JOINT BUDGET COMMITTEE

STAFF BUDGET BRIEFING
FY 2020-21

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

(Medicaid Behavioral Health Community Programs)

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

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CONTENTS

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

DEPARTMENT OVERVIEW

The Department of Health Care Policy and Financing (HCPF) helps pay health and long-term care expenses for low-income and vulnerable populations. To assist with these costs the Department receives significant federal matching funds, but must adhere to federal rules regarding program eligibility, benefits, and other features, as a condition of accepting the federal 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.

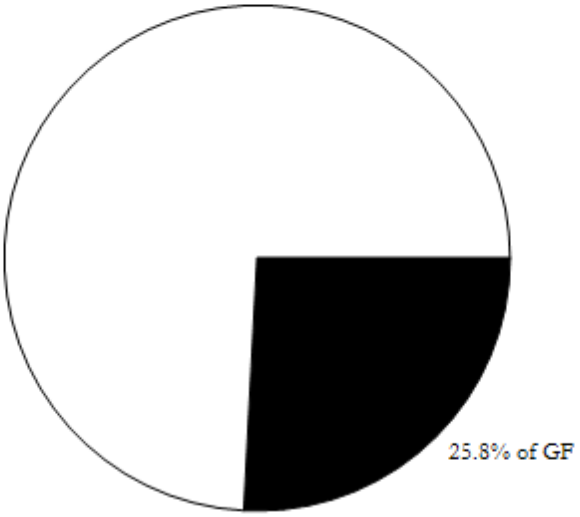
DEPARTMENT BUDGET: RECENT APPROPRIATIONS

FUNDING SOURCE	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21 *
General Fund	$173,946,012	$188,367,662	$201,872,261	$232,219,820
Cash Funds	23,499,835	29,000,474	38,385,780	51,681,069
Reappropriated Funds	0	0	0	0
Federal Funds	338,172,782	446,117,475	482,816,394	567,422,750
TOTAL FUNDS	**$535,618,629**	**$663,485,611**	**$723,074,435**	**$851,323,639**
Full Time Equiv. Staff	0.0	0.0	0.0	0.0

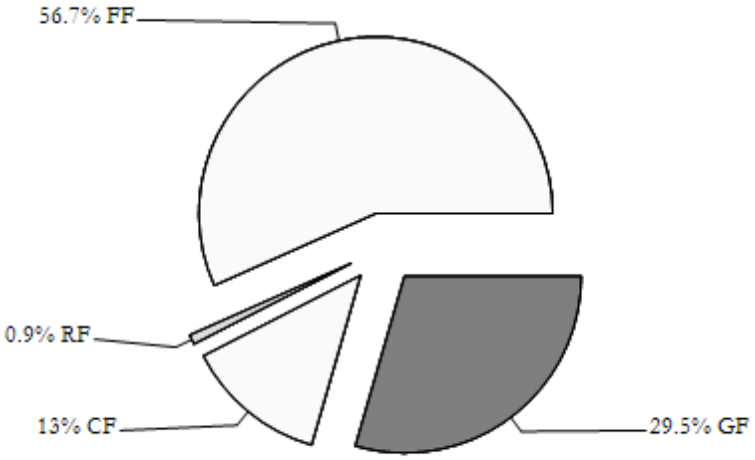
*Requested appropriation.

DEPARTMENT BUDGET: GRAPHIC OVERVIEW

Department's Share of Statewide General Fund

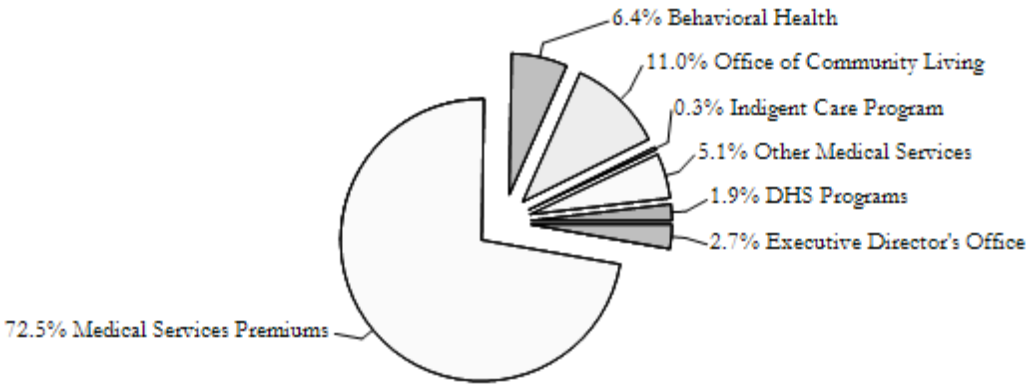


Department Funding Sources

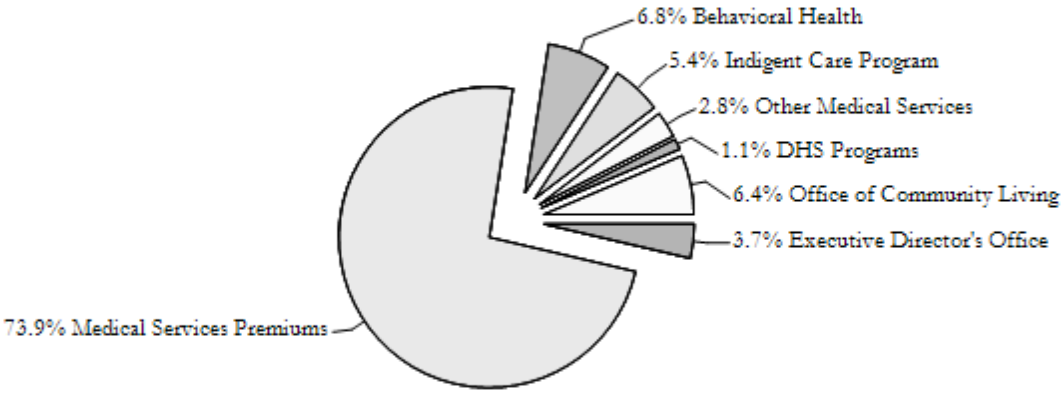


All charts are based on the FY 2019-20 appropriation.

Distribution of General Fund by Division



Distribution of Total Funds by Division



All charts are based on the FY 2019-20 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 2019-20, the FMAP for most Colorado Medicaid expenditures is 50.0 percent. However, for adults newly eligible under the federal Affordable Care Act, there is an enhanced federal match rate, which is scheduled to decrease annually until it reaches 90 percent in calendar year 2020. Colorado will receive a match rate of 93.0 percent match for calendar year 2019, resulting in a match rate of 91.5 percent for this population in FY 2019-20.

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 66.8 percent federal Medicaid funds, 27.9 percent General Fund, and 5.3 percent cash funds in FY 2019-20. 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.

