JOINT BUDGET COMMITTEE

STAFF BUDGET BRIEFING
FY 2019-20

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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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 funds. The largest program administered by HCPF is the Medicaid program (marketed by the Department as Health First Colorado), which serves people with low incomes 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 prevention and promotion of emotional health, prevention and treatment services for mental health and substance use disorders, and recovery support. Most behavioral health services are provided to Medicaid-eligible clients through a statewide managed care or "capitated" program through which the Department contracts with "regional accountable entities" (RAEs) to provide or arrange for medically necessary behavioral health services to Medicaid-eligible clients. Each RAE receives a pre-determined monthly amount for each client who is eligible for Medicaid behavioral health services and enrolled with that RAE.

In addition to funding for capitation payments to RAEs, a separate appropriation covers fee-for-service payments for a limited set of behavioral health services to treat mental health conditions and diagnoses that are not covered by the capitation program (e.g., autism spectrum disorders). This line item also covers the client share of expenditures for individuals who are eligible for both Medicaid and Medicare and who receive mental health services under their Medicare benefits package.

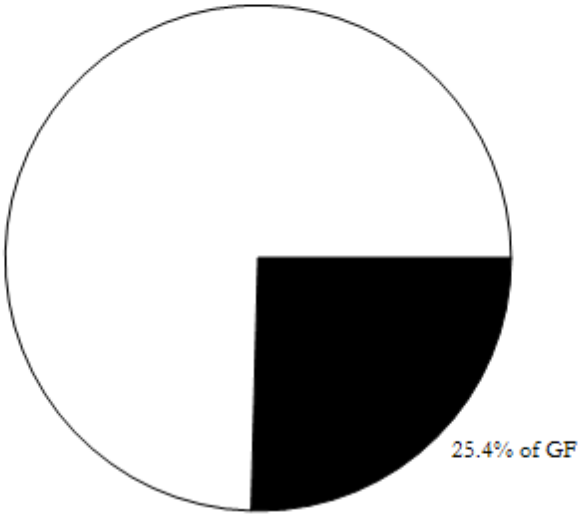
DEPARTMENT BUDGET: RECENT APPROPRIATIONS

Department of Health Care Policy and Financing, Behavioral Health Community Programs				
Funding Source	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20 *
General Fund	$170,423,670	$173,502,009	$184,437,583	$197,407,474
Cash Funds	18,132,712	23,499,835	30,054,951	36,775,589
Reappropriated Funds	0	0	0	0
Federal Funds	435,524,439	338,172,782	442,394,896	450,755,287
TOTAL FUNDS	**$624,080,821**	**$535,174,626**	**$656,887,430**	**$684,938,350**
Full Time Equiv. Staff	0.0	0.0	0.0	0.0

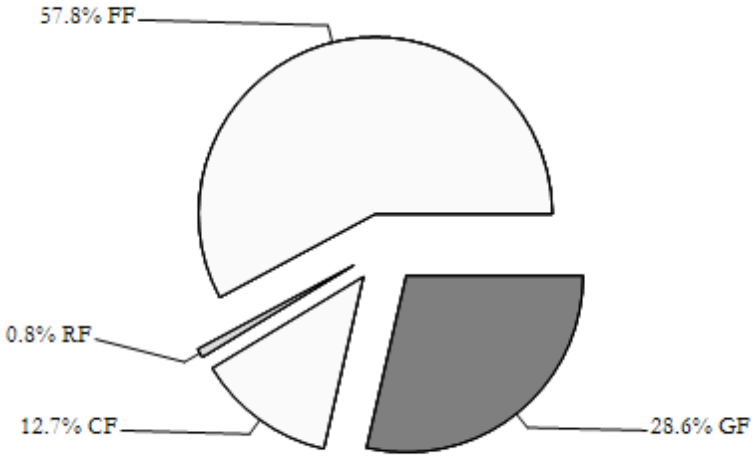
*Requested appropriation.

DEPARTMENT BUDGET: GRAPHIC OVERVIEW

Department's Share of Statewide General Fund

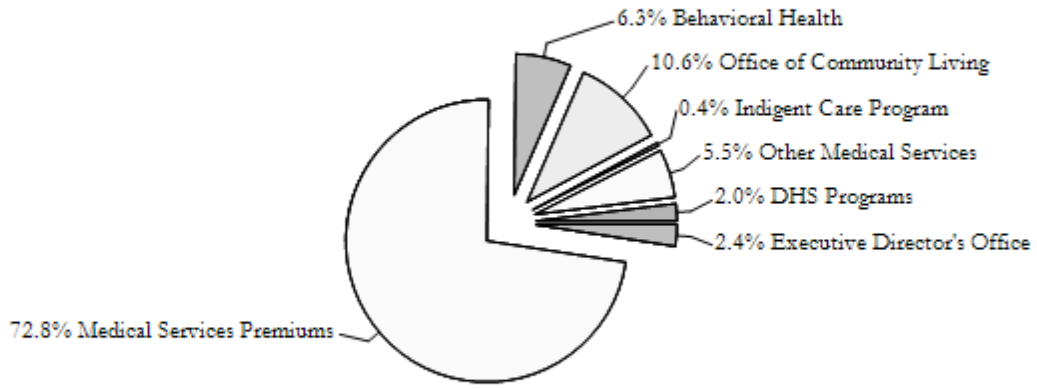


Department Funding Sources

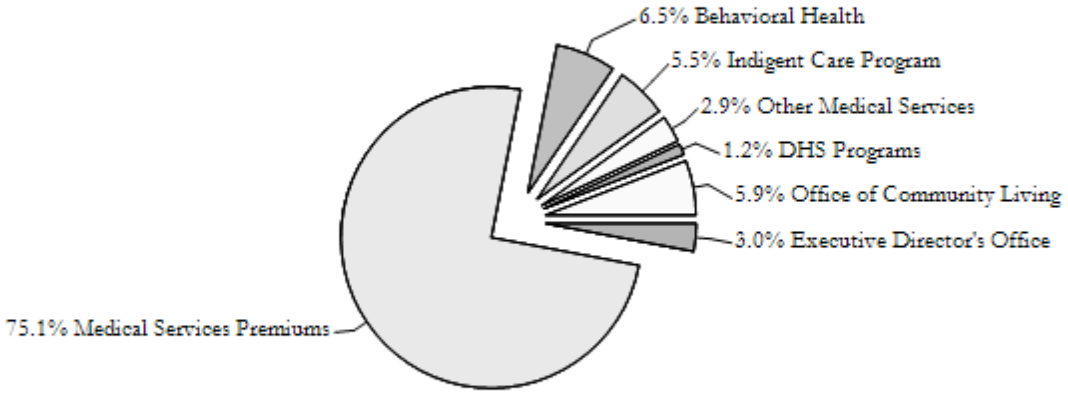


All charts are based on the FY 2018-19 appropriation.

Distribution of General Fund by Division



Distribution of Total Funds by Division



All charts are based on the FY 2018-19 appropriation.

GENERAL FACTORS DRIVING THE BUDGET

The Medicaid program provides health insurance to people with low incomes and to people needing long-term care. 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, 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 affect the number of people who meet the income eligibility criteria, and state and federal policy changes.

State expenditures are affected 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 service provided, and the population receiving services. For state fiscal year 2018-19, the FMAP for most Colorado Medicaid expenditures is 50.0 percent. However, for adults newly eligible under the federal Affordable Care Act, Colorado will receive a 94.0 percent federal match for calendar year 2018 and a 93.0 percent match for calendar year 2019, resulting in an average match of 93.5 percent for FY 2018-19. The federal match rate for this population is scheduled to decrease annually until it reaches 90 percent in calendar year 2020.

Most appropriations for Medicaid clients' *behavioral health services* are included in the "Behavioral Health Community Programs" section of the Department's budget. Funding in this section consists of 67.3 percent federal Medicaid funds, 28.1 percent General Fund, and 4.6 percent cash funds. Cash fund sources include the Healthcare Affordability and Sustainability Fee Cash Fund, and the Breast and Cervical Cancer Prevention and Treatment Fund.

BEHAVIORAL HEALTH CAPITATION PAYMENTS

Most behavioral health services are provided to Medicaid-eligible clients through a statewide managed care or "capitated" program through which the Department contracts with "regional accountable entities" (RAEs) to provide or arrange for behavioral health services to Medicaid-eligible clients. All Medicaid clients who are eligible for medical benefits are also eligible for behavioral health services, with the exception of two populations: (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.

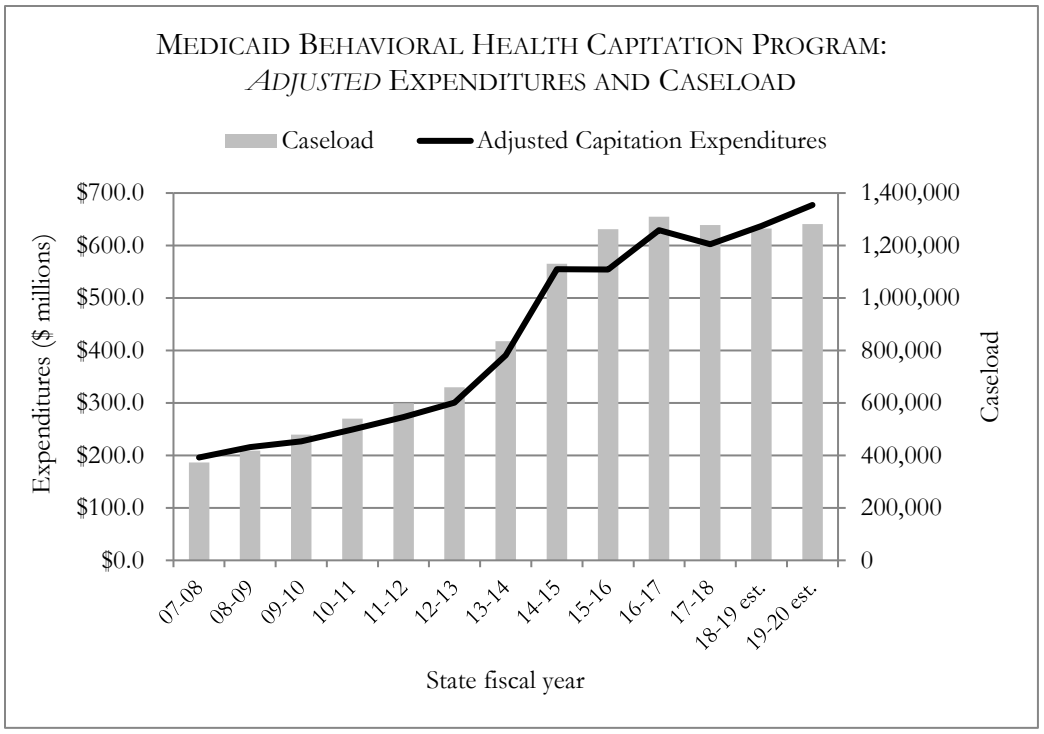
In order to receive services through behavioral health capitation, a client must have a covered diagnosis and receive a covered service or procedure[1] that is medically necessary. RAEs manage behavioral health services ranging from prevention services to outpatient group therapy to inpatient psychiatric hospital services.

Each RAE receives a pre-determined monthly amount for each client who is eligible for Medicaid behavioral health services and enrolled with that RAE. The "per-member-per-month" rates paid to each RAE are unique for each Medicaid eligibility category in each geographic region. The Department periodically adjusts these rates based on historical rate experience and client service utilization.

[1] RAEs offer all Medicaid State Plan mental health services plus services approved through the Department's federal 1915 (b)(3) waiver.

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.

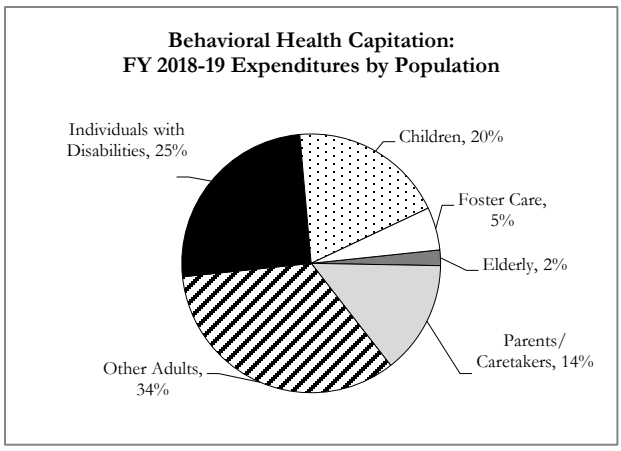
The following chart depicts recent annual expenditures for the Behavioral Health Capitation Program, along with the number of Medicaid clients eligible for behavioral health services each year. The chart reflects "adjusted" data, meaning that expenditures appear in the same fiscal year in which services were provided. This eliminates the variation caused when significant payments or recoupments occur in a subsequent fiscal year. *See Appendix E for more details concerning these adjustments.*

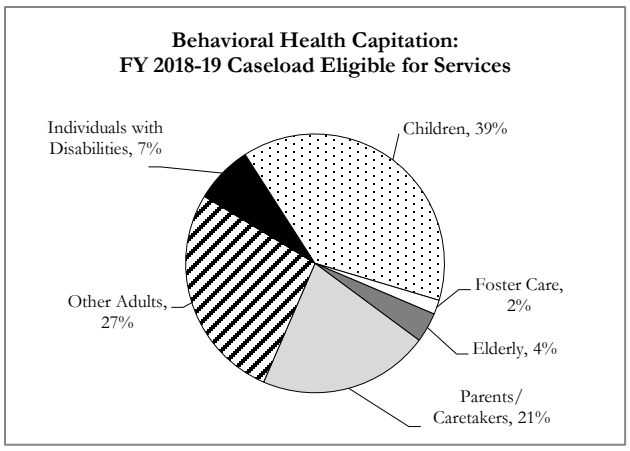


Caseload and expenditure increases in FY 2013-14 and FY 2014-15 reflect the expansion of Medicaid eligibility and the expansion of substance use disorder benefits covered by Medicaid; both expansions became effective in January 2014. During this period, expenditures grew more rapidly than the caseload due to changes in the composition of the eligible population.

Specifically, the newly eligible population of Adults Without Dependent Children is more expensive to serve than other large populations (e.g. Children), causing the average annual per capita expenditure to increase from $456 in FY 2012-13 to $491 in FY 2014-15. The next two charts illustrate the expenditures and caseload for each eligibility category as a percentage of the total. The populations that are most expensive to serve on a per capita basis include:

- Individuals with Disabilities (an estimated $1,654 for FY 2018-19);
- Individuals In or Formerly in Foster Care ($1,431); and
- Adults Without Dependent Children ($593).





While the caseload continued to expand in FY 2015-16, Capitation program expenditures were relatively flat despite an 11.6 percent caseload increase. This is largely due to Department actions to reduce the per capita rates paid for the newly eligible Adults Without Dependent Children population. The rates that were initially established for this population proved to be too high based on actual costs and service utilization.

In FY 2017-18, expenditures declined due to a 2.5 percent caseload decrease. In addition, average expenditures per capita declined again due to Department actions to reduce certain rates. New federal managed care regulations impose more federal scrutiny on the Department's rate setting process, which resulted in a loss of flexibility for the State and necessary rate reductions for some populations. *See Appendices F and G for more details concerning estimated per capita rates for each population. For more information about caseload and expenditure trends in FY 2018-19 through FY 2019-20, see the first issue brief.*

OTHER DEPARTMENT BEHAVIORAL HEALTH EXPENDITURES

Some behavioral health-related expenditures for Medicaid clients are funded through line item appropriations that are <u>not</u> part of the behavioral health community programs section of the budget.

First, the Medical Services Premiums line item appropriation covers:

- expenditures for the provision of *inpatient medical treatment* for clients with acute medical conditions that include a substance use disorder diagnosis (an estimated $210.8 million in FY 2017-18);
- behavioral health-related *pharmaceutical expenditures* (an estimated $60.8 million after rebates in FY 2017-18, including $23.4 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 ($1.4 million in FY 2017-18).

In addition, starting July 1, 2018, the Medical Service Premiums line item will cover short-term behavioral health services that a RAE-enrolled client receives by a licensed behavioral health clinician at their primary care medical provider's office. These services include:

- diagnostic evaluation without medical services;
- individual psychotherapy for up to 60 minutes; and
- family psychotherapy.

These expenditures are limited to six visits per client per state fiscal year.

Second, Medicaid covers residential substance use disorder treatment for pregnant women through the "Special Connections Program", which is administered by the Department of Human Services (DHS) with Medicaid funding transferred from HCPF ($1.1 million in FY 2017-18). The Medicaid funding for this program appears in the "High Risk Pregnant Women Program" line item within the last section of the HCPF budget that includes funding for programs that are administered by DHS.

Third, administrative expenses related to behavioral health programs are funded through various line items in HCPF's Executive Director's Office.

SUMMARY: FY 2018-19 APPROPRIATION & FY 2019-20 REQUEST

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2018-19 APPROPRIATION:						
HB 18-1322 (Long Bill)	$656,838,829	$184,413,282	$30,054,951	$0	$442,370,596	0.0
Other legislation	48,601	24,301	0	0	24,300	0.0
TOTAL	**$656,887,430**	**$184,437,583**	**$30,054,951**	**$0**	**$442,394,896**	**0.0**
FY 2019-20 REQUESTED APPROPRIATION:						
FY 2018-19 Appropriation	$656,887,430	$184,437,583	$30,054,951	$0	$442,394,896	0.0
R2 Behavioral health forecast	26,909,077	12,743,445	6,764,296	0	7,401,336	0.0
R13 Provider rates	66,946	14,006	3,817	0	49,123	0.0
Annualize prior year budget actions	1,074,897	212,440	(47,475)	0	909,932	0.0
TOTAL	**$684,938,350**	**$197,407,474**	**$36,775,589**	**$0**	**$450,755,287**	**0.0**
INCREASE/(DECREASE)	$28,050,920	$12,969,891	$6,720,638	$0	$8,360,391	0.0
Percentage Change	4.3%	7.0%	22.4%	0.0%	1.9%	0.0%

R2 BEHAVIORAL HEALTH FORECAST: The request includes an increase of $26.9 million total funds, including $12.7 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.]*

R13 PROVIDER RATES: The request includes an increase of $66,946 total funds for an across-the-board increase of 0.75 percent for most community providers. This proposed rate increase applies to fee-for-service payments made for behavioral health services, but it does not apply to payments made through the statewide capitation program.

ANNUALIZE PRIOR YEAR BUDGET ACTIONS: The request includes an increase of $1.0 million total funds, including $212,440 General Fund, to reflect the second-year impact of 2018 legislation and two FY 2018-19 budget actions.

ANNUALIZE PRIOR YEAR BUDGET ACTIONS						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
Annualize HB 17-1353 Medicaid delivery and payment initiatives	$1,414,051	$287,685	$215,351	$0	$911,015	0.0
Annualize HB 18-1407 Access to disability services	58,383	29,191	0	0	29,192	0.0
Annualize FY 18-19 R9 Provider rate adjustments	7,806	1,885	331	0	5,590	0.0
Annualize FY 17-18 R6 Delivery system and payment reform	(405,343)	(106,321)	(263,157)	0	(35,865)	0.0
TOTAL	**$1,074,897**	**212,440**	**($47,475)**	**$0**	**$909,932**	**0.0**

ISSUE: OVERVIEW OF DEPARTMENT'S FY 2019-20 REQUEST FOR BEHAVIORAL HEALTH COMMUNITY PROGRAMS (R2)

The Department's most recent caseload and expenditure projections for Medicaid behavioral health community programs indicate that the General Assembly will need to increase General Fund appropriations by $13.0 million for FY 2019-20.

SUMMARY

- Compared to existing FY 2018-19 appropriations, the Governor's budget request for FY 2019-20 reflects an overall increase of $45.5 million total funds (4.5 percent) for behavioral health programs administered by the Department of Health Care Policy and Financing (HCPF) and the Department of Human Services (DHS). This includes an increase of $28.0 million (4.3 percent) for HCPF programs and $17.4 million (5.1 percent) for DHS programs.

