JOINT BUDGET COMMITTEE

STAFF FIGURE SETTING
FY 2023-24

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
(Behavioral Health Only)

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

PREPARED BY:
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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. A similar overview table is provided for each division, but the description of incremental changes is not repeated, since it is available under the Department Overview. More details about the incremental changes are provided in the sections following the Department Overview and the division summary tables.

Decision items, both department-requested items and staff-initiated items, are discussed either in the Decision Items Affecting Multiple Divisions or at the beginning of the most relevant division. Within a section, decision items are listed in the requested priority order, if applicable.

In some of the analyses of decision items in this document, you may see language denoting certain 'levels of evidence', e.g. theory-informed, evidence-informed, or proven. For a detailed explanation of what is meant by 'levels of evidence', and how those levels of evidence are categorized, please refer to Section 2-3-210 (2), C.R.S.

DEPARTMENT OVERVIEW

The Department helps pay medical and long-term care expenses for low-income and vulnerable populations. To assist with these costs the Department receives significant federal matching funds, but must adhere to federal rules regarding program eligibility, benefits, and other features, as a condition of accepting the federal money. The major programs administered by the Department include:

- **Medicaid** – serves people with low income and people needing long-term care
- **Children's Basic Health Plan** – provides a low-cost insurance option for children and pregnant women with income slightly higher than the Medicaid eligibility criteria
- **Colorado Indigent Care Program** – defrays a portion of the costs to providers of uncompensated and under-compensated care for people with low income, if the provider agrees to program requirements for discounting charges to patients on a sliding scale based on income
- **Old Age Pension Health and Medical Program** – serves elderly people with low income who qualify for a state pension but do not qualify for Medicaid or Medicare.

The Department also performs functions related to improving the health care delivery system, including advising the General Assembly and the Governor, distributing tobacco tax funds through the Primary Care and Preventive Care Grant Program, financing Public School Health Services, and housing the Commission on Family Medicine Residency Training Programs.

SUMMARY OF STAFF RECOMMENDATIONS

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2022-23 APPROPRIATION						
H.B. 22-1329 (Long Bill)	$14,175,863,675	$4,079,738,465	$1,805,089,552	$94,985,445	$8,196,050,213	711.7
Other Legislation	255,337,083	(226,654,689)	(7,154,037)	46,276	489,099,533	30.1
Recommended Long Bill Add-on	230,058,964	(199,264,983)	59,855,587	0	369,468,360	0.0
TOTAL	**$14,661,259,722**	**$3,653,818,793**	**$1,857,791,102**	**$95,031,721**	**$9,054,618,106**	**741.8**
FY 2023-24 RECOMMENDED APPROPRIATION						
FY 2022-23 Appropriation	$14,661,259,722	$3,653,818,793	$1,857,791,102	$95,031,721	$9,054,618,106	741.8
NP Local Affairs housing vouchers	(4,215,888)	(2,107,944)	0	0	(2,107,944)	0.0
R10a Skilled respite for children	3,274,471	0	1,637,236	0	1,637,235	0.0
R1 Medical Services Premiums	160,173,584	459,048,342	(23,454,035)	(6,310,453)	(269,110,270)	0.0
R2 Behavioral Health	76,203,576	45,426,079	(1,413,228)	0	32,190,725	0.0
R3 Child Health Plan Plus	46,988,338	19,576,972	(571,891)	0	27,983,257	0.0
R4 Medicare Modernization Act	3,285,804	3,285,804	0	0	0	0.0
R5 Office of Community Living	52,858,713	67,353,095	(291,256)	0	(14,203,126)	0.0
R6 Value-based payments	8,897,109	2,871,558	326,112	0	5,699,439	0.0
R7a Provider rates	163,656,476	61,534,993	6,364,320	0	95,757,163	0.0
R7b Targeted provider rates	124,590,841	40,289,535	13,810,844	0	70,490,462	0.0
R8 Cost and quality indicators	7,305,880	976,856	701,458	0	5,627,566	0.0
R9 Perinatal services	1,670,879	818,373	0	0	852,506	0.0
R10b Children with complex needs	648,645	192,129	132,193	0	324,323	3.6
R11 Compliance	(9,611,364)	(3,101,499)	(1,502,994)	0	(5,006,871)	6.4
R12 Non Medicaid BH eligibility & claims	2,765,368	2,765,368	0	0	0	8.0
R13 Case management redesign	3,602,309	168,000	1,533,155	0	1,901,154	0.0

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
R14 Convert contracts to FTE	(107,195)	(45,322)	(8,276)	0	(53,597)	3.7
R15 Transfers between lines	0	0	0	0	0	0.0
BA6 Eligibility redeterminations	12,891,024	3,176,828	1,278,762	0	8,435,434	0.0
BA7 Community based access to services	6,341,474	175,000	2,974,232	0	3,192,242	0.0
BA8 ARPA HCBS adjustments	37,376,530	0	19,420,499	0	17,956,031	5.7
BA9 Public school health services	8,828,258	0	9,518,849	0	(690,591)	0.0
BA10 Provider enrollment fee & estate recoveries	0	85,525	(517,603)	0	432,078	0.0
BA11 Behavioral health crisis response	203,040	203,040	0	0	0	0.0
BA12 eConsult technical adjustment	0	0	0	0	0	0.0
BA19 Alternative payment model	2,750,667	735,028	157,297	0	1,858,342	0.0
BA20 Clinical navigation services	271,904	135,953	0	0	135,951	1.9
NP Promoting equity through technology	3,475,761	487,674	204,431	374,415	2,409,241	4.6
Centrally appropriated items	9,622,759	4,337,030	435,760	(64,564)	4,914,533	5.0
Human Services programs	2,575,472	1,268,980	0	0	1,306,492	0.0
NP Statewide operating inflation	326,891	136,797	24,356	4,649	161,089	0.0
Indirect cost recoveries	264,914	0	(76,093)	118,832	222,175	0.0
Annualize prior year budget actions	(7,674,075)	87,991,062	(133,505,086)	11,156,916	26,683,033	(12.1)
Transfers to other state agencies	1,063	532	0	0	531	0.0
Tobacco forecast	(53,250)	(26,625)	(26,625)	0	0	0.0
Technical adjustment	0	0	0	0	0	0.0
TOTAL	**$15,380,449,700**	**$4,451,577,956**	**$1,754,943,519**	**$100,311,516**	**$9,073,616,709**	**768.6**
INCREASE/(DECREASE)	**$719,189,978**	**$797,759,163**	**($102,847,583)**	**$5,279,795**	**$18,998,603**	**26.8**
Percentage Change	4.9%	21.8%	(5.5%)	5.6%	0.2%	3.6%
FY 2023-24 EXECUTIVE REQUEST	**$14,970,628,423**	**$4,439,026,247**	**$1,756,542,318**	**$105,752,975**	**$8,669,306,883**	**785.5**
Request Above/(Below) Recommendation	($409,821,277)	($12,551,709)	$1,598,799	$5,441,459	($404,309,826)	16.9

DESCRIPTION OF INCREMENTAL CHANGES

ENROLLMENT/UTILIZATION TRENDS

FY 22-23

LONG BILL SUPPLEMENTAL: Staff recommends a supplemental based on enrollment and utilization trends identified in the Department's February forecast and technical corrections. In total, the supplemental represents a decrease of $38.1 million total funds, including a decrease of $24.0 million General Fund, for the Behavioral Health Community Programs. Enrollment and per capita costs are both higher than expected in the current appropriation but that increase is more than offset by a reduction for the reconciliation of recoupments under the risk corridor for substance use benefits in FY 2021-22. Extension of the enhanced federal match for an additional two quarters beyond what was assumed in the November forecast is also driving the General Fund decrease. See the discussion of R2 in the Decision Items section of this document for more detail.

