JOINT BUDGET COMMITTEE

STAFF FIGURE SETTING
FY 2019-20

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

(Behavioral Health Community Programs)

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

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CONTENTS

HOW TO USE THIS DOCUMENT

The Department Overview contains a table summarizing the staff recommended incremental changes followed by brief explanations of each incremental change. More details about the incremental changes are provided in the sections following the Department Overview and the division summary table. Decision items are listed in the requested priority order, if applicable.

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 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.

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

Finally, the HCPF budget also includes appropriations of General Fund and federal Medicaid funds that are transferred to the Department of Human Services for behavioral health programs administered by that department. Please note that these recommendations are excluded from the following "Summary of Staff Recommendations" table, and are instead summarized at the beginning of the narrative concerning that section of the budget.

SUMMARY OF STAFF RECOMMENDATIONS

BEHAVIORAL HEALTH COMMUNITY PROGRAMS

	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
SB 19-113 (Supplemental bill)	(16,862,088)	(208,296)	(1,526,548)	0	(15,127,244)	0.0
Long Bill Supplemental	23,460,269	4,138,375	472,071	0	18,849,823	0.0
TOTAL	**$663,485,611**	**$188,367,662**	**$29,000,474**	**$0**	**$446,117,475**	**0.0**

BEHAVIORAL HEALTH COMMUNITY PROGRAMS						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2019-20 RECOMMENDED APPROPRIATION			472071	0	18849823	
FY 2018-19 Appropriation	$663,485,611	$188,367,662	$29,000,474	$0	$446,117,475	0.0
R2 Behavioral health forecast	49,846,697	10,870,960	8,972,635	0	30,003,102	0.0
R13 Provider rate adjustments	93,697	21,621	4,879	0	67,197	0.0
Annualize prior year budget actions	1,074,897	212,440	(47,475)		909,932	
TOTAL	**$714,500,902**	**$199,472,683**	**$37,930,513**	**$0**	**$477,097,706**	**0.0**
INCREASE/(DECREASE)	**$51,015,291**	**$11,105,021**	**$8,930,039**	**$0**	**$30,980,231**	**0.0**
Percentage Change	7.7%	5.9%	30.8%	n/a	6.9%	n/a
FY 2019-20 EXECUTIVE REQUEST	**$684,938,350**	**$197,407,474**	**$36,775,589**	**$0**	**$450,755,287**	**0.0**
Request Above/(Below) Recommendation	($29,562,552)	($2,065,209)	($1,154,924)	$0	($26,342,419)	0.0

DESCRIPTION OF INCREMENTAL CHANGES

FY 2018-19

LONG BILL SUPPLEMENTAL: The recommendation includes a $23.5 million increase in existing FY 2018-19 appropriations (including an increase $4.1 million General Fund) for both the capitation and fee-for-service Medicaid behavioral health programs based on the Department's February 2019 caseload and expenditure forecast.

FY 2019-20

R2 BEHAVIORAL HEALTH FORECAST: The recommendation includes an increase of $49.8 million total funds (including $10.9 million General Fund), compared to the adjusted FY 2018-19 appropriation, for both the capitation and fee-for-service Medicaid behavioral health programs. The recommendation is based on the Department's February 2019 caseload and expenditure forecast.

R13 PROVIDER RATE ADJUSTMENTS: The recommendation includes an increase of $93,697 total funds for an across-the-board increase of 1.0 percent for community providers. Consistent with previous practice, this 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 recommendation includes an increase of $1.1 million total funds (including $212,440 General Fund) to reflect the out-year impact of recent legislation and two recent 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**

MAJOR DIFFERENCES FROM THE REQUEST

FY 2018-19: The Department recently provided an updated caseload and expenditure forecast for both FY 2018-19 and FY 2019-20 that incorporates data through December 2018. Due to significant changes reflected in the February 2019 forecast, staff has included a recommendation to increase FY 2018-19 appropriations by $23.5 million (including $4.1 million General Fund). This second mid-year adjustment would be included as a separate section within the FY 2019-20 Long Bill.

FY 2019-20: Overall, staff's recommendations for FY 2019-20 are $29.6 million higher than the request (including General Fund recommendations that are $2.1 million higher than the request) based on the Department's February 2019 caseload and expenditure forecast, and based on the application of the Committee's policy for a 1.0 percent (rather than the requested 0.75 percent) provider rate increase.

(3) BEHAVIORAL HEALTH COMMUNITY PROGRAMS

This section of the Department's budget provides funding for the purchase of behavioral health services from "regional accountable entities" (RAEs). RAEs manage mental health and substance use disorder services for eligible Medicaid clients in a capitated, risk-based model. This section also includes funding for fee-for-service payments for behavioral health services to treat mental health conditions and diagnoses that are not covered by the behavioral health capitation program, including autism spectrum disorder and gender identity disorders. This section also includes fee-for-service payments to cover a Medicaid client's share of costs associated with mental health services that are provided under the client's Medicare benefits package.

DECISION ITEMS – BEHAVIORAL HEALTH COMMUNITY PROGRAMS

➔ R2 BEHAVIORAL HEALTH FORECAST

REQUEST: The Department's November 1, 2018, budget request included a decision item to add $26.9 million total funds (including $12.7 million General Fund) to cover projected caseload and expenditure changes in both the managed care and fee-for-service Medicaid behavioral health programs. This incremental change was the difference between the original FY 2018-19 appropriation and the Department's expenditure projections based on data through June 2018, less any incremental changes attributed to prior year legislation and budget decisions.

RECOMMENDATION: The Committee has already taken action to adjust FY 2018-19 appropriations based on the Department's November 2018 caseload and expenditure forecast. The Department recently provided an updated forecast for both FY 2018-19 and FY 2019-20 that incorporates data through December 2018. **Due to significant changes reflected in the February 2019 forecast, staff recommends a further adjustment to FY 2018-19 appropriations and staff recommends higher appropriations than requested for FY 2019-20**.

For FY 2018-19, staff recommends increasing appropriations by a total of $23.5 million, including an increase of $22.9 million for capitation payments and $0.5 million for fee-for-service payments. With respect to fund sources, the recommended increase includes $4.1 million General Fund, $0.4 million cash funds, and $18.8 million federal funds.

For FY 2019-20, staff recommends adding $49.8 million total funds (including $10.9 million General Fund). This incremental change is calculated based on the adjusted FY 2018-19 appropriation recommended above. Thus, this change is not directly comparable to the Department's incremental request for R2.

ANALYSIS:

FY 2018-19

The most recent forecast reflects a 25,803 (2.0 percent) *caseload decrease* compared to the level projected last November. The Department has decreased the projected caseload for every eligibility category except for Adults Age 65 and Over. The most significant caseload decreases are projected for the income-driven eligibility categories (Children, Adults Without Dependent Children, and Parents/Caretakers). Absent other changes, this caseload decrease would reduce expenditures by $10.7 million.

However, caseload-driven expenditure reductions are more than offset by recent *increases in per-member-per-month rates*. The Department discovered that many of the individuals losing Medicaid eligibility were using few, if any, behavioral health services. This increased the overall utilization rate for those remaining eligible for services. As a result, the per-member-per-month rates that were paid in the first six months of FY 2018-19 and that were used for the November 2018 forecast were deemed actuarially unsound under guidance from the federal Centers for Medicare and Medicaid Services (CMS). Rates were revised accordingly and implemented January 1, 2019. The Department included the following table in its request to detail the impacts of caseload changes and rate changes, by eligibility category. The most significant expenditure increases are in the Adults Without Dependent Children (titled "MAGI Adults" in the table) and Children eligibility categories.