- For FY 2018-19, HCPF estimates that existing appropriations for Medicaid behavioral health programs can be decreased by $16.9 million total funds. However, the General Fund share of the appropriation will only decrease slightly. This overall reduction is primarily due to a lower than anticipated caseload. The total number of Medicaid clients eligible for behavioral health services actually declined in FY 2017-18; this was the first caseload decline in the last ten years.

- Compared to the revised estimate for FY 2018-19, HCPF's request for FY 2019-20 represents a $44.9 million (7.0 percent) increase in total funds, including an increase of $13.2 million General Fund. The Department's projections for FY 2019-20 are based on moderate growth in caseload (1.3 percent) and per capita rates (4.9 percent).

DISCUSSION

OVERALL FUNDING REQUEST FOR BEHAVIORAL HEALTH PROGRAMS FOR FY 2019-20

The majority of publicly funded behavioral health services in Colorado are funded through two program areas: HCPF's Behavioral Health Community Programs section, and the Office of Behavioral Health within DHS. The FY 2019-20 budget requests for these two program areas propose an overall increase of $45.5 million (4.5 percent) compared to existing appropriations, including a $28.4 million (6.9 percent) increase in General Fund appropriations. As detailed in Table 1, the overall increase includes $12.9 million for HCPF programs and $15.5 million for DHS programs. This issue brief provides an overview of the components of the HCPF share of the FY 2019-20 request and the underlying trends affecting the request.

TABLE 1: TOTAL APPROPRIATIONS FOR BEHAVIORAL HEALTH PROGRAMS: FY 2018-19 AND FY 2019-20						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2018-19 Appropriation						
Department of Human Services (DHS), Office of Behavioral Health	$345,186,673	$230,506,014	$52,643,884	$20,606,933	$41,429,842	1,353.0
Department of Health Care Policy and Financing (HCPF), Behavioral Health Community Programs	656,887,430	184,437,583	30,054,951	0	442,394,896	0.0
TOTAL	**$1,002,074,103**	**$414,943,597**	**$82,698,835**	**$20,606,933**	**$483,824,738**	**1,353.0**
FY 2019-20 Request						
DHS, Office of Behavioral Health	$362,623,827	$245,985,152	$53,744,891	$21,219,135	$41,674,649	1,403.9
HCPF, Behavioral Health Community Programs	684,938,350	197,407,474	36,775,589	0	450,755,287	0.0
TOTAL	**$1,047,562,177**	**$443,392,626**	**$90,520,480**	**$21,219,135**	**$492,429,936**	**1,403.9**
DHS: Increase/(Decrease)	$17,437,154	$15,479,138	$1,101,007	$612,202	$244,807	50.9
Percentage Change	*5.1%*	*6.7%*	*2.1%*	*3.0%*	*0.6%*	*3.8%*
HCPF: Increase/(Decrease)	$28,050,920	$12,969,891	$6,720,638	$0	$8,360,391	0.0
Percentage Change	*4.3%*	*7.0%*	*22.4%*	*n/a*	*1.9%*	*n/a*
TOTAL: Increase/(Decrease)	**$45,488,074**	**$28,449,029**	**$7,821,645**	**$612,202**	**$8,605,198**	**50.9**
Percentage Change	*4.5%*	*6.9%*	*9.5%*	*3.0%*	*1.8%*	*3.8%*

BEHAVIORAL HEALTH EXPENDITURE TRENDS

The Department of Health Care Policy and Financing's most recent caseload and expenditure forecast for behavioral health programs includes adjustments for both FY 2018-19 and FY 2019-20. As indicated below, the Department anticipates submitting a mid-year request to reduce existing appropriations for FY 2018-19 appropriations. Table 2 splits out the requested changes in R2 by fiscal year to provide a more informative overview of the request for FY 2019-20.

TABLE 2: BEHAVIORAL HEALTH COMMUNITY PROGRAMS SUMMARY OF REQUESTED CHANGE BY FISCAL YEAR AND FUND SOURCE					
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS
Appropriation for FY 2018-19	$656,887,430	$184,437,583	$30,054,951	$0	$442,394,896
Changes reflected in most recent Medicaid forecast for FY 2018-19	(16,862,088)	(208,296)	(1,526,548)	0	(15,127,244)
Subtotal: FY 2018-19 Estimate	**$640,025,342**	**$184,229,287**	**$28,528,403**	**$0**	**$427,267,652**
R2 Behavioral health forecast (compared to new estimate for FY 2018-19)	43,771,165	12,951,741	8,290,844	0	22,528,580
Annualize prior year budget actions	1,074,897	212,440	(47,475)	0	909,932
R13 Provider rates	66,946	14,006	3,817	0	49,123
Total FY 2019-20 Request	**$684,938,350**	**$197,407,474**	**$36,775,589**	**$0**	**$450,755,287**
FY 2019-20 Request v. FY 2018-19 Estimate	**$44,913,008**	**$13,178,187**	**$8,247,186**	**$0**	**$23,487,635**
Percent change	*7.0%*	*7.2%*	*28.9%*	*n/a*	*5.5%*

FY 2018-19 BUDGET ESTIMATE

Overall for FY 2018-19 and FY 2019-20, the Department is anticipating that the total caseload will remain relatively flat (a 1.1 percent year-over-year decrease in FY 2018-19 and a 1.3 percent increase in FY 2019-20). The projected increase in expenditures each year is largely due to projected year-over-year increases in per capita rates (6.9 percent for FY 2018-19 and 4.9 percent in FY 2019-20).

The existing FY 2018-19 appropriation for Medicaid behavioral health community programs provides a total of $656.9 million total funds for the provision of services to an estimated 1,310,621 Medicaid clients. Based on an actual caseload decline in FY 2017-18, the Department is now projecting a caseload for FY 2018-19 that is 46,507 (3.5 percent) lower than previously anticipated (1,264,114). Based on its current estimates, the Department anticipates submitting a supplemental request in January 2019 that would reduce FY 2018-19 appropriations by a total of $16.9 million. Most of this reduction, however, is projected to come from federal funds.

The mix of funds that pay for behavioral health services for Medicaid clients is based on a client's eligibility criteria. Generally, the "traditional" eligibility categories are financed with a 50/50 mix of General Fund and federal funds, and the populations that have been added more recently are financed with a larger share of federal funds and a state match provided from the Healthcare Affordability and Sustainability Fee Cash Fund. Because the current declines in caseload are primarily occurring in the eligibility categories that were added recently, this caseload decline will not have a significant impact on General Fund appropriations. In addition, the Department has increased the caseload forecast for Individuals with Disabilities, which has a significant impact on General Fund expenditures due to the relatively high per-member-per-month rates for this population.

In addition, the Department has also modified per capita rates for FY 2018-19. Some rates are higher, some rates are lower, but the overall average per capita rate is projected to increase by a small amount ($1.89 or 0.4 percent). The most significant rate increases were in two traditional eligibility categories, thereby mitigating the impact of the lower projected caseload on General Fund appropriations:

- Individuals with Disabilities (an increase from $1,620 to $1,654); and
- Adults Age 65 and older (an increase from $233 to $248).

Finally, the Department is now projecting slightly higher incentive payments to BHO's based on performance measures tied to services provided in FY 2017-18. Specifically, the Department is now projecting incentive payments of up to $28.3 million, compared to earlier estimates of up to $26.7 million. *Appendix F details the caseload and rate data that underlie the Department's revised Capitation payment estimates for FY 2018-19, including anticipated incentive payments and other payment adjustments.*

FY 2019-20 BUDGET ESTIMATE

The Department's FY 2019-20 budget request includes $684.9 million total funds for the provision of services to a projected membership of 1,281,165. Compared to the revised estimate for FY 2018-19, the request represents a $44.9 million (7.0 percent) year-over-year increase in total funds, and a $13.2 million (7.2 percent) increase in General Fund [see Table 2]. The projection is based on a 1.3 percent overall caseload increase, and an average increase of 4.9 percent in Capitation rates (excluding payments associated with previous fiscal years).

Tables 3 through 5 show the year-over-year changes projected for FY 2019-20 in Medicaid enrollment, payments through the capitation program, and expenditures per capita by enrollment category. *See Appendix G for the detailed caseload and rate data that underlies the Department's capitation payments request for FY 2019-20.*

TABLE 3: BEHAVIORAL HEALTH CAPITATION PROGRAM: ENROLLMENT				
CATEGORY	FY 18-19 ESTIMATE	FY 19-20 REQUEST	DIFFERENCE	PERCENT
Children to 147% FPL	489,098	490,473	1,375	0.3%
Adults w/out Dependent Children to 138% FPL	343,166	347,535	4,369	1.3%
Parents/Caretakers to 68% FPL; Pregnant Adults to 200% FPL	198,865	201,456	2,591	1.3%
Parents/Caretakers 69% to 138% FPL	71,253	73,355	2,102	3.0%
Individuals with Disabilities to age 64 (to 450% FPL)	91,756	95,812	4,056	4.4%
Adults age 65+ (to SSI)	47,339	49,114	1,775	3.7%
Foster Care to 26 years	22,483	23,290	807	3.6%
Breast & Cervical Cancer to 250% FPL	154	130	(24)	-15.6%
TOTAL	**1,264,114**	**1,281,165**	**17,051**	**1.3%**

TABLE 4: BEHAVIORAL HEALTH CAPITATION PROGRAM: ANNUAL EXPENDITURES				
CATEGORY	FY 18-19 ESTIMATE	FY 19-20 REQUEST	DIFFERENCE	PERCENT
Children to 147% FPL	$116,551,703	$120,749,857	$4,198,154	3.6%
Adults w/out Dependent Children to 138% FPL	203,585,893	216,614,180	13,028,287	6.4%
Parents/Caretakers to 68% FPL; Pregnant Adults to 200% FPL	71,832,205	76,451,641	4,619,436	6.4%
Parents/Caretakers 69% to 138% FPL	13,415,427	14,510,889	1,095,462	8.2%
Individuals with Disabilities to age 64 (to 450% FPL)	151,772,885	163,290,610	11,517,725	7.6%
Adults age 65+ (to SSI)	11,725,083	12,873,630	1,148,547	9.8%
Foster Care to 26 years	32,165,665	34,457,529	2,291,864	7.1%
Breast & Cervical Cancer to 250% FPL	44,543	39,349	(5,194)	-11.7%
Rate change for adults without dependent children (for previous year)	946,398	0	(946,398)	n/a
Health insurance provider fee payments (for previous year)	0	6,149,191	6,149,191	n/a
Estimated incentive payments (for previous year)	28,696,148	30,130,828	1,434,680	n/a
TOTAL	**$630,735,950**	**$675,267,704**	**$44,531,754**	**7.1%**

TABLE 5: BEHAVIORAL HEALTH CAPITATION PROGRAM: ANNUAL PER CAPITA EXPENDITURES				
CATEGORY	FY 18-19 ESTIMATE	FY 19-20 REQUEST	DIFFERENCE	PERCENT
Children to 147% FPL	$238	$246	$8	3.3%
Adults w/out Dependent Children to 138% FPL	593	623	30	5.1%
Parents/Caretakers to 68% FPL; Pregnant Adults to 200% FPL	361	379	18	5.1%
Parents/Caretakers 69% to 138% FPL	188	198	10	5.1%
Individuals with Disabilities to age 64 (to 450% FPL)	1,654	1,704	50	3.0%
Adults age 65+ (to SSI)	248	262	14	5.8%
Foster Care to 26 years	1,431	1,479	49	3.4%
Breast & Cervical Cancer to 250% FPL	289	303	13	4.6%
TOTAL (excluding adjustments and payments associated with previous fiscal years)	**$476**	**$499**	**$23**	**4.9%**

Next month the Department will submit a supplemental request for FY 2018-19 based on the caseload and expenditure data in the relevant columns above. In February, the Department will submit an updated forecast that incorporates data through December 2018, which will inform the Committee's final decisions in March 2019 concerning the FY 2018-19 and FY 2019-20 budgets.

ISSUE: LEVERAGING MEDICAID FUNDING TO IMPROVE BEHAVIORAL HEALTHCARE

This issue brief explores how the State may better leverage Medicaid funds to provide cost-effective, clinically appropriate behavioral health services for vulnerable populations, including individuals involved in the criminal and juvenile justice systems.

SUMMARY

- The Department of Health Care Policy and Financing (HCPF) is in the process of implementing two key initiatives that impact the delivery of behavioral healthcare services to Medicaid clients:
    - Integrating the administration of primary and behavioral health care; and
    - Closing the coverage gap for substance use disorder services.

- These two initiatives overlap, and need to be implemented in a way that takes into consideration the overall impact on clients and providers.

- In addition, recent federal changes to Medicaid managed care rules and recent federal legislation related to the opioid crisis could significantly affect these initiatives.

- The General Assembly and other state agencies are devoting significant time and resources to addressing the challenges associated with individuals with behavioral health disorders who become involved in the criminal and juvenile justice systems. The Medicaid program provides critical health care resources for these individuals, so it is important to consider whether the State is appropriately leveraging federal Medicaid funding to provide cost-effective, clinically appropriate care for these individuals.

RECOMMENDATION

Staff recommends that the Committee ask the Department to discuss the following issues concerning whether the State is appropriately leveraging Medicaid funding for behavioral healthcare services:

- The Department's efforts to ensure Medicaid clients have access to appropriate residential and inpatient psychiatric care within their communities.
- The changes recommended by the Behavioral Health Licensing Task Force.
- The implementation of the revised federal managed care rule that limits the use of Medicaid funding to cover inpatient psychiatric care in certain settings.
- The recently passed federal *SUPPORT for Patients and Communities Act*, and the potential implications for the Medicaid Capitation program and the expansion of the Medicaid benefit for substance use disorder services.
- Department plans to ensure that county departments of human services, jails, the Department of Corrections, the Department of Human Services' Division of Youth Services, and the Department of Human Services' mental health institutes are aware of and know how to effectively use the new "suspend" functionality within the Medicaid claims and eligibility systems.

DISCUSSION

The Department of Health Care Policy and Financing (HCPF) is in the process of implementing two key initiatives that affect the delivery of behavioral healthcare services to Medicaid clients. These initiatives overlap, and need to be implemented in a way that takes into consideration the overall impact on clients and providers. In addition, recent federal changes to Medicaid managed care rules and recent federal legislation related to the opioid crisis could significantly affect both of these initiatives.

In addition, the General Assembly and other state agencies are devoting significant time and resources to addressing the challenges associated with individuals with behavioral health disorders who become involved in the criminal and juvenile justice systems. The Medicaid program provides critical health care resources for these individuals, so it is important to consider whether the State is appropriately leveraging federal Medicaid funding to provide cost-effective, clinically appropriate care for these individuals.

This issue brief is organized as follows:

1. Medicaid managed care and the federal "IMD" exclusion
2. Integrating the administration of primary and behavioral health care
3. Recent changes to federal managed care rules limiting inpatient care reimbursement
4. Expanding the substance use disorder benefit
5. Recent federal legislation concerning inpatient substance use disorder services
6. Implementation of the "suspension" of Medicaid benefits

1 - MEDICAID MANAGED CARE AND THE FEDERAL "IMD" EXCLUSION

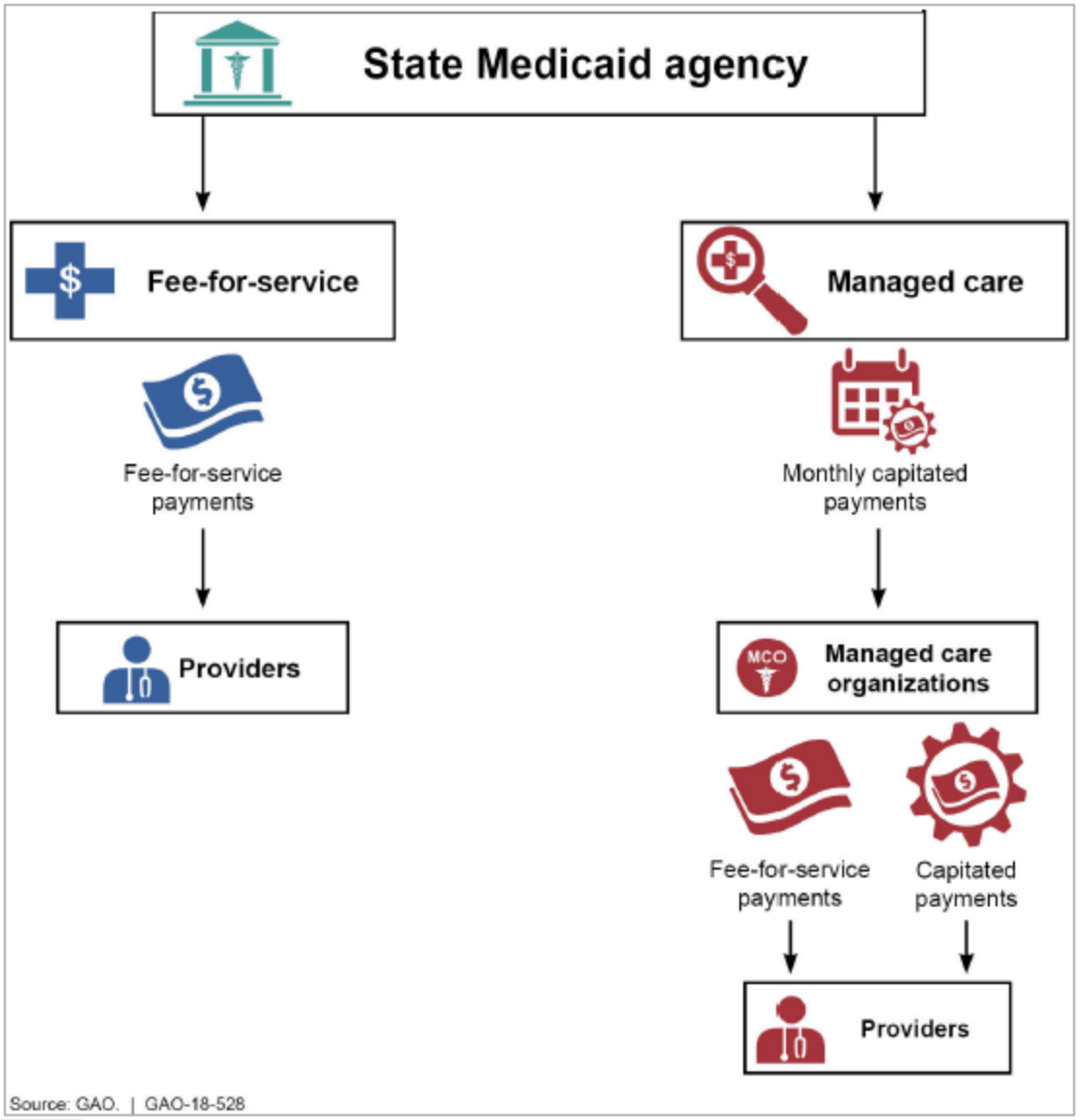
MANAGED CARE DELIVERY MODEL FOR BEHAVIORAL HEALTH SERVICES

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 to provide or arrange for behavioral health services for clients within their geographic region who are eligible for and enrolled in the Medicaid program. These regional entities 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.

The graphic on the following page[2] illustrates the difference between the traditional "fee-for-service" model of delivering Medicaid services and the managed care model.

[2] Source: U.S. Government Accountability Office report, "Medicaid Managed Care: Improvements Needed to Better Oversee Payment Risks", dated July 2018 (GAO-18-528).

Figure 1: Medicaid Fee-for-Service and Managed Care Delivery Models



Notes:

States may have different types of managed care arrangements in their Medicaid programs, some of which have a limited benefit package or do not assume financial risk for services provided. In this report, we are referring to comprehensive, risk-based managed care provided through MCOs, which is the most common managed care arrangement.

Managed care organizations may also pay providers through other payment approaches in which the provider assumes some risk for covered services.

For a number of years (through FY 2017-18), HCPF contracted with 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. BHOs shared the financial 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

were part owners of the BHO[3]. During this period, per capita costs under the Capitation program remained relatively flat.

THE FEDERAL "IMD" EXCLUSION

The federal Social Security Act bars states from receiving federal Medicaid funding for any (medical or behavioral health care) services provided to individuals ages 21 through 64 who are patients in an "institution for mental disease" (IMD).