FY 23-24

R2 BEHAVIORAL HEALTH PROGRAMS: Staff recommends a net increase of $76.2 million total funds, including $45.4 million General Fund, for projected changes in caseload, per capita expenditures, and

fund sources for behavioral health services. *That change is relative to the FY 2022-23 appropriation assuming the adjustments recommended above for the Long Bill supplemental.* The forecast anticipates decreased enrollment in FY 2023-24 with the expiration of the public health emergency and anticipated disenrollments from Medicaid. However, anticipated increases in per capita expenses and the annualization of the risk corridor and medical loss ratio adjustments from FY 2022-23 more than offset the decrease associated with enrollment. In addition, tapering down the enhanced federal match will increase necessary General Fund. See the discussion of R2 in the Decision Items section of this document for more detail.

OTHER DECISION ITEMS

R12 NON-MEDICAID BH ELIGIBILITY & CLAIMS: The recommendation includes an increase of $2.8 million General Fund, increasing to $3.1 million and 10.0 FTE in FY 2024-25, for ongoing operation of information technology systems that support eligibility determinations, claims processing, and data reporting for non-Medicaid behavioral health services. The Department previously received funding for development of the systems and the recommendation would provide ongoing support for the system as well as analytics staff to utilize the data generated through the system.

BA11 BEHAVIORAL HEALTH CRISIS RESPONSE FUNDING: The recommendation includes an increase of $203,040 General Fund for FY 2023-24 associated with the implementation of statewide training for the crisis response system required by H.B. 21-1166 (Behavioral Health Crisis Response Training) and H.B. 22-1189 (Behavioral Health Crisis Response Training Deadlines, a JBC bill). The Department's FY 2022-23 supplemental bill (S.B. 23-117) reduced the FY 2022-23 appropriation for this purpose by $135,360 General Fund based on delays in implementation of the program. The staff recommendation for the supplemental bill anticipated the need for an appropriation of $203,040 in FY 2023-24 to allow the Department to make all of the expenditures for the program in that fiscal year.

MAJOR DIFFERENCES FROM THE REQUEST

Almost all of the difference between the JBC staff recommendation and the Department request is attributable to the JBC staff using the Department's February 2022 forecast of expenditures for Behavioral Health, the Children's Basic Health Plan, and the Medicare Modernization Act.

DECISION ITEMS

ENROLLMENT/UTILIZATION TRENDS

Requests R1 through R5 changes to both FY 2022-23 and FY 2023-24 based on a new forecast of caseload and expenditures under current law and policy (only R2 is addressed in this document). They are described as requests by the Department, but they are not really discretionary, because they represent what the Department expects to spend absent a change in current law or policy. Most of Medicaid operates as an entitlement program, meaning that the people determined eligible have a legal right to the plan benefits. The Department has specific statutory authority, in Section 24-75-109 (1)(a), C.R.S., to overexpend the Medicaid appropriation, if necessary to pay the plan benefits. If the Department's forecast is correct, then these expenditures will happen and the only way to prevent

them from happening, or to change the level of expenditures, would be to change current law or policy, such as adjusting the eligibility criteria, plan benefits, or provider rates.

On February 17, 2023, the Department submitted an update to the forecast requests. This update is not an "official" request and it is not accounted for in the Governor's budget balancing. It was submitted after the General Assembly's budget request deadlines. However, it represents the most current forecast of expenditures available. The November 2022 forecast used for the Governor's request incorporated data through June 2022. The February 2022 forecast incorporates data through December 2022 and also incorporates the changes to federal law relating to the enhanced federal match for Medicaid and the contiguous coverage provisions that have prohibited disenrollment of Medicaid members throughout the public health emergency.

- As the Committee has discussed previously, the enhanced federal match will begin stepping down in April 2023, from 6.2 percent through March 31 to 5.0 percent for April 1 through June 30, 2.5 percent for July 1 through September 30, and 1.5 percent through the end of the calendar year. The February forecast accounts for this transition, with federal funds higher than anticipated in the November request throughout the forecast period.
- The changes to federal law also terminate the contiguous coverage provision as of March 31, 2023. As a result, states will begin the process of disenrolling members that are no longer eligible in April, with that process expected to take a year to complete. That certainty is driving anticipated reductions in enrollment/membership in FY 2023-24.

➔ R2 BEHAVIORAL HEALTH

R2 BEHAVIORAL HEALTH

REQUEST

The Department requests a change to the Behavioral Health Community Programs for both FY 2022-23 and FY 2023-24 based on a new forecast of caseload and expenditures under current law and policy. Behavioral health services, which include both mental health and substance use-related services, are provided to Medicaid clients primarily 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]. 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. These rates are periodically adjusted based on clients' actual utilization of behavioral health services and the associated expenditures.

On February 17, 2023, the Department submitted an update to the R2 forecast. This update is not an "official" request and it is not accounted for in the Governor's budget balancing. It was submitted after the General Assembly's budget request deadlines. However, it represents the most current forecast of expenditures available. Compared to the Governor's request, the February 2023 forecast is lower in FY 2022-23 by $38.1 million total funds, including a reduction of $24.0 million General Fund, and higher in FY 2023-24 by $93.9 million total funds, including an increase of $13.3 million General Fund. The cumulative General Fund difference over the two years is $10.7 million lower than the Governor's November request.

