JOINT BUDGET COMMITTEE

STAFF FIGURE SETTING
FY 2024-25

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

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

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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
- **Behavioral Health Community Programs** – provides capitated managed care payments for mental health and substance use disorder treatment
- **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 2023-24 APPROPRIATION						
FY 2023-24 Appropriation	$15,340,335,131	$4,509,692,766	$1,788,606,414	$117,280,880	$8,924,755,071	805.5
Long bill supplemental	(348,990,191)	(56,920,693)	(31,583,344)	0	(260,486,154)	0.0
TOTAL	**$14,991,344,940**	**$4,452,772,073**	**$1,757,023,070**	**$117,280,880**	**$8,664,268,917**	**805.5**
FY 2024-25 RECOMMENDED APPROPRIATION						
FY 2023-24 Appropriation	$14,991,344,940	$4,452,772,073	$1,757,023,070	$117,280,880	$8,664,268,917	805.5
Enrollment/utilization trends						
R1 Medical Services Premiums	488,069,566	310,722,337	48,532,452	0	128,814,777	0.0
R2 Behavioral Health	(109,762,232)	(10,980,415)	(7,628,662)	0	(91,153,155)	0.0
R3 Child Health Plan Plus	71,926,571	15,997,713	9,821,673	0	46,107,185	0.0
R4 Medicare Modernization Act	(729,368)	(729,368)	0	0	0	0.0
R5 Office of Community Living	45,002,004	28,990,641	2,467,507	0	13,543,856	0.0
BA9 Public school health services	9,682,177	0	9,246,240	0	435,937	0.0
Eligibility/benefit changes						
R9 Access to benefits	308,000	153,999	0	0	154,001	0.9
Provider rates						
R6a Provider rates	181,974,452	69,860,142	7,242,701	0	104,871,609	0.0
R6b Targeted provider rates	198,389,998	57,140,818	27,182,819	0	114,066,361	0.0
Administration and other						
R7 Behavioral health continuum	4,382,060	934,458	316,094	0	3,131,508	1.4
R8 Eligibility process compliance	8,479,360	788,878	633,101	0	7,057,381	1.8

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
R10 Assessments for skilled nursing	1,938,600	484,650	0	0	1,453,950	0.0
R11 Program support	570,508	223,810	16,635	0	330,063	2.9
R12a Accessibility	353,971	134,310	42,675	0	176,986	0.9
R12b Senior dental administration	75,000	75,000	0	0	0	0.0
R13 Convert contracts to FTE	133,723	(53,845)	(33,016)	307,417	(86,833)	12.6
R14 Contract true up	43,910	90,668	(47,844)	0	1,086	0.0
R15 Denver Health	0	0	0	0	0	0.0
BA6 Public health emergency unwind	21,670,244	5,378,942	1,805,859	0	14,485,443	3.2
BA7 Transportation credentialing and reviews	279,533	83,861	55,907	0	139,765	0.7
BA8 Community-based access to services	118,959	325,564	19,150	0	(225,755)	0.0
BA10 CO Benefits Management System	0	0	0	0	0	0.0
BA11 ARPA HCBS adjustments	4,608,068	0	2,495,840	0	2,112,228	29.0
BA14 Legal services	237,200	71,160	47,440	0	118,600	0.0
DACA Recipients	(2,061,189)	(1,030,594)	0	0	(1,030,595)	0.0
Autism report	(62,000)	(31,000)	0	0	(31,000)	0.0
Payments to OIT	7,888,029	1,665,364	688,427	1,068,127	4,466,111	0.0
Centrally appropriated items	10,530,499	4,757,805	781,868	23,179	4,967,647	0.0
Human Services	3,868,746	2,786,159	(47,820)	0	1,130,407	0.0
Transfers to other departments	745,851	352,690	0	0	393,161	0.0
Indirect costs	136,603	(136,603)	77,822	161,372	34,012	0.0
Annualize prior year funding	(53,277,109)	23,193,213	(63,660,167)	445	(12,810,600)	(24.2)
TOTAL	**$15,886,866,674**	**$4,964,022,430**	**$1,797,079,771**	**$118,841,420**	**$9,006,923,053**	**834.7**
INCREASE/(DECREASE)	**$895,521,734**	**$511,250,357**	**$40,056,701**	**$1,560,540**	**$342,654,136**	**29.2**
Percentage Change	6.0%	11.5%	2.3%	1.3%	4.0%	3.6%
FY 2024-25 EXECUTIVE REQUEST	**$16,460,377,917**	**$4,970,656,091**	**$1,844,949,470**	**$134,016,094**	**$9,510,756,262**	**832.2**
Request Above/(Below) Recommendation	$573,511,243	$6,633,661	$47,869,699	$15,174,674	$503,833,209	(2.5)

DESCRIPTION OF INCREMENTAL CHANGES

ENROLLMENT/UTILIZATION TRENDS

FISCAL YEAR 2023-24

LONG BILL SUPPLEMENTAL: Staff recommends a supplemental based on additional enrollment and utilization trends identified by the Department after the February forecast submission. In total, the supplemental represents a decrease of $26.9 million total funds, including an increase of $5.4 million General Fund, for behavioral health programs.

FISCAL YEAR 2024-25

R2 BEHAVIORAL HEALTH PROGRAMS: Staff recommends a decrease of $109.8 million total funds, including $11.0 million General Fund, for projected changes in caseload, per capita expenditures, and risk corridor reconciliation. The decrease is relative to the FY 2023-24 appropriation, assuming the adjustments recommended above for the Long Bill supplemental. The forecast anticipates decreased enrollment, but increases in per capita rates from the FY 2023-24 appropriation.

