COLORADO GENERAL ASSEMBLY
JOINT BUDGET COMMITTEE

FY 2016-17 STAFF BUDGET BRIEFING

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

(Medicaid Behavioral Health Community Programs Only)

JBC Working Document - Subject to Change
Staff Recommendation Does Not Represent Committee Decision

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December 9, 2015

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DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

Department Overview

The Department of Health Care Policy and Financing (HCPF) helps pay health and long-term care expenses for low-income and vulnerable populations. To assist with these costs the Department receives significant federal matching funds, but must adhere to federal rules regarding program eligibility, benefits, and other features, as a condition of accepting the federal money. The largest program administered by HCPF is the Medicaid program, which serves people with low income and people needing long-term care. The Department also performs functions related to improving the health care delivery system. This Joint Budget Committee staff budget briefing document concerns the behavioral health community programs administered by HCPF.

Behavioral health services include both mental health and substance use disorder services. Most behavioral health services are provided to Medicaid-eligible clients through a statewide managed care or "capitated" program. The Department contracts with five regional entities, known as behavioral health organizations or BHOs, to provide or arrange for medically necessary behavioral health services to Medicaid-eligible clients. Each BHO receives a pre-determined monthly amount for each client who is eligible for Medicaid behavioral health services. In addition to funding for capitation payments to BHOs, a separate appropriation covers fee-for-service payments for behavioral health services provided to clients who are not enrolled in a BHO and for the provision of behavioral health services that are not covered by the BHO contract.

Finally, the HCPF budget includes appropriations of General Fund and federal Medicaid funds that are transferred to the Department of Human Services for behavioral health programs administered by that department.

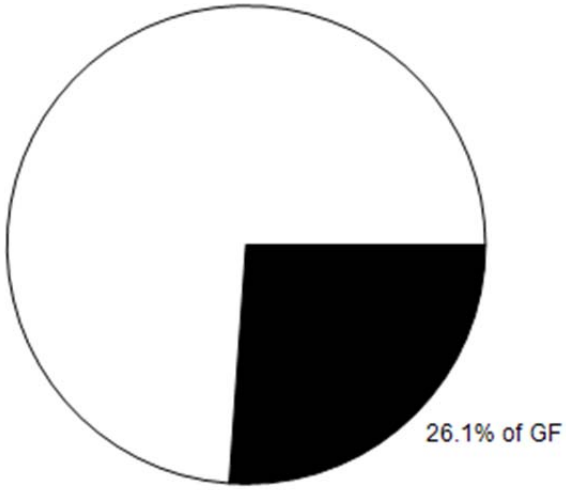
Department Budget: Recent Appropriations

Funding Source	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17 *
General Fund	$2,067,258,413	$2,352,444,300	$2,507,080,610	$2,642,647,613
Cash Funds	986,463,698	899,805,052	1,031,847,224	991,324,107
Reappropriated Funds	10,483,522	6,104,791	7,805,549	7,059,407
Federal Funds	3,592,923,500	4,673,350,937	5,343,721,014	5,252,128,000
Total Funds	**$6,657,129,133**	**$7,931,705,080**	**$8,890,454,397**	**$8,893,159,127**
Full Time Equiv. Staff	358.3	390.9	421.2	424.5

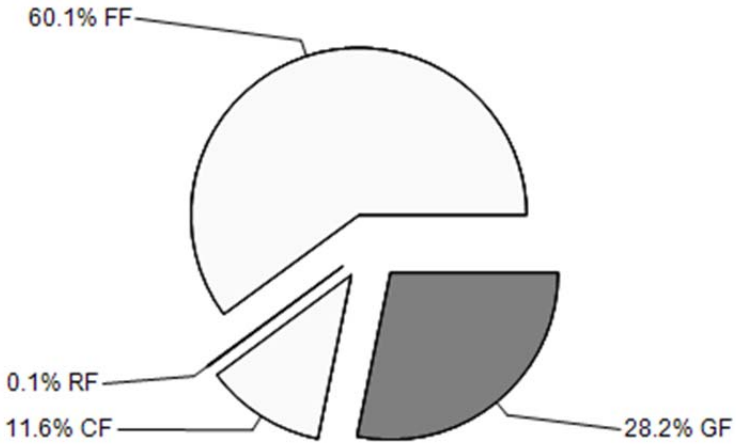
*Requested appropriation.

Department Budget: Graphic Overview

Department's Share of Statewide General Fund

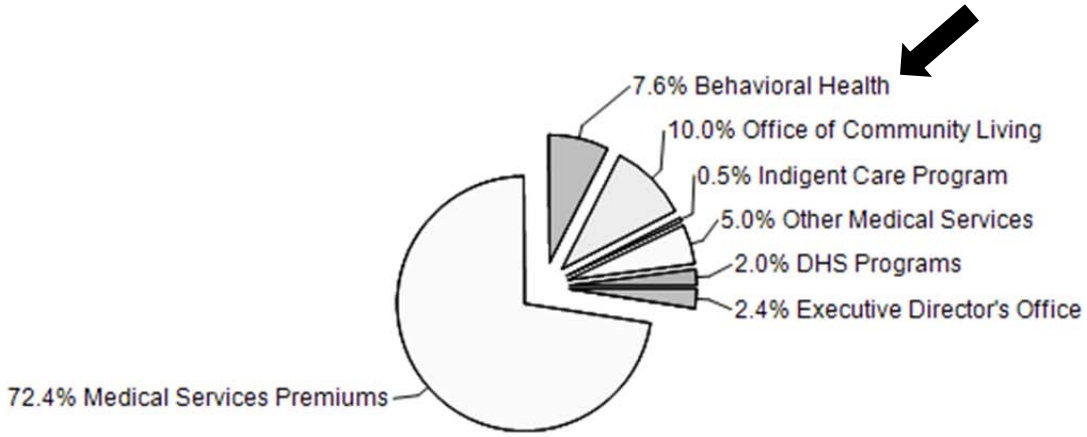


Department Funding Sources

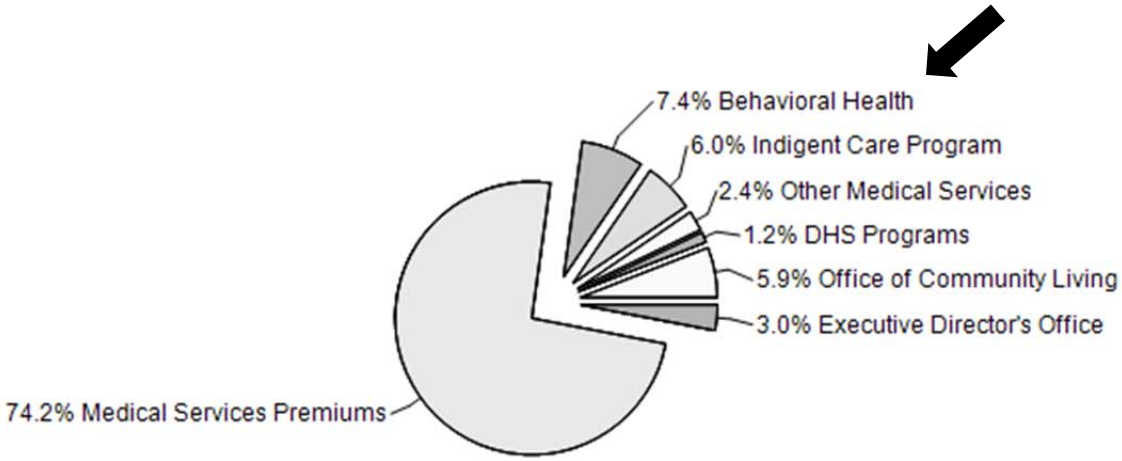


All charts are based on the FY 2015-16 appropriation.

Distribution of General Fund by Division



Distribution of Total Funds by Division



All charts are based on the FY 2015-16 appropriation.

General Factors Driving the Budget

A total of $8.9 billion is appropriated to HCPF for FY 2015-16, including $654.4 million (7.4 percent of the total) for behavioral health community programs. More than two-thirds of funding for behavioral health community programs is from federal Medicaid funding; the General Fund provides 29.2 percent of funding, and the remainder is from cash funds (including hospital provider fees and tobacco litigation settlement funds). The factors that affect expenditures in the behavioral health community programs section of HCPF's budget are reviewed below, followed by a brief description of behavioral health-related expenditures supported by appropriations in other sections of HCPF's budget.

Behavioral Health Capitation Payments

Behavioral health services, which include both mental health and substance use-related services, are generally provided to Medicaid clients through a statewide managed care or "capitated" program. The Department contracts with regional entities, called behavioral health organizations (BHOs), to provide or arrange for behavioral health services for clients within their geographic region who are eligible for and enrolled in the Medicaid program. In order to receive services through a BHO, a client must have a covered diagnosis and receive a covered service or procedure that is medically necessary.

BHO Services

Covered services include traditional Medicaid State Plan services such as:

- behavioral health assessment;
- individual, family, or group therapy;
- targeted case management;
- medication management;
- outpatient psychiatric care and intensive outpatient substance use disorder services;
- detoxification services;
- emergency/crisis services; and
- inpatient psychiatric hospital mental health services[1].

In addition, pursuant to the Department's federal 1915 (b) (3) waiver, BHOs offer a number of alternative services designed to support clients' recovery and avoid the need for more intensive services. This may include services such as prevention and intervention, employment assistance, clubhouse or drop-in centers, respite care, and residential mental health services.

BHO Clients

The following groups of Medicaid clients receive behavioral health services through BHOs[2]:

- Adults 65 years of age and older;
- Children and adults with disabilities through age 64;

[1] While the State Medicaid Plan does not cover inpatient hospitalization for substance use disorder, the Department has agreed to cover inpatient hospitalization costs during the assessment period of a client's hospitalization, even if the client's primary diagnosis is ultimately determined to be a substance use disorder.

[2] Medicaid eligibility is delineated in Sections 25.5-5-101 and 25.5-5-201, C.R.S.