	Adults 65 and Older	Individuals with Disabilities	Low Income Adults	Expansion Parents & Caretakers	MAGI Adults	Eligible Children	Foster Care	Breast and Cervical Cancer Program	Total
Caseload Change from R-2	510	(1,056)	(6,750)	(5,104)	(5,828)	(7,191)	(371)	(13)	(25,803)
Difference Due to Caseload	$128,214	($1,751,651)	($2,440,530)	($962,206)	($3,470,924)	($1,713,759)	($531,124)	($4,700)	($10,746,679)
Rate Change from R-2	$0.22	$1.54	$0.84	$1.11	$4.23	$1.00	$2.85	$0.84	$2.01
Difference Due to Rates	$124,975	$1,695,651	$2,004,559	$949,090	$17,419,106	$5,869,176	$768,919	$1,552	$28,833,028
Difference Due to Caseload and Rates	$253,189	($56,000)	($435,971)	($13,116)	$13,948,182	$4,155,417	$237,795	($3,148)	$18,086,349

Finally, the Department changed the timing of the federally required Health Insurance Provider Fee Payment related to services provided in FY 2017-18 (the last year of the BHOs). This $5.4 million payment will be made in FY 2018-19 rather than FY 2019-20.

See Appendix B for the detailed caseload and rate data that underlies the Department's revised capitation payment estimates for FY 2018-19. See Appendix D for more information about the Health Insurance Provider Fee Payment and other adjustments, recoupments, and incentive payments.

FY 2019-20

Overall, staff recommends increasing appropriations by a total of $49.8 million for FY 2019-20, including $10.9 million General Fund, $9.0 million cash funds, and $30.0 million federal funds. This increase reflects a full 12 months of the new (higher) *per-member-per-month rates*, plus some increases based on cost and utilization trends. Overall, the Department is projecting a 7.5 percent increase in per-member-per-month rates.

The $49.8 million increase also reflects a modest projected *caseload* increase of 15,393 (1.2 percent) compared to the revised projections for FY 2018-19. The forecast projects a continued decline in the number of eligible children, modest growth in the adult expansion populations, and larger growth in the traditional eligibility categories.

The following three tables provide a comparison of the Department's most recent Medicaid enrollment and expenditures forecasts for FY 2018-19 and FY 2019-20, by eligibility category.

BEHAVIORAL HEALTH CAPITATION PROGRAM: ENROLLMENT

CATEGORY	FY 18-19 REVISED ESTIMATE	FY 19-20 REVISED ESTIMATE	DIFFERENCE	PERCENT
Children to 147% FPL	481,907	479,492	(2,415)	-0.5%
Adults w/out Dependent Children to 138% FPL	337,338	343,167	5,829	1.7%
Parents/Caretakers to 68% FPL; Pregnant Adults to 200% FPL	192,115	194,250	2,135	1.1%
Individuals with Disabilities to age 64 (to 450% FPL)	90,700	93,640	2,940	3.2%
Parents/Caretakers 69% to 138% FPL	66,149	70,601	4,452	6.7%
Adults age 65+ (to SSI)	47,849	49,615	1,766	3.7%
Foster Care to 26 years	22,112	22,808	696	3.1%
Breast & Cervical Cancer to 250% FPL	141	131	(10)	-7.1%
TOTAL	**1,238,311**	**1,253,704**	**15,393**	**1.2%**

BEHAVIORAL HEALTH CAPITATION PROGRAM: ANNUAL EXPENDITURES

CATEGORY	FY 18-19 REVISED ESTIMATE	FY 19-20 REVISED ESTIMATE	DIFFERENCE	PERCENT
Children to 147% FPL	$120,613,839	$127,768,727	$7,154,888	5.9%
Adults w/out Dependent Children to 138% FPL	217,195,197	244,819,458	27,624,261	12.7%
Parents/Caretakers to 68% FPL; Pregnant Adults to 200% FPL	71,333,951	76,305,937	4,971,986	7.0%
Individuals with Disabilities to age 64 (to 450% FPL)	151,702,077	161,182,394	9,480,317	6.2%
Parents/Caretakers 69% to 138% FPL	13,336,499	15,591,832	2,255,333	16.9%
Adults age 65+ (to SSI)	11,980,804	12,822,849	842,045	7.0%
Foster Care to 26 years	32,391,341	34,716,315	2,324,974	7.2%
Breast & Cervical Cancer to 250% FPL	41,268	41,468	200	0.5%
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)	5,419,061	0	(5,419,061)	n/a
Estimated incentive payments (for previous year)	28,696,147	31,007,689	2,311,542	n/a
TOTAL	**$653,656,582**	**$704,256,669**	**$50,600,087**	**7.7%**

BEHAVIORAL HEALTH CAPITATION PROGRAM: ANNUAL PER CAPITA EXPENDITURES				
CATEGORY	FY 18-19 REVISED ESTIMATE	FY 19-20 REVISED ESTIMATE	DIFFERENCE	PERCENT
Children to 147% FPL	$250	$266	$16	6.5%
Adults w/out Dependent Children to 138% FPL	644	713	70	10.8%
Parents/Caretakers to 68% FPL; Pregnant Adults to 200% FPL	371	393	22	5.8%
Individuals with Disabilities to age 64 (to 450% FPL)	1,673	1,721	49	2.9%
Parents/Caretakers 69% to 138% FPL	202	221	19	9.5%
Adults age 65+ (to SSI)	250	258	8	3.2%
Foster Care to 26 years	1,465	1,522	57	3.9%
Breast & Cervical Cancer to 250% FPL	293	317	24	8.2%
TOTAL (excluding adjustments and payments associated with previous fiscal years)	**$500**	**$537**	**$37**	**7.5%**

➔ R13 PROVIDER RATE ADJUSTMENTS

REQUEST: The Department's November 1, 2018, budget request included $66,946 total funds for a 0.75 percent community provider rate increase. This proposed rate increase applies to fee-for-service payments made for behavioral health services, but does not apply to payments made through the statewide capitation program.

RECOMMENDATION: **Staff recommends appropriating $93,697 (including $21,621 General Fund). Staff's recommended increase is consistent with the Committee's common policy provider rate adjustment (1.0 percent)**, and staff has applied this increase to the FY 2019-10 expenditures from the most recent Department forecast.

LINE ITEM DETAIL — BEHAVIORAL HEALTH COMMUNITY PROGRAMS

BEHAVIORAL HEALTH CAPITATION PAYMENTS

This line item supports the provision of most behavioral health services to Medicaid clients. Behavioral health services, which include both mental health and substance use-related services, are provided to Medicaid clients through a statewide managed care or "capitated" program. The Department contracts with "regional accountable entities" (RAEs) to provide or arrange for behavioral health services for clients enrolled with each RAE[1]. The Department used a competitive bid process to award RAE contracts for each region. The existing RAE contracts went into effect July 1, 2018.

