determine where a child will be placed and under whose jurisdiction. The DYC works very closely with judges and others from the judicial system to ensure children and youth are served appropriately to keep them, their families, and their communities safe.

c. Is DYC being used as a placement of last resort for youth with mental illness?

DHS Response: Colorado has youth services located in three separate entities: the Judicial Branch, when a child is in probation; Child Welfare, when a youth is placed in the legal custody of a county department of human services; and the DYC, when a youth is committed to the legal custody of the CDHS. This trifurcation creates challenges at the case service level that each community must address. The CDHS is working to enable access to mental health and other services to address the needs of the youth when mental health issues are first assessed. Youth should not have to get worse in order to get help.

The CDHS does not currently have actual data that suggests the DYC is a placement of last resort for youth with mental illness. However, a DYC commitment is often the last resort for a youth after a number of other interventions have been attempted at the local level. Current law allows significant discretion on the part of the courts in determining the disposition of youth who are adjudicated as juvenile delinquents. As a result, youth with serious mental health issues can be, and frequently are, sentenced to the three different systems mentioned above. Despite the State's trifurcated system of serving adjudicated juvenile delinquents, there is growing evidence that Colorado's focus on earlier identification and intervention, particularly through local collaboratives such as S.B. 91-94 and H.B. 04-1451, is producing very positive results in the form of lower reliance upon out-of-home placements through both the DCW and DYC systems. As shown in the graphs below, there has been a significant reduction in out-of-home placements as well as the commitment average daily population over the last five years.

Figure 1

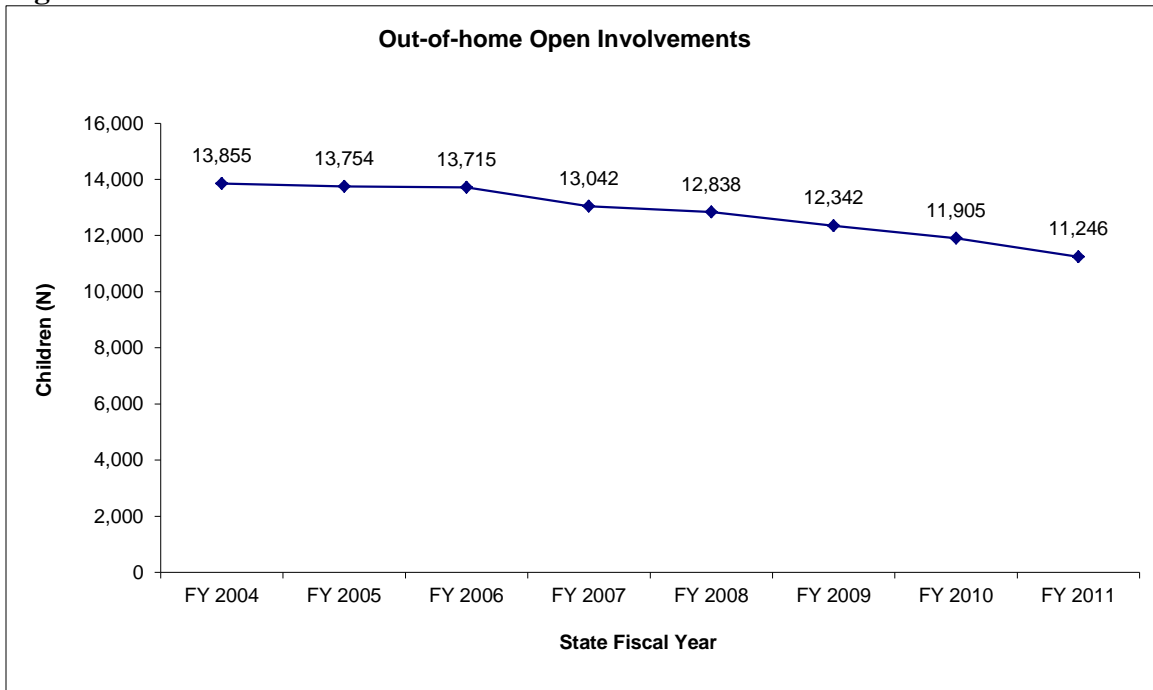
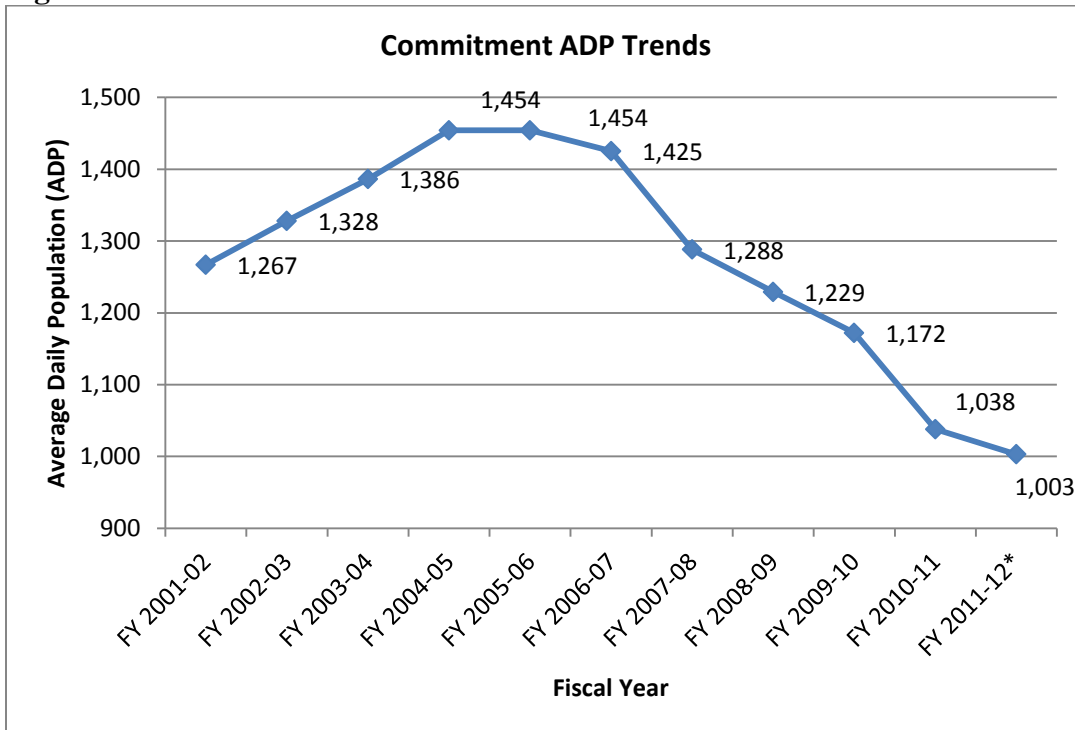


