COLORADO
Department of Health Care Policy & Financing
Client & Clinical Care Office
1570 Grant Street
Denver, CO 80203

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The following report was conducted as part of a Quality Improvement Project undertaken by Health Care Policy and Financing in partnership with the Colorado Department of Human Services-Division of Child Welfare.

Since completion of the report in the fall of 2015, several additional steps in the project have been implemented:

- Data analysis on behavioral health utilization for children on Medicaid that are also involved in Child Welfare is being completed by Colorado State University.
- A tool kit for families and child welfare staff to assist in navigating the complexity of the two systems is drafted and being vetted by community partners.
- BHO Directors have participated in Early Prevention Screening Diagnosis and Treatment (EPSDT) training. Several BHOs have subsequently invited department staff to train case managers and other staff on EPSDT requirements.
- A standardized training for Child Welfare Staff on EPSDT has been developed for the Child Welfare Academy.
- The Department continues to collaborate with the BHOs to develop improved processes for children and families involved in Child Welfare to get access to behavioral health services they need, either through their local Community Mental Health Center or a qualified Independent Practice Network.

Thank you to all of the focus group participants and community partners who have provided input and comments to the report.

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Quality Health Improvement Project - Improving Access to Key Services for At-Risk Children and Families

Colorado Department of Healthcare Policy and Financing

March 30, 2016

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INTRODUCTION

In the summer of 2015, Colorado Department of Health Care Policy and Financing (HCPF) contracted with Public Consulting Group, Inc. (PCG) to help identify strategies to improve access to behavioral health services for children and families. For the purposes of this report, behavioral health services include services to treat mental health and substance use disorders (SUD).

PCG has previously partnered with HCPF and other Colorado state agencies including the Colorado Department of Human Services' Division of Child Welfare (DCW) to address the needs of at-risk populations. The work performed for this report has its origins in a number of prior initiatives, including a summary assessment PCG completed for DCW in February, 2014. This 2014 assessment identified opportunities to expand support for children and families served by DCW by leveraging Medicaid funding for services/programs that are currently paid for with state revenues. The report that PCG submitted to DCW[1] included recommendations to expand the provider networks within the Behavioral Health Organizations (BHOs) and increase coordination with Regional Care Collaborative Organizations (RCCOs). Additionally, PCG recommended the continued expansion of the Dental Administrative Service Organizations, increased training/support for front-line staff, and revised cost allocation practices. A primary recommendation from this assessment was to further examine services through the County Core Services programs, which often finance behavioral health services for children and parents/caregivers that may be Medicaid-reimbursable.

Following that study, PCG, staff at HCPF and DCW continued to explore the opportunities noted in the 2014 report. In February, 2015, HCPF invited PCG to join a meeting of a statewide collaborative group to discuss challenges associated with access to behavioral health services for children and adolescents. The entities that participated in this collaborative meeting included HCPF, DCW, the Office of Behavioral Health, the state's Behavioral Health Organizations (BHOs), County Child Welfare departments, County Human Services Directors Association (CHSDA), Colorado Counties Inc. (CCI), and the Community Mental Health Centers (CMHCs). This meeting gave a variety of stakeholders the opportunity to provide perspectives on how children/families access behavioral health services and the capacity of the provider network to impact change within the current landscape.

During the Collaborative Group meeting, participants acknowledged that the systems landscape for accessing, providing and financing behavioral health services is complex. To help clarify the various entities involved in providing, authorizing, approving, and managing behavioral health services for families, we included an organizational glossary, outlining state/local agencies involved in development of the report.
(Appendix 1 – Glossary of Organizations/Agencies Involved in Behavioral Health Services).

From a client and family perspective, navigating the behavioral health system is challenging. It has been discussed that a concerted state-local collaborative effort is needed to improve accessibility and strengthen service quality. It was identified that there was an overriding need to strategically organize systems to ease the burdens that hinder children and families from navigating the system for behavioral health services.

Some of the other key points identified by the Collaborative Group that support this need include, but are not limited to:

- Detailed crosswalk between BHO-contracted providers and DCW contracted providers
- Establishing data exchange between HCPF/BHOs and DCW
- Developing a "common language" and cross training between BHOs and DCW
- Designing care coordination processes to help children/families better access services
- Drafting protocols/strategies to help BHOs and DCW better leverage funding for needed services
- Better aligning the service planning between County child welfare caseworkers and BHO providers, as well as enhanced cross-training between the two entities.

[1] Colorado Department of Human Services: Medicaid Refinancing in Child Welfare, February 24, 2014

Based on recommendations from previous assessments, the meeting in February 2015, and other internal efforts within HCPF and DCW, the scope for completing this report was developed. The purpose of this report is to provide HCPF and state/local partners with analysis, stakeholder feedback, and recommendations to address key issues. This report will identify Colorado's major barriers and recommend strategies to improve access to services for at-risk children and families.

The following summary recommendations are made for HCPF's consideration:

- Focus on immediate, "quick win" efforts to strengthen communication between state agencies to align strategy and program operations.
- Realign current Medicaid programs and services to better meet the needs of children/families that are not directly accessing services through typical channels. Examples of this include: youth involved in the child welfare system; preventative services for families targeting social determinants of health; and enhanced coordination for children and families referred from other sources.
- Structure fiscal incentives and administrative processes to support enhanced provider networks for Medicaid service provision
- Complete a three-phased process with progressive action steps over an approximate two year period:

  Phase I (6-9 Months):
  - Implement quick wins with a particular focus on communications
  - Lay the foundation for significant system continuous improvement work at the state and local levels

  Phase II (9-18 Months):
  - Implement significant system improvements not requiring major new state appropriations, statutory changes, and/or Federal approval
  - Plan RCCO-BHO re-procurement and include targeted outreach for specific populations
  - Strengthen collaborations at the local level through data sharing, role clarification, joint communications, aligned service/treatment planning, and measurement strategies for outcome indicators
  - Align strategies of HCPF, DCW, and OBH

  Phase III (18+ Months):
  - Execute RCCO/BHO re-procurement
  - Fully implement Project COMMIT[2]
  - Implement significant system improvements requiring major new state appropriations, statutory changes, and/or Federal approval
  - Set up and begin using mechanisms for continuous improvement of policy, process, tools, and measures

[2] Project COMMIT refers to HCPF's process to replace its Medicaid Management Information System, which will redefine systems and business processes for the Colorado Medicaid agency. This process will replace the legacy MMIS and fiscal agent services with a service delivery model that is flexible and adaptable, with Business Intelligence and Analytics tools that will provide easy access to data and comprehensive reporting.

METHODOLOGY

The PCG project team completed its work through the following phases:

a) Project Kick-Off and Initial Data Gathering;
b) Conduct On-Site Information Gathering and Focus Groups;
c) Gather Additional Feedback to Further Test Hypotheses:
d) Compile Results and Final Summary Report(s).

a) Project Kick-Off and Initial Data Gathering

The project was initiated by a kick-off meeting, led by the PCG project team and HCPF staff. The meeting included representatives from HCPF and other key stakeholders (DCW State/County Offices, BHOs and/or RCCOs). During the project kick-off meeting, the overall scope of the project was clarified. In addition, there was also a facilitated discussion regarding the need to develop an action plan to address access to high quality services. The Project kick-off meeting helped shape the protocol PCG used to communicate the project and solidify key questions for on-site focus groups. The participants in the project kick-off meeting also helped to identify a detailed list of stakeholders to be a part of the project and key materials for the PCG team to review. The written materials collected/reviewed by PCG throughout the project are listed in Appendix 2 – Listing of Documents/Materials Collected.

b) Conducted On-Site Information Gathering and Focus Groups

The PCG project team conducted various key interviews and focus groups to understand how services are administered at the state and local levels. The primary goal of the meetings/activities in this phase were to identify barriers impacting families covered by Medicaid from front-line staff that have the most contact with the clients being served. The focus group meetings and document reviews also helped the project team explore opportunities to leverage more prevention services for children/families.

Focus group meetings included child welfare case workers and supervisors, CMHC case managers and clinicians, management staff from RCCOs, BHOs, CMHCs, and private providers from the following counties:

- Mesa
- Larimer
- Pueblo
- Logan
- Weld

A number of focus group participants provided details about the broader regions and counties they work in including RCCO representatives with experience throughout multi-county regions and private providers from neighboring counties who traveled to take advantage of the opportunity to speak with the PCG team.