An IMD is defined as a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services[4]. Thus, the state mental health institutes and private psychiatric hospitals are considered IMDs. A general hospital that provides inpatient psychiatric treatment for some patients (e.g., Denver Health) is not considered an IMD because psychiatric treatment is not the hospital's primary focus. Before Congress created the Medicaid program, inpatient behavioral health services were funded by states, and the IMD payment exclusion was aimed at preserving this financing and preventing states from shifting mental health services provided by states onto the federal budget through Medicaid.

Despite the general prohibition in federal law, there are three main ways that states can receive federal Medicaid funds for IMD services for individuals ages 21 through 64:

- *Section 1115 demonstration waivers.* These types of federal waivers related to behavioral health remain the most frequent type of waiver sought and obtained by states[5]. The IMD waivers distinguish between payments for substance use disorder (SUD) services and mental health services. All 12 states with approved IMD waivers to date have authority to use federal Medicaid funds to pay for IMD SUD services[6]. One state (Vermont) also has waiver authority for IMD mental health services, although those payments must be phased out between 2021 and 2025. Both Vermont and Illinois recently sought authority for IMD mental health and SUD services, and the federal Centers for Medicare and Medicaid Services (CMS) only approved the SUD authority.

- *Medicaid managed care "in lieu of" authority.* Federal managed care regulations permit states to use federal Medicaid funds for capitation payment to managed care plans that cover IMD inpatient or crisis residential services for individuals ages 21 through 64 "in lieu of" other services covered by the Medicaid State Plan. Recent revisions to federal managed care regulations limit federal payments for IMD services to 15 days per month. [This recent rule change is discussed in more detail later in this issue brief.] In addition, IMD services must be medically appropriate and cost-effective, and enrollees cannot be required to accept IMD services instead of those covered by the State Plan.

[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).

[4] See 42 CFR 440.1009.

[5] Henry J. Kaiser Family Foundation issue brief, "Key Questions about Medicaid Payment for Services in 'Institutions for Mental Disease'", dated June 18, 2018 (https://www.kff.org/medicaid/issue-brief/key-questions-about-medicaid-payment-for-services-in-institutions-for-mental-disease/).

[6] Ibid. These states include: California, Indiana, Illinois, Kentucky, Louisiana, Maryland, Massachusetts, New Jersey, Utah, Vermont, Virginia, and West Virginia.

- *Disproportionate share hospital (DSH) payments.* States must make Medicaid DSH payments to offset uncompensated care costs incurred by hospitals that serve a disproportionate number of low-income patients, and federal law allows states to spend some of their DSH funds on IMD services.

2 – Integrating Administration of Primary and Behavioral Health Care

Accountable Care Collaborative

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;
- 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 health care providers receive for primary health care services.

Accountable Care Collaborative – Phase II

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 indicated that the goals of this next phase are to improve health and life outcomes for members, and to 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.

In November 2016, HCPF released a draft request for proposals for phase II. HCPF solicited feedback on the draft RFP from clients, families, advocates, health care providers, vendors, legislators, and the public. HCPF released the final RFP in the spring of 2017. The resulting contracts went into effect July 1, 2018, and 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:

- 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 are relaxed to allow clients to receive limited therapies in a physical health setting. These services are charged to the Medical Services Premiums line item rather than the Capitation program.

- New performance incentives will reward increased behavioral health screening and the co-location of physical health and behavioral health services.
- RCCO and BHO regions were realigned, affecting two counties. *Elbert County* moved 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* moved to the region that includes all the western counties. *[See Appendix H for a map of the RAE regions.]*
- Clients are attributed to RAEs based on the location of their primary care provider, rather than their own address, to reduce the number of RAEs with which a primary care provider might need to contract[7].

LEGISLATIVE AND BUDGETARY IMPLEMENTATION OF PHASE II

The HCPF budget request for FY 2017-18 included a decision item (R6) concerning the ACC. Overall, HCPF requested 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 characterized as delivery system and payment reforms. HCPF proposed 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 (estimated at 4.0 percent) 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".

The Joint Budget Committee sponsored legislation in 2017 to provide a statutory framework for the existing ACC. House Bill 17-1353 also authorizes elements that are featured in phase II of the ACC, authorizes performance-based payments to providers, and places guidelines and reporting requirements on these initiatives. *[For a more complete description of the act, see Appendix B.]*

The act was not expected to have any fiscal impact on FY 2017-18 expenditures, but the act was anticipated to result in costs and savings beginning in FY 2018-19. HCPF anticipates that better coordination of physical and behavioral health care will lead to improved clinical outcomes. The Department's related savings estimates in R6 were based on several studies that identified net cost savings associated with integrating primary and behavioral healthcare. These documented savings, however, pertain only to clients with severe and persistent mental illness (SPMI) and clients with substance use disorders (SUDs). The savings for both populations primarily relate to reduced use of emergency department and inpatient hospital services, and thus primarily affect the Medical Services Premiums line item rather than any appropriations in the Behavioral Health section.

NEW RAE CONTRACTS

About a year ago, the Department announced the entities that would be awarded RAE contracts. The following table lists the RAE awardees along with the behavioral health organizations (BHOs) and regional accountable collaborative entities (RCCOs) for FY 2017-18.

[7] Previously, a Medicaid client could request and receive an individual exemption if BHO enrollment was not in his or her best clinical interest. For these individuals, expenditures related to behavioral health care were covered through the Behavioral Health Fee-for-service Payments line item appropriation. As of July 1, 2018, a member cannot request exemption from RAE enrollment in alignment with new authority contained in the new Accountable Care Collaborative 1916(b) Waiver and CRS 25.5-5-402(6).

PREVIOUS AND CURRENT VENDORS FOR MEDICAID BEHAVIORAL HEALTH CAPITATION				
REGION	COUNTIES (based on revised RAE regions)	BHO	RCCO	RAE
1	Archuleta, Delta, Dolores, Eagle, Garfield, Grand, Gunnison, Hinsdale, Jackson, La Plata, *Larimer*, Mesa, Moffat, Montezuma, Montrose, Ouray, Pitkin, Rio Blanco, Routt, San Juan, San Miguel, and Summit	Colorado Health Partnerships	Rocky Mountain Health Plans	Rocky Mountain Health Plans
2	Cheyenne, *Elbert*, Kit Carson, Lincoln, Logan, Morgan, Phillips, Sedgwick, Washington, Weld, and Yuma	Colorado Access	Colorado Access	Northeast Health Partners
3	Adams, Arapahoe, and Douglas	Behavioral Healthcare, Inc.	Colorado Access	Colorado Access
4	Alamosa, Baca, Bent, Chaffee, Conejos, Costilla, Crowley, Custer, Fremont, Huerfano, Kiowa, Lake, Las Animas, Mineral, Otero, Prowers, Pueblo, Rio Grande, and Saguache	Colorado Health Partnerships	Integrated Community Health Partners	Health Colorado, Inc.
5	Denver	Colorado Access	Colorado Access	Colorado Access
6	Boulder, Broomfield, Clear Creek, Gilpin, and Jefferson	Foothills Behavioral Health Partners	CO Community Health Alliance	CO Community Health Alliance
7	El Paso, Elbert, Park, and Teller		Community Care of Central Colorado	CO Community Health Alliance

PERFORMANCE INCENTIVE PAYMENTS

To be eligible to earn performance incentives for FY 2017-18, a BHO was required to perform certain administrative duties (complete corrective action plan submissions and activities, submit monthly encounter data, and demonstrate documentation accuracy). If a BHO meets these minimum requirements, it can qualify for incentive payments based on improvements in incentive performance measures and incentive process measures. There are seven incentive performance measures applicable to FY 2017-18:

- Mental health engagement (all members excluding foster care)
- Mental health engagement (foster care)
- Engagement of substance use disorder (SUD) treatment
- Follow-up appointment within 7 days after a hospital discharge for a mental health condition
- Follow-up appointment within 30 days after a hospital discharge for a mental health condition
- Emergency department utilization for a mental health condition
- Emergency department utilization for a substance use disorder

There are also three incentive process measures:

- Suicide risk assessment
- Documented care coordination agreements
- Denials: dual diagnosis.

The Department provided the following data for BHO incentive payments that have or may be paid in FY 2018-19 related to services provided in FY 2017-18.

INCENTIVE PAYMENTS TO BHOS FOR SERVICES PROVIDED IN FY 2017-18			
BEHAVIORAL HEALTH ORGANIZATION (BHO)	COUNTIES IN REGION	INCENTIVE PAID TO BHOS (AS OF 11/2018)	POTENTIAL INCENTIVE REMAINING AVAILABLE
Behavioral Healthcare, Inc. (BHI)	Adams, Arapahoe, Douglas (including City of Aurora)	$2,695,597	$3,294,619
Access Behavioral Care (Colorado Access or ABC-D)	Denver	2,570,710	3,141,979
Colorado Health Partnerships (CHP)	Alamosa, Archuleta, Baca, Bent, Chaffee, Conejos, Costilla, Crowley, Custer, Delta, Dolores, Eagle, El Paso, Fremont, Garfield, Grand, Gunnison, Hinsdale, Huerfano, Jackson, Kiowa, Lake, La Plata, Las Animas, Mesa, Mineral, Moffat, Montezuma, Montrose, Otero, Ouray, Park, Pitkin, Pueblo, Prowers, Rio Blanco, Rio Grande, Routt, Saguache, San Juan, San Miguel, Summit, and Teller	4,275,586	5,225,716
Foothills Behavioral Health Partners (FBHP)	Boulder, Broomfield, Clear Creek, Gilpin, Jefferson	1,754,141	2,143,950
Access Behavioral Care (Colorado Access or ABC-NE)	Cheyenne, Elbert, Kit Carson, Larimer, Lincoln, Logan, Morgan, Phillips, Sedgwick, Washington, Weld, Yuma	1,438,844	1,758,587
Total		**$12,734,878**	**$15,564,851**

For the first year of the RAE contracts, the Department chose to utilize fewer measures, to maintain similar measures related to engagement and follow-up, and to add a couple of measures related to screening and assessment:

- Engagement in Outpatient Substance Use Disorder (SUD) Treatment - Percent of members with a new episode of substance use disorder who initiated outpatient treatment and who had two or more additional services for a primary diagnosis of SUD within 30 days of the initiation visit
- Follow-up within seven days after an Inpatient Hospital Discharge for a Mental Health Condition - Percent of member discharges from an inpatient hospital episode for treatment of a covered mental health diagnosis to the community or a non-24-hour treatment facility who were seen on an outpatient basis by a mental health provider within seven days
- Follow-up within seven days after an Emergency Department Visit for a SUD - Percent of member discharges from an emergency department episode for treatment of a covered SUD to the community or a non-24-hour treatment facility who were seen on an outpatient basis by a behavioral health provider within seven days
- Follow-up after a Positive Depression Screen - Percent of members engaged in mental health service within 30 days of screening positive for depression
- Behavioral Health Screening or Assessment for Foster Care Children - Percentage of foster care children who received a behavioral screening or assessment within 30 days of RAE enrollment

In response to a staff request, the Department prepared the following two tables to estimate FY 2019-20 payments to RAEs for administrative, primary care, and behavioral health care services provided in FY 2018-19.

Table 1: Total Estimated RAE Expenditure in MSP for Services Occurring in FY 2018-19					
Row	**Regional Accountable Entity (RAE)**	**Estimated PMPM Payments in MSP**	**Potential Incentive Payments in MSP**	**Total Estimated Payments in MSP**	**Percentage of Total**
A	Rocky Mountain Health Plans (RAE 1)	$24,133,684	$8,394,325	$32,528,008	15.30%
B	Northeast Health Partners (RAE 2)	$11,482,153	$3,993,792	$15,475,945	7.28%
C	Colorado Access (RAE 3)	$35,475,183	$12,339,194	$47,814,377	22.49%
D	Health Colorado (RAE 4)	$16,883,851	$5,872,644	$22,756,495	10.70%
E	Colorado Access (RAE 5)	$27,426,600	$9,539,687	$36,966,288	17.39%
F	Colorado Community Health Alliance (RAE 6)	$19,295,114	$6,711,344	$26,006,459	12.23%
G	Colorado Community Health Alliance (RAE 7)	$23,061,968	$8,021,554	$31,083,522	14.62%
H	**Total Payments**	**$157,758,553**	**$54,872,541**	**$212,631,094**	

Table 2: Total Estimated RAE Expenditure in Behavioral Health Community Programs for Services Occurring in FY 2018-19					
Row	**Regional Accountable Entity (RAE)**	**Estimated Behavioral Health Expenditure**	**Potential Behavioral Health Incentive Payments**	**Total Estimated Payments in Behavioral Health Programs**	**Percentage of Total**
A	Rocky Mountain Health Plans (RAE 1)	$88,518,637	$4,425,803	$92,944,440	14.69%
B	Northeast Health Partners (RAE 2)	$38,110,608	$1,905,475	$40,016,083	6.32%
C	Colorado Access (RAE 3)	$124,152,833	$6,207,461	$130,360,293	20.60%
D	Health Colorado (RAE 4)	$73,297,757	$3,664,781	$76,962,538	12.16%
E	Colorado Access (RAE 5)	$118,079,344	$5,903,795	$123,983,140	19.59%
F	Colorado Community Health Alliance (RAE 6)	$89,099,847	$4,454,863	$93,554,710	14.79%
G	Colorado Community Health Alliance (RAE 7)	$71,375,100	$3,568,651	$74,943,751	11.84%
H	**Total Payments**	**$602,634,125**	**$30,130,829**	**$632,764,954**	

Table 1 includes a total of $212.6 million in estimated payments to RAEs that will be charged to the Medical Services Premiums line item. This includes $157.8 million for estimated administrative "per-member-per-month" (PMPM) payments that will be paid in FY 2018-19, and $54.9 million in potential

incentive payments that will be paid in FY 2019-20. The Department withholds $4.00 from RAEs' PMPM payments, and a RAE can earn this amount back depending on their performance on certain key performance measures. These measures relate to a variety of primary care services, ranging from the percent of members who receive professional dental visits to the number of emergency department visits. This set of performance measures also includes one designed to increase access to behavioral healthcare – the percent of members that access behavioral health services.

Table 2 includes a total of $632.8 million in estimated payments to RAEs that will be charged to the Behavioral Health Capitation Payments line item. This includes $602.6 million for estimated PMPM Capitation payments that will be paid to RAEs in FY 2018-19 to cover the costs of behavioral health care services provided in FY 2018-19, and $30.1 million in potential incentive payments that will be paid in FY 2019-20. Each RAE is eligible to receive up to 5.0 percent of total Capitation expenditure in incentive payments based on performance.

CARING FOR VULNERABLE CLIENTS

Given that the Department's Phase II savings estimates were based on improving the care provided to clients with severe and persistent mental illness (SPMI) and clients with substance use disorders (SUDs), staff asked the Department to describe what it is doing to ensure the RAEs are providing adequate and appropriate services for these vulnerable clients. The Department indicated that it took a variety of steps during the transition from the BHOs to the RAEs to ensure that the RAEs have the capacity to provide adequate and appropriate services for these clients and to confirm that they are doing so:

- For the months leading up to July 1, 2018, the Department tracked the RAEs' weekly progress on their contracting with behavioral health providers. The Department created a specific tool listing all community mental health centers to ensure that they were all contracted with at least the RAE overseeing their region, as well as other RAEs.
- The Department also created a question form on the Department's external website for providers, members, and other stakeholders to submit questions they had. This external form identified provider issues and concerns that informed the updating of Department polices and system processes and enhanced the Department's oversight of the RAEs.
- For the first two months after the RAEs began operations and before the formal submission of behavioral health encounter data to the Department, the RAEs manually reported the number of behavioral health claims submitted to the RAEs for reimbursement. This data was reported on the Department's weekly executive dashboard to ensure that services were being delivered in each of the regions.
- The Department created a weekly dashboard to review the claims processing of the short-term behavioral health services to monitor utilization and trends.

The Department also indicates that it has multiple mechanisms within its contract with the RAEs to monitor service delivery, including the following:

- *Capitated behavioral health benefit annual reporting measures*. These are standard measures that the Department has used for multiple years to monitor the BHOs and will continue to use with the RAEs. Examples include inpatient utilization, hospital readmissions, and follow-up appointments following a visit to the emergency department.
- *Behavioral Health Incentive Program*. These measures will assess RAEs' performance with high-risk populations, including children in foster care and individuals with substance use disorders.

- *1915(b)(3) waiver services report.* Each quarter the RAEs report their expenditures on non-state plan services that are community-based treatment for individuals with severe and persistent mental illness.
- *Population Health Management Plan and Report.* The RAEs must provide an annual strategy of interventions to support the health and well-being of all of their members, highlighting interventions for those with significant behavioral health needs. A quarterly report will provide an update on the numbers and types of services the RAEs have provided members.
- *Grievance and Appeals Report.* Submitted quarterly, this report provides details on the numbers and types of grievances and appeals received by the RAE.

Finally, the Department indicates that it plans to track key statistics that include inpatient admission rates, emergency room utilization, total cost of care, and medication adherence (filled prescriptions). The Department will also apply analytical tools that compare services rendered to typical standards of care as defined by clinical experts in the field. The Department notes that there is a lag between when services are rendered and when the Department receives data indicating the services were rendered due to the need for providers to submit claims. For behavioral health services, the delay is longer because the data first goes through the RAE before coming to the Department. Consequently, since ACC Phase II has been in effect for less than five months and there is a data lag, there is minimal complete data to evaluate currently.

EXPANDING NON-IMD INPATIENT PSYCHIATRIC CARE

Given the federal restrictions on using Medicaid funding to pay for both primary and behavioral health care in IMD settings, staff believes that it is in the State's interest to expand psychiatric care capacity in non-IMD settings (both general hospitals and other residential care settings with 16 or fewer beds). This would better leverage Medicaid funding and should allow clients to access care closer to home. It also ensures that any medical care a psychiatric patient may need can also be covered by Medicaid (rather than state General Fund, as is the case for the mental health institutes).

Staff asked the Department to describe whether it is taking any action in incentivize this type of capacity expansion. Staff has provided their response below.

> "Inpatient beds are an important tool to help stabilize members with a behavioral health crisis; however, they are not the only tool. The Office of Behavioral Health, the Department, and their vendors have been working to develop a full continuum of services to more effectively meet the behavioral health needs of clients. A large focus of the work, and a guiding principle for the BHOs and RAEs, has been developing comprehensive community-based services to reduce the reliance on inpatient services.
>
> HCPF and OBH, along with other stakeholders, are actively engaged in multiple activities impacting the availability and funding of inpatient psychiatric care. This includes resolving funding for IMDs based on the new federal managed care regulations and designing the new residential and inpatient substance use disorder Medicaid benefit. The FY2020 Governor's Budget also includes requests by CDHS for additional funding to expand both civil and forensic bed capacity at the Mental Health Institutes by a total of 86 beds.
>
> The Department is also pursuing strategies within its authority to leverage increased access for Medicaid members. First and foremost, the RAEs have a responsibility and incentive to

strengthen relationships with providers of inpatient psychiatric beds to encourage increased access for Medicaid members. When members do not have access to the appropriate level of care, they tend to have even higher costs than they would otherwise have. RAEs being at full financial risk for behavioral health services means they have an incentive to connect clients with the right level of care. The Department will use contract deliverables, site visits, and other mechanisms to monitor the RAEs' activities in these areas.

In addition to action taken by the RAEs, other Department initiatives will promote growth of services where gaps are identified. For example, the Hospital Transformation Program is requiring hospitals to include an analysis of inpatient psychiatric and SUD beds as part of their community assessment. If a community identifies a need for inpatient psychiatric and SUD beds, then the Department is seeking to tie a portion of supplemental funding to hospitals making extra beds available for Medicaid clients.

