JOINT BUDGET COMMITTEE

STAFF BUDGET BRIEFING
FY 2017-18

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

(Medicaid Behavioral Health Community Programs)

JBC WORKING DOCUMENT - SUBJECT TO CHANGE
STAFF RECOMMENDATION DOES NOT REPRESENT COMMITTEE DECISION

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CONTENTS

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

DEPARTMENT OVERVIEW

The Department of Health Care Policy and Financing (HCPF) helps pay health and long-term care expenses for low-income and vulnerable populations. To assist with these costs the Department receives significant federal matching funds, but must adhere to federal rules regarding program eligibility, benefits, and other features, as a condition of accepting the federal money. The largest program administered by HCPF is the Medicaid program (marketed by the Department as Health First Colorado), which serves people with low income and people needing long-term care. The Department also performs functions related to improving the health care delivery system. This Joint Budget Committee staff budget briefing document concerns the behavioral health community programs administered by HCPF.

Behavioral health services include both mental health and substance use disorder services. Most behavioral health services are provided to Medicaid-eligible clients through a statewide managed care or "capitated" program. The Department contracts with five regional entities, known as behavioral health organizations (BHOs), to provide or arrange for medically necessary behavioral health services to Medicaid-eligible clients. Each BHO receives a pre-determined monthly amount for each client who is eligible for Medicaid behavioral health services. In addition to funding for capitation payments to BHOs, a separate appropriation covers fee-for-service payments for behavioral health services provided to clients who are not enrolled in a BHO and for the provision of behavioral health services that are not covered by the BHO contract.

Behavioral health services are primarily supported by General Fund and federal funds. Cash fund sources include the Hospital Provider Fee Cash Fund and the Breast and Cervical Cancer Prevention and Treatment Fund.

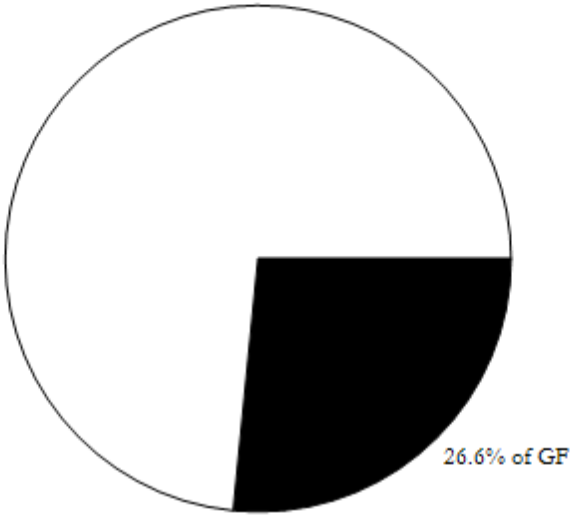
DEPARTMENT BUDGET: RECENT APPROPRIATIONS

FUNDING SOURCE	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18 *
General Fund	$2,352,933,836	$2,500,140,061	$2,654,394,214	$2,797,230,737
Cash Funds	902,103,342	1,156,297,382	1,012,485,521	1,020,139,119
Reappropriated Funds	6,104,791	17,003,651	12,406,599	16,069,145
Federal Funds	4,675,575,363	5,438,943,180	5,437,594,544	5,656,948,374
TOTAL FUNDS	**$7,936,717,332**	**$9,112,384,274**	**$9,116,880,878**	**$9,490,387,375**
Full Time Equiv. Staff	390.9	422.2	435.8	452.9

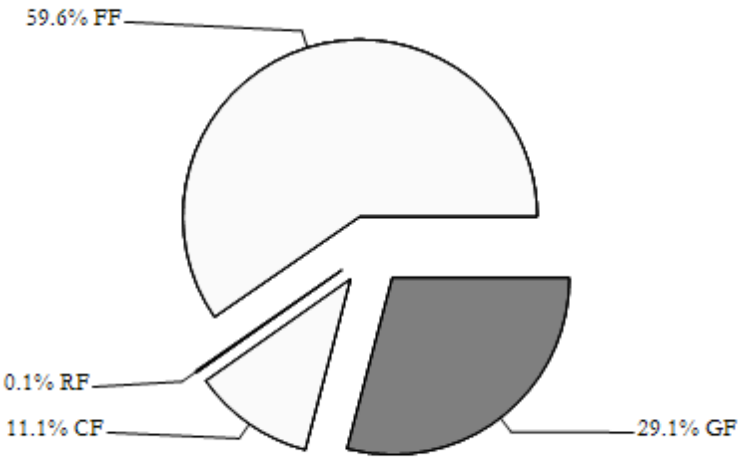
*Requested appropriation.

DEPARTMENT BUDGET: GRAPHIC OVERVIEW

Department's Share of Statewide General Fund

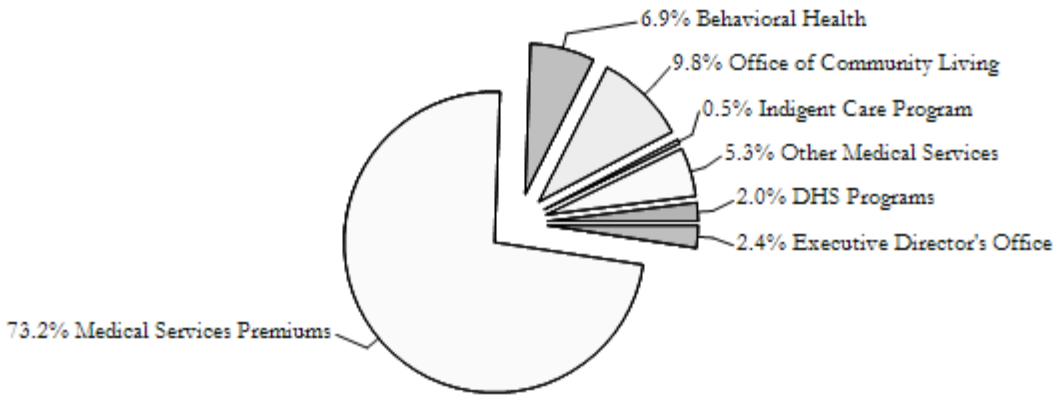


Department Funding Sources

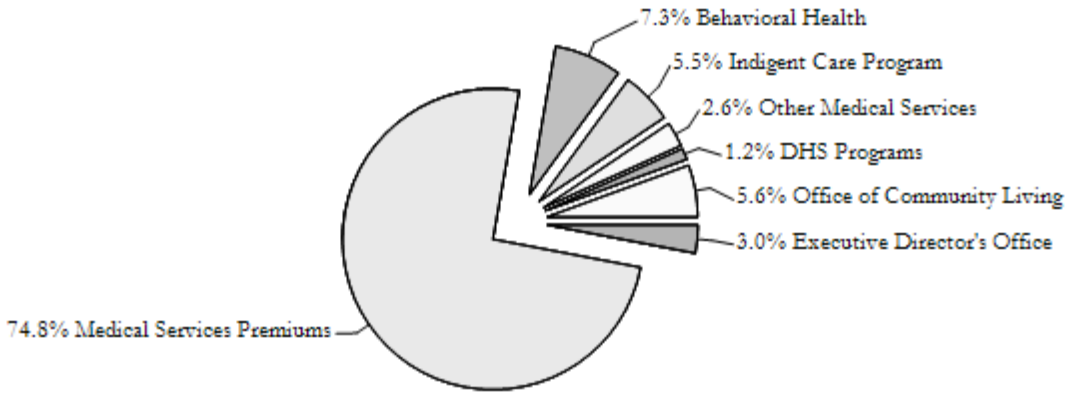


All charts are based on the FY 2016-17 appropriation.

Distribution of General Fund by Division



Distribution of Total Funds by Division



All charts are based on the FY 2016-17 appropriation.

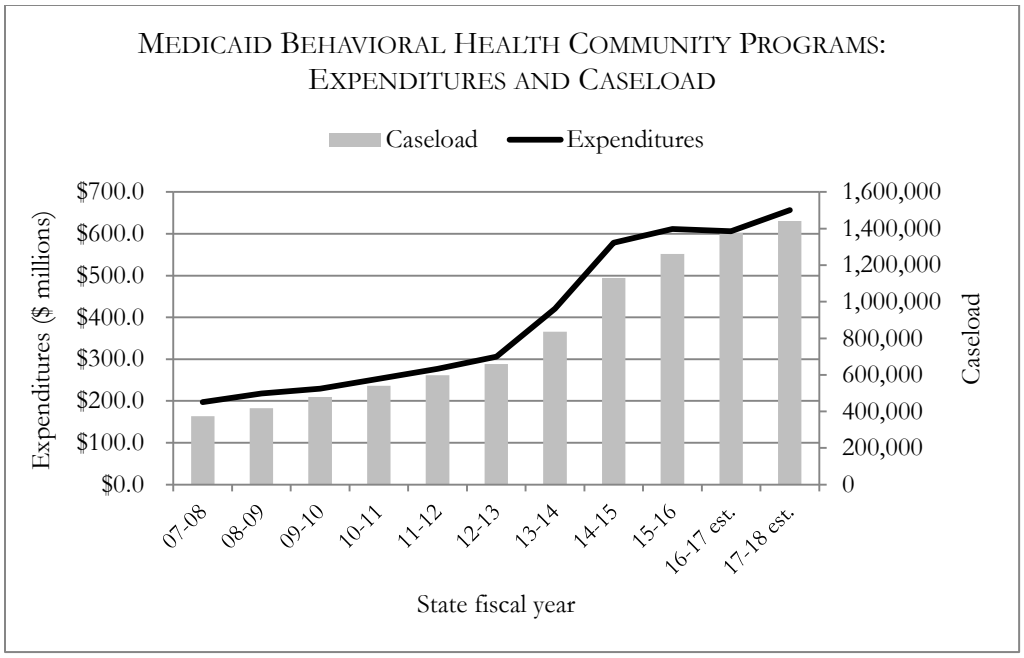
GENERAL FACTORS DRIVING THE BUDGET

The Medicaid program provides health insurance to people with low incomes and to people needing long-term care. Participants generally do not pay annual premiums and copayments at the time of service are either nominal or not required. The financing, administration, and policy-making responsibilities for the program are shared between the federal and state governments. Medicaid generally operates as an entitlement program, meaning the people deemed eligible have a legal right to the plan benefits. As a result, if the eligible population and/or the eligible services utilized are greater than expected, then the state and federal government must pay the resulting higher cost, regardless of the initial appropriation. The most significant factor affecting overall Medicaid expenditures is enrollment. Medicaid enrollment has increased significantly in recent years, due to increases in the state population, economic conditions that impact the number of people who meet the income eligibility criteria, and state and federal policy changes regarding eligibility.

Expenditures of state funds are impacted by the federal match rate for the Medicaid program. The federal medical assistance percentage ("FMAP") can vary based on economic conditions in the state, the type of services being provided, and the population receiving services. For state fiscal year 2016-17, the average FMAP for the majority of Colorado Medicaid expenditures is 50.2 percent. For adults "newly eligible" pursuant to the federal Affordable Care Act, Colorado will receive a 100 percent federal match in calendar year 2016 and a 95 percent federal match for calendar year 2017, and the federal match is scheduled to step down in increments annually until it reaches 90 percent in calendar year 2020. The factors driving Medicaid *behavioral health* expenditures are reviewed below.

Behavioral health services include both mental health and substance use-related services. Most appropriations for Medicaid clients' behavioral health services are currently included in the "Behavioral Health Community Programs" section of the Department's budget. Funding in this section consists of 27.7 percent General Fund, 2.5 percent cash funds, and 69.8 percent federal funds. Sources of cash funds include the Hospital Provider Fee Cash Fund and the Breast and Cervical Cancer Prevention and Treatment Fund. Federal funds are appropriated as matching funds to the Medicaid program (through Title XIX of the Social Security Administration Act).

The following chart depicts annual expenditures for all line items within the Behavioral Health Community Programs section and the total number of Medicaid clients eligible for behavioral health services each year. Caseload and expenditure increases that began in FY 2013-14 reflect the expansion of Medicaid eligibility and the expansion of substance use disorder benefits covered by Medicaid; both expansions became effective in January 2014. In addition, FY 2014-15 expenditures include $5.3 million of one-time funding that was provided to expand school-based prevention and early intervention services for youth (S.B. 14-215, concerning disposition of legal marijuana related revenue).



BEHAVIORAL HEALTH CAPITATION PAYMENTS

Behavioral health services, which include both mental health and substance use-related services, are generally provided to Medicaid clients through a statewide managed care or "capitated" program. Two groups of Medicaid clients that are eligible for certain medical benefits are not eligible for behavioral health services: (1) non-citizens; and (2) adults who are eligible for both Medicaid and Medicare but for whom the Medicaid benefit is limited to payment of Medicare premiums and co-insurance payments.

The Department contracts with regional entities, currently known as behavioral health organizations (BHOs), to provide or arrange for behavioral health services for clients within their geographic region who are enrolled in the Medicaid program. In order to receive services through a BHO, a client must have a covered diagnosis and receive a covered service or procedure that is medically necessary. Each BHO receives a pre-determined monthly amount for each Medicaid client who is eligible for behavioral health services within its geographic area. The "per-member-per-month" rates paid to each BHO are unique for each Medicaid eligibility category in each geographic region. These rates are adjusted periodically based on clients' actual utilization of behavioral health services and the associated expenditures.

Capitated behavioral health program expenditures are thus affected by changes in the number of individuals who are eligible for Medicaid, client utilization and the associated costs of providing behavioral health services, and changes to the Medicaid State Plan or waiver program that affect the diagnoses, services, and procedures that are covered for Medicaid clients. The State's share of expenditures is also affected by changes in the federal match rate for various eligibility categories.

The following three tables show the year-over-year changes projected for FY 2017-18 in Medicaid enrollment, payments made to BHOs through the capitation program, and expenditures per capita by enrollment category.

BEHAVIORAL HEALTH CAPITATION PROGRAM: ENROLLMENT				
CATEGORY	FY 16-17 REVISED	FY 17-18 REQUEST	DIFFERENCE	PERCENT
Children to 147% FPL	552,392	571,582	19,190	3.5%
Adults w/out Dependent Children to 138% FPL	366,209	391,871	25,662	7.0%
Parents / Caretakers to 68% FPL; and Pregnant Adults to 200% FPL	209,008	215,934	6,926	3.3%
Parents / Caretakers 69% to 138% FPL	98,910	108,821	9,911	10.0%
Individuals with Disabilities to age 64 (to 450% FPL)	85,959	89,039	3,080	3.6%
Adults age 65+ (to SSI)	43,412	44,137	725	1.7%
Foster Care to 26 years	20,185	20,290	105	0.5%
Breast & Cervical Cancer to 250% FPL	286	179	(107)	-37.4%
TOTAL	**1,376,361**	**1,441,853**	**65,492**	**4.8%**

BEHAVIORAL HEALTH CAPITATION PROGRAM: ANNUAL EXPENDITURES				
CATEGORY	FY 16-17 REVISED	FY 17-18 REQUEST	DIFFERENCE	PERCENT
Children to 147% FPL	$131,688,422	$130,870,654	($817,768)	-0.6%
Adults w/out Dependent Children to 138% FPL	235,424,333	242,009,101	6,584,768	2.8%
Parents / Caretakers to 68% FPL; and Pregnant Adults to 200% FPL	72,836,622	72,315,476	(521,146)	-0.7%
Parents / Caretakers 69% to 138% FPL	19,825,432	20,740,703	915,271	4.6%
Individuals with Disabilities to age 64 (to 450% FPL)	143,908,153	143,179,056	(729,097)	-0.5%
Adults age 65+ (to SSI)	9,282,036	9,062,083	(219,953)	-2.4%
Foster Care to 26 years	30,464,850	29,393,930	(1,070,920)	-3.5%
Breast & Cervical Cancer to 250% FPL	99,022	59,302	(39,720)	-40.1%
Rate reconciliations	(46,181,231)	0	46,181,231	-100.0%
TOTAL	**$597,347,639**	**$647,630,305**	**$50,282,666**	**8.4%**

BEHAVIORAL HEALTH CAPITATION PROGRAM: ANNUAL PER CAPITA EXPENDITURES				
CATEGORY	FY 16-17 REVISED	FY 17-18 REQUEST	DIFFERENCE	PERCENT
Children to 147% FPL	$238	$229	($9)	-4.0%
Adults w/out Dependent Children to 138% FPL	643	618	(25)	-3.9%
Parents / Caretakers to 68% FPL; and Pregnant Adults to 200% FPL	348	335	(14)	-3.9%
Parents / Caretakers to 138% FPL	200	191	(10)	-4.9%
Individuals with Disabilities to age 64 (to 450% FPL)	1,674	1,608	(66)	-3.9%
Adults age 65+ (to SSI)	214	205	(8)	-4.0%
Foster Care to 26 years	1,509	1,449	(61)	-4.0%
Breast & Cervical Cancer to 250% FPL	346	331	(15)	-4.3%
TOTAL [1]	**$434**	**$449**	**$15**	**3.5%**

[1] While rate reconciliations appear in the Annual Expenditures table, staff has not included them in the Annual Per Capita Expenditures table. For FY 2016-17, these repayments from BHOs relate to prior fiscal years.

MEDICAID BEHAVIORAL HEALTH FEE-FOR-SERVICE PAYMENTS

In addition to funding for capitation payments to BHOs, a separate appropriation supports fee-for-service payments for the provision of behavioral health services under three circumstances: (1) when a Medicaid client has a diagnosis that is not covered by the BHO contract (e.g., autism spectrum disorder, developmental disability, dementia, etc.); (2) when a Medicaid client has received an individual exemption from BHO enrollment; or (3) when the State is required to pay the client share of the cost of mental health services provided to a "partial dual-eligible" individual under their Medicare benefits package.

The fee-for-service program covers all Medicaid State Plan mental health and substance use disorder services. The fee-for-service program does not, however, cover services approved through the Department's federal 1915 (b) (3) waiver. Expenditures are reported using three categories: inpatient services, outpatient services, and physician services.

Fee-for-service expenditures for outpatient services increased significantly in FY 2014-15 (by $2.5 million or 62.3 percent), and now account for 86 percent of fee-for-service expenditures. The Department indicates that this increase is primarily attributed to the newly eligible adults without dependent children. Total fee-for-service expenditures are anticipated to be slightly lower than originally projected for the current fiscal year, but to grow by 4.8 percent in FY 2017-18 largely due to projected Medicaid caseload increases. The following table details recent expenditure trends for this line item, along with the Department's most recent estimates for FY 2016-17, and the request for FY 2017-18.

MEDICAID BEHAVIORAL HEALTH FEE-FOR-SERVICE PAYMENTS

	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17		FY 2017-18
				Current Appropriation	November 2016 Estimate	Nov. 1, 2016 Request
Fee-for-service Expenditures:						
Inpatient Services	$1,277,088	$1,037,617	$1,084,479	$1,202,553	$1,182,986	$1,239,277
Outpatient Services	3,956,128	6,421,463	6,937,930	7,693,303	7,568,124	7,928,241
Physician Services	63,135	66,344	64,431	71,446	70,283	73,627
Accounting Adjustment [1]	(516)	0	0	n/a	n/a	n/a
Total Expenditures	**$5,295,835**	**$7,525,424**	**$8,086,840**	**$8,967,302**	**$8,821,393**	**$9,241,145**
Annual Dollar Change	$726,637	$2,229,589	$561,416	$880,462	$734,553	$419,752
Annual Percent Change	*15.9%*	*42.1%*	*7.5%*	*10.9%*	*9.1%*	*4.8%*
Medicaid Clients Eligible for Behavioral Health Services	**835,098**	**1,130,439**	**1,261,752**	**1,347,086**	**1,376,361**	**1,441,853**
Annual Caseload Change	175,994	295,341	131,313	85,334	114,609	65,492
Annual Caseload % Change	*26.7%*	*35.4%*	*11.6%*	*6.8%*	*9.1%*	*4.8%*

1/ The Department overlays MMIS data onto CORE data to approximate expenditures by eligibility category. In some instances, this overlay process results in totals which do not match actual expenditures. This adjustment ensures that total actual expenditures are reflected above.

