Colorado Behavioral Health Organizations Bend the Cost Curve While Increasing Access to Care for Medicaid Beneficiaries

FACT SHEET
June 2011

Background and Methods

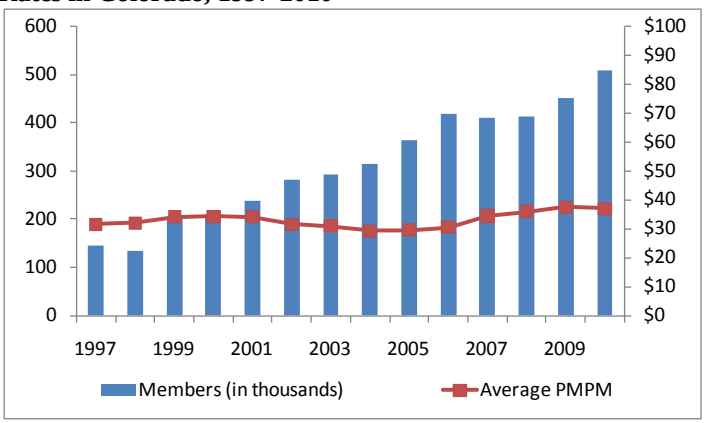
The Colorado Community Mental Health Services Program is a statewide managed care program that provides comprehensive mental health services to all Coloradans with Medicaid. The program is managed by the Colorado Department of Health Care Policy & Financing (HCPF) and is financed under a 1915(b) Managed Care/Freedom of Choice Waiver from the Centers for Medicare and Medicaid Services (CMS). Based on where they live, Medicaid members are assigned to one of five Behavioral Health Organization (BHO)—Access Behavioral Care, Behavioral HealthCare, Inc., Colorado Health Partnerships, Foothills Behavioral Health Partners, and Northeast Behavioral Health Partnership —that arrange or provide for medically necessary mental health services to members in their defined geographic areas of the State. These behavioral health plans are also commonly referred to as carve-out plans. BHOs further their collaboration and strengthen the delivery and coordination of comprehensive behavioral and psychiatric services through membership in the Colorado Behavioral Healthcare Council (CBHC). CBHC is a non-profit 501 (c) 3 membership organization that represents Colorado's statewide network of community behavioral healthcare providers inclusive of 17 community mental health centers (MHCs), 2 specialty clinics, and 5 behavioral health organizations (BHOs).

The CBHC contracted with Altarum Institute, a nonprofit research institution, to conduct an examination of the impact of the managed behavioral health care carve-out model in Colorado on Medicaid spending, quality, and access to care. To conduct this review, Altarum Institute examined and conducted analyses using aggregated data from the CMS and secondary data from Colorado BHOs. In addition, Altarum conducted a focused literature review of the performance of behavioral health care carve-outs compared with other Medicaid financing models, including integrated, carve-in, and fee-for-service models.

Medicaid Behavioral Managed Care Plans Slowed Cost Growth During Rapid Period of Enrolled Member Expansion

In the past twelve years, the number of members enrolled in Colorado behavioral managed care plans has increased substantially, from approximately 150,000 in 1997 to 510,000 in 2010. As the number of enrolled members has more than tripled, BHO plans have been able to sustain their rate increase from approximately $35 Per Member Per Month (PMPM) in 1997 to only $37 PMPM in 2010 (see Exhibit 1). This rate of increase is far less than has been experienced in the overall medical sector. BHO leaders largely attribute their ability to maintain this relatively "flat cost-curve" due to a shift toward community alternatives, early identification and prevention actions. For example, in 1992, prior to implementing behavioral health managed care, 53% of behavioral health expenses in Colorado were devoted to inpatient care, as compared to only 7% in 2010.

Exhibit 1: Enrolled Members in Behavioral Health Plans and Rates in Colorado, 1997-2010

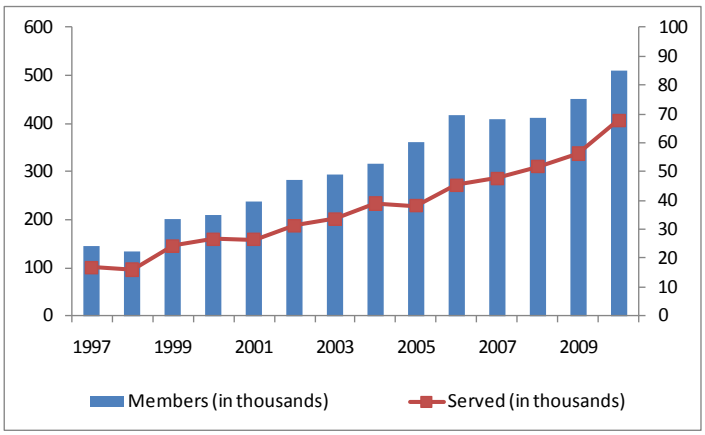


Source: Altarum Institute analysis of Colorado BHO data. The average BHO Per Member Per Month (PMPM) rates above were normalized based on 2010 Eligibility Groups.

BHOs Increased Access to Services to Accommodate Increasing Need While Maintaining Quality

While controlling costs per member, the BHOs have increased access to care. The number of members receiving care has increased more than four-fold from almost 17,000 in 1997 to nearly 68,000 in 2010 (see Exhibit 2).