In order to receive services through behavioral health capitation, a client must have a covered diagnosis and receive a covered service or procedure that is medically necessary. **Services for Medicaid clients that are managed by RAEs** are listed below, with the first group including services that are covered by the State Medicaid Plan, and the second group including services that are authorized under a federal waiver.

[1] Clients are attributed to RAEs based on the location of their primary care provider, rather than their own address.

Covered State Plan Services

- school-based behavioral health services
- targeted case management
- drug screening and monitoring
- outpatient services, including:
  - physician services (including psychiatric care)
  - rehabilitative services (including: individual, group, and family behavioral health therapy; behavioral health assessment; pharmacologic management; day treatment; and emergency/crisis services)
- detoxification services
- medication-assisted treatment
- inpatient psychiatric hospital services, with some exceptions:
  - The federal Social Security Act bars states from receiving federal Medicaid funding for any services (medical or behavioral health) provided to individuals ages 21 through 64 who are patients in an "institution for mental disease" (IMD)[2]. However, if a state 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. Recent revisions to federal managed care regulations limit these services to 15 days in a calendar 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.
  - For individuals under age 21 and over age 64 who reside in an IMD, Medicaid covers inpatient psychiatric care without any limitation on the number of days of care[3].
  - Inpatient psychiatric hospital services are not covered for a client – regardless of age – for whom the primary diagnosis is a substance use disorder (SUD). However, the Department does cover service costs during the assessment period when a client presents as having a covered mental health diagnosis but is subsequently determined to have a primary SUD diagnosis. This policy change was designed to cover individuals in an inpatient setting who present with psychiatric symptoms, but clear within 72 hours warranting a primary SUD diagnosis[4].

Alternate Services Covered by the Federal "1915 (b)(3)" Waiver

- prevention/early intervention services
- vocational services
- clubhouse and drop-in center services

[2] 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 [42 CFR 440.1009]. Thus, the State mental health institutes and private psychiatric hospitals are considered IMDs. However, a general hospital that provides inpatient psychiatric treatment for some patients (e.g., Denver Health and Porter Adventist Hospital) is not considered an IMD because psychiatric treatment is not the hospital's primary focus.
[3] HCPF previously limited these payments to 45 days, but this limitation has been removed.
[4] House Bill 18-1136 adds residential and inpatient substance use disorder treatment and medical detoxification services as a benefit under the Colorado Medicaid Program, conditional upon federal approval and the receipt of federal financial participation for the costs of the new services. The Department currently anticipates that the expanded benefit will go into effect for FY 2020-21.

- assertive community treatment
- intensive case management
- residential services (24-hour psychiatric care provided in a non-hospital, non-nursing home setting; excludes room and board), except that these services are not covered for a client for whom the primary diagnosis is a substance use disorder (SUD)[5].
- respite care
- recovery services

Each RAE receives a pre-determined monthly amount for each Medicaid client who is eligible for behavioral health services and enrolled with the RAE. The "per-member-per-month" rates paid to each RAE are unique for each Medicaid eligibility category in each geographic region. The Department adjusts these rates periodically based on historical rate experience and data concerning client service utilization. Currently, the Department divides the state into seven geographic regions for the provision of behavioral health services to the following **Medicaid eligibility categories**[6]:

- Adults age 65 and older;
- Children and adults with disabilities under age 65;
- Parents and caretakers;
- Pregnant adults;
- Adults without dependent children;
- Children;
- Children and young adults in or formerly in foster care (through age 26); and
- Adults served through the Breast and Cervical Cancer Treatment and Prevention Program.

Two Medicaid populations that are eligible for certain medical benefits are not eligible for behavioral health services through the Medicaid program: (1) Non-citizens; and (2) Partial dual-eligible individuals (i.e., individuals who are eligible for both Medicare and Medicaid benefits, but for whom the Medicaid benefit is limited to payment of Medicare premiums and co-insurance payments).

In addition, Medicaid-eligible clients who are enrolled in a Program of All-inclusive Care for the Elderly (PACE Program) are excluded from enrollment in a RAE.

Finally, in some instances **certain behavioral health services for Medicaid clients are not covered by Capitation**, and are instead covered through other appropriations to the Department of Health Care Policy and Financing (HCPF):

[5] Ibid.

[6] The Department renamed certain eligibility categories to be more consistent with terminology used in other states and to more accurately estimate expenditures by fund source. The term "MAGI" refers to the new federal Modified Adjusted Gross Income standard that states are required to use when determining income for purposes of Medicaid eligibility.

- *Services Provided Through Primary Care.* Starting July 1, 2018, the Medical Service Premiums line item appropriation to HCPF 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.

- *Services for Children and Youth in the Custody of the Department of Human Services (DHS).* Children and youth in the custody of the DHS Division of Child Welfare or the DHS Division of Youth Services are enrolled in RAEs, and each RAE receives per-member-per-month payments for these individuals. However, if one of these children or youth is placed in a psychiatric residential treatment facility (PRTF) or a residential childcare facility (RCCF), the behavioral health services provided by that facility are not covered by the RAE and these costs are not considered as part of the associated per-member-per-month capitation rate. Instead, these costs are covered by appropriations of Medicaid funds to HCPF that are transferred to the DHS Division of Child Welfare and the Division of Youth Services.

- *Services for Individuals with Intellectual and Developmental Disabilities (IDD).* Individuals with IDD are enrolled in RAEs, and each RAE receives per-member-per-month payments for these individuals. However, for individuals who reside in a facility that is licensed as an "intermediate care facility" for individuals with IDD, the behavioral health services provided by that facility are not covered by the RAE and these costs are not considered as part of the associated per-member-per-month capitation rate. Instead, these costs are billed on a fee-for-service basis and are covered by other appropriations. Specifically:

    - For the Wheat Ridge Regional Center and for some beds within the Grand Junction Regional Center that are also licensed as an intermediate care facility, residents' behavioral health care services are covered by appropriations of Medicaid funds to HCPF that are transferred to DHS for these Regional Centers. In contrast, for individuals with IDD who reside in "adult comprehensive waiver homes" connected with the Grand Junction or Pueblo Regional Centers, as of July 1, 2018, these services are covered by the Capitation program.

    - For individuals with IDD who reside in a private intermediate care facility (e.g., Bethesda Lutheran), the behavioral health services are included in the Medicaid per diem rate paid to that facility, similar to the Regional Centers. These costs are covered by the Medical Service Premiums line item appropriation to HCPF.

STATUTORY AUTHORITY: Articles 4, 5, and 6 of Title 25.5 [Colorado Medical Assistance Act]; C.R.S. Sections: 25.5-4-401.2 [Performance-based payments]; 25.5-4-403 [Reimbursement for community mental health centers and clinics]; 25.5-4-405 [Mental health managed care service providers]; 25.5-5-325 [Residential and inpatient substance use disorder treatment]; 25.5-5-402 to 410 [Statewide

managed care system]; 25.5-5-415 [Medicaid payment reform and innovation pilot program]; 25.5-5-419 [Accountable Care Collaborative]

REQUEST:
FY 2018-19: The Department submitted a request to change the FY 2018-19 appropriation as required in January 2019. The Committee acted on that request in January.

FY 2019-20: The Department requests $675.3 million total funds (including $195.4 million General Fund) for FY 2019-20 based on its November 2018 caseload and expenditure forecast.