OTHER DECISION ITEMS

R7 BEHAVIORAL HEALTH CONTINUUM: The recommendation includes an increase of $4.4 million total funds, including $934,458 General Fund and 1.4 FTE, related to multiple behavioral health programs provided in the table below.

R7 BEHAVIORAL HEALTH CONTINUUM SUMMARY						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
IMD Stays	$2,450,304	$582,769	$162,017	$0	$1,705,518	0.0
Partial Hospitalization	1,025,500	243,900	67,807	0	713,793	0.0
Permanent Supportive Housing	661,532	0	71,697	0	589,835	0.0
Value Based Pricing Methodology	349,000	174,500	0	0	174,500	0.0
Housing and pricing FTE	145,724	58,289	14,573	0	72,862	1.4
SUD Admin Decrease	(250,000)	(125,000)	0	0	(125,000)	0.0
TOTAL	**$4,382,060**	**$934,458**	**$316,094**	**$0**	**$3,131,508**	**1.4**

ANNUALIZATIONS AND TECHNICAL ADJUSTMENTS

ANNUALIZE PRIOR YEAR FUNDING: The recommendation includes a net increase of $11,584 total funds to reflect the out-year impact of prior year budget actions. Details are provided in the table below.

ANNUALIZE PRIOR YEAR FUNDING						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 23-24 R7 rate adjustment	$11,584	$3,876	$749	$0	$6,959	0.0
FY 23-24 R10 Youth complex and co-occurring needs	0	60,709	0	0	(60,709)	0.0
TOTAL	**$11,584**	**$64,585**	**$749**	**$0**	**($53,750)**	**0.0**

MAJOR DIFFERENCES FROM THE REQUEST

The February Forecast and a FY 2023-24 rate adjustment provided in March constitute most of the difference between the request and recommendation. Staff also recommends a lower amount for R7 Behavioral Health Continuum to reflect Committee common policy on new FTE in the first year.

DECISION ITEMS

ENROLLMENT/UTILIZATION TRENDS

Requests R1 through R5 reflect changes to both FY 2023-24 and FY 2024-25 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.

➔ R2 BEHAVIORAL HEALTH

R2 BEHAVIORAL HEALTH

REQUEST

The Department requests a change to the Behavioral Health Community Programs for both FY 2023-24 and FY 2024-25 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 15, 2024, 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 is expected to represent the most current forecast of expenditures available. The February 2024 forecast is $108.8 million total funds, and $19.2 million General Fund, lower than the Governor's November request for FY 2023-24. The updated forecast is also $178.8 million total funds, and $23.0 million General Fund lower than the request for FY 2024-25. The base forecast represents a total General Fund difference of $42.2 million General Fund across both fiscal years.

On March 1, 2024, the Department amended the February forecast for Behavioral Health. Following greater than anticipated disenrollments from the public health emergency unwind, the Department conducted a review of FY 2023-24 to determine if rates were still actuarially sound. The review included utilization trends, cost trends, and patient acuity. The actuaries identified a variation from the

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

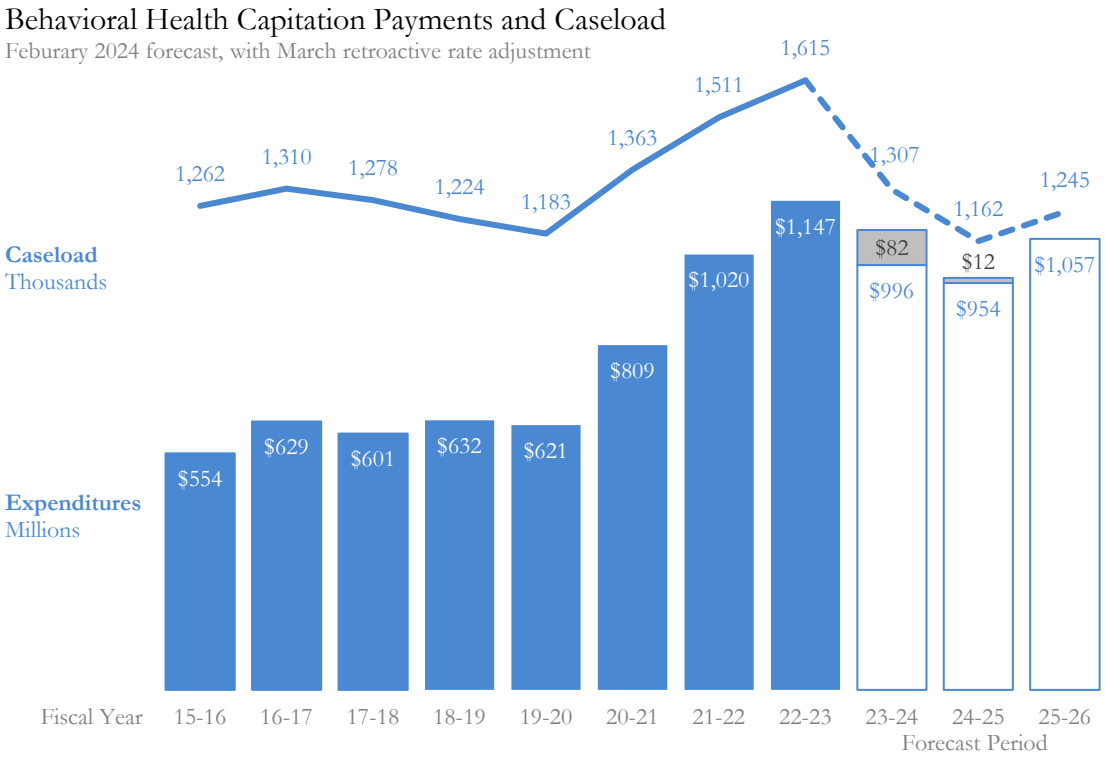
current rates larger than 1.5 percent from agreed-upon rates, triggering a rate adjustment under federal law (42 CFR 438.7). The rate adjustment will be retroactive to July 1, 2023.