Lastly, The Office of Behavioral Health is primarily responsible for designating and regulating all facilities approved pursuant to C.R.S. 27-65 for the care and treatment of persons with a mental illness, including inpatient psychiatric care facilities. CDHS, HCPF and CDPHE are participating in the Governor's Behavioral Health Licensing task force to clarify facility licensing and program oversight or approval that will include recommendations for Acute Treatment Units and Crisis Service Units as part of the continuum of treating patients in acute behavioral health crisis. The findings and recommendations resulting from this task force will provide greater insight into the existing status of inpatient psychiatric beds, from acute through long-term care, and identify gaps in capacity and funding. The General Assembly's careful consideration and support of the task force's potential statutory and budgetary recommendations will enhance the state's continuum of care."

Staff recommends that the Committee ask the Department to discuss the above efforts at its budget hearing. Staff would also like to highlight the effort described in the last paragraph above, and suggest that the Committee ask the Department(s) to provide an overview of the recommended changes to the State's behavioral healthcare licensing, certification, and program approval processes. Staff is aware of many of the barriers these processes create for community-based (and particularly rural) providers as they develop the innovative and cost-effective services that best meet the needs in their communities. The work of the Behavioral Health Licensing Task Force is a great example of what can be accomplished when the Governor's Office, multiple state agencies, community-based providers, and consumer advocates all work together to study and identify constructive solutions to improve Colorado's behavioral health system.

3– Recent Changes to Federal Managed Care Rules

As indicated earlier in this issue brief, the Capitation program covers inpatient psychiatric hospital services for individuals under age 21 and over age 64, whether or not they reside in an IMD. There is no time limitation on these services for these clients.

For individuals ages 21 through 64, the federal IMD exclusion bars Colorado from using Medicaid funding to pay for inpatient psychiatric care in an IMD. However, because Colorado has implemented a managed care plan for behavioral health services, it is allowed to use Medicaid funding to pay for inpatient psychiatric services provided for those ages 21 through 64 who reside in an IMD as an "in

lieu of" State Plan service. IMD services must be medically appropriate and cost-effective, and enrollees cannot be required to accept IMD services instead of those covered by the State Plan. Until recently, there was no time limitation on the use of Capitation program funding to pay for this care for these clients.

Recent revisions to federal managed care regulations now limit federal payments for IMD services to 15 days per month. Specifically, a Medicaid agency may make a monthly capitation payment for a Medicaid client ages 21 through 64 who resides in an IMD for a short-term stay of up to 15 days during the period of the monthly capitation payment. The Medicaid agency may use the utilization of these short-term inpatient psychiatric services when developing the capitation rate.

This federal regulation took effect July of 2016, but the Department waited until the start of the new RAE contracts to implement this regulation (following the passage of H.B. 18-1431, which amends statutory provisions to align with the federal managed care rules).

The Department has indicated that under this new rule, if a Medicaid client requires inpatient care in an IMD for more than 15 days in a calendar month, "no federal Medicaid funding can be used to cover any portion of the inpatient stay during the month." The Department further states that, "This means that neither the RAE nor the Department can cover any portion of an IMD stay that exceeds 15 days in a calendar month."

If Capitation funds cannot be used to pay for any portion of an inpatient stay that exceeds 15 days in a calendar month, this means that other entities will need to cover these costs. Staff assumes that if the IMD is a mental health institute, the General Fund will cover it. For private psychiatric hospitals, this increases the financial risk of admitting Medicaid clients. In order to assess the potential impact of this new policy, staff asked the Department to provide data concerning the length of stay for Medicaid patients who require inpatient psychiatric care. As indicated in the following table (prepared by the Department), while the average length of stay is about one week, some clients require care for more than seven months.

Inpatient Length of Stay Statistics by Fiscal Year

Fiscal Year	Count of Stays	Minimum Length of Stay (Days)	Maximum Length of Stay (Days)	Total Days	Average Length of Stay (Days)
FY 2014-15	7,378	1	174	57,012	7.73
FY 2015-16	8,362	1	133	62,468	7.47
FY 2016-17	9,410	1	94	69,485	7.38
FY 2017-18	6,364	1	225	47,878	7.52

The Department indicates that it has been working with its partners over the past several months to develop an allowable solution to safeguard IMDs that deliver services to Medicaid enrolled individuals for inpatient stays beyond 15 days in a calendar month. No final resolution has been reached to date, but the Department has convened a group to continue working on finding a resolution. The Department believes that this issue can be addressed through value-based payment arrangements.

Staff suggests that the Committee ask the Department to discuss its implementation of this revised rule at their hearing. It is staff understands that some states are interpreting and implementing this new rule differently than what the Department has described to date. Specifically, while a state cannot

include costs associated with inpatient stays that exceed 15 days when calculating capitation rates, it may use Medicaid revenue to pay for the costs of inpatient stays that exceed 15 days. For example, in June of 2017, Michigan's Department of Health and Human Services issued the following guidance on this issue (emphasis added):

"**2. Paying for Services when an IMD length of stay exceeds 15 days in a given month**

A Medicaid enrollee, with an IMD stay beyond 15 days in a given month, retains their Medicaid eligibility, but loses their ability to participate in Medicaid managed care for that month. This impact extends to both the Medicaid managed behavioral health care administered through the Department's contracts with PIHPs and the Medicaid managed care provided by the Medicaid Health Plans. The Department is still analyzing the capitation payment implications associated with a longer than 15-day IMD stay and the potential need to retroactively recoup capitation payments made for individuals who exceed that limitation.

The Medicaid and Healthy Michigan capitation rates currently paid to the PIHPs reflect the implementation of this rule in two significant ways. The costs of all services for individuals who exceed a 15-day length of stay in an IMD in a given month have been excluded from the rates paid to PIHPs. This exclusion includes the services provided in the IMD during the month in question and all non-IMD services provided during that month. In contrast, the costs of services for IMD stays of 15 days or less and the costs for all other managed behavioral health care services are included in the rates paid to the PIHPs.

The Department has received inquiries concerning a PIHP's ability to use Medicaid and Healthy Michigan Plan revenue to pay for IMD and non-IMD service costs when an individual has a greater than 15-day length of stay in an IMD in a given month. As noted above, the rates paid to the PIHP are calculated in full compliance with the rules and don't include those costs. The Department's position is that the PIHP is able to use Medicaid and Healthy Michigan Plan revenue for the IMD and non-IMD behavioral health costs for individuals with Medicaid and Healthy Michigan Plan eligibility, including the use of those funds to cover behavioral health costs when an individual exceeds a 15-day length of stay in an IMD in a given month. This position is supported by the need to ensure continuity in both service delivery and reimbursement for individuals who have received behavioral health services before or after a greater than 15-day IMD stay.

In response to CMS guidance on this subject, the Department is also working with its actuarial firm Milliman to ensure that rate setting activities fully reflect the inclusion of all allowable costs in the rate setting process.[8]"

4 – Expanding the Substance Use Disorder Benefit

Gaps in Covering a Full Continuum of Care

Prior to January 2014, Medicaid delivered certain outpatient substance use disorder (SUD) benefits under the Fee-for-service program. In January 2014, these outpatient benefits were expanded to include intensive outpatient and partial hospitalization services. These benefits were also shifted into

[8] Source: Letter from Thomas J. Renwick, Director of the Bureau of Community Based Services, Michigan Department of Health and Human Services, to the Executive Directors of Prepaid Inpatient Health Plans (dated June 16, 2017).

the Capitation program. This change allowed behavioral health organizations to increase access to low- and mid-level SUD services and mitigate the need for more intensive services.

The Colorado Medicaid behavioral health benefit for individuals with an SUD currently covers lower intensity services, including:

- early intervention;
- outpatient services;
- intensive outpatient services; and
- partial hospitalization services.

This benefit also includes the highest level of care, medically managed intensive inpatient services, when warranted by a medical diagnosis[9].

Colorado's Medicaid program does not generally cover the levels of care in between – residential and inpatient services. Exceptions include the following:

- Children and young adults up to age 20 who are eligible for Medicaid may receive residential care under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program.
- Pregnant women and post-partum women who are eligible for Medicaid may receive residential SUD services through the Special Connections program. This program is funded by Medicaid but administered by the Department of Human Services.

RECENT LEGISLATION

The General Assembly has passed two bills in the last two legislative sessions to close the SUD treatment gap for Medicaid clients.

House Bill 17-1351 required the Department of Health Care Policy and Financing (HCPF), with assistance from the Office of Behavioral Health in the Department of Human Services (OBH), to prepare a written report concerning the feasibility of providing *residential* and *inpatient* SUD treatment as part of the Medicaid program or as a state-funded program. The act directed HCPF to consider and report on a number of topics, including information concerning potential cost savings for the Medicaid program or other public assistance programs if these services are included as part of the Medicaid program (e.g., emergency room visits, hospital stays, county law enforcement contacts and jail expenses, etc.).

HCPF contracted with the Colorado Health Institute to prepare the required report, and this report was submitted in November 2017 to the Joint Budget Committee, the Opioid and Other Substance Use Disorders Interim Study Committee, and the relevant House and Senate committees of reference.[10]

[9] Please note that the Medicaid benefit does not cover inpatient psychiatric hospital services for an individual for whom the primary diagnosis is a substance use disorder. However, the Department does cover inpatient psychiatric service costs during the assessment period of a client's hospitalization even if the primary diagnosis is ultimately determined to be a substance use disorder.

[10] The CHI report titled: "Exploring Options for Residential and Inpatient Treatment of Substance Use Disorder in Health First Colorado" can be accessed at: https://www.colorado.gov/pacific/sites/default/files/HCPF%202017%20Inpatient%20SUD%20Treatment%20Report.pdf

House Bill 18-1136, which was recommended by the Opioid and Other Substance Use Disorders Interim Study Committee, adds residential and inpatient SUD treatment and medical detoxification services as a benefit under the Colorado Medicaid Program. This expansion is conditional upon federal approval and the receipt of federal financial participation for the costs of the new services. The act limits these new services to persons who meet nationally recognized, evidence-based, level of care criteria for residential and inpatient SUD treatment and medical detoxification services.

The act requires HCPF, no later than October 1, 2018, to seek federal authorization to provide residential and inpatient substance use disorder treatment and medical detoxification services with full federal financial participation. Prior to seeking federal approval, the act requires HCPF to seek input from relevant stakeholders regarding:

- The coordination of benefits with managed service organizations and the office of behavioral health in the department of human services;
- The most appropriate entity for administration of the benefit;
- The provision of wraparound services needed during treatment and the provision of required services following treatment that may not be covered through the medical assistance program;
- The authorization process for approval of services; and
- The development of a reimbursement rate methodology to ensure sustainability that considers a provider's cost of providing care including lower-volume providers in rural areas.

Finally, the act requires HCPF to prepare and submit a performance review report no later than January 15, 2022, to the Joint Budget Committee and the relevant committees of reference concerning the expanded SUD benefits.

The final Legislative Council Staff fiscal note for the act identified the following fiscal impact:

Table 1
State Fiscal Impacts Under HB 18-1136

		FY 2018-19	FY 2019-20	FY 2020-21
Revenue		-	-	-
Expenditures	General Fund	$155,193	$148,745	$34,243,205
	Cash Funds	$81,634	$78,242	$11,554,286
	Federal Funds	$236,828	$226,987	$128,359,478
	Centrally Appropriated	$20,326	$27,101	$27,101
	Total	**$493,981**	**$481,075**	**$174,184,070**
	Total FTE	**1.5 FTE**	**2.0 FTE**	**2.0 FTE**
Transfers	**Total**	-	-	-

The above fiscal impact was based on the assumption that HCPF will require two years to seek federal authorization and design the new benefit, so the new services will become available on July 1, 2020. The $174.2 million cost estimate for FY 2020-21 includes some ongoing administrative expenses for 2.0 FTE, contractor/actuarial expenses, and facility licensing, but the figure primarily reflects the estimated cost of the new services. The fiscal note does indicate that to the extent inpatient and residential treatment are more effective than existing treatment options for certain clients, then

Medicaid may have costs savings. For example, if persons enter and stay in recovery from substance use disorders, then Medicaid will spend less on repeat instances of substance use treatment, emergency care associated with overdose, and long-term medical costs associated with substance use disorders. However, these potential savings could not be quantified.

The fiscal note also indicated that the expanded Medicaid benefit should reduce expenditures by the DHS' Office of Behavioral Health. However, given the overall demand for services and provider funding, it is assumed that any such savings will be reprioritized toward other eligible purposes.

STATUS OF IMPLEMENTING AN EXPANDED BENEFIT

On September 21, 2018, HCPF sent a letter to CMS requesting assistance and engagement on this issue to explore the available federal options and develop an approach that will work best for Colorado. HCPF staff expect to have monthly calls with CMS staff to continue these discussions. HCPF has hired staff and engaged a contractor to discuss this issue with other states and summarize recent federal legislation and its impact on this issue. HCPF is also accessing federal technical assistance that is available through the national association for State Medicaid Directors.

On October 26, 2018, HCPF held its first stakeholder meeting for a public discussion concerning the implementation of H.B. 18-1136. Key themes raised include:

- leveraging existing community assets;
- building a strong continuum; and
- ensuring provider and workforce capacity is understood and accounted for in the building of a benefit.

Staff has identified some key discussion points that emerged during this first meeting[11]:

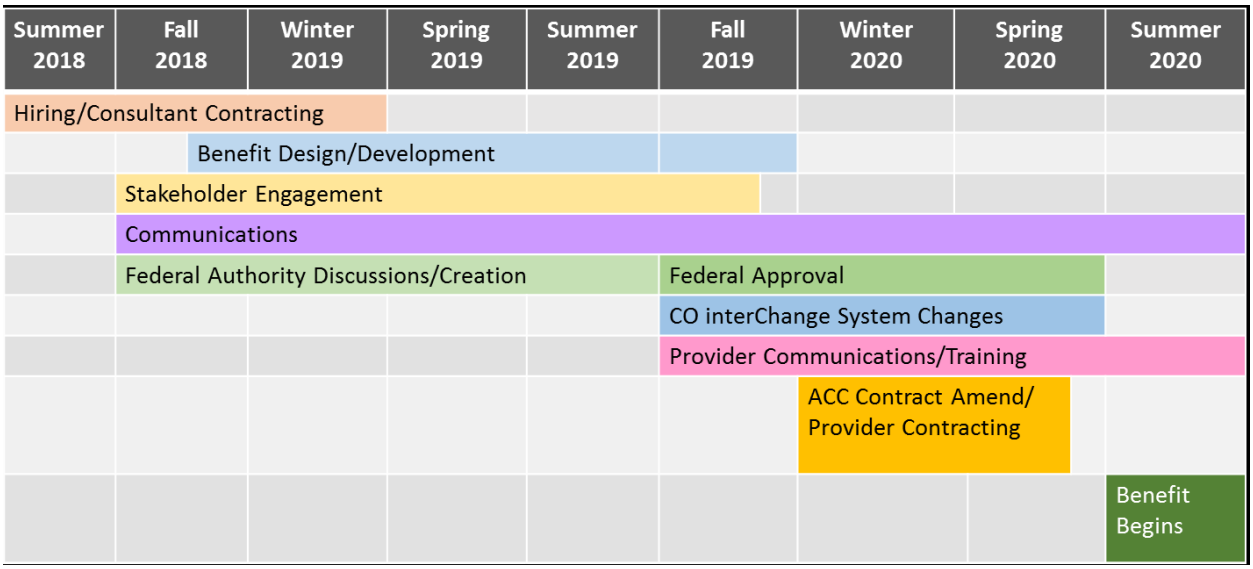
- HCPF expects that the expanded benefit will be managed by the RAEs, along with other behavioral health benefits that are covered by the Capitation program.
- This work will require close collaboration between HCPF and DHS' Office of Behavioral Health, involving data sharing, streamlining the assessment and intake processes, and aligning regulatory requirements and accountability measures. When this Medicaid benefit is expanded, funding administered by DHS will no longer be needed for certain types of treatment and should be utilized to cover supportive services that are not included as a Medicaid benefit (e.g., room and board, transportation, childcare, etc.). Further, services that are administered by DHS (e.g., the behavioral health crisis response system, and programs that involve partnerships with law enforcement) will serve as points of entry and sources of referrals.
- Workforce issues will need to be assessed and addressed to ensure statewide access to services. This will require consideration of rate adequacy and the ability for providers to bill Medicaid for services that are provided at sites that integrate or co-locate services (e.g., physical healthcare, mental healthcare, withdrawal management, etc.), services provided by peer professionals, and services provided via telehealth technology.
- Licensure issues affect individual professionals as well as provider agencies and facilities. Thus, HCPF will also need to collaborate with the Department of Regulatory Agencies and the

[11] HCPF will be posting summaries of every stakeholder meeting on its website: https://www.colorado.gov/hcpf/committees-boards-and-collaboration, under "Inpatient and Residential Substance Use Disorder (SUD) Benefits (HB 18-1136)"

Department of Public Health and Environment to ensure that regulatory requirements do not create unnecessary barriers for individuals to access care.

- Utilization management will be a critical function to ensure that care is not inappropriately shifted to settings that are more expensive. The focus should be on providing a full continuum of services and ensuring that individuals can access the appropriate level of care in a timely manner.

The Department proposed the following timeline for implementing the expanded benefit:



5 – Recent Federal Legislation Concerning Inpatient Substance Use Disorder Services

On October 24, 2018, President Trump signed into law the *Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act*. This legislation addresses many aspects of the opioid epidemic, including treatment, prevention, recovery, and enforcement. While very broad in scope, the final legislation contains a number of provisions related to Medicaid's role in helping states provide coverage and services to people who need substance use disorder (SUD) treatment, particularly those needing opioid use disorder treatment.

Several key provisions of the legislation that may affect Colorado's behavioral health services for Medicaid clients are summarized below:

- [Title I, Section 1001 – At-risk Youth Medicaid Protection] This provision requires state Medicaid programs to suspend, rather than terminate, a juvenile's (an individual under age 21) Medicaid eligibility when the juvenile is incarcerated. This requires a state to redetermine eligibility prior to release without requiring a new application and to restore coverage upon release. While Medicaid does not pay for health care services during incarceration, this measure is intended to facilitate access to coverage and care after release from prison or jail.

- [Title I, Section 1006 – Medicaid Health Homes for SUD Medicaid Enrollees] This section requires state Medicaid programs to cover medication-assisted treatment (MAT), including all

FDA-approved drugs, counseling services, and behavioral therapy, from October 2020 through September 2025.

- [TitleV, Subtitle F – IMD Care Act] These provisions provide state Medicaid programs with the option to cover care in certain IMDs for Medicaid clients ages 21 through 64 with an SUD for federal fiscal years 2019 to 2023. State Medicaid programs may receive federal reimbursement for up to 30 total days of care in an IMD during a 12-month period for eligible clients. To qualify for this option, a state Medicaid program must meet certain requirements including covering certain outpatient and inpatient levels of care, maintaining certain state spending requirements, and abiding by other reporting and notification rules.

- [Title VII, Subtitle S, Section 7181 – State Response to the Opioid Abuse Crisis] This provision reauthorizes and improves the State Targeted Response Grants from the *21st Century Cures Act* (which was signed into law on December 13, 2016) to provide funding to Tribes and to improve the flexibility for states using the grants.

- [Title VIII, Subtitle G – Human Services] These provisions require the federal Department of Health and Human Services (HHS) to provide guidance to states identifying opportunities to support family-focused residential substance abuse treatment programs. Beginning in federal FY 2019, states are eligible for federal matching funds for maintenance costs when an at-risk child is placed in family-focused residential treatment, as well as when the child is placed in foster care. In federal FY 2020, states will also be eligible to receive funding to provide evidence-based substance abuse prevention and treatment services to families with children at risk of entering foster care, even if the child is not placed in, or eligible for, federally funded foster care.

  This provision also authorizes $20 million for HHS to award to states to develop, enhance, or evaluate family-focused treatment programs to increase the number of evidence-based programs that will later qualify for funding under the *Family First Prevention Services Act*.

Staff suggests that the Committee ask the Department (in collaboration with the Department of Human Services if appropriate) to discuss its work thus far in reviewing this legislation and the potential implications for the Medicaid Capitation program and the expansion of the Medicaid substance use disorder benefit.