- Confidential conversations with foster parents involved with the child welfare system who struggled in obtaining needed services to address behavioral health needs of the adolescents in their care.
- Focused Interview with representatives from RCCO Region 6.
- Listed in Appendix 3 – Stakeholder participants that took part in our project meetings

In each focus group, participants provided a detailed description of how families currently access services. This included policy-related, structural, programmatic, and fiscal barriers that impact their ability to access services. Recommendations for HCPF and other partners could consider to improve access were also made. Each stakeholder session was guided by the protocol in Appendix 4 – Guiding Protocol for Focus Groups and included ad-hoc discussions in areas of importance to participants.

c) Gathered Additional Feedback via Survey

For counties or other individual participants unable to attend regional on-site focus groups, the PCG team also gathered additional responses from a survey which mirrored the protocol used in focus groups. The survey was provided electronically to all county office staff (caseworkers, supervisors, senior team members, etc.), Community Mental Health Centers (CMHCs), Behavioral Health Organizations (BHOs), Regional Collaborative Care Organizations, and other entities involved in providing care, coordination, case management, and/or direct services to children and families. The survey was available for a week (June 22 – 26), in which PCG project team collected 178 responses. The eight-question survey gathered feedback regarding current provider networks, service timeframes, and general capacity. The survey results are summarized and discussed in the Findings section.

Below we include an aggregated breakdown of the participants. This includes categorical totals for the interviews/focus groups, as well as the feedback survey (which includes over 260 stakeholder encounters).

Organization/Entity	# of Interview or Focus Group Participants	# of Survey Participants
HCPF	12	
CDHS-DCW	6	
	7	28
	30	72
RCCO	7	6
BHO	3	4
CMHCs, BH Frontline & Supervisor, Private Providers	16	5
Other	3 (Families, CASA, Guardian ad Litem)	63
TOTAL	84	178

d) Compiled Results and Final Summary Report(s)

The final report was drafted based on the findings from project. This includes the collaborative meetings with HCPF and state partners, focus groups, interviews, surveys, and documentation review. This report includes recommendations to improve access to services for at-risk children, adolescents, and families, strategies to better align the goals of DCW and Medicaid partners across the state, streamline program operations to simplify county Medicaid, and approaches to potentially reform services.

KEY PRINCIPLES

Throughout the project, the PCG project team noted key principles that were reiterated by stakeholders:

1) Message the rationale for and implications of changes effectively, openly, and honestly to all impacted state and county staff
2) Examine problems from the perspective of consumers
3) Where possible, streamline/simplify processes and procedures versus adding new processes and procedures
4) Connect/align new change initiatives with existing initiatives, under an umbrella of rationalized and simplified overall strategic priorities
5) Leverage this project to strengthen systematic collaboration between HCPF, DCW, and OBH on solutions both under this project and across a broader plane
6) Plan action steps for maximum likelihood of success and sustainability, including organizing them into a roadmap with priorities and phases and assigning accountabilities with attention paid to staff capacity and Identifying and accomplishing quick wins early

FINDINGS

The following are key themes that emerged from our assessment of Colorado's state-supported behavioral health system. The information in the findings section incorporate the summaries for the stakeholder meetings, interviews, and focus groups.

Organizational Readiness for Change

Colorado is uniquely active in innovating both frontline practices and organizational practices which leads to both positive and negative impacts throughout the system. Medicaid covered behavioral health services generally require collaboration between multiple partners at both state and local levels and with multiple steps required before coordinated services can be delivered. This collaboration is hampered by staff turnover and a relative lack of coordination among numerous change initiatives.

Strengths:

- HCPF and DCW have worked successfully in the recent past on joint change efforts. These successful collaborations indicate the two organizations can work together to drive change.

- Both DCW and HCPF demonstrate strong alignment and clarity on core organizational values and priorities. DCW leaders and staff are committed to ensuring children/families are connected to a targeted and tailored set of services. HCPF's overriding focus is managing the administration of Medicaid programs, and providing consistent and fair services to all eligible recipients.

- Many staff members interviewed stated that key changes such as increased reimbursement for Medicaid-supported behavioral health services, and the Collaborative Management Program (CMP) which incentivizes county-level interagency coordination have been beneficial improvements.

- All staff members we interviewed expressed a strong desire to see the needs of vulnerable children, adolescents and families met. We found numerous examples of administrators and service providers at the local level advocating doggedly for the children and adolescents in their care. County DSS/DCW and RCCO administrators were found to be exploring creative options for relieving administrative burdens for Medicaid service providers. State HCPF administrators closely collaborate with DCW counterparts to understand and strengthen the ways Medicaid-supported services can be enhanced with other funding in integrated systems of care, frequently going beyond what was required in their roles to try to meet the needs of uniquely vulnerable populations.

Gaps:

- Public agency staff (state, local, etc.) and other stakeholders involved in the administration of Medicaid programs have reported struggling with the rate and volume of change. There is a multi-year pattern at both HCPF and DCW of frequent change in policies, procedures, and frontline practices needing the following:

    - Analysis as to how these changes impact the ability of staff to successfully implement the changes alongside all other work already assigned to them.

    - Prioritization of changes with respect to other initiatives being implemented at the same time.

    - Communication regarding how the changes build on those that have come before, align with other initiatives being implemented at the same time, and prepare the system for additional changes planned for the future.

- Staff members at both state and county levels and across all major organizational units whose staff we interviewed reported feelings of constant "churn" and confusion regarding priorities. County DCW leadership staff reported that they felt like they were constantly trying to explain how changes fit into an overall strategy, without having adequate tools or communication from the State to assist them. PCG also observed that a multitude of simultaneous initiatives were overarching and not well integrated into the overall DCW mission.

Local staff noted that the multiple strategic frameworks, reporting requirements, working groups, and measures are difficult to implement and can negatively impact day-to-day work. Some of these initiatives that are currently happening, or were recently implemented include Systems of Care, the Accountable Care Collaborative, Behavioral Health Transformation, the Collaborative Management Program (CMP), the Colorado Opportunity Project, The Two Generation Framework, Colorado's Title IV-E Waiver demonstration project, and C-Stat as well as numerous rollouts of evidence-based practices and legislative mandated initiatives. Many of these initiatives cross state agencies and provider organizations, however there is a lack of coordination amongst the State agencies impacted by these initiatives. This results in unintended barriers for front-line staff working directly with children and families, particularly with county DCW staff, BHO providers, and private providers.

- HCPF is actively engaged in Project COMMIT, a project to re-procure and enhance all aspects of the state's Medicaid Management Information System (MMIS), data analytics system, pharmacy benefits systems. This system manages the Medicaid program costs, operations of claims, and overall reporting for Medicaid services. Upgraded systems are scheduled to come online in a phased fashion over the course of 2016 and 2017. The key areas that will change include provider enrollment, current portals for billing and collecting clinical data, and updates to the case management system. While this is a potential strength from a data management and reporting standpoint, it also is one more major initiative taking staff time and energy to properly implement this large scale project.

- There is a multi-year pattern of high staff turnover among state staff and county service providers (e.g., child welfare caseworkers and CMHC therapists). This has led to gaps in knowledge and communication related to Medicaid-supported services and their administrative and programmatic requirements.

- OBH is very short staffed, which makes it hard for them to participate actively in the kinds of systemic and systematic continuous improvement efforts like the one generated in this report.

Service Quality and Access

Medicaid is underutilized for eligible behavioral health services, and particularly outside of the ten biggest counties in terms of population (the "big ten counties"). Some key reasons identified for this problem is an inadequate provider network experienced in treating children and families and the complexity of navigating families to services. There are not enough private providers accepting clients with Medicaid coverage, either because they have not been credentialed by the BHO to serve Medicaid clients or they choose to not accept clients with Medicaid coverage. It was also noted that many providers felt that the overall behavioral health system in Colorado is complicated and difficult to navigate. That said, unique features of Colorado's system (e.g., CMHCs, RCCOs) do provide children, adolescents, and their care givers with service options and access that exceeds those in many other states.

<u>Strengths:</u>

- Colorado's unique network of CMHCs, RCCOs, and Crisis Intervention Teams provide low income, at-risk children/families with service navigation and access to affordable mental health treatment services at levels beyond those available in many other states.