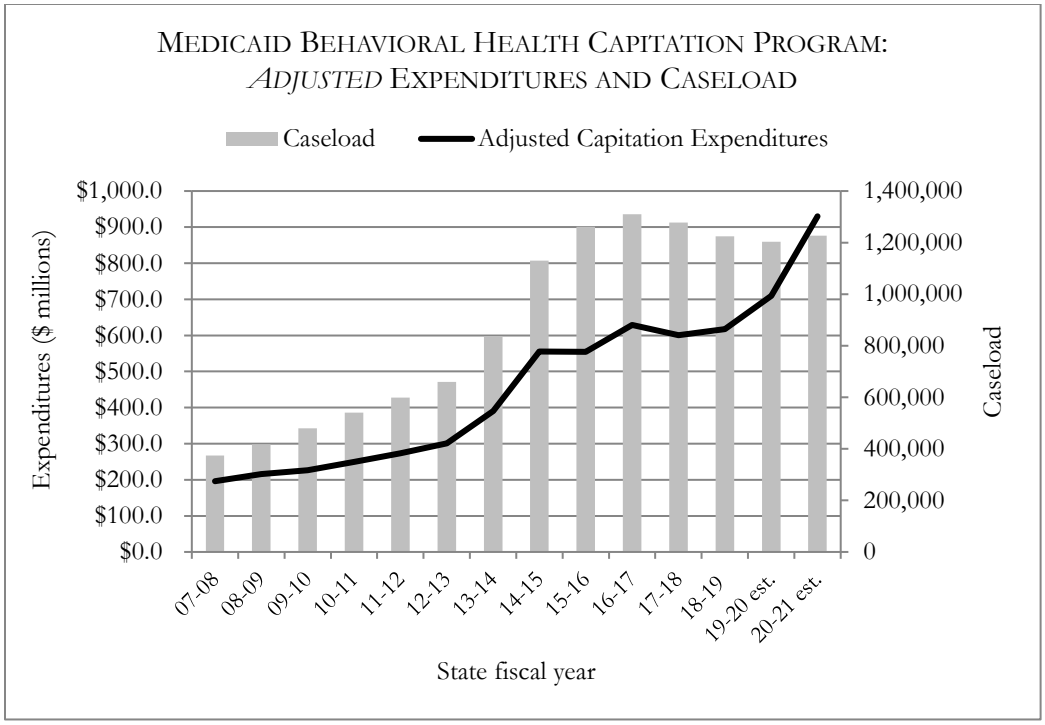
In order to receive services through behavioral health capitation, a client must have a covered diagnosis and receive a covered service or procedure[1] that is medically necessary. RAEs manage behavioral health services ranging from prevention services to outpatient group therapy to inpatient psychiatric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

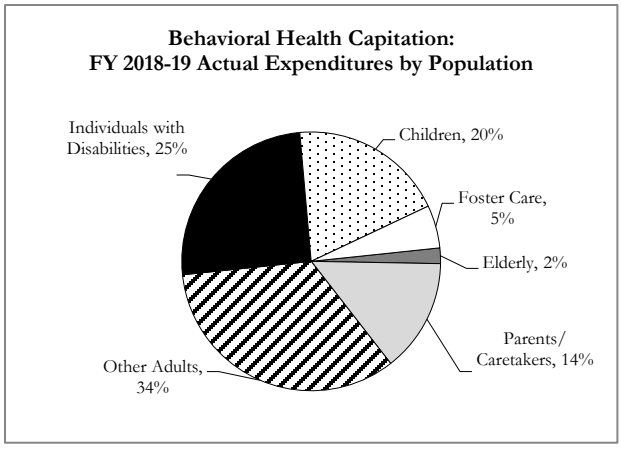
The following chart depicts recent annual expenditures for the Behavioral Health Capitation Program, along with the number of Medicaid clients eligible for behavioral health services each year. The chart reflects "adjusted" data, meaning that expenditures appear in the same fiscal year in which services 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.*

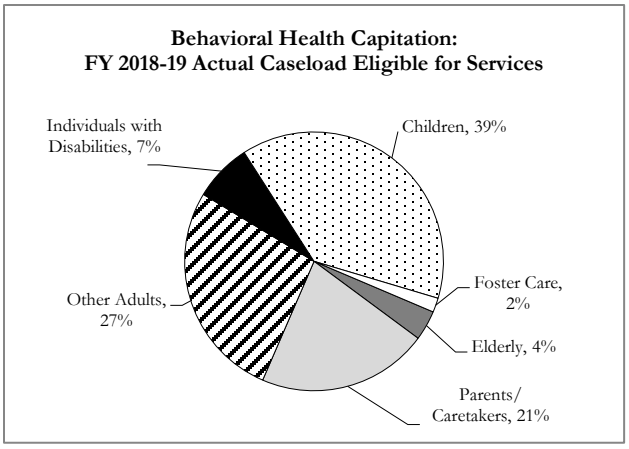


Caseload and expenditure increases in FY 2013-14 and FY 2014-15 reflect the expansion of Medicaid eligibility and the expansion of substance use disorder benefits covered by Medicaid; both expansions became effective in January 2014. During this period, expenditures grew more rapidly than the caseload 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 $1,686 for FY 2020-21);
- Individuals In or Formerly in Foster Care ($1,610); and
- Adults Without Dependent Children ($774).





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.

In FY 2018-19, caseload continued to decline by 4.2 percent. However, adjusted expenditures increased by 2.8 percent over FY 2017-18.

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 2019-20 through FY 2020-21, 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 $214.0 million in FY 2018-19);
- behavioral health-related *pharmaceutical expenditures* (an estimated $49.6 million after rebates in FY 2018-19, including $20.9 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 2018-19).

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 ($1.5 million in FY 2018-19). 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. For FY 2018-19, this includes a transfer to DHS of $384,074 General Fund that would have otherwise been a reversion, pursuant to Section 27-80-119 (3)(a), C.R.S.