The rate change results in an increase of $81.9 million total funds, including $24.6 million General Fund, above the February forecast for Behavioral Health capitated payments. Staff expects a rate increase to carry into FY 2024-25, but the Department indicates that FY 2024-25 rates will be under evaluation in the coming months. The Department intends to incorporate any potential FY 2024-25 rate adjustments into the November 2024 forecast and related budget request.

RECOMMENDATION

Staff recommends using the Department's February 2024 forecast of enrollment and expenditures to modify both the FY 2023-24 and FY 2024-25 appropriations. Staff further recommends approval of amounts associated with the retroactive rate adjustment for FY 2023-24, and carrying the adjustment forward into FY 2024-25.

The chart below summarizes trends in behavioral health capitation payments and caseload from the February forecast. The gray boxes in FY 2023-24 and FY 2024-25 represent the Department's proposed impact for the March retroactive payment increase.



PRIOR YEARS

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 2019-20 through FY 2021-22 and the decrease from FY 2022-23 through FY 2024-25 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.

FY 2023-24

The table below shows the most significant factors driving the change in the forecast for FY 2023-24. Note that this table displays changes from the appropriation and not changes from FY 2022-23. 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. Even with the retroactive rate increase, the forecast reflects a total decrease from the FY 2023-24 Supplemental appropriation but a General Fund increase.

FY 2023-24 Behavioral Health Enrollment/Utilization Trends				
	Total Funds	General Fund	Other State	Federal Funds
FY 2023-24 Supplemental Appropriation	$1,165,320,142	$278,093,995	$89,659,732	$797,566,415
Enrollment	(126,860,020)	(21,216,813)	(1,370,302)	(104,272,905)
Per capita	18,007,476	2,007,818	(4,903,417)	20,903,075
Retroactive rate increase	81,931,539	24,612,693	3,270,615	54,048,231
Total	**$1,138,399,137**	**$283,497,693**	**$86,656,628**	**$768,244,816**
Increase/(Decrease)	(26,921,005)	5,403,698	(3,003,104)	(29,321,599)
Percentage Change	(2.3%)	1.9%	(3.3%)	(3.7%)

Enrollment

The enrollment forecast adjustment is driven by disenrollments due to the public health emergency unwind.

Per Capita

The Department contracts with RAEs on an assumed per-member-per-month rate. Disenrollments are expected to skew toward low utilization, low acuity clients. Therefore, expenses realized by providers may not have decreased as significantly as enrollment changes would imply. Per capita rates are therefore expected to increase as enrollments decrease through the PHE unwind. The forecast adjusts rates based on the mix of members attributed to each RAE and lower-than-anticipated date of death retractions.

Retroactive Rate Increase

The increase reflects amended rates following actuarial reviews that identified a variation larger than 1.5 percent from agreed-upon rates, triggering a rate adjustment retroactive to July 1, 2023 under federal law. The increase is the result of trends described under the per capita section, where per-member rates are increasing as disenrollments skew toward low acuity, low utilization clients.

FY 2024-25

The retroactive rate adjustment submitted on March 1 only applies to FY 2023-24. The Department indicates that FY 2024-25 rates will be evaluated in the coming months and intends to reflect any rate changes in the 2024 November forecast and budget request submission. Staff assumes that rate increases should be anticipated to continue into FY 2024-25. The Department provided two options for FY 2024-25 detailed in the tables below. Option one reflects the February forecast without adjustment, and Option 2 carries the FY 2023-24 adjustment into FY 2024-25, but includes a risk corridor driving down the total impact.

HCPF Option 1: FY 2024-25 Behavioral Health February Forecast				
	Total Funds	General Fund	Other State	Federal Funds
FY 2023-24 Projection	$1,138,399,137	$283,497,693	$86,656,628	$768,244,816
Enrollment	(104,665,740)	(12,636,720)	(7,939,865)	(84,089,155)
Per capita	55,127,125	17,599,805	(244,927)	37,772,246
Annualize out retroactive rate increase	(81,931,539)	(24,612,693)	(3,270,615)	(54,048,231)
Annualize out 23-24 risk corridor and MLR	9,787,968	2,347,353	2,964,622	4,475,993
Removal of enhanced federal match	0	2,802,123	386,580	(3188,702)
TOTAL	**$1,016,716,951**	**$268,997,561**	**$78,552,423**	**$669,166,967**
Increase/(Decrease)	(121,682,186)	(14,500,132)	(8,104,205)	(99,077,849)
Percentage Change	(10.69%)	(5.11%)	(9.35%)	(12.90%)

HCPF Option 2: Maintain Retroactive Rate Increase				
	Total Funds	General Fund	Other State	Federal Funds
FY 2023-24 Projection	$1,138,399,137	$283,497,693	$86,656,628	$768,244,816
Enrollment	(104,665,740)	(12,636,720)	(7,939,865)	(84,089,155)
Per capita	55,127,125	17,599,805	(244,927)	37,772,246
Annualize out retroactive rate increase	0	0	0	0
Preliminary 24-25 risk corridor and MLR	(70,000,000)	(21,028,391)	(2,794,322)	(46,177,287)
Annualize out 23-24 risk corridor and MLR	9,787,968	2,347,353	2,964,622	4,475,993
Removal of enhanced federal match	0	2,802,123	386,580	(3188,702)
TOTAL	**$1,023,648,490**	**$271,079,834**	**$78,829,122**	**$673,739,534**
Increase/(Decrease)	(114,750,647)	(12,417,859)	(7,827,506)	(94,505,282)
Percentage Change	(10.08%)	(4.38%)	(9.03%)	(12.30%)

If the rate increase from FY 2023-24 is maintained, the Department recommends including a risk corridor to decrease the impact by $70.0 million total funds. The Department indicates that the amount is based on preliminary information on reconciliations attributable to FY 2022-23 utilization of the SUD inpatient residential benefit.