- Many RCCOs and County DHS/DSS offices are doing positive, innovative work to increase provider choice and quality for Medicaid clients. This includes helping private providers become credentialed and provide administrative supports to increase capacity to serve Medicaid clients. They are also leading continuous quality improvement efforts to streamline and strengthen communication and process flows between CMHCs, private providers, BHOs, and county DCW.

- In addition to federally-funded supports (e.g., Medicaid administrative funding, mental health and substance abuse disorder (SUD) block grants), Colorado's legislature and state agencies have provided counties with a uniquely flexible and broad array of funding to help counties meet the needs of particularly vulnerable populations. Examples include Core Services and Child Welfare Block Grant funds to help meet the needs of children and adolescents in child welfare. Also, there are specialized funds for incarcerated adults and juveniles, and twelve (12) Medicaid waivers to support home and community based services for children, adolescents, and adults with moderate to severe disabilities and mental illness.

- In some counties, child welfare administrators emphasized their increased attention and investment in trauma-informed services, signaling a potential shift towards preventing and immediately addressing underlying causes of trauma rather than focusing primarily on treating manifestations of past trauma later in childhood and early adulthood.

Gaps:

- While there are numerous innovative services and programs available to children/families throughout Colorado, Colorado's behavioral health system is highly complex and difficult to navigate for customers and service providers. At the state level, there are behavioral health programs administered by various offices and departments in both the Department of Human Services (e.g., DCW, OBH) and HCPF (e.g., DIDD, Health Programs Office, Long Term Supports and Services), which each issue their own regulations and guidance to county staff and behavioral health stakeholders. At the local level, BHOs, RCCOs, CMHCs, private providers, county DCW, and Community Centered Boards (CCB's – local boards legislatively mandated to coordinate local services for individuals with disabilities) all play important roles in connecting individuals and families with needed behavioral health services, including screening and referral, determination of eligibility, documentation of services, provision of services, planning and coordination of services, funding of services, and claiming reimbursement for services.

- Throughout this effort, the PCG project team has sought clear narratives that describe how customers navigate through the system. These paths differ depending on what the child's presenting needs are, what their income levels are, and other factors. It has been the team's aim to gain a holistic understanding of how the system is supposed to work. The team instead found descriptions of individual behavioral health programs with inadequate reference to how they fit into an overall system. Conversations with state and local stakeholders (e.g., focus group, interview, and working group participants) about how the system works and is supposed to work surfaced differing perspectives regarding, e.g., organizational roles, eligibility for programs and funding support, and funding hierarchy (e.g., which funding source should be tapped first for which service, and under which conditions).

- There are multiple definitions and interpretations of "medical necessity". Medical necessity is the main basis on which children are approved or denied behavioral health services for Medicaid reimbursement. There is a specific definition of medical necessity for children/youth within federal rule. However, many BHOs are not considering this guidance, and have their own applied definitions. BHOs and hospitals appear to interpret medical necessity more narrowly than other stakeholders, causing conflict and multiple inadequate courses of treatment. For example, we were cited multiple instances of a child/adolescent/family member having a course of mental health treatment disrupted. In these cases, therapists considered the course of treatment not yet successfully completed, but the BHO determined that treatment has progressed to a point at which it was no longer medically necessary and therefore no longer eligible for Medicaid reimbursement. BHOs do not need to publish or otherwise disclose the criteria used to determine Medical necessity – these are considered protected, proprietary intellectual property. As a result, approval of therapies and courses of behavioral health treatment for Medicaid reimbursement varies from BHO region to BHO region.
  **There are current efforts across the state (led by HCPF) to create a single, uniform definition of Medical Necessity for all programs, rules, and Department contracts. The development of a single Medical necessity definition is ongoing and is still in its interim stages at the time of this report.*

- HCPF includes EPSDT language within its contracts (with BHOs, RCCOs, services providers, etc.), however it is not consistently followed. Outside of interviews with HCPF staff, the EPSDT (Early Prevention, Screening, Diagnostic, and Treatment) program was not discussed. It appears to be a lack of awareness/understanding about the EPSDT program, even though it is federally mandated methodology for Medicaid clients under the age of 21 and wrapped into HCPF contracts.

- There is a perception among local stakeholders, and particularly child welfare administrators and workers, that opportunities for consistent, timely, appropriate, and high-quality behavioral health care are more limited through Medicaid, leading case managers to opt for service referrals for non-Medicaid providers. This seems to show that Medicaid is not understood by child welfare staff or local providers of services.

- Some common complaints of Medicaid funded services that we heard include:

- Longer wait times between intake, assessment, and initiation of services. For example, the project team was told specific examples of children who waited weeks or even months for specialized services. This includes mental health treatment, intensive community based services for youth, and other developmental delay and disability assessments. As another example, county staff noted that initial intake appeared to generally take place in a timely way and in accordance with contractual and statutory requirements. However, what constituted intake (e.g., assessments administered) varied widely from county to county and service provider to service provider, ranging from a screening, or basic medical history and demographics history to a wide- ranging, comprehensive assessment. Additionally, frequency of therapeutic sessions, with intervals between sessions ranging from every two weeks to once a month that do not align with a child's developmental stage of development for making behavioral changes do not seem to be considered.

- Limited provider choice, due to few providers outside of the CMHC contracted with BHO/Medicaid, and experienced providers able to work with families presented with histories of intergenerational trauma, SUD and risk factors.

- Less well coordinated care: Examples provided include confusion about clinicians able to participate in county child welfare-led Family Engagement Meetings or other staffing after having been told that BHO/Medicaid reimburses only for therapeutic sessions.

- Less continuity of care due to high turnover of therapists at CMHCs, inadequate and inconsistent interpretation of what services Medicaid will pay for, and the role the BHOs play in determining medical necessity. (for example, EPSDT and maintenance of therapeutic sessions)

- The project team observed numerous examples of confusion among both state and local level administrators and front line service providers about what BHO/Medicaid reimburses. HCPF maintains a list of Medicaid-reimbursable interventions. This list changes annually in response to changes in federal rules and regulations, benefit changes. HCPF staff are contacted frequently (sometimes several times per day) with inquiries about Medicaid-reimbursable services.

- Case management and therapeutic services for adolescents (12+) dominated focus group discussions while resources for the early childhood (0-8) population were minimally discussed, suggesting a focus on triage/crisis response versus prevention.
  "Throughout the focus groups and interviews, there was not any mention of the Early Childhood Mental Health (ECMH) partners stationed at each CMHC, who are paid by CDHS. The ECMH providers appear to be ideal partners in providing more preventative services to families with younger children before issues escalate into serious problems for adolescents.

- There are county/local concerns about gaps in key services, some of which varied across localities. The key gaps that focus group participants and interviewees noted are:
  1. Intellectual and Developmental Disabilities
  2. outpatient substance use disorder treatment services for adolescents (ages 12+)
  3. early childhood (ages 0-8) treatment
  4. intensive substance use disorder treatment
  5. resources/programs directed at the middle childhood population (ages 8-12)
  6. trauma informed care that is adequate for families

Fiscal Oversight

The behavioral health services provided by HCPF does not sufficiently target children and families involved with other state systems such as Child Welfare. The availability and flexibility of alternative funds appear to have a generally negative impact on the utilization of Medicaid services. Alternative ways to pay for services, results in potentially duplicative payments due to fewer administrative requirements and less complexity in alternative funding sources. The complexity of the system has also led to confusion about funding hierarchy. Additionally, the way HCPF contracts for local Medicaid care coordination and fiscal administrative services appears to create barriers to efficient local

collaboration.

Strengths:

- Colorado's counties have a pool of funding for behavioral health services generally broader and more flexible than those in many other States. This pool includes funds from DCW (Child Welfare Block Grant and Core Services), OBH (Federal Substance Abuse Prevention and Treatment (SAPT) Block Grant) and HCPF (Medicaid Administration Funds).
- HCPF's contracts with RCCOs and BHOs provide some leverage to increase collaboration amongst local behavioral health stakeholders, and the project team heard examples of some collaboration to strengthen provider networks and close local gaps in service.
- HCPF has recently raised reimbursement rates to levels comparable to other third-party payers.