- Parents and caretakers;
- Adults without dependent children;
- Eligible children;
- Children 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) Medicare clients for whom the Medicaid benefit is limited to payment of Medicare premiums and co-insurance payments. In addition, the following groups of Medicaid-eligible clients are eligible for behavioral health services, but not through a BHO:

- individuals enrolled in a Program of All-inclusive Care for the Elderly (PACE);
- certain individuals who have an intellectual or developmental disability and who are receiving care through an Intermediate Care Facility (ICF-IID) or a regional center "waiver bed", or who reside in the state regional centers and associated satellite residences for more than 90 days;
- children and youth who are in the custody of the Department of Human Services' Division of Child Welfare or Division of Youth Corrections, and who are placed by those agencies in a Psychiatric Residential Treatment Facility or a Residential Child Care Facility; and
- individuals being treated at one of the Colorado Mental Health Institutes who are between the ages of 21 and 64[3], or who are: (1) ordered by a criminal court to be evaluated for competency to stand trial; (2) found by a criminal court to be incompetent to proceed to trial; or (3) found by a criminal court to be not guilty by reason of insanity.

Finally, a Medicaid client may request and receive an individual exemption if BHO enrollment is not in their best clinical interest [pursuant to 10 CCR 2505-10, Section 8.212.2][4].

BHO Payments

Each BHO receives a pre-determined monthly amount for each Medicaid client who is eligible for behavioral health services within its geographic area. The "per-member-per-month" rates paid to each BHO are unique for each Medicaid eligibility category in each geographic region. These rates are adjusted annually based on client utilization and BHO expenditures.

Capitation Expenditures

Capitated behavioral health program expenditures are affected by caseload changes, rate changes, and changes to the Medicaid State Plan or waiver program that affect the diagnoses, services, and procedures that are covered for Medicaid clients. Caseload changes include changes in Medicaid eligibility, as well as demographic and economic changes that affect the

[3] The institutes are considered "institutions for mental disease" (IMD) under federal law because they have more than 16 beds and are primarily engaged in providing diagnosis, treatment, or care of persons with mental health disorders, including medical attention, nursing care, and related services. Under the "IMD exclusion", Medicaid will not reimburse the State for the inpatient hospitalization of adults ages 21 through 64 at the institutes. In addition, for Medicaid-eligible patients outside this age range (*i.e.*, under age 21 or over age 64), there is a 45-day Medicaid inpatient psychiatric benefit limit.

[4] In FY 2014-15, no Medicaid clients were exempted under this State rule.

number of eligible individuals. The State's share of expenditures is also affected by changes in the federal match rate for various eligibility categories. The following table details recent expenditure and caseload trends for Medicaid Behavioral Health Capitation Payments.

Medicaid Behavioral Health Capitation Payments						
	FY 2012-13	FY 2013-14	FY 2014-15	FY 2015-16		FY 2016-17
	Actual	Actual	Actual 1/	Appropriation	Nov. 1, 2015 Estimate	Request 2/
Capitation Payments	**$301,303,046**	**$415,933,333**	**$565,420,239**	**$646,025,263**	**$599,933,435**	**$663,569,890**
Annual Dollar Change	$27,926,432	$114,630,287	$149,486,906	$80,605,024	$34,513,196	$63,636,455
Annual Dollar % Change	*10.2%*	*38.0%*	*35.9%*	*14.3%*	*6.1%*	*10.6%*
Caseload (eligible clients)	**659,104**	**835,098**	**1,130,439**	**1,255,060**	**1,255,644**	**1,311,920**
Annual Caseload Change	60,782	175,994	295,341	124,621	125,205	56,276
Annual Caseload % Change	*10.2%*	*26.7%*	*35.4%*	*11.0%*	*11.1%*	*4.5%*
Expenditures per capita	**$457**	**$498**	**$500**	**$515**	**$478**	**$506**

1/ The "Capitation Payments" figure for FY 2014-15 excludes $4,540,153 expended by BHOs' for school-based substance abuse prevention and intervention programs pursuant to S.B. 14-215.

2/ The "Capitation Payments" figure for FY 2016-17 includes 54 cases and $16,512 for the projected impact of the Department of Public Health and Environment's request to expand eligibility for cervical cancer services.

As detailed in the above table, the Capitation Program caseload increased by more than 470,000 (71.5 percent) from FY 2012-13 to FY 2014-15, and is anticipated to grow another 125,000 in the current fiscal year. These increases are primarily due to the expansion of Medicaid eligibility authorized through S.B. 13-200, effective January 1, 2014. Initially, the Department anticipated that per capita expenditures would increase due to: (a) an increase in the proportion of adults within the overall caseload; (b) the implementation of an enhanced substance use disorder benefit starting January 1, 2014; and (c) general increases in rates over time. However, the overall utilization and needs of the newly eligible population have not been as high as anticipated.

The next three tables show the year-over-year projected changes for enrollment, expenditures, and expenditures per capita for each enrollment category. While children comprise more than 40 percent of eligible clients, they account for only one-fifth of expenditures. Per capita costs are highest for children and youth in foster care, and individuals with disabilities.

Behavioral Health Capitation Program: Enrollment				
Category	**FY 15-16 Revised**	**FY 16-17 Request**	**Difference**	**Percent**
Children to 147% FPL	534,231	558,804	24,573	4.6%
Adults w/out Dependent Children to 138% FPL	293,091	303,341	10,250	3.5%
Parents / Caretakers to 68% FPL; and Pregnant Adults to 200% FPL	198,210	210,972	12,762	6.4%
Individuals with Disabilities to age 64 (to 450% FPL)	84,791	88,875	4,084	4.8%
Parents / Caretakers 69% to 138% FPL	82,897	86,948	4,051	4.9%
Adults age 65+ (to SSI)	42,218	42,830	612	1.4%
Foster Care to 26 years	19,923	19,943	20	0.1%
Breast & Cervical Cancer to 250% FPL	283	207	(76)	-26.9%
TOTAL	**1,255,644**	**1,311,920**	**56,276**	**4.5%**

Behavioral Health Capitation Program: Annual Expenditures				
Category	**FY 15-16 Revised**	**FY 16-17 Request**	**Difference**	**Percent**
Children to 147% FPL	$127,960,239	$136,936,202	$8,975,963	7.0%
Adults w/out Dependent Children to 138% FPL	202,489,486	233,317,240	30,827,754	15.2%
Parents / Caretakers to 68% FPL; and Pregnant Adults to 200% FPL	61,823,610	67,584,562	5,760,952	9.3%
Individuals with Disabilities to age 64 (to 450% FPL)	135,824,683	149,007,395	13,182,712	9.7%
Parents / Caretakers 69% to 138% FPL	21,251,172	22,730,270	1,479,098	7.0%
Adults age 65+ (to SSI)	7,547,824	7,752,850	205,026	2.7%
Foster Care to 26 years	44,190,178	47,293,637	3,103,459	7.0%
Breast & Cervical Cancer to 250% FPL	88,005	65,321	(22,684)	-25.8%
Date of death retractions	(1,241,762)	(1,117,587)	124,175	-10.0%
TOTAL	**$599,933,435**	**$663,569,890**	**$63,636,455**	**10.6%**

Behavioral Health Capitation Program: Annual Per Capita Expenditures				
Category	**FY 15-16 Revised**	**FY 16-17 Request**	**Difference**	**Percent**
Children to 147% FPL	$240	$245	$6	2.3%
Adults w/out Dependent Children to 138% FPL	691	769	78	11.3%
Parents / Caretakers to 68% FPL; and Pregnant Adults to 200% FPL	312	320	8	2.7%
Individuals with Disabilities to age 64 (to 450% FPL)	1,602	1,677	75	4.7%
Parents / Caretakers to 138% FPL	256	261	5	2.0%
Adults age 65+ (to SSI)	179	181	2	1.2%
Foster Care to 26 years	2,218	2,371	153	6.9%
Breast & Cervical Cancer to 250% FPL	311	316	5	1.5%
TOTAL	**$478**	**$506**	**$28**	**5.9%**

Medicaid Behavioral Health Fee-for-service Payments

In addition to funding for capitation payments to BHOs, a separate appropriation supports fee-for-service payments for the provision of behavioral health services under three circumstances: (1) when a Medicaid client has a diagnosis that is not covered by the BHO contract (*e.g.*, autism spectrum disorder, developmental disability, dementia, etc.); (2) when a Medicaid client has received an individual exemption from BHO enrollment; or (3) when the State is required to pay the client share of the cost of mental health services provided to a "partial dual-eligible" individual under their Medicare benefits package.

The fee-for-service program covers all Medicaid State Plan mental health and substance use disorder services. The fee-for-service program does not, however, cover services approved through the Department's federal 1915 (b) (3) waiver. Expenditures are reported using three categories: inpatient services, outpatient services, and physician services.

Fee-for-service expenditures for outpatient services increased significantly in FY 2014-15 (by $2.5 million or 62.3 percent), and now account for 85 percent of fee-for-service expenditures. The Department indicates that this increase is primarily attributed to the newly eligible adults without dependent children. Total fee-for-service expenditures are anticipated to be slightly lower than originally projected for the current fiscal year, but to grow by 3.4 percent in FY 2016-17 largely due to projected Medicaid caseload increases. The following table details recent expenditure trends for this line item, along with the Department's most recent estimates for FY 2015-16, and the request for FY 2016-17.

Medicaid Behavioral Health Fee-for-service Payments						
	FY 2012-13	FY 2013-14	FY 2014-15	FY 2015-16 1/		FY 2016-17 2/
	Actual	Actual	Actual	Appropriation	Nov. 1, 2015 Estimate	Nov. 1, 2015 Request
Inpatient Services	$973,629	$1,277,088	$1,037,617	$1,159,633	$1,152,541	1,192,106
Outpatient Services	3,513,329	3,956,128	6,421,463	7,176,580	7,132,690	7,377,538
Physician Services	82,240	63,135	66,344	74,146	73,692	76,222
Accounting Adjustment 3/	0	(516)	0	n/a	n/a	n/a
Total Fee-for-Service Funding	**$4,569,198**	**$5,295,835**	**$7,525,424**	**$8,410,359**	**$8,358,923**	**$8,645,866**
Annual Dollar Change	$675,159	$726,637	$2,229,589	$884,935	$833,499	$286,943
Annual Dollar % Change	*17.3%*	*15.9%*	*42.1%*	*11.8%*	*11.1%*	*3.4%*

1/ These amounts include $140,586 for a community provider rate increase, pro rated across each expenditure category based on the Department's base expenditure estimates for FY 2015-16.