The forecast typically includes adjustments for Medical Loss Ratio (MLR) and risk corridor reconciliation. As required by CMS, the Department's contracts with RAEs include a risk corridor. If actual costs are higher or lower than the risk corridor, the rate is adjusted in a future fisacl year. Risk corridor adjustments may therefore vary greatly from year to year, and there is not a "typical" or expected amount to account for. Recent adjustments are included in the table below. Fiscal years 2022-23 and prior reflect actual expenditures, while FY 2023-24 and beyond reflect the data provided in the February forecast.

RECENT RISK CORRIDOR RECONCILIATIONS	
FY 2019-20	$0
FY 2020-21	13,389,550
FY 2021-22	(40,989,926)
FY 2022-23	(102,936,880)
FY 2023-24*	(9,787,968)
FY 2024-25*	9,787,968
FY 2025-26*	0

**Amounts reflected in the February 2024 forecast expected to change in future forecasts.*

The risk corridor proposed by the Department is associated with an inpatient and residential substance use disorder (SUD) benefit implemented in FY 2022-23 that has been under-utilized compared to the expenditure assumptions made by the Department when the benefit was implemented. The Department indicates that risk corridors are always included for new benefits as there is not data available to estimate utilization. Utilization has been under initial estimates, and under the risk corridor, in the first years of implementation.

The Department indicates that initial funding for the benefit included in 2022 was based on incomplete survey data extrapolated to ensure adequate funding would be available for the benefit. Over-estimates of utilization as well as start-up capacity constraints for providers were significant enough that impacts from FY 2022-23 are still being realized. The Department indicates that establishing new benefits often takes time to right-size true utilization, and anticipates that FY 2023-24 and ongoing rates are expected to more accurately reflect actual utilization following a few years of data collection.

The risk corridor included by the Department reflects under-utilization in FY 2022-23 that will impact payments to RAEs in FY 2024-25. The Department currently estimates that the impact will be $70.0-80.0 million total funds, but based on current understanding is most comfortable with assuming a $70.0 million decrease.

Staff questioned why the risk corridor was only incorporated if the rate increase is also incorporated, concerned that the Executive Branch was potentially underestimating General Fund costs in FY 2024-25 by not carrying the retroactive rate increase forward. However, the Department indicates that the two impacts (rate increase and risk corridor) are not known with certainty, but are expected to have impacts of similar magnitude in opposite directions. Therefore, the Committee should account for both or neither, but risks over-appropriating General Fund if the rate increase is accounted for in FY 2024-25 without the risk corridor.

Finally, providers have indicated concern that rate increases may not be passed on from the RAEs to providers. The Department indicates that federal regulation requires 85.0 percent of the capitation payment to be used on direct services. This amount constitutes the Medical Loss Ratio (MLR) that may be reconciled as part of the forecast. RAEs may have the flexibility to utilize funding for a range of priorities within their existing contracts, including:

- Increase payments for safety net providers;
- Increase access to SUD services;
- Support care for children and youth with high acuity needs; and/or
- Increase access to high intensity outpatient care.

The Department further specifies that the adjustment is based on the acuity level of Medicaid members and is considered payment in full for services to Medicaid members. The adjustment should not be considered as gap coverage for non-Medicaid members.

Realistically, the Committee will reconsider FY 2024-25 appropriations with better data in the next budget cycle. Staff recommends approval of the forecasted amounts provided in Option 2 to account for the current best estimate of ongoing impacts to behavioral health capitated payments.

OTHER DECISION ITEMS

➔ R7 BEHAVIORAL HEALTH CONTINUUM

R7 BEHAVIORAL HEALTH CONTINUUM

REQUEST: The request includes an increase of $4.4 million total funds, including $945,354 General Fund, and 1.4 FTE in FY 2024-25. The request includes increased funding related to increasing support for multiple programs within the behavioral health continuum of care as described below.

R7 BEHAVIORAL HEALTH CONTINUUM REQUEST SUMMARY

	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
IMD Stays	$2,450,304	$582,769	$162,017	$0	$1,705,518	0.0
Partial Hospitalization	1,025,500	243,900	67,807	0	713,793	0.0
Permanent Supportive Housing	661,532	0	71,697	0	589,835	0.0
Supportive Housing FTE	56,304	22,522	5,630	0	28,152	0.5
Value Based Pricing Methodology	349,000	174,500	0	0	174,500	0.0
Pricing Methodology FTE	116,658	46,663	11,666	0	58,329	0.9
SUD Admin Decrease	(250,000)	(125,000)	0	0	(125,000)	0.0
TOTAL	**$4,409,298**	**$945,354**	**$318,817**	**$0**	**$3,145,127**	**1.4**

RECOMMENDATION: Staff recommends an appropriation of $4.4 million total funds, including $934,458 General Fund and 1.4 FTE, in FY 2024-25. The recommendation includes all portions of the request without centrally appropriated line items to reflect Committee common policy for FTE in the first year.

ANALYSIS: The request includes four components described below. Approval or denial of any portion of the request does not require approval or denial of another portion.