Gaps:

- At the local level, the variety and flexibility of funds available to pay for behavioral health services provides a viable alternative to strongly pursue Medicaid reimbursement for services. This fact combines with a substantial community of local stakeholders -- most notably county child welfare administrators and private providers – that perceive Medicaid as carrying an excessive administrative burden not adequately compensated through current Medicaid reimbursement rates. As a result, county child welfare administrators and staff routinely utilize funding allocated by the State for child welfare wrap-around services for many behavioral health services that are reimbursable by Medicaid. As a result, these funds are diverted from wrap-around and/or prevention services not reimbursed by Medicaid, with negative impacts on the speed and breadth of implementation of evidence-supported prevention work (e.g., trauma screening and treatment). The project team was told that counties are, for example, paying up to $120 per hour for mental health therapeutic services, which is well beyond reimbursement rates for Medicaid or other third party payers, which allows providers reduced administrative burden.
- There appears to be local confusion regarding which funding sources should be used in what sequence to help at-risk children, adolescents, and families pay for behavioral health services.
- The HCPF contracts with RCCOs and BHOs although they differ significantly in tone and emphasized priorities. BHO contracts read like traditional managed care contracts with major accountabilities focusing on responsible stewardship of public funds and key initiatives (reimbursement, rate capitation, and efficiency). The contract language for RCCOs focus major accountabilities on community collaboration, holistic and integrated care, and expansion of Medicaid service provider networks. The difference in contracting has led to contrasting posture toward local partnerships, day-to-day communication, and differing administrative priorities.

Data and Information Systems

Many at-risk families are receiving behavioral health services administered by multiple state agencies and local offices. This means that data needs to be integrated across information systems to effectively coordinate and track service delivery. Data sharing is currently inadequate at both state and local levels for coordinating care for key populations. Due to minimal state-level interoperability, local staff members are frequently expected to double-enter data for numerous cases, which appears to happen inconsistently and inadequately. HCPF's COMMIT Project represents a major investment of funds and energy with the potential to have a significant positive impact on data analysis, sharing, and reporting capacity.

Strengths:

- The State currently has information systems with useful information regarding client demographics and behavioral health service delivery for data analysis and reporting, including DCW's Statewide Automated Child Welfare Information System, Trails, Colorado Client Assessment Record (CCAR) and HCPF's Business Utilization System (BUS).
- The project team found a number of examples of manual work being required to create services reports for key populations. These reports were generally used for oversight and management decision-making. For example, CDHS recently implemented referral guidelines to counties for all children under the age of 3

being served to be referred to Early Intervention for screening/intervention. This is one of the key populations being monitored and measured at CDHS.

- At the local level, a number of formal mechanisms exist to share information about plans related to behavioral health service delivery for children and adolescents in foster care. This includes county child welfare staff-facilitated Family Engagement Meetings and regularly scheduled case coordination meetings between CMHC therapists, county child welfare workers, and supervisors from both organizations.

- At the state level, there are mandated programs that can be used to share data to better coordinate services for children/youth. Specifically, EPSDT data is required to be collected under Center for Medicare and Medicaid Services (CMS) guidelines, which is broken into child welfare categories that could be useful for CDHS purposes (more informed assessments, joint service planning, and C-Stat measures).

Gaps:

- At the local level, data regarding service provision for adults (parents of the children in treatment) and children/adolescents is generally not integrated, even within individual CMHCs. As a result, service providers to children and adolescents often do not know what, if any, services are being provided to the adults in the same family and vice versa.

- State IT systems have places to enter case information regarding mental health and behavioral health services, but these systems are cumbersome and underutilized:

    - Mental and behavioral health data needs to be entered manually by case workers versus auto-populating (e.g., from provider systems, from each other's systems);

    - The systems are generally complex to navigate. For example, the project team witnessed an IT/Trails expert taking close to ten (10) minutes to navigate to wrap-around screens in Trails. County child welfare staff with access to BUS report that it is complex to navigate as well.

    - County child welfare workers generally do not have clerical support, leading the full burden of behavioral health service documentation to fall on them;

    - Data reports/trends/etc. are not routinely reported to the county child welfare case workers who are expected to double enter information about behavioral health service provision to children and adolescents in foster care, leading them to see limited benefits in their own work from time spent entering data.

    - Screens and fields related to mental and behavioral health are generally not mandatory and/or linked to prompts (e.g., pop-ups, automatic emails) that would keep data entry in the worker's awareness.

    - Clinicians in the CMHCs are required to populate a CCAR (Colorado Client Assessment Record) which includes demographic and clinical data on the overlapping population of DCW and OBH clients, as well as Medicaid covered children.

    - The project team saw evidence in Trails of missing and incompletely entered data, which the team attributes to the factors noted above. Due to the time-limited nature of the project, the team did not have the chance to review sample records from any other systems, including BUS.

- Key populations (e.g., uniquely vulnerable populations like children and adolescents with Intellectual and Developmental Disabilities in the foster care systems) do not appear to have staff assigned to monitor care trends (e.g., from critical incident reports), creating risk that major gaps in care may go undetected and/or unaddressed.

Communication and Coordination

The way organizational stakeholders communicate about and coordinate services for families greatly influences how

services are accessed. Local families, administrators, front-line caseworkers, therapists, and other service providers strongly noted that there are gaps in understanding how to navigate the state's system of care to obtain needed services. Due to the high number of stakeholders that impact service provisions for families; frequent and strategic communications are needed to coordinate and administer appropriate services to children, adolescents, and families in need.

Strengths:

- As noted above, most counties have at least some formal mechanisms for stakeholder dialogue related to coordination of care, including Family Engagement Meetings between frontline workers, families, and natural supports for families and CMHC-DCW staff dialogues and case worker/supervisor/therapist monthly meetings to discuss cases and care trends. The project team also heard about numerous examples of RCCOs brokering community dialogues.

- Among administrators, in participating counties (which currently includes more than half of the State's 64 counties) the Collaborative Management Program appears to have not only sparked dialogues between local government agencies, but also formal and informal dialogue between county DCW leadership, RCCO, CMHC, BHO, and other (e.g., schools, Private Providers) key local behavioral health stakeholders.
- Communication between key state staff (within DCW and HCPF, and between the two agencies/departments) is currently relatively strong, due to:
    - A couple of key DCW positions explicitly devoted to DCW-HCPF coordination (e.g., related to Systems of Care, Individuals with Intellectual and Developmental Disabilities, and a new staff member devoted to Alternative Courts)
    - Regular meetings and discussions between senior-level and mid-level (to a limited degree) DCW and HCPF staff
    - Co-location in the same building of DCW staff (e.g., child welfare licensing/monitoring staff and other key DCW staff) and HCPF staff (e.g., staff newly moved into the 12th floor of the main administration building), respectively
    - Inter-personal relationships between administrative staff
- There appears to be solid potential for strengthened DCW-HCPF collaboration even further:
    - DCW and HCPF both expressed to the project team an interest in strengthened collaboration, both related to strategy and day-to-day operations
    - Cross-departmental initiatives (e.g., Colorado Opportunity Project, Systems of Care, and the Cross Agency Collaborative) that can provide an impetus for more systematic collaboration and coordination
    - Consolidation of key HCPF staff in one building versus spread across several buildings
    - Regular meetings at senior administrator levels with expressed interest in sponsoring coordinated efforts among mid-level staff

Gaps:

- Staff and families report that local behavioral health stakeholder groups generally do not appear to be on the same page about how to best provide services and how to best leverage Medicaid. When they ask the same question (e.g., regarding what services Medicaid will help pay for and who to turn to help get connected with services), they get different answers.

- Communication between key state staff at DCW and HCPF has never been formally instituted, due to departmental silos within agencies that impact children receiving behavioral health services (e.g.,

Placement Services vs. Medicaid Waiver Administration vs. Office of Behavioral Health). Key staff are located on different floors and/or in different buildings, there have not always been routine/systematic mechanisms for inter-departmental communication, and staff turnover at mid- and senior-levels has been high.

- As noted above, local misconceptions (described as "myths" by a number of people interviewed) regarding Medicaid rules and regulations are pervasive, e.g., restrictions on frequency and nature of Medicaid-supported behavioral health services ("no more than one therapy session every 2-4 weeks", "Medicaid doesn't pay for participation in Family Engagement Sessions"). These restrictions appear to result from CMHC local decisions (e.g., as evidenced by the differences in restrictions imposed from county/region to county/region) versus state/ federal regulations.

- At the local level, agencies do not adequately communicate with each other regarding availability of services, options for navigating families to services, and strategies to maximize continuums of care for children with special circumstances.

- Formal processes for communications from the state level to counties are currently inadequate. Strengthened processes may help dispel some of the misconceptions regarding Medicaid rules and regulations.