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

SUMMARY: FY 2019-20 APPROPRIATION & FY 2020-21 REQUEST

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2019-20 APPROPRIATION:						
SB 19-207 (Long Bill)	723,029,646	201,872,261	38,370,104	0	482,787,281	0.0
Other legislation	44,789	0	15,676	0	29,113	0.0
TOTAL	**$723,074,435**	**$201,872,261**	**$38,385,780**	**$0**	**$482,816,394**	**0.0**
FY 2020-21 REQUESTED APPROPRIATION:						
FY 2019-20 Appropriation	$723,074,435	201,872,261	$38,385,780	$0	$482,816,394	0.0
R2 Behavioral Health	41,588,549	13,337,312	7,561,171	0	20,690,066	0.0
R10 Provider rates	(281,896)	(65,991)	(18,573)	0	(197,332)	0.0
R11 Substance use disorder patient placement and benefit implementation	(86,934,035)	(17,074,274)	(5,752,247)	0	(64,107,514)	0.0
Annualize HB 18-1136 Residential and inpatient SUD treatment	173,868,069	34,148,547	11,504,494	0	128,215,028	0.0
Annualize prior year budget actions	8,517	1,965	444	0	6,108	0.0
TOTAL	**$851,323,639**	**$232,219,820**	**$51,681,069**	**$0**	**$567,422,750**	**0.0**
INCREASE/(DECREASE)	$128,249,204	$30,347,559	$13,295,289	$0	$84,606,356	0.0
Percentage Change	17.7%	15.0%	34.6%	n/a	17.5%	n/a

R2 BEHAVIORAL HEALTH FORECAST: The request includes an increase of $41.6 million total funds, including $13.4 million General Fund, for projected caseload and expenditure changes in both the capitation and fee-for-service Medicaid behavioral health programs. *[For more information, see the first issue brief.]*

R10 PROVIDER RATES: The request includes a decrease of $281,896 total funds for FY 2020-21 provider rates. This proposed rate decrease applies to fee-for-service payments made for behavioral health services, but it does not apply to payments made through the statewide capitation program. The Department request seeks to decrease rates for certain services there were above 100 percent of the benchmark rate, including fee-for-service behavioral health services. *This request was discussed during the Health Care Policy and Financing briefing by Eric Kurtz on December 9, 2019.*

R11 SUBSTANCE USE DISORDER PATIENT PLACEMENT AND BENEFIT IMPLEMENTATION: The FY 2020-21 request includes two components:

- A decrease of $86.9 million total funds, including $17.1 million General Fund, related to the expansion of the SUD benefit required by H.B. 18-1136 (Substance Use Disorder Treatment), and
- An increase of $1.4 million total funds, including $451,440 General Fund, for the creation of a patient placement tool, which will guide placement in the appropriate level of SUD treatment.

[For more information, see the first issue brief.]

ANNUALIZE HB 18-1136 RESIDENTIAL AND INPATIENT SUD TREATMENT: The request includes $173.9 million total funds, including $34.1 million General Fund, to expand Medicaid benefits to

include inpatient and residential substance use disorder treatment and medical detoxification services as required by H.B. 18-1136 (Substance Use Disorder Treatment).

ANNUALIZE PRIOR YEAR BUDGET ACTIONS: The request includes an increase of $8,517 total funds, including $1,965 General Fund, for the second-year impact of FY 2019-20 provider rate adjustments.

ISSUE: OVERVIEW OF DEPARTMENT'S FY 2020-21 REQUEST FOR BEHAVIORAL HEALTH COMMUNITY PROGRAMS

The Department's total request for FY 2020-21 represents a $128.2 million (17.7 percent) increase in total funds, including an increase of $30.3 million General Fund. The Department's projections for FY 2020-21 are based on a slight growth in caseload (2.0 percent) and per capita rates (4.5 percent) over the revised estimate for FY 2019-20, as well as the addition of the Medicaid substance use disorder benefit beginning July 1, 2020.

SUMMARY

- Compared to existing FY 2019-20 appropriations, the Governor's **total** budget request for FY 2020-21 reflects an overall increase of $136.8 million total funds (13.6 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 $128.3 million (17.7 percent) for HCPF programs and $8.5 million (2.2 percent) for DHS programs.

- For FY 2019-20, HCPF estimates that existing appropriations for Medicaid behavioral health programs can be decreased by $15.7 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 and FY 2018-19; this was the first caseload decline in the last ten years.

DISCUSSION

OVERALL FUNDING REQUEST FOR BEHAVIORAL HEALTH PROGRAMS FOR FY 2020-21

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 2020-21 budget requests for these two program areas propose an overall increase of $136.8 million (13.6 percent) compared to existing appropriations, including a $41.0 million (9.9 percent) increase in General Fund appropriations. As detailed in Table 1, the overall increase includes $128.3 million for HCPF programs and $8.5 million for DHS programs. This issue brief provides an overview of the components of the HCPF share of the FY 2020-21 request and the underlying trends affecting the request

TABLE 1: TOTAL APPROPRIATIONS FOR BEHAVIORAL HEALTH PROGRAMS: FY 2019-20 AND FY 2020-21						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2019-20 Appropriation						
DHS Office of Behavioral Health	$381,866,917	$258,154,935	$52,955,722	$28,586,291	$42,169,969	1,426.40
HCPF Behavioral Health Community Programs	723,074,435	201,872,261	38,385,780	0	482,816,394	0
TOTAL	**$1,002,074,103**	**$414,943,597**	**$82,698,835**	**$20,606,933**	**$483,824,738**	**1,353.00**
FY 2020-21 Request						
DHS, Office of Behavioral Health	$390,367,455	$268,797,762	$52,291,999	$26,916,576	$42,361,118	1,469.70
HCPF, Behavioral Health Community Programs	851,323,639	232,219,820	51,681,069	0	567,422,750	0
TOTAL	**$1,047,562,177**	**$443,392,626**	**$90,520,480**	**$21,219,135**	**$492,429,936**	**1,403.90**
DHS: Increase/(Decrease)	$8,500,538	$10,642,827	($663,723)	($1,669,715)	$191,149	43.3
Percentage Change	*2.2%*	*4.1%*	*(1.3%)*	*(5.8%)*	*0.5%*	*3.0%*
HCPF: Increase/(Decrease)	$128,249,204	$30,347,559	$13,295,289	$0	$84,606,356	0
Percentage Change	*17.7%*	*15.0%*	*34.6%*	*n/a*	*17.5%*	*n/a*
TOTAL: Increase/(Decrease)	**$136,749,742**	**$40,990,386**	**$12,631,566**	**($1,669,715)**	**$84,797,505**	**43.3**
Percentage Change	*13.6%*	*9.9%*	*15.3%*	*(8.1%)*	*17.5%*	*3.2%*

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 2019-20 and FY 2020-21. As indicated below, the Department anticipates submitting a mid-year request to reduce existing appropriations for FY 2019-20 appropriations. Table 2 splits out the requested changes in R2 by fiscal year to provide a more informative overview of the request for FY 2020-21.