OTHER DEPARTMENT BEHAVIORAL HEALTH-RELATED EXPENDITURES

Please note that some behavioral health-expenditures for Medicaid clients are funded through line item appropriations that are not part of the behavioral health community programs section of the budget. Specifically, the Medical Services Premiums line item appropriation covers:

- expenditures for the provision of inpatient medical treatment for clients with acute medical conditions that involve a substance use disorder diagnosis (a total of $129.1 million in FY 2015-16);
- behavioral health-related pharmaceutical expenditures (an estimated $58.1 million after rebates in FY 2015-16, including $31.3 million related to antipsychotic drugs); and
- inpatient substance use disorder treatment for children and youth under age 21 provided under the early and periodic screening, diagnostic and treatment benefit ($1.8 million in FY 2015-16).

In addition, Medicaid covers residential substance use disorder treatment for pregnant women through the "Special Connections Program", which is administered by the Department of Human Services with Medicaid funding transferred from HCPF ($0.7 million in FY 2015-16). Finally, administrative expenses related to behavioral health programs are funded through various line items in the Executive Director's Office.

SUMMARY: FY 2016-17 APPROPRIATION & FY 2017-18 REQUEST

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING					
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FEDERAL FUNDS	FTE
FY 2016-17 APPROPRIATION:					
HB 16-1405 (Long Bill)	$662,617,330	$183,627,684	$16,633,015	$462,356,631	0.0
TOTAL	**$662,617,330**	**$183,627,684**	**$16,633,015**	**$462,356,631**	**0.0**
FY 2017-18 REQUESTED APPROPRIATION:					
FY 2016-17 Appropriation	$662,617,330	$183,627,684	$16,633,015	$462,356,631	0.0
R2 Behavioral health forecast	20,962,544	(406,491)	11,420,458	9,948,577	0.0
R6 Delivery system and payment reform	(26,717,069)	(7,215,319)	(1,090,836)	(18,410,914)	0.0
Annualize prior year budget actions	8,645	(28,516)	32,856	4,305	0.0
TOTAL	**$656,871,450**	**$175,977,358**	**$26,995,493**	**$453,898,599**	**0.0**
INCREASE/(DECREASE)	($5,745,880)	($7,650,326)	$10,362,478	($8,458,032)	0.0
Percentage Change	(0.9%)	(4.2%)	62.3%	(1.8%)	0.0%

R2 BEHAVIORAL HEALTH FORECAST: The request includes an increase of $21.0 million total funds, including a decrease of $0.4 million General Fund, for projected caseload and expenditure changes in both the capitation and fee-for-service Medicaid behavioral health programs. *[For more information, see the first issue brief.]*

R6 DELIVERY SYSTEM AND PAYMENT REFORM: Overall, the Department requests a net increase of $3.2 million total funds (including a decrease of $200,342 General Fund), for a number of changes that the Department characterizes as delivery system and payment reforms. The Department proposes taking a portion of the money currently paid to certain providers and transforming it into incentive payments based on health outcomes and performance. With respect to behavioral health, incentive payments would be financed using the savings from further projected decreases in behavioral health capitation rates. The behavioral health performance payments related to FY 2017-18 would not be paid out until FY 2018-19, resulting in a one-time savings in FY 2017-18. These savings offset funding requests for administrative expenses and continuation of the "primary care rate bump".

ANNUALIZE PRIOR YEAR BUDGET ACTIONS: The request includes $8,645 total funds to reflect the second-year impact of two FY 2016-17 budget actions.

ANNUALIZE PRIOR YEAR BUDGET ACTIONS					
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FEDERAL FUNDS	FTE
Annualize HB 16-1321 Medicaid buy-in eligibility	$8,645	($28,516)	$32,837	$4,324	0.0
Annualize FY 16-17 Cervical cancer eligibility	0	0	19	(19)	0.0
TOTAL	**$8,645**	**(28,516)**	**$32,856**	**$4,305**	**0.0**

ISSUE: OVERVIEW OF DEPARTMENT'S FY 2017-18 REQUEST FOR BEHAVIORAL HEALTH COMMUNITY PROGRAMS (R2)

The Department's most recent projections for behavioral health community programs indicate that the General Assembly will likely be able to reduce General Fund appropriations by $6.4 million in the current fiscal year, followed by another $1.3 million reduction in FY 2017-18.

SUMMARY

- Compared to existing FY 2016-17 appropriations, the Governor's budget request for FY 2017-18 reflects a $5.2 million (0.6 percent) overall decrease in funding for behavioral health programs administered by the Department of Human Services (DHS) and the Department of Health Care Policy and Financing (HCPF). This includes an increase of $0.6 million for DHS programs and a decrease of $5.7 million for HCPF programs.

- For FY 2016-17, HCPF estimates that existing appropriations for Medicaid behavioral health programs can be decreased by $56.4 million total funds, including $6.4 million General Fund. This is primarily due to lower than anticipated per capita expenditures for the expansion populations and for children and youth in (or formerly in) foster care. This decrease is also the result of higher than anticipated recoupments from BHOs for payments that were made in FY 2015-16.

- Compared to the revised estimate for FY 2016-17, HCPF's request for FY 2017-18 represents a $50.7 million (8.4 percent) increase in total funds, including a decrease of $1.3 million General Fund. The estimated expenditure increase primarily reflects continued growth in the number of low income adults and children enrolling in Medicaid, and the anticipated absence of any recoupments from BHOs.

DISCUSSION

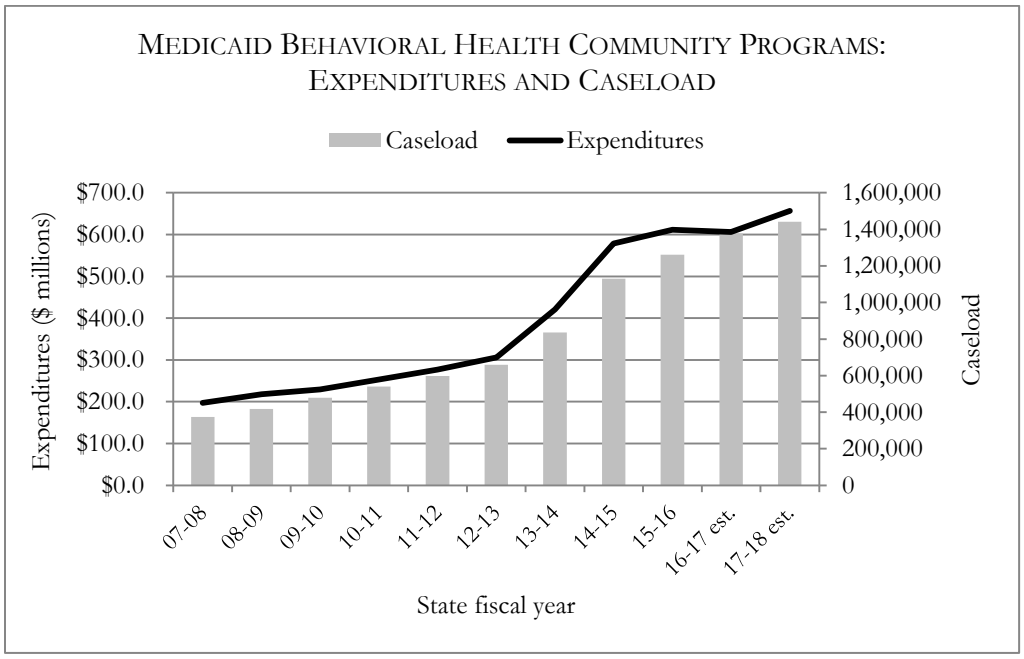
Overall Funding Requested for Behavioral Health Programs for FY 2016-17

The majority of publicly funded behavioral health services in Colorado are funded through two program areas: the Department of Health Care Policy and Financing's (HCPF's) Behavioral Health Community Programs section, and the Department of Human Services' (DHS') Behavioral Health Services section. As detailed in the following table, the FY 2017-18 budget requests for these two program areas propose an overall reduction of $5.2 million (0.6 percent) compared to existing appropriations. The proposed change includes an increase of $0.6 million for DHS programs and a decrease of $5.7 million for HCPF programs. This issue brief provides an overview of the components of the HCPF share of the FY 2017-18 request and the underlying trends affecting the request.

TOTAL APPROPRIATIONS FOR BEHAVIORAL HEALTH PROGRAMS: FY 2016-17 AND FY 2017-18						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2016-17 Appropriation						
Department of Human Services (DHS), Behavioral Health Services	$265,785,330	$189,816,707	$22,063,002	$18,683,329	$35,222,292	1,293.6
Department of Health Care Policy and Financing (HCPF), Behavioral Health Community Programs	662,617,330	183,627,684	16,633,015	0	462,356,631	0.0
TOTAL	**$928,402,660**	**$373,444,391**	**$38,696,017**	**$18,683,329**	**$497,578,923**	**1,293.6**
FY 2017-18 Requested Appropriation						
DHS, Behavioral Health Services	$266,377,351	$190,289,073	$22,160,782	$18,698,856	$35,228,640	1,303.2
HCPF, Behavioral Health Community Programs	656,871,450	175,977,358	26,995,493	0	453,898,599	0.0
TOTAL	**$923,248,801**	**$366,266,431**	**$49,156,275**	**$18,698,856**	**$489,127,239**	**1,303.2**
DHS: Increase/(Decrease)	$592,021	$472,366	$97,780	$15,527	$6,348	9.6
Percentage Change	*0.2%*	*0.2%*	*0.4%*	*0.1%*	*0.0%*	*0.7%*
HCPF: Increase/(Decrease)	($5,745,880)	($7,650,326)	$10,362,478	$0	($8,458,032)	0.0
Percentage Change	*-0.9%*	*-4.2%*	*62.3%*	*n/a*	*-1.8%*	*n/a*
TOTAL: Increase/(Decrease)	**($5,153,859)**	**($7,177,960)**	**$10,460,258**	**$15,527**	**($8,451,684)**	**9.6**
Percentage Change	*-0.6%*	*-1.9%*	*27.0%*	*0.1%*	*-1.7%*	*0.7%*

Funding Requested for Medicaid Behavioral Health Community Programs for FY 2017-18

The following chart depicts actual expenditure and caseload changes for Medicaid behavioral health community programs since FY 2007-08, along with HCPF's most recent expenditure estimate for FY 2016-17 and its request for FY 2017-18.



The Department's most recent caseload and expenditure forecast includes adjustments for both FY 2016-17 and FY 2017-18. Thus, the Department anticipates submitting a request for a mid-year adjustment to FY 2016-17 appropriations. The following table splits out the requested changes by fiscal year to provide a more accurate depiction of the request. A discussion of caseload and

expenditure trends experienced in the last two fiscal years, and the Department's most recent forecasts for FY 2016-17 and FY 2017-18, follow.

BEHAVIORAL HEALTH COMMUNITY PROGRAMS SUMMARY OF REQUESTED INCREASE BY FISCAL YEAR AND FUND SOURCE	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FEDERAL FUNDS
Appropriation for FY 2016-17	$662,617,330	$183,627,684	$16,633,015	$462,356,631
Changes reflected in most recent Medicaid forecast for FY 2016-17	(56,448,298)	(6,379,746)	569,523	(50,638,075)
Subtotal: FY 2016-17 Estimate	**$606,169,032**	**$177,247,938**	**$17,202,538**	**$411,718,556**
Annualize prior year budget actions	8,645	(28,516)	32,856	4,305
R2 Behavioral health forecast	77,410,842	5,973,255	10,850,935	60,586,652
R6 Delivery system and payment reform	(26,717,069)	(7,215,319)	(1,090,836)	(18,410,914)
Total FY 2017-18 Request	**$656,871,450**	**$175,977,358**	**$26,995,493**	**$453,898,599**

FY 2014-15 and FY 2015-16 Caseload and Expenditure Trends

Actual expenditures for FY 2014-15 and FY 2015-16 reflect a full two fiscal years of Medicaid eligibility expansion, as well as a full two fiscal years of expanded substance use disorder benefits. The number of Medicaid clients eligible for behavioral health services through BHOs (called "membership") increased by 51.1 percent over this two year period, and the associated payments to BHOs increased at a slightly lower rate (45.0 percent).

What are the overall utilization trends underlying FY 2014-15 and FY 2015-16 expenditures?

The Department indicates that utilization and cost patterns by behavioral health service category were relatively similar to recent periods. Client utilization of substance use disorder services increased between the years, from 21.3 percent of BHO utilizers in FY 2014-15 to 24.8 percent in FY 2015-16. This aligns with expectations from the BHOs that the program would ramp up and experience higher utilization in FY 2015-16.

What do we now know about the behavioral health needs of the Medicaid expansion population?

According to FY 2015-16 data, the Medicaid expansion population comprises 39 percent of the total BHO membership, and approximately 13 percent of the total Medicaid expansion population utilizes BHO services. This penetration rate is slightly higher than the non-expansion population. Most Medicaid clients (77 percent) access behavioral health services at community mental health centers (Centers). BHOs share the financial risk with Centers by paying a "sub-capitation" payment for the number of Medicaid-eligible clients within a Center's region. While Centers are also the predominant service delivery location for the expansion population, recent data indicates the proportion is lower than the non-expansion population (i.e., 49 percent for the expansion population compared to 66 percent for the non-expansion population). The Department indicates that this may be attributed to the expansion population's slightly higher utilization rate for emergency room services (9.0 percent for the expansion population, compared to 6.3 percent for the non-expansion population).

In addition, the Department indicates that the expansion population has utilized substance use disorder treatment at a higher rate than other Medicaid populations (35.8 percent for the expansion population compared to 16.3 percent for the non-expansion population). The Department expected this initial trend due to pent up demand, but anticipated that it would decrease over time. However,

the BHOs have reported that this increased utilization remains steady. The Department also notes that while females are generally more likely to utilize behavioral health services, the utilizers of the expanded substance use disorder benefit are disproportionately males, and this trend continued through FY 2015-16. Finally, the BHOs have reported that Methadone treatment and detoxification represented over 50 percent of substance use disorder claims in FY 2015-16. The Department indicates that it continues to work with the BHOs and the Department of Human Services to further explore the substance use disorder service needs of the Medicaid population, including the expansion population.

FY 2016-17 Budget Estimate

The FY 2016-17 appropriation for Medicaid behavioral health community programs currently provides a total of $662.6 million total funds (including $183.6 million General Fund) for the provision of services to a projected membership of 1,347,086. The Department is now projecting a higher rate of caseload growth in FY 2016-17, primarily due to expansion populations. However, the Department estimates that the existing FY 2016-17 appropriation can be decreased by $56.4 million total funds (8.5 percent) based on more recent projections. This adjustment is primarily related to two factors:

- The per-member-per-month rates paid to BHOs are higher than anticipated for some eligibility categories and lower for others. The most significant rate decreases were for the expansion population and foster care categories. *For more information about capitation rates, see the next issue brief. In addition, Appendix E details the caseload and rate data that underlies the Department's revised capitation payment estimates for FY 2016-17.*

- The Department anticipates receiving $46.1 million back from BHOs for previous payments. These "reconciliation" payments are $29.9 million higher than anticipated, and they relate to three different circumstances:
    - Due to the uncertainty of the cost of serving the newly eligible Adults Without Dependent Children population, the Department placed a "risk corridor" on the associated capitation rates to protect both the State and BHOs from undue risk. The $24.2 million recoupment is due to the rates being set higher than actual costs.
    - An $18.9 million recoupment is needed for payments made in FY 2015-16 for some individuals in the Parents/ Caretakers (69% to 138% FPL) category. These payments were incorrectly based on the higher Adults Without Dependent Children category rate.
    - A $3.1 million recoupment is needed for payments made in FY 2015-16 for some children. These children were incorrectly categorized and paid based on the Individuals with Disabilities category rate.

FY 2017-18 Budget Estimate

The Department's FY 2017-18 budget request includes $656.9 million total funds (including $176.0 million General Fund) for the provision of services to a projected membership of 1,441,853. Compared to the revised estimate for FY 2016-17, the request represents a $50.7 million (8.4 percent) year-over-year increase in total funds. In addition to the caseload changes that occur every year due to demographic and economic factors, this estimate is driven by continued growth in the numbers of low income adults and low income children enrolling in Medicaid. The Department is also anticipating that per-member-per-month capitation rates will decrease by another 4.0 percent in FY 2017-18. The following table compares the caseload and expenditure data that correspond to the Department's most recent estimates for FY 2016-17 and the Department's FY 2017-18 request.

Finally, the Department's projections for FY 2017-18 do not include the $46.2 million in recoupments that are anticipated to be received in FY 2016-17. *See Appendix F for the detailed caseload and rate data that underlies the Department's capitation payments request for FY 2017-18.*

FY 2017-18 Medicaid Behavioral Health Community Programs Budget Overview

Description	FY 2016-17 Revised		FY 2017-18 Estimate		Annual Change	
	Caseload	Funding	Caseload	Funding	Caseload	Funding
Capitation Payments						
Eligibility Categories						
Adults age 65+ (to SSI)	43,412	$9,385,692	44,137	$9,548,634	725	$162,942
Adults:						
Parents/ Caretakers (to 68% FPL) and Pregnant Adults (to 200% FPL)	209,008	72,853,993	215,934	75,317,477	6,926	2,463,484
Parents/ Caretakers (69% to 138% FPL)*	98,910	19,833,190	108,821	21,574,725	9,911	1,741,535
Adults without Dependent Children (to 138% FPL)*	366,209	235,561,673	391,871	252,074,474	25,662	16,512,801
Breast and Cervical Cancer Program (to 250% FPL)	286	99,798	179	62,476	(107)	(37,322)
Individuals With Disabilities to age 64 (to 450% FPL)	85,959	144,279,296	89,039	149,467,123	3,080	5,187,827
Children (to 147% FPL)	552,392	131,696,180	571,582	136,273,370	19,190	4,577,190
Individuals In/ Formerly In Foster Care (up to age 26)	20,185	30,486,199	20,290	30,629,530	105	143,331
Subtotal	1,376,361	644,196,021	1,441,853	674,947,809	65,492	30,751,788
Adjustments:						
Date of death retractions		(667,151)		(600,435)		66,716
Adults without dependent children risk corridor reconciliation [1]		(24,165,590)		0		24,165,590
Parents/ Caretakers (69% to 138% FPL) rate reconciliation [2]		(18,947,943)		0		18,947,943
Children rate reconciliation [3]		(3,067,698)		0		3,067,698
Budget Initiatives:						
R6 Delivery system and payment reform		n/a		(26,717,069)	0	(26,717,069)
Total Capitation Payments	**1,376,361**	**$597,347,639**	**1,441,853**	**$647,630,305**	**65,492**	**$50,282,666**
Fee-for-service Payments						
Inpatient		$1,182,986		$1,239,277		$56,291
Outpatient		7,568,124		7,928,241		360,117
Physician		70,283		73,627		3,344
Total Fee-for-Service Payments		**$8,821,393**		**$9,241,145**		**$419,752**
GRAND TOTAL	**1,376,361**	**$606,169,032**	**1,441,853**	**$656,871,450**	**65,492**	**$50,702,418**
Incremental Percentage Change					***4.8%***	***8.4%***

* These are new eligibility categories authorized by S.B. 13-200.