RECOMMENDATION:
FY 2018-19: **Staff recommends increasing the existing FY 2018-19 appropriation for this line item by $22.9 million total funds** (including $3.8 million General Fund) **based on the Department's February 2019 caseload and expenditure forecast.**

FY 2019-20: **Staff recommends appropriating $704.3 million total funds for FY 2019-20** (including $197.1 million General Fund) **based on the Department's February 2019 caseload and expenditure forecast**.

The staff recommendations for this line item are detailed in the following table. *In addition, Appendices B and C detail the caseload and rate data that underlie the Department's February 2019 forecast for FY 2018-19 and FY 2019-20.*

BEHAVIORAL HEALTH COMMUNITY PROGRAMS, BEHAVIORAL HEALTH CAPITATION PAYMENTS						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2018-19 APPROPRIATION						
HB 18-1322 (Long Bill)	$647,450,482	$182,146,673	$29,656,683	$0	$435,647,126	0.0
Other legislation	48,601	24,301	0	0	24,300	0.0
SB 19-113 (Supplemental bill)	(16,763,133)	191,904	(1,570,369)	0	(15,384,668)	0.0
Long Bill Supplemental	22,920,631	3,782,810	490,617	0	18,647,204	0.0
TOTAL	**$653,656,581**	**$186,145,688**	**$28,576,931**	**$0**	**$438,933,962**	**0.0**
FY 2019-20 RECOMMENDED APPROPRIATION						
FY 2018-19 Appropriation	$653,656,581	$186,145,688	$28,576,931	$0	$438,933,962	0.0
R2 Behavioral health	49,532,997	10,752,546	8,867,893	0	29,912,558	0.0
Annualize prior year budget actions	1,067,091	210,555	(47,806)	0	904,342	0.0
TOTAL	**$704,256,669**	**$197,108,789**	**$37,397,018**	**$0**	**$469,750,862**	**0.0**
INCREASE/(DECREASE)	**$50,600,088**	**$10,963,101**	**$8,820,087**	**$0**	**$30,816,900**	**0.0**
Percentage Change	7.7%	5.9%	30.9%	n/a	7.0%	n/a
FY 2019-20 EXECUTIVE REQUEST	**$675,267,704**	**$195,384,248**	**$36,224,217**	**$0**	**$443,659,239**	**0.0**
Request Above/(Below) Recommendation	($28,988,965)	($1,724,541)	($1,172,801)	$0	($26,091,623)	0.0

BEHAVIORAL HEALTH FEE-FOR-SERVICE PAYMENTS

This line item supports certain "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 behavioral health capitation program, including autism spectrum disorder and gender identity disorders. In addition, if "partial dual-eligible" individuals receive mental health services under their Medicare benefits package, this line item covers that portion of expenditures that would have been the responsibility of the client.

While the fee-for-service program does cover all Medicaid State Plan mental health and substance use disorder services, it does not cover services approved through the Department's federal 1915 (b)(3) waiver.

STATUTORY AUTHORITY: Articles 4, 5, and 6 of Title 25.5 [Colorado Medical Assistance Act]

REQUEST:

FY 2018-19: The Department submitted a request to change the FY 2018-19 appropriation as required in January 2018. The Committee acted on that request in January.

FY 2019-20: The Department requests $9.7 million total funds (including $2.0 million General Fund) for FY 2019-20 based on its November 2018 caseload and expenditure forecast.

RECOMMENDATION:
FY 2018-19: **Staff recommends increasing the existing FY 2018-19 appropriation by $539,638** (including $355,565 General Fund) **based on the Department's February 2019 caseload and expenditure forecast.**

FY 2019-20: **Staff recommends appropriating $10.2 million for FY 2019-20** (including $2.4 million General Fund) **based on the Department's February 2019 caseload and expenditure forecast.** The staff recommendations for this line item are detailed in the following table.

BEHAVIORAL HEALTH COMMUNITY PROGRAMS, BEHAVIORAL HEALTH FEE-FOR-SERVICE PAYMENTS

	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2018-19 APPROPRIATION						
HB 18-1322 (Long Bill)	$9,388,347	$2,266,609	$398,268	$0	$6,723,470	0.0
SB 19-113 (Supplemental bill)	(98,955)	(400,200)	43,821	0	257,424	0.0
Long Bill Supplemental	539,638	355,565	(18,546)	0	202,619	0.0
TOTAL	**$9,829,030**	**$2,221,974**	**$423,543**	**$0**	**$7,183,513**	**0.0**
FY 2019-20 RECOMMENDED APPROPRIATION						
FY 2018-19 Appropriation	$9,829,030	$2,221,974	$423,543	$0	$7,183,513	0.0
R2 Behavioral health	313,700	118,414	104,742	0	90,544	0.0
R13 Provider rate adjustments	93,697	21,621	4,879	0	67,197	0.0
Annualize prior year budget actions	7,806	1,885	331	0	5,590	0.0
TOTAL	**$10,244,233**	**$2,363,894**	**$533,495**	**$0**	**$7,346,844**	**0.0**
INCREASE/(DECREASE)	**$415,203**	**$141,920**	**$109,952**	**$0**	**$163,331**	**0.0**
Percentage Change	4.2%	6.4%	26.0%	n/a	2.3%	n/a

BEHAVIORAL HEALTH COMMUNITY PROGRAMS, BEHAVIORAL HEALTH FEE-FOR-SERVICE PAYMENTS						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2019-20 EXECUTIVE REQUEST	**$9,670,646**	**$2,023,226**	**$551,372**	**$0**	**$7,096,048**	**0.0**
Request Above/(Below) Recommendation	($573,587)	($340,668)	$17,877	$0	($250,796)	0.0

(7) DEPARTMENT OF HUMAN SERVICES MEDICAID-FUNDED PROGRAMS, (F) OFFICE OF BEHAVIORAL HEALTH – MEDICAID FUNDING

This division reflects the amount of Medicaid funds appropriated for programs administered by the Department of Human Services' Office of Behavioral Health.

DEPARTMENT OF HUMAN SERVICES MEDICAID-FUNDED PROGRAMS, OFFICE OF BEHAVIORAL HEALTH SERVICES - MEDICAID FUNDING						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2018-19 APPROPRIATION						
HB 18-1322 (Long Bill)	$10,093,608	$5,046,804	$0	$0	$5,046,804	0.0
SB 19-113 (Supplemental bill)	509,080	254,540	0	0	254,540	0.0
TOTAL	**$10,602,688**	**$5,301,344**	**$0**	**$0**	**$5,301,344**	**0.0**
FY 2019-20 RECOMMENDED APPROPRIATION						
FY 2018-19 Appropriation	$10,602,688	$5,301,344	$0	$0	$5,301,344	0.0
Annualize prior year salary survey	31,988	15,994	0	0	15,994	0.0
Annualize HB 18-1136 Substance use disorder treatment	30,000	15,000	0	0	15,000	0.0
Annualize SB 18-200 PERA	4,136	2,068	0	0	2,068	0.0
NPBA4 DHS Mental health institute revenue adjustments	0	0	0	0	0	0.0
NP Provider rate increase	0	0	0	0	0	0.0
TOTAL	**$10,668,812**	**$5,334,406**	**$0**	**$0**	**$5,334,406**	**0.0**
INCREASE/(DECREASE)	**$66,124**	**$33,062**	**$0**	**$0**	**$33,062**	**0.0**
Percentage Change	0.6%	0.6%	n/a	n/a	0.6%	n/a
FY 2019-20 EXECUTIVE REQUEST	**$11,117,434**	**$5,553,546**	**$5,171**	**$0**	**$5,558,717**	**0.0**
Request Above/(Below) Recommendation	$448,622	$219,140	$5,171	$0	$224,311	0.0

DESCRIPTION OF INCREMENTAL CHANGES

ANNUALIZE PRIOR YEAR SALARY SURVEY: The recommendation includes $31,988 for salary increases that were awarded in FY 2018-19.