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 2019-20	$723,074,435	$201,872,261	$38,385,780	$0	$482,816,394
Changes reflected in most recent Medicaid forecast for FY 2019-20	(15,654,741)	(2,733,519)	(985,814)	0	(11,935,408)
Subtotal: FY 2019-20 Estimate	**$707,419,694**	**$199,138,742**	**$37,399,966**	**$0**	**$470,880,986**
Appropriation for FY 2019-20	$723,074,435	$201,872,261	$38,385,780	$0	$482,816,394
R2 Behavioral health forecast	41,588,549	13,337,312	7,561,171	0	20,690,066
R10 Provider rates	(281,896)	(65,991)	(18,573)	0	(197,332)
R11 Substance use disorder patient placement and benefit implementation	(86,934,035)	(17,074,274)	(5,752,247)		(64,107,514)
Annualize prior year budget actions	173,876,586	34,150,512	11,504,938	0	128,221,136
FY 2020-21 Total Request	**$851,323,639**	**$232,219,820**	**$51,681,069**	**$0**	**$567,422,750**
FY 2020-21 Request v. FY 2019-20 Estimate	**$143,903,945**	**$33,081,078**	**$14,281,103**	**$0**	**$96,541,764**
Percent change	*20.3%*	*16.6%*	*38.2%*	*n/a*	*20.5%*

FY 2019-20 BUDGET ESTIMATE

Overall for FY 2019-20 and FY 2020-21, the Department is anticipating that the total caseload will remain relatively flat (a 1.7 percent year-over-year decrease in FY 2019-20 and a 2.0 percent increase in FY 2020-21). The projected increase in expenditures each year is largely due to projected year-over-year increases in per capita rates (10.3 percent for FY 2019-20 and 4.5 percent in FY 2020-21).

The existing FY 2019-20 appropriation for Medicaid behavioral health community programs provides a total of $714.5 million total funds for the provision of services to an estimated 1,253,704 Medicaid clients. Based on an actual caseload decline in FY 2018-19, the Department is now projecting a

caseload for FY 2019-20 that is 50,659 (4.0 percent) lower than previously anticipated (1,203,045). Based on its current estimates, the Department anticipates submitting a supplemental request in January 2019 that would reduce FY 2019-20 appropriations by a total of $15.7 million. Most of this reduction, however, is projected to come from federal funds ($12.0 million).

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.

Finally, the Department is now projecting slightly higher incentive payments to RAE's based on performance measures tied to services provided in FY 2018-19. Specifically, the Department is now projecting incentive payments of up to $35.7 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 2020-21 BUDGET ESTIMATE

The Department's FY 2020-21 budget request includes $851.3 million total funds for the provision of services to a projected membership of 1,227,264. Compared to the revised estimate for FY 2019-20, the request represents a $143.9 million (20.3 percent) year-over-year increase in total funds, and a $33.1 million (16.6 percent) increase in General Fund [see Table 2]. The projection is based on a 2.0 percent overall caseload increase, and an average increase of 4.5 percent in Capitation rates (excluding payments associated with previous fiscal years).

Tables 3 through 5 show the year-over-year changes projected for FY 2020-21 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 19-20 ESTIMATE	FY 20-21 REQUEST	DIFFERENCE	PERCENT
Children to 147% FPL	471,242	477,518	6,276	1.3%
Adults w/out Dependent Children to 138% FPL	322,747	328,175	5,428	1.7%
Parents/Caretakers to 68% FPL; Pregnant Adults to 200% FPL	184,614	187,704	3,090	1.7%
Parents/Caretakers 69% to 138% FPL	61,682	66,543	4,861	7.9%
Individuals with Disabilities to age 64 (to 450% FPL)	92,010	95,005	2,995	3.3%
Adults age 65+ (to SSI)	48,835	50,183	1,348	2.8%
Foster Care to 26 years	21,783	22,018	235	1.1%
Breast & Cervical Cancer to 250% FPL	132	118	(14)	-10.6%
TOTAL	**1,203,045**	**1,227,264**	**24,219**	**2.0%**

TABLE 4: BEHAVIORAL HEALTH CAPITATION PROGRAM: ANNUAL EXPENDITURES				
CATEGORY	FY 19-20 ESTIMATE	FY 20-21 REQUEST	DIFFERENCE	PERCENT
Children to 147% FPL	$143,383,080	$150,625,787	$7,242,707	5.1%
Adults w/out Dependent Children to 138% FPL	237,267,082	254,161,966	16,894,884	7.1%
Parents/Caretakers to 68% FPL; Pregnant Adults to 200% FPL	69,501,707	74,427,000	4,925,293	7.1%
Parents/Caretakers 69% to 138% FPL	17,824,028	20,256,376	2,432,348	13.6%
Individuals with Disabilities to age 64 (to 450% FPL)	150,551,541	160,156,882	9,605,341	6.4%
Adults age 65+ (to SSI)	14,763,503	15,949,778	1,186,275	8.0%
Foster Care to 26 years	33,925,361	35,459,627	1,534,266	4.5%
Breast & Cervical Cancer to 250% FPL	49,785	46,858	(2,927)	-5.9%
Health insurance provider fee payments (for previous year)	0	9,317,988	9,317,988	n/a
Estimated incentive payments (for previous year)	29,618,169	33,519,820	3,901,651	n/a
TOTAL	**$696,884,256**	**$753,922,082**	**$57,037,826**	**8.2%**

TABLE 5: BEHAVIORAL HEALTH CAPITATION PROGRAM: ANNUAL PER CAPITA EXPENDITURES				
CATEGORY	FY 19-20 ESTIMATE	FY 20-21 REQUEST	DIFFERENCE	PERCENT
Children to 147% FPL	$304	$315	$11	3.7%
Adults w/out Dependent Children to 138% FPL	735	774	39	5.3%
Parents/Caretakers to 68% FPL; Pregnant Adults to 200% FPL	376	397	20	5.3%
Parents/Caretakers 69% to 138% FPL	289	304	15	5.3%
Individuals with Disabilities to age 64 (to 450% FPL)	1,636	1,686	50	3.0%
Adults age 65+ (to SSI)	302	318	16	5.1%
Foster Care to 26 years	1,557	1,610	53	3.4%
Breast & Cervical Cancer to 250% FPL	377	397	20	5.3%
TOTAL (excluding adjustments and payments associated with previous fiscal years)	**$555**	**$579**	**$25**	**4.5%**

Next month the Department will submit a supplemental request for FY 2019-20 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 2019, which will inform the Committee's final decisions in March 2020 concerning the FY 2019-20 and FY 2020-21 budgets.

ISSUE: R11 SUBSTANCE USE DISORDER PATIENT PLACEMENT AND BENEFIT IMPLEMENTATION

This issue brief provides an overview of the Department's R11 request related to substance use disorder (SUD) treatment services. The request includes two components: a decrease in funding related to the expansion of the SUD benefit required by H.B. 18-1136 (Substance Use Disorder Treatment) and increase in funding for the creation of a patient placement tool, which would guide placement in the appropriate level of SUD treatment.

SUMMARY

- House Bill 18-1136 (Substance Use Disorder Treatment) adds residential and inpatient SUD treatment and medical detoxification services as a benefit under the Colorado Medicaid Program. The final fiscal note for the bill estimated the FY 2020-21 costs to be $174.2 million total funds.