FY 2017-18 Medicaid Behavioral Health Community Programs Budget Overview						
	FY 2016-17 Revised		FY 2017-18 Estimate		Annual Change	
Description	Caseload	Funding	Caseload	Funding	Caseload	Funding

[1] Due to the uncertainty of the cost of serving this population, the Department placed a "risk corridor" on the associated capitation rates, thereby splitting the risk of not setting an accurate rate between the Department and the behavioral health organizations (BHOs). The Department has determined that rates were initially set higher than BHOs' actual costs.

[2] This recoupment is needed for payments made in FY 2015-16 for some individuals in the Parents/ Caretakers (69% to 138% FPL) category. These payments were incorrectly based on the higher Adults Without Dependent Children category rate.

[3] This recoupment is needed for payments made in FY 2015-16 for some children. These children were incorrectly categorized and paid based on the Individuals with Disabilities category rate.

Please note that it is anticipated that in January 2017 the Department will submit a supplemental request for FY 2016-17 that reflects the caseload and expenditure data described above. In addition, in February 2017 the Department will submit an updated caseload and expenditure forecast for both FY 2016-17 and FY 2017-18 that incorporates data through December 2016. Thus, the Committee will have updated information available when it makes decisions concerning the FY 2016-17 and FY 2017-18 budgets.

ISSUE: CAPITATION RATE TRENDS (R7)

The average amount that the Department pays to behavioral health organizations for the provision of behavioral health services for Medicaid-eligible clients initially increased when Medicaid eligibility was expanded in January 2014. Based on actual utilization and costs, as well as new federal managed care regulations, rates have since declined and are projected to continue to decline in FY 2017-18.

SUMMARY

- Total behavioral health capitation payment expenditures have increased more than three-fold over the last eight years due largely to a growing number of individuals eligible for Medicaid services. However, the average cost per Medicaid-eligible client has generally been stable or declined over this time period.

- The capitation rates for the eligibility populations that were added in January 2014 were initially set based on the information available. These rates have been reduced based on lower than anticipated client service utilization and lower than anticipated provider costs.

- New federal managed care regulations impose more federal scrutiny on the Department's rate setting process, resulting in a loss of flexibility for the State. To ensure the State complies with these regulations, the Department has conducted audits of some of the larger community mental health centers. Audit findings have resulted in some capitation rate reductions.

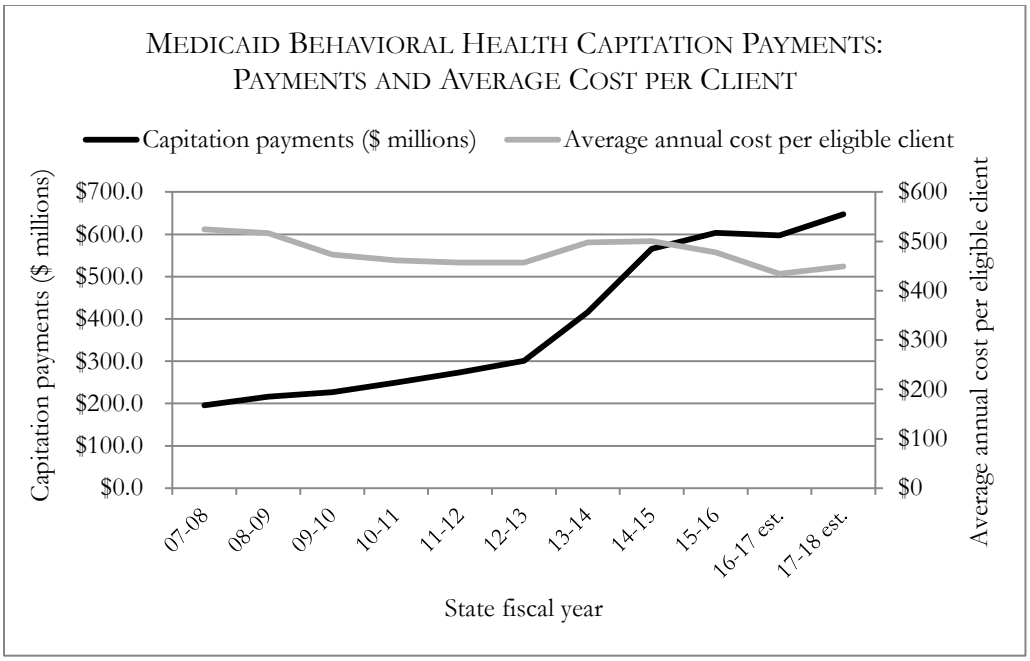
- The Department is also requesting additional resources (through R7) to hire an auditor to conduct a thorough review of community mental health center cost reports on an annual basis to ensure the State's capitation rates comply with federal regulations.

DISCUSSION

Per Capita Rate Trends

The Department currently contracts with regional entities, known as behavioral health organizations (BHOs), to provide or arrange for behavioral health services for clients within their geographic region who are enrolled in the Medicaid program. Each BHO receives a pre-determined monthly amount for each Medicaid client who is eligible for behavioral health services within its geographic area. The "per-member-per-month" rates paid to each BHO are unique for each Medicaid eligibility category in each geographic region. These rates are adjusted periodically based on clients' actual utilization of behavioral health services and the associated expenditures.

Total capitation payment expenditures have increased more than threefold (207.7 percent) over the last eight years, rising from $196.0 million in FY 2007-08 to $603.2 million in FY 2015-16. The number of Medicaid clients eligible for behavioral health services increased by an even greater percent over this time period (237.8 percent), rising from 373,557 to 1,261,752. As illustrated in the following chart, total capitation payments have increased at a slower rate than caseload, resulting in an average cost per Medicaid-eligible client that has generally been stable or decreased over this time period.



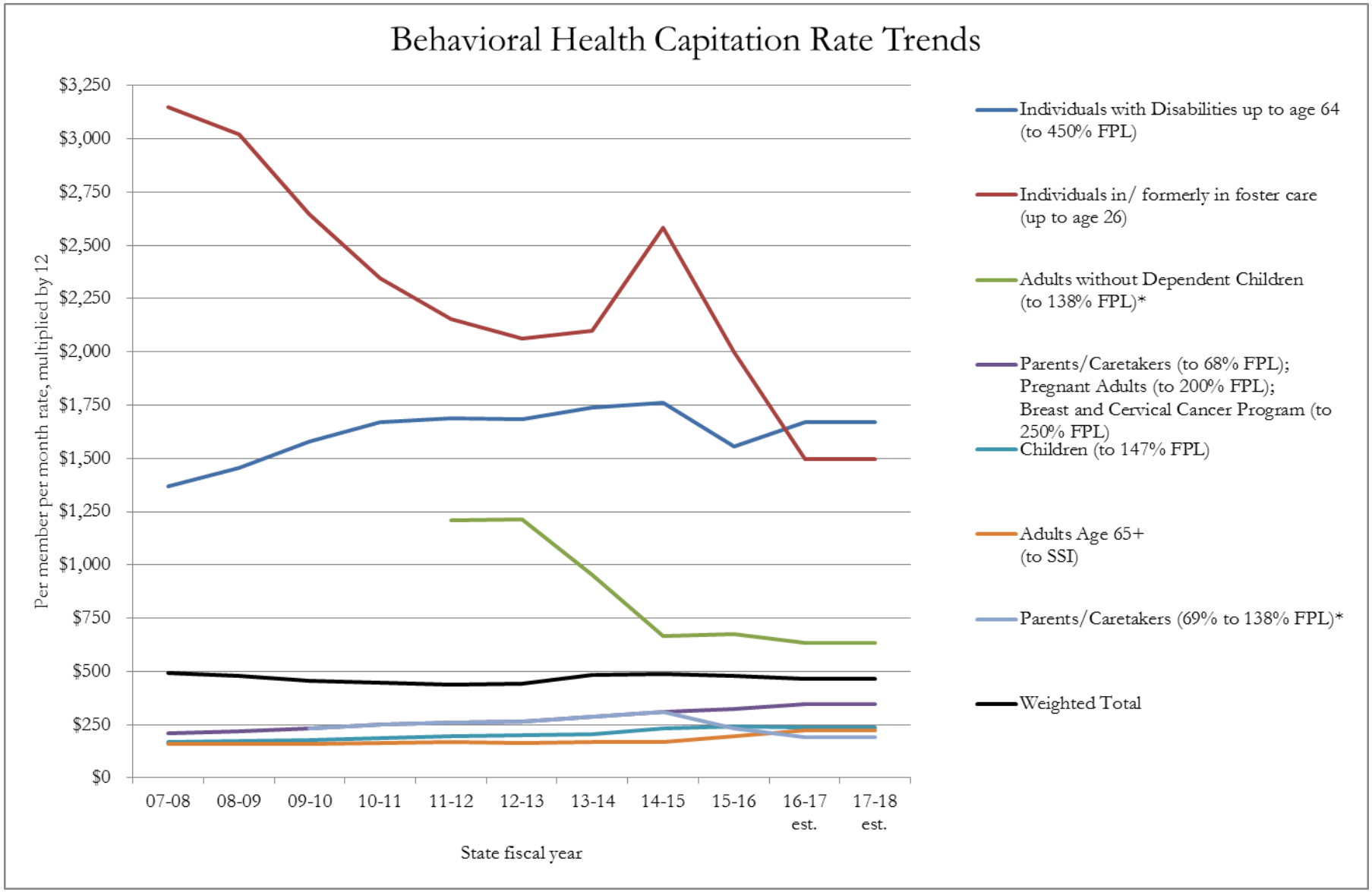
The average cost per eligible Medicaid client increased initially when Medicaid eligibility was expanded and the substance use disorder benefit was expanded. Due to the uncertainty of the cost of serving the newly eligible "adults without dependent children" population, the Department placed a "risk corridor" on the associated capitation rates to protect both the State and BHOs from undue risk. The utilization and costs associated with this newly eligible population have not been as high as originally anticipated. As a result, the associated rates have been reduced and some BHOs have been required to make payments back to the State.

The chart on the following page illustrates the variation in capitation rates for various Medicaid eligibility populations. Consistent with the above chart, the next chart also illustrates that overall the average cost per eligible Medicaid client has been relatively stable over the last eight years. The average per capita costs for three traditional eligibility categories has also been relatively stable:

- Low income adults (traditional eligibility categories[1]);
- Children; and
- Adults age 65 and older.

In contrast, the average annual per capita costs for the expansion populations declined from FY 2013-14 to FY 2016-17 (from $952.56 to $634.32 for Adults Without Dependent Children and from $287.76 to $189.96 for Parents and Caretakers (69% to 138% FPL). The per capita costs for Individuals with Disabilities and Foster Care populations have also fluctuated significantly in the last few years. Finally, please note that the rate changes reflected on the next page are aggregate amounts; actual rate changes vary by BHO. In addition, please note that the "Weighted Total" rates reflect changes in client utilization of behavioral health services, the cost of providing those services, and the mix of clients who are eligible for the Medicaid program.

[1] For purposes of the chart on the following page, this group includes: Parents/Caretakers (to 68% FPL); Pregnant Adults (to 200% FPL); and Breast and Cervical Cancer Program (to 250% FPL).


Behavioral Health Capitation Rate Trends
$3,250
$3,000
$2,750
$2,500
$2,250
$2,000
$1,750
$1,500
$1,250
$1,000
$750
$500
$250
$0
Per member per month rate, multiplied by 12
07-08
08-09
09-10
10-11
11-12
12-13
13-14
14-15
15-16
16-17 est.
17-18 est.
State fiscal year
Individuals with Disabilities up to age 64 (to 450% FPL)
Individuals in/ formerly in foster care (up to age 26)
Adults without Dependent Children (to 138% FPL)*
Parents/Caretakers (to 68% FPL); Pregnant Adults (to 200% FPL); Breast and Cervical Cancer Program (to 250% FPL)
Children (to 147% FPL)
Adults Age 65+ (to SSI)
Parents/Caretakers (69% to 138% FPL)*
Weighted Total

Rate Setting Process

The rates for BHOs are set based on a complicated set of calculations. These rates are based on data from the three different types of providers that contract with BHOs to provide services to Medicaid clients:

- Community mental health centers;
- Independent practitioners and other outpatient service providers; and
- Hospitals, physicians, laboratories, and other costs related to inpatient treatment.

These entities periodically submit cost reports to the Department detailing actual costs incurred to provide services. These costs may only be included in the rate setting calculations if they fall under the Capitation contract and they are allowable by the federal Medicaid program. For community mental health centers, the allowable costs are projected forward to account for projected utilization changes and inflationary increases. For hospitals, independent practitioners and service providers, and laboratories, the allowable costs are based on the actual amount paid or applicable fee schedule, and actual utilization. The sum of these service provision costs are then increased by 12 to 15 percent to account for BHO administrative costs such as claims processing and utilization management. This additional administrative funding can also be used to pay for services that are not otherwise covered by the Capitation contract.

The impact of capitation rate changes on individual service providers is affected by the contractual relationship between the service provider and the BHO. In some cases, the BHO may choose to pay for services on a fee-for-service basis. In other cases, the BHO may choose to share the financial risk with a service provider by making a "sub-capitation" payment. In some regions, up to 80 percent of the funding received by a BHO is paid to the local community mental health centers through a sub-capitation arrangement.

Impact of New Federal Managed Care Regulations

New federal managed care regulations impose new requirements on the Department and BHOs. These regulations generally emphasize increased accountability and transparency. For FY 2017-18, these regulations require the Department to set an actuarially certified rate point, rather than allowing the Department to negotiate a rate within an actuarially certified rate range. These regulations impose a significantly higher level of federal scrutiny by the federal Centers for Medicare and Medicaid Services' Office of the Actuary, resulting in a loss of flexibility to the State. These regulations place increased scrutiny on administrative expenditures, and increase the amount of documentation required to justify rates. The Department indicates that the BHO rates for FY 2016-17 are near the top of the existing actuarially certified rate range. The Department is thus anticipating that the rates for FY 2017-18 will be approximately 4.0 percent lower.

As community mental health centers provide a majority of the mental health and substance use-related services to Medicaid clients, BHO capitation payments are largely based on costs incurred and reported by community mental health centers. Through a recent audit of four of the larger community mental health centers, the Department identified $8 million of incorrectly reported costs that had been used to determine BHO rates. The largest findings included:

- $3 million of misclassified administrative costs;
- $2 million in pharmacy costs in the RVU[2] column;
- $1.5 million in non-RVU residential costs in the RVU column; and
- $1 million in unallowable interest expense in the RVU column.

Additionally, there were over $5 million in donated costs that were ultimately allowed as reported, but prompted clarification in the Accounting and Auditing guidelines for future cost reporting.

As a result of these findings, the Department has reduced some BHO rates. The Department is also requesting additional resources (through R7) so that it can hire an auditor to conduct a thorough financial review of all community mental health centers' annual cost reports. This will ensure that all capitation payments represent the true cost of delivering services and are in compliance with federal regulations. Finally, as discussed in the next issue, the Department is proposing using some of the flexibility that is allowed under the new federal regulations to make incentive payments to BHOs.

[2] "Relative value unit" (RVU) is a measure of value used to determine reimbursements or rates for the federal Medicare and Medicaid programs.

ISSUE: ACCOUNTABLE CARE COLLABORATIVES PHASE II (R6)

On November 4, 2016, the Department of Health Care Policy and Financing (HCPF) released a draft request for proposals for phase II of the Accountable Care Collaborative. As part of an effort to integrate physical and behavioral health care, the Department proposes to combine the administrative functions of behavioral health organizations with those of regional care collaborative organizations starting July 1, 2018.

SUMMARY

- Since 1998, Colorado has provided behavioral health services to most Medicaid clients through a statewide "capitated" program, under which behavioral health organizations (BHOs) and their community mental health center partners function as fully at-risk managed care organizations. BHOs have been successful at providing a full continuum of client services, containing costs, and meeting contractual performance and quality measures.

- In 2011, HCPF launched the Accountable Care Collaborative (ACC) with goals to improve quality, increase access, and reduce costs in Medicaid. Under the ACC, regional collaborative care organizations (RCCOs) and primary care medical providers receive payments to coordinate clients' care and meet certain performance indicators, but reimbursements for health care services continue to be paid on a fee-for-service basis.

- In April 2015, HCPF announced that the administrative functions of the RCCOs and the BHOs will be integrated into a single regional accountable entity (RAE) in each of seven state regions, beginning July 1, 2017. HCPF, however, will pay directly for all clinical services, including behavioral health services. In February 2016, HCPF announced two important changes to this proposal: (a) a one year delay in implementation to July 1, 2018; and (2) retention of a capitation payment methodology for core behavioral health services.

- From now through January 13, 2017, HCPF will continue to solicit feedback on the draft RFP. HCPF plans to release the final RFP in the Spring of 2017, announce RAE awards in the Fall of 2017, and sign the contracts in early 2018 to go into effect July 1, 2018.

RECOMMENDATION

Staff suggests that the Committee ask HCPF to provide information at their January 3 hearing about any concerns they have received from behavioral health clients, providers, or advocacy groups. Staff also suggests that the Committee ask the Department to discuss at their January 3 hearing:

- Plans to use incentive payments for improved performance to mitigate anticipated decreases in behavioral health capitation rates and the associated loss of flexibility to implement innovative programs and services; and
- Plans to ensure continuity of care for those clients with severe mental illness or substance use issues both during and after the transition to the RAEs.

DISCUSSION

Background Information: Medicaid Behavioral Health Capitation Program

Since 1998, Colorado has provided behavioral health services to most Medicaid clients through a statewide managed care or "capitated" program. The Department contracts with regional entities, called behavioral health organizations (BHOs), to provide or arrange for behavioral health services for clients within their geographic region who are eligible for and enrolled in the Medicaid program. In order to receive services through a BHO, a client must have a covered diagnosis and receive a covered service or procedure that is medically necessary.

Each BHO receives a pre-determined monthly amount for each Medicaid client who is eligible for behavioral health services within its geographic area. The "per-member-per-month" rates paid to each BHO are unique for each Medicaid eligibility category in each geographic region. These rates are adjusted annually based on client utilization and BHO expenditures. The BHOs function as fully at-risk managed care organizations; they assume the risk of more clients than expected needing care or needing more intensive services than anticipated, and they are incentivized to ensure appropriate levels of care are provided while not exceeding anticipated cost and utilization rates. BHOs share this risk with the not-for-profit community mental health centers (Centers) in their region, providing sub-capitated payments based on the number of clients in their area. In fact, in three of the five regions Centers are part owners of the BHO[3]. As described in the previous issue brief, per capita costs under the capitation program have remained relatively flat.

In order to ensure that BHOs' cost containment efforts do not result in inappropriate care, HCPF contracts with BHOs include a number of performance measures, including 16 key indicators such as:

- Hospital readmissions at 7, 30, 90, and 180 days;
- The percent of members prescribed redundant/duplicated atypical antipsychotic medication;
- Psychotropic utilization in children;
- Engagement of alcohol or other drug dependence treatment;
- Penetration rates;
- Members with physical health well-care visits;
- Emergency department utilization for mental health condition; and
- Follow-up appointments within 7 and 30 days after hospital discharge for a mental health condition.