ANNUALIZE HB 18-1136 SUBSTANCE USE DISORDER TREATMENT: The recommendation includes $30,000 for the anticipated increase in the number of treatment facilities that will need to be licensed by the Office of Behavioral Health.

ANNUALIZE SB 18-200 PERA: The recommendation reflects the out-year impact of S.B. 18-200 on the employer contribution to PERA.

NPBA4 DHS MENTAL HEALTH INSTITUTE REVENUE ADJUSTMENTS: The recommendation does not include any adjustments to the Medicaid funds anticipated to be earned by the Mental Health Institutes.

NP PROVIDER RATE INCREASE: The recommendation does not apply the community provider rate increase to the Medicaid funding that supports two substance use disorder treatment programs.

MAJOR DIFFERENCES FROM THE REQUEST

The recommendation is lower than the request for several reasons:

- The recommendation does not include any adjustments to the Medicaid funds anticipated to be earned by the Mental Health Institutes. The request includes an increase of $431,542 compared to the adjusted FY 2018-19 appropriation.
- The recommendation does not apply the community provider rate increase to the Medicaid funding that supports two substance use disorder treatment programs. The Department's request includes $18,436 for this purpose.
- The recommendation uses a different allocation of fund sources for the incremental change related to H.B. 18-1136, maintaining the existing practice of funding all Medicaid-funded administration costs for this Office with 50 percent General Fund and 50 percent federal funds. This results in $5,171 more General Fund and $5,171 less cash funds.
- Staff's recommendation is slightly higher than the request because staff apportioned the incremental increase related to S.B. 18-200 based on the continuing base appropriation (excluding the increase related to H.B. 18-1136). This resulted in a slightly higher amount of this increase coming from Medicaid funds.

LINE ITEM DETAIL — DEPARTMENT OF HUMAN SERVICES MEDICAID-FUNDED PROGRAMS, OFFICE OF BEHAVIORAL HEALTH – MEDICAID-FUNDING

COMMUNITY BEHAVIORAL HEALTH ADMINISTRATION

This line item reflects the amount of Medicaid funds appropriated for the personal services and operating expenses for the Department of Human Services' (DHS') Office of Behavioral Health.

STATUTORY AUTHORITY: Section 26-1-201, C.R.S. [Programs administered and services provided by DHS]; Section 27-60-101, et seq., C.R.S. [Behavioral health crisis response system]; Section 27-66-101, et seq., C.R.S. [Community mental health services]; Section 27-80-101, et seq., C.R.S. [Alcohol and substance use – programs and services]; Section 27-81-101, et seq., C.R.S. [Alcohol use, education, prevention, and treatment]; Section 27-82-101, et seq., C.R.S. [Substance use prevention, education, and treatment]

REQUEST: The Department requests $483,120 total funds for this line item.

RECOMMENDATION: **Staff recommends appropriating a total of $484,476 for this line item, including $472,250 for Personal Services and $12,226 for Operating Expenses.** Staff's recommendation is slightly higher than the request because staff apportioned the incremental increase related to S.B. 18-200 based on the continuing base DHS appropriation (excluding the increase related to H.B. 18-1136). This resulted in a slightly higher amount of this increase coming from Medicaid funds.

In addition, based on recent discussions with the Department of Health Care Policy and Financing, staff recommends a different allocation of fund sources for the incremental change related to H.B. 18-1136. The recommendation maintains the existing practice of funding all Medicaid-funded administration costs for this Office with 50 percent General Fund and 50 percent federal funds. The following table details staff's calculation of the Personal Services component of this line item.

DEPARTMENT OF HUMAN SERVICES MEDICAID-FUNDED PROGRAMS, OFFICE OF BEHAVIORAL HEALTH SERVICES - MEDICAID FUNDING, PERSONAL SERVICES						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2018-19 APPROPRIATION						
HB 18-1322 (Long Bill)	$406,126	$203,063	$0	$0	$203,063	0.0
TOTAL	**$406,126**	**$203,063**	**$0**	**$0**	**$203,063**	**0.0**
FY 2019-20 RECOMMENDED APPROPRIATION						
FY 2018-19 Appropriation	$406,126	$203,063	$0	$0	$203,063	0.0
HUM Annualize HB 18-1136 Substance use disorder treatment	30,000	15,000	0	0	15,000	0.0
HUM Annualize SB 18-200 PERA	4,136	2,068	0	0	2,068	0.0
HUM Annualize prior year salary survey	31,988	15,994	0	0	15,994	0.0
TOTAL	**$472,250**	**$236,125**	**$0**	**$0**	**$236,125**	**0.0**
INCREASE/(DECREASE)	**$66,124**	**$33,062**	**$0**	**$0**	**$33,062**	**0.0**
Percentage Change	16.3%	16.3%	n/a	n/a	16.3%	n/a
FY 2019-20 EXECUTIVE REQUEST	**$470,894**	**$230,276**	**$5,171**	**$0**	**$235,447**	**0.0**
Request Above/(Below) Recommendation	($1,356)	($5,849)	$5,171	$0	($678)	0.0

~~MENTAL HEALTH TREATMENT SERVICES FOR YOUTH (H.B. 99-1116)~~ CHILDREN AND YOUTH MENTAL HEALTH TREATMENT ACT

This line item reflects the amount of Medicaid funds appropriated for the Children and Youth Mental Health Treatment Act. This program is administered by DHS, and it provides funding for mental health treatment services for children and youth under age 21[7]. The program is designed to make services available for children and youth who are at risk of out-of-home placement, but a dependency and neglect action is neither appropriate nor warranted. Services may include mental health treatment services and care management, including any residential treatment, community-based care, or any post-residential follow-up services that may be appropriate.

The CYMHTA applies to two groups of children, with different application and payment processes for each group.

- *Children who are categorically Medicaid-eligible and have a covered mental health diagnosis.* A parent or guardian of a Medicaid-eligible child may apply for residential treatment through the local regional accountable entity (RAE). If the child is determined to require a residential level of care, the RAE is responsible for covering the residential treatment costs.

[7] An individual must be under the age of 18 to become eligible for services through this program. However, once an individual becomes eligible, he or she may remain eligible until his or her 21st birthday.

- *Children Who Are NOT Categorically Eligible for Medicaid.* If a child is at risk of being placed out of the home because they have a mental illness and they require a residential treatment level of care or equivalent community-based services, the parent or guardian may apply for such services through the local community mental health center (Center) or another mental health agency. The Center or mental health agency is required to evaluate the child or youth and clinically assess their need for mental health services.