2/ The request includes a reduction of $87,332 for Medicaid provider rate reductions (R12). These amounts have been pro rated across each expenditure category based on the Department's base expenditure estimates for FY 2016-17.

3/ The Department overlays MMIS data onto CORE data to approximate expenditures by eligibility category. In some instances, this overlay process results in totals which do not match actual expenditures. This adjustment ensures that total actual expenditures are

Other Department Behavioral Health-related Expenditures

Please note that funding in the behavioral health community programs section of HCPF's budget excludes funding for certain behavioral health-expenditures. The Medical Services Premiums line item appropriation covers:

- expenditures for the provision of inpatient medical treatment for clients with acute medical conditions that involve a substance use disorder diagnosis (a total of $110.7 million in FY 2014-15);
- behavioral health-related pharmaceutical expenditures (an estimated $51.7 million after rebates in FY 2014-15, including $37.0 million related to antipsychotic drugs); and
- inpatient substance use disorder treatment for children and youth under age 21 provided under the early and periodic screening, diagnostic and treatment benefit ($1.9 million in FY 2014-15).

In addition, Medicaid covers residential substance use disorder treatment for pregnant women through the "Special Connections Program", which is administered by the Department of Human Services with Medicaid funding transferred from HCPF ($1.0 million in FY 2014-15). Finally, administrative expenses related to behavioral health programs are funded through various line items in the Executive Director's Office.

Summary: FY 2015-16 Appropriation & FY 2016-17 Request

Department of Health Care Policy and Financing	Total Funds	General Fund	Cash Funds	Federal Funds	FTE
FY 2015-16 Appropriation					
SB 15-234 (Long Bill)	$654,139,950	$190,886,935	$9,111,432	$454,141,583	0.0
Other legislation	295,672	144,850	0	150,822	0.0
TOTAL	**$654,435,622**	**$191,031,785**	**$9,111,432**	**$454,292,405**	**0.0**
FY 2016-17 Requested Appropriation					
FY 2015-16 Appropriation	$654,435,622	$191,031,785	$9,111,432	$454,292,405	0.0
R2 Behavioral health programs	13,430,867	(3,793,986)	7,447,782	9,777,071	0.0
R12 Provider rates	(87,332)	(18,463)	(2,279)	(66,590)	0.0
NP Cervical cancer eligibility	16,512	0	5,732	10,780	0.0
Annualize prior year budget decisions	3,969,688	914,489	6,283	3,048,916	0.0
Annualize HB 15-1186 children with autism	450,399	220,650	0	229,749	0.0
TOTAL	**$672,215,756**	**$188,354,475**	**$16,568,950**	**$467,292,331**	**0.0**
Increase/(Decrease)	$17,780,134	($2,677,310)	$7,457,518	$12,999,926	0.0
Percentage Change	2.7%	(1.4%)	81.8%	2.9%	0.0%

Description of Requested Changes

R2 Behavioral health programs: The request includes an increase of $13.4 million total funds (including a decrease of $3.8 million General Fund) for projected caseload and expenditure changes in both the managed care and fee-for-service Medicaid behavioral health programs. *For more information about this budget request, see staff's issue brief in this document titled "Overview of Department's FY 2016-17 Request for Behavioral Health Community Programs".*

R12 Provider rates: The Department's overall request includes a reduction of $35.8 million total funds (including $12.9 million General Fund) for an overall 1.0 percent decrease in rates paid to most Medicaid physical health fee-for-service and managed care providers, as well as behavioral health fee-for-service providers.

NP Cervical cancer eligibility: The Department's overall request includes an increase of $291,528 for FY 2016-17 (including $107,119 cash funds from the Breast and Cervical Cancer Prevention and Treatment Fund and $184,409 federal funds) to reflect the additional treatment costs anticipated to result if the General Assembly approves the Department of Public Health and Environment's request (R4) to expand the eligibility of women being screened for cervical cancer

to include women ages 21 to 39. With respect to behavioral health community programs, the Department anticipates an increase of $16,512 beginning in FY 2016-17.

Annualize prior year budget decisions: The request for behavioral health community programs includes an increase of $4.0 million (including $0.9 million General Fund) related to prior year budget decisions, including the following adjustments:

- FY 2015-16 R6 CHP+ Enrollment – increase of $3,942,077 (including $364,154 General Fund). The request reflects the second-year impact of changes to the CHP+ enrollment policies
- *FY 2015-16 R12 Provider rate increase – increase of $27,611 (including $6,658 General Fund).* The request reflects the impact of the 1.7 percent rate increase approved for FY 2015-16 for providers that receive payments through the behavioral health fee-for-service program.
- *FY 2015-16 BA17 FMAP adjustment – increase of $543,677 General Fund and $5,954 cash funds, offset by decrease in federal funds.* The request includes a fund source adjustment to reflect the full-year impact of the change in the federal Medicaid assistance percentage (FMAP) for FY 2015-16.

Annualize HB 15-1186 children with autism: The Department's overall request includes an increase of $8.4 million (including $3.6 million General Fund) to reflect the second year impact of expanding services for children with autism. With respect to behavioral health community programs, the Department's request includes $450,399 (including $220,650 General Fund) for FY 2016-17.

Informational Issue: Overview of Department's FY 2016-17 Request for Behavioral Health Community Programs

The Department's most recent projections for behavioral health programs indicate that the General Assembly will likely be able to reduce General Fund appropriations by $17.0 million in the current fiscal year, but the majority of this funding will need to be reinstated for FY 2016-17.

SUMMARY:

- Compared to existing FY 2015-16 appropriations, the Governor's budget request for FY 2016-17 includes a $26.2 million (2.9 percent) overall increase in funding for behavioral health programs administered by the Department of Human Services and the Department of Health Care Policy and Financing (HCPF). Of the total increase, two-thirds ($17.8 million) is requested for HCPF programs.

- For FY 2015-16, HCPF estimates that existing appropriations for Medicaid behavioral health programs can be decreased by $46.1 million total funds, including $17.0 million General Fund. This is primarily due to lower than anticipated per capita expenditures for the newly eligible adults without dependent children, for individuals with disabilities, and for children and youth in (or formerly in) foster care.

- Compared to the revised estimate for FY 2015-16, HCPF's request for FY 2016-17 represents a $63.9 million (10.5 percent) increase in total funds, including $14.3 million General Fund. The estimated expenditure increase primarily reflects continued growth in the number of low income adults and children enrolling in Medicaid and anticipated increases in behavioral health capitation rates.

DISCUSSION:

Overall Funding Requested for Behavioral Health Programs for FY 2016-17

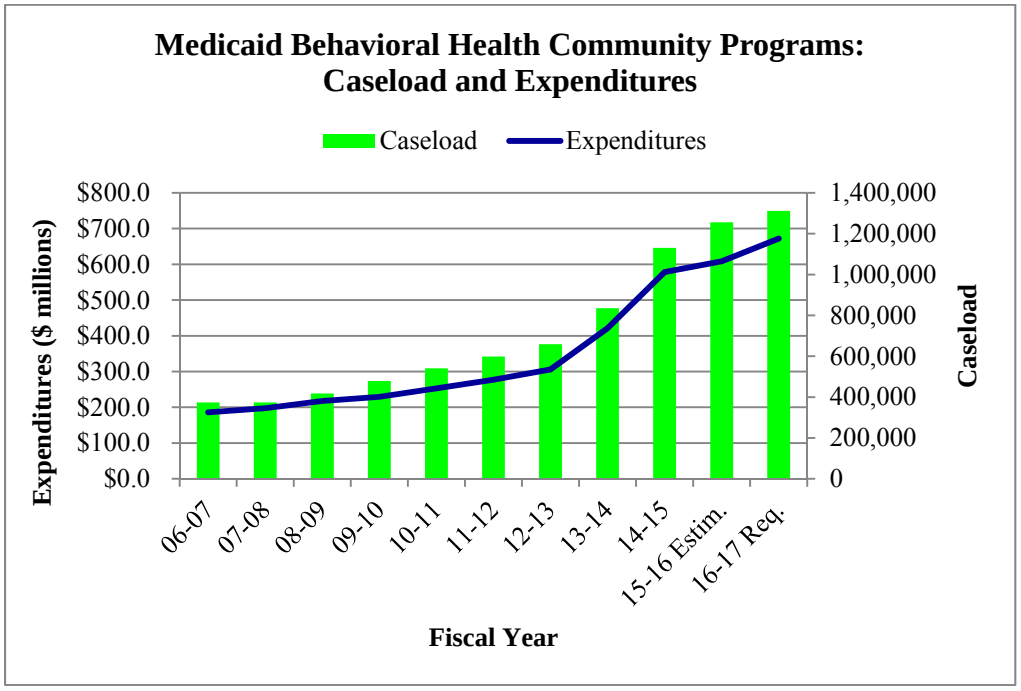
The majority of publicly funded behavioral health services in Colorado are funded through two program areas: the Department of Health Care Policy and Financing's (HCPF's) Behavioral Health Community Programs section, and the Department of Human Services' Behavioral Health Services section. As detailed in the following table, the FY 2016-17 budget requests for these two program areas propose increasing funding by a total of $26.2 million (2.9 percent), including a small overall reduction ($0.2 million) in direct General Fund appropriations.