6 – Implementation of the "Suspension" of Medicaid Benefits

Ten years ago the General Assembly passed legislation (S.B. 08-006) requiring that persons who are eligible for Medicaid just prior to their confinement in a jail, juvenile commitment facility, Department of Corrections facility, or Department of Human Services facility, shall have their Medicaid benefits suspended, rather than terminated, during the period of their confinement. It was anticipated at the time that both the Medicaid Management Information System (MMIS) and the Colorado Benefits Management System (CBMS) would need to be modified to implement the bill.

The Department encountered a number of barriers while attempting to implement this bill. With the expansion of Medicaid eligibility to Adults Without Dependent Children in 2014, and the recent implementation of the new MMIS system in 2016, the Department was finally been able to implement this act. The Department provided the following description of this functionality (emphasis added):

> "Under the Social Security Act, Medicaid may not pay for covered services administered to inmates of a public institution unless that inmate was admitted to the hospital as an inpatient for longer than 24 hours. While Medicaid is prohibited from paying for covered services, the inmate remains eligible to be enrolled in the Medicaid program while incarcerated. **In March 2017, the suspend function was fully implemented in both the MMIS (claims) and CBMS (eligibility) systems.** Medicaid members who become incarcerated experience a change in the living location, at which time County Eligibility Technicians change the inmate's status to incarcerated in CBMS. This status sends an indicator to the MMIS, at which the individual is placed in the "Incarcerated Benefits Package". This benefits package limits the member to only inpatient hospital services and those services related to the inpatient stay."

The Department issued a policy memo on October 16, 2018, to provide guidance to County Eligibility Technicians, the Department of Corrections, and County Jails and other stakeholders[12]. This policy memo is effective as of March 1, 2017.

Justice-involved individuals have disproportionately high rates of chronic conditions, infectious disease, and behavioral health problems[13]. The Medicaid program can play a key role in ensuring continued access to both primary and behavioral health care as these individuals transition back to the community. Access to Medicaid coverage for justice-involved individuals can provide continuity of care that may improve health outcomes, reduce recidivism, improve public safety, and lower the costs of incarceration[14].

Please note that this suspend functionality also impacts individuals who receive care in the mental health institutes, and should offer similar benefits in terms of reducing the likelihood of repeated psychiatric hospitalizations.

While it is certainly good news that the Department finally implemented this suspend functionality, it is staff's perception that further outreach efforts are warranted to actually leverage it to improve individuals' healthcare and achieve other positive public outcomes. Even though the suspend function was implemented in March of 2017, the associated policy memo was issued in October of 2018. Colorado Counties, Inc., prioritized this issue as one of its 2019 administrative initiatives:

> "CCI will work with our state partners, including the sheriffs and the Colorado Department of Health Care Policy and Financing (HCPF) to implement the suspension, rather than termination, of Medicaid coverage for inmates statewide."

Staff also learned in September of this year that the mental health institutes were not aware of this new functionality. Staff recommends that the Committee ask the Department to describe how it plans to ensure that affected entities are aware of this new functionality and are able to use it effectively.

[12] Policy Memo "HCPF PM 18-003" can be accessed at: https://www.colorado.gov/hcpf/memo-series.
[13] Source: Federal Department of Health and Human Services ASPE issue brief, "The Importance of Medicaid Coverage for Criminal Justice Involved Individuals Reentering Their Communities (April 2016).
[14] Ibid.

Appendix A: Number Pages

	FY 2016-17 Actual	FY 2017-18 Actual	FY 2018-19 Appropriation	FY 2019-20 Request	Request vs. Appropriation
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING **Kim Bimestefer, Executive Director**					
(3) BEHAVIORAL HEALTH COMMUNITY PROGRAMS					
This section provides funding for the purchase of behavioral healthcare services through administrative entities. Prior to July 1, 2018, these entities were "behavioral health organizations" (BHOs); as of July 1, 2018, "regional accountable entities" (RAEs) perform this function. Each RAE manages mental health and substance use disorder services for eligible Medcaid clients within a specified region through a capitated, risk-based funding model. This section of the budget also provides funding for Medicaid behavioral health fee-for-service programs for those mental health and substance use disorder services not covered within the capitation contracts and rates. This section is primarily supported by federal Medicaid funds, General Fund, and the Colorado Healthcare Affordability and Sustainability Cash Fund.					
Behavioral Health Capitation Payments	603,888,726	512,884,063	647,499,083	675,267,704 *	
General Fund	157,456,205	171,717,548	182,170,974	195,384,248	
Cash Funds	17,292,866	21,637,199	29,656,683	36,224,217	
Reappropriated Funds	0	0	0	0	
Federal Funds	429,139,655	319,529,316	435,671,426	443,659,239	
Behavioral Health Fee-for-service Payments	7,793,562	9,300,665	9,388,347	9,670,646 *	
General Fund	1,762,029	2,093,383	2,266,609	2,023,226	
Cash Funds	189,409	355,200	398,268	551,372	
Reappropriated Funds	0	0	0	0	
Federal Funds	5,842,124	6,852,082	6,723,470	7,096,048	
TOTAL - (3) Behavioral Health Community Programs	611,682,288	522,184,728	656,887,430	684,938,350	4.3%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	159,218,234	173,810,931	184,437,583	197,407,474	7.0%
Cash Funds	17,482,275	21,992,399	30,054,951	36,775,589	22.4%
Reappropriated Funds	0	0	0	0	0.0%
Federal Funds	434,981,779	326,381,398	442,394,896	450,755,287	1.9%

Appendix A: Number Pages

	FY 2016-17 Actual	FY 2017-18 Actual	FY 2018-19 Appropriation	FY 2019-20 Request	Request vs. Appropriation
TOTAL - Department of Health Care Policy and Financing	611,682,288	522,184,728	656,887,430	684,938,350	4.3%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	159,218,234	173,810,931	184,437,583	197,407,474	7.0%
Cash Funds	17,482,275	21,992,399	30,054,951	36,775,589	22.4%
Reappropriated Funds	0	0	0	0	0.0%
Federal Funds	434,981,779	326,381,398	442,394,896	450,755,287	1.9%

APPENDIX B
RECENT LEGISLATION AFFECTING DEPARTMENT BUDGET

2017 SESSION BILLS

S.B. 17-267 (SUSTAINABILITY OF RURAL COLORADO): With respect to behavioral health programs, the act repeals the Hospital Provider Fee and creates the Healthcare Affordability and Sustainability (HAS) Fee as part of an enterprise for purposes of the Taxpayer's Bill of Rights (TABOR) such that the revenue from the HAS Fee does not count against the state fiscal year spending limit (Referendum C cap).

For FY 2017-18, the act replaces $597,380,996 in cash fund appropriations to the Department from the Hospital Provider Fee with cash fund appropriations from the HAS Fee Cash Fund. In addition, the appropriation includes for the Department $264,100,000 from the HAS Fee CF and an anticipated like amount of federal funds, which is the amount of provider fees from hospitals that was restricted in S.B. 17-256. The act also reduces appropriations to the Department by $1,818,901 total funds, including $320,035 General Fund, $64,835 cash funds, and $1,434,031 federal funds based on the projected fiscal impact of the increase in Medicaid copayments.

H.B. 17-1351 (STUDY INPATIENT SUBSTANCE USE DISORDER TREATMENT): Requires the Department of Health Care Policy and Financing (HCPF), with assistance from the Department of Human Services' Office of Behavioral Health, to prepare a written report concerning the feasibility of providing residential and inpatient substance use disorder treatment as part of the Medicaid program or as a state-funded benefit. Requires HCPF to submit the report to several legislative committees by November 1, 2017. Requires the State Treasurer to transfer $37,500 cash funds from the Marijuana Tax Cash Fund to the General Fund on June 30, 2018. Appropriates $37,500 General Fund to HCPF for FY 2017-18, and states that this appropriation is based on the assumption that HCPF will receive $37,500 federal funds to implement the act.

H.B. 17-1353 (IMPLEMENT MEDICAID DELIVERY & PAYMENT INITIATIVES): Provides a statutory framework for the existing Accountable Care Collaborative (ACC), authorizes elements to be featured in phase II of the ACC, authorizes performance-based payments to providers, and places guidelines and reporting requirements on these initiatives. With regard to the ACC, the act:

- Lists elements that must be included in the ACC, such as providing a primary care medical home for all Medicaid clients and integrating the delivery of behavioral health and physical health services
- Requires the creation of stakeholder advisory committees
- Requires an annual report on the ACC. The statutory annual report combines elements of an existing statutory report and an annual request for information submitted by the JBC.
- Requires a report outlining changes required to align state statute with a new federal rule regarding managed care
- Clarifies that the Medical Services Board has oversight and must promulgate rules to implement the ACC

Regarding performance-based payments, the act:

- Authorizes the Department to implement performance-based payments and specifically authorizes performance payments for:
    - Primary care providers
    - Federally qualified health centers
    - Providers of long-term services and supports
    - Behavioral health providers
- Requires that prior to implementing performance payments the Department must submit to the JBC:
    - Either:
        i. Evidence that the payments are designed to achieve budget savings, or
        ii. A budget request for costs associated with the performance-based payments
    - The estimated performance-based payments compared to total reimbursements for the affected service
    - A description of the stakeholder engagement process and the Department's response to stakeholder feedback
- Requires an annual report on performance payments including factors such as the evidence for the performance payments, the expected outcomes, the stakeholder engagement process, and evaluation results

The bill is not expected to have any fiscal impact on FY 2017-18 expenditures, but there are projected costs and savings associated with different elements beginning in FY 2018-19 as summarized in the table below.

ACCOUNTABLE CARE COLLABORATIVE/PERFORMANCE-BASED PAYMENTS LEGISLATION

	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FEDERAL FUNDS	FTE
FY 2018-19					
Accountable Care Collaborative (ACC)					
Administrative staff	$268,092	$134,046	$0	$134,046	3.7
Mandatory enrollment	29,183,877	11,177,425	1,138,171	16,868,281	
Increase PMPM by $1	15,086,585	5,778,162	588,377	8,720,046	
Savings - Mandatory enrollment	(50,830,650)	(21,621,473)	(1,882,759)	(27,326,418)	
Savings - Physical-behavioral health	(57,785,147)	(15,364,614)	(1,897,370)	(40,523,163)	
Subtotal - ACC	*($64,077,243)*	*($19,896,454)*	*($2,053,581)*	*($42,127,208)*	*3.7*
Performance payments					
Rate analyst	$66,999	$33,499	$0	$33,500	0.9
Primary care	58,062,151	20,231,923	1,159,202	36,671,026	
Federally Qualified Health Centers	0	0	0	0	
Behavioral Health	26,717,069	7,215,319	1,090,836	18,410,914	
Subtotal - Performance payments	*$84,846,219*	*$27,480,741*	*$2,250,038*	*$55,115,440*	*0.9*
TOTAL FY 2018-19	**$20,768,976**	**$7,584,287**	**$196,457**	**$12,988,232**	**4.6**

ACCOUNTABLE CARE COLLABORATIVE/PERFORMANCE-BASED PAYMENTS LEGISLATION					
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FEDERAL FUNDS	FTE
FY 2019-20					
Accountable Care Collaborative (ACC)					
Administrative staff	$271,907	$135,953	$0	$135,954	4.0
Mandatory enrollment	26,169,379	10,022,872	1,020,606	15,125,901	
Increase PMPM by $1	15,379,665	5,890,412	599,807	8,889,446	
Savings - Mandatory enrollment	(95,391,901)	(41,260,953)	(3,155,463)	(50,975,485)	
Savings - Physical-behavioral health	(117,205,890)	(31,164,084)	(4,909,831)	(81,131,975)	
Subtotal - ACC	*($170,776,841)*	*($56,375,801)*	*($6,444,881)*	*($107,956,159)*	**4.0**
Performance payments					
Contract performance evaluator	$150,000	$75,000	$0	$75,000	
Rate analyst	67,977	33,988	0	33,989	1.0
Primary care	59,055,014	20,577,889	1,492,346	36,984,779	
Federally Qualified Health Centers	0	0	0	0	
Behavioral Health	28,131,120	7,503,004	1,306,187	19,321,929	
Subtotal - Behavioral health	*$87,404,111*	*$28,189,881*	*$2,798,533*	*$56,415,697*	*1.0*
TOTAL FY 2018-19	**($83,372,730)**	**($28,185,920)**	**($3,646,348)**	**($51,540,462)**	**5.0**

2018 SESSION BILLS

S.B. 18-195 (HEALTHCARE AFFORDABILITY AND SUSTAINABILITY FEE CASH FUND APPROPRIATIONS): Makes money in the Healthcare Affordability and Sustainability Fee (HAS Fee) Cash Fund subject to annual appropriation by the General Assembly, rather than continuously appropriated to the Colorado Healthcare Affordability and Sustainability Enterprise.

SB 18-266 (CONTROLLING MEDICAID COSTS): Authorizes four new initiatives intended to control Medicaid expenditures:

- Create a resource control unit of six people (5.4 FTE in the first year) dedicated to controlling costs
- Deploy cost and quality technology for the Regional Accountable Entities and providers that identifies the most effective providers and medications to help steer clients to the best health outcomes and reduce expenditures
- Implement a comprehensive hospital admission review program, including pre-admission certification, continued stay reviews, discharge planning, and retrospective claims reviews
- Purchase commercial technology that would periodically update billing system safeguards that identify and reject inappropriate claims

The act includes requirements for stakeholder engagement, technology testing, and reporting to the General Assembly, and parameters around coverage determinations for hospital stays. For FY 2018-19, the act includes appropriations and assumptions about federal funds and FTE with a net result for the Department of Health Care Policy and Financing of a decrease of $2,061,973 total funds, including a decrease of $730,316 General Fund, an increase of $222,613 cash funds, a decrease of $1,554,270 federal funds, and an increase of 6.8 FTE.

HB 18-1003 (OPIOID MISUSE PREVENTION): Implements several policies related to the prevention of opioid and substance misuse. Makes appropriations to several departments, including an appropriation of $925,000 cash funds from the Marijuana Tax Cash Fund to the Department of Health Care Policy and Financing for the Screening, Brief Intervention, and Referral to Treatment (SBIRT) training program for the development of a training module on substance-exposed pregnancies and additional funding for SBIRT grants.

H.B. 18-1136 (EXPAND MEDICAID BENEFIT FOR SUBSTANCE USE DISORDER): Adds residential and inpatient substance use disorder treatment and medical detoxification services as a benefit under the Colorado Medicaid Program, conditional upon federal approval. If the new benefit is enacted, requires Managed Service Organizations (MSOs) to determine to what extent money allocated from the MTCF may be used to assist in providing substance use disorder services if those services are not otherwise covered by private or public insurance. Appropriates a total of $236,827 in state funds to the Department of Health Care Policy and Financing (HCPF) for FY 2018-19 (including $155,193 General Fund and $81,634 cash funds from the Healthcare Affordability and Sustainability Fee Cash Fund), and states the assumption that HCPF will receive $236,828 federal funds for FY 2018-19.

APPENDIX C
FOOTNOTES AND INFORMATION REQUESTS

UPDATE ON LONG BILL FOOTNOTES

The FY 2018-19 Long Bill does not include any footnotes that directly pertain to the Behavioral Health Community Programs section.

UPDATE ON REQUESTS FOR INFORMATION

1 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)(b), C.R.S., the Department of Health Care Policy and Financing is required to publish an **Annual Performance Report** for the *previous fiscal year* 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 the designated fiscal year. In addition, pursuant to Section 2-7-204 (3)(a)(I), C.R.S., the Department is required to develop a **Performance Plan** and submit the plan for the *current fiscal year* to the Joint Budget Committee and appropriate Joint Committee of Reference by July 1 of each year.

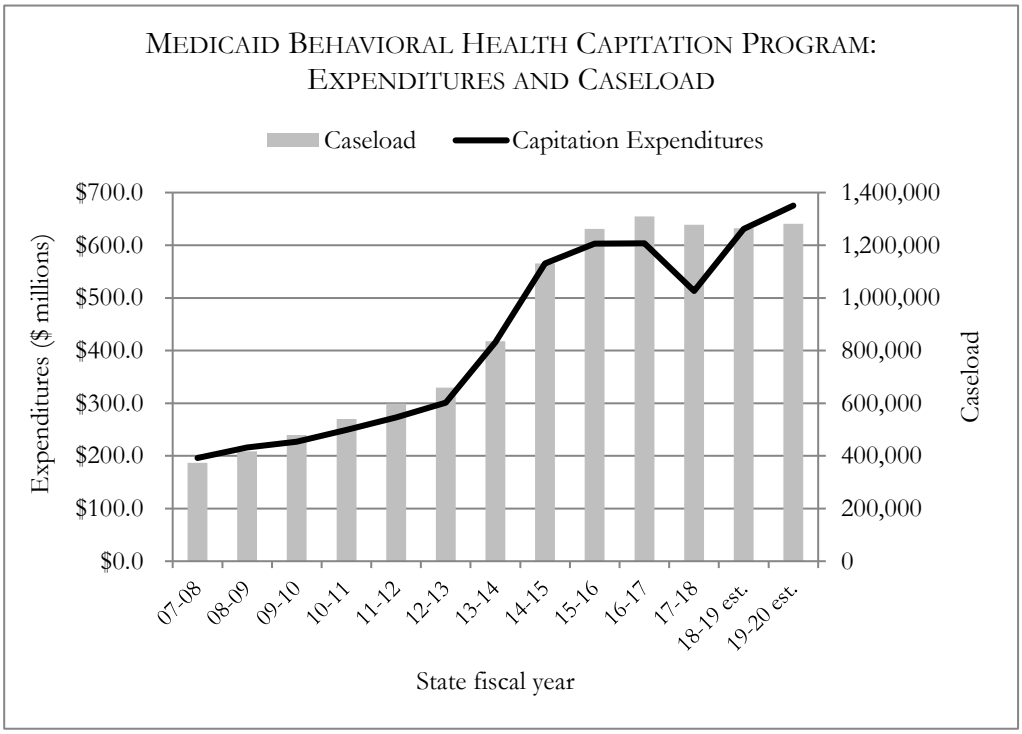
For consideration by the Joint Budget Committee in prioritizing the Department's FY 2019-20 budget request, the FY 2017-18 Annual Performance Report dated October 2018 and the FY 2018-19 Performance Plan [undated] can be found at the following link:

https://www.colorado.gov/pacific/performancemanagement/department-performance-plans

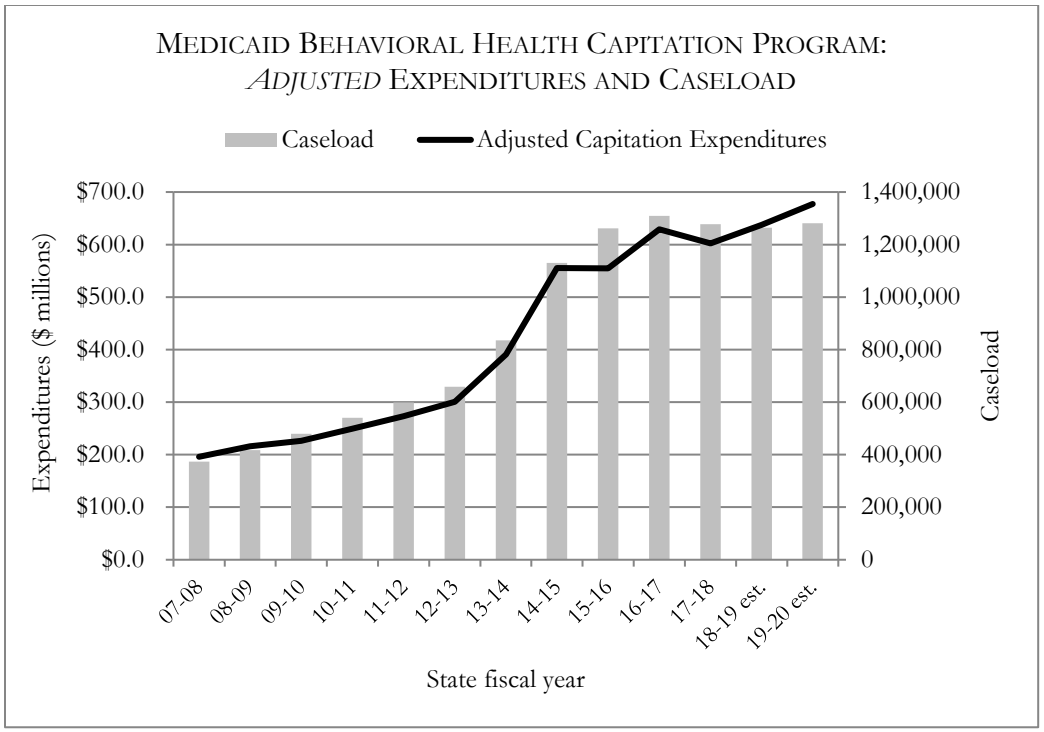
APPENDIX E
CALCULATION OF CAPITATION PROGRAM "ADJUSTED" EXPENDITURES

The following two charts both depict annual expenditure and caseload changes for the Medicaid Behavioral Health Capitation Program since FY 2007-08. The difference between the two charts is the method used to allocate expenditures by fiscal year.