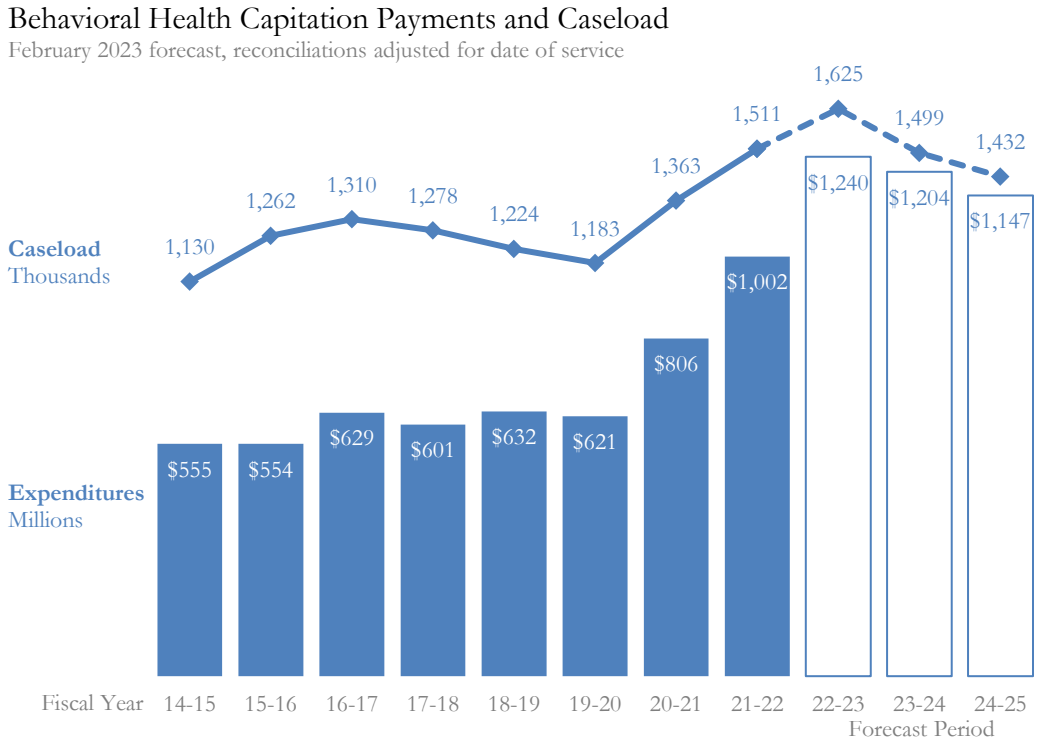
RECOMMENDATION

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

Staff recommends using the Department's February 2023 forecast of enrollment and expenditures to modify both the FY 2022-23 and FY 2023-24 appropriations. This is the best estimate available of what the actual costs will be for the program based on current law and policy. As noted above, the cumulative General Fund difference over the two years is $10.7 million lower than the Governor's official request for FY 2022-23 (including the supplemental already passed by the General Assembly) and FY 2023-24 (including budget amendment BA2).

The chart below summarizes trends in behavioral health capitation payments and caseload. To offer a better sense of the relationship between caseload and expenditures, reconciliation payments and savings have been adjusted to appear in the fiscal year when the service was provided. This is different from the way the money is appropriated, which is based on when the expenditures or savings impact the state's cash flow.

There can be lags between when changes in utilization and cost of care are picked up in the behavioral health rates. For example, in FY 2015-16 capitation rates for many eligibility groups went down based on cost of care data from the prior year, helping to explain why overall expenditures decreased that year when overall enrollment increased.



In FY 2017-18 rates went down due to a change in federal managed care rules that limited how much Colorado could pay providers. In FY 2018-19 and FY 2019-20 the reductions in overall caseload were primarily in low utilizers of behavioral health services and the remaining members were higher utilizers, resulting in an increase in rates.

The $325 million increase from FY 2020-21 to FY 2021-22 is primarily due to higher rates ($104.4 million) driven by a higher percentage of Medicaid clients utilizing behavioral health services, the higher caseload ($83.1 million), and the ramp-up of the substance use disorder benefit ($73.8 million).

The rapid enrollment increase from FY 19-20 through FY 21-22 and the decrease from FY 22-23 through FY 24-25 is largely due to a provision of the federal Families First Coronavirus Response Act that gives continuous eligibility for Medicaid through the end of the federal public health emergency regardless of changes in family income. Beginning in April 2023, the Department will go through a process to disenroll people from Medicaid who are no longer eligible. To disenroll people the Department must collect the necessary documentation to redetermine eligibility, notify the client, and then work through appeals. The process is expected to take a year before enrollment reaches a new baseline level. Although the Department expects to complete the disenrollments in FY 23-24, the fiscal year will still include some months of very high enrollment.

FY 22-23

The table below shows the most significant factors driving the change in the forecast for FY 2022-23. Note that this table displays changes from the appropriation and not changes from FY 2021-22. As a result, a negative number may simply mean slower growth than had been assumed – and not a negative change year-over-year. Also, note that this table shows the change from the appropriation as adjusted by the regular supplemental bill rather than the change from the Governor's request.

FY 2022-23 Behavioral Health Enrollment/Utilization Trends				
	Total Funds	General Fund	Other State	Federal Funds
FY 2022-23 Appropriation	$1,176,260,183	$260,711,300	$89,414,007	$826,134,876
Enrollment	55,844,919	11,248,299	5,431,879	39,164,741
Per capita	5,327,161	473,884	(674,835)	5,528,112
Medical loss ratio reconciliation	(99,298,766)	(20,124,183)	(488,631)	(78,685,952)
Federal match for public health emergency	0	(15,610,937)	(1,130,174)	16,741,111
TOTAL	**$1,138,133,497**	**$236,698,363**	**$92,552,246**	**$808,882,888**
Increase/(Decrease)	(38,126,686)	(24,012,937)	3,138,239	(17,251,988)
Percentage Change	-3.2%	-9.2%	3.5%	-2.1%

Enrollment

The enrollment forecast increased partly due to the extension of the continuous coverage requirement under the federal public health emergency and partly due to higher year-to-date actuals.

Per Capita

The forecast makes true-ups to expected per capita costs.

Medical Loss Ratio and Risk Corridor Reconciliation

The forecast includes a decrease of $99.3 million total funds, including a decrease of $20.1 million General Fund for medical loss ratio adjustments and the risk corridor adjustment for the substance use disorder (SUD) benefit *relative to the current appropriation as adjusted by the supplemental bill.* The supplemental bill included a reduction of $7.0 million total funds associated with the medical loss ratio applied to the Regional Accountable entities *in FY 2020-21* – but the February forecast includes a

further decrease of $99.3 million which is driven by a risk corridor applied to substance use benefits *for FY 2021-22*.

As required by CMS, the Department's contract with the Regional Accountable Entities (RAEs) includes a risk corridor for the SUD benefit. If actual costs for the SUD benefit are higher or lower than the risk corridor, then the rate is adjusted the next year. In FY 21-22 the actual costs for the SUD benefit were lower than the risk corridor, decreasing the rates in FY 22-23 by $99.3 million relative to the amounts assumed in the November request and the Department's supplemental bill.