Total Appropriations for Behavioral Health Programs: FY 2015-16 and FY 2016-17	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
FY 2015-16 Appropriation						
Department of Human Services (DHS), Behavioral Health Services	$254,178,268	$183,638,257	$16,715,045	$18,560,075	$35,264,891	1,281.1
Department of Health Care Policy and Financing (HCPF), Behavioral Health Community Programs	654,435,622	191,031,785	9,111,432	0	454,292,405	0.0
TOTAL	**908,613,890**	**374,670,042**	**25,826,477**	**18,560,075**	**489,557,296**	**1,281.1**
FY 2016-17 Request						
DHS, Behavioral Health Services	262,620,934	186,085,146	22,637,653	18,610,889	35,287,246	1,292.5
HCPF, Behavioral Health Community Programs	672,215,756	188,354,475	16,568,950	0	467,292,331	0.0
TOTAL	**$934,836,690**	**$374,439,621**	**$39,206,603**	**$18,610,889**	**$502,579,577**	**1,292.5**
DHS: Increase/(Decrease)	$8,442,666	$2,446,889	$5,922,608	$50,814	$22,355	11.4
Percentage Change	3.3%	1.3%	35.4%	0.3%	0.1%	0.9%
HCPF: Increase/(Decrease)	$17,780,134	($2,677,310)	$7,457,518	$0	$12,999,926	0.0
Percentage Change	2.7%	(1.4%)	81.8%	n/a	2.9%	n/a
TOTAL: Increase/(Decrease)	**$26,222,800**	**($230,421)**	**$13,380,126**	**$50,814**	**$13,022,281**	**11.4**
Percentage Change	2.9%	(0.1%)	51.8%	0.3%	2.7%	0.9%

Of the total $26.2 million increase proposed for FY 2016-17, more than two-thirds ($17.8 million) is requested for HCPF programs. This issue brief provides an overview of the components of the HCPF share of the FY 2016-17 request and the underlying trends affecting the request.

Funding Requested for Medicaid Behavioral Health Community Programs for FY 2016-17

The following chart depicts actual caseload and expenditure changes for Medicaid behavioral health community programs since FY 2006-07, along with HCPF's most recent expenditure estimate for FY 2015-16 and its request for FY 2016-17.



The overall $17.8 million (2.7 percent) increase requested by HCPF for FY 2016-17 represents a much less significant annual increase relative to the last two fiscal years. However, the Department's most recent caseload and expenditure forecast includes adjustments for both FY 2015-16 and FY 2016-17. Thus, the Department anticipates submitting a request for a mid-year adjustment to FY 2015-16 appropriations. The following table splits out the requested changes by fiscal year to provide a more accurate depiction of the request. A discussion of caseload and expenditure trends experienced in FY 2014-15, and the Department's most recent forecasts for FY 2015-16 and FY 2016-17, follows.

Department of Health Care Policy and Financing: Summary of Requested Increase by Fiscal Year and Fund Source				
	Total Funds	**General Fund**	**Cash Funds**	**Federal Funds**
Appropriation for FY 2015-16	$654,435,622	$191,031,785	$9,111,432	$454,292,405
Changes reflected in most recent Medicaid forecast for FY 2015-16	(46,143,264)	(16,974,835)	(278,601)	(28,889,828)
Subtotal: FY 2015-16 Estimate	**608,292,358**	**174,056,950**	**8,832,831**	**425,402,577**
Annualizations of prior year budget actions and legislation	4,420,087	1,135,139	6,283	3,278,665
Changes reflected in most recent Medicaid forecast for FY 2016-17	59,574,131	13,180,849	7,726,383	38,666,899
R12 Provider rates	(87,332)	(18,463)	(2,279)	(66,590)
NP Cervical cancer program eligibility	16,512	0	5,732	10,780
Total FY 2016-17 Request	**$672,215,756**	**$188,354,475**	**$16,568,950**	**$467,292,331**

FY 2014-15 Caseload and Expenditure Trends

Actual expenditures for FY 2014-15 reflect a full 12 months of Medicaid eligibility expansion, as well as a full 12 months of expanded substance use disorder benefits. The number of Medicaid clients eligible for behavioral health services through BHOs (called "membership") increased by 35.4 percent, and the associated payments to BHOs increased by a similar magnitude (35.9 percent). The Department provided the following data concerning membership and expenditures for each BHO region.

Behavioral Health Capitation Program: FY 2014-15						
	Behavioral Healthcare, Inc.	Access Behavioral Care - Northeast Region	Access Behavioral Care - Metro Region	Colorado Health Partnerships	Foothills Behavioral Health Partners	Total
Membership 1/	277,466	143,018	183,095	394,166	141,386	1,139,131
% of total	*24.4%*	*12.6%*	*16.1%*	*34.6%*	*12.4%*	*100.0%*
Expenditures 2/						
State funds	$41,388,813	$21,032,424	$27,086,669	$62,860,698	$27,741,670	$180,110,274
Federal funds	87,873,400	43,251,552	61,811,083	132,010,891	64,903,198	389,850,124
Total funds	$129,262,213	$64,283,976	$88,897,752	$194,871,589	$92,644,868	$569,960,398
% of total	*22.7%*	*11.3%*	*15.6%*	*34.2%*	*16.3%*	*100.0%*
Average expenditure per member	$465.87	$449.48	$485.53	$494.39	$655.26	$500.35

1/ Membership data is the average monthly membership for each BHO over the course of FY 2014-15 as reported in the JBC Monthly Report

2/ Figures include expenditures for school-based substance abuse prevention and intervention programs ($4,540,153). In addition, the Department indicates that MMIS claims data was used to create a distribution for final FY 2014-15 expenditures reported in CORE. Reconciliation transactions occur outside of MMIS, so the Department estimated final fund splits by BHO.

What are the overall utilization trends underlying FY 2014-15 expenditures?
The Department indicates that utilization and cost patterns by behavioral health service category were relatively similar to recent periods with one exception. The final quarter of FY 2014-15 had significantly higher utilization of substance use disorder services in all regions. The BHOs have indicated that this increase in utilization and expenditure is reflective of a program ramp up and that the last quarter of FY 2014-15 at the higher utilization level should be expected to continue.

What do we now know about the behavioral health needs of the Medicaid expansion population?
According to CY 2014 data, the Medicaid expansion population comprises one-third of the total BHO membership, and approximately 14 percent of the total Medicaid expansion population utilizes BHO services. This penetration rate is similar to the non-expansion population. Most Medicaid clients (77 percent) access behavioral health services at community mental health centers (Centers). While Centers are also the predominant service delivery location for the expansion population, recent data indicates the proportion is lower than the non-expansion population (*e.g.*, 62 percent for expansion adults and 61 percent for expansion parents). The Department indicates that this may be attributed to the expansion population's slightly higher utilization rate for emergency room services (12.3 percent for the expansion population, compared to 9.0 percent for the non-expansion population).

In addition, the Department indicates that the expansion population has utilized substance use disorder treatment at a higher rate than other Medicaid populations. The Department expected this initial trend due to pent up demand, but anticipated that it would decrease over time. However, the BHOs have reported that this increased utilization remains steady. The Department also notes that while females are generally more likely to utilize behavioral health services, the utilizers of the expanded substance use disorder benefit are disproportionately males. Finally, the BHOs have reported that Methadone treatment and detoxification represented 50 percent of claims. The Department indicates that it is working with the BHOs and the Department of Human Services to further explore the substance use disorder service needs of the Medicaid population, including the expansion population.

FY 2015-16 Budget Estimate

The FY 2015-16 appropriation for Medicaid behavioral health community programs currently provides a total of $654.4 million total funds (including $191.0 million General Fund) for the provision of services to a projected caseload of 1,255,060. The Department is still expecting significant caseload growth in FY 2015-16, primarily due to expansion populations. However, the Department estimates that the existing FY 2015-16 appropriation can be decreased by $46.1 million total funds (7.1 percent) based on more recent projections. This adjustment is primarily related to two factors:

- The per-member-per-month rates paid to BHOs have decreased for many eligibility categories in aggregate, but fluctuate by BHO. This was the result of the BHOs' most recent submission of financial information. The most significant rate decreases were for the Individuals with Disabilities and Foster Care categories – the two most expensive eligibility categories. *See Appendix E for the detailed caseload and rate data that underlies the Department's revised capitation payment estimates for FY 2015-16.*

- The Department anticipates receiving $20.6 million back from BHOs for previous payments. Due to the uncertainty of the cost of serving the newly eligible Adults Without Dependent Children population, the Department placed a "risk corridor" on the associated capitation rates to protect both the State and BHOs from undue risk. The expected recoupment is due to the rates being set higher than actual costs.

The following table compares the caseload and expenditure data that correspond to the FY 2015-16 appropriation and the Department's most recent estimate.

FY 2015-16 Medicaid Behavioral Health Community Programs Budget Overview						
	FY 2015-16 Appropriation		FY 2015-16 November 1 Estimate		Change Due to Revision	
Description	Caseload	Funding	Caseload	Funding	Caseload	Funding
Capitation Payments						
Eligibility Categories						
Adults age 65+ (to SSI)	42,971	$7,277,158	42,218	$7,547,824	(753)	$270,666
Adults:						
Parents/ Caretakers (to 68% FPL) and Pregnant Adults (to 200% FPL)	197,397	66,715,087	198,210	61,823,610	813	(4,891,477)
Parents/ Caretakers (69% to 138% FPL)*	85,311	28,832,914	82,897	21,251,172	(2,414)	(7,581,742)
Adults without Dependent Children (to 138% FPL)*	287,239	208,653,660	293,091	219,403,218	5,852	10,749,558
Breast and Cervical Cancer Program (to 250% FPL)	179	60,207	283	88,005	104	27,798
Individuals With Disabilities to age 64 (to 450% FPL)	85,135	154,906,187	84,791	135,824,683	(344)	(19,081,504)
Children (to 147% FPL)	536,591	126,732,162	534,231	127,960,239	(2,360)	1,228,077
Individuals In/ Formerly In Foster Care (up to age 26)	20,237	53,264,149	19,923	44,190,178	(314)	(9,073,971)
Subtotal	1,255,060	646,441,524	1,255,644	618,088,929	584	(28,352,595)
Adjustments:						
Date of death retractions		(416,261)		(1,241,762)		(825,501)
Adults without dependent children risk corridor reconciliation 1/		0		(20,613,732)		(20,613,732)
Adults without dependent children rate reconciliation 2/		0		3,700,000		3,700,000
Capitation Payments Total	**1,255,060**	**$646,025,263**	**1,255,644**	**$599,933,435**	**584**	**($46,091,828)**
Fee for Service						
Inpatient		$1,159,633		$1,152,541		($7,092)
Outpatient		7,176,580		7,132,690		(43,890)
Physician		74,146		73,692		(454)
Fee for Service Total		**$8,410,359**		**$8,358,923**		**($51,436)**
Total Behavioral Health Community Programs	**1,255,060**	**$654,435,622**	**1,255,644**	**$608,292,358**	**584**	**($46,143,264)**
Incremental Percentage Change					***0.0%***	***-7.1%***

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

1/ Due to the uncertainty of the cost of serving this population, the Department placed a "risk corridor" on the associated capitation rates, thereby splitting the risk of not setting an accurate rate between the Department and the behavioral health organizations (BHOs). For the period January to June 2014, the Department expects to recoup $20.6 million due to rates being set higher than

2/ This adjustment corrects a systems issue that caused some adults to be incorrectly categorized, resulting in BHO payments that were based on inappropriately high per-member-per-month rates.