- While the Department expects to beginning offering the benefit beginning July 1, 2020, the Department is requesting a reduction to the FY 2020-21 appropriation to reflect a lower caseload due to a lack of treatment capacity.

- The request includes funding to contract for a patient placement tool, which would assist treatment providers in identifying the appropriate level of care for substance use disorder treatment.

RECOMMENDATION

Staff recommends that the Committee asks both the Department of Health Care Policy and Financing and the Department of Human Services to discuss substance use treatment capacity at their hearings, including the following:

- What is the existing treatment capacity across the state?
- What are the barriers to building additional capacity?
- Are capacity concerns based solely on a shortage of total providers in the state, or is capacity further limited by the number of Medicaid providers?

DISCUSSION

BACKGROUND

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 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[2].
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.

The General Assembly has passed two bills in recent 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.[3]

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.

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[2] 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.

[3] 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

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.

FUNDING

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

The Department submitted the Section 1115 waiver application to the Centers for Medicare and Medicaid (CMS) in October 2019. While the application is under review, the Department is in the process of mapping SUD treatment capacity across the state according to the American Society of Addiction Medicine (ASAM) levels, as well as demand for services. The Department will host a series of Regional Capacity Meetings from December 2019 through February 2020 in order to receive input about capacity and demand from communities and stakeholders. CMS approval is expected prior to July 1, 2020, when the benefit is expected to go into effect.

FY 2020-21 REQUEST

The FY 2020-21 request includes three components related to the SUD benefit:

- An increase of $173.9 million total funds, including $34.1 million General Fund, to reflect the final FY 2020-21 cost included in the fiscal note for H.B. 18-1136;
- A request to reduce that amount by $86.9 million total funds, including $17.1 million General Fund; and
- An increase of $1.4 million total funds, including $451,440 General Fund, for the implementation of a patient placement tool.

COST ADJUSTMENT FOR SUBSTANCE USE DISORDER BENEFIT

The Department anticipates that the cost of the benefit will be significantly less than the projected fiscal impact of H.B. 18-1136 due to a lower estimated caseload associated with a lack of treatment capacity. The fiscal note used assumptions from a report authored by the Colorado Health Institute (CHI) that estimated the cost of the expanded benefit based on the assumption that 17,000 enrollees would utilize the new treatment options each year. New estimates from CHI indicate that provider capacity will result in less than half of the expected utilization. In other words, the reduction is based on a lack of capacity, not a reduction in the number of people needing the service.

As a result, the Department is requesting to reduce the appropriation for FY 2020-21 by 50.0 percent. The Department believes this is a conservative reduction, and it is likely that actual expenditures will be lower. However, much like Medicaid expansion, it will take some time for numbers to settle.

PATIENT PLACEMENT TOOL

The Department must submit an implementation plan to the Centers for Medicare and Medicaid (CMS) that outlines how providers would place patients in SUD treatment based on evidence-based, SUD-specific criteria. CMS requires that:

- "Providers assess treatment needs based on SUD-specific, multi-dimensional assessment tools, e.g., the ASAM (American Society of Addiction Medicine) Criteria, or other patient placement assessment tools that reflect evidence-based clinical treatment guidelines," and
- "Utilization management approaches are implemented to ensure that (a) beneficiaries have access to SUD services at the appropriate level of care, (b) interventions are appropriate for the diagnosis and level of care, and (c) there is an independent process for reviewing placement in residential treatment settings."

This can be done by either a centralized, uniform decision support system or by requiring each Medicaid provider to develop their own system to justify patient placement decisions.

The Department is requesting $80,000 total funds, including $26,400 General Fund, in FY 2019-20 and $1,368,000 total funds, including $451,440 General Fund, in FY 2020-21 to contract for a centralized patient placement tool for use by SUD providers. The Department indicates that this tool will be helpful in the following ways:

- Gaining approval of the SUD waiver from CMS by demonstrating an ability to determine adequate patient placement and utilization management;
- Helping the Department reach its goal to improve the delivery of member programs and health outcomes by ensure members receive the most appropriate treatment; and
- Controlling Medicaid costs by ensuring members receive the right level of care.

Once the system is implemented, the appropriation would cover ongoing system support costs, as well as software subscriptions for providers.

Appendix A: Numbers Pages

	FY 2017-18 Actual	FY 2018-19 Actual	FY 2019-20 Appropriation	FY 2020-21 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 Medicaid 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	512,884,063	615,097,094	712,830,202	840,856,117 *	
General Fund	171,717,548	179,075,725	199,508,367	229,776,392	
Cash Funds	21,637,199	28,513,064	37,852,285	50,995,361	
Reappropriated Funds	0	0	0	0	
Federal Funds	319,529,316	407,508,305	475,469,550	560,084,364	
Behavioral Health Fee-for-service Payments	9,300,665	10,625,080	10,244,233	10,467,522 *	
General Fund	2,093,383	2,465,737	2,363,894	2,443,428	
Cash Funds	355,200	336,984	533,495	685,708	
Reappropriated Funds	0	0	0	0	
Federal Funds	6,852,082	7,822,359	7,346,844	7,338,386	
TOTAL - (3) Behavioral Health Community Programs	522,184,728	625,722,174	723,074,435	851,323,639	17.7%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	173,810,931	181,541,462	201,872,261	232,219,820	15.0%
Cash Funds	21,992,399	28,850,048	38,385,780	51,681,069	34.6%
Reappropriated Funds	0	0	0	0	0.0%
Federal Funds	326,381,398	415,330,664	482,816,394	567,422,750	17.5%

Appendix A: Numbers Pages

	FY 2017-18 Actual	FY 2018-19 Actual	FY 2019-20 Appropriation	FY 2020-21 Request	Request vs. Appropriation
TOTAL - Department of Health Care Policy and Financing	522,184,728	625,722,174	723,074,435	851,323,639	17.7%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	173,810,931	181,541,462	201,872,261	232,219,820	15.0%
Cash Funds	21,992,399	28,850,048	38,385,780	51,681,069	34.6%
Reappropriated Funds	0	0	0	0	0.0%
Federal Funds	326,381,398	415,330,664	482,816,394	567,422,750	17.5%

APPENDIX B
RECENT LEGISLATION AFFECTING DEPARTMENT BUDGET

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.

2019 SESSION BILLS

S.B. 19-113 (SUPPLEMENTAL BILL): Modifies FY 2018-19 and FY 2017-18 appropriations to the Department.

S.B. 19-195 (BEHAVIORAL HEALTH SERVICES FOR CHILDREN AND YOUTH): Requires the Department of Health Care Policy and Financing (HCPF) and the Department of Human Services (DHS) to work collaboratively to provide Medicaid-covered wraparound services for children and youth at risk of out-of-home placement or who are currently in out-of-home placement. Requires HCPF to seek federal authorization to provide such services by July 1, 2020, and upon federal authorization, requires that managed care entities implement such services. Appropriates $619,484 General Fund to HCPF for FY 2019-20, and states the assumptions that HCPF will receive $771,903 federal funds and require 3.9 FTE.