- There are misunderstandings between local/county knowledge of Medicaid rules, and state formation of Medicaid rules.

Survey Results

As a part of the assessment of access to services for at-risk families, a survey was distributed across the state to gather feedback on the current network of services available and general timeframes for accessing these services. The survey included six (6) multiple-choice questions and two open-ended questions. Multiple-choice questions were generally answered using a four-point scale, ranging from "Agree Strongly", "Agree Somewhat", "Disagree Somewhat", and "Disagree Strongly." To further our findings regarding Colorado families' access to services, the survey results are summarized below (which includes 169 responses from various stakeholders).

Listed in Appendix 4 – Detailed Survey Results, the responses to each question are compiled and reported.

1. **How many responses did we receive from stakeholders? How does our response group represent the community of entitles/providers that serve children and families?**
   The survey received 169 completed responses from approximately 42 of the 64 counties. This group of responses includes the larger and smaller counties (in terms of geographical size, funding, and population served). There is also a strong mixture of personnel that responded to the survey, as approximately 28% of the responses came from caseworkers, with sizeable representation of county management and supervisors.

2. **What appears to be an area of relative gap(s)?**
   Many of the survey question responses showed gaps in children/families having the appropriate access to mental/behavioral health services. The biggest gaps appeared to be families accessing services in a timeframe that meets their needs, as over 70% of respondents felt that this area was not adequate (Question 4 in Detailed Survey Results, combined between "Disagree Strongly" and Disagree Somewhat"). This likely refers to the concerns with service coordination at the local level, as many children have to wait on services in search of Medicaid providers with open slots and/or confusion about how to access services. Many children/families are instead navigated to non-Medicaid providers due to timeliness of care (which is funded through Core Services dollars). This gap aligns with responses from other survey questions, which showed that approximately 15% of respondents noted children/families getting services from Medicaid providers within two weeks. However, 34% of respondents noted that children/families get services from non-Medicaid providers within two weeks.

3. **What appears to be an area of relative strength(s)?**
   An area covered in the survey that showed promise relates to information sharing amongst

mental/behavioral health providers in communities. Approximately 45% of respondents agreed that information is shared between community partners (includes responses for "Agree Somewhat" and "Agree Strongly"). It is important to note that information sharing was noted numerous times as one of the things working well in helping families' access services, and also noted strongly in things not working well to help families' access services. It appears that the level of information shared between providers (county offices, health care providers, RCCOs, BHOs, etc.) varies by county, as some counties have found methods to be more successful at it than others. A potential strength could be using the models from successful counties and implementing these with counties that are not adequately exchanging information.

4. **What are the things that seem to be working well and not working well in families accessing mental/behavioral health?**
   In response to the open-ended questions, respondents reported the following success factors and struggles to helping families access mental/behavioral health services.

   Things Working Well (Success Factors)
   - Increased collaboration and coordination amongst providers (ie.integrated care)
   - Enhanced communications, specifically with caseworker staff
   - CMHC involvement in family engagement meetings
   - Convenient locations of services providers (in-house with county DCW offices, in schools, etc.)

   Things Not Working Well (Struggles)
   - Inadequate provider network (lack of resources and providers that accept Medicaid)
   - High turnover rates (therapists and caseworkers)
   - Major gap areas (minimal respite services, lack of bi-lingual services, substance use treatment)
   - Long time periods before children can receive services and access to intensive services to stabilize children and adolescents in their home and community,
   - Behavioral health systems not responsive to the needs of children and adolescents in the child welfare system

5. **What are the major takeaways from the survey?**
   The survey helped to confirm that there are issues with the structures and systems that impact how children/families can access services. Even though there are some local examples of success stories, the overall responses showed that it is difficult for families involved in the child welfare system to obtain Medicaid services in a timely manner to address mental/behavioral health needs. The key barriers include administrative requirements for utilizing Medicaid services, developing and maintaining the needed provider network to serve this population, and ensuring the families can access actual services in a timely manner (from their initial entry point of involvement with the system).

RECOMMENDATIONS

The following recommendations flow from the project team's analysis of the findings noted above as well as our experience helping health and human services agencies across the United States plan and implement change processes. We propose a three-phased process with the major progressive action steps unfolding over approximately two years. Our recommendations concern both *what* HCPF and its partners may wish to consider doing, and *how* they may wish to consider doing it:

What

Phase I (6-9 months)
Identify and implement "quick wins" while building a foundation for phase II and III action steps requiring advanced planning and resource mobilization:

1) Explore options and implement "quick wins" for lowering the administrative burden on local Medicaid and OBH-supported service providers and DCW staff:
   a) Review Medicaid program business processes and associated documentation requirements for potential streamlining/simplification/greater alignment. *(HCPF/OBH)*
   b) Provide local service providers and child welfare administrators with tools to review their current local

Medicaid administrative practices against what is required in order to identify potential efficiencies *(HCPF, with OBH and DCW)*

2) Review clinician's reimbursement for Medicaid service provision, ensuring general consistency/equity across the state. Strive for parity with reimbursement rates by other third party payers like private insurance companies. *(HCPF)*
3) Strengthen training and communication with county staff and stakeholders (e.g., child welfare, CMHC, BHO, RCCO). Leverage existing statewide opportunities and prioritize clarification of state and federal rules. For example, what Medicaid will pay for, including local Family Engagement Meetings, treatment planning, and frequency of therapy sessions that are allowable.
    a) Identify topics to focus on and key audiences for each topic, including the following:
        i) Guidance for private providers interested in becoming credentialed to service Medicaid clients – benefits to the Provider, how to become credentialed, administrative requirements, available supports
        ii) Guidance for Medicaid clients and frontline staff (e.g., child welfare workers, therapists) - clarification of key terms (e.g., Medical necessity, EPSDT) and why they matter. Additionally, identification of key local and state organizations, Medicaid reimbursable services in general terms, step-by-step guide to getting the help you need. Also consider including core values and/or a client "bill of rights".
        iii) Guidance for "the expert" (i.e., BHO and RCCO staff)-Develop a funding hierarchy for CMHC, county child welfare, and private providers. Documentation of Medicaid reimbursable services in specific terms, options for ensuring continuity of care. For example, how to use non-Medicaid funds to ensure continuity of care for children and adolescents coming into foster care who already receive behavioral health services from non-Medicaid providers. Additionally, leveraging EPSDT Medical necessity definitions, strategies to avoid interruptions in care, how to bill and get reimbursed for services, how to stay current (e.g., with Medicaid billing codes), administrative policies and procedures
    b) Inventory training/communication materials across all Medicaid waivers and Medicaid services and look for opportunities to align, streamline, and/or enhance them (e.g., with easy-to-use desk aids, graphics on such topics as funding hierarchy and preferred/typical client flows). Consider using local staff and stakeholders (e.g., county HCBS waiver program administrators, RCCO and BHO liaisons to HCPF) as reviewers of drafts to ensure that communication tools meet local needs.
    c) Have HCPF staff collaborate with the child welfare training academy staff to prepare to integrate key content specifically about Medicaid- and OBH-supported services into the training academy.
    d) Leverage regular meetings with HCPF contractors and partners (e.g., Collaborative Group, RCCOs) to disseminate updated training/communication materials. Consider additional training options for BHO, RCCO, CMHC, and local child welfare staff, including joint regional training sessions with all key stakeholder groups represented in the room to generate a potential boost to local collaboration.
    e) Review regular process and timeframes for:
        i) Communicating changes to Medicaid rules and regulations (e.g., available billing codes, documentation requirements)
        ii) Periodic updating of communication/training materials to keep documentation current.
4) 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.
    a) Data sharing to ensure that providers have a comprehensive picture of behavioral health services received by all members of a family.
    b) Coordination of services for clients with multiple diagnoses and service needs such as sharing of service plans.
    c) Standardize communication with clients to ensure consistent answers to common questions.
5) Prepare for DCW and HCPF senior leader joint work to streamline and rationalize strategic frameworks and set shared priorities.
    a) Identify a joint group of senior leaders to meet regularly on issues of shared strategic importance
    b) Identify champions of DCW-HCPF collaboration to serve as co-chairs of the group
    c) Draft a short, written charter to frame and guide the joint work of this group
    d) Begin discussions toward identifying shared priorities, including ultimate outcomes and key populations
6) Identify ways to strengthen data sharing and reporting in counties, with a particular focus on connecting records regarding mental and behavioral services to children, adolescents, and adults within the same families.
    a) Review barriers due to privacy regulations (particularly HIPAA and 42 CFR) and identify ways to overcome them.
7) Identify ways to strengthen joint DCW-HCPF reporting pending phase III implementation of the COMMIT