Accountable Care Collaborative (ACC) Program

In 2011, HCPF launched the Accountable Care Collaborative (ACC) with the goals to improve quality, increase access, and reduce costs in Medicaid. The ACC consists of three components:

- Regional collaborative care organizations (RCCOs), which are responsible for network development, provider support, care coordination, and accountability and reporting;

[3] These BHOs include: Behavioral Healthcare, Inc. (equally owned by the three Centers that serve Adams, Arapahoe, and Douglas counties and the City of Aurora); Foothills Behavioral Health Partners (equally owned by the two Centers that serve Boulder, Broomfield, Clear Creek, Gilpin, and Jefferson counties and by Beacon Health Options); and Colorado Health Partnerships (equally owned by the eight Centers that serve the 43 counties in southern and western Colorado and by Beacon Health Options).

- Primary care medical providers (PCMPs), which serve as a "medical home" for ACC members; and
- A statewide data and analytics contractor, which provides operational support and data to HCPF, RCCO staff, and PCMPs.

Each RCCO and PCMP receives a small per-member-per-month amount, and has the ability to earn additional funding based on their region's performance in meeting certain performance indicators. These payments are over and above traditional fee-for-service reimbursements providers receive for primary health care services.

ACC Phase II and Regional Accountable Entities

In April 2015, HCPF announced that the administrative functions of the RCCOs and BHOs will be integrated into a single "regional accountable entity" (RAE) in each of seven state regions. HCPF indicates that the goals of the next phase are to: (1) improve health and life outcome for members; and (2) use state resources wisely. The objectives of phase II include the following:

- Join physical and behavioral health under one accountable entity;
- Strengthen coordination of services by advancing team-based care and health neighborhoods;
- Promote member choice and engagement;
- Pay providers for the increased value they deliver; and
- Ensure greater accountability and transparency.

On November 4, 2016, the Department of Health Care Policy and Financing (HCPF) released a draft request for proposals for phase II. From now through January 13, 2017, HCPF will continue to solicit feedback on the draft RFP from clients, families, advocates, health care providers, vendors, legislators, and the public. HCPF plans to release the final RFP in the Spring of 2017, announce contract awards in the Fall of 2017, and sign the contracts in early 2018 to go into effect July 1, 2018. The contracts are anticipated to cover a seven year period (compared to five year term that has been used for BHO contracts).

Some key behavioral health-related changes in Phase II include:

- Functions of the BHOs and the RCCOs will be merged into the new RAEs. Capitation payments will be paid to RAEs, who will be responsible for managing the health needs of Medicaid enrollees in their region.
- The capitation payment will continue to support a full continuum of behavioral health services, from outpatient therapy to alternative community services to crisis response and hospitalization. This continuum will continue to include the list of alternative services covered by the current capitation program and the associated federal 1915 (b) (3) waiver.
- Clients seeking behavioral health services will continue to need to meet standards of "medical necessity". A client will also continue to need to have a "covered diagnosis" for Medicaid to pay for emergency department visits, inpatient hospitalization, and laboratory tests. However, requirements that a client have a covered diagnosis to receive behavioral health services will be relaxed to allow clients to receive limited therapies in a physical health setting.
- New performance incentives will reward increased behavioral health screening and the co-location of physical health and behavioral health services.
- RCCO and BHO regions would be realigned, affecting two counties. *Elbert County* would move from the region that includes El Paso, Teller, and Park counties to the region that includes

Douglas, Arapahoe, and Adams counties. Behavioral health services for *Larimer County* would move to the region that includes all the western counties. *[See Appendix G for a map of current BHO regions, Appendix H for a comparison of the current RCCO regions and the proposed RAE regions, and Appendix I for a listing of existing behavioral health service provider regions for each county.]*

- Clients would be attributed to RAEs based on the location of their primary care provider, rather than their own address, to reduce the number of RAEs that a primary care provider might need to contract with.

Behavioral Health Provider Concerns

Behavioral health providers have demonstrated their support for integrating behavioral and primary health care by investing the time and resources necessary to launch multiple local initiatives. However, a year ago, BHOs and community mental health centers expressed significant concerns about HCPF's plans for ACC Phase II. Many of these concerns related to HCPF's initial proposal to move away from the capitation payment method for behavioral health services to a modified fee-for-service payment method, and the short time frame for implementing a new funding and service delivery model. In February 2016, HCPF announced that it would: (1) retain the capitation payment methodology for core behavioral health services; and (2) delay the implementation by one year to July 1, 2018.

Due to timing of the release of the RFP, staff has not been able to attend related HCPF stakeholder meetings or gather meaningful feedback from behavioral health providers. Staff suggests that the Committee ask HCPF to provide information at their January 3 hearing (or at a date after January 13 when the stakeholder feedback process closes) about any concerns they have received from behavioral health clients, providers, or advocacy groups. Staff also suggests that the Committee ask the Department to discuss:

- Plans to use incentive payments for improved performance to mitigate anticipated decreases in behavioral health capitation rates and the associated loss of flexibility to implement innovative programs and services; and
- Plans to ensure continuity of care for those clients with severe mental illness or substance use issues both during and after the transition to the RAEs.

Appendix A: Number Pages

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	Request vs. Appropriation
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING **Sue Birch, Executive Director**					
(3) BEHAVIORAL HEALTH COMMUNITY PROGRAMS					
This section provides for behavioral health services through the purchase of services from five regional behavioral health organizations (BHOs), which manage mental health and substance use disorder services for eligible Medicaid recipients in a capitated, risk-based model. This section also contains funding for Medicaid behavioral health fee-for-service programs for those services not covered within the capitation contracts and rates. The funding for this section is primarily from the General Fund and federal Medicaid funds. Cash fund sources include the Hospital Provider Fee Cash Fund and the Breast and Cervical Cancer Prevention and Treatment Fund.					
Behavioral Health Capitation Payments	565,420,239	603,218,669	653,650,029	647,630,305	*
General Fund	173,415,971	166,102,477	181,949,404	173,967,178	
Cash Funds	5,333,335	9,773,437	16,383,180	26,612,883	
Federal Funds	386,670,933	427,342,755	455,317,445	447,050,244	
Behavioral Health Fee-for-service Payments	7,525,423	8,086,839	8,967,301	9,241,145	*
General Fund	2,946,662	1,881,329	1,678,280	2,010,180	
Cash Funds	20,963	71,017	249,835	382,610	
Federal Funds	4,557,798	6,134,493	7,039,186	6,848,355	
School-based Prevention and Intervention Substance Use Disorder Services	4,540,153	0	0	0	
General Fund	2,132,374	0	0	0	
Federal Funds	2,407,779	0	0	0	
School-based Substance Abuse Prevention and Intervention Grant Program	795,909	0	0	0	
General Fund	795,909	0	0	0	

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	Request vs. Appropriation
Contract Reprocurement	203,752	0	0	0	
General Fund	101,876	0	0	0	
Federal Funds	101,876	0	0	0	
TOTAL - (3) Behavioral Health Community Programs	578,485,476	611,305,508	662,617,330	656,871,450	(0.9%)
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	179,392,792	167,983,806	183,627,684	175,977,358	(4.2%)
Cash Funds	5,354,298	9,844,454	16,633,015	26,995,493	62.3%
Federal Funds	393,738,386	433,477,248	462,356,631	453,898,599	(1.8%)

NOTES:
An asterisk (*) indicates that the FY 2017-18 request for a line item is affected by one or more decision items.

APPENDIX B
RECENT LEGISLATION AFFECTING DEPARTMENT BUDGET

2015 SESSION BILLS

S.B. 15-228 (MEDICAID PROVIDER RATE REVIEW): Establishes an annual process for the Department of Health Care Policy and Financing to review Medicaid provider rates, creates an advisory committee, and requires reporting to the Joint Budget Committee. Provides $539,823 total funds, including $269,912 General Fund and $269,911 federal funds, and 4.0 FTE to implement the rate review process.

H.B. 15-1186 (SERVICES FOR CHILDREN WITH AUTISM): For the Children with Autism waiver program the bill:

1. Expands eligibility to add children ages 6 to 8
2. Allows children who begin receiving services before age 8 to receive a full three years of services, and no more than three years
3. Allows General Fund support and thereby eliminates the current enrollment cap of 75 children
4. Eliminates the annual statutory $25,000 per child expenditure cap on services and allows the cap to be adjusted through the budget process

Provides for an annual evaluation of the effectiveness of services for people with autism

To implement these changes, the bill provides a total of $10.6 million to the Department of Health Care Policy and Financing in FY 2015-16. This amount includes $295,672 for behavioral health services. The source of cash funds is tobacco settlement moneys deposited in the Autism Treatment Cash Fund.

H.B. 15-1368 (CROSS-SYSTEM RESPONSE PILOT INTELLECTUAL AND DEVELOPMENTAL DISABILITIES): Establishes the Cross-system Response for Behavioral Health Crises Pilot Program (Pilot Program) to provide crisis intervention, stabilization, and follow-up services to individuals who:

- Have both an intellectual or developmental disability and a mental health or behavioral disorder;
- Require services not available through an existing Medicaid waiver; and
- Are not covered under the Colorado behavioral health care system.

Requires the Pilot Program to begin on or before March 1, 2016 and consist of multiple sites that represent different geographic areas of the state. The Pilot Program must provide access to intensive coordinated psychiatric, behavioral, and mental health services as an alternative to emergency department care or in-patient hospitalization; offer community-based, mobile supports to individuals with dual diagnoses and their families; offer follow-up supports to individuals with dual diagnoses, their families, and their caregivers to reduce the likelihood of future crises; provide education and training for families and service agencies; provide data about the cost in Colorado of providing such services throughout the state; and provide data to inform changes to existing regulatory or procedural barriers to the authorized use of public funds across systems, including the Medicaid

state plan, home- and community-based service Medicaid waivers, and the capitated mental health system.

Requires the Department of Health Care Policy and Financing (Department) to conduct a cost-analysis study related to the services that would need to be added to eliminate service gaps and ensure that individuals with intellectual and developmental disabilities are fully included in the Colorado behavioral health system. Also, requires the Department to provide recommendations for eliminating the service gap. Authorizes the Departments of Human Services and Health Care Policy and Financing to examine the feasibility of allowing a Community Centered-Board to use a vacant Regional Center group home for the Pilot Program. Appropriates $1,695,000 cash funds from the Intellectual and Developmental Disabilities Services Cash Fund to the Cross-system Response for Behavioral Health Crises Pilot Program Fund and reappropriates this money for the pilots in the Department of Health Care Policy and Financing for FY 2015-16.

2016 SESSION BILLS

H.B. 16-1407 (EXTEND MEDICAID PAYMENT REFORM & INNOVATION PILOT): Extends the Medicaid Payment Reform and Innovation Pilot Program (established through H.B. 12-1281) that allows contractors to work with providers and managed care entities to develop a payment reform project and submit a proposal to the Department. Removes statutory dates concerning the selection of and completion of payment reform projects, allowing projects that have been approved to continue beyond June 30, 2016, and allowing the Department to continue selecting new projects for the Pilot Program. Amends associated evaluation and reporting requirements. Appropriates $245,639 General Fund to the Department of Health Care Policy and Financing for FY 2016-17, and states that the appropriation is based on the assumptions that the Department will require an additional 1.0 FTE and that the Department will receive $347,064 federal funds to implement the act. This funding essentially reinstates full funding for the Department to evaluate proposals that are submitted, validate and certify provider rates, review managed care contracts, evaluate the payment reform projects that are approved, and prepare the required reports.

APPENDIX C
FOOTNOTES AND INFORMATION REQUESTS

UPDATE ON LONG BILL FOOTNOTES

This footnote was included in the FY 2015-16 Long Bill, and was not continued in the subsequent two Long Bills. Staff has included it in this briefing in order to provide an update on the implementation of the rate increase that was initially funded for FY 2015-16, and has been continued for FY 2016-17 and FY 2017-18.

17 Department of Health Care Policy and Financing, Department of Human Services Medicaid-funded Programs, Behavioral Health Services - Medicaid Funding, High Risk Pregnant Women Program -- This appropriation is intended to include sufficient funding for the Department of Health Care Policy and Financing to implement the following provider rate increases for this program: (a) a $13.98 (91.3 percent) increase in the outpatient group rate; (b) a $31.26 (20.0 percent) increase in the per diem rate; plus (c) an overall rate increase of 1.7 percent.

COMMENT: This footnote was included in the FY 2015-16 Long Bill to identify the specific rate increases for which funding was provided. The Department submitted the necessary State Plan Amendment (Clinical Services SPA) on June 3, 2015, and the federal Centers for Medicare and Medicaid Services (CMS) approved it on April 12, 2016. The Department indicated that the increase to the per diem rate, which is the largest portion of expenditure for this line item, was implemented in April, and the mass adjustment necessary to account for the July 1, 2015, effective date of the increase was completed by May 9, 2016. The adjustments were made directly to the claims in the Medicaid Management Information System (MMIS), and the Department estimates that $54,464 was paid out in FY 2015-16 for the rate increase.

As of the date that this document was finalized, the Department was investigating whether the outpatient group rate increase and retroactive adjustment have been completed.

UPDATE ON REQUESTS FOR INFORMATION

2 Department of Health Care Policy and Financing, Executive Director's Office -- The Department is requested to submit monthly Medicaid expenditure and caseload reports on the Medical Services Premiums, behavioral health capitation, and the intellectual and developmental disabilities line items to the Joint Budget Committee, by the fifteenth or first business day following the fifteenth of each month. The Department is requested to include in the report the managed care organization caseload by aid category. The Department is also requested to provide caseload and expenditure data for the Children's Basic Health Plan, the Medicare Modernization Act State Contribution Payment, and the Old Age Pension State Medical Program within the monthly report. The Department is also requested to include in the report the number of applications and the number of approvals for new intermediate care facilities for individuals with intellectual disabilities, including the number of beds and the cost of those beds.

COMMENT: The Department submitted the requested information each month, as directed. The information is also available on the Department's website at:
https://www.colorado.gov/pacific/hcpf/premiums-expenditures-and-caseload-reports
This information can be used to track changes in caseloads and rates that affect behavioral health capitation payments.

APPENDIX D
DEPARTMENT ANNUAL PERFORMANCE REPORT

Pursuant to Section 2-7-205 (1) (a) (I), C.R.S., the Office of State Planning and Budgeting is required to publish an Annual Performance Report for the Department of Health Care Policy and Financing by November 1 of each year. This report is to include a summary of the Department's performance plan and most recent performance evaluation. For consideration by the Joint Budget Committee in prioritizing the Department's budget request, the FY 2015-16 report dated October 2016 can be found at the following link:

https://drive.google.com/file/d/0B8ztIiGduUWbb05BRXN6dWRGS0E/view

Pursuant to Section 2-7-204 (3) (a) (I), C.R.S., the Department of Health Care Policy and Financing is required to develop a performance plan and submit that plan to the Joint Budget Committee and appropriate Joint Committee of Reference by July 1 of each year. For consideration by the Joint Budget Committee in prioritizing the Department's budget request, the FY 2016-17 plan dated June 24, 2016 can be found at the following link:

https://drive.google.com/file/d/0B8ztIiGduUWba04wWnJIdTloV0E/view

APPENDIX E
FY 2016-17 BEHAVIORAL HEALTH CAPITATION PAYMENTS CALCULATIONS

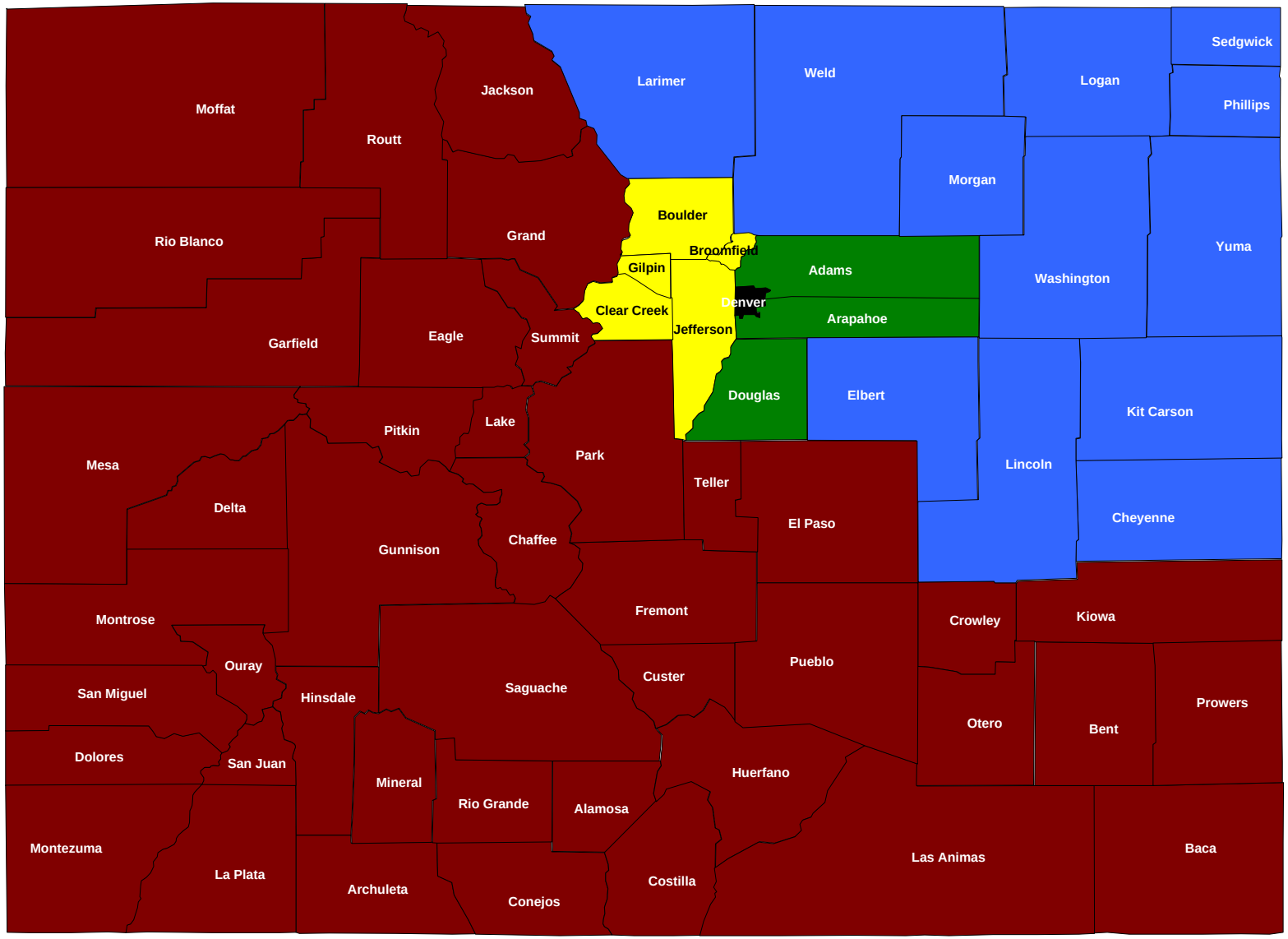
	Eligibility Category								
Description	Adults Age 65+ (to SSI)	Individuals With Disabilities up to age 64 (to 450% FPL)	Parents/ Caretakers (to 68% FPL); Pregnant Adults (to 200% FPL)	Parents/ Caretakers (69% to 138% FPL)*	Adults without Dependent Children (to 138% FPL)*	Children (to 147% FPL)	Individuals In/ Formerly In Foster Care (up to age 26)	Breast and Cervical Cancer Program (to 250% FPL)	Total
Weighted capitation rate (per member, per month)	$18.03	$139.91	$29.07	$16.53	$53.62	$19.87	$125.80	$29.07	
Estimated monthly caseload	43,412	85,959	209,008	98,910	366,209	552,392	20,185	286	1,376,361
Number of months rate is effective	12	12	12	12	12	12	12	12	
Total estimated capitated payments	**$9,392,620**	**$144,318,284**	**$72,910,351**	**$19,619,788**	**$235,633,519**	**$131,712,348**	**$30,471,276**	**$99,768**	**$644,157,955**
Estimated expenditures:									
Claims paid in current period	$9,341,900	$143,697,715	$72,640,583	$19,509,917	$234,620,295	$131,290,868	$30,422,522	$99,678	$641,623,478
Claims from prior periods	43,792	581,581	213,410	323,273	941,378	405,312	63,677	120	2,572,543
Estimated date of death retractions	(103,656)	(371,143)	(17,371)	(7,758)	(137,340)	(7,758)	(21,349)	(776)	(667,151)
Total expenditures after retractions	$9,282,036	$143,908,153	$72,836,622	$19,825,432	$235,424,333	$131,688,422	$30,464,850	$99,022	$643,528,870
Other payment adjustments:									
Risk corridor reconciliation	$0	$0	$0	($973,545)	($23,192,045)	$0	$0	$0	($24,165,590)
Expansion parents rate reconciliation	0	0	0	(18,947,943)	0	0	0	0	(18,947,943)
Adjustment for clients placed in incorrect eligibility categories	0	(3,348,474)	0	0	0	280,776	0	0	(3,067,698)
NET EXPENDITURES	**$9,282,036**	**$140,559,679**	**$72,836,622**	**($96,056)**	**$212,232,288**	**$131,969,198**	**$30,464,850**	**$99,022**	**$597,347,639**
Annual per capita expenditure (excl. other payment adjustments)	**$213.81**	**$1,674.15**	**$348.49**	**$200.44**	**$642.87**	**$238.40**	**$1,509.28**	**$346.23**	**$467.56**

* These are new eligibility categories authorized by S.B. 13-200.