  When a child or youth is approved for funding through this program and the child or youth requires residential treatment, the child or youth may become eligible for Medicaid funding through the federal supplemental security income (SSI) eligibility process. If a child has been in residential services for more than 30 days, or is expected to remain in residential services for more than 30 days, the child can qualify for SSI due to being considered a "household of one" per the federal Social Security Administration. Once a child obtains SSI, the child automatically acquires fee-for-service Medicaid. Medicaid funding pays for the treatment costs of residential services, but does not fund room and board costs.

  Due to federal regulations, the SSI benefit is paid directly to the child or payee (typically the parent) to fund a portion of the residential room and board rate. The parent will then give all but $30 of the SSI award to the residential provider. SSI awards vary based on the child's treatment location and family income, ranging from $30 to $700 per month.

Private insurance benefits must be exhausted prior to accessing any public benefits. In addition, the parents are responsible for paying a portion of the cost of services that is not covered by private insurance or by Medicaid funding; the parent share is based on a sliding fee scale that is based on child support guidelines.

When and if the child is in residential care and funded by the CYMHTA, expenses are covered by parental fees, SSI benefits (if benefits are approved), and CYMHTA funds. If the child or youth is placed in a psychiatric residential treatment facility, treatment expenses are covered by a Medicaid per diem rate and "room and board" expenses are covered by parental fees and CYMHTA funds. If the child is in non-residential care, expenses are covered by SSI benefits, parental fees, and CYMHTA funds.

STATUTORY AUTHORITY: Section 25.5-5-307, C.R.S. [Child mental health treatment and family support program]; Section 27-67-101 et seq., C.R.S. [Children and Youth Mental Health Treatment Act]

REQUEST: This Department requests $126,610 total funds, which is the same as the FY 2018-19 appropriation.

RECOMMENDATION: **Staff recommends approving this Department's request for a continuation level of funding. In addition, consistent with staff's recommendation for the corresponding line item appropriation to the DHS, staff recommends renaming this line item, Children and Youth Mental Health Treatment Act.**

HIGH RISK PREGNANT WOMEN PROGRAM

This line item reflects the amount of Medicaid funds appropriated for the "Special Connections" program for pregnant women who are eligible for Medicaid and who have a substance use disorder. This program, which is administered by DHS, helps women have healthier pregnancies and healthier babies by providing case management, individual and group counseling, health education, and residential treatment during pregnancy and up to one year after delivery. This program was developed to: deliver a healthy baby; reduce or stop the substance using behavior of the pregnant woman during and after the pregnancy; promote and assure a safe child-rearing environment for the newborn and other children; and maintain the family unit. DHS contracts with several providers to operate Special Connections Programs.

STATUTORY AUTHORITY: Section 25.5-5-309 through 312, C.R.S.

REQUEST: The Department requests $1,857,090 total funds, which reflects an $18,436 increase for a 1.0 percent provider rate increase.

RECOMMENDATION: **Consistent with staff's recommendation for the corresponding line item appropriation to DHS, staff recommends maintaining the existing appropriation of $1,838,654.** DHS reports minimal expenditure of Medicaid funds for this program in the last two fiscal years ($675 in FY 2016-17 and $0 in FY 2017-18), so staff does not recommend increasing this source of funding either for the provider rate increase or for the leap year.

MENTAL HEALTH INSTITUTES

This line item reflects the amount of Medicaid funds appropriated for fee-for-service payments to the Colorado Mental Health Institutes. These Medicaid funds support personal services, operating expenses, and pharmaceutical expenses associated with inpatient psychiatric services for Medicaid-eligible "forensic" patients (i.e., individuals who are admitted to the Institutes through the criminal or juvenile justice system) who are under the age of 21 or over the age of 64. From July 1, 2018, through February 20, 2019, the Institutes provided services to 74 patients within this category (including 51 who were under age 21, and 23 who were over age 64).

Services Not Covered By This Line Item

Please note that the Institutes bill regional accountable entities (RAEs) for services provided to Medicaid-eligible patients who are under the age of 21 or over the age of 64, and who are referred to the Institutes from a community mental health center or another health care provider (and are thus classified as "civil" patients). From July 1, 2018, through February 20, 2019, the Institutes provided services to 20 patients within this category, all of whom were under age 21.

For Medicaid-eligible patients age 21 through 64, Colorado Medicaid rules do not allow the Institutes to receive any Medicaid funding, whether the patient is classified as civil or forensic. From July 1, 2018, through February 20, 2019, the Institutes provided services to 145 patients within this category, including 95 civil patients and 50 forensic patients.

STATUTORY AUTHORITY: Section 25.5-5-202 (1)(a), (i), and (j), C.R.S.; 10 CCR 2505-10 8.212.4.A1. [Medical Services Board rules concerning the inpatient psychiatric hospital services benefit, which

excludes services to adults ages 21 through 64 who receive services through a State Institute of Mental Disease]

REQUEST: This Department requests $8,650,614 total funds.

RECOMMENDATION: **Consistent with the request from the Department of Human Services, staff recommends appropriating a total of $8,219,072**. The staff recommendation for the affected line items in both the Department of Human Services and the Department of Health Care Policy and Financing are consistent with the action taken by the Committee on a supplemental request for FY 2018-19 (DHS S5) that made a number of revenue adjustments for the mental health.

LONG BILL FOOTNOTES AND REQUESTS FOR INFORMATION

LONG BILL FOOTNOTES

There are currently no Long Bill footnotes specific to the programs and services covered in this document.

REQUESTS FOR INFORMATION

There are currently no Requests for Information specific to the programs and services covered in this document.

Appendix A: Number Pages

	FY 2016-17 Actual	FY 2017-18 Actual	FY 2018-19 Appropriation	FY 2019-20 Request	FY 2019-20 Recommendation	
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	653,656,581	675,267,704	704,256,669	*
General Fund	157,456,205	171,717,548	186,145,688	195,384,248	197,108,789	
Cash Funds	17,292,866	21,637,199	28,576,931	36,224,217	37,397,018	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	429,139,655	319,529,316	438,933,962	443,659,239	469,750,862	
Behavioral Health Fee-for-service Payments	7,793,562	9,300,665	9,829,030	9,670,646	10,244,233	*
General Fund	1,762,029	2,093,383	2,221,974	2,023,226	2,363,894	
Cash Funds	189,409	355,200	423,543	551,372	533,495	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	5,842,124	6,852,082	7,183,513	7,096,048	7,346,844	
TOTAL - (3) Behavioral Health Community Programs	611,682,288	522,184,728	663,485,611	684,938,350	714,500,902	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	159,218,234	173,810,931	188,367,662	197,407,474	199,472,683	
Cash Funds	17,482,275	21,992,399	29,000,474	36,775,589	37,930,513	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	434,981,779	326,381,398	446,117,475	450,755,287	477,097,706	

An asterisk (*) indicates that the FY 2019-20 requested amount for a line item is affected by one or more decision items.