S.B. 19-207 (LONG BILL): General appropriations act for FY 2019-20. Includes provisions modifying FY 2017-18 and FY 2018-19 appropriations to the Department.

S.B. 19-222 (BEHAVIORAL HEALTH CARE FOR INDIVIDUALS AT RISK): Requires the Department of Health Care Policy and Financing (HCPF) and the Department of Human Services (DHS) to improve access to behavioral health services for individuals at risk of institutionalization. Also requires the Office of Behavioral Health in DHS to collaborate with HCPF to develop an implementation plan to increase the number of high-intensity behavioral health treatment programs statewide. Appropriates $51,000 General Fund and $24,000 cash funds to HCPF for FY 2019-20, and states the assumption that HCPF will receive $75,000 federal funds.

H.B. 19-1269 (BEHAVIORAL HEALTH CARE COVERAGE): Requires private health insurers and the State's Medicaid plan to provide medically necessary coverage for behavioral, mental health, and substance use disorder services on par with the coverage for physical health services and to demonstrate compliance through new reporting requirements. Appropriates $113,560 General Fund and $53,440 cash funds to the Department of Health Care Policy and Financing (HCPF) for FY 2019-20, and states the assumptions that HCPF will receive $167,001 federal funds and require 3.0 FTE.

H.B. 19-1287 (TREATMENT FOR SUBSTANCE USE DISORDERS): Enacts several initiatives to improve access to behavioral health and substance use disorder treatment, including requiring the Department of Human Services (DHS) to establish a care navigation system to assist individuals in accessing substance use disorder treatment. Appropriates $21,733 General Fund and $10,228 cash funds to the Department of Health Care Policy and Financing (HCPF) for FY 2019-20 to assist in care coordination for Medicaid clients, and states the assumptions that HCPF will receive $31,961 federal funds and require 0.8 FTE.

H.B. 19-1302 (CANCER TREATMENT & LICENSE PLATE SURCHARGE: Reauthorizes the Breast and Cervical Cancer Treatment and Prevention Program and Fund in the Department of Health Care Policy and Financing. Provides $2,425,021 to the Department in FY 2019-20, including $857,783 cash funds and $1,567,238 federal funds.

APPENDIX C
FOOTNOTES AND INFORMATION REQUESTS

UPDATE ON LONG BILL FOOTNOTES

16 Department of Health Care Policy and Financing, Behavioral Health Community Program, Behavioral Health Capitation Payments – It is the General Assembly's intent that a 2.0 percent increase in community-based provider workforce salaries be passed through in its entirety to Community Mental Health Centers and other mental health and substance use providers, excluding hospitals and Federally Qualified Health Centers. The Department of Health Care Policy and Financing is expected to increase rates for Community Mental Health Centers and other mental health and substance use disorder providers impacted by the policy to reflect the entire 2.0 percent workforce salary increase.

COMMENT: This footnote was added to the FY 2019-20 Long Bill to state the General Assembly's intent that the funds be used to increase salary reimbursement for behavioral health providers. The 2.0 percent increase was incorporated during rate setting for FY 2019-20. Additionally, the Department provided the following memo to the RAE's expressing the legislative intent.

COLORADO
Department of Health Care Policy & Financing

Behavioral Health Workforce Capitated Payment Increase

Accountable Care Collaborative August 5th, 2019

Background

During the 2019 legislative session, the Colorado General Assembly appropriated to the Department a 2% increase in funds for the capitated behavioral health benefit. The stated legislative purpose for the additional funds is to increase salary reimbursement for community-based behavioral health providers. The funding is to be incorporated into the managed care rates and is intended to be passed through in its entirety to behavioral health providers to address workforce issues. The appropriation excludes increased reimbursement for behavioral health providers employed by hospitals and Federally Qualified Health Centers.

The state fiscal year 2019-2020 Long Bill (Senate Bill 19-207) Footnote 16 states:

> "…It is the General Assembly's intent that a 2.0 percent increase in community-based provider workforce salaries be passed through in its entirety to Community Mental Health Centers and other mental health and substance use disorder providers, excluding hospitals and Federally Qualified Health Centers. The Department of Health Care Policy and Financing is expected to increase rates for Community Mental Health Centers and other mental health and substance use disorder providers impacted by the policy to reflect the entire 2.0 percent workforce salary increase."[1]

Managed Care Rate Setting

To incorporate the funding into the Regional Accountable Entity (RAE) contracts so that the RAEs can pass the funds on to providers as stated in the Long Bill, the Department included a "public policy adjustment" in the RAEs' behavioral health managed care rates for FY 2019-20. This adjustment added sufficient funding to increase all eligible provider rates by 2% above and beyond the underlying historical pricing and trend.

[1] https://leg.colorado.gov/sites/default/files/documents/2019A/bills/2019a_hcp_act.pdf

Guiding Principles

1. The funding must be passed through to eligible providers in its entirety.

2. The funding must be used in a manner that is consistent with the legislative intent as stated in the FY 2019-20 Long Bill.

3. The RAEs must be able to demonstrate that the funding has been passed on to eligible providers and provide documentation of its distribution strategy to the Department upon request.

4. The RAEs have autonomy to determine how best to disseminate the funds; however, the Department expects the RAEs to consider the context and stated intent of the statute when determining how to distribute the increase to providers.

Frequently Asked Questions

Can we implement a quality program to disperse the funds?

While the RAEs have some flexibility in distributing the funds, it is important to honor the legislative intent of the funding increase. The intent of the increased funding is to bolster the behavioral health workforce. A quality program may not do this directly. In addition, the funding was intended to be available 7/1/19; whereas under a quality program there could likely be delays in funding flowing to providers. To the extent the RAE wishes to implement a quality program with the funds, please discuss doing so with your contract manager to ensure the proposal is consistent with the legislative intent.

Can the funds be distributed as a lump sum payment instead of increasing rates on individual services?

Yes. This could be an effective way to support workforce development. If you pursue this strategy, note that it may result in more or less than a 2% increase depending on actual utilization patterns.

Can the fee schedule just be adjusted by 2% for eligible providers?

Yes, that would satisfy the legislative intent.

Some Community Mental Health Centers (CMHCs) are providing direction on how the funding must be spent. Is it accurate?

Any guidance regarding how the funding must be spent should come from the Department. That said, the Department does expect the RAEs to collaborate with the Community Mental

Health Centers to develop a disbursement strategy that most effectively supports increases in workforce salaries.