APPENDIX F
FY 2017-18 BEHAVIORAL HEALTH CAPITATION PAYMENTS CALCULATIONS

	Eligibility Category								
Description	Adults Age 65+ (to SSI)	Individuals With Disabilities up to age 64 (to 450% FPL)	Parents/ Caretakers (to 68% FPL); Pregnant Adults (to 200% FPL)	Parents/ Caretakers (69% to 138% FPL)*	Adults without Dependent Children (to 138% FPL)*	Children (to 147% FPL)	Individuals In/ Formerly In Foster Care (up to age 26)	Breast and Cervical Cancer Program (to 250% FPL)	Total
Weighted capitation rate (per member, per month)	$18.03	$139.91	$29.07	$16.53	$53.62	$19.87	$125.80	$29.07	
Estimated monthly caseload	44,137	89,039	215,934	108,821	391,871	571,582	20,290	179	1,441,853
Number of months rate is effective	12	12	12	12	12	12	12	12	
Total estimated capitated payments	**$9,549,481**	**$149,489,358**	**$75,326,417**	**$21,585,734**	**$252,145,476**	**$136,288,012**	**$30,629,784**	**$62,442**	**$675,076,704**
Estimated expenditures:									
Claims paid in current period	$9,497,914	$148,846,554	$75,047,709	$21,464,854	$251,061,250	$135,851,890	$30,580,776	$62,386	$672,413,333
Claims from prior periods	50,720	620,569	269,768	109,871	1,013,224	421,480	48,754	90	2,534,476
Estimated date of death retractions	(93,290)	(334,029)	(15,634)	(6,982)	(123,606)	(6,982)	(19,214)	(698)	(600,435)
Total expenditures after retractions	$9,455,344	$149,133,094	$75,301,843	$21,567,743	$251,950,868	$136,266,388	$30,610,316	$61,778	$674,347,374
Other payment adjustments:									
Risk corridor reconciliation	$0	$0	$0	$0	$0	$0	$0	$0	$0
Expansion parents rate reconciliation	0	0	0	0	0	0	0	0	0
Adjustment for clients placed in incorrect eligibility categories	0	0	0	0	0	0	0	0	0
Decision items:									
R6 Delivery system and payment reform	(393,261)	(5,954,038)	(2,986,367)	(827,040)	(9,941,767)	(5,395,734)	(1,216,386)	(2,476)	(26,717,069)
NET EXPENDITURES	**$9,062,083**	**$143,179,056**	**$72,315,476**	**$20,740,703**	**$242,009,101**	**$130,870,654**	**$29,393,930**	**$59,302**	**$647,630,305**
Annual per capita expenditure	**$205.32**	**$1,608.05**	**$334.90**	**$190.59**	**$617.57**	**$228.96**	**$1,448.69**	**$331.30**	**$449.17**

* These are new eligibility categories authorized by S.B. 13-200.

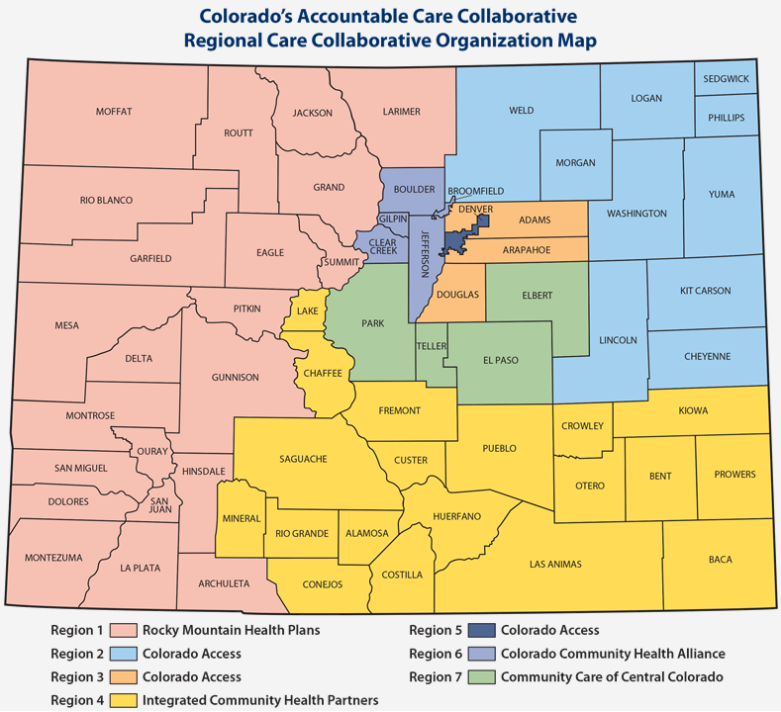


Colorado Medicaid Capitation
Behavioral Health Organizations
by Geographic Service Area

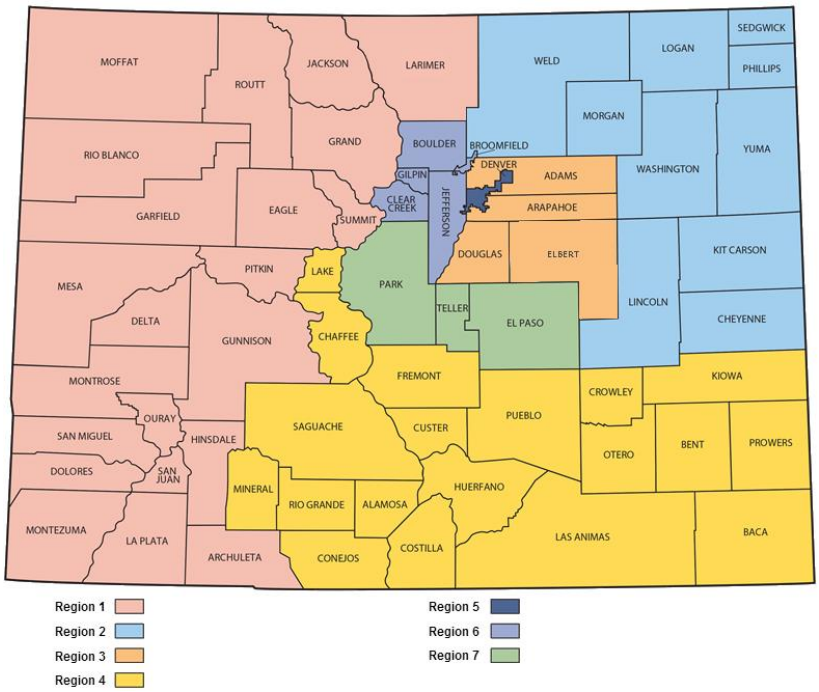
- Northeast: Access Behavioral Care (Colorado Access)
- Metro: Access Behavioral Care (Colorado Access)
- Metro West: Foothills Behavioral Health Partners, LLC
- Metro East: Behavioral Healthcare, Inc.
- Colorado Health Partnerships, LLC

Provided by the Colorado Behavioral Healthcare Council

ACC Phase I: Current RCCO Map



ACC Phase II: Regional Accountable Entity Map



Provided by the Department of Health Care Policy and Financing

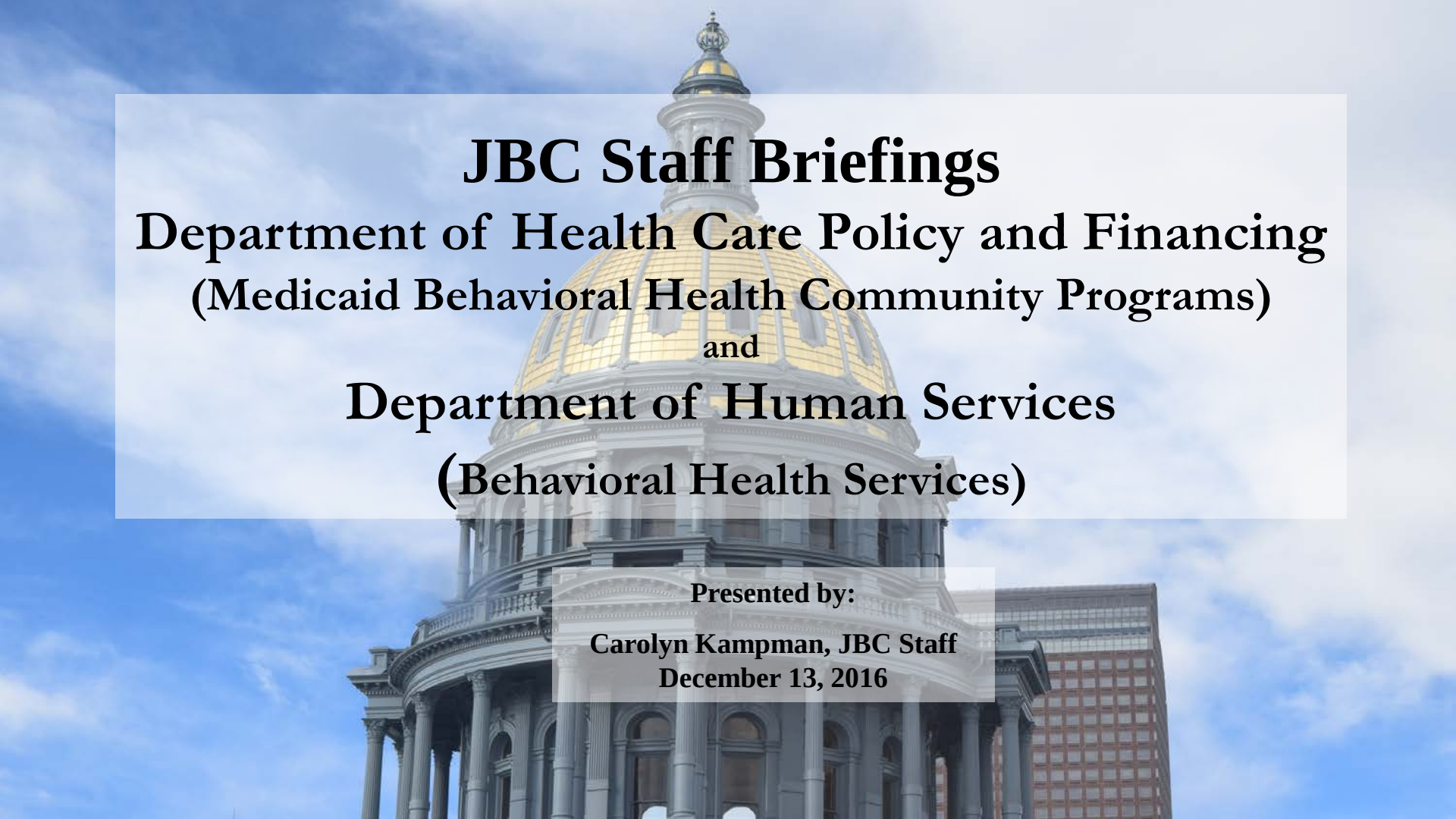
Appendix C - State Agency Service Area Crosswalk

County	County Designation	CMHC	BHO	Crisis Services Region	MSO	SSPA	RCCO
Adams	Urban	Community Reach Center (Community Reach)	Behavioral Healthcare, Inc. (BHI)	Community Crisis Connection	Signal Behavioral Health Network, Inc.	2 (Metro Denver)	Region 3-Colorado Access
Alamosa	Rural	San Luis Valley	Colorado Health Partnerships, LLC (CHP)	AspenPointe	Signal Behavioral Health Network, Inc.	4 (Southeast)	Region 4-Integrated Community Health Partners
Arapahoe	Urban	AllHealth	Behavioral Healthcare, Inc. (BHI)	Community Crisis Connection	Signal Behavioral Health Network, Inc.	2 (Metro Denver)	Region 3-Colorado Access
Archuleta	Rural	Axis Health	Colorado Health Partnerships, LLC (CHP)	West Slope Casa	West Slope Casa, LLC	5 (Southwest)	Region 1-Rocky Mountain Health Plans
Baca	Frontier	Southeast	Colorado Health Partnerships, LLC (CHP)	AspenPointe	Signal Behavioral Health Network, Inc.	4 (Southeast)	Region 4-Integrated Community Health Partners
Bent	Frontier	Southeast	Colorado Health Partnerships, LLC (CHP)	AspenPointe	Signal Behavioral Health Network, Inc.	4 (Southeast)	Region 4-Integrated Community Health Partners
Boulder	Urban	Mental Health Partners (MHP)	Foothills Behavioral Health Partners, LLC (FBHP)	Community Crisis Connection	Mental Health Partners	7	Region 6-Colorado Community Health Alliance
Broomfield	Urban	Mental Health Partners (MHP)	Foothills Behavioral Health Partners, LLC (FBHP)	Community Crisis Connection	Mental Health Partners	7	Region 6-Colorado Community Health Alliance
Chaffee	Rural	SolVista Health (Solvista)	Colorado Health Partnerships, LLC (CHP)	AspenPointe	AspenPointe	3	Region 4-Integrated Community Health Partners
Cheyenne	Frontier	Centennial	Access Behavioral Care - Northeast (Colorado Access; ABC-NE)	Northeast Behavioral Health	Signal Behavioral Health Network, Inc.	1 (Northeast)	Region 2-Colorado Access
Clear Creek	Urban	Jefferson	Foothills Behavioral Health Partners, LLC (FBHP)	Community Crisis Connection	Signal Behavioral Health Network, Inc.	2 (Metro Denver)	Region 6-Colorado Community Health Alliance
Conejos	Rural	San Luis Valley	Colorado Health Partnerships, LLC (CHP)	AspenPointe	Signal Behavioral Health Network, Inc.	4 (Southeast)	Region 4-Integrated Community Health Partners
Costilla	Frontier	San Luis Valley	Colorado Health Partnerships, LLC (CHP)	AspenPointe	Signal Behavioral Health Network, Inc.	4 (Southeast)	Region 4-Integrated Community Health Partners
Crowley	Rural	Southeast	Colorado Health Partnerships, LLC (CHP)	AspenPointe	Signal Behavioral Health Network, Inc.	4 (Southeast)	Region 4-Integrated Community Health Partners
Custer	Frontier	SolVista Health (Solvista)	Colorado Health Partnerships, LLC (CHP)	AspenPointe	AspenPointe	3	Region 4-Integrated Community Health Partners
Delta	Rural	The Center for Mental Health (CMH)	Colorado Health Partnerships, LLC (CHP)	West Slope Casa	West Slope Casa, LLC	5 (Southwest)	Region 1-Rocky Mountain Health Plans
Denver	Urban	Mental Health Center of Denver (MHCD)	Access Behavioral Care - Denver Metro (Colorado Access; ABC-Denver	Community Crisis Connection	Signal Behavioral Health Network, Inc.	2 (Metro Denver)	Region 5: Colorado Access
Dolores	Frontier	Axis Health	Colorado Health Partnerships, LLC (CHP)	West Slope Casa	West Slope Casa, LLC	5 (Southwest)	Region 1-Rocky Mountain Health Plans
Douglas	Urban	AllHealth	Behavioral Healthcare, Inc. (BHI)	Community Crisis Connection	AspenPointe	3	Region 3-Colorado Access
Eagle	Rural	Mind Springs	Colorado Health Partnerships, LLC (CHP)	West Slope Casa	West Slope Casa, LLC	6 (Northwest)	Region 1-Rocky Mountain Health Plans
El Paso	Urban	AspenPointe	Colorado Health Partnerships, LLC (CHP)	AspenPointe	AspenPointe	3	Region 7-Community Care of Central Colorado
Elbert	Urban	Centennial	Access Behavioral Care - Northeast (Colorado Access; ABC-NE)	Northeast Behavioral Health	Signal Behavioral Health Network, Inc.	1 (Northeast)	Region 7-Community Care of Central Colorado