INSTITUTES OF MENTAL DISEASE STAYS (IMD)

A facility with 16 or more beds primarily engaged in providing diagnosis, treatment, or care for individuals with mental health or substance use diagnoses is referred to as an Institute of Mental Disease (IMD). The federal government established an IMD exclusion in 1965 that prohibits states from receiving federal funding for stays within an IMD to reduce institutionalization and increase community based care.[2]

The Department covers eligible members for up to 15 days in an IMD as part of psychiatric inpatient coverage under the behavioral health capitation. Since 2016, federal restrictions allow federal match for IMD stays up to 15 days per calendar month only if a state has a Medicaid managed care plan and

[2] HCPF IMD Rule.

can offer IMD stays as an in-lieu-of-service.[3] Therefore, the Department currently reimburses IMD stays that do not exceed 15 days in a calendar month. A 16th day results in no payment for the stay at all.

The Department states that from 2020 to 2022 there was an average of 180 stays per year for members that need care longer than 15 days. The average length of stay from 2019 to 2022 varied from 28 to 34 days. Providers are not paid at all for services provided for those stays, resulting in an estimated 8,500 total IMD days per year that providers are currently not reimbursed. The current system incentivizes providers to prematurely discharge patients by the 15th day, which may not allow for appropriate treatment, transition planning, and cause patients to cycle back to high cost inpatient care due to premature discharge.

The request includes $2.5 million total funds, including $582,769 General Fund, to cover the first 15 days of IMD stays that exceed 15 days. The cost estimate includes daily cost of IMD stay, the current number of stays exceeding 15 days, and anticipated increases to the number of stays exceeding 15 days that would result from the policy change. The Department anticipates that it would need to amend the existing 1115 waiver to implement the request.

Under an 1115 IMD waiver, the Department could receive federal match for services provided in an IMD for up to 60 days per member, as long as the average length of stay does not exceed 30 days. While other states operate under this waiver, the request does not specify whether the Department intends to pursue an increased waiver or why it would not pursue this extension. During the briefing the Committee requested information from the Department regarding the cost of a 30- or 60-day waiver. The Department indicated that CMS offers a Serious Mental Illness (SMI)/Serious Emotional Disturbance (SED) 1115 waiver that allows states to pay for member stays in an IMD up to 60 days as long as the average length of stay does not exceed 30 days.

The Department contracted with Health Management Associates in 2020 to evaluate an SMI/SED 1115 waiver. The analysis concluded that the waiver would not significantly expand access to the IMD benefit in Colorado.[4] Impacts were not expected to be significant because only 2.7 percent of stays exceeded 15 days (under a system where stays over 15 days are not reimbursed). Implementation of the requested amounts to cover the first 15 days for days that exceed 15 days was expected to be the most impactful policy change. The report estimates a cost of $7.2 million total funds, including $1.8 million General Fund to cover an average length of stay up to 30 days.

PARTIAL HOSPITALIZATION PROGRAMS (PHP)

House Bill 18-1136 (Substance Use Disorder Treatment) required the Department to secure a 1115 SUD Demonstration Waiver to cover services rendered in Institutions for Mental Disease (IMD) and a State Plan Amendment to cover residential services in other settings. Currently, the Department provides SUD services under the waiver to ensure a full continuum of care. As part of the waiver, the Department must follow American Society of Addiction Medicine (ASAM) criteria, which range from early intervention to intensive inpatient services.

[3] https://www.macpac.gov/subtopic/payment-for-services-in-institutions-for-mental-diseases-imds/ https://www.kff.org/report-section/state-options-for-medicaid-coverage-of-inpatient-behavioral-health-services-report/

[4] IMD Waiver Implementation Plan Report (2023).

The Department currently covers all levels of ASAM care except Partial Hospitalization. Partial Hospitalization is available to non-Medicaid patients through 98 providers across the state. The Department states that many of these providers are Medicaid providers, but do not offer this level of care to Medicaid members as it is not a covered benefit. The program provides clinical outpatient support for 20 hours per week, 5 days a week.

The request includes an increase of $1.0 million total funds, including $243,900 General Fund, to implement the PHP level of care. The Department estimates a total cost of $6.4 million to implement the program, offset by an anticipated decrease of $5.4 million from patients currently in a higher or lower level of care that would be more appropriately served through PHP. The Department states that establishing this service as a Medicaid covered benefit will reduce unnecessary reliance on inpatient coverage for those who could be better served in the community, as well as a higher level of care for patients who may currently cycle through residential withdrawal services. The Department worked with providers to understand how the benefit would impact utilization, and anticipates that implementing the program could result in long-term savings from decreased reliance on inpatient care.

PERMANENT SUPPORTIVE HOUSING (PSP)

The Department has supported a Statewide Supportive Housing Expansion (SWSHE) pilot project in partnership with the Department of Local Affairs (DOLA) through ARPA funds approved in a FY 2021-22 budget request. The program is intended to assist unhoused Medicaid members with behavioral health needs in obtaining and retaining permanent housing. Participants receive housing vouchers from DOLA and tenancy support services through HCPF. Services include outreach, housing navigation, leasing navigation, and move-in assistance. Funding for the pilot is expected to expire December 2024.

The Department indicated that this portion of the request is evidence informed pursuant to S.B. 21-284 (Evidence-based Evaluations for Budget). CMS considers permanent supportive housing as an evidence-based practice that can improve outcomes for chronic health conditions, including behavioral health. The Executive Branch provided two reports from CMS and the Federal Department of Health and Human Services to support this level of evidence, and demonstrates that supportive housing can decrease emergency room visits, hospital stays, Medicaid costs, and criminal justice involvement.[5]

The Department intends to continue to research and collect data on program success through FY 2023-24 with existing funding. Research will be used to determine whether the Department will pursue additional funding in future fiscal years to expand access through a 1115 demonstration waiver. In the meantime, the Department can receive federal match to continue limited services for members with a behavioral health diagnosis through an existing 1915b(3) waiver. The Department anticipates that program participants are eligible for a 90.0 percent federal match under the Affordable Care Act.