APPENDIX B
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)	$21.17	$139.77	$30.97	$16.82	$53.86	$20.86	$122.15	$30.97	
Estimated monthly caseload	47,849	90,700	192,115	66,149	337,338	481,907	22,112	141	1,238,311
Number of months rate is effective	12	12	12	12	12	12	12	12	
Total estimated capitated payments	**$12,155,560**	**$152,125,668**	**$71,397,619**	**$13,351,514**	**$218,028,296**	**$120,630,960**	**$32,411,770**	**$52,401**	**$620,153,788**
Estimated expenditures:									
Claims paid in current period	$12,148,267	$151,973,542	$71,311,942	$13,335,492	$217,810,268	$120,510,329	$32,405,288	$52,349	$619,547,477
Claims from prior periods	5,803	140,622	79,414	13,349	219,074	123,863	6,029	66	588,220
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	$11,980,804	$151,702,077	$71,333,951	$13,336,499	$217,195,197	$120,613,839	$32,391,341	$41,268	$618,594,976
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	106,208	1,329,251	623,854	116,649	1,905,251	1,054,163	283,227	458	5,419,061
Estimated incentive payments	475,273	6,772,695	3,399,374	404,392	10,368,217	5,762,662	1,511,020	2,514	28,696,147
NET EXPENDITURES	**$12,562,285**	**$159,804,023**	**$75,357,179**	**$13,648,742**	**$230,623,861**	**$127,430,664**	**$34,185,588**	**$44,240**	**$653,656,582**
Annual per capita expenditure (excluding payment adjustments)	**$250.39**	**$1,672.57**	**$371.31**	**$201.61**	**$643.85**	**$250.28**	**$1,464.88**	**$292.68**	**$499.55**

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

APPENDIX C
FY 2019-20 BEHAVIORAL HEALTH CAPITATION PAYMENTS CALCULATIONS

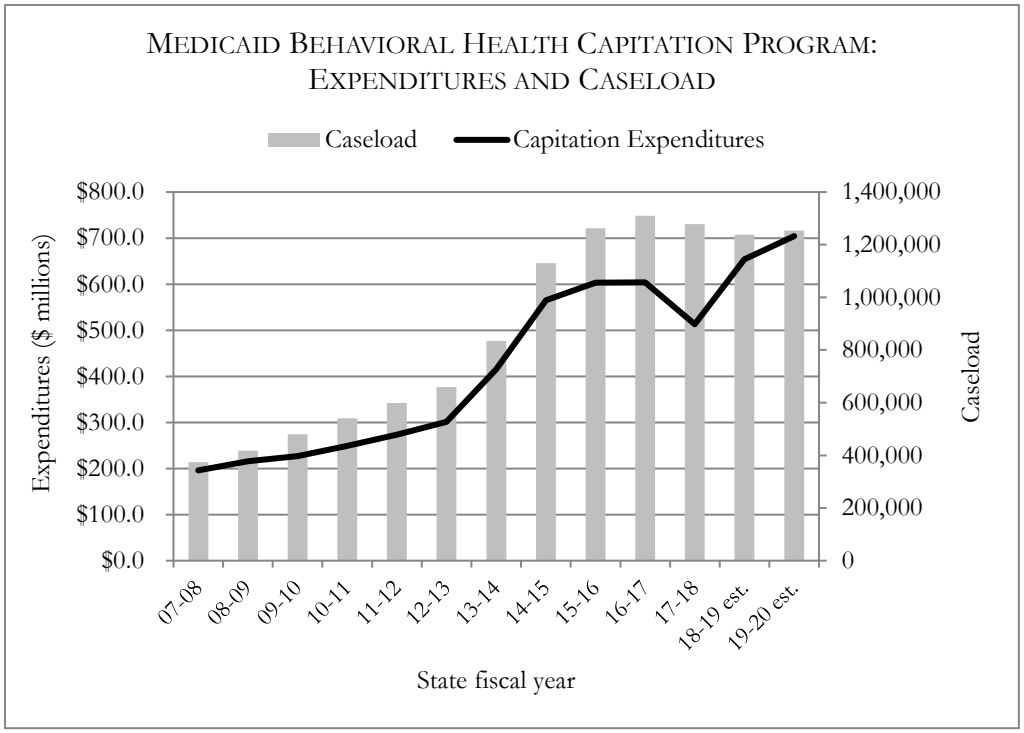
	Eligibility Category								
Description	Adults Age 65+ (to SSI)	Individuals With Disabilities up to age 64 (to 450% FPL)	Parents/ Caretakers (to 68% FPL); Pregnant Adults (to 200% FPL)	Parents/ Caretakers (69% to 138% FPL)*	Adults without Dependent Children (to 138% FPL)*	Children (to 147% FPL)	Individuals 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)	$21.80	$143.78	$32.76	$18.42	$59.64	$22.21	$126.91	$32.76	
Estimated monthly caseload	49,615	93,640	194,250	70,601	343,167	479,492	22,808	131	1,253,704
Number of months rate is effective	12	12	12	12	12	12	12	12	
Total estimated capitated payments	**$12,979,284**	**$161,562,710**	**$76,363,560**	**$15,605,645**	**$245,597,759**	**$127,794,208**	**$34,734,759**	**$51,499**	**$674,689,424**
Estimated expenditures:									
Claims paid in current period	$12,971,496	$161,401,147	$76,271,924	$15,586,918	$245,352,161	$127,666,414	$34,727,812	$51,448	$674,029,320
Claims from prior periods	7,293	152,126	85,677	16,022	218,028	120,631	6,482	52	606,311
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	$12,822,849	$161,182,394	$76,305,937	$15,591,832	$244,819,458	$127,768,727	$34,716,315	$41,468	$673,248,980
Other payment adjustments:									
Health insurance provider fee payment	0	0	0	0	0	0	0	0	0
Estimated incentive payments	607,721	7,605,930	3,569,672	667,462	10,901,785	6,031,885	1,620,613	2,621	31,007,689
NET EXPENDITURES	**$13,430,570**	**$168,788,324**	**$79,875,609**	**$16,259,294**	**$255,721,243**	**$133,800,612**	**$36,336,928**	**$44,089**	**$704,256,669**
Annual per capita expenditure (excluding payment adjustments)	**$258.45**	**$1,721.30**	**$392.82**	**$220.84**	**$713.41**	**$266.47**	**$1,522.11**	**$316.55**	**$537.01**