Project. Priorities for enhanced reporting may include:
   a) Sharing of Individual level service data across programs with a focus on identifying and troubleshooting major gaps in services
   b) Identification of key services being provided to target populations and what outcomes these services are generating.
   c) Explore how public funds invested in programs and practices compares with documented outcomes. Utilize data to prioritize and focusing investments on interventions that work.
8) Identify local behaviors that HCPF, DCW, and OBH want to incentivize. Review RCCO, BHO, CMHC, and county child welfare reporting requirements and performance measures and explore alignment of incentives to drive outcomes.
9) Explore opportunities to augment local capacity to provide:
   a) Administrative support to local DCW case workers and/or local DCW staff member experts on wrap- around services, with a particular focus on Medicaid clients.
   b) Administrative support to private providers interested in becoming Medicaid providers.
   c) Align and leverage case management and assessment services for specialized populations (e.g., children and adolescents with Intellectual and Developmental Disabilities or adolescents with a SUD diagnosis.)
10) Inventory and communicate promising care coordination practices across the state.
11) Explore options for limiting the negative impact of differing regional medical necessity determinations on access and continuity of care:
   a) Define and communicate in more specific terms guidance regarding application of "medical necessity" in federal rules for EPSDT and BHO application of medical necessity in determining Reimbursement.
   b) Study states and localities that have succeeded in defining involvement with the child welfare system as medical necessity (e.g., Milwaukee, WI; New Jersey)
   c) Prioritize continuity of care. Explore development of service and billing manual for children and adolescents involved with DCW. There are opportunities to require a Family Engagement Meeting with participation by the contracted BHO therapist before it is determined that a child does not meet medical necessity criteria.
   d) Ensure access in all counties to information regarding the process to appeal denials of coverage on the grounds of medical necessity. Improve the understanding of EPSDT medical necessity defined as "... to correct or ameliorate defects and physical and mental illnesses and conditions. This allows consistency of medical necessity to assure a level of coverage sufficient to treat an already-existing illness or injury, but also to prevent the development or worsening of conditions, illnesses, and disabilities.
   e) Train DCW staff and providers to document child and adolescent needs with a focus toward making a case for medical necessity.
12) Leverage the COMMIT Project to identify existing business processes and the extent to which these business processes will need to change. Where possible, influence system design to support effective administration of Medicaid behavioral health programs and interoperability with DCW systems.
13) Identify options for closing key gaps in service, including:
   a) Incentives and supports for service providers to provide
      i) long-term residential and intensive treatment options for children and adolescents with severe mental illness;
      ii) residential and intensive outpatient SUD treatment programs for adolescents;
      iii) services targeting the unique needs of children ages 8-12; and,
   b) Explore innovative ways to strengthen supports for family members and other care givers (e.g., foster parents, guardians) of children and adolescents with severe behavioral health needs, and particularly those outside of the "big 10" counties. Consider enhanced use of telemedicine and peer support models (e.g., parent2parent) to reach families across the state while limiting burdens on both families and medical professionals.
14) Identify options for closing key gaps in timely screening and assessment, including in particular:
   a) Screening of young children (0-8) for developmental delays and/or trauma and social determinants of health
   b) Specialized assessment to determine medical necessity for specific service needs like Autism or other IDDs
   c) Screening of adolescents and parents for SUD
15) Consider incentivizing service providers based in "big 10" counties to travel on a regular schedule to rural counties on the Western Slope, in the Northeast, and in the Southern regions of the state.

16) Identify options for strengthening fiscal incentives for county child welfare to use Medicaid versus State general funds to pay for reimbursable behavioral health services.
17) Develop an action plan for implementing changes needed in phase II and III.

Phase II (9-18 months)
Begin implementing the action plan developed in Phase I, with particular attention paid to roles, relationships and communications. Continuously improve the action based on regular monitoring of progress, impact, and lessons learned:

1) Investigate options for lowering the administrative burden on local Medicaid and OBH service providers.
2) Explore reimbursement methodologies for Medicaid service provision.
3) Further strengthen training and communication with county staff and stakeholders.
4) Strengthen data sharing and reporting in counties.
5) Update reporting requirements and performance measures with stronger incentives for desired local stakeholder alignment that would not requiring state statutory changes and/or federal approval of changes to waiver provisions and/or Medicaid State Plan.
6) Incentivize promising care coordination practices across the state.
7) Identify actions to close key gaps in timely assessment.
8) Examine options for strengthening fiscal incentives for county child welfare to use Medicaid versus State general funds to pay for reimbursable behavioral health services.

Begin work on remedying the most challenging barriers to effective administration of Medicaid services to vulnerable children and adolescents:

9) 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.
10) 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.
11) 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. Align values/guiding principles and develop a logic model from major programs/funding streams through outputs to outcomes, and a performance dashboard of a key shared performance measures.
12) Work to influence system designs as part of the COMMIT Project to support effective administration of Medicaid-supported behavioral health programs.
13) Prepare for RCCO and BHO joint re-procurement using a performance-based contracting model:
    a) Study performance-based contracting models and experiences from other states/sectors
    b) Develop array of output and outcomes measures, including those with meaningful annual results and others requiring the full life of the contract to show an impact
    c) Identify consistent ways to report on and track output and outcomes measures
    d) Identify and incorporate opportunities for:
        i) defining Medical necessity in greater detail and with more consistency
        ii) incorporating EPSDT more systematically into the day-the-day planning and administration of Medicaid-supported behavioral health services
        iii) growing the Medicaid provider network

iv) incentivizing innovative care coordination practices that have shown to be effective, and incentivize continued experimentation/innovation
v) hardwiring continuous improvement of business processes

e) Identify payment structures that both reward performance exceeding benchmarks and penalize performance below benchmarks

Phase III (18+ months)

1) Continue implementing the action plan developed in Phase I and continuously improve based on lessons learned from Phase II, including implementing options requiring statutory changes, new funding appropriation requests, changes to current appropriations, and/or Federal government approval for desired changes.
2) 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.
3) Support implementation of the COMMIT Project, with a particular eye toward strengthening Medicaid waiver program administration, DCW, HCPF, and OBH interoperability, and reporting to support implementation of the newly integrated strategic framework.
4) Seek ways to strengthen joint reporting/interoperability between DCW, HCPF, and OBH.
5) Implement options for incentivizing counties to use Core Services funds for services that Medicaid does not reimburse.
6) Implement RCCO and BHO joint re-procurement using a performance-based contracting model.

How

1) Overall, PCG recommends that HCPF and its partners at DCW – the steering group that has overseen the development of this report – and OBH move from recommendations to an implementable action plan:
   a) Prioritize recommendations and identify a final set of action steps that the group will recommend to DCW, OBH, and HCPF senior leadership for implementation
   b) Identify a lead staff member charged with overseeing implementation and continuous improvement of agreed to action steps (e.g., a "Child and Adolescents Behavioral Health Improvement Manager" as described in *what* recommendation #3 above)
   c) Identify lead staff people for each action step approved by senior leadership
   d) Have the lead staff people identify more discrete action steps and timeframes for completion of Phase I action steps
   e) Combine these discrete action steps into a Phase I action plan and begin implementing, monitoring the plan regularly for progress, impact, and lessons learned; adjust the plan as needed in response to evolving lessons learned
   f) At completion of Phase I, develop and begin implementing a Phase II action plan, repeating steps a-d
   g) At completion of Phase II, develop and begin implementing a Phase III action plan, repeating steps a-d
2) Changes with an impact on county staff and other stakeholders will have the highest likelihood of success and sustainability if they:
   a) improve communication and make work easier/more streamlined
   b) are well explained, with a clear rationale
   c) feel "co-owned" by county stakeholders through use of state-county working groups and/or multiple feedback loops prior to statewide rollout
3) Phase II and III will be made slightly easier if DCW, HCPF, and OBH can find and implement a few Phase I "quick win" opportunities. These opportunities could help align DCW, HCPF, and OBH strategic priorities and clarify state and county accountabilities, priorities and performance expectations.