Exhibit 2: Enrolled Members and Members Served in Behavioral Health Plans in Colorado, 1997-2010



Source: Altarum Institute analysis of Colorado BHO data.

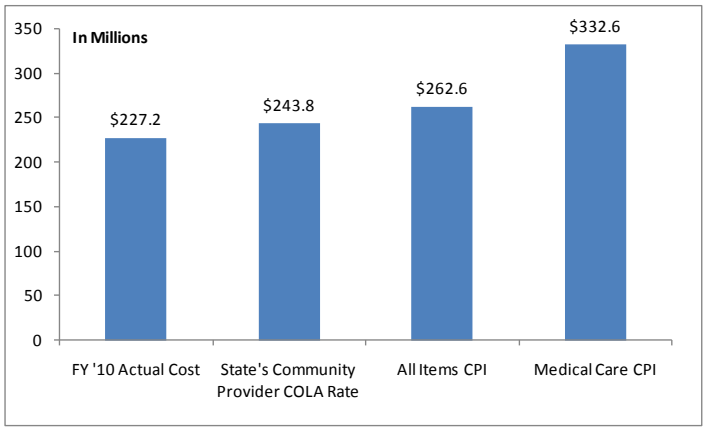
During this period, the 30-day inpatient recidivism rate – one commonly used quality metric – decreased from 13% in 2003 to 11% in 2010. These percentages are equal to or

better than reported averages for other behavioral health plans.[1]

Slower Price Increases in BHO Rates Compared to Comparable Services Saves Colorado Millions

Since 1996, BHO rates have increased at much slower rates when compared to other similar services, resulting in millions of dollars of likely savings for the state of Colorado. For example, in 2010, Colorado spent $227 million on Medicaid behavioral health care. However, if BHO rates had increased similar to the Colorado Community Provider appropriated cost-of-living adjustment rate, it would have cost the State $16.6 million more in FY 2010 to serve all Medicaid eligibles. If rates had increased based on the Medical Care Consumer Price Index (CPI), Colorado would have spent an additional $105 million to treat this population (see Exhibit 3).

Exhibit 3. Actual Cost in 2010 Compared to Projected Costs in 2010 for Colorado If Prices Had Increased at the Same Rate as for Other Services



Source: Altarum Institute analysis of BHO data.

Focused Review of Literature Reveals Behavioral Carve-Outs Consistently Outperform FFS Plans

The experience of Colorado behavioral health carve-out plans is consistent with that observed by a government-sponsored study conducted for the National Institute of Mental Health (NIMH).[2] According to the 4-year study by NIMH, per-member plan costs for mental health/substance abuse service declined by about 40 percent after the carve-out plan was implemented. Access to service, however, increased as treatment prevalence rose almost 50 percent, while the number of visits per patient stayed about the same (see Exhibit 4).

Exhibit 4. Change in Costs and Use in NIMH study of Managed Behavioral Health Carve-Out

Item	Year 1	Year 4	Difference Y 1 to Yr 4
Treatment Prevalence	5.0%	7.3%	+46%
Change in plan costs	---	-7%	-39%
Admissions per 1,000	5.6	5.2	-6%
Mean length of stay in days	24.9	9.1	-66%
Any outpatient use	4.7%	7.0%	+49%
Mean visits per user	7.4	7.6	+3%

Source: Zuveka et. al., 2002

Other studies have demonstrated similar findings that states' Medicaid managed care cost savings are largely attributable to decreases in inpatient utilization. Other common themes we observed during our literature review included the ability of these arrangements to address inefficiencies in the delivery of high cost mental health services. This is accomplished in part, through networks of specialty providers who are experienced in treating this population of patients. Carve-outs also provide service flexibility and tend to shift services towards rehabilitation.

Moving Ahead

Colorado BHOs have demonstrated their ability to bend the cost curve while increasing access to behavioral health care for Medicaid beneficiaries:

- Spending levels experienced by Colorado BHOs over the past decade are lower than would have likely been achieved under traditional fee-for-service or other alternative payment systems.
- While maintaining relatively flat rates, the Colorado BHOs have provided care to many more Medicaid enrollees.

Health care reform presents both challenges and opportunities for designing strategies for maximizing quality and value and achieving efficiencies in behavioral health care. The task is to optimize the value of specialization through behavioral health carve-outs (e.g., demonstrated success in bending the cost curve, highly specialized management expertise and strong provider networks) and the application of strategies to enhance linkage/integration with general medical care (e.g., enhanced communication/information flow, mutual quality accountability, shared savings/incentives). Colorado BHOs have already demonstrated leadership in this area, working in collaboration with the MHCs to implement over 102 integration projects including private primary care providers, federally qualified health centers, community health centers, hospitals, school based health clinics, health departments, and departments of social services.

[1] Hermann RC, Chan J, Chiu WT, Provost SE. Statistical benchmarks for quality measures of mental health and substance-related care. Center for Quality Assessment & Improvement in Mental Health. 2002

[2] Zuvekas SH, Regier DA, Rae DS, et al. The impacts of mental health parity and managed care in one large employer group. *Health Affairs* 2002; 21 (3): 148-59.