FY 2016-17 Budget Estimate

The Department's FY 2016-17 budget request includes $672.2 million total funds (including $188.4 million General Fund) for the provision of services to a caseload of 1,311,920. Compared to the revised estimate for FY 2015-16, the request represents a $63.9 million (10.5 percent) year-over-year increase in total funds. In addition to the caseload changes that occur every year due to demographic and economic factors, this estimate is driven by continued growth in the numbers of low income adults and low income children enrolling in Medicaid. The Department is also anticipating that per-member-per-month capitation rates will increase by 2.9 percent on average, including a rebound in the rates for both the Individuals with Disabilities and Foster Care categories. The following table compares the caseload and expenditure data that correspond to the Department's most recent estimates for FY 2015-16 and the Department's FY 2016-17 request. Finally, the Department's projections for FY 2016-17 do not include the $20.6 million in recoupments that are anticipated to be received in FY 2015-16. *See Appendix F for the detailed caseload and rate data that underlies the Department's capitation payments request for FY 2016-17.*

Please note that it is anticipated that in January 2016 the Department will submit a supplemental request for FY 2015-16 that reflects the caseload and expenditure data described above. In addition, in February 2016 the Department will submit an updated caseload and expenditure forecast for both FY 2015-16 and FY 2016-17 that incorporates data through December 2015. Thus, the Committee will have updated information available when it makes decisions concerning the FY 2015-16 and FY 2016-17 budgets.

FY 2016-17 Medicaid Behavioral Health Community Programs Budget Overview						
	FY 2015-16 November 1 Estimate		FY 2016-17 Request		Annual Change	
Description	Caseload	Funding	Caseload	Funding	Caseload	Funding
Capitation Payments						
Eligibility Categories						
Adults age 65+ (to SSI)	42,218	$7,547,824	42,830	$7,752,850	612	$205,026
Adults:						
Parents/ Caretakers (to 68% FPL) and Pregnant Adults (to 200% FPL)	198,210	61,823,610	210,972	67,584,562	12,762	5,760,952
Parents/ Caretakers (69% to 138% FPL)*	82,897	21,251,172	86,948	22,730,270	4,051	1,479,098
Adults without Dependent Children (to 138% FPL)*	293,091	219,403,218	303,341	233,317,240	10,250	13,914,022
Breast and Cervical Cancer Program (to 250% FPL)	283	88,005	153	48,809	(130)	(39,196)
Individuals With Disabilitiesto age 64 (to 450% FPL)	84,791	135,824,683	88,875	149,007,395	4,084	13,182,712
Children (to 147% FPL)	534,231	127,960,239	558,804	136,936,202	24,573	8,975,963
Individuals In/ Formerly In Foster Care (up to age 26)	19,923	44,190,178	19,943	47,293,637	20	3,103,459
Subtotal	1,255,644	618,088,929	1,311,866	664,670,965	56,222	46,582,036
Adjustments:						
Date of death retractions		(1,241,762)		(1,117,587)		124,175
Budget Initiatives:						
Adults without dependent children risk corridor reconciliation 1/		(20,613,732)		0		20,613,732
Adults without dependent children rate reconciliation 2/		3,700,000		0		(3,700,000)
NP5 (DPHE R4) Cervical cancer eligibility expansion		n/a	54	16,512	54	16,512
Capitation Payments Total	**1,255,644**	**$599,933,435**	**1,311,920**	**$663,569,890**	**56,276**	**$63,636,455**
Fee for Service						
Inpatient		$1,152,541		$1,204,147		$51,606
Outpatient		7,132,690		7,452,059		319,369
Physician		73,692		76,992		3,300
Subtotal		8,358,923		8,733,198		374,275
Provider Rate Change		Included above		(87,332)		(87,332)
Fee for Service Total		**$8,358,923**		**$8,645,866**		**$286,943**
Total Behavioral Health Community Programs	**1,255,644**	**$608,292,358**	**1,311,920**	**$672,215,756**	**56,276**	**$63,923,398**
Incremental Percentage Change					***4.5%***	***10.5%***

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

1/ Due to the uncertainty of the cost of serving this population, the Department placed a "risk corridor" on the associated capitation rates, thereby splitting the risk of not setting an accurate rate between the Department and the behavioral health organizations (BHOs). For the period January to June 2014, the Department expects to recoup $20.6 million due to rates being set higher than actual costs.

2/ This adjustment corrects a systems issue that caused some adults to be incorrectly categorized, resulting in BHO payments that were based on inappropriately high per-member-per-month rates.

Informational Issue: Integrating Behavioral and Primary Health Care

The Department of Health Care Policy and Financing (HCPF) indicates that the integration of behavioral health services and primary health care is critical, since a significant share of total health costs and population outcomes are attributable to behavior, decision-making, and substance use. Significant initiatives are under way to address barriers to successful care integration.

SUMMARY:

- Colorado is recognized as a national leader in integrating behavioral and primary health care, and there are many successful and innovative integrated care programs across the state. A year ago the State was awarded a four-year $65 million federal grant to expand access to integrated primary care and behavioral health services.

- There are a number of barriers to care integration, including two parallel systems of payment in Medicaid – a fee-for-service payment system for primary care and a full-risk capitation payment system for behavioral health services.

- Pursuant to H.B. 12-1281, HCPF is supporting a pilot program in six Western Slope counties which involves a collaboration of Rocky Mountain Health Plans, the local community mental health center, and the associated behavioral health organization. This pilot program is using a comprehensive, full-risk capitation program for both primary care and behavioral health services; this risk is shared among pilot partners and with participating primary care practices.

DISCUSSION:

Integrated Care Initiatives in Colorado

Over the last two years staff has had opportunities to visit a number of community mental health centers (Centers) and behavioral health organizations (BHOs). In every case staff has learned about initiatives to integrate behavioral and primary health care. Integrated care may be aimed at improving the physical health care of individuals with serious mental illness or substance use disorder by providing accessible primary care in the same location where they receive their behavioral health care. This may be addressed by locating primary care staff or other medical services in a Center, or co-locating a Center and a federally qualified health center. Integrated care may also be aimed at providing behavioral health supports to primary care providers to screen for behavioral health needs (*e.g.*, depression or substance use disorder) or improving the ability of clients to follow through with behavioral changes that are necessary to manage a chronic disease (*e.g.*, diabetes) or chronic pain. Addressing this goal may involve locating Center clinicians in primary care environments.

Colorado is recognized as a national leader in integrated care, and there are many successful and innovative integrated care programs across the state[5]. A recent study conducted by the Western Interstate Commission for Higher Education (WICHE) for the Department of Human Services titled, "Colorado Office of Behavioral Health Needs Analysis: Current Status, Strategic Positioning, and Future Planning"[6], also discusses integrated care initiatives under way in Colorado and some of the barriers to successful implementation. Since 2009, the Colorado Behavioral Healthcare Council (CBHC) has maintained an interactive online Integrated Care Map, pinpointing all locations where Colorado's community behavioral health system is providing integrated primary and behavioral healthcare services[7]. The map includes more than 150 sites statewide, and it allows the user to filter the sites by various regions (community mental health center, BHO, or regional care collaborative organization), by level of integration (based on federal definitions), and by type of site (*e.g.*, rural health center, school based health center, private primary care practice, etc.).

In December 2014, the federal Centers for Medicare and Medicaid Services awarded Colorado a $65 million State Innovation Model (SIM) grant to implement a plan to innovate state health care over four years. The grant involves the Department of Health Care Policy and Financing (HCPF) as well as the Department of Human Services, the Department of Public Health and Environment, and the Governor's Office (which houses the central "SIM office"). The State's stated goal is to, "improve the health of Coloradans by providing access to integrated primary care and behavioral health services in coordinated community systems, with value-based payment structures, for 80 percent of the state's residents by 2019". In addition to $10.0 million allocated for the various staff involved in grant oversight and implementation, grant funding has been allocated as follows:

- Practice Transformation ($19,996,669) – Provision of technical assistance to providers in primary care practices across the state, with services broadly focused on technology, culture, and business improvements
- Health Information Technology ($15,434,547) – Development of a statewide data management system and output system (including both clinical and claims data) that provides meaningful data to providers, communities, and policy makers
- Transformation Fund ($5,644,253) – Incentive payments that support physical and behavioral health provider participation in learning collaboratives and achievement of milestones
- External Evaluation ($5,527,606) – Actuarial analysis to assess the total cost of care savings from model work as well as the work of an external evaluator
- Bi-directional Health Homes ($5,463,164) – Integration of physical health services into community mental health centers to treat severely and persistently mentally ill clients

[5] "Tri-Agency Regulatory Alignment Initiative to Support Integrated Care", a report prepared by the Departments of Human Services, Health Care Policy and Financing, and Public Health and Environment, page 5 [accessible at: https://drive.google.com/file/d/0B6eUVZvBBTHjekVCRzJBN3lpZFk/view].