The request includes $717,836 total funds, including $22,522 General Fund, and 0.5 FTE to continue housing support services for current providers and approximately 700 members being served by the pilot. Amounts reflect partial year funding beginning in January once ARPA funds are expected to be exhausted at the end of the calendar year. Funding will continue to support services for existing clients while the Department evaluates a 1115 waiver that would serve approximately 2,600 members per

[5] PSP Literature Review.

year. DOLA indicates that there are currently 3,000 permanent supportive housing units in the state, and anticipates an additional 300 units to be added annually.

The FTE is a continuation of administrative work currently supported with ARPA funds. The position is expected to oversee provider selection, data collection, regulatory revisions, and coordinate system changes. The position also ensures adherence to state and federal regulatory and contractual requirements. Calculations are based on DOLA's assumption that 30.0 percent of the 700 slots turnover each fiscal year, and 96.0 percent of new tenants require pre-tenancy services. This indicates a total of 202 new members served, each requiring 80 hours of case management service per year. Existing tenants are expected to require 10 hours of case management per year. Case management calculations provided by the Department reflect an hourly workload that would be associated with 9.9 FTE.

VALUE BASED PRICING METHODOLOGIES FOR SAFETY NET PROVIDERS

Senate Bill 19-222 (Individuals at Risk of Institutionalization) required the Department to create a behavioral health safety net system, and incentives for providers to accept Medicaid recipients with severe behavioral health disorders. The bill included a one-time appropriation of $150,000 total funds for the Department to hire a contractor to evaluate alternative payment plans. The fiscal note indicates that additional funding would be necessary in future fiscal years to actually implement provider incentives or address increased utilization.

House Bill 22-1278 (Behavioral Health Administration) charged the BHA with implementing a comprehensive behavioral health safety net system rather than HCPF. The bill further requires HCPF to align all community-based behavioral health safety net providers. The request notes that the Department has been coordinating with the BHA to identify viable payment reform options to embed quality-based metrics into the payment and reporting system for behavioral health.

The Department worked with a contractor through S.B. 19-222 to model rate methodologies for value-based payment (VBP) models for behavioral health safety net providers as defined by the BHA. VBP models are intended to reward inventive payments for the quality of care delivered by providers. VBP has the goal of moving toward compensating providers based on the quality, rather than the quantity of services delivered.[6]

The modeling resulted in selecting a single Prospective Payment System (PPS) rate for comprehensive providers, with carve outs for select services and utilization. PPS rates are payments for all services in a specific time period (day, month) based on historic utilization. The Department currently utilizes PPS rates to reimburse Federally Qualified Health Centers (FQHC), and PPS is utilized under the Certified Community Behavioral Health Clinic (CCBHC) model. Both FQHC and CCBHC are frequently noted by behavioral health safety net providers as having favorable payment structures.

The BHA has established standards for providers to become designated as comprehensive or essential safety net providers. Comprehensive providers are required to provide all safety net services as determined by the BHA and may not refuse service based on insurance. Essential providers may choose to provide one or more of the services required by comprehensive providers. Comprehensive providers are expected to receive the favorable PPS rate from HCPF while essential providers are not.

[6] CMS VBP Models.

The Department is required to establish requirements for cost-based reimbursements updated annually under H.B. 23-1236 (Implementation Updates to BHA). The fiscal note for the bill indicates that resources for ongoing reporting and services may be addressed as part of the annual budget process as potential cost drivers for the Department were unknown at the time.

The request includes $349,000 total funds, including $174,500 General Fund, on an ongoing basis to support a contractor to conduct actuarial analysis, rate reviews, and auditing for comprehensive provider PPS rates and the essential provider fee schedule to ensure compliance with statute. The amount is based on similar contracts the Department has procured in the past, and includes assumed fees and workload related to actuarial, analytical, accounting, auditing, and review rates.

The request also includes $116,658 total funds, including $46,663 General Fund, for 1.0 FTE ongoing to set fee schedule rates for the safety net system. Workload is based on comparable work for the HCBS waiver programs. The position would be responsible for cross-state research, working directly with clinical staff, BHA staff, and contractors to implement and maintain rates. Once rate methodologies are set, the Department will incorporate the fee schedule rates into the RAE capitation rates through the budget process. The Department specifies that the request is not aimed at increasing the types of services available, but may increase the provider network and incentivize higher quality of care.

SUBSTANCE USE DISORDER ADMIN DECREASE

The request includes a decrease of $250,000 total funds split equally between General Fund and federal funds. The decrease is for Substance Use Disorder (SUD) administration, used to offset the Partial Hospitalization portion of the request due to assumed cost savings from implementing PHP. The decrease brings the total budget for SUD administration to $1.3 million total funds, and decreases the impact of the PHP request to $775,500 total funds in FY 2024-25.

RECOMMENDATION

Staff recommends approval of the request without centrally appropriated line items to reflect Committee common policy for FTE in the first year. Staff finds that requested FTE are either related to existing positions or align with staffing for similar programs. Requested increases are expected to address long-standing gaps in care within the behavioral healthcare continuum.