4) Review/strengthen communication with counties about ALL available Medicaid- and OBH-supported services for child welfare, and ideally non-Medicaid supported wrap around services as well.
5) Any change that may be perceived by stakeholders shifts in resource investment and should ideally be communicated as part of a "package" of changes that also includes perceived "value adds".
6) Physically locate HCPF staff members knowledgeable about Medicaid-supported services for child welfare at DCW for a portion of each week (e.g., two regularly scheduled days, so DCW staff knows when/where to contact him/her/them).
7) Leverage a portion of HCPF staff time at DCW to also strengthen connections and collaboration with OBH staff.
8) Look for opportunities to engage OBH actively in implementation efforts going forward.

Appendix 1 – Glossary of Organizations/Agencies/Programs Involved in Behavioral Health Services

- BHO – Behavioral Health Organization
- CASA – Court Appointed Special Advocates
- CCI – Colorado Counties Inc.
- CHSDA – County Human Services Directors' Association
- CMHC – Community Mental Health Center
- DCW – Colorado Department of Human Services, Division of Child Welfare
- DHS County – County Offices that Administer DCW Services
- DIDD – Division of Intellectual and Developmental Disabilities
- EPSDT[3] - Early Periodic Screenings, Diagnosis, and Testing
- GAL – Guardian Ad Litem
- HCPF – Colorado Department of Health Care Policy and Financing
- MHASA – Mental Health Assessment and Service Agency
- OBH – Office of Behavioral Health
- RCCO – Regional Care Collaborative Organization

[3] The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program is a mandatory service under Medicaid that provides preventive and comprehensive health services for Medicaid-eligible children and youth up to age twenty-one (21). The EPSDT Program was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) legislation and includes periodic screening, vision, dental and hearing services. These services were expanded in section 1905 (r) (5) of the Social Security Act (the Act) to require that any medically necessary health care service listed in section 1905 (a) of the Act be provided to an EPSDT beneficiary even if the service is not available under the State Plan.

Appendix 2 – Listing of Documents/Materials Collected

- HCPF Provider Bulletin, May 2015: The periodic update released to inform the provider community on upcoming initiatives/events related to Colorado's Medicaid programs
- Child Welfare SubPac – Developmental Disabilities Task Group Meeting (March 27, 2014): Policy Advisory committee notes regarding rule changes, statutory changes, and policy issues
- Interim Report from the Policy and Finance Task Group (October 2012): Overview of the study, conclusions, and funding model methodology to best serve youth with developmental disabilities in the child welfare system
- Themes from Gap Analysis Community Meetings and Survey: Summary of Colorado Collaborative for Autism and Neurodevelopmental Disabilities Options (CANDO) to build a responsive system for coordinated services, crisis prevention, management, and stabilization for people with neurodevelopmental disabilities
- Behavioral Health Care for Children in the Child Welfare System – A Vision for Colorado: Interagency report on the vision for an "ideal" behavioral health system for children
- Improving Behavioral Health Outcomes for Children and Youth in the Child Welfare system: Notes from a series of regional forums hosted by the Office of Behavioral Health in Pueblo, Brighton, and Glenwood Springs (July/August 2014)
- Behavioral Health Needs Analysis: Study conducted for the Human Service's Office of Behavioral health regarding an analysis of Colorado's needs for behavioral health services
- Center for Health Care Strategies, Inc. – Making Medicaid Work for Children in Child Welfare: Examples from the Field (June 2013)
- State Policy Advocacy and Reform Center – Child Welfare Funding Opportunities: Title IV-E and Medicaid
- State of Colorado, House Bill 13-1314
- Pueblo County Department of Social Services Strategic Plan for Child Welfare Division
- Foothills Behavioral Health Partners – county Department of Human Services Staff Survey Report (3/17/2015)
- Form CMS-416: Annual EPSDT Participation Report (Fiscal Year 2013)
- National Institute of Disability and Rehabilitations Research, United States Department of Education and the Center for Mental Health Services – Things People Never Told Me
- Behavioral Health Organization Contracts and Performance Measurement Scope Documents (HCPF Website, www.colorado.gov/hcpf)

Appendix 3 – 2015 Stakeholder Register

(Name, Position, and Department/Agency):

- Camille Harding, Quality and Health Improvement Unit Manager, HCPF
- Gina Robinson, Program Administrator, HCPF
- Lenya Robinson, BH and Managed Care Program Section Manager, HCPF
- Christian Koltonski, Quality and Health Improvement Unit, HCPF
- Melinda Cox, Core Services and Prevention Programs Administrator, DCW
- Crestina Martinez, Government Relations and Partner Outreach, HCPF
- Heidi Walling, Quality Unit, HCPF
- Gretchen Russo, Permanency Unit Manager, DCW
- Andrew Johnson, Youth Services Manager, DCW
- Robert Werthwein, Director, DCW
- Les Cowger, Finance Manager, DCW
- Claudia Zundel, Family and Children's Programs Director, DCW
- Jennifer Martinez, HCBS Supervisor, HCPF
- Candace Bailey, Children's Waiver Specialist, HCPF
- Jed Ziegenhagen, Deputy Medicaid Director, HCPF
- Lori Thompson, Deputy Division Director, HCPF
- Sheila Peil, Children's Program Specialist, HCPF
- Christina Chavez, HCPF Systems, HCPF
- Randi Wilson, HCPF rates, HCPF
- Mesa DHS County Office
- Larimer DHS County Office
- Pueblo DHS County Office
- Logan DHS County Office
- Weld DHS County Office
- Mindsprings Health
- Rocky Mountain Health Plan
- Colorado Access
- Touchstone Health Partners
- AspenPointe
- Other State Partners (Regional Collaborative Care Organizations, Community Mental Health Centers, Behavioral Health Organizations, Service Providers, etc.)
- Survey Participants from over 42 Counties

Appendix 4 – Guiding Protocol for Visioning Sessions

I. OVERVIEW

A. Brief Overview and Purpose

As a part of PCG's support for the Quality Health Improvement (QHI) project, PCG is preparing to provide consultation and expertise to the Colorado Department of Health Care Policy and Financing (HCPF). This support will help HCPF, as well as other service entities in the state, improve access to key services for at-risk families. PCG's support activities include the facilitation of collaboration meetings, key informant interviews, focus groups, and other related tasks. This document will serve as the guide for all support activities.

PCG will use a collaborative approach to provide HCPF a comprehensive report, outlining recommendations to better engage Colorado stakeholders and improve system access/coordination of services for at-risk families. An additional support offering includes the provision of technical expertise for Colorado State University in matching child welfare data (obtained directly from DCW – Colorado Department of Human Services) with Medicaid claims information.

The following DHS county offices were targeted to participate in the QHI support activities:

- Northern Region – Larimer County
- Eastern Region – Logan County
- Southern Region – Pueblo County
- Western Region – Mesa County

PCG aims to conduct six (6) interviews and at least four (4) focus groups with a range of leaders, staff, and other stakeholders within Colorado's provider network (HCPF, DCW, County DHS Offices, and the Behavioral Health Organizations). During these meetings, participants will discuss methods to leverage available provider services (specifically county DHS offices and BHOs) for at-risk families, identify opportunities for "quick wins" that can make an immediate impact on current services, and longer-term considerations for policies, system integration, and stronger collaborations.

B. Schedule

Below is tentative schedule of the QHI support activities and dates:

QHI Support Activity Schedule	
Activity	***Date***
Identify the 4 counties targeted for participation in focus group forums (HCPF)	5/13/15
Make initial contact with 4 targeted counties (HCPF)	5/28/15
Conduct Stakeholder Kick-Off Meeting (PCG/HCPF)	5/28/15
Distribute agendas to all 4 counties (PCG/HCPF)	6/3/15
Set schedules for onsite visits (PCG/HCPF)	6/3/15
Onsite visits (PCG/HCPF)	6/8 – 6/11/15
Colorado materials review (PCG)	5/28/15 – 6/11/15
Submit Draft Report (PCG)	6/30/15

II. QHI Support Activities

A. Material Review

The stakeholders targeted to participate in the focus groups and interviews will provide the PCG team with any written materials that will help to inform the provider network review plan and final reform recommendations. Materials should include but not be limited to any prior surveys, organizational assessments, strategic plans, data reports, strategic communications, and meeting notes that would give the PCG team additional insight and a deeper understanding of the stakeholder's current strategy, approach to work, and communications with other organizations.