Figure 2



* YTD as of October 2011

The CDHS does believe that there are youth in both the DCW and DYC systems who have a previously undiagnosed mental illness, and for whom earlier intervention and treatment would be the most appropriate approach, as opposed to waiting until a legal

disposition places them in a position to receive services. This is why the CDHS has included in its Strategic Plan a key priority to develop a more coordinated and effective behavioral health system of care for adolescents. This will be a key area of focus for the Office of Behavioral Health and the Office of Children, Youth, and Families over the next year.

d. To what extent is there an exposure to civil rights lawsuits if we are failing to serve kids with mental illness in the least restrictive environment (*e.g.*, if they are being committed to the Division of Youth Corrections due to insufficient treatment alternatives in the community)?

DHS Response: The CDHS is not aware of, nor has it been a party to any litigation, past or present, asserting the State's failure to serve youth with mental illness in the least restrictive environment.

12. How should the State tackle the problems resulting from the multiple funding streams?

a. How do other states manage this funding? Is there a model we could use to improve our system?

DHS Response: Each state approaches funding according to their unique needs within federal funding restrictions and policy guidance.

Possible ideas to explore further in collaboration with other State agencies include:

- **Federal IV-E Waiver. The IV-E Waiver option is discussed later in this document.**
- **Medicaid for community-based mental health services for children, similar to the New York State's home and community-based services waiver, which allows eligible children with serious emotional disturbances to have a package of services geared towards their needs. There are similar waivers in Kansas and Indiana.**
- **Targeted Case Management, trauma assessments of all Medicaid children entering care, and mental health assessments of all children entering care. The CDHS was advised that other states are accessing Medicaid Targeted Case Management funding for children served by child welfare for activities of: referral and linkages, assessment, care planning and monitoring. Medicaid Targeted Case Management funding is available for children who are not eligible for federal Title IV-E.**

Additionally, both the CDHS and HCPF are continuing the research that began as a result of the FY 2011-12 joint legislative Request for Information #2.

b. Do we need to change some of the current funding streams (*e.g.*, carve more or less out of mental health capitation/county departments?)