County	County Designation	CMHC	BHO	Crisis Services Region	MSO	SSPA	RCCO
Fremont	Rural	SolVista Health (Solvista)	Colorado Health Partnerships, LLC (CHP)	AspenPointe	AspenPointe	3	Region 4-Integrated Community Health Partners
Garfield	Rural	Mind Springs	Colorado Health Partnerships, LLC (CHP)	West Slope Casa	West Slope Casa, LLC	6 (Northwest)	Region 1-Rocky Mountain Health Plans
Gilpin	Urban	Jefferson	Foothills Behavioral Health Partners, LLC (FBHP)	Community Crisis Connection	Signal Behavioral Health Network, Inc.	2 (Metro Denver)	Region 6-Colorado Community Health Alliance
Grand	Rural	Mind Springs	Colorado Health Partnerships, LLC (CHP)	West Slope Casa	West Slope Casa, LLC	6 (Northwest)	Region 1-Rocky Mountain Health Plans
Gunnison	Frontier	The Center for Mental Health (CMH)	Colorado Health Partnerships, LLC (CHP)	West Slope Casa	West Slope Casa, LLC	5 (Southwest)	Region 1-Rocky Mountain Health Plans
Hinsdale	Frontier	The Center for Mental Health (CMH)	Colorado Health Partnerships, LLC (CHP)	West Slope Casa	West Slope Casa, LLC	5 (Southwest)	Region 1-Rocky Mountain Health Plans
Huerfano	Frontier	Health Solutions	Colorado Health Partnerships, LLC (CHP)	AspenPointe	Signal Behavioral Health Network, Inc.	4 (Southeast)	Region 4-Integrated Community Health Partners
Jackson	Frontier	Mind Springs	Colorado Health Partnerships, LLC (CHP)	West Slope Casa	West Slope Casa, LLC	6 (Northwest)	Region 1-Rocky Mountain Health Plans
Jefferson	Urban	Jefferson	Foothills Behavioral Health Partners, LLC (FBHP)	Community Crisis Connection	Signal Behavioral Health Network, Inc.	2 (Metro Denver)	Region 6-Colorado Community Health Alliance
Kiowa	Frontier	Southeast	Colorado Health Partnerships, LLC (CHP)	AspenPointe	Signal Behavioral Health Network, Inc.	4 (Southeast)	Region 4-Integrated Community Health Partners
Kit Carson	Frontier	Centennial	Access Behavioral Care - Northeast (Colorado Access; ABC-NE)	Northeast Behavioral Health	Signal Behavioral Health Network, Inc.	1 (Northeast)	Region 2-Colorado Access
La Plata	Rural	Axis Health	Colorado Health Partnerships, LLC (CHP)	West Slope Casa	West Slope Casa, LLC	5 (Southwest)	Region 1-Rocky Mountain Health Plans
Lake	Rural	SolVista Health (Solvista)	Colorado Health Partnerships, LLC (CHP)	AspenPointe	AspenPointe	3	Region 4-Integrated Community Health Partners
Larimer	Urban	SummitStone	Access Behavioral Care - Northeast (Colorado Access; ABC-NE)	Northeast Behavioral Health	Signal Behavioral Health Network, Inc.	1 (Northeast)	Region 1-Rocky Mountain Health Plans
Las Animas	Frontier	Health Solutions	Colorado Health Partnerships, LLC (CHP)	AspenPointe	Signal Behavioral Health Network, Inc.	4 (Southeast)	Region 4-Integrated Community Health Partners
Lincoln	Frontier	Centennial	Access Behavioral Care - Northeast (Colorado Access; ABC-NE)	Northeast Behavioral Health	Signal Behavioral Health Network, Inc.	1 (Northeast)	Region 2-Colorado Access
Logan	Rural	Centennial	Access Behavioral Care - Northeast (Colorado Access; ABC-NE)	Northeast Behavioral Health	Signal Behavioral Health Network, Inc.	1 (Northeast)	Region 2-Colorado Access
Mesa	Urban	Mind Springs	Colorado Health Partnerships, LLC (CHP)	West Slope Casa	West Slope Casa, LLC	6 (Northwest)	Region 1-Rocky Mountain Health Plans
Mineral	Frontier	San Luis Valley	Colorado Health Partnerships, LLC (CHP)	AspenPointe	Signal Behavioral Health Network, Inc.	4 (Southeast)	Region 4-Integrated Community Health Partners
Moffat	Frontier	Mind Springs	Colorado Health Partnerships, LLC (CHP)	West Slope Casa	West Slope Casa, LLC	6 (Northwest)	Region 1-Rocky Mountain Health Plans
Montezuma	Rural	Axis Health	Colorado Health Partnerships, LLC (CHP)	West Slope Casa	West Slope Casa, LLC	5 (Southwest)	Region 1-Rocky Mountain Health Plans
Montrose	Rural	The Center for Mental Health (CMH)	Colorado Health Partnerships, LLC (CHP)	West Slope Casa	West Slope Casa, LLC	5 (Southwest)	Region 1-Rocky Mountain Health Plans
Morgan	Rural	Centennial	Access Behavioral Care - Northeast (Colorado Access; ABC-NE)	Northeast Behavioral Health	Signal Behavioral Health Network, Inc.	1 (Northeast)	Region 2-Colorado Access
Otero	Rural	Southeast	Colorado Health Partnerships, LLC (CHP)	AspenPointe	Signal Behavioral Health Network, Inc.	4 (Southeast)	Region 4-Integrated Community Health Partners

County	County Designation	CMHC	BHO	Crisis Services Region	MSO	SSPA	RCCO
Ouray	Rural	The Center for Mental Health (CMH)	Colorado Health Partnerships, LLC (CHP)	West Slope Casa	West Slope Casa, LLC	5 (Southwest)	Region 1-Rocky Mountain Health Plans
Park	Urban	AspenPointe	Colorado Health Partnerships, LLC (CHP)	AspenPointe	AspenPointe	3	Region 7-Community Care of Central Colorado
Phillips	Rural	Centennial	Access Behavioral Care - Northeast (Colorado Access; ABC-NE)	Northeast Behavioral Health	Signal Behavioral Health Network, Inc.	1 (Northeast)	Region 2-Colorado Access
Pitkin	Rural	Mind Springs	Colorado Health Partnerships, LLC (CHP)	West Slope Casa	West Slope Casa, LLC	6 (Northwest)	Region 1-Rocky Mountain Health Plans
Prowers	Rural	Southeast	Colorado Health Partnerships, LLC (CHP)	AspenPointe	Signal Behavioral Health Network, Inc.	4 (Southeast)	Region 4-Integrated Community Health Partners
Pueblo	Urban	Health Solutions	Colorado Health Partnerships, LLC (CHP)	AspenPointe	Signal Behavioral Health Network, Inc.	4 (Southeast)	Region 4-Integrated Community Health Partners
Rio Blanco	Frontier	Mind Springs	Colorado Health Partnerships, LLC (CHP)	West Slope Casa	West Slope Casa, LLC	6 (Northwest)	Region 1-Rocky Mountain Health Plans
Rio Grande	Rural	San Luis Valley	Colorado Health Partnerships, LLC (CHP)	AspenPointe	Signal Behavioral Health Network, Inc.	4 (Southeast)	Region 4-Integrated Community Health Partners
Routt	Rural	Mind Springs	Colorado Health Partnerships, LLC (CHP)	West Slope Casa	West Slope Casa, LLC	6 (Northwest)	Region 1-Rocky Mountain Health Plans
Saguache	Frontier	San Luis Valley	Colorado Health Partnerships, LLC (CHP)	AspenPointe	Signal Behavioral Health Network, Inc.	4 (Southeast)	Region 4-Integrated Community Health Partners
San Juan	Frontier	Axis Health	Colorado Health Partnerships, LLC (CHP)	West Slope Casa	West Slope Casa, LLC	5 (Southwest)	Region 1-Rocky Mountain Health Plans
San Miguel	Frontier	The Center for Mental Health (CMH)	Colorado Health Partnerships, LLC (CHP)	West Slope Casa	West Slope Casa, LLC	5 (Southwest)	Region 1-Rocky Mountain Health Plans
Sedgwick	Frontier	Centennial	Access Behavioral Care - Northeast (Colorado Access; ABC-NE)	Northeast Behavioral Health	Signal Behavioral Health Network, Inc.	1 (Northeast)	Region 2-Colorado Access
Summit	Rural	Mind Springs	Colorado Health Partnerships, LLC (CHP)	West Slope Casa	West Slope Casa, LLC	6 (Northwest)	Region 1-Rocky Mountain Health Plans
Teller	Urban	AspenPointe	Colorado Health Partnerships, LLC (CHP)	AspenPointe	AspenPointe	3	Region 7-Community Care of Central Colorado
Washington	Frontier	Centennial	Access Behavioral Care - Northeast (Colorado Access; ABC-NE)	Northeast Behavioral Health	Signal Behavioral Health Network, Inc.	1 (Northeast)	Region 2-Colorado Access
Weld	Urban	North Range Behavioral Health (North Range)	Access Behavioral Care - Northeast (Colorado Access; ABC-NE)	Northeast Behavioral Health	Signal Behavioral Health Network, Inc.	1 (Northeast)	Region 2-Colorado Access
Yuma	Frontier	Centennial	Access Behavioral Care - Northeast (Colorado Access; ABC-NE)	Northeast Behavioral Health	Signal Behavioral Health Network, Inc.	1 (Northeast)	Region 2-Colorado Access
Adams/ Arapahoe		Aurora Mental Health Center (Aurora)	Behavioral Healthcare, Inc. (BHI)	Community Crisis Connection	Signal Behavioral Health Network, Inc.	2 (Metro Denver)	Region 3-Colorado Access

County Designation source: Colorado Department of Public Health and Environment (CDPHE) **https://www.colorado.gov/pacific/cdphe/download-data-gis-format**. Data was updated to reflect the 2008-2012 Five-Year American Community Survey estimates and 2010 U.S. Census data.



JBC Staff Briefings

Department of Health Care Policy and Financing

(Medicaid Behavioral Health Community Programs)

and

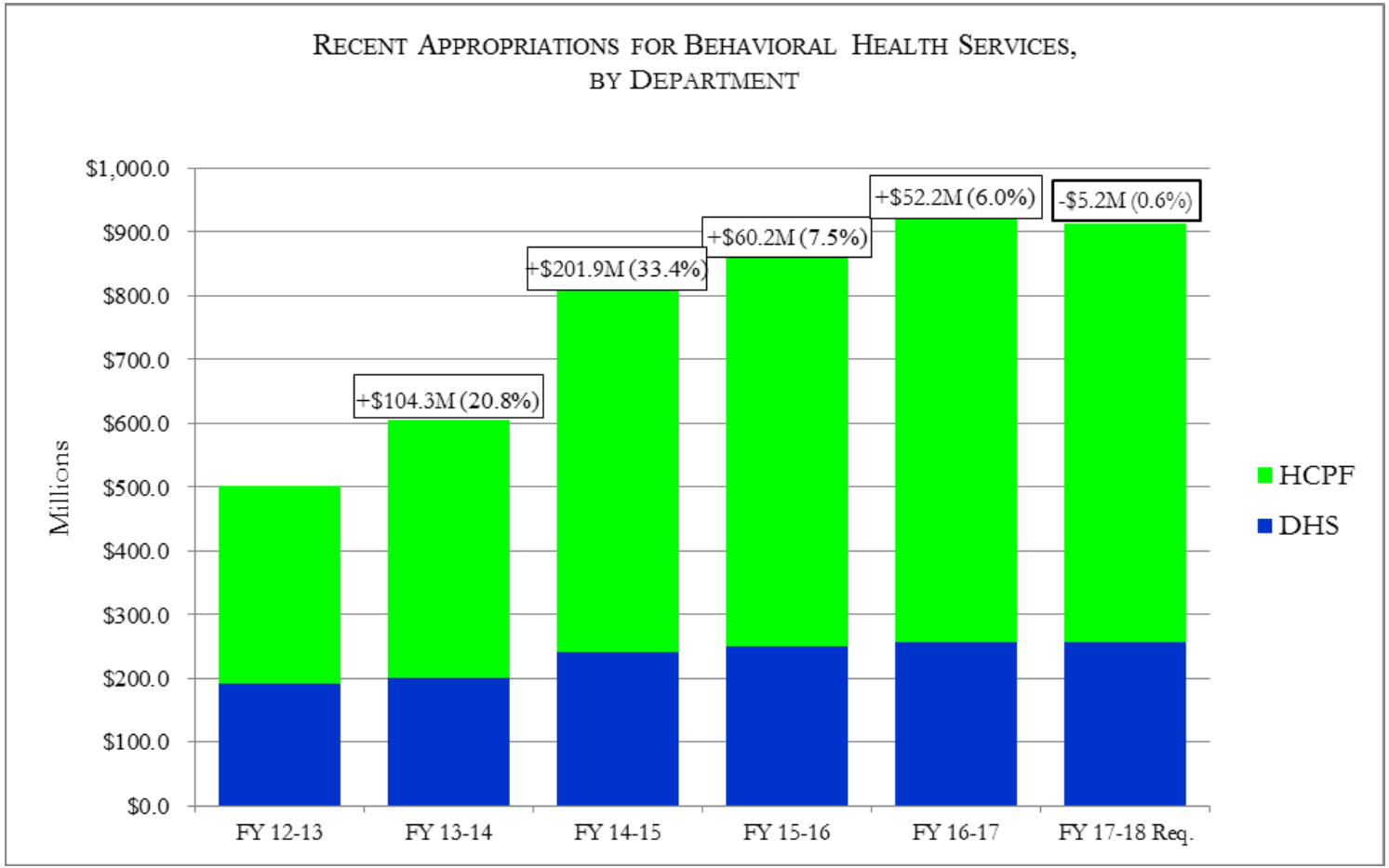
Department of Human Services

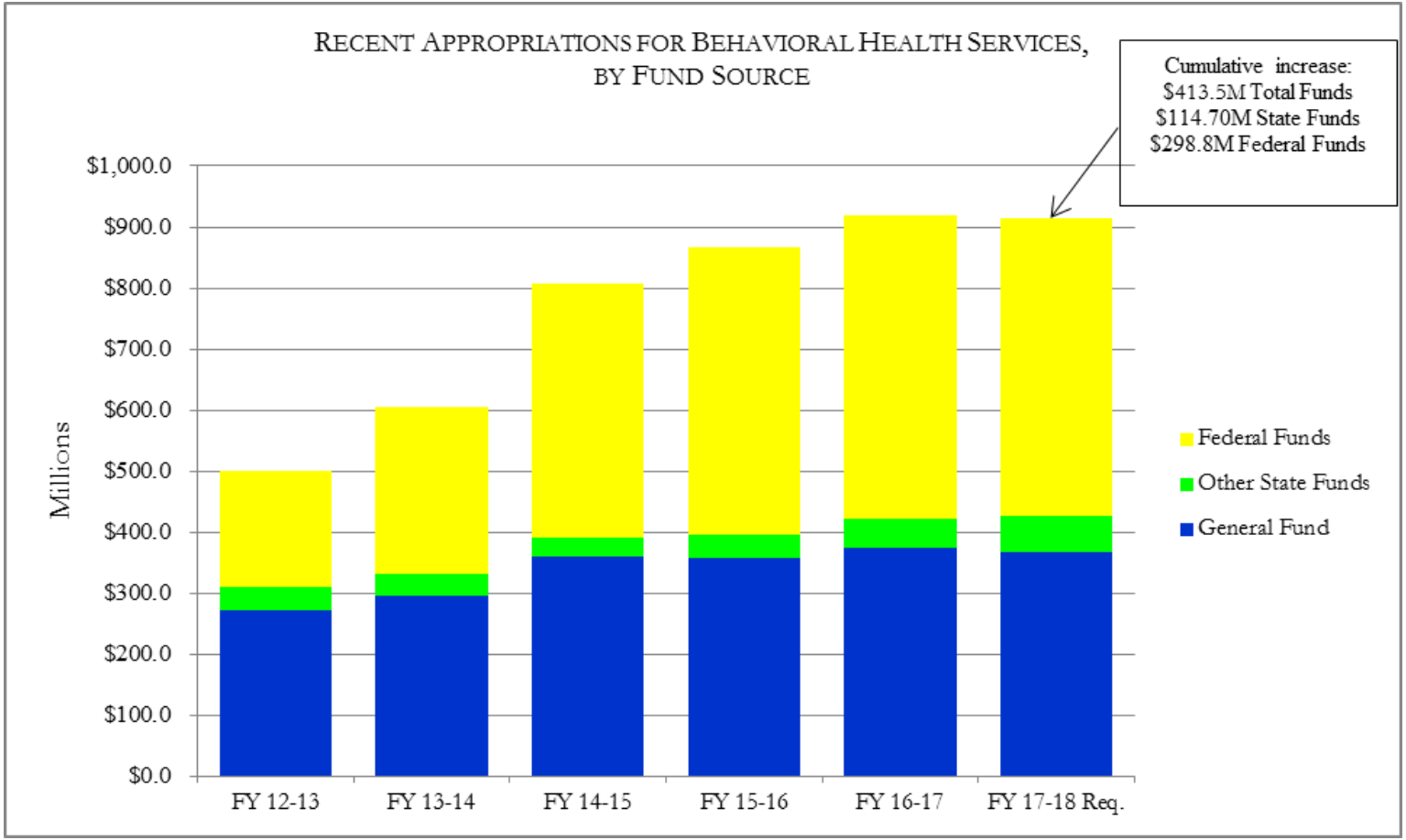
(Behavioral Health Services)

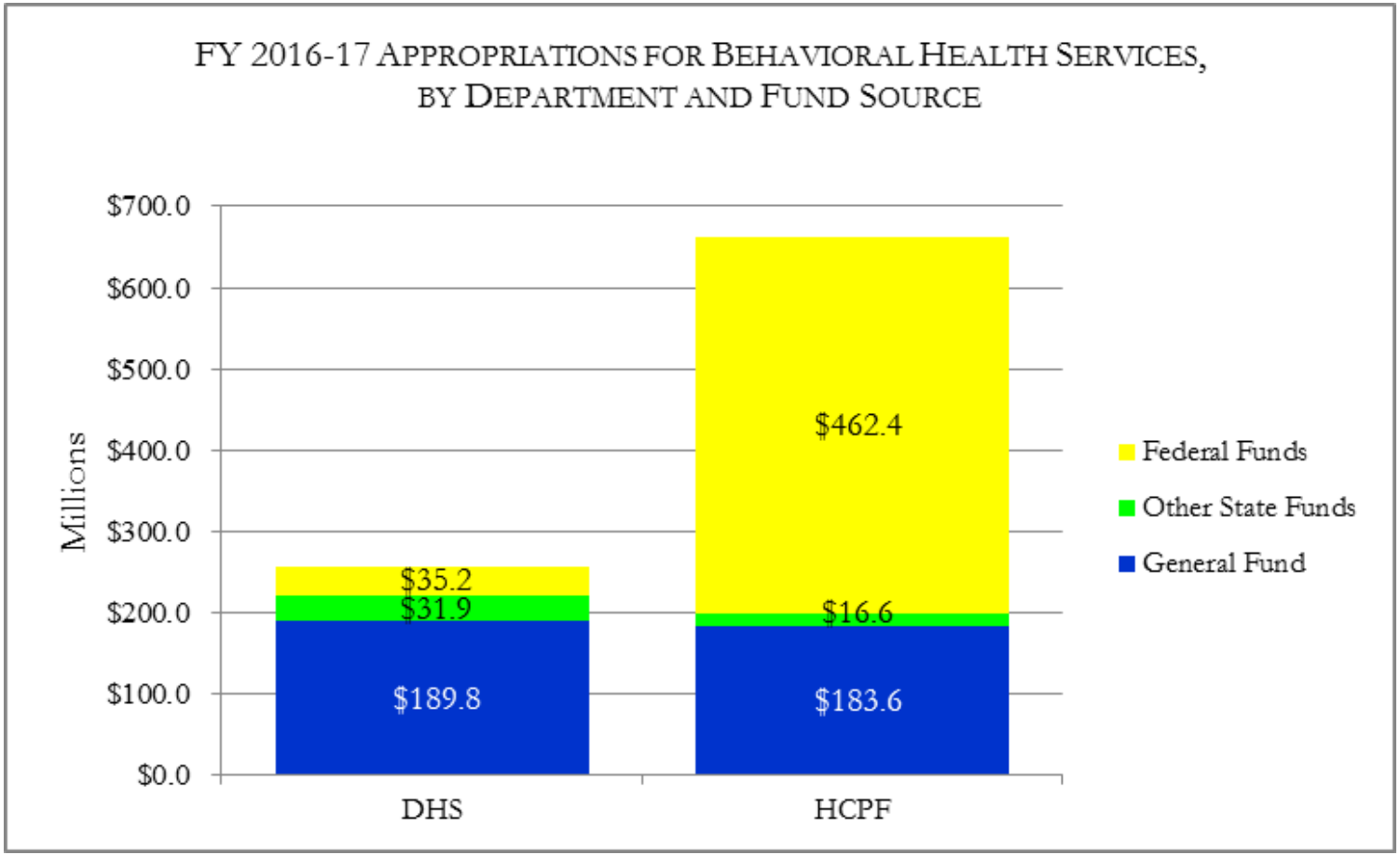
Presented by:

Carolyn Kampman, JBC Staff

December 13, 2016


RECENT APPROPRIATIONS FOR BEHAVIORAL HEALTH SERVICES, BY DEPARTMENT
$1,000.0
$900.0
$800.0
$700.0
$600.0
$500.0
$400.0
$300.0
$200.0
$100.0
$0.0
Millions
+$104.3M (20.8%)
+$201.9M (33.4%)
+$60.2M (7.5%)
+$52.2M (6.0%)
-$5.2M (0.6%)
FY 12-13
FY 13-14
FY 14-15
FY 15-16
FY 16-17
FY 17-18 Req.
HCPF
DHS


RECENT APPROPRIATIONS FOR BEHAVIORAL HEALTH SERVICES, BY FUND SOURCE
Cumulative increase:
$413.5M Total Funds
$114.70M State Funds
$298.8M Federal Funds
Millions
$1,000.0
$900.0
$800.0
$700.0
$600.0
$500.0
$400.0
$300.0
$200.0
$100.0
$0.0
FY 12-13
FY 13-14
FY 14-15
FY 15-16
FY 16-17
FY 17-18 Req.
Federal Funds
Other State Funds
General Fund


FY 2016-17 Appropriations for Behavioral Health Services, by Department and Fund Source
Millions
$700.0
$600.0
$500.0
$400.0
$300.0
$200.0
$100.0
$0.0
$35.2
$31.9
$189.8
$462.4
$16.6
$183.6
DHS
HCPF
Federal Funds
Other State Funds
General Fund

JBC Staff Briefing

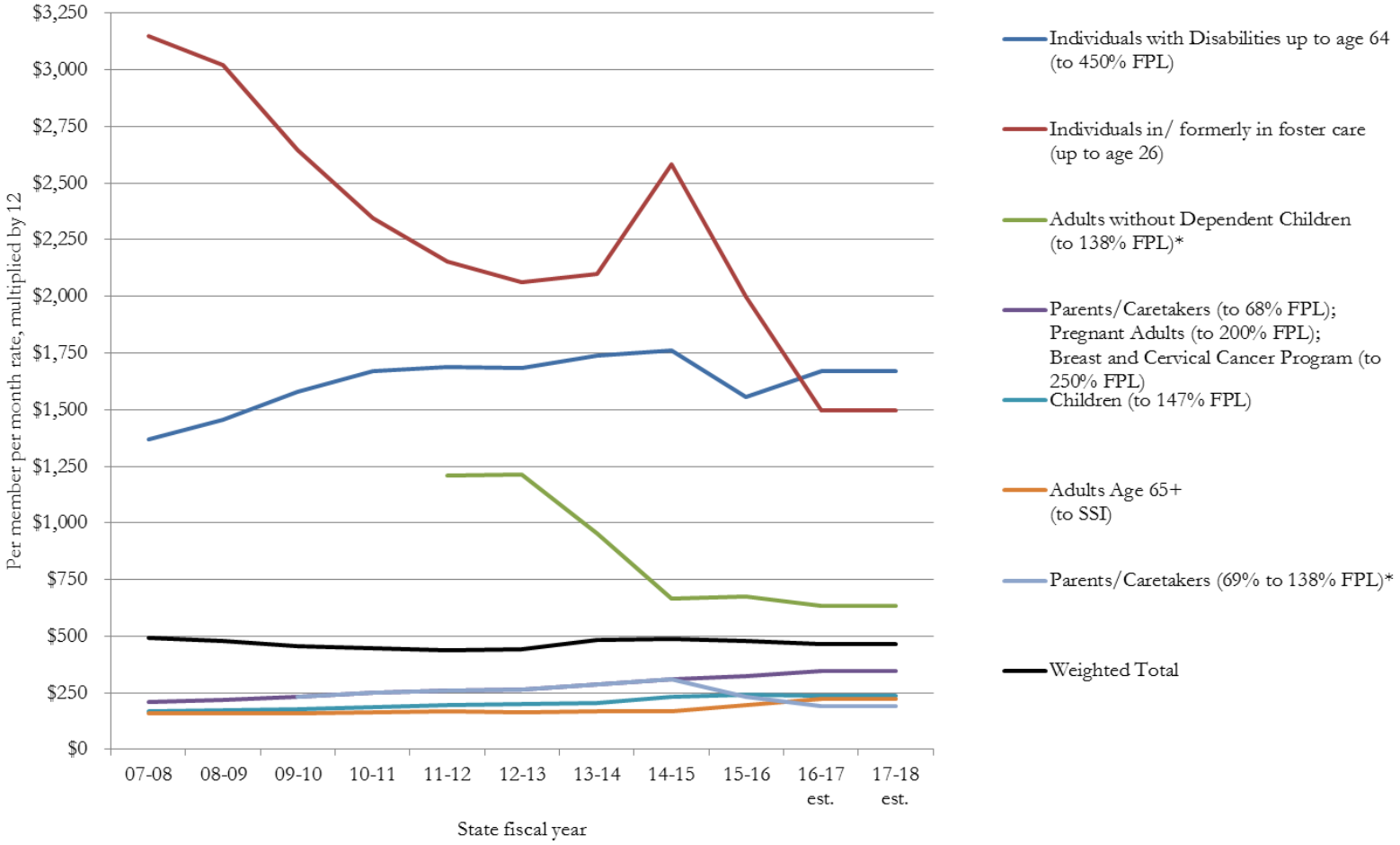
Department of Health Care Policy and Financing

(Medicaid Behavioral Health Community Programs)

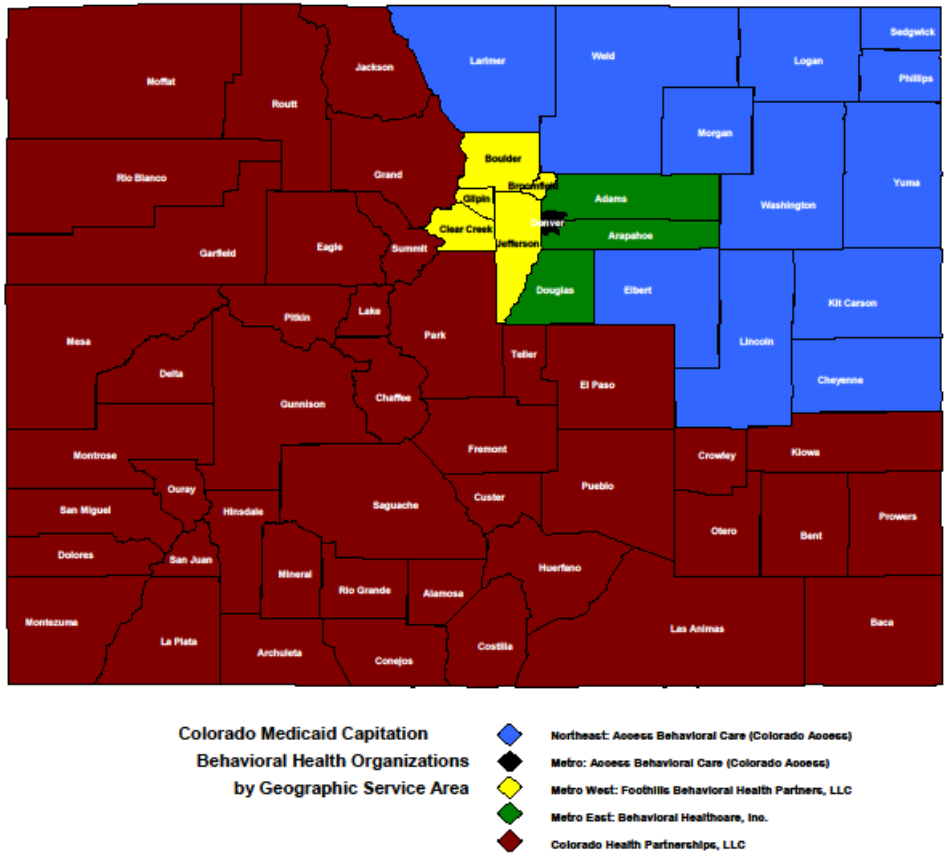
Presented by:

Carolyn Kampman, JBC Staff
December 13, 2016

Behavioral Health Capitation Rate Trends

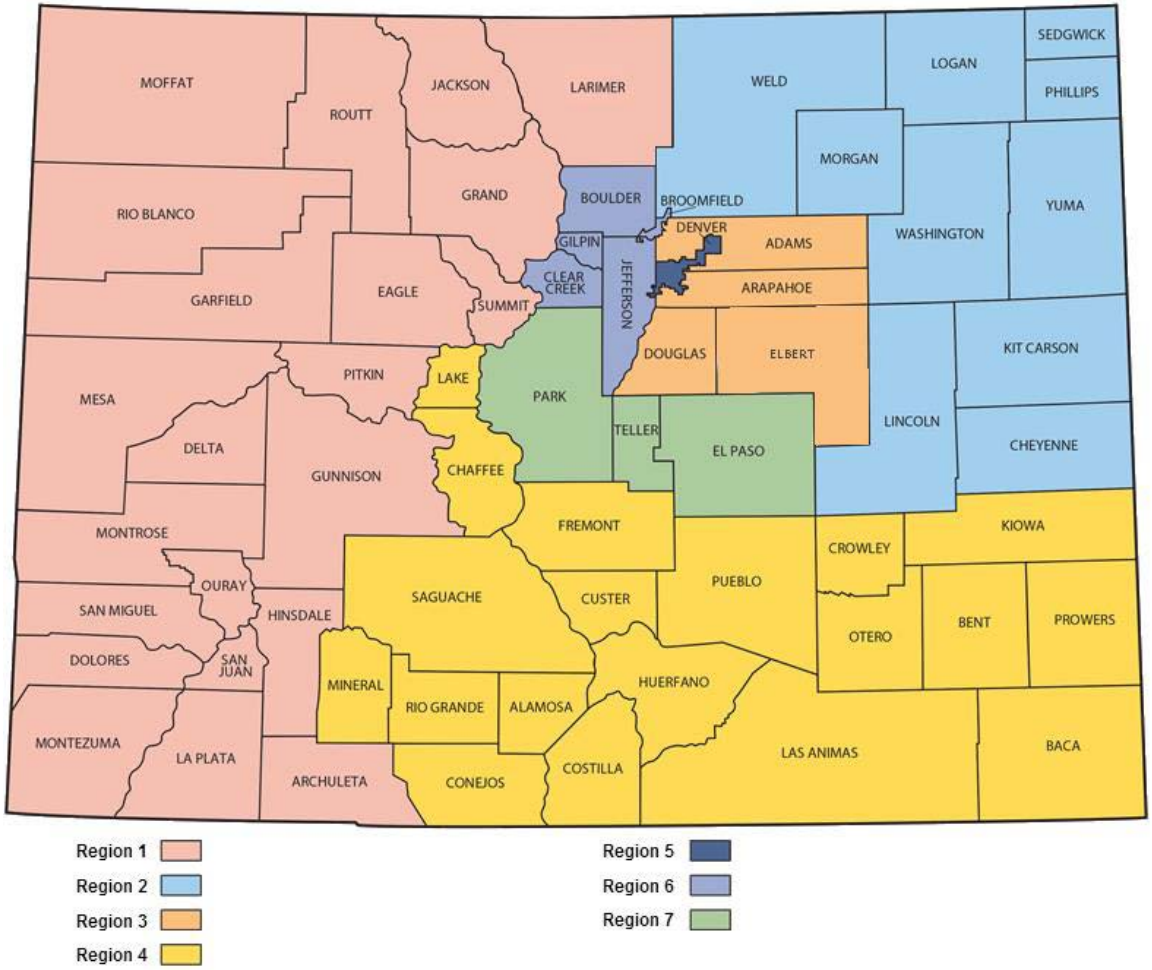


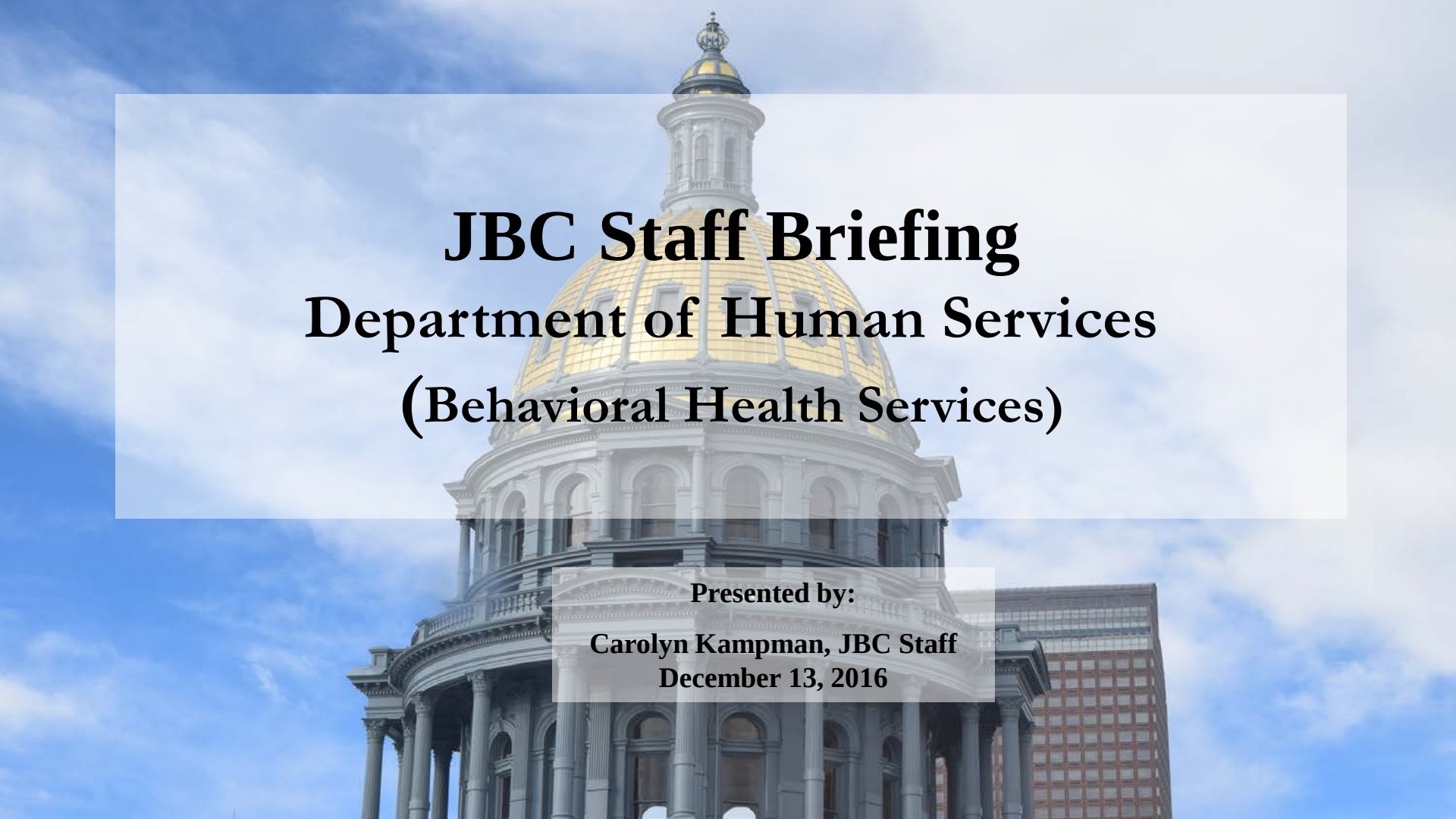
Behavioral Health Organization (BHO) Regions