Federal match for public health emergency

The forecast includes a decrease of $15.6 million General Fund and a decrease in cash funds and a corresponding increase in federal funds associated with the extension of the federal public health emergency. As discussed above, the enhanced federal match will begin stepping down on a quarterly basis from April 1 through the end of the calendar year.

FY 23-24

The next table shows the most significant factors driving the forecasted change in expenditures from FY 2022-23 to FY 2023-24. Please note that this table is showing the year-over-year change from the forecasted expenditures in FY 2022-23 to FY 2023-24.

FY 2023-24 Behavioral Health Enrollment/Utilization Trends				
	Total Funds	General Fund	Other State	Federal Funds
FY 2022-23 Projection	$1,138,133,497	$236,698,363	$92,552,246	$808,882,888
Enrollment	(74,101,639)	(15,140,797)	(4,382,441)	(54,578,401)
Per capita	41,064,185	11,331,784	(4,314,492)	34,046,893
Annualize out medical loss ratio reconciliation	107,038,447	22,085,510	5,255,399	79,697,538
Federal match for public health emergency	0	26,691,579	1,902,579	(28,594,158)
TOTAL	**$1,212,134,490**	**$281,666,439**	**$91,013,291**	**$839,454,760**
Increase/(Decrease)	74,000,993	44,968,076	(1,538,955)	30,571,872
Percentage Change	6.5%	19.0%	-1.7%	3.8%

Enrollment

The forecast includes a projected 7.8 percent enrollment decrease, driven by the end of the federal public health emergency and the continuous coverage requirement.

Per capita

The forecast estimates a 5.3 percent increase in capitation rates based on utilization trends, continued ramp up of the new Substance Use Disorder (SUD) benefit, and an assumption that disenrollments due to the public health emergency will mostly be among low utilizers of behavioral health services.

Annualize SUD risk corridor adj.

The forecast includes a $107.0 million increase in total funds, including $22.1 million General Fund, to adjust for the medical loss ratio and risk corridor reductions in the FY 2022-23 appropriation (discussed above). The increase to annualize the risk corridor amount more than offsets the projected reduction in caseload.

Federal match for public health emergency

The forecast includes an increase of $26.7 million General Fund and an increase in cash funds and a corresponding decrease in federal funds associated with the end of the federal public health emergency.

➔ R12 NON-MEDICAID BH ELIGIBILITY & CLAIMS

REQUEST

Request R12 proposes an increase of 2.9 million General Fund and 8.4 FTE *for the Executive Director's Office*, increasing to $3.0 million and 10.0 FTE in FY 2024-25, for ongoing operation of information technology systems that support eligibility determinations, claims processing, and data reporting for non-Medicaid behavioral health services. As part of the Behavioral Health Administration (BHA) initiative, the Department previously received funding for development of the systems (with $7.5 million General Fund appropriated in FY 2021-22 and a total of $7.8 million in expenditures through FY 2022-23). The Behavioral Health Administration has not yet estimated or captured the expected financial efficiencies, but the Department anticipates needing money for ongoing operations beginning in FY 2023-24. The Department identified this request as theory-informed.

RECOMMENDATION

Staff recommends approving a total increase of $2.8 million General Fund and 8.0 FTE, increasing to $3.1 million and 10.0 FTE in FY 2024-25, for ongoing operation and analysis associated with the system. Given the resources already invested in the system, and what appears to be "upside" potential, staff recommends approving the requested resources to provide ongoing support for the roll-out of the new system. The following table shows the components of the recommendation, by line item.

R2 NON MEDICAID BH ELIGIBILITY AND CLAIMS

	FY 2023-24 REQUEST		FY 2023-24 REC.		FY 2024-25 IMPACT	
	GENERAL FUND	FTE	GENERAL FUND	FTE	GENERAL FUND	FTE
Line Item						
EDO, General Admin, Personal Services	$644,882	8.4	$663,671	8.0	$796,407	10.0
EDO, General Admin, Operating Expenses	70,906		78,850		13,500	
Leased Space	42,627		42,627		46,500	
IT - MMIS Maintenance and Projects	1,121,000		1,121,000		1,154,630	
IT - CBMS Operating and Contracts	859,220		859,220		884,997	
Subtotal (General Fund)	**$2,738,635**	**8.4**	**$2,765,368**	**8.0**	**$2,896,034**	**10.0**
Centrally appropriated line items	150,667		0		184,811	
Total - R12 (General Fund)	**$2,889,302**	**8.4**	**$2,765,368**	**8.0**	**$3,080,845**	**10.0**

The Committee may wish to consider a request for information that would go to both HCPF and the BHA asking for updates on the implementation of the system (across providers and across additional agencies) and the utility of the data/reporting at some point in the future. Staff suspects that a November 2023 response would not be very informative given the pace of "roll-out" and implementation. However, a November 2024 report to inform the budget process for FY 2025-26 could be more useful. If the Committee would like to make such a request, staff can work with the Department to develop it before the requests for information are sent.

BACKGROUND AND ANALYSIS

The General Assembly approved a decision item in FY 2021-22 appropriating $7.5 million General Fund to create this system. As shown in the table below (from the FY 2021-22 figure setting document), the request and funding included 23.0 temporary staff.[2] The Department reports approximately $7.8 million in total expenditures through FY 2022-23. Similar to this year's request, however, the bulk of the funding was actually for contract hours for development and testing of the components of the system, including changes to the Medicaid Management Information System (MMIS), the Business Intelligence Data Management System (BIDM), the Colorado Benefits Management System (CBMS), and the Program and Eligibility Application Kit (PEAK). The appropriation was for FY 2021-22 but included roll-forward authority allowing the Department to spend the money through FY 2022-23.

FY 2021-22 R23 BEHAVIORAL HEALTH CLAIMS AND ELIGIBILITY PROCESSING ESTIMATES FOR APPROPRIATIONS

	UNITS		RATE	TOTAL FUNDS
Temporary staff (including benefits)	23	FTE	$90,879.35	$2,090,225
MMIS				
System design and development	15,600	hrs	$116.00	1,809,600
Testing	5,200	hrs	$118.53	616,356
Call center support	4,160	hrs	$30.67	127,587
BIDM enhancements	3,600	hrs	$166.67	600,012
CBMS				
System design and development	13,000	hrs	$138.00	1,794,000
Testing	3,000	hrs	$143.00	429,000
TOTAL				$7,466,780

Requested as a "precursor" to the BHA initiative, the goal of the system is to leverage the Department's existing systems and experience and to standardize procedures across programs, creating a single point of access and fiscal management system for clients and providers in the publicly-funded behavioral health system. It is staff's understanding that the vision would include all claims information for *all* state/publicly funded behavioral health services, so that it would not matter whether a client was a Medicaid member, eligible through means tested programs through the BHA, eligible for non-means tested programs through the BHA, or receiving services through a behavioral health program funded through another agency.