The first chart is based on actual expenditures reported by the Department. These expenditures are essentially reflected on a cash flow basis based on the fiscal year in which they were booked. The amounts for FY 2018-19 and FY 2019-20 are based on the Department's most recent expenditure estimates.



In contrast, the second chart depicts annual expenditures related to Capitation reconciliations, recoupments, health insurance provider fee payments, and incentive payments in the fiscal year associated with dates of service, rather than in the fiscal year in which they were booked. The second chart thus provides a more accurate depiction of annual expenditures in relation to the total number of clients who were eligible to receive behavioral health services in that particular year.



The following table details the various types of reconciliations, recoupments, and payments that occurred starting in FY 2016-17 and those that are expected to occur. For each type of adjustment, this table also indicates (in the six columns titled, "Dates of Service") the relevant fiscal year in which the associated services were provided. Following the table, staff has provided a description of each type of adjustment.

SUMMARY OF CAPITATION RECONCILIATIONS: FY 2016-17 THROUGH FY 2019-20							
FISCAL YEAR IN WHICH RECOUPMENT/ PAYMENT OCCURRED	DATES OF SERVICE						TOTAL
	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	
FY 2016-17							
Risk corridor reconciliation	($17,524,964)	$0	$0	$0	$0	$0	($17,524,964)
Expansion parent rate reconciliation	0	(19,040,337)	0	0	0	0	(19,040,337)
Parent indicator issue	0	0	12,144,633	0	0	0	12,144,633
Total: FY 2016-17	**(17,524,964)**	**(19,040,337)**	**12,144,633**	**0**	**0**	**0**	**(24,420,668)**
FY 2017-18							
Risk corridor reconciliation	0	(47,729,415)	0	0	0	0	($47,729,415)
Adjustment for children incorrectly placed in disability eligibility category	0	(1,848,939)	0	0	0	0	(1,848,939)
Adjustment for parents/caretakers eligible for Transitional Medicaid	(4,377)	939,161	667,135	0	0	0	0
Expansion parent rate reconciliation	0	0	(17,786,031)	0	0	0	(17,786,031)
Parent indicator issue	0	0	(86,606)	0	0	0	(86,606)
Health insurance provider fee payment	0	0	5,891,487	0	0	0	5,891,487
Total: FY 2017-18	**(4,377)**	**(48,639,193)**	**(11,314,015)**	**0**	**0**	**0**	**(61,559,504)**

SUMMARY OF CAPITATION RECONCILIATIONS: FY 2016-17 THROUGH FY 2019-20							
FISCAL YEAR IN WHICH RECOUPMENT/ PAYMENT OCCURRED	DATES OF SERVICE						TOTAL
	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	
FY 2018-19							
Rate change for adults without dependent children	0	0	0	946,398	0	0	$946,398
BHO incentive payments (HB 17-1353)	0	0	0	28,696,148	0	0	28,696,148
Health insurance provider fee payment	0	0	0	0	0	0	0
Total: FY 2018-19	**0**	**0**	**0**	**29,642,546**	**0**	**0**	**29,642,546**
FY 2019-20							
RAE incentive payments (HB 17-1353)	0	0	0	0	30,130,828	0	30,130,828
Health insurance provider fee payment	0	0	0	0	6,149,191	0	6,149,191
Total: FY 2019-20	**0**	**0**	**0**	**0**	**36,280,019**	**0**	**36,280,019**
FY 2020-21							
RAE incentive payments (HB 17-1353)	0	0	0	0	0	32,022,492	32,022,492
Health insurance provider fee payment	0	0	0	0	0	6,231,147	6,231,147
Total: FY 2020-21	**0**	**0**	**0**	**0**	**0**	**38,253,639**	**38,253,639**
TOTALS	**($17,529,341)**	**($67,679,530)**	**$830,618**	**$29,642,546**	**$36,280,019**	**$38,253,639**	**$18,196,032**

- *Risk corridor reconciliation:* Due to the uncertainty of the cost of serving the newly eligible Adults Without Dependent Children and Parents/Caretakers (69% to 138% FPL) populations, the Department placed a "risk corridor" on the associated Capitation rates to protect both the State and BHOs from undue risk. The recoupments in the above table are due to the rates paid in FY 2014-15 and FY 2015-16 being set higher than actual costs.

- *Expansion parent rate reconciliation:* These recoupments are due to payments made in FY 2015-16 and FY 2016-17 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 due to system limitations in the previous Medicaid Management Information System (MMIS) payment system.

- *Parent indicator issue:* This payment issue is essentially the reverse of the above reconciliation item, but it occurred upon implementation of the new Colorado interChange payment system that was implemented in March 2017. The new system initially made payments for a group of adults with low incomes based on the lower Parents/Caretakers (69% to 138% FPL) category rate, rather than the rate for Adults Without Dependent Children. The Department identified and was able to mostly corrected this issue within FY 2016-17, the same year that the associated services were provided.

- *Adjustment for children incorrectly placed in disability eligibility category:* This recoupment was needed for payments made in FY 2015-16 for some children that were incorrectly categorized and paid based on the Individuals with Disabilities category rate.

- *Adjustment for parents/caretakers eligible for Transitional Medicaid*: These payments are due to a group of adults with low incomes who should have been placed on Transitional Medicaid in FY 2015-16 and FY 2016-17. These payments were incorrectly based on the lower Parents/Caretakers (69% to 138% FPL) category rate.

- *Health insurance provider fee payment:* Under the federal Affordable Care Act, a fee is charged to covered entities that provide health insurance. This fee only applies to for profit insurers, and it is based on the insurer's market share. This mandate was waived for calendar year 2017. The $5.9 million fee that the Department paid for FY 2016-17 was on behalf of two behavioral health organizations (BHOs): Foothills Behavioral Health Partners, LLC, and Colorado Health Partnerships, LLC. The Department's estimates for FY 2019-20 and FY 2020-21 assume that this fee will continue to be required for some of the regional accountable entities. Any payments for CY 2018 will be paid in FY 2019-20, and any payments made for CY 2019 will be paid in FY 2020-21.

- *Rate change for adults without dependent children:* Due to a significant decrease in caseload for Adults Without Dependent Children, the per-member-per-month rates paid to BHOs were no longer actuarially sound. The Department recalculated the rates to be actuarially sound and calculated the amount owed to the BHOs in FY 2017-18 based on the new, higher rates.

- *BHO/RAE incentive payments (HB 17-1353):* BHOs are eligible to receive incentive payments in FY 2018-19 based on services provided in FY 2017-18 (and related performance measures). The regional accountable entities (RAEs) will be eligible for incentive payments starting in FY 2019-20 based on services provided in FY 2018-19.

APPENDIX F
FY 2018-19 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)	$20.95	$138.23	$30.13	$15.71	$49.63	$19.86	$119.30	$30.13	
Estimated monthly caseload	47,339	91,756	198,865	71,253	343,166	489,098	22,483	154	1,264,114
Number of months rate is effective	12	12	12	12	12	12	12	12	
Total estimated capitated payments	**$11,901,025**	**$152,201,183**	**$71,901,629**	**$13,432,616**	**$204,375,943**	**$116,561,835**	**$32,186,663**	**$55,680**	**$602,616,573**
Estimated expenditures:									
Claims paid in current period	$11,886,744	$151,988,101	$71,750,636	$13,404,408	$203,762,815	$116,398,648	$32,170,570	$55,624	$601,417,546
Claims from prior periods	11,605	196,871	138,974	23,361	657,223	173,408	15,071	66	1,216,579
Estimated date of death retractions	(173,266)	(412,087)	(57,405)	(12,342)	(834,145)	(20,353)	(19,976)	(11,147)	(1,540,721)
Total expenditures after retractions	$11,725,083	$151,772,885	$71,832,205	$13,415,427	$203,585,893	$116,551,703	$32,165,665	$44,543	$601,093,404
Other payment adjustments:									
Rate change for adults without dependent children	0	0	0	(208,798)	1,155,196	0	0	0	946,398
Health insurance provider fee payment	0	0	0	0	0	0	0	0	0
Estimated incentive payments	566,574	7,246,723	3,423,229	639,402	9,734,045	5,550,912	1,532,611	2,652	28,696,148
NET EXPENDITURES	**$12,291,657**	**$159,019,608**	**$75,255,434**	**$13,846,031**	**$214,475,134**	**$122,102,615**	**$33,698,276**	**$47,195**	**$630,735,950**
Annual per capita expenditure (excluding payment adjustments)	**$247.68**	**$1,654.09**	**$361.21**	**$188.28**	**$593.26**	**$238.30**	**$1,430.67**	**$289.24**	**$475.51**

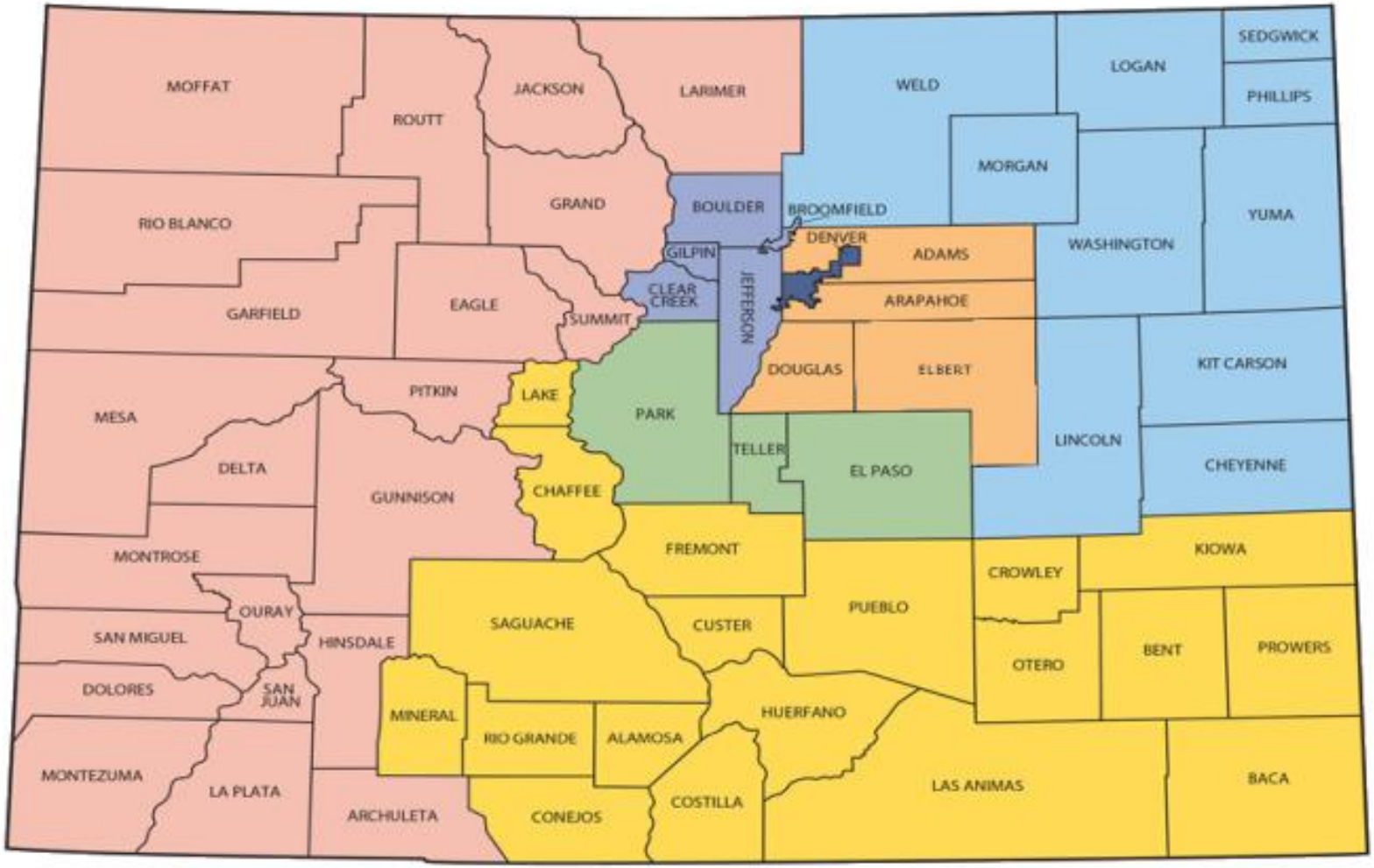
* These are new eligibility categories authorized by S.B. 13-200.

APPENDIX G
FY 2019-20 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)	$22.11	$142.36	$31.65	$15.60	$52.13	$20.52	$123.36	$31.65	
Estimated monthly caseload	49,114	95,812	201,456	73,355	347,535	490,473	23,290	130	1,281,165
Number of months rate is effective	12	12	12	12	12	12	12	12	
Total estimated capitated payments	**$13,030,926**	**$163,677,556**	**$76,512,989**	**$13,732,056**	**$217,403,995**	**$120,774,072**	**$34,476,653**	**$49,374**	**$639,657,620**
Estimated expenditures:									
Claims paid in current period	$13,015,289	$163,448,407	$76,352,312	$14,493,789	$216,751,783	$120,604,988	$34,459,415	$49,325	$639,175,308
Claims from prior periods	14,281	213,082	150,993	28,208	613,128	163,187	16,093	56	1,199,028
Estimated date of death retractions	(155,940)	(370,879)	(51,664)	(11,108)	(750,731)	(18,318)	(17,979)	(10,032)	(1,386,651)
Total expenditures after retractions	$12,873,630	$163,290,610	$76,451,641	$14,510,889	$216,614,180	$120,749,857	$34,457,529	$39,349	$638,987,685
Other payment adjustments:									
Health insurance provider fee payment	95,179	1,351,379	721,071	146,380	2,470,112	1,068,743	296,059	268	6,149,191
Estimated incentive payments	594,900	7,609,027	3,594,376	671,369	10,220,704	5,828,433	1,609,235	2,784	30,130,828
NET EXPENDITURES	**$13,563,709**	**$172,251,016**	**$80,767,088**	**$15,328,638**	**$229,304,996**	**$127,647,033**	**$36,362,823**	**$42,401**	**$675,267,704**
Annual per capita expenditure (excluding payment adjustments)	**$262.12**	**$1,704.28**	**$379.50**	**$197.82**	**$623.29**	**$246.19**	**$1,479.50**	**$302.68**	**$498.76**

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

Map of Regions and Associated Counties



Region 1	Rocky Mountain Health Plans (RMHP)	Region 5	Colorado Access
Region 2	Northeast Health Partners (NHP)	Region 6	Colorado Community Health Alliance (CCHA)
Region 3	Colorado Access	Region 7	Colorado Community Health Alliance (CCHA)
Region 4	Health Colorado Inc. (HCI)		

JBC Staff Briefings

Department of Health Care Policy and Financing

(Medicaid Behavioral Health Community Programs)