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

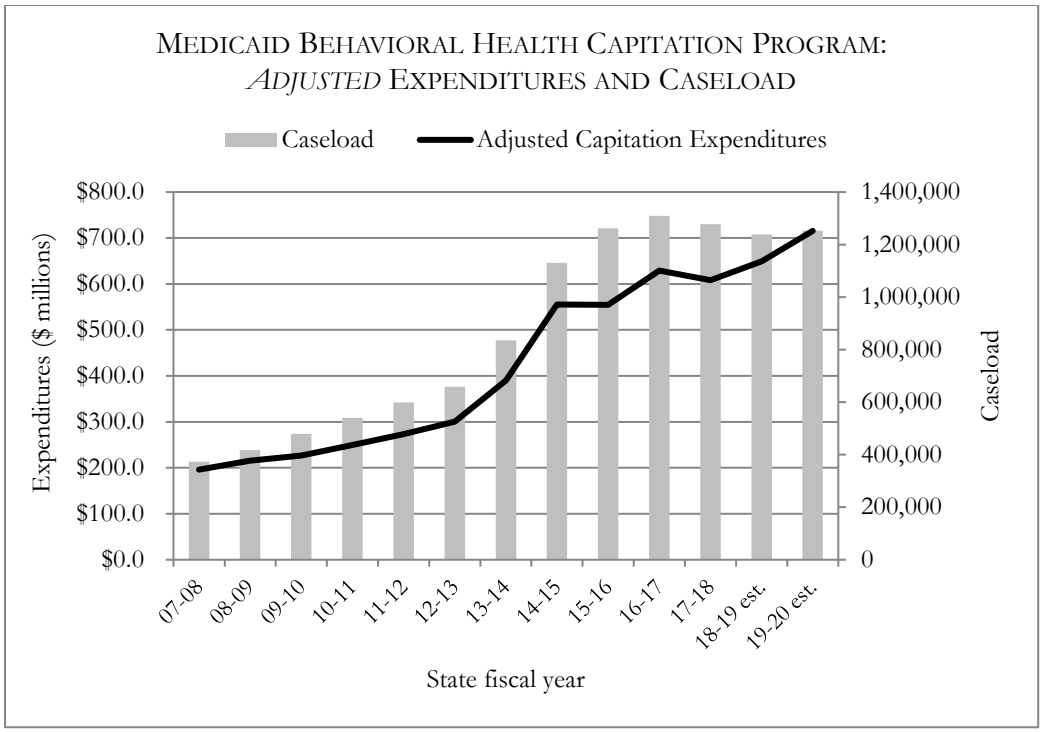
APPENDIX D
CALCULATION OF CAPITATION PROGRAM "ADJUSTED" EXPENDITURES

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	28,696,147	0	0	28,696,147
Health insurance provider fee payment	0	0	0	5,419,060	0	0	5,419,060
Total: FY 2018-19	**0**	**0**	**0**	**35,061,605**	**0**	**0**	**35,061,605**
FY 2019-20							
RAE incentive payments (HB 17-1353)	0	0	0	0	31,007,689	0	31,007,689
Health insurance provider fee payment	0	0	0	0	0	0	0
Total: FY 2019-20	**0**	**0**	**0**	**0**	**31,007,689**	**0**	**31,007,689**
FY 2020-21							
RAE incentive payments (HB 17-1353)	0	0	0	0	0	33,734,470	33,734,470
Health insurance provider fee payment	0	0	0	0	0	8,384,949	8,384,949
Total: FY 2020-21	**0**	**0**	**0**	**0**	**0**	**42,119,419**	**42,119,419**
TOTALS	**($17,529,341)**	**($67,679,530)**	**$830,618**	**$35,061,605**	**$31,007,689**	**$42,119,419**	**$22,208,541**

- *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.

- *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.

JBC Staff FY 2019-20 Figure Setting Department of Health Care Policy and Financing

(Behavioral Health Community Programs)

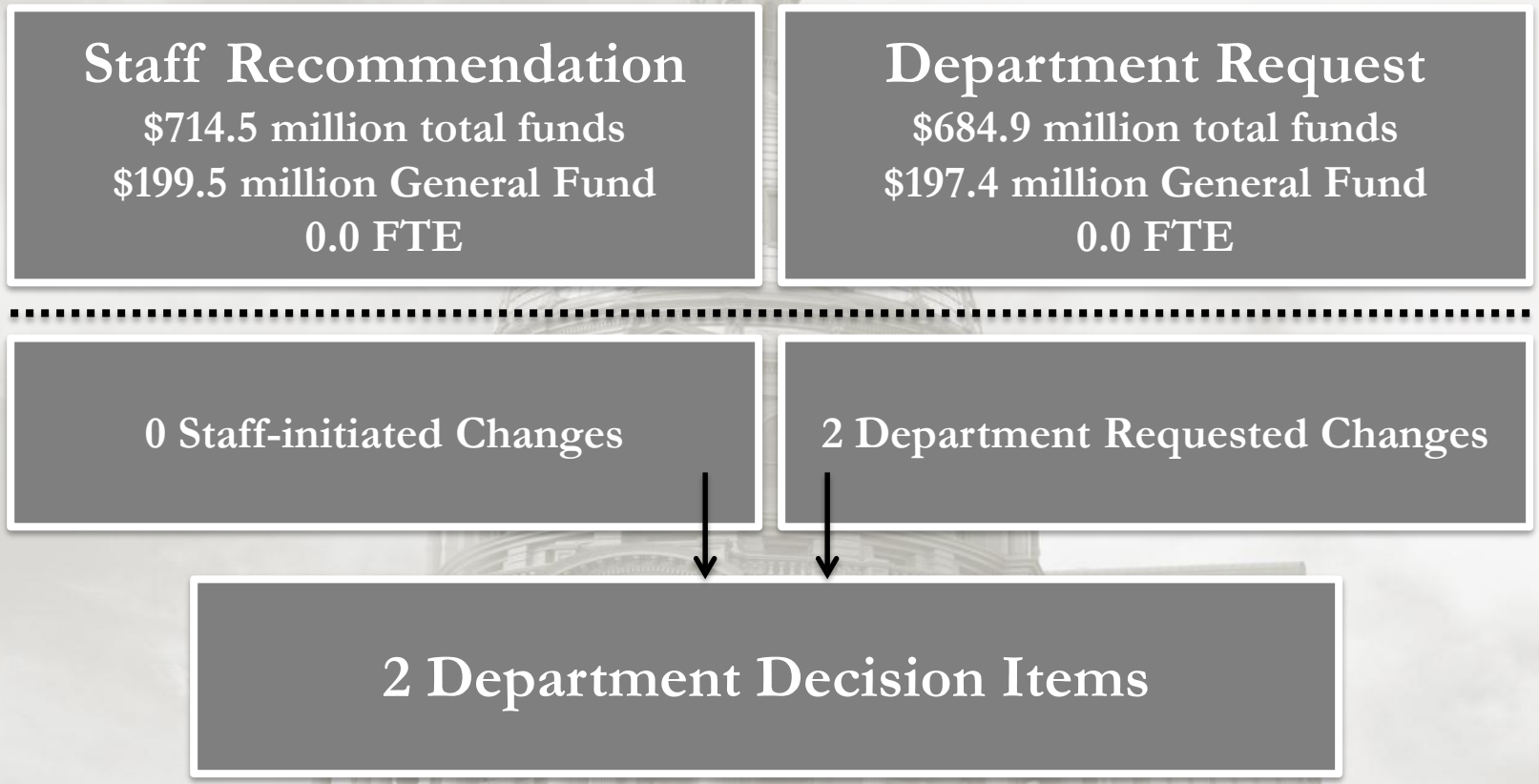
Presented by:
Carolyn Kampman, JBC Staff
March 5, 2019

Agencies Included in Staff Figure Setting Document

Behavioral Health Community Programs
(Page 1)

Dept. of Human Services Medicaid-funded Programs, Office of Behavioral Health
(Page 13)

Overview – Behavioral Health Community Programs



(3) Behavioral Health Community Programs

Change Requests

- ☐ R2 Behavioral health forecast (p.3-6)
- ☐ R13 Provider rate adjustments (p.6 and separate memo)

Line Items, Base Appropriations, and Other Changes

- ☐ (3) Behavioral Health Community Programs (p.6-12)

Line Items, Base Appropriations, and Other Changes

- ☐ (7)(F) Office of Behavioral Health Medicaid Funding (p.13-18)

(7) DHS Medicaid-funded Programs

Long Bill Footnotes and Requests for Information

- None (p.18)

JBC Staff FY 2019-20 Figure Setting Department of Health Care Policy and Financing

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