Source: Colorado Behavioral Healthcare Council

Proposed Regional Accountable Entity (RAE) Regions





JBC Staff Briefing

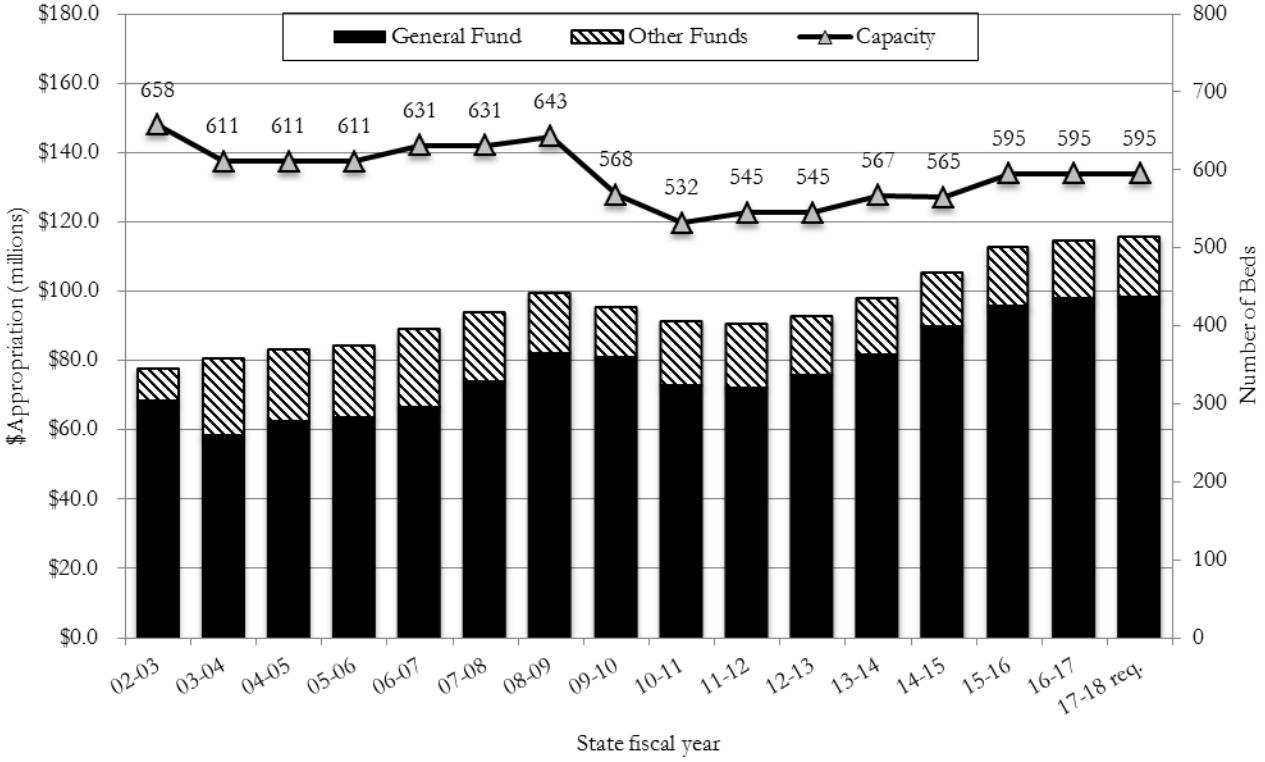
Department of Human Services

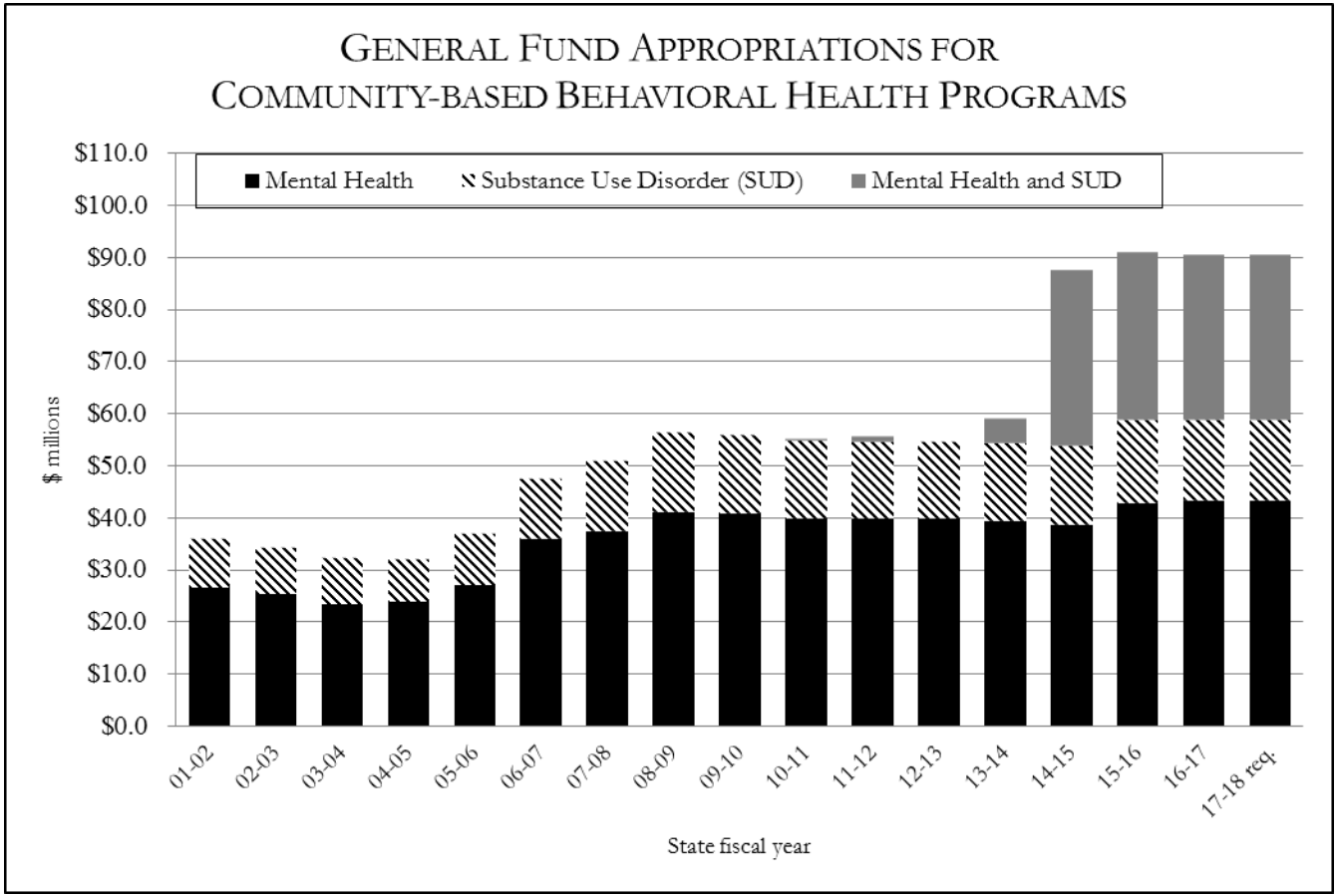
(Behavioral Health Services)

Presented by:

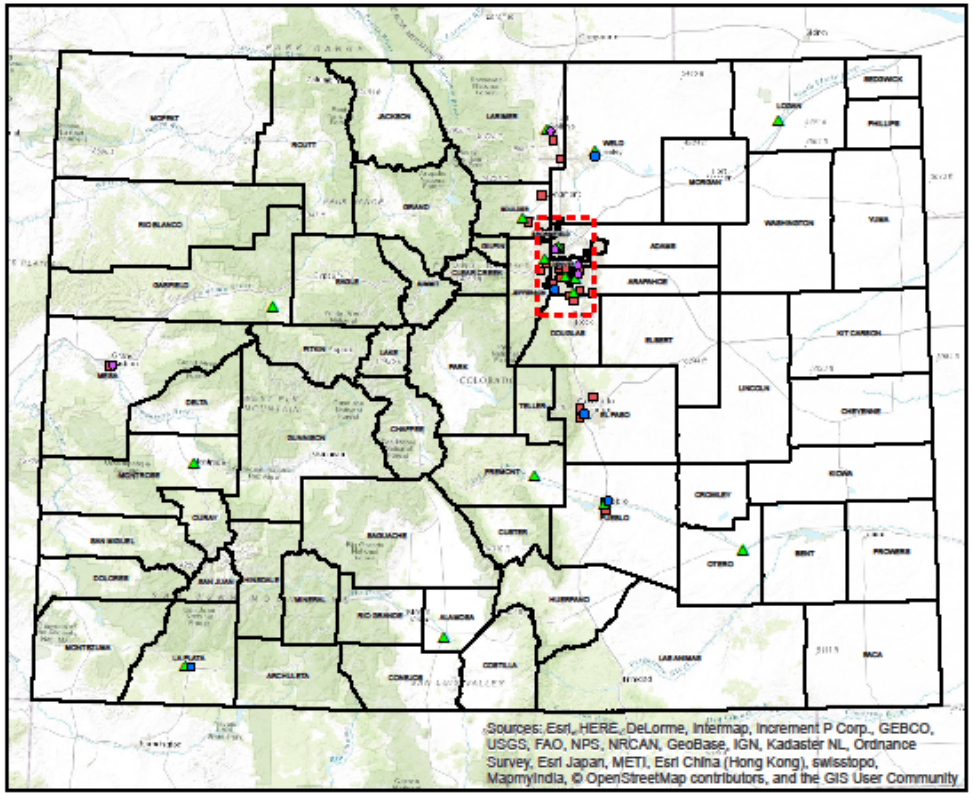
Carolyn Kampman, JBC Staff
December 13, 2016

MENTAL HEALTH INSTITUTES: FUNDING AND CAPACITY




GENERAL FUND APPROPRIATIONS FOR
COMMUNITY-BASED BEHAVIORAL HEALTH PROGRAMS
Mental Health
Substance Use Disorder (SUD)
Mental Health and SUD
$110.0
$100.0
$90.0
$80.0
$70.0
$60.0
$50.0
$40.0
$30.0
$20.0
$10.0
$0.0
$ millions
01-02
02-03
03-04
04-05
05-06
06-07
07-08
08-09
09-10
10-11
11-12
12-13
13-14
14-15
15-16
16-17
17-18 req.
State fiscal year

Mental Health Facilities by Type (September 2016)



LEGEND

Type of Mental Health Facility

- Acute Treatment Unit (5)
- Community Mental Health Center (17)
- CSU; CSU/RCCF (5)
- Hospital; Hospital, PRTF, RCCF (33)
- County (64)

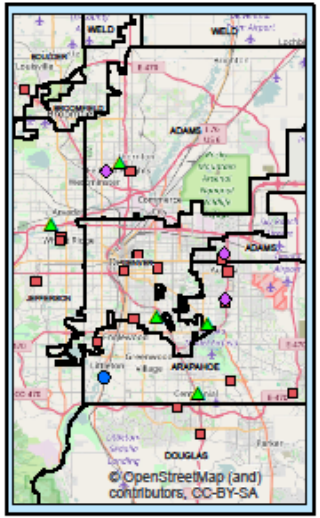
0 10 20 40 60 80 Miles

1:3,450,000 1 inch = 54.45 miles

N

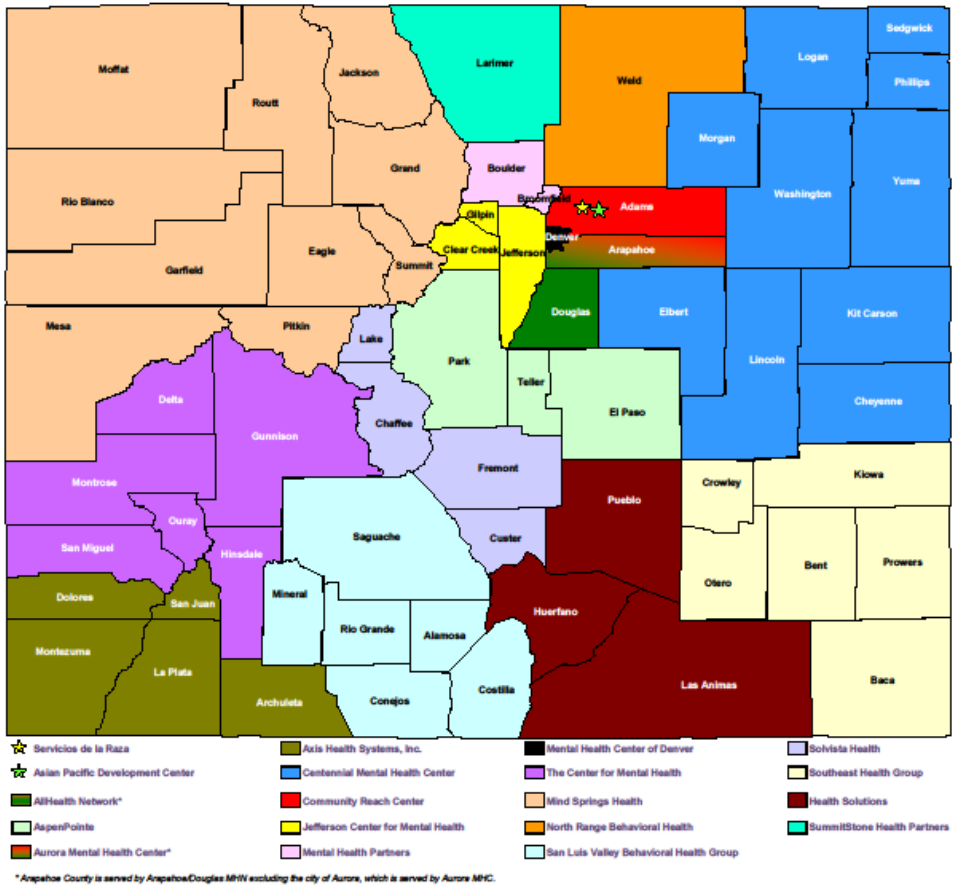
Data Sources:
Mental Health Facilities (CDPHE, August 17, 2016)
Counties (US Census Bureau, 2015)

Coordinate System: NAD83
UTM Zone 13N
9/27/2016 QT



VERSION 1b

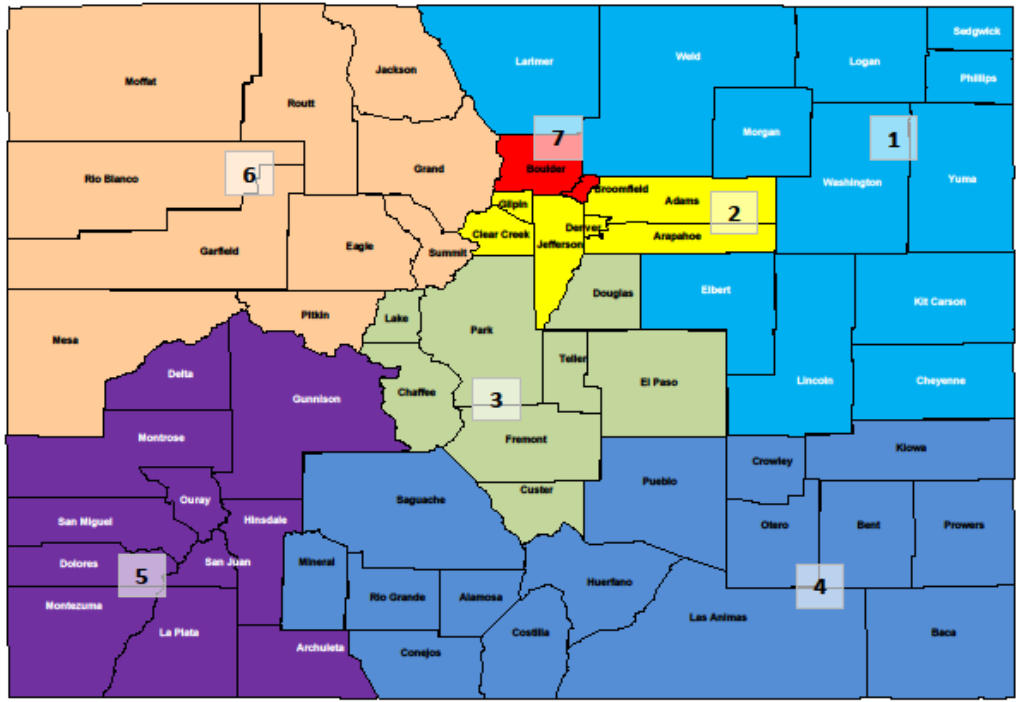
Community Mental Health Centers by County Served



Colorado Community Mental Health Centers by County Served

Source: Colorado Behavioral Healthcare Council

Managed Service Organization (MSO) Regions

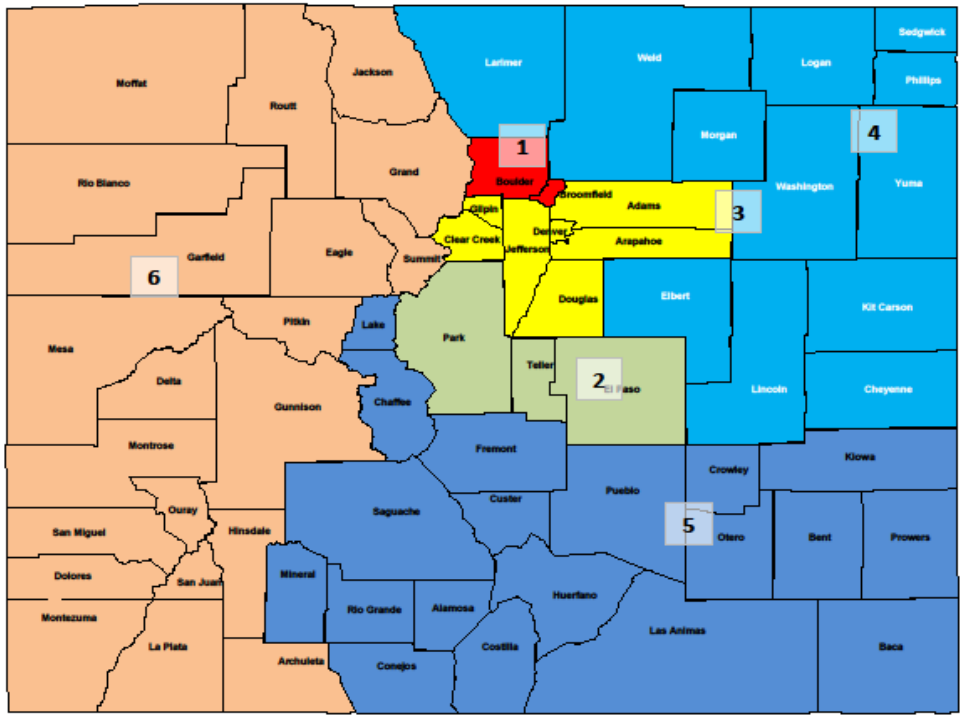


Colorado Managed Service Organizations
Catchment Areas by Sub-State Planning Areas (SSPA)

MSO	SSPA
Mental Health Partners	7
AspenPointe	3
Signal Behavioral Health Network, Inc.	1, 2, 4
West Slope Casa, LLC	5, 6

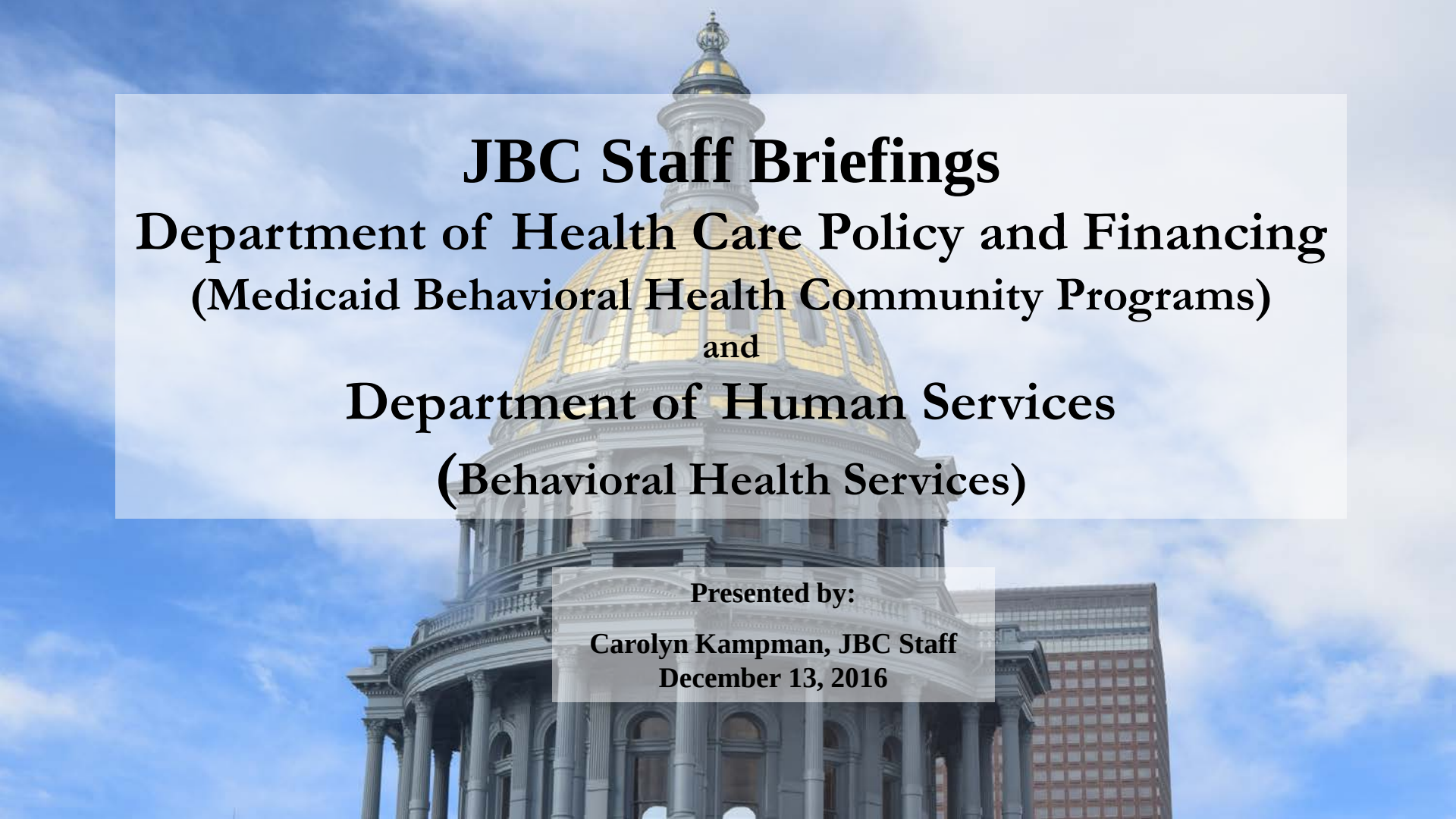
Source: Colorado Behavioral Healthcare Council

Behavioral Health Crisis Response System Regions



MHCs within Region	
MHP	Region 1
AspenPointe	Region 2
ADMHN, AuMHC, CRC, JCMH, MHCD	Region 3
Centennial, NRBH, Touchstone	Region 4
SEMHS, SLVMHC, SPMHC, NRBH	Region 5
Axis, CWRMHC, MWMHC	Region 6

Source: Colorado Behavioral Healthcare Council



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