Do different provider types get different increases? I've heard CMHCs should get a 3% increase and other providers less.

The funding was incorporated as a 2% increase on all eligible utilization. See the response to other questions for guidance on distribution.

Does every eligible provider need to receive a 2% increase?

It may not be necessary for every eligible provider to receive a 2% increase. For example, some providers may have a very low volume such that updating contracts or fee schedules might not make sense. Nevertheless, the Department expects the RAEs to consider the political sensitivity regarding excluding any provider from the rate increase policy. Actual workforce needs in your network should also be considered when developing and implementing a strategy.

Note that the increase was assumed in the rates for all eligible utilization. If you exclude any utilization/providers, you will need to consider increasing reimbursement to providers that are included in the policy by an amount greater than 2%.

Excluding otherwise eligible providers that have a sufficient amount of utilization with your RAE will require a reasonable justification.

UPDATE ON REQUESTS FOR INFORMATION

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

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

APPENDIX D
DEPARTMENT ANNUAL PERFORMANCE REPORT

Pursuant to Section 2-7-205 (1)(a)(I), C.R.S., the Office of State Planning and Budgeting is required to publish an **Annual Performance Report** for the *previous fiscal year* for the Department of Health Care Policy and Financing. 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.

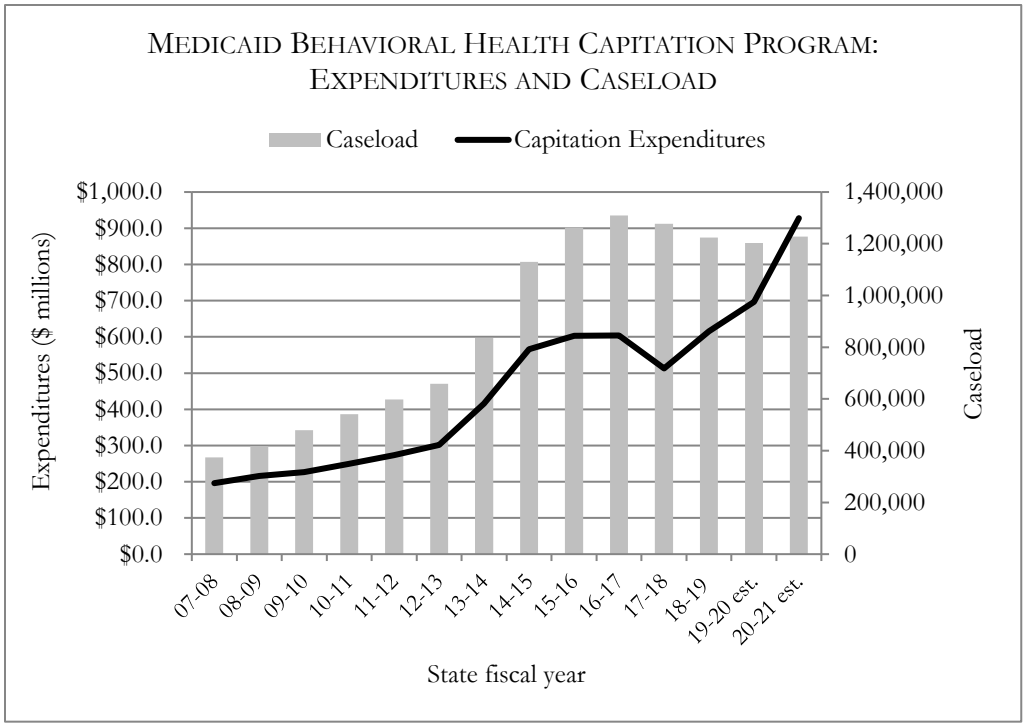
For consideration by the Joint Budget Committee in prioritizing the Department's FY 2020-21 budget request, the FY 2018-19 Annual Performance Report and the FY 2019-20 Performance Plan can be found at the following link:

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

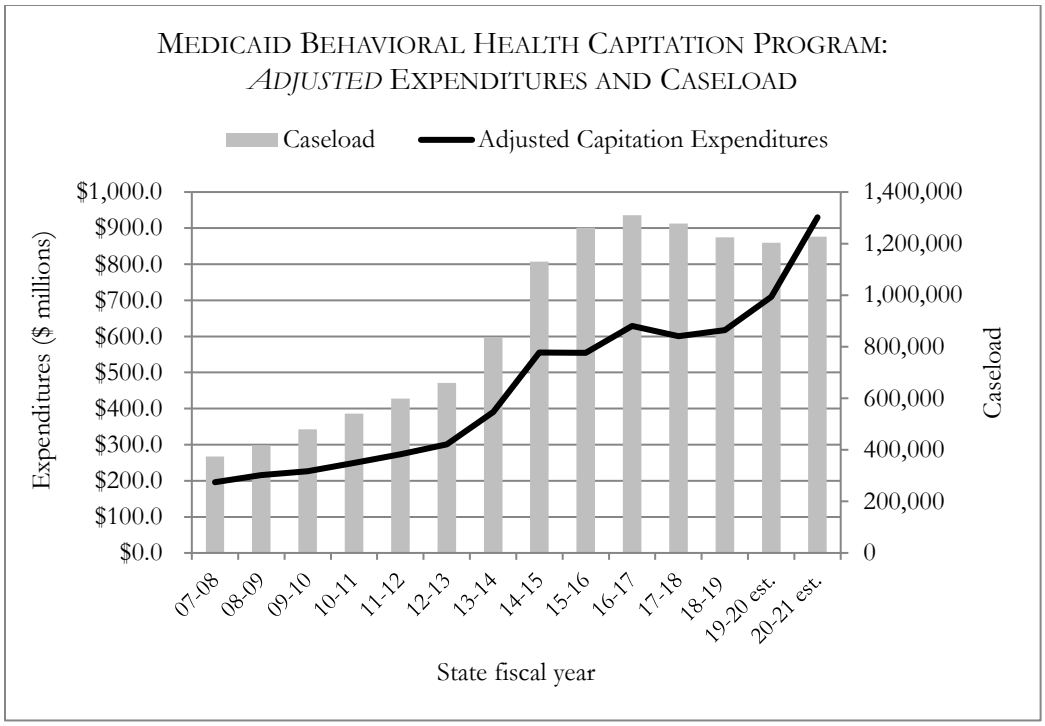
APPENDIX E
CALCULATION OF CAPITATION PROGRAM "ADJUSTED" EXPENDITURES

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 2019-20 and FY 2020-21 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 2020-21								
	DATES OF SERVICE							TOTAL
	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21	
FY 2016-17								
Risk corridor reconciliation	($17,524,964)	$0	$0	$0	$0	$0	$0	($17,524,964)
Expansion parent rate reconciliation	0	(19,040,337)	0	0	0	0	0	(19,040,337)
Parent indicator issue	0	0	12,144,633	0	0	0	0	12,144,633
Total: FY 2016-17	**(17,524,964)**	**(19,040,337)**	**12,144,633**	**0**	**0**	**0**	**0**	**(24,420,668)**
FY 2017-18								
Risk corridor reconciliation	0	(47,729,415)	0	0	0	0	0	($47,729,415)
Adjustment for children incorrectly placed in disability eligibility category	0	(1,848,939)	0	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	1,601,919
Expansion parent rate reconciliation	0	0	(17,786,031)	0	0	0	0	(17,786,031)
Parent indicator issue	0	0	(86,606)	0	0	0	0	(86,606)
Health insurance provider fee payment	0	0	5,891,487	0	0	0	0	5,891,487
Total: FY 2017-18	**(4,377)**	**(48,639,193)**	**(11,314,015)**	**0**	**0**	**0**	**0**	**(59,957,585)**
FY 2018-19								
Rate change for adults without dependent children	0	0	0	946,398	0	0	0	$946,398