and

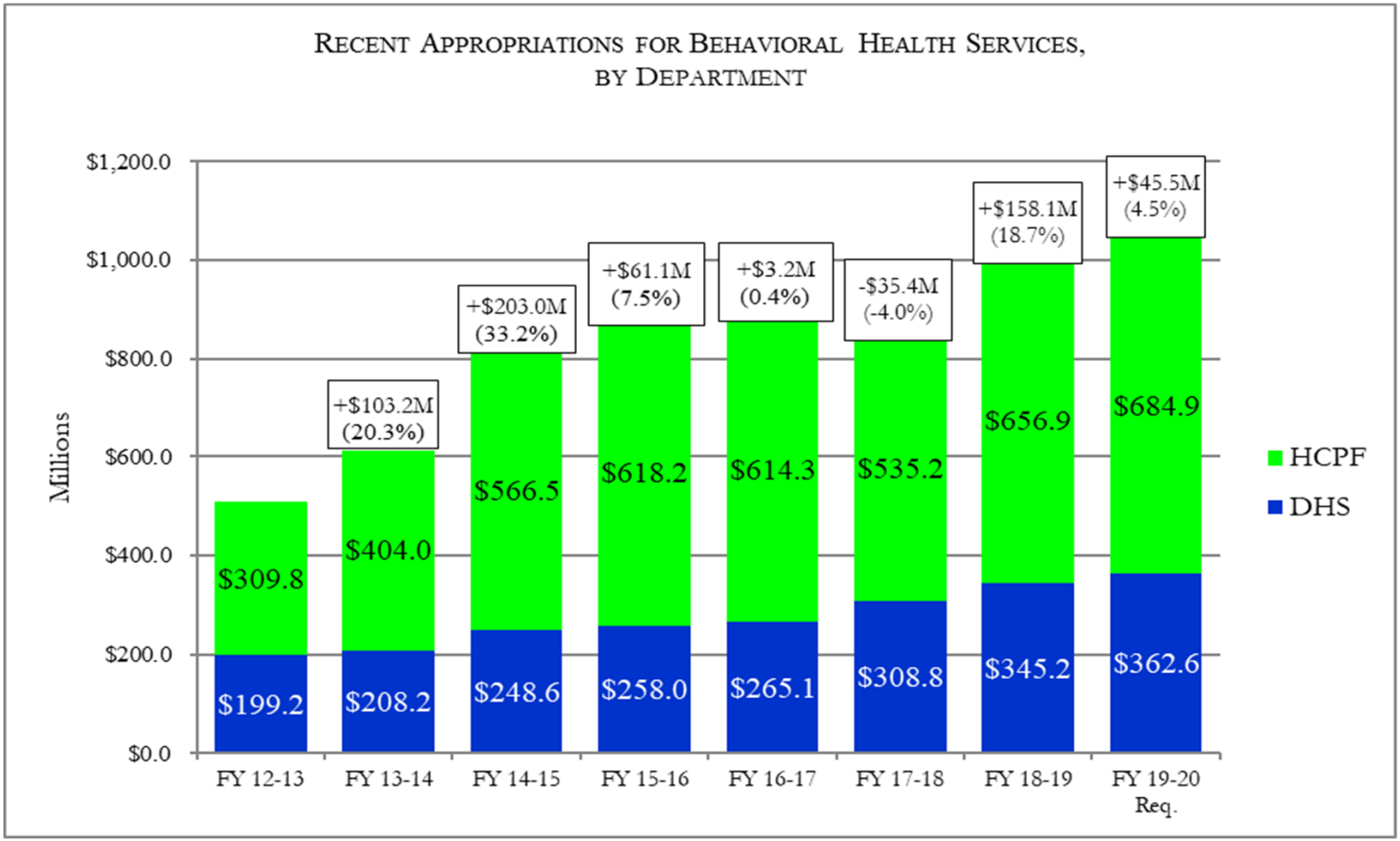
Department of Human Services

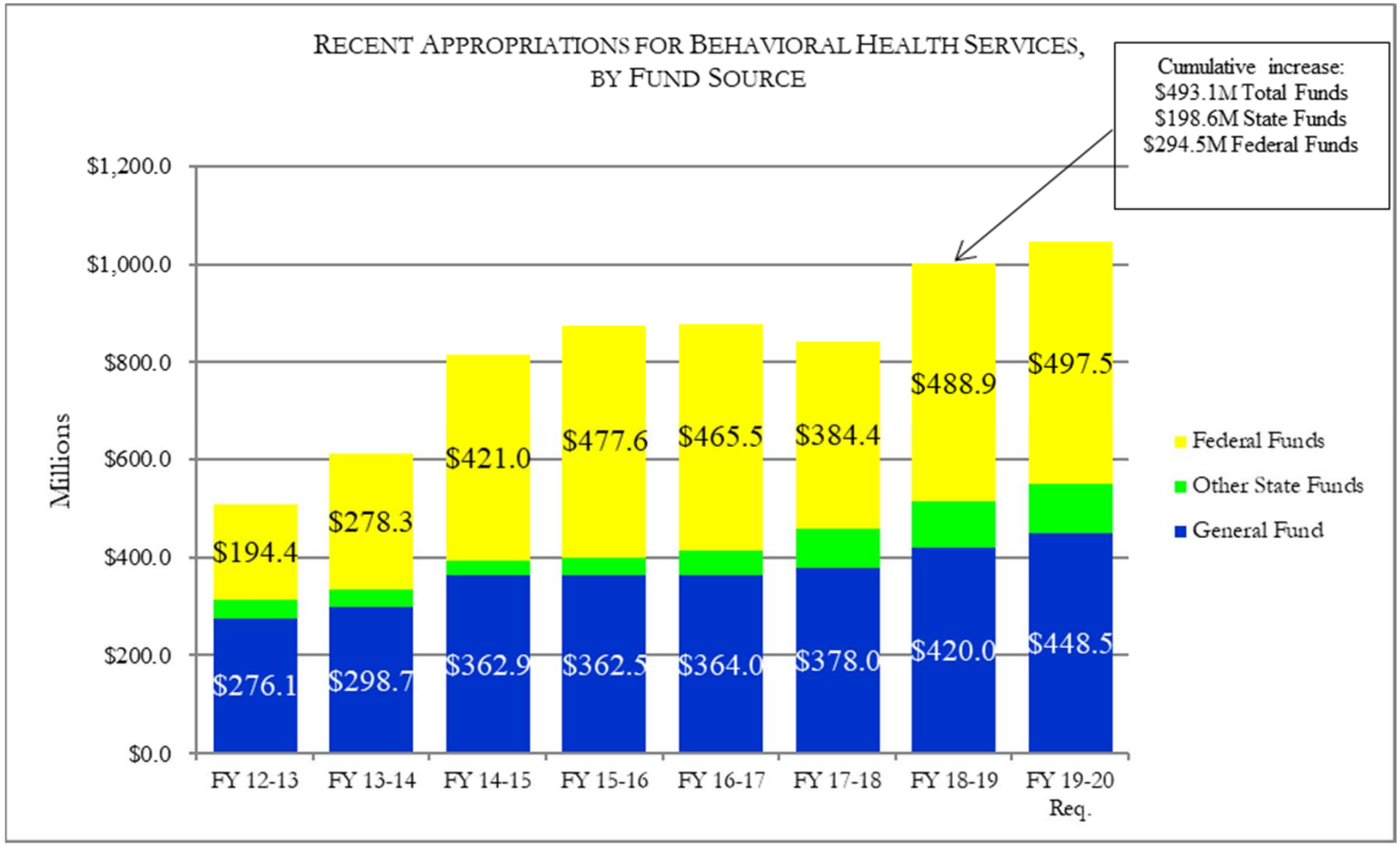
(Office of Behavioral Health)

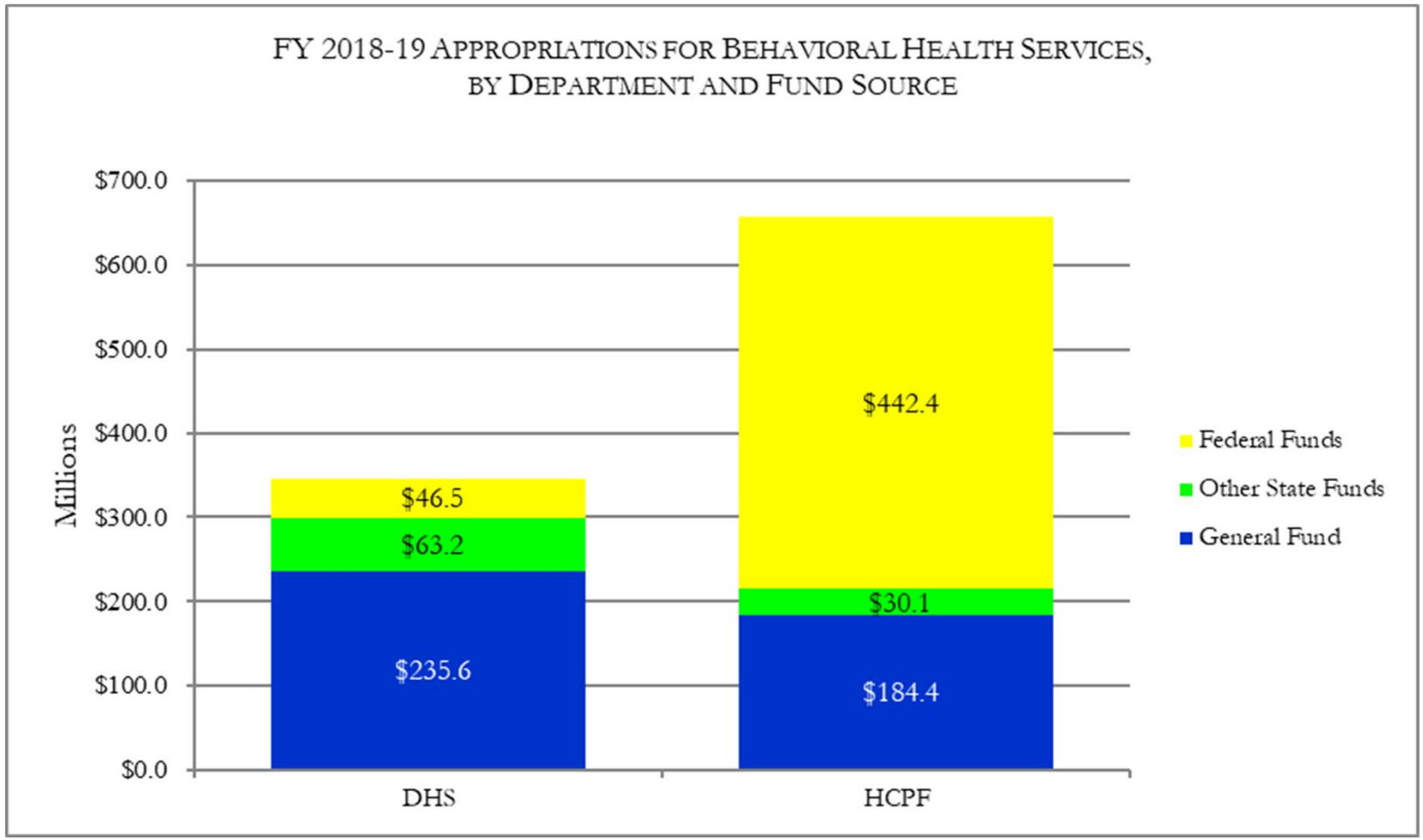
Presented by:

Carolyn Kampman, JBC Staff

December 11, 2018


RECENT APPROPRIATIONS FOR BEHAVIORAL HEALTH SERVICES, BY DEPARTMENT
Millions
$1,200.0
$1,000.0
$800.0
$600.0
$400.0
$200.0
$0.0
+$103.2M (20.3%)
+$203.0M (33.2%)
+$61.1M (7.5%)
+$3.2M (0.4%)
-$35.4M (-4.0%)
+$158.1M (18.7%)
+$45.5M (4.5%)
$309.8
$404.0
$566.5
$618.2
$614.3
$535.2
$656.9
$684.9
$199.2
$208.2
$248.6
$258.0
$265.1
$308.8
$345.2
$362.6
FY 12-13
FY 13-14
FY 14-15
FY 15-16
FY 16-17
FY 17-18
FY 18-19
FY 19-20 Req.
HCPF
DHS


RECENT APPROPRIATIONS FOR BEHAVIORAL HEALTH SERVICES, BY FUND SOURCE
Cumulative increase:
$493.1M Total Funds
$198.6M State Funds
$294.5M Federal Funds
Millions
$1,200.0
$1,000.0
$800.0
$600.0
$400.0
$200.0
$0.0
$194.4
$278.3
$421.0
$477.6
$465.5
$384.4
$488.9
$497.5
$276.1
$298.7
$362.9
$362.5
$364.0
$378.0
$420.0
$448.5
FY 12-13
FY 13-14
FY 14-15
FY 15-16
FY 16-17
FY 17-18
FY 18-19
FY 19-20 Req.
Federal Funds
Other State Funds
General Fund


FY 2018-19 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
$46.5
$63.2
$235.6
$442.4
$30.1
$184.4
DHS
HCPF
Federal Funds
Other State Funds
General Fund

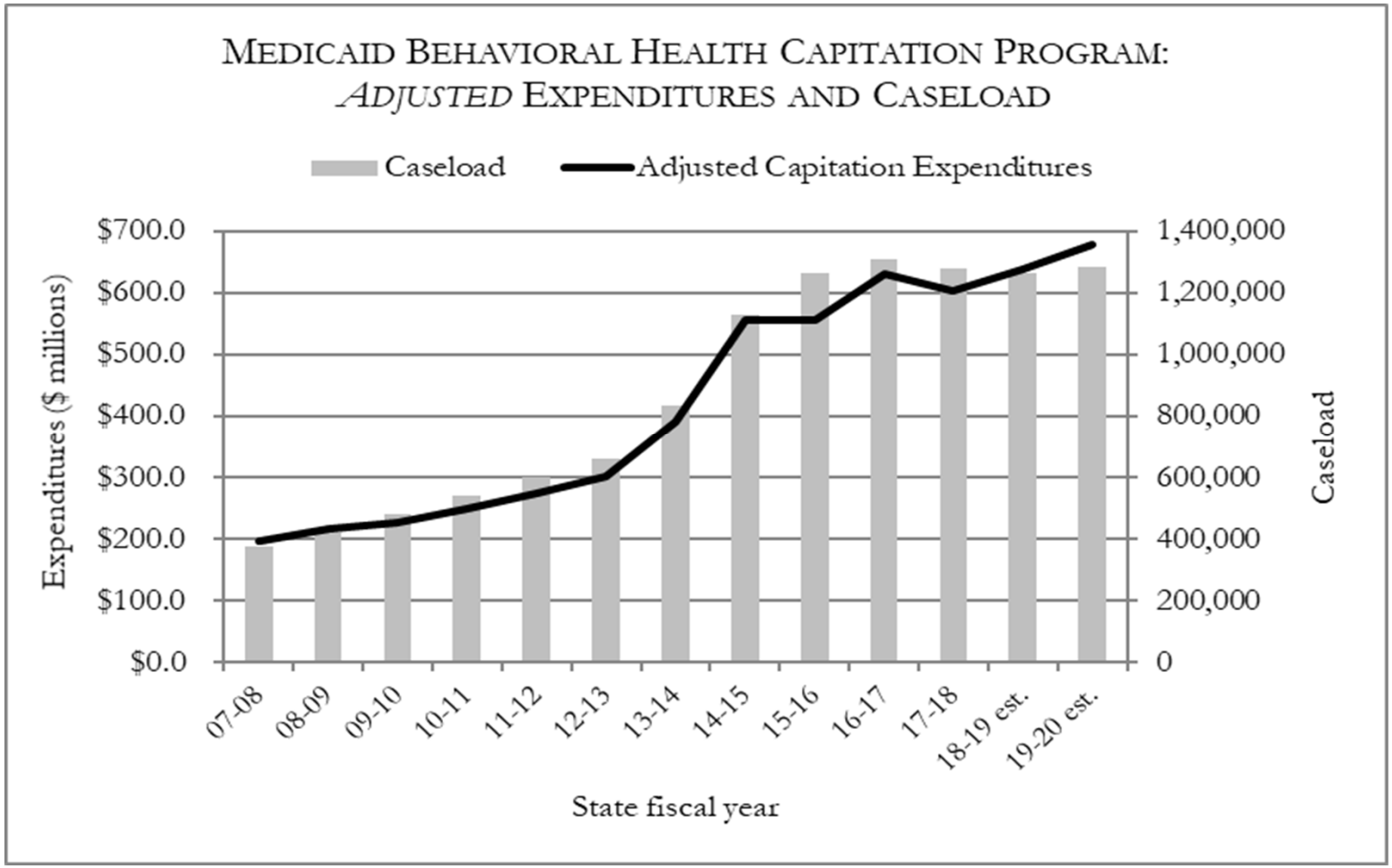
JBC Staff Briefing

Department of Health Care Policy and Financing

(Medicaid Behavioral Health Community Programs)

Presented by:

Carolyn Kampman, JBC Staff
December 11, 2018


MEDICAID BEHAVIORAL HEALTH CAPITATION PROGRAM:
ADJUSTED EXPENDITURES AND CASELOAD
Caseload
Adjusted Capitation Expenditures
Expenditures ($ millions)
$700.0
$600.0
$500.0
$400.0
$300.0
$200.0
$100.0
$0.0
1,400,000
1,200,000
1,000,000
800,000
600,000
400,000
200,000
0
Caseload
07-08
08-09
09-10
10-11
11-12
12-13
13-14
14-15
15-16
16-17
17-18
18-19 est.
19-20 est.
State fiscal year

