

## **CBHC BOARD POSITION STATEMENT 22.0:**

### ***Medicaid Managed Care & the Accountable Care Collaborative Phase II***

#### **Position Statement**

Colorado's Medicaid design must utilize managed care systems that are locally responsive, community oriented, and strengthen Colorado's existing safety net providers.

#### **Background**

In 1995, Colorado took incremental steps to revolutionize the way we understand, deliver, and pay for healthcare with the inception of the Mental Health Managed Care Program. Two years later, [Senate Bill 97-005](#) expanded the program statewide, and the General Assembly declared that it was in the State's best interest to adopt a managed care system to advance Colorado towards the triple aim of healthcare: improving patient experience and healthcare outcomes while lowering costs.

These movements created Colorado's behavioral health capitation model, administered by the Behavioral Health Organizations (BHO), with the primary goals of increasing access to community-based mental health services and lowering the costs of this population to the state. **Nationally, Colorado is known as a trailblazer in healthcare innovation for its established capitated system and dedication to value-based population health care.**

For nearly twenty years, the BHOs served at Colorado's managed care entities (MCEs) for the Medicaid behavioral health benefit. The Centers for Medicaid Medicare & Medicaid Services (CMS) define MCEs as entities that provide services to beneficiaries on a risk basis through a network of employed or affiliated providers. The primary functionality of an MCE is described as accepting a set payment to manage the services for a defined population. CMS outlines that States can better manage costs, utilization, and health outcomes by contracting with an MCE to serve as the benefit manager for a defined population.

In October 2015, HCPF released a concept paper that outlined its vision for Phase II of the Accountable Care Collaborative (ACC). The concept included significant changes to how behavioral health services would be financed and delivered, including eliminating the carved-out mental health capitation program. CBHC members were vocal in our concerns with this proposed shift. HCPF responded to the concerns voiced by advocates of the community-based behavioral health system. On February 5th, HCPF announced that ACC Phase II would be delayed by one year and that the State would retain a modified version of mental health capitation.

In July of 2016, the Harvard Business Review published [The Case for Capitation](#) solidifying the importance of population based payments and a capitated system in achieving the key benchmarks in healthcare reform: improving clinical outcomes, eliminating unnecessary spending, and lowering costs. The article highlighted that provider driven capitation, backed by good reporting and quality measures, is the only payment methodology that adequately achieves necessary components towards this aim:

- ❖ Equips providers with the financial incentives to reduce all types of healthcare waste.
  - By ensuring that providers and insurers have a direct investment in good outcomes population based payments incentivize providing early, high quality care, at lower costs.
  - By controlling for provider risk, capitation allows care providers to realize financial incentives through achieving savings, and not by withholding or limiting care.

- ❖ Allows providers to invest in innovations that control spending and increase value
  - Through incentivizing savings, providers are encouraged to try innovative models that promote best clinical outcomes and reduce costs.
  - By focusing on proactive care, savings are enjoyed by both providers and consumers.
  
- ❖ Creates population health systems that combine payors' and providers' investment
  - By promoting shared risk and shared savings, providers and insurers may join to invest in high quality, high savings care within a population-based payment system.

In 2017, HCPF released the final request for proposals for the new Regional Accountable Entities (RAE), which were designed to bring the management of both primary and behavioral health under one roof. In March of 2017, the CBHC board took a position on the released request for proposals (RFP), outlining the memberships concerns that it did not reflect behavioral health proportionally to the reality of the funding within the program. CBHC members requested that a final RFP “reflects the prominence of behavioral health as the funding indicates, and a recognition that this change to Colorado’s Medicaid program may be significant in the context of shifting healthcare policies at the federal level.”

Following the release of a final RFP, HCPF announced the future RAEs in each region in the fall of 2017. Moving forward, CBHC will continue our commitment to protecting and enhancing the role of safety net providers in Colorado’s Medicaid system, and ensuring that non-profit, locally owned providers have a strong and unified voice in shaping the direction of the ACC.

## Policy Priorities

### 22.1 Supporting Safety-Net Providers

In Colorado’s new Medicaid organization, the RAE in each region has heavy influence over the majority of public dollars dedicated for safety-net services for individuals who are on Medicaid benefits. To ensure that these critical services remain available to Coloradans across the state and that their connection to local communities stays strong, safety-net providers must be leveraged in the ACC Phase II landscape. CBHC members are united in a strong core commitment to provide care for people with limited or no access to care (see CBHC Board Policy Position 9 – Safety Net)

- ❖ CBHC supports policies, regulations, and legislation that requires each RAE to collaborate with and make appropriate finance arrangements with the existing community provider system in their region.
  - Sustain and enhance requirements to pay mental health centers reasonable and actual costs.
  - Promote sub-capitation arrangements and the utilize payment methodology that is closely tied to performance, local community need, and provider risk.
  - Enhance communities’ and local provider input and feedback in policy and regulatory decision making by HCPF and the RAEs.

### 22.2 Appropriate Representation of Behavioral Health

CBHC members have long advocated for an understanding of the impact that appropriate and responsible behavioral health services have on an individual’s life and Colorado’s healthcare landscape. The organization and management of Colorado’s Medicaid program must demonstrate this understanding as well, for the ACC Phase II to achieve the highest possible impact.

- ❖ CBHC supports system reform that appropriately represents the importance of behavioral health providers in Colorado’s Medicaid system and promotes an understanding that behavioral health impacts every aspect of an individual’s life.
  - Promotion of integrated services wherever an individual may be or may prefer them, including the ability for providers to partner effectively.
  - Specific emphasis on the high need population served by community mental health centers, and performance incentives tied to meaningful impact for their care and well-being.
  - Promotion of cross-systems collaboration for prevention and early care programs that protect individuals from needing a higher level of care.
  - Enhancement of behavioral health tenants of recovery and resilience as a driving factor in ACC design, in alignment with the primary composition of the funding.

### **22.3 Connection to Statewide Systems of Care**

CBHC members have long served as the safety net providers for a complex population that relies on various state systems to have access to needed care. To maximize the benefits of this system, achieve the best possible healthcare outcomes, and achieve the cost savings and care coordination goals of the ACC, clear requirements on cooperation between systems must be incorporated into the design of the program.

- ❖ CBHC supports policies, legislation, and regulatory reform that supports a collaboration between various healthcare delivery systems and leverages the strengths of different providers to promote whole-person health and good outcomes.
  - Requirements on the RAEs to engage with Colorado’s Crisis Service Organizations to coordinate how crisis service are utilized by Colorado’s Medicaid population.
  - Clear goals for collaboration between RAEs and the Managed Service Organizations to address the needs of Coloradans living with substance use disorders.
  - Enhancement of the role of Medicaid for criminal justice-involved individuals and other unique populations that have historically experienced lapses in care.

#### **Effective Period**

The Colorado Behavioral Healthcare Council (CBHC) Board of Directors approved this policy on 01/18/2018. It is reviewed as required by the Public Policy Advisory Committee.

#### **Policy Updated**

Updates to this policy position were approved by the CBHC Board of Directors on 04/19/18.

**Expiration: 04/19/18.**