[6] See the WICHE study chapter concerning "Whole Health Integration", starting on page 388. The full report can be accessed at the following web address: https://drive.google.com/file/d/0B6eUVZvBBTHjSGhSYUJjVE95ck0/view

[7] Access CBHC's Integrated Care Map at: http://www.cbhc.org/integration/map.

- Population Health ($2,220,000) – Support for new and existing community-led efforts to improve population health (*e.g.*, substance use, mental illness, and obesity)
- Stakeholder Engagement ($670,000) – meeting and travel expenses for stakeholders across the state to gather to learn from each other and experts in the field

Barriers to Integrated Care

The Department of Human Services, the Department of Public Health and Environment, and HCPF convened a group of stakeholders to examine state department administrative rules that present barriers to integration. The group's findings expanded to incorporate broader themes and areas of work for the state system. Several barriers were identified, including the following[8]:

- Rules related to assessment requirements for behavioral health and licensure of sites for specific services such as substance use disorder treatment;
- Rules allowing children age 15 and older to consent to treatment and health insurance billing requirements;
- *Two parallel systems of payment in Medicaid – one for primary care and another for behavioral health care*;
- Payment structures that require individuals to have a diagnosis in order for services to be reimbursed, which deters models based on prevention and early intervention, chronic disease management, and recovery;
- Payment policies for specific populations, including individuals with autism, Alzheimer's, dementia, and traumatic brain injury;
- Differences in the ways that pre-authorization, utilization review, and medical necessity are applied to behavioral health conditions;
- Differences in access, standards of care, and regulatory requirements for substance use disorder treatment based on three different payment systems (Medicaid fee-for-service, Medicaid capitation, and federal block grant funding);
- Different requirements and credentials for primary care and behavioral health provider networks;
- Federal limitations on sharing health data; and
- Federal rules prohibiting Medicaid payments to institutions for mental disease (IMDs).

Community Mental Health Centers (Centers) have indicated that one of the biggest barriers to successful integration for Medicaid clients is the inability of providers to receive reimbursement for the types of services that make integrated care work. HCPF recently "turned on" many Medicaid billing codes related to integrated care (listed below), but it is not yet using these codes for purposes of reimbursing providers:

- 96150- Health and behavior assessment (initial) 15 min
- 96151-Health and behavior assessment (re-assessment) 15 min
- 96152-Health and behavior assessment (individual) 15 min
- 96153-Health and behavior assessment (group) 15 min
- 96154-Health and behavior assessment (family w/ patient) 15 min
- 96155- Health and behavior assessment (family w/o patient) 15 min
- S5190- Wellness assessment performed by non-physician

[8] Tri-Agency Regulatory Alignment Initiative to Support Integrated Care report.

- S9450- Nutrition class, non-physician provider

Providers are hopeful that the data available by turning on the above codes will facilitate changes to the Colorado's Medicaid State Plan to fund effective and efficient models of integrated care.

The remainder of this briefing issue discusses a program on the Western Slope that is testing a model that eliminates the two parallel systems of payment in Medicaid (the third barrier listed above).

Accountable Care Collaborative Payment Reform Initiative (H.B. 12-1281)

House Bill 12-1281

House Bill 12-1281 directs HCPF to facilitate collaboration among Medicaid providers, clients, advocates, and payors in order to improve health outcomes and patient satisfaction and support the financial sustainability of the Medicaid program. The act included a legislative declaration stating that:

> "(I) Increasing health care costs in Colorado's medicaid program creates challenges for the state's budget. Further, the increasing health care costs do not necessarily reflect improvements in either health outcomes for patients or in patient satisfaction with the care received;
>
> (II) Moreover, the fee-for-service payment model may not support or align financially with evolving care coordination and delivery systems;
>
> (III) The reform of medicaid payment policies offers a significant opportunity for the state to contain costs and improve quality;
>
> (IV) New payment methodologies, including global payments, have been developed to respond to rising costs and the complexities of health care delivery. Opportunities now exist to explore, test, and implement such payment reforms in the medicaid program;
>
> (V) The state department should explore how these new payment methodologies may result in improved health outcomes and patient satisfaction and support the financial sustainability of the medicaid program…".

The act creates the Medicaid Payment Reform and Innovation Pilot Program to explore, test and implement new payment methodologies. The act requires HCPF to select payment projects by July 1, 2013, and requires the projects to be implemented at least two years but shall not extend beyond June 30, 2016.

Pilot Program Selected

The Department solicited proposals from the seven Accountable Care Collaborative Regional Care Collaborative Organizations (RCCOs) and received 10 proposals. In July 2013, the Department selected a proposal submitted by Rocky Mountain Health Plans (RMHP), "because it

promised the most innovation and opportunity for improving quality while addressing the upward trend in health care costs"[9].

The Pilot, called "RMHP Prime", is a cooperative effort involving RMHP, Mind Springs Health (the community mental health center serving 10 northwest counties), and Colorado Health Partnerships (the behavioral health organization (BHO) serving Medicaid clients in 43 counties in western and southern Colorado). RMHP Prime serves Medicaid clients who reside in Garfield, Gunnison, Mesa, Montrose, Pitkin or Rio Blanco counties. RMHP Prime is focused on adult clients and children who qualify for Medicaid based on disability status. Enrollment began in September 2014 using a phased approach to allow the Department, RMHP, and providers time to transition to the new program. As of June 30, 2015, enrollment totaled 33,978.

Payments
RMHP Prime is a comprehensive, full-risk capitation program with an enhanced focus on integrating behavioral and physical health services:

- Instead of receiving both per-member-per month payments (as a RCCO) and fee-for-service payments (for primary care services provided), RMHP will receive one payment for all primary care delivered to RMHP Prime members. The payment amounts differ depending on the age and eligibility type of the member.

- HCPF's payment to RMHP is tied to quality using a "medical loss ratio". A medical loss ratio is a measure of how much money a health plan spends providing health care services compared to administrative services and profit; these ratios are typically between 85 and 90 percent. If RMHP fails to spend the required percentage on medical expenses, it must repay the difference to HPCF. HCPF established a medical loss ratio of 93.5 percent for FY 2014-15; this ratio will decrease by two percentage points for each of four quality measure targets that RMHP meets or exceeds.

- The four quality measures proposed by RMHP for FY 2014-15 align with other state initiatives and they match well-established and certified measures for clinical quality reporting[10]. Three of the measures approximate practice proficiency in preventative care, chronic condition management, and behavioral health. The fourth measure is a tool (the Patient Activation Measure or PAM) used to assess a patient's level of engagement in their health care. The PAM tool allows providers to match interventions and health care strategies to clients based on their level of health knowledge and readiness to change. For the duration of RMHP Prime, HCPF will track and monitor additional quality measures through claims data and surveys. For FY 2015-16, HCPF is looking at emergency room utilization and BHO penetration rate.

[9] Report from HCPF to the Joint Budget Committee, House Health, Insurance, and Environment Committee, House Public Health Care and Human Services Committee, and Senate Health and Human Services Committee on Medicaid Payment Reform and Innovation Pilot Program, September 15, 2015, page 2.
[10] The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by many health plans to measure care and quality of service.

- RMHP providers are reimbursed by RMHP in a way that promotes flexibility, accountability, and behavioral health integration. RMHP pays their primary care medical providers (PCMPs) a global payment based on the number of clients attributed to each provider (rather than the number of services provided), and the payments are risk adjusted based on clients' health risk. PCMPs have both upside and downside financial risk. RMHP will share any savings with physical and behavioral health providers contingent on meeting quality targets. This payment structure increases provider accountability for both the total cost of care and health outcomes.

- RMHP has included additional payments to PCMPs that employ behavioral health providers as part of their comprehensive care teams.

Community Mental Health Center Role[11]

In addition to training primary care practices in depression screening, Mind Springs is taking a key role in reducing primary care expenditures and improving health outcomes. RMHP Prime staff began their work by analyzing claims data with the assistance of both physical and behavioral health actuaries. Based on the data, they decided to focus on reducing emergency room visits and hospitalizations. They recruited, trained, and deployed "community health workers" to work with clients who are high utilizers of emergency room services. As a community health worker is not a certified position in Colorado, they created their own training program for these staff.

These workers are connected with specific medical practices and work as part of a primary care team. They each work with about 25 clients to extend support for health, behavior, and social determinants of health beyond the walls of the practice. They build rapport with the clients by meeting them in their homes and communities, accompanying them to appointments, providing transportation, and assisting with needed resources such as housing, nutrition, employment, child care, and financial assistance. They also work to improve communication between clients and physicians. These workers use targeted interventions based on a logic model that divides clients into four quadrants based on physical and behavioral health diagnostic complexity. For those clients with high physical and behavioral health needs, the workers focus on: medication adherence, behavior change, pain management, addiction disorder, and primary care access.

RMHP Prime reports an overall reduction in ER visits among clients served by the community health workers (1.87 visits per client in the first quarter compared to 1.32 visits per client in the second quarter). During the same period, these clients' visits to primary PCMPs increased. Mind Springs is beginning to get direct client referrals from ERs and paramedics, and they are looking at the possibility of placing a Community Health Worker in the ER to help spot emerging issues and direct clients to the appropriate level of care.

[11] This information is based, in part, on JBC staff discussions with Sharon Raggio, President and CEO of Mind Springs Health and Dr. Amy Gallagher, Director of Integrated Care at Mind Springs Health during a site visit that occurred in late September 2015.

Mind Springs staff indicate that overall, health expenditures are higher for RMHP Prime participants in several areas, including:

- primary care;
- substance use disorder therapy;
- outpatient mental health therapy;
- case management; and
- home health.

Offsetting the above increases are reduced expenditures for emergency room services and prescription drugs.