B. Targeted Focus Groups and Individual Interviews

For this specific assessment, the PCG Team plans to conduct interviews with senior leaders and focus groups with a representative sample of staff across each organization or regional office. The PCG Team generally targets key individuals with disproportionate influence over the organization/office (e.g., directors, program managers, board members, and executive leadership) for one-one interviews or, where it makes most sense, small focus groups (with no more than three individuals at once), with each interview lasting approximately 45 minutes.

In addition, for focus groups we target a representative cross-section of staff and other stakeholders able to provide insight into the organization's service provision and front-line interactions with children and families. Our ideal is focus groups 1.5 hours long and consisting of 6-12 participants per session, though we have conducted focus groups with larger numbers.

We recommend meeting with supervisory staff separately from individual contributors. For individual contributor staff, we propose integrated focus groups that include staff members from different programs in the same room together. Ideally, we meet separately with staff who share similar roles (e.g., caseload-carrying staff, data team members, administrative, etc.). However, if scheduling does not permit this separation, we can also accommodate staff sessions with a mix of roles represented. Our number one priority is to provide staff with valuable insights, maximum opportunity to participate, and the ability to work with lead staff to develop customized schedules and groupings that work best for the organization/office.

C. Logistics

For interviews, we need a space where confidential conversations can take place and seating arrangements that allow for relaxed dialogue between people positioned as equals (e.g., seated at a table versus across the interviewee's desk). We ideally need a table of some kind to allow for comfortable note taking.

For focus groups, we need a space to comfortably accommodate all participants. Our preference is for an "open u" or boardroom-style room set-up that allows all participants to see each other's faces while being oriented toward a space for the facilitator to occupy. We need at least one flipchart with markers, an easel, and adhesive for sticking paper to the wall (i.e., either "self-sticking" flipcharts or masking tape). If possible, facilitators should be able to get into the room for focus groups at least 15 minutes prior to the beginning of the session.

For all interactions that the PCG team will have with stakeholders, we want to ensure that the reason for this scope is clearly explained and understood by all participants. To this end, we will use the following language for written and verbal communications to introduce all HCPF assessment and planning activities:

"The Colorado Department of Health Care Policy and Financing (HCPF) and Public Consulting Group (PCG) are working together to develop strategies that improve access to key services for children and families. PCG has almost 30 years of experience helping health, human services, and education agencies improve services and outcomes for individuals and families in need of public assistance.

PCG's support aims to help HCPF and other Colorado stakeholders improve outcomes for youth receiving services from multiple providers. Our support activities include a materials review, on-site interviews and focus groups, remote conference calls with key stakeholders, and a summary report with actionable recommendations. The summary report will aggregate any feedback obtained through interviews and focus groups into cross-cutting themes; at no time will input provided be tied directly to any individual.

Our focus is on how the state's systems (Medicaid system and Child Welfare system) work together in ways that either help or make accessing services more difficult for children and their families. Our focus is NOT on funding allocation or budget reductions, but solely on improving the access and provision of services."

D. Interview/Focus Group Questions

Below is a short menu of the questions that may be asked of the group/interviewees. The focus and energy of the group/interview will determine which specific questions will be chosen:
**Current set of questions are written specifically from the perspective of County DHS Offices.*

1. What was your best day on the job in the past year? Why?

2. To what extent are DHS children/families getting services (Medicaid/BHO services) they need? In a timely manner? Of desired quality? Do the youth and families you serve agree with this? To what extent do feel they are getting timely and quality care and treatment? And how do you know?

3. How do you see the difference and relationships between the Behavioral Health Organization (BHO), Accountable Care Collaborative (ACC), and Community Mental Health Center (CMHC) in your community? How and how frequently does your organization interact with each entity (how frequently, at what levels of the respective organizations, etc.)?

4. Do you know that other providers are available under the BHO network outside of the CMHC? Do you know what primary care offices also include behavioral health so that families have access to a one stop shop? Do you know how to locate a therapist that has been trained in trauma care?

5. What is the general cultural makeup of the community your agency services? What specific efforts are made to ensure that children and families receive culturally competent mental and behavioral health services?

6. Describe the protocol DHS county staff utilizes to access Medicaid/BHO services:
    - Have children/families ever been denied services? If so, are there clear reasons and is there an appeals process?
    - To what extent are these services included in case plans?
    - In what ways do you help families' access services when a child is placed outside of your county and/or in the catchment area of a different BHO or ACC?

7. Describe any case-specific collaborative experiences between DHS and BHOs. For example, have there been children/youth/families that have benefited from joint planning between DHS and BHOs? If yes, how did that go? If no, why not?

8. More generally, what is currently going well in terms of collaboration with Medicaid/BHO providers in your region? What is not going as well? Why do you think that is, and what could help make things better?

9. Think about a family's typical experience in navigating the system to access available resources (both DHS-related and health-related):
    - Can you think of specific examples of positive experiences? What went well with those specific cases?
    - Can you think of specific examples of experiences that were not as positive? What did not go as well with those specific cases?
    - What helps DHS staff most in helping families achieve successful outcomes?

10. What, if any, other kinds of information (child-specific data, materials, family records, etc.) would help you better connect children/families with health interventions/treatments? Are there improvements that can be made to the information you already get?

11. What is your understanding of what constitutes "medical necessity"? To what extent do you feel that you can identify medical necessity?

12. What doesn't Medicaid pay for that you generally use Core Services dollars to cover?

Appendix 5 – Detailed Survey Results

2. Please select your position type.		
Answer Options	Response Percent	Response Count
DCW County Staff - Management	15.8%	27
DCW County Staff - Supervisor	10.5%	18
DCW County Staff - Caseworker	28.1%	48
Community Mental Health Center	2.9%	5
Behavioral Health Organization	2.3%	4
Regional Collaborative e Care Organization	3.5%	6
Other	36.8%	63
	answered question	171
	skipped question	0

3. Please select a response to the following: Children/Families are generally able to access the quality mental and behavioral health services that meets their needs.		
Answer Options	Response Percent	Response Count
1 - Disagree Strongly	24.0%	41
2 - Disagree Somewhat	38.0%	65
3 - Agree Somewhat	33.3%	57
4 - Agree Strongly	4.7%	8
	answered question	171
	skipped question	0

4. Please select a response to the following: Children/Families are generally able to access quality mental and behavioral health services in a timeframe that meets their needs.

Answer Options	Response Percent	Response Count
1 - Disagree Strongly	35.7%	61
2 - Disagree Somewhat	35.1%	60
3 - Agree Somewhat	25.7%	44
4 - Agree Strongly	3.5%	6
	answered question	171
	skipped question	0

5. Please select a response to the following: The Medicaid provider network in the community(ies) you serve generally meet the needs of children/families served by the County Department of Human Services

Answer Options	Response Percent	Response Count
1 - Disagree Strongly	25.7%	44
2 - Disagree Somewhat	32.7%	56
3 - Agree Somewhat	33.9%	58
4 - Agree Strongly	7.6%	13
	answered question	171
	skipped question	0

6. Please select a response to the following: Information is generally shared effectively between mental/behavioral health providers in your community(ies) (Departments of Human Services, physical health care providers, the Regional Collaborative Care Organizations, and Behavioral Health Organizations, private providers)

Answer Options	Response Percent	Response Count
1 - Disagree Strongly	22.2%	38
2 - Disagree Somewhat	32.7%	56
3 - Agree Somewhat	36.3%	62
4 - Agree Strongly	8.8%	15
	answered question	171
	skipped question	0

7. What is the typical length of time from intake to first receipt of mental/behavioral health services (e.g., first therapy session) from Medicaid providers for children/families served by the County Department of Human Services?		
Answer Options	Response Percent	Response Count
1 - One week or less	2.9%	5
2 - 1-2 weeks	11.7%	20
3 - 2-4 weeks	40.9%	70
4 - 5-10 weeks	15.2%	26
5 - More than 10 weeks	2.9%	5
6 - Unknown	26.3%	45
	answered question	171
	skipped question	0

8. What is the typical length of time from intake to first receipt of mental/behavioral health services (e.g. first therapy session) from non-Medicaid providers from children/families served by the County Department of Human Services?		
Answer Options	Response Percent	Response Count
1 – One (1) week or less	12.3%	21
2 – 1-2 weeks	21.1%	36
3 – 2-4 weeks	19.9%	34
4 – 5-10 weeks	11.7%	20
5 – More than 10 weeks	1.8%	3
6 - Unknown	33.3%	57
	answered question	171
	skipped question	0

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