It is staff's understanding that the Department anticipated (and continues to anticipate) several categories of benefit from the new system.

- *Clients/providers:* First, the decision item write-up focuses on reducing fragmentation in the behavioral health funding system (a common theme in requests associated with the Behavioral Health Administration), with clients and providers being able to access the system with no "wrong door" regardless of the agency/program paying for the services. The Department believes that the single fiscal management system will streamline the system for both providers and clients.
- *Double Billing:* Second, it is staff's understanding that part of the origin of this particular system was concern about potential "double billing" by providers that could bill both Medicaid and other programs (such as those in the BHA) for the same services. Without a single fiscal management system, proving or disproving such claims has been difficult. Staff notes that the Department (HCPF) has indicated that staff there still believe that it is "highly likely that double billing/payments is a problem." The current (manual) process

[2] The JBC Staff analysis of the original decision item is available beginning on page 70 of the FY 2021-22 figure setting document at: https://leg.colorado.gov/sites/default/files/fy2021-22_hcpfig1.pdf

for identifying such issues is time intensive. The single system would allow the Department to identify instances when an individual received a service that was billed/reimbursed across more than one program (intentionally or not) and provide additional support to providers to prevent those instances.

- *Analysis/System Improvement:* Third, the request includes analytical staff that would use the data in an effort to support the BHA in improving behavioral health services statewide by identifying gaps, underserved populations, etc. The Department reports that the analytical staff in this request are unique and not duplicative of the analytical staff actually requested by the BHA because the HCPF staff would be the only ones analyzing the claims/billing/encounters data provided by this system. The BHA staff would be directly analyzing other data sources and would be directing the analysis by the HCPF staff. In the end, the assumption is that the downstream impact would be improved services to clients.

The Department reports that the system is on schedule to begin operations in July 2023, as anticipated in the original decision item and has submitted R12 to provide the ongoing funds for both: (1) contract work to maintain/enhance the system; and (2) State FTE and associated costs to support the system and analyze the data collected through the system.

Maintenance/Enhancement Contracts: The request includes a total of $1,980,220 General Fund in contract money to maintain and enhance the system improvements, equating to 68.5 percent of the total request for $2,889,302 in FY 2023-24. That amount includes:

- $859,220 that would be reappropriated to the Governor's Office of Information Technology (OIT) to maintain and update the CMBC and PEAK systems (OIT has submitted a corresponding "non-prioritized" request). The Department reports that ongoing changes to eligibility requirements, regulations, additional programs, etc., will require ongoing updates to the system. The request also includes funding for "user acceptance testers to ensure system changes are implemented as intended.
- $761,000 to maintain system integrations for the MMIS system and to provide support to providers that are using the system. Similar to CBMS, the Department reports that the system will need to be updated on an ongoing basis. The Department has also included funding here to support new providers that are submitting claims/encounters into the new system, including call center support (with the MMIS vendor) for those providers.
- $360,000 to maintain and enhance the Department's data warehouse. The Department would contract with the vendor to scope, design, and develop new reports based on the new changes to the system.

Staff recommends approving the contract amounts. Given the amount that the State has already invested in the system, staff suggests that it is worth the investment to see whether it improves the experience of clients and providers – and provides the kind of data that would be useful for policy makers. The recommendation includes the following increases:

- $1,121,000 for the Information Technology Contracts and Projects – MMIS Maintenance and Projects line item.
- $859,220 for the Information Technology Contracts and Projects – Colorado Benefits Management Systems, Operating and Contracts line item.

Staff is admittedly uncertain how to evaluate the Department's estimates of the number of hours required for these updates – but agrees that not maintaining and updating the system as problems arise does not make sense if the General Assembly wishes to have a single system.

State FTE: The request includes a total of $909,082 General Fund associated with 8.4 state FTE (annualizing to $1,001,154 and 10.0 FTE in FY 2024-25).

- The FY 2023-24 total includes $150,667 in centrally appropriated amounts that the Committee would not fund in the first year under it's common policies for new FTE, bringing the total request associated with the new FTE down to $708,553.

- Applying the Committee's common policies for new FTE (eliminating the centrally appropriated items and updating for starting salaries and operating expenses) would bring the cost for all 10 positions to $785,148.
- The request assumes August 1 start dates for all positions, and staff recommends including that assumption for any positions approved by the Committee.

The requested positions include:

- A BHA MMIS Benefit Plan Analyst (Analyst IV, annual salary of $76,919) to conduct evaluations of policy, regulation, and rule change to determine the impact to system design and configuration and collaborate with the BHA, the MMIS vendor, and others that are potentially impacted by BHA changes.
- A BHA MMIS Claims Adjudication and Financial Analyst (Analyst IV, annual salary of $76,919) to conduct evaluations of the claims payment policies that are applied to BHA payments and identify the appropriate fund codes for the BHA financial team to ensure that payments are property assigned to the necessary programs (including clients that may have multiple program coverages).
- A BHA Policy Specialist (Policy Advisor IV, annual salary of $76,919) to provide ongoing technical maintenance and support for benefit and managed care policies specific to the BHA. The position would serve as the liaison between the BHA and HCPF on policy matters specific to state-wide behavioral health services and alignment with Medicaid.
- A BHA Rates Analyst (Rate and Financial Analyst IV, annual salary of $89,050) to coordinate with the BHA on various rates and data analysis to align capitation and provider reimbursements under Medicaid with the BHA payments.
- A BHA Data & Analytics Supervisor (Statistical Analyst IV, annual salary of $94,715) to supervise the analytics team and take on advanced reporting and "dashboarding" responsibilities.
- A BHA Data Analyst (Statistical Analyst II, annual salary of $74,209) to query the data warehouse and pull claims and other data sets to perform analysis, including statistical work as well as data visualizations.
- A BHA Reporting Analyst (Analyst IV, annual salary of $76,919) to ensure that BHA reporting needs from the data warehouse are met through change requirements and business requirements. This position would be the liaison between the BHA and the HCPF data warehouse vendor to ensure that reporting requirements are met.
- An Eligibility Systems Analyst (Analyst IV, annual salary of $76,919) to provider operations an business analyst expertise to the Medicaid Operations Office related to BHA priorities. The Department says the position would require a strong working knowledge of Medicaid/CHP+, CBMS, and PEAK, and would be responsible for ensuring that reporting meets the BHA's needs while staying in compliance with other laws and regulations.
- A BHA Eligibility Policy Specialist (Policy Advisor IV, annual salary of $76,919) that would be responsible for researching and responding to eligibility policies as they relate to the BHA. The position would serve as the liaison between the BHA and the Medicaid eligibility policy staff to maximize alignment between the two entities.
- A PEAKP Pro Supervisor (Analyst IV, annual salary of $76,919) to be accountable for coordination between the Department and relevant stakeholders regarding technical support for the PEAK system (which is the interface that providers use to access the fiscal management system). This position would lead PEAK projects and be responsible for training efforts for providers.