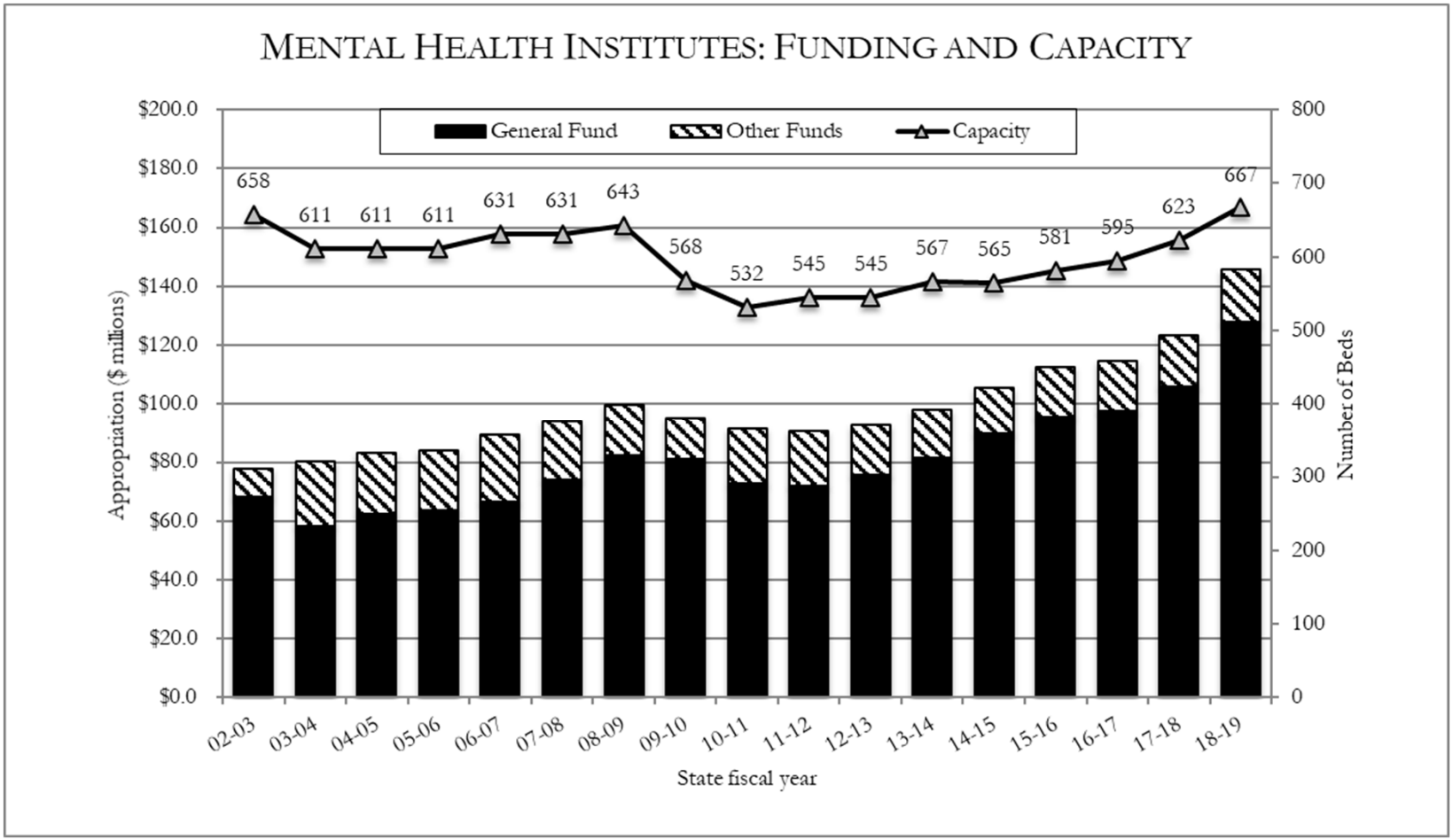
JBC Staff Briefing

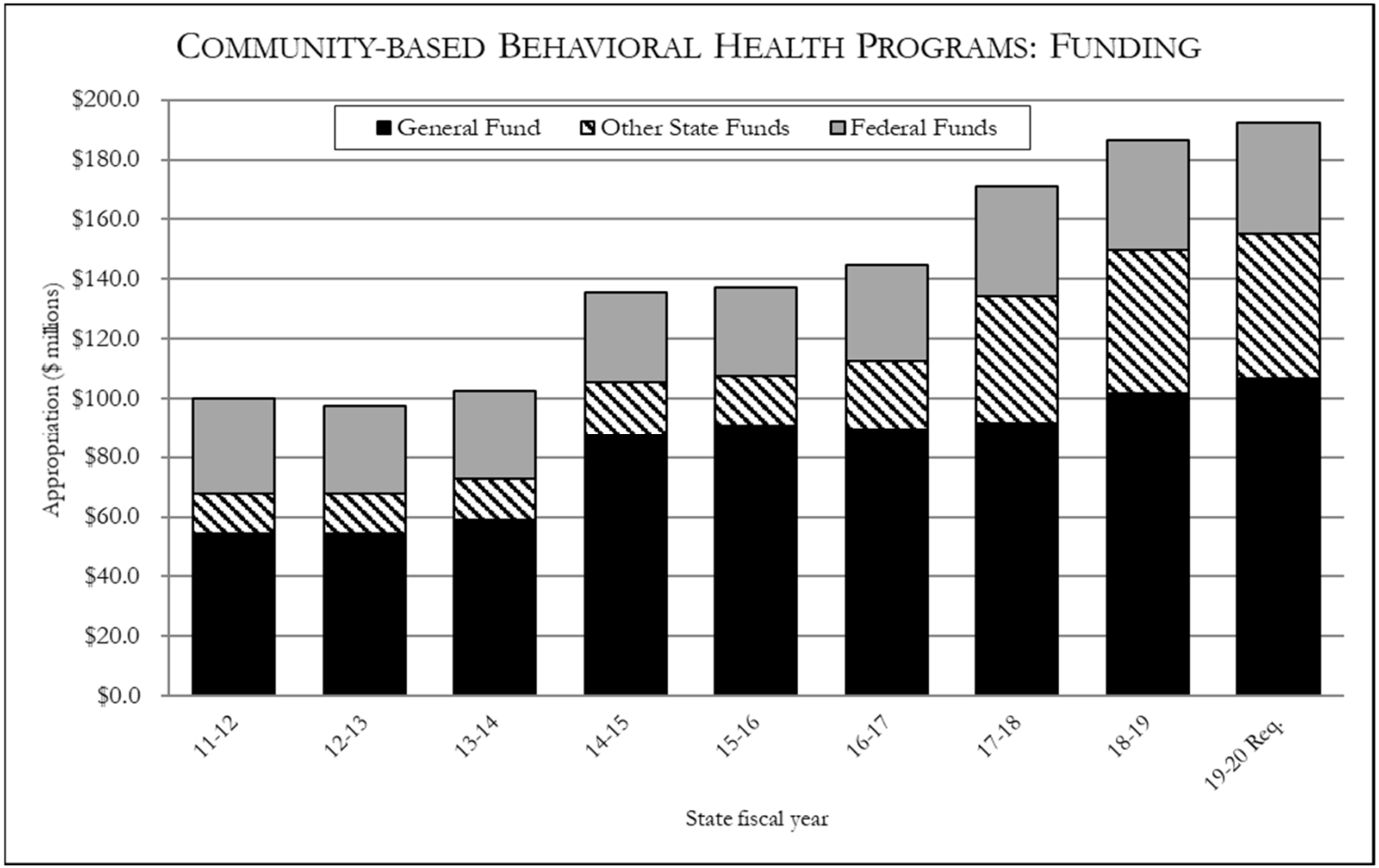
Department of Human Services

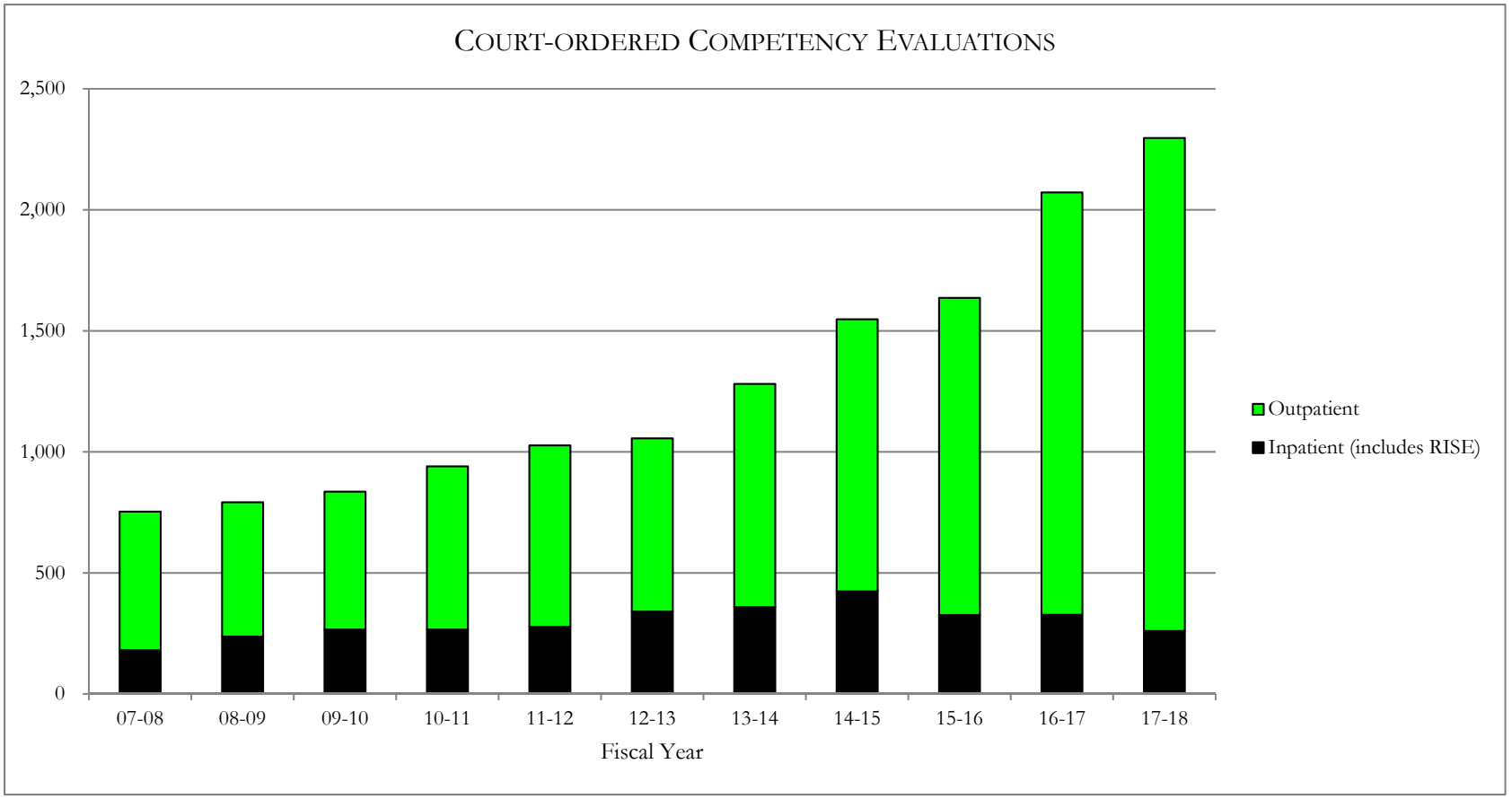
(Office of Behavioral Health)

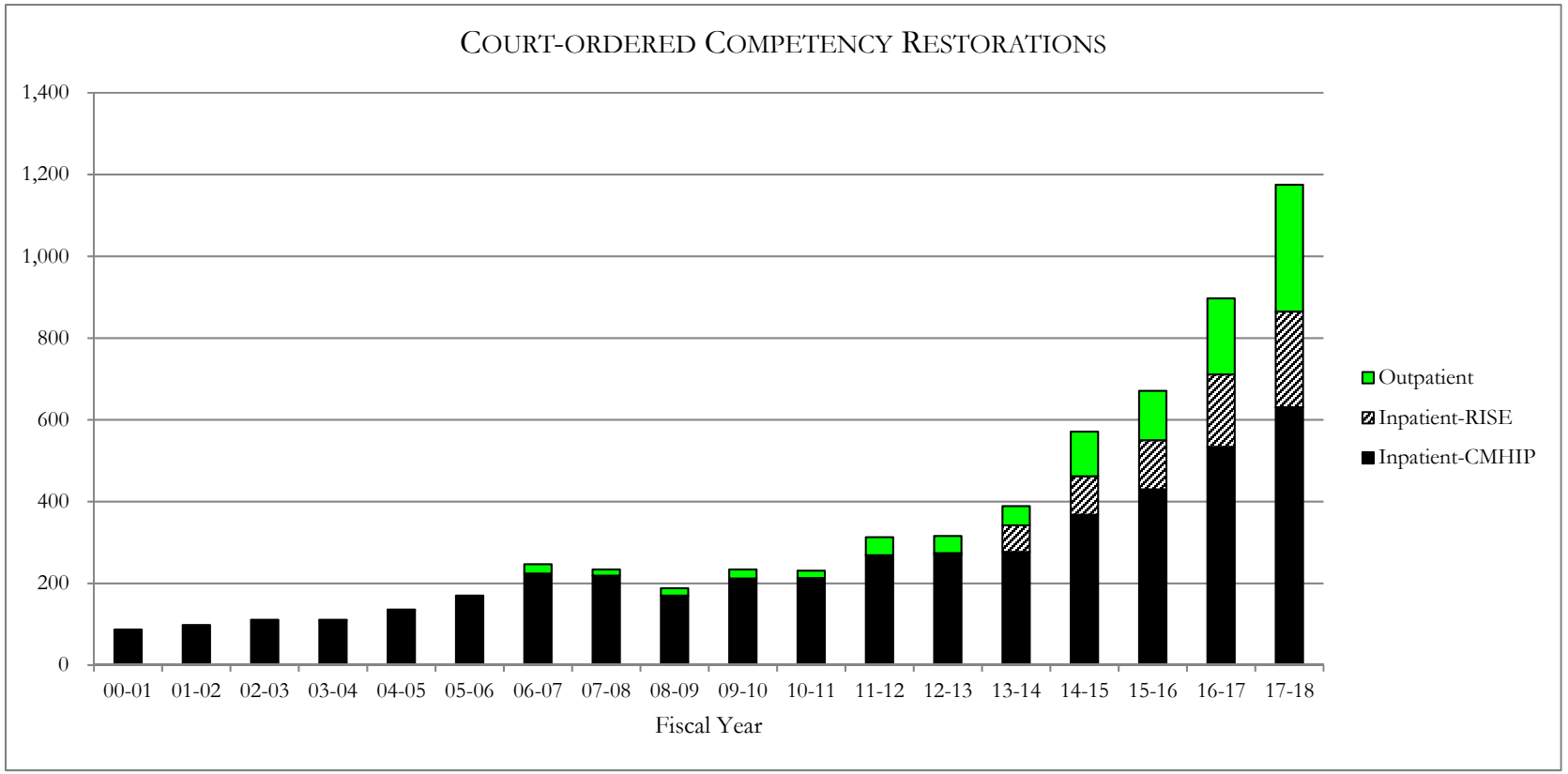
Presented by:

Carolyn Kampman, JBC Staff
December 11, 2018

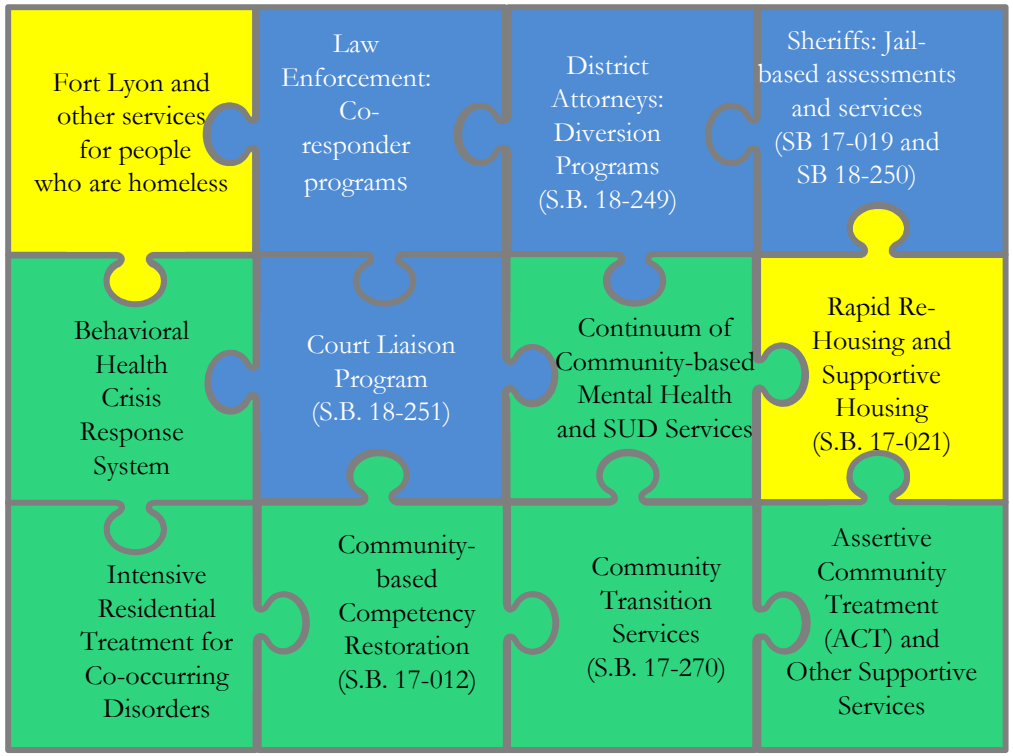

MENTAL HEALTH INSTITUTES: FUNDING AND CAPACITY
General Fund
Other Funds
Capacity
Appropriation ($ millions)
Number of Beds
$200.0
$180.0
$160.0
$140.0
$120.0
$100.0
$80.0
$60.0
$40.0
$20.0
$0.0
800
700
600
500
400
300
200
100
0
658
611
611
611
631
631
643
568
532
545
545
567
565
581
595
623
667
02-03
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
18-19
State fiscal year


COMMUNITY-BASED BEHAVIORAL HEALTH PROGRAMS: FUNDING
General Fund
Other State Funds
Federal Funds
Appropriation ($ millions)
$200.0
$180.0
$160.0
$140.0
$120.0
$100.0
$80.0
$60.0
$40.0
$20.0
$0.0
11-12
12-13
13-14
14-15
15-16
16-17
17-18
18-19
19-20 Req
State fiscal year

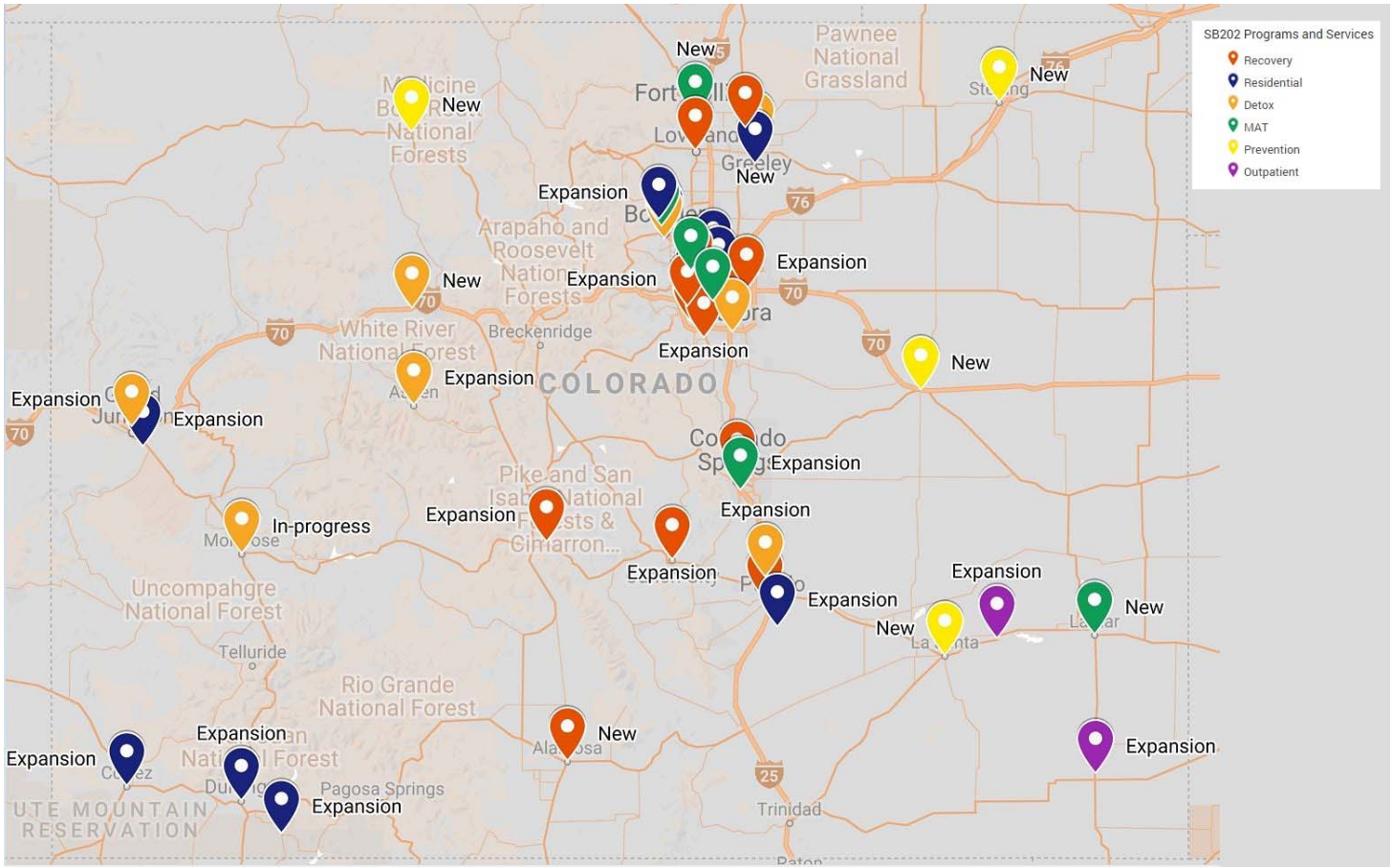

COURT-ORDERED COMPETENCY EVALUATIONS
2,500
2,000
1,500
1,000
500
0
07-08
08-09
09-10
10-11
11-12
12-13
13-14
14-15
15-16
16-17
17-18
Fiscal Year
Outpatient
Inpatient (includes RISE)


COURT-ORDERED COMPETENCY RESTORATIONS
1,400
1,200
1,000
800
600
400
200
0
00-01
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
Fiscal Year
Outpatient
Inpatient-RISE
Inpatient-CMHIP

Addressing Behavioral Health Needs of Justice-involved Individuals

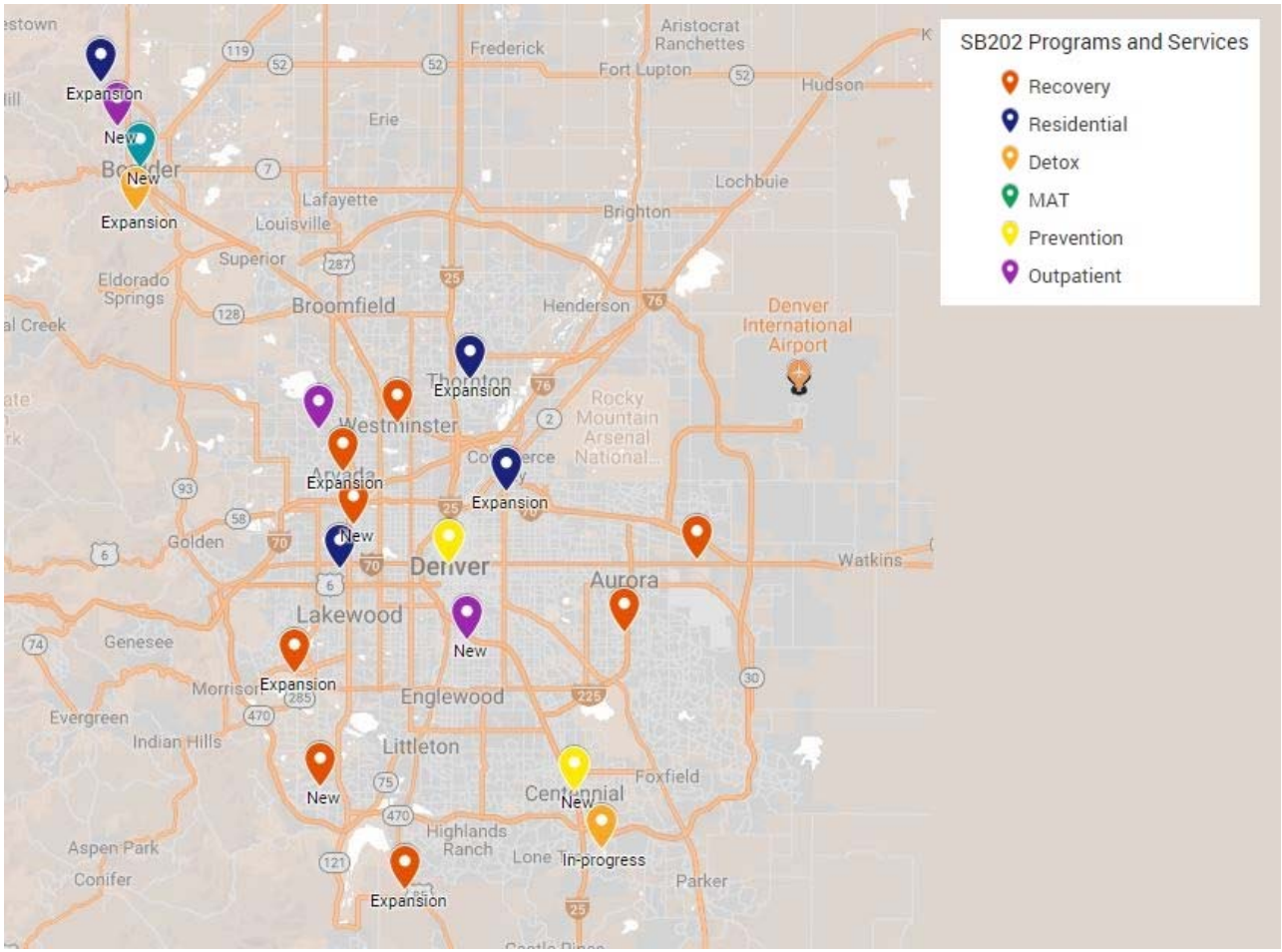


S.B. 16-202: New and Expanded Substance Use Programs and Services



Source: Signal Behavioral Health Network

S.B. 16-202: New and Expanded Substance Use Programs and Services



Source: Signal Behavioral Health Network