(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 2023-24 Appropriation						
FY 2023-24 Appropriation	1,165,320,142	278,093,995	89,659,732	0	797,566,415	0.0
Long bill supplemental	($26,921,005)	$5,403,698	($3,003,104)	$0	($29,321,599)	0.0
TOTAL	**$1,138,399,137**	**$283,497,693**	**$86,656,628**	**$0**	**$768,244,816**	**0.0**
FY 2024-25 RECOMMENDED APPROPRIATION						
FY 2023-24 Appropriation	$1,138,399,137	$283,497,693	$86,656,628	$0	$768,244,816	0.0
R2 Behavioral Health	(109,762,232)	(10,980,415)	(7,628,662)	0	(91,153,155)	0.0
R6a Provider rates	251,738	55,821	15,178	0	180,739	0.0
R7 Behavioral health continuum	4,137,336	826,669	301,521	0	3,009,146	0.0
Annualize prior year funding	11,584	64,585	749	0	(53,750)	0.0
TOTAL	**$1,033,037,563**	**$273,464,353**	**$79,345,414**	**$0**	**$680,227,796**	**0.0**
INCREASE/(DECREASE)	**($105,361,574)**	**($10,033,340)**	**($7,311,214)**	**$0**	**($88,017,020)**	**0.0**
Percentage Change	(9.3%)	(3.5%)	(8.4%)	0.0%	(11.5%)	0.0%
FY 2024-25 EXECUTIVE REQUEST	**$1,199,781,438**	**$292,850,305**	**$91,910,564**	**$0**	**$815,020,569**	**0.0**
Request Above/(Below) Recommendation	$166,743,875	$19,385,952	$12,565,150	$0	$134,792,773	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[7]. The Department used a competitive bid process to award RAE contracts for each region.

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.

<u>Covered State Plan Services</u>

- 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)

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

- 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)[8]. 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. The decision item R7 Behavioral Health Continuum would allow the Department to apply for a waiver to cover the first 15 days of an IMD stay if the total stay exceeds 15 days.
    - 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[9].

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)[10].
- respite care
- recovery services

Each RAE receives a pre-determined monthly amount for each Medicaid client who is eligible for behavioral health services and enrolled with the RAE. The "per-member-per-month" rates paid to each RAE are unique for each Medicaid eligibility category in each geographic region. The Department adjusts these rates periodically based on historical rate experience and data concerning client service utilization. Currently, the Department divides the state into seven geographic regions for the provision of behavioral health services to the following **Medicaid eligibility categories**[11]:

- Adults age 65 and older;
- Children and adults with disabilities under age 65;
- Parents and caretakers;

[8] 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.
[9] HCPF previously limited these payments to 45 days, but this limitation has been removed.
[10] Ibid.
[11] 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.

- 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 Child Welfare or the DHS Division of Youth Services are enrolled in RAEs, and each RAE receives per-member-per-month payments for these individuals. However, if one of these children or youth is placed in a psychiatric residential treatment facility (PRTF) or a residential childcare facility (RCCF), the behavioral health services provided by that facility are not covered by the RAE and these costs are not considered as part of the associated per-member-per-month capitation rate. Instead, these costs are covered by appropriations of Medicaid funds to HCPF that are transferred to the DHS Division of Child Welfare and the Division of Youth Services.
- *Services for Individuals with Intellectual and Developmental Disabilities (IDD).* Individuals with IDD are enrolled in RAEs, and each RAE receives per-member-per-month payments for these individuals. However, for individuals who reside in a facility that is licensed as an "intermediate care facility" for individuals with IDD, the behavioral health services provided by that facility are not covered by the RAE and these costs are not considered as part of the associated per-member-per-month capitation rate. Instead, these costs are billed on a fee-for-service basis and are covered by other appropriations. Specifically:
    - For the Wheat Ridge Regional Center and for some beds within the Grand Junction Regional Center that are also licensed as an intermediate care facility, residents' behavioral health care services are covered by appropriations of Medicaid funds to HCPF that are transferred to DHS for these Regional Centers. In contrast, for individuals with IDD who reside in "adult comprehensive waiver homes" connected with the Grand Junction or Pueblo Regional Centers, 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*, *R7 Behavioral Health Continuum,* and annualizations of prior year budget actions.

RECOMMENDATION: **The staff recommendation is provided in the table below.**

BEHAVIORAL HEALTH COMMUNITY PROGRAMS, BEHAVIORAL HEALTH CAPITATION PAYMENTS						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2023-24 APPROPRIATION						
FY 2023-24 Appropriation	$1,152,693,941	$275,120,854	$88,913,362	$0	$788,659,725	0.0
Long bill supplemental	(26,205,413)	5,572,201	(2,960,804)	0	(28,816,810)	0.0
TOTAL	**$1,126,488,528**	**$280,693,055**	**$85,952,558**	**$0**	**$759,842,915**	**0.0**
FY 2024-25 RECOMMENDED APPROPRIATION						
FY 2023-24 Appropriation	$1,126,488,528	$280,693,055	$85,952,558	$0	$759,842,915	0.0
Enrollment/utilization						
R2a Behavioral Health forecast	(121,239,319)	(14,511,666)	(8,080,418)	0	(98,647,235)	0.0
R2b Retro-active rate increase	81,931,539	24,612,693	3,270,615	0	54,048,231	0.0
R2c SUD risk corridor	(70,000,000)	(21,028,391)	(2,794,322)	0	(46,177,287)	0.0
Forecast Subtotal	*(109,307,780)*	*(10,927,364)*	*(7,604,125)*	*0*	*(90,776,291)*	0.0
Administration						
R7 Behavioral health continuum	4,137,336	826,669	301,521	0	3,009,146	0.0
Annualize prior year funding	0	60,709	0	0	(60,709)	0.0
TOTAL	**$1,021,318,084**	**$270,653,069**	**$78,649,954**	**$0**	**$672,015,061**	**0.0**
INCREASE/(DECREASE)	**($105,170,444)**	**($10,039,986)**	**($7,302,604)**	**$0**	**($87,827,854)**	**0.0**
Percentage Change	(9.3%)	(3.6%)	(8.5%)	0.0%	(11.6%)	0.0%
FY 2024-25 EXECUTIVE REQUEST	**$1,187,271,197**	**$289,844,351**	**$91,168,440**	**$0**	**$806,258,406**	**0.0**
Request Above/(Below) Recommendation	$165,953,113	$19,191,282	$12,518,486	$0	$134,243,345	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. 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*, *R6 Provider rates*, and the annualization of prior year budget actions.