DHS/HCPF Joint Response: The CDHS is working to improve our funding options and flexibility. The CDHS anticipates pursuing a Title IV-E funding waiver that will result in reductions to entries into foster care while increasing safe family reunifications. The CDHS and HCPF are working together to identify funding stream changes that would

enhance efficiency and service provision without negatively impacting life, health, or safety of clients of either department.

The CDHS does not support carving out funds for this purpose from county child welfare allocations. Carving funding from the counties would have a negative impact on the overall service array offered by county departments. If funds are carved out for this specific activity and the court orders the service to be delivered to the child irrespective of whether the behavioral health organization agrees to serve the child, then counties would have to provide the service within their existing reduced funds.

The Departments are working to improve and expand the availability and coordination of mental health services for children and youth by providing access to trauma and mental health assessments for any child entering out of home care.

c. Is more state oversight or review of placements for youth with multiple needs required?

DHS Response: The Departments do not believe that more State oversight of county departments will resolve the issue. Expanding and enhancing the local collaborative management teams under H.B. 04-1451 and S.B. 91-94 will improve local efforts to build systems of care for families and youth. As shown previously in Figure 1, the counties have done a good job in reducing the number of children in out-of-home care of all types.

For DYC populations, state oversight and review of placement decisions would require state agency participation in decision-making at the county and judicial district. Absent that level of integration, the reviews of individual placements would likely be based on limited information.

The Office of Children, Youth, and Families and the Office of Behavioral Health are currently working together to develop a plan to better serve children and youth with mental health needs who are in the Child Welfare and DYC systems.

d. Does the issue need further study? If so, what would be the best forum for this, *e.g.*, an existing Executive committee or task force? A new group tasked with this created by the Executive or through legislation?

DHS Response: The CDHS, in full partnership with the counties, has three working groups studying these funding issues. One group is focusing on increasing federal revenue of all types. Another work group is focusing on the federal IV-E waiver proposal. A third group is planning the implementation of H.B. 10-1196, which will enhance county flexibility for prevention services.

e. Are there actions you believe the JBC or Committees of Reference could or should take to help address this problem?

DHS Response: The CDHS and the counties are working on several bills for the upcoming session that would benefit from your support. One of the initiatives will expand the definition of kinship, so that children will have an expanded group of caretakers who could be their permanent guardians. Also, the counties will bring forward a bill to expand Differential Response to additional counties beyond the original group of five.

13. Is there any current work being done on this issue that relates to the work of the JBC or the Audit Committee?

DHS Response: The CDHS has set the continuous improvement of the child welfare system as one of its major strategies, including the implementation of the Colorado Practice Model, a data-driven continuous quality improvement effort that leverages best and promising practices through a county peer-to-peer relationship.

a. Are there any initiatives in this year's budget request for Human Services or Health Care Policy and Financing that address this issue?

DHS/HCPF Joint Response: There are currently no initiatives addressing this issue in the budget requests since the Departments are still researching how Medicaid could be utilized to assist counties with funding for the treatment of mental health needs of children who come into the Child Welfare system. The FY 2012-13 budget submission annualizes FY 2011-12 BRI-5: "Refinance \$3,000,000 of Child Welfare Services with TANF" and FY 2009-10 BA #36: "Refinance Core Programs" in which General Fund was refinanced with TANF in the Child Welfare Block and Core line item appropriations.

b. Have there been any audit findings or recommendations that identify this problem and/or recommend a solution?

DHS Response: Not at this time.

14. Have you determined why the Departments of Human Services and Health Care Policy and Financing have such different estimates of the number of children receiving Child Welfare Core Services who are eligible for Medicaid (one department was reflecting 35 percent; the other 64 percent)? If not, when do you expect to know this?

DHS/HCPF Joint Response: The Departments are currently researching the reason(s) for the difference and will submit a written response to the Joint Budget Committee as soon as possible.