SUMMARY OF CAPITATION RECONCILIATIONS: FY 2016-17 THROUGH FY 2020-21								
	DATES OF SERVICE							TOTAL
	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21	
BHO incentive payments (HB 17-1353)	0	0	0	21,623,666	0	0	0	21,623,666
Health insurance provider fee payment	0	0	0	5,419,060	0	0	0	5,419,060
Total: FY 2018-19	**0**	**0**	**0**	**27,989,124**	**0**	**0**	**0**	**27,989,124**
FY 2019-20								
RAE incentive payments (HB 17-1353)	0	0	0	0	29,618,168	0	0	29,618,168
Health insurance provider fee payment	0	0	0	0	0	0	0	0
Total: FY 2019-20	**0**	**0**	**0**	**0**	**29,618,168**	**0**	**0**	**29,618,168**
FY 2020-21								
RAE incentive payments (HB 17-1353)	0	0	0	0	0	33,519,820	0	33,519,820
Health insurance provider fee payment	0	0	0	0	0	9,317,988	0	9,317,988
Total: FY 2020-21	**0**	**0**	**0**	**0**	**0**	**42,837,808**	**0**	**42,837,808**
FY 2021-22								
RAE incentive payments (HB 17-1353)	0	0	0	0	0	0	35,710,730	35,710,730
Health insurance provider fee payment	0	0	0	0	0	0	9,524,363	9,524,363
Total: FY 2021-22	**0**	**0**	**0**	**0**	**0**	**0**	**45,235,093**	**45,235,093**
TOTALS	**($17,529,341)**	**($67,679,530)**	**$830,618**	**$27,989,124**	**$29,618,168**	**$42,837,808**	**$45,235,093**	**$16,066,847**

- *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 the prior fiscal year.

APPENDIX F
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)	$25.87	$137.20	$31.42	$24.11	$61.68	$25.36	$129.94	$31.42	
Estimated monthly caseload	48,835	92,010	184,614	61,682	322,747	471,242	21,783	132	1,203,045
Number of months rate is effective	12	12	12	12	12	12	12	12	
Total estimated capitated payments	**$15,160,337**	**$151,485,264**	**$69,606,863**	**$17,845,836**	**$238,884,420**	**$143,408,365**	**$33,965,796**	**$49,769**	**$670,406,651**
Estimated expenditures:									
Claims paid in current period	$15,170,949	$151,470,115	$69,544,217	$17,829,775	$238,908,308	$143,365,342	$33,965,796	$49,719	$670,304,221
Claims from prior periods	(6,770)	14,062	59,560	10,012	(21,907)	37,159	0	66	92,182
Estimated date of death retractions	(400,676)	(932,636)	(102,070)	(15,759)	(1,619,319)	(19,421)	(40,435)	0	(3,130,316)
Total expenditures after retractions	$14,763,503	$150,551,541	$69,501,707	$17,824,028	$237,267,082	$143,383,080	$33,925,361	$49,785	$667,266,087
Other payment adjustments:									
Health insurance provider fee payment	0	0	0	0	0	0	0	0	0
Estimated incentive payments	577,207	7,329,304	3,353,516	703,380	10,260,803	5,881,585	1,509,879	2,495	29,618,169
NET EXPENDITURES	**$15,340,710**	**$157,880,845**	**$72,855,223**	**$18,527,408**	**$247,527,885**	**$149,264,665**	**$35,435,240**	**$52,280**	**$696,884,256**
Annual per capita expenditure (excluding payment adjustments)	**$302.31**	**$1,636.25**	**$376.47**	**$288.97**	**$735.15**	**$304.27**	**$1,557.42**	**$377.16**	**$554.65**

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

APPENDIX G
FY 2020-21 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)	$27.15	$141.30	$33.09	$25.39	$64.95	$26.29	$134.36	$33.09	
Estimated monthly caseload	50,183	95,005	187,704	66,543	328,175	477,518	22,018	118	1,227,264
Number of months rate is effective	12	12	12	12	12	12	12	12	
Total estimated capitated payments	**$16,349,621**	**$161,090,478**	**$74,533,504**	**$20,274,321**	**$255,779,595**	**$150,647,379**	**$35,500,062**	**$46,855**	**$714,221,816**
Estimated expenditures:									
Claims paid in current period	$16,361,066	$161,074,369	$74,466,424	$20,256,074	$255,805,173	$150,602,185	$35,500,062	$46,808	$714,112,161
Claims from prior periods	(10,612)	15,149	62,646	16,061	(23,888)	43,023	0	50	102,429
Estimated date of death retractions	(400,676)	(932,636)	(102,070)	(15,759)	(1,619,319)	(19,421)	(40,435)	0	(3,130,316)
Total expenditures after retractions	$15,949,778	$160,156,882	$74,427,000	$20,256,376	$254,161,966	$150,625,787	$35,459,627	$46,858	$711,084,274
Other payment adjustments:									
Substance use disorder treatment**	12,244,842	23,181,580	42,100,169	16,236,744	80,075,942	0	0	28,792	173,868,069
Health insurance provider fee payment	213,303	2,101,643	972,390	264,506	3,336,990	1,965,399	463,146	611	9,317,988
Estimated incentive payments	758,209	7,574,209	3,480,189	891,989	11,944,320	7,170,125	1,698,290	2,489	33,519,820
NET EXPENDITURES	**$29,166,132**	**$193,014,314**	**$120,979,748**	**$37,649,615**	**$349,519,218**	**$159,761,311**	**$37,621,063**	**$78,750**	**$927,790,151**
Annual per capita expenditure (excluding payment adjustments)	**$317.83**	**$1,685.77**	**$396.51**	**$304.41**	**$774.47**	**$315.43**	**$1,610.48**	**$397.10**	**$579.41**

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

** Authorized by H.B. 18-1136.