Given the resources that the General Assembly has invested in the system to date, staff is inclined to recommend the requested FTE. Combined with the BHA initiative, these positions appear to be responsive to likely needs under the system. The staff recommendation would include:

- $663,671 and 8.0 FTE for the Executive Director's Office, General Administration, Personal Services line item (increasing to $796,407 and 10.0 FTE in FY 2024-25). The 8.0 FTE in FY 2023-24 aligns with the August 1 start date for 10.0 positions, and the personal services amounts are set based on the minimum salaries for each position.

- $78,850 for Executive Director's Office, General Administration, Operating Expenses (decreasing to $13,500 in FY 2024-25).
- $42,627 for leased space costs for the new FTE.

The recommendation does not include $150,532 in centrally appropriated amounts for the new FTE in FY 2023-24 but would anticipate a need for $184,811 for those purposes in FY 2024-25.

As the Committee considers the recommendation and the overall situation with the BHA, staff notes the following, framed as questions that the Committee may be asking.

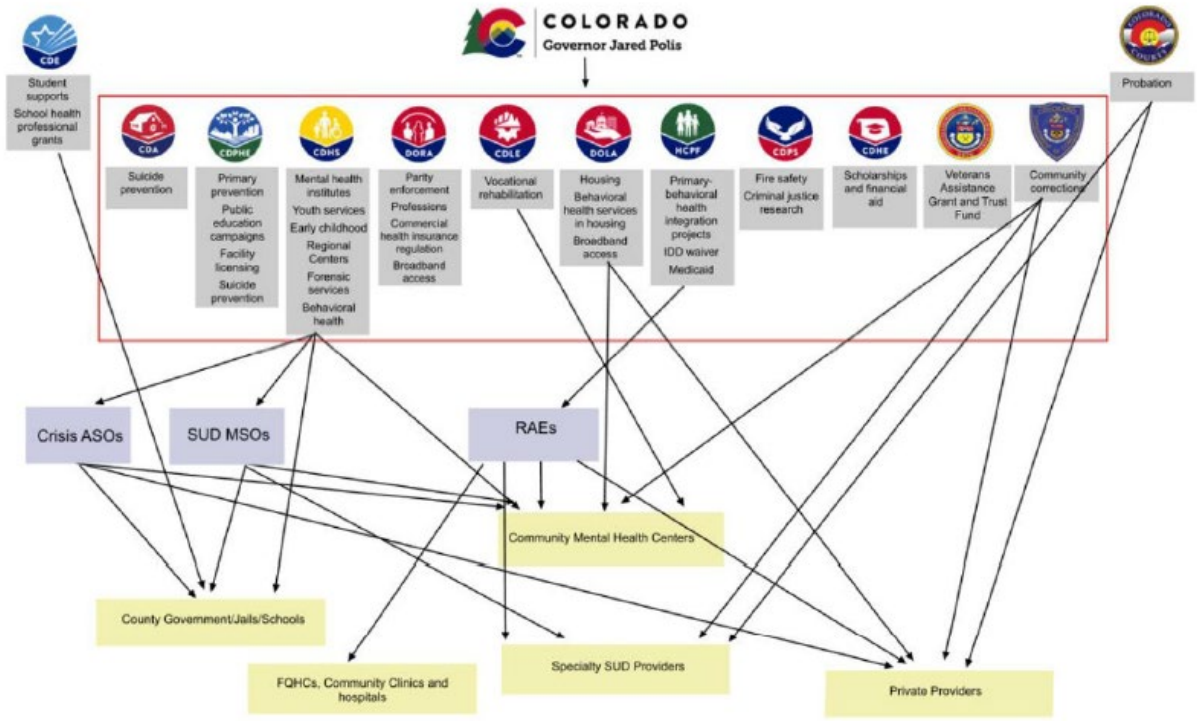
Why are these positions in HCPF rather than the BHA, as it would appear that they would primarily be responsive to the needs of the BHA? According to the Department, federal law (HIPAA) requires the employees that would have access to the Medicaid data to be HCPF employees. The HCPF employees can have access to the BHA data because HCPF is the BHA's "third party administrator" but the direct BHA staff cannot have access to the Medicaid information. As a result, it would appear that HCPF does require staff to analyze the information and ensure that any data provided to the BHA complies with those requirements.

Why is additional funding/staff necessary, and why is this all General Fund? The Department's existing staff are heavily federally funded and cannot work on this system without billing that time to General Fund as the federal funds cannot be used to support a state-only system. Thus, standing up and supporting the new system, specifically to support programs other than Medicaid, requires 100 percent state funding.

Does this fully address the fragmentation that the departments have spoken of since before the creation of the BHA? The short answer is "no, at least not in the near term." Since the Behavioral Health Task Force first proposed the creation of a BHA, the Committee has received many documents pointing to a 2020 Colorado Health Institute study that identified $1.4 billion in state funds for behavioral health spread across 75 programs and multiple agencies. Those discussions have often included the graphic that staff has included on the following page.

The graphic is used to illustrate the degree of fragmentation in the current system – which the BHA initiative is intended to address. It also shows the web of potential programs and agencies through which a client may receive (and a provider may bill for) services. Eligibility for each program is currently determined individually for each program, often by the providers using criteria from the state. This makes it likely that clients may get funneled to services that are less than ideal for their circumstances or may not find all the services for which they are eligible and would benefit. It also results in duplication of effort across programs and an administrative burden on both providers and program staff. The system addressed in R12 is intended to address those concerns.

However, it is important to note that, at least in the near term the system will only support HCPF and programs that are actually directly managed by the BHA. Other Human Services programs (such as forensics) and other agencies' programs will not flow through the system until at least a later date (the timing seems uncertain).



Is this system going to create efficiencies and savings? The original FY 2021-22 request indicated that the system could create efficiencies and savings that would offset the ongoing costs of maintenance and support of the system through administrative efficiencies (and potentially through the reduction/elimination of instances of double billing). At this point, HCPF notes that any administrative savings would occur in other departments. Staff is not aware of any such savings identified to date and is skeptical that such an identification will happen.

➔ BA11 BEHAVIORAL HEALTH CRISIS RESPONSE FUNDING

REQUEST

The Department's official request proposes an increase of $135,360 General Fund associated with the implementation of statewide training for the crisis response system required by H.B. 21-1166 (Behavioral Health Crisis Response Training) and H.B. 22-1189 (Behavioral Health Crisis Response Training Deadlines, a JBC bill). Those bills require the Department to implement statewide training on a comprehensive care coordination and treatment model for providers serving people with intellectual and developmental disabilities and co-occurring behavioral health needs.