Quality Measures

The September 15, 2015, report submitted by HCPF reflects only six months of data, and data was only available for one of the four quality measures. RMHP Prime implemented the PAM in 24 practice sites – more than twice as many as expected. With respect to emergency room (ER) utilization, HCPF indicates that the frequency of ER visits for RMHP Prime clients is comparable to that of clients in fee-for-service Medicaid (38 visits per 1,000 member months for RMHP Prime compared to 39 for Fee-for-service). However, the Department noted that the populations predominantly enrolled in RMHP Prime are the expansion adult population and individuals with disabilities, and this population may have either pent up demand or an increased need to use ER services.

With respect to the BHO penetration rate (*i.e.*, the proportion of clients who received services from the BHO), HCPF indicates that the penetration rate for RMHP Prime clients (17 percent) is comparable to the rate of the larger BHO service area (19 percent). The report indicates that a full year of program data is needed to better judge the impact of behavioral health services integration on BHO service utilization. Staff notes that the recent WICHE study conducted for the Department of Human Services indicates that there is a significant disparity in behavioral health penetration rates within the region served by Colorado Health Partnership (the BHO used by HCPF to evaluate the RMHP Prime penetration rate). Specifically, the penetration rate for the Western Slope region is consistently less than half that of the Southern/Southeastern region data – and this is true based on analyses of both HCPF and Department of Human Services data[12].

Provider Participation and Satisfaction

There are 51 primary care practices contracted to serve RMHP Prime participants. These practices report that the new payment methodology allows their staff members to "practice at the top of their licenses" and to provide high quality care to the "whole client". Most practices like the fact that they are moving away from a volume driven model towards a value driven model. It is important for both practices and community health workers to have real-time admission, discharge, and transfer data to provide timely care management for clients. This service is provided by Quality Health Network, the health information exchange for the Western Slope.

[12] See the chapter concerning "Penetration Rates and Relative Need for Services", starting on page 162 of the WICHE study.

Quality Health Network is working to include psychiatric hospital admission, discharge, and transfer information into this system.

Involved stakeholders highlight community partnership and collaboration as key components of the program. Since the shared savings arrangements necessitates that all the partners perform well on quality measures, primary care and behavioral health providers are incentivized to work together in ways they may not have in the past. This has led to process and procedure updates, new referral policies, greater dialogue, and other changes that have improved the way that clients receive care.

In its RMHP Prime program report, HCPF indicates that the Accountable Care Collaborative will use RMHP Prime to learn more about how to use payment strategies to better integrate care throughout the state. Further:

> "Health care integration is critical to the creation of better value within the Medicaid program, and a better client experience. The integration of behavioral health services in an accountable system of care is of primary importance, since a significant share of total health costs and population health outcomes are attributable to behavior, decision-making, and substance use." [13]

[13] Report from HCPF to the Joint Budget Committee, House Health, Insurance, and Environment Committee, House Public Health Care and Human Services Committee, and Senate Health and Human Services Committee on Medicaid Payment Reform and Innovation Pilot Program, September 15, 2015, page 6.

Issue: Accountable Care Collaboratives Phase II

The Department of Health Care Policy and Financing (HCPF) recently announced a plan to combine the administrative functions of behavioral health organizations with those of regional care collaborative organizations. The Department's goal is to provide a full continuum of behavioral health interventions throughout the health care system to help address the less acute behavioral health needs of many clients and reduce health care expenditures overall. Behavioral health providers have raised concerns about some potential unintended consequences of eliminating the existing full risk-based capitation payment system for behavioral health services.

SUMMARY:

- Since 1998, Colorado has provided behavioral health services to most Medicaid clients through a statewide "capitated" program, under which behavioral health organizations (BHOs) and their community mental health center partners function as fully at-risk managed care organizations. BHOs have been successful at providing a full continuum of client services, containing costs, and meeting contractual performance and quality measures.

- In 2011, HCPF launched the Accountable Care Collaborative (ACC) with goals to improve quality, increase access, and reduce costs in Medicaid. Under the ACC, regional collaborative care organizations (RCCOs) and primary care medical providers receive payments to coordinate clients' care and meet certain performance indicators, but reimbursements for health care services continue to be paid on a fee-for-service basis.

- In April 2015, HCPF announced that the administrative functions of the RCCOs and the BHOs will be integrated into a single regional accountable entity (RAE) in each of seven state regions, beginning July 1, 2017. The RAEs will be responsible for a "primary care case management system of care" and payments to RAEs will include "value-based components" (*e.g.*, payments tied to key performance indicators, shared savings, and a competitive pool); RAES will make similar value-based administrative payments to their network of health providers. HCPF, however, will pay directly for all clinical services, including behavioral health services.

RECOMMENDATION:

Behavioral health providers have demonstrated their support for integrating behavioral and primary health care by investing the time and resources necessary to launch multiple local initiatives. However, BHOs and community mental health centers have raised several concerns about HCPF's plans for the next phase of the Accountable Care Collaborative. Staff recommends that the Committee ask HCPF to discuss its plans for ACC Phase II, and address the potential negative consequences identified by BHOs and community mental health centers (listed at the end of this issue brief).

DISCUSSION:

Medicaid Behavioral Health Capitation Program

Since 1998, Colorado has provided behavioral health services to most Medicaid clients through a statewide managed care or "capitated" program. *See Appendix G for a legislative history of the behavioral health capitation program.* The Department contracts with regional entities, called behavioral health organizations (BHOs), to provide or arrange for behavioral health services for clients within their geographic region who are eligible for and enrolled in the Medicaid program. In order to receive services through a BHO, a client must have a covered diagnosis and receive a covered service or procedure that is medically necessary.

Each BHO receives a pre-determined monthly amount for each Medicaid client who is eligible for behavioral health services within its geographic area. The "per-member-per-month" rates paid to each BHO are unique for each Medicaid eligibility category in each geographic region. These rates are adjusted annually based on client utilization and BHO expenditures. The BHOs function as fully at-risk managed care organizations; they assume the risk of more clients than expected needing care or needing more intensive services than anticipated, and they are incentivized to ensure appropriate levels of care are provided while not exceeding anticipated cost and utilization rates. BHOs share this risk with community mental health centers in their region, providing sub-capitated payments based on the number of clients in their area.

JBC staff asked HCPF to provide a recent history of Capitation Program membership, expenditures, and per capita costs. Staff also requested comparable data for clients who receive services through the Medicaid fee-for-service programs. The two tables below thus provide a comparison of per capita costs under each of these existing systems. Per capita costs under the Capitation Program have remained relatively flat; FY 2014-15 costs were about four percent lower than FY 2007-08 costs. Per capita costs under the Fee-for-service system increased steadily from FY 2007-08 to FY 2010-11, and stabilized in the last four years. However, per capita costs in FY 2014-15 were nearly twice per capita costs in FY 2007-08.

Behavioral Health Enrollment and Expenditure History for Clients Served Through BHOs								
	FY 07-08	**FY 08-09**	**FY 09-10**	**FY 10-11**	**FY 11-12**	**FY 12-13**	**FY 13-14**	**FY 14-15 1/**
Expenditure	$196,001,003	$215,860,937	$226,620,818	$251,146,027	$271,506,635	$301,303,046	$415,933,333	$569,960,398
Eligible population	369,894	413,232	473,435	534,499	592,804	653,741	828,824	1,124,988
Per capita	$ 529.88	$ 522.37	$ 478.67	$ 469.87	$ 458.00	$ 460.89	$ 501.84	$ 506.64
Per-member-per-month	$ 44.16	$ 43.53	$ 39.89	$ 39.16	$ 38.17	$ 38.41	$ 41.82	$ 42.22

1/ Expenditures include $4,540,153 for school-based substance abuse prevention and intervention programs pursuant to S.B. 14-215.

2/ Eligible population includes only those members enrolled in a BHO. Data is from HCPF's JBC monthly premiums report.

Behavioarl Health Enrollment and Expenditure History for Clients Served FEE-FOR-SERVICE								
	FY 07-08	**FY 08-09**	**FY 09-10**	**FY 10-11**	**FY 11-12**	**FY 12-13**	**FY 13-14**	**FY 14-15 1/**
Expenditure	$1,335,736	$1,776,253	$2,587,662	$3,870,594	$3,892,397	$4,569,198	$5,296,351	$7,525,424
Eligible population	391,962	436,812	498,797	560,759	619,963	682,994	860,957	1,161,206
Per capita	$ 3.41	$ 4.07	$ 5.19	$ 6.90	$ 6.28	$ 6.69	$ 6.15	$ 6.48
Per-member-per-month	$ 0.28	$ 0.34	$ 0.43	$ 0.58	$ 0.52	$ 0.56	$ 0.51	$ 0.54

In order to ensure that BHOs' cost containment efforts do not result in inappropriate care, HCPF contracts with BHOs include a number of performance measures, including 16 key indicators such as:

- Hospital readmissions at 7, 30, 90, and 180 days;
- The percent of members prescribed redundant/duplicated atypical antipsychotic medication;
- Psychotropic utilization in children;
- Engagement of alcohol or other drug dependence treatment;
- Penetration rates;
- Members with physical health well-care visits;
- Emergency department utilization for mental health condition; and
- Follow-up appointments within 7 and 30 days after hospital discharge for a mental health condition.

Accountable Care Collaborative (ACC) Program

In 2011, HCPF launched the Accountable Care Collaborative (ACC) with the goals to improve quality, increase access, and reduce costs in Medicaid. The ACC consists of three components:

- Regional collaborative care organizations (RCCOs), which are responsible for network development, provider support, care coordination, and accountability and reporting;
- Primary care medical providers (PCMPs), which serve as a "medical home" for ACC members; and
- A statewide data and analytics contractor, which provides operational support and data to HCPF, RCCO staff, and PCMPs.

Each RCCO and PCMP receives a small per-member-per-month amount, and has the ability to earn additional funding based on their region's performance in meeting certain performance indicators. These payments are over and above traditional fee-for-service reimbursements providers receive for primary health care services.