RECOMMENDATION: **The staff recommendation is provided in the table below.**

BEHAVIORAL HEALTH COMMUNITY PROGRAMS, BEHAVIORAL HEALTH FEE-FOR-SERVICE PAYMENTS						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2023-24 APPROPRIATION						
FY 2023-24 Appropriation	$12,626,201	$2,973,141	$746,370	$0	$8,906,690	0.0
Long bill supplemental	(715,592)	(168,503)	(42,300)	0	(504,789)	0.0
TOTAL	**$11,910,609**	**$2,804,638**	**$704,070**	**$0**	**$8,401,901**	**0.0**
FY 2024-25 RECOMMENDED APPROPRIATION						
FY 2023-24 Appropriation	$11,910,609	$2,804,638	$704,070	$0	$8,401,901	0.0
R6a Provider rates	251,738	55,821	15,178	0	180,739	0.0
Annualize prior year funding	11,584	3,876	749	0	6,959	0.0
R2 Behavioral Health	(454,452)	(53,051)	(24,537)	0	(376,864)	0.0
TOTAL	**$11,719,479**	**$2,811,284**	**$695,460**	**$0**	**$8,212,735**	**0.0**
INCREASE/(DECREASE)	**($191,130)**	**$6,646**	**($8,610)**	**$0**	**($189,166)**	**0.0**
Percentage Change	(1.6%)	0.2%	(1.2%)	0.0%	(2.3%)	0.0%
FY 2024-25 EXECUTIVE REQUEST	**$12,510,241**	**$3,005,954**	**$742,124**	**$0**	**$8,762,163**	**0.0**
Request Above/(Below) Recommendation	$790,762	$194,670	$46,664	$0	$549,428	0.0

LONG BILL FOOTNOTES AND REQUESTS FOR INFORMATION

LONG BILL FOOTNOTES

The FY 2023-24 Long Bill did not include any footnotes specific to the behavioral health community programs. Staff does not recommend adding any footnotes to this section.

REQUESTS FOR INFORMATION

Staff recommends **CONTINUING** the following request for information:

1 Department of Health Care Policy and Financing, Behavioral Health Community Programs -- The Department is requested to submit a report by November 1, discussing member utilization of capitated behavioral health services in ~~FY 2021-22~~ FY 2022-23 and the Regional Accountable Entity's (RAE's) performance on network provider expansion, timeliness of processing provider claims within contract requirements, and timeliness of credentialing and contracting network providers. The report should include aggregated data on the number of members accessing inpatient and residential mental health treatment, inpatient and residential substance use disorder treatment, outpatient mental health and substance use disorder services, and alternative services allowed under the Department's waiver with the Centers for Medicare and Medicaid Services. For Calendar Year ~~2022~~ 2023, the Department shall report aggregated provider data by quarter showing changes in the number of providers contracted, monthly claims processing timeframes by each RAE, and timeliness of provider credentialing and contracting by each RAE. Also, please discuss differences in the performance of the RAEs, how the Department monitors these performance measures, and any actions the Department has taken to improve RAE performance and client behavioral health outcomes.

APPENDIX A:
NUMBERS PAGES

Appendix A: Numbers Pages

	FY 2021-22 Actual	FY 2022-23 Actual	FY 2023-24 Appropriation	FY 2024-25 Request	FY 2024-25 Recommendation	
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING **Kim Bimestefer, Executive Director**						
(3) BEHAVIORAL HEALTH COMMUNITY PROGRAMS						
Healthcare Affordability and Sustainability Cash Fund.						
Behavioral Health Capitation Payments	852,041,516	1,073,070,076	1,126,488,528	1,187,271,197	1,021,318,084	*
General Fund	0	215,820,743	280,693,055	289,844,351	270,653,069	
Cash Funds	63,158,906	92,271,268	85,952,558	91,168,440	78,649,954	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	788,882,610	764,978,065	759,842,915	806,258,406	672,015,061	
Behavioral Health Fee-for-service Payments	12,592,071	8,929,133	11,910,609	12,510,241	11,719,479	*
General Fund	2,280,953	1,692,019	2,804,638	3,005,954	2,811,284	
Cash Funds	871,824	558,233	704,070	742,124	695,460	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	9,439,294	6,678,881	8,401,901	8,762,163	8,212,735	
TOTAL - (3) Behavioral Health Community Programs	864,633,587	1,081,999,209	1,138,399,137	1,199,781,438	1,033,037,563	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	2,280,953	217,512,762	283,497,693	292,850,305	273,464,353	
Cash Funds	64,030,730	92,829,501	86,656,628	91,910,564	79,345,414	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	798,321,904	771,656,946	768,244,816	815,020,569	680,227,796	

	FY 2021-22 Actual	FY 2022-23 Actual	FY 2023-24 Appropriation	FY 2024-25 Request	FY 2024-25 Recommendation
TOTAL - Department of Health Care Policy and Financing	864,633,587	1,081,999,209	1,138,399,137	1,199,781,438	1,033,037,563
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	2,280,953	217,512,762	283,497,693	292,850,305	273,464,353
Cash Funds	64,030,730	92,829,501	86,656,628	91,910,564	79,345,414
Reappropriated Funds	0	0	0	0	0
Federal Funds	798,321,904	771,656,946	768,244,816	815,020,569	680,227,796