RECOMMENDATION

Based on updated information provided by the Department as well as the Committee's decision for the FY 2022-23 supplemental bill, staff recommends approving an increase of $203,040 General Fund for this purpose for FY 2023-24. While the original legislation assumed that expenditures would take place over in FY 2021-22 and FY 2022-23), delays in procurement have slowed implementation of the program and the Department now expects *all* expenditures for the program (a total of $203,040 based on the Final Legislative Council Staff Fiscal Note for H.B. 21-1166) will take place in FY 2023-24.

BACKGROUND AND ANALYSIS

House Bills 21-1166 requires the Department to implement statewide training on a comprehensive care coordination and treatment model for providers serving people with intellectual and developmental disabilities and co-occurring behavioral health needs. The bill set specific deadlines for procurement and the implementation of training. The bill appropriated $67,680 General Fund to the Department for FY 2021-22 to begin implementation and assumed an appropriation of $135,360 in FY 2022-23 to complete the trainings (that amount was appropriated in the FY 2022-23 Long Bill).

However, a failed procurement delayed the Department's implementation of the bill and the entire FY 2021-22 appropriation reverted to the General Fund. In 2022 the JBC sponsored H.B. 22-1189 to eliminate the deadlines from the original bill – but that bill did not adjust any of the appropriations. Following the reversion in FY 2021-22 and anticipating reversions in FY 2022-23, the Department is requesting adjustments in S11 to align appropriations with anticipated expenditures.

The following summarizes the timeline to date for the implementation of the program.

- June 15, 2021: Governor signs H.B. 21-1166 into law. The bill required the Department to procure a vendor to implement the training by January 1, 2022, regional service agencies to nominate up to 20 providers to receive the training by March 1, 2022, and selected providers to complete the training by March 30, 2023. The bill includes an appropriation of $67,680 General Fund for FY 2021-22 – and the Final Legislative Council Staff Fiscal Note for the bill estimates a need for $135,360 in FY 2022-23.
- October 27, 2021: The Department issues a solicitation for vendors to provide the training. However, no vendors responded to the solicitation. The Department did not have any costs associated with the bill in FY 2021-22 and reverted $67,680 to the General Fund.
- January 2022: The Department submits a supplemental request proposing to roll-forward the FY 2021-22 appropriation because of the lack of response to the solicitation. Instead, the JBC sponsors H.B. 22-1189 to eliminate the deadlines for procurement and adjust the deadlines for providers to identify participants (within 60 days of vendor selection) and to train participants (within 1 year of vendor selection). The bill does not include any changes to appropriations but the Final Legislative Council Staff Fiscal Note indicates that it assumes that any changes will be addressed through the budget process.
- April 2022: The FY 2022-23 Long Bill appropriates $135,360 for this training in FY 2022-23, consistent with the Fiscal Note's expectations for year 2 of implementation.
- October 11, 2022: The Department issues a second solicitation and receives one response. As of January 2023, the Department is still in negotiations with the vendor.
- January 2023: The Department submits S11/BA11 proposing to align appropriations for the program with the current timeline for implementation (reducing the appropriation for FY 2022-23 by $67,680 and proposing an appropriation of $135,360 for FY 2023-24).

While the request assumes that the Department would spend $67,680 in FY 2022-23, the Department now reports that "it has recently become clear through this [procurement and negotiation] process that the vendor will not be able to start the trainings until FY 2023-24, with training cohorts taking place in the fall of 2023 and the spring of 2024. All of the work will be completed in FY 2023-24."

Based on that information, the Department submitted revised tables to JBC Staff proposing to eliminate the entire appropriation of $135,360 General Fund for FY 2022-23 and instead appropriate a total of $203,040 General Fund for FY 2023-24. That amount aligns with the total appropriation anticipated in the original legislation but would make the entire appropriation in FY 2023-24 rather than spreading the amount over two years.

(3) BEHAVIORAL HEALTH

This section provides funding for Medicaid clients' behavioral health care. Most mental health and substance use disorder 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 certain behavioral health services that are not covered by the capitation program. 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.

BEHAVIORAL HEALTH COMMUNITY PROGRAMS						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2022-23 Appropriation						
H.B. 22-1329 (Long Bill)	$1,131,039,135	$272,281,483	$84,161,905	$0	$774,595,747	0.0
Other Legislation	45,221,048	(11,570,183)	5,252,102	0	51,539,129	0.0
Recommended Long Bill Add-on	(38,126,686)	(24,012,937)	3,138,239	0	(17,251,988)	0.0
TOTAL	**$1,138,133,497**	**$236,698,363**	**$92,552,246**	**$0**	**$808,882,888**	**0.0**
FY 2023-24 RECOMMENDED APPROPRIATION						
FY 2022-23 Appropriation	$1,138,133,497	$236,698,363	$92,552,246	$0	$808,882,888	0.0
R2 Behavioral Health	76,203,576	45,426,079	(1,413,228)	0	32,190,725	0.0
R7 Provider rates	277,717	61,548	16,743	0	199,426	0.0
R10 Children with complex needs	6,070,873	2,974,728	0	0	3,096,145	0.0
Annualize prior year budget actions	(2,202,583)	(458,003)	(125,727)	0	(1,618,853)	0.0
TOTAL	**$1,218,483,080**	**$284,702,715**	**$91,030,034**	**$0**	**$842,750,331**	**0.0**
INCREASE/(DECREASE)	**$80,349,583**	**$48,004,352**	**($1,522,212)**	**$0**	**$33,867,443**	**0.0**
Percentage Change	7.1%	20.3%	(1.6%)	0.0%	4.2%	0.0%
FY 2023-24 EXECUTIVE REQUEST	**$1,124,408,166**	**$271,430,134**	**$82,965,102**	**$0**	**$770,012,930**	**0.0**
Request Above/(Below) Recommendation	($94,074,914)	($13,272,581)	($8,064,932)	$0	($72,737,401)	0.0

LINE ITEM DETAIL

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[3]. The Department used a competitive bid process to award RAE contracts for each region.

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

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.

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)[4]. 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[5].

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

- prevention/early intervention services
- vocational services
- clubhouse and drop-in center services
- 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)[6].
- respite care
- recovery services

[4] 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.
[5] HCPF previously limited these payments to 45 days, but this limitation has been removed.
[6] Ibid.

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**[7]:

- 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):

- *Services Provided Through Primary Care.* The Medical Service Premiums line item appropriation to HCPF covers 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 expenditures are limited to six visits per client per state fiscal year. The services include:
    - diagnostic evaluation without medical services;
    - individual psychotherapy for up to 60 minutes; and
    - family psychotherapy.
- *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

[7] 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.

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, 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: The Department's request includes changes associated with requests *R2 Behavioral health*, *R10 (Children with Complex Needs, addressed in a separate figure setting presentation on March 8, 2023),* and annualizations of prior year budget actions.

RECOMMENDATION: The staff recommended changes are summarized in the table below. The total amount is pending the Committee's decisions regarding request R10 (Children With Complex Needs). Staff will incorporate the Committee's decisions on that time into the Long Bill appropriation. See the descriptions of the decision items for more detail.

BEHAVIORAL HEALTH COMMUNITY PROGRAMS, BEHAVIORAL HEALTH CAPITATION PAYMENTS

	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2022-23 APPROPRIATION						
H.B. 22-1329 (Long Bill)	$1,118,068,471	$269,399,988	$83,315,662	$0	$765,352,821	0.0
Other Legislation	$46,775,087	($11,110,422)	$5,383,252	$0	$52,502,257	0.0
Recommended Long Bill Add-on	(38,305,489)	(23,904,020)	3,097,645	0	(17,499,114)	0.0
TOTAL	**$1,126,538,069**	**$234,385,546**	**$91,796,559**	**$0**	**$800,355,964**	**0.0**
FY 2023-24 RECOMMENDED APPROPRIATION						
FY 2022-23 Appropriation	$1,126,538,069	$234,385,546	$91,796,559	$0	$800,355,964	0.0
R2 Behavioral Health	77,129,185	45,374,249	(1,300,690)	0	33,055,626	0.0
R10 Children with complex needs	6,070,873	3,035,437	0	0	3,035,436	0.0
Annualize prior year budget actions	(2,228,413)	(463,741)	(127,412)	0	(1,637,260)	0.0
TOTAL	**$1,207,509,714**	**$282,331,491**	**$90,368,457**	**$0**	**$834,809,766**	**0.0**
INCREASE/(DECREASE)	**$80,971,645**	**$47,945,945**	**($1,428,102)**	**$0**	**$34,453,802**	**0.0**
Percentage Change	7.2%	20.5%	(1.6%)	0.0%	4.3%	0.0%
FY 2023-24 EXECUTIVE REQUEST	**$1,113,835,257**	**$269,039,402**	**$82,325,517**	**$0**	**$762,470,338**	**0.0**

BEHAVIORAL HEALTH COMMUNITY PROGRAMS, BEHAVIORAL HEALTH CAPITATION PAYMENTS						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
Request Above/(Below) Recommendation	($93,674,457)	($13,292,089)	($8,042,940)	$0	($72,339,428)	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: The Department's request includes changes associated with *R2 Behavioral health*, *R7 Provider rates*, and the annualization of prior year budget actions (in this case provider rate appropriations in FY 2022-23).

RECOMMENDATION: The staff recommended changes are summarized in the table below. See the descriptions of the decision items for more detail. Request R7 (Provider Rates) was previously addressed in a separate figure setting presentation on March 8, 2023.

BEHAVIORAL HEALTH COMMUNITY PROGRAMS, BEHAVIORAL HEALTH FEE-FOR-SERVICE PAYMENTS						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2022-23 APPROPRIATION						
H.B. 22-1329 (Long Bill)	$12,970,664	$2,881,495	$846,243	$0	$9,242,926	0.0
Recommended Long Bill Add-on	$178,803	($108,917)	$40,594	$0	$247,126	0.0
Other Legislation	(1,554,039)	(459,761)	(131,150)	0	(963,128)	0.0
TOTAL	**$11,595,428**	**$2,312,817**	**$755,687**	**$0**	**$8,526,924**	**0.0**
FY 2023-24 RECOMMENDED APPROPRIATION						
FY 2022-23 Appropriation	$11,595,428	$2,312,817	$755,687	$0	$8,526,924	0.0
R7 Provider rates	277,717	61,548	16,743	0	199,426	0.0
Annualize prior year budget actions	25,830	5,738	1,685	0	18,407	0.0
R2 Behavioral Health	(925,609)	51,830	(112,538)	0	(864,901)	0.0
TOTAL	**$10,973,366**	**$2,431,933**	**$661,577**	**$0**	**$7,879,856**	**0.0**
INCREASE/(DECREASE)	**($622,062)**	**$119,116**	**($94,110)**	**$0**	**($647,068)**	**0.0**
Percentage Change	(5.4%)	5.2%	(12.5%)	0.0%	(7.6%)	0.0%
FY 2023-24 EXECUTIVE REQUEST	**$10,572,909**	**$2,390,732**	**$639,585**	**$0**	**$7,542,592**	**0.0**
Request Above/(Below) Recommendation	($400,457)	($41,201)	($21,992)	$0	($337,264)	0.0

LONG BILL FOOTNOTES AND REQUESTS FOR INFORMATION

LONG BILL FOOTNOTES

The FY 2022-23 Long Bill did not include any footnotes specific to the behavioral health community programs.

REQUESTS FOR INFORMATION

Likewise, there were no legislative requests for information specific to the behavioral health community programs for FY 2022-23.

Appendix A: Numbers Pages

	FY 2020-21 Actual	FY 2021-22 Actual	FY 2022-23 Appropriation	FY 2023-24 Request	FY 2023-24 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 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	811,992,425	852,041,516	1,126,538,069	1,113,835,257	1,207,509,714	*
General Fund	173,123,597	0	234,385,546	269,039,402	282,270,782	
Cash Funds	52,718,658	63,158,906	91,796,559	82,325,517	90,368,457	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	586,150,170	788,882,610	800,355,964	762,470,338	834,870,475	
Behavioral Health Fee-for-service Payments	14,851,894	12,592,071	11,595,428	10,572,909	10,973,366	*
General Fund	2,692,858	2,280,953	2,312,817	2,390,732	2,431,933	
Cash Funds	989,215	871,824	755,687	639,585	661,577	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	11,169,821	9,439,294	8,526,924	7,542,592	7,879,856	
TOTAL - (3) Behavioral Health Community Programs	826,844,319	864,633,587	1,138,133,497	1,124,408,166	1,218,483,080	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	175,816,455	2,280,953	236,698,363	271,430,134	284,702,715	
Cash Funds	53,707,873	64,030,730	92,552,246	82,965,102	91,030,034	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	597,319,991	798,321,904	808,882,888	770,012,930	842,750,331	

	FY 2020-21 Actual	FY 2021-22 Actual	FY 2022-23 Appropriation	FY 2023-24 Request	FY 2023-24 Recommendation
TOTAL - Department of Health Care Policy and Financing	826,844,319	864,633,587	1,138,133,497	1,124,408,166	1,218,483,080
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	175,816,455	2,280,953	236,698,363	271,430,134	284,702,715
Cash Funds	53,707,873	64,030,730	92,552,246	82,965,102	91,030,034
Reappropriated Funds	0	0	0	0	0
Federal Funds	597,319,991	798,321,904	808,882,888	770,012,930	842,750,331