ACC Phase II and Regional Accountable Entities

In April 2015, HCPF announced that the administrative functions of the RCCOs and BHOs will be integrated into a single "regional accountable entity" (RAE) in each of seven state regions. HCPF indicates that the goal of the next phase is to "optimize health for those served by Medicaid through accountability for value and client experience at every level of the health system and at every life stage"[14]. In order to achieve this goal, Phase II will focus on the following key principles:

[14] "Accountable Care Collaborative Phase II Concept Paper", prepared by HCPF October 20, 2015, page 9.

- person- and family-centeredness – maximizing client choice and control to drive the development of an individualized services and support plan
- outcomes-focused and value-based – using specific metrics to track progress toward outcomes
- accountability at every level, including: (1) clients; (2) health neighborhoods (consisting of the PCMP and long-term services and supports case management agency, behavioral health provider, or certain specialists, if needed); (3) RAEs; and (4) HCPF.

Clients will be automatically enrolled in the ACC through mandatory enrollment and immediately connected with a PCMP. A PCMP must be a medical practitioner with a focus on primary care. RAES will be given greater latitude to contract only with those PCMPs that meet a basic set of requirements.

RAEs will be responsible for a "primary care case management system of care", and payments to RAEs will include "value-based components" such as payments tied to key performance indicators, shared savings, and a competitive pool. The RAEs will be responsible for making value-based administrative payments to health team providers. HCPF, however, will pay directly for clinical services, including behavioral health. HCPF will develop utilization management strategies that ensure that clients receive appropriate access to high value services.

Existing RCCO contracts expire June 30, 2017, and HCPF's new Medicaid Management Information System and its associated data and analytics systems will be implemented prior to 2017, so HCPF plans implement the new RAE contracts effective July 1, 2017. The most recent BHO contracts were awarded for the period July 2014 through June 2019, so this will require HCPF to end these contracts two years earlier than planned. HCPF is currently in the process of meeting with stakeholders and developing federal waivers and contracts. HCPF plans to release a draft request for proposals in the spring of 2016, and transition to the new RAE contracts in the first six months of 2017.

Behavioral Health Provider Concerns

Behavioral health providers have demonstrated their support for integrating behavioral and primary health care by investing the time and resources necessary to launch multiple local initiatives. However, BHOs and community mental health centers have raised several concerns about HCPF's plans for ACC Phase II. Staff has attempted to describe these concerns below, along with some responses from HCPF in response to staff questions.

- *Cost containment and a full continuum of care for clients.* BHOs and their community mental health center partners indicate that the reason that they have been effective in containing behavioral health costs while providing access to a full continuum of community-based services is the capitation payment. BHOs are fully at risk so they are responsible for managing utilization of inpatient psychiatric hospital services and other high cost, intensive services. The capitated payment allows them the flexibility to invest in alternative client services not otherwise reimbursed by Medicaid (assertive community treatment, clubhouses, transportation and housing supports, care coordination and case management, etc.).

- HCPF proposes paying for all behavioral health services based on encounters or services rendered instead of the current risk-based capitated model. HCPF indicates that it plans to control costs through:
  (a) setting service limits or prior authorization criteria;
  (b) building payment structures that hold providers accountable for total cost (*i.e.*, shared savings);
  (c) establishing rate models that promote efficient and high value expenditures (*i.e.*, regular outpatient check-ups); and
  (d) instituting contract requirements that set clear enforceable standards.

  HCPF indicates that its priority is paying similarly for services in order to remove the current barriers to the delivery of integrated, whole person care. By removing the current covered diagnosis capitation model, the Department seeks to provide a full continuum of behavioral health interventions throughout the health care system to help address the less acute behavioral health needs of many clients and reduce healthcare expenditures overall for both the short and long-term.

  HCPF indicates that Colorado is one of six state Medicaid programs (the other states being Connecticut, Iowa, Louisiana, Nebraska, and Wisconsin) that is considering removal of its behavioral health "carve out" in order to provide integrated care models that can reduce excess costs associated with comorbid physical and behavioral health conditions. Connecticut recently stopped using managed care arrangements and moved to a self-insured, managed fee for service Administrative Services Organization model. Connecticut expects this shift will lead to greater consistency in reimbursement rates and requirements for prior authorization of services, improved experience and understanding by Medicaid beneficiaries, more timely and consistent provider payments, and a complete and accurate view of the utilization of Medicaid services.

- *Potential shift of funding away from behavioral health to cover primary health care costs.* Funding for primary health care services through the Medical Services Premiums line item is nearly ten times as large as funding for behavioral health services. If the state pays a single entity to provide both physical and behavioral health services, some financial resources that are currently dedicated to behavioral health services may be redirected for primary health care and other medical services.

- *Federal IMD exclusion and limited access to inpatient psychiatric services.* BHOs and their community mental health center partners have used the flexibility provided through the capitation program and the associated federal 1915 (b) (3) waiver to pay for clients to receive necessary inpatient hospitalization services at private psychiatric facilities; these facilities are considered institutions for mental disease (IMD), and thus would not be reimbursed by Medicaid under a fee-for-service arrangement. Given the limited availability of psychiatric beds for Medicaid clients at general hospitals and at the State's mental health institutes, the loss of this flexibility under a fee-for-service model could limit clients' access to these services.

  - HCPF has indicated that its priority is continuing the alternative services allowed under the federal waiver and providing a means for clients to receive "in lieu" services while residing in an IMD. HCPF recently began conversations with the federal Centers for Medicare and Medicaid Services (CMS) to determine how it could preserve this flexibility.

- *Loss of funding that currently supports local integrated care initiatives.* BHOs and their community mental health center partners have used the flexibility provided through the capitation program and the associated federal 1915 (b) (3) waiver to initiate and pay for many local integrated care initiatives. The proposed payment methodology would appear to eliminate this flexibility, thereby eliminating much of the funding that is supporting existing integrated care initiatives.

  - HCPF indicates that it is committed to continuing the alternative services made possible by the current waiver, and it recently began conversations with CMS about the best approach to implement the program and what waiver(s) will be necessary.

- *Premature implementation of new funding and service delivery model.* The State is only in the first year of a four-year SIM grant initiative to integrate physical and behavioral health care. HCPF's first payment reform initiative under H.B. 12-1281 (RMHP Prime) has been operating for a year but HCPF has only been able to evaluate six months of expenditure and outcome data to date. HCPF only recently "turned on" key Medicaid billing codes related to integrated care services. If HCPF plans to use these initiatives to learn more about how to use payment strategies to better integrate care throughout the state, wouldn't it make more sense to delay the proposed release of the RAES request for proposals and the subsequent contracting process?

Staff recommends that the Committee ask HCPF to discuss its plans for ACC Phase II, and address the potential negative consequences identified by BHOs and community mental health centers.

Appendix A: Number Pages

	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	Request vs. Appropriation
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING					
Sue Birch, Executive Director					
(3) BEHAVIORAL HEALTH COMMUNITY PROGRAMS					
This section provides for behavioral health services through the purchase of services from five regional behavioral health organizations (BHOs), which manage mental health and substance use disorder services for eligible Medicaid recipients in a capitated, risk-based model. This section also contains funding for Medicaid behavioral health fee-for-service programs for those services not covered within the capitation contracts and rates. The funding for this section is primarily from the General Fund and federal Medicaid funds. Cash fund sources include the Hospital Provider Fee Cash Fund and the Breast and Cervical Cancer Prevention and Treatment Fund.					
Behavioral Health Capitation Payments	415,933,333	565,420,239	646,025,263	663,569,890	*
General Fund	151,532,141	173,415,971	188,346,101	186,526,613	
Cash Funds	12,402,378	5,333,335	8,967,481	16,343,330	
Federal Funds	251,998,814	386,670,933	448,711,681	460,699,947	
School-based Prevention and Intervention Substance Use Disorder Services	0	4,540,153	0	0	
General Fund	0	2,132,374	0	0	
Cash Funds	0	0	0	0	
Federal Funds	0	2,407,779	0	0	
Behavioral Health Fee-for-service Payments	5,295,835	7,525,423	8,410,359	8,645,866	*
General Fund	2,475,020	2,946,662	2,685,684	1,827,862	
Cash Funds	6,385	20,963	143,951	225,620	
Federal Funds	2,814,430	4,557,798	5,580,724	6,592,384	
School-based Substance Abuse Prevention and Intervention Grant Program	0	795,909	0	0	
General Fund	0	795,909	0	0	

	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	Request vs. Appropriation
Contract Reprocurement	0	203,752	0	0	
General Fund	0	101,876	0	0	
Federal Funds	0	101,876	0	0	
TOTAL - (3) Behavioral Health Community Programs	421,229,168	578,485,476	654,435,622	672,215,756	2.7%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	154,007,161	179,392,792	191,031,785	188,354,475	(1.4%)
Cash Funds	12,408,763	5,354,298	9,111,432	16,568,950	81.8%
Federal Funds	254,813,244	393,738,386	454,292,405	467,292,331	2.9%

	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	Request vs. Appropriation
(7) DEPARTMENT OF HUMAN SERVICES MEDICAID-FUNDED PROGRAMS					
This section reflects the Medicaid funding used by the Department of Human Services. The Medicaid dollars appropriated to that Department are first appropriated in this section and then transferred to the Department of Human Services. See the Department of Human Services for additional details about the line items contained in this division					
(F) Behavioral Health Services - Medicaid Funding					
Community Behavioral Health Administration	318,262	323,369	416,056	416,056	
General Fund	159,131	161,684	204,741	208,294	
Federal Funds	159,131	161,685	211,315	207,762	
Mental Health Treatment Services for Youth (H.B. 99-1116)	20,624	8,677	123,624	122,388 *	
General Fund	10,312	4,284	60,836	60,680	
Federal Funds	10,312	4,393	62,788	61,708	
High Risk Pregnant Women Program	1,138,015	969,806	1,600,000	1,589,306 *	
General Fund	569,008	478,103	787,360	787,978	
Federal Funds	569,007	491,703	812,640	801,328	
Mental Health Institutes	1,050,942	6,077,240	6,000,000	6,000,000 *	
General Fund	516,910	2,795,085	2,952,600	3,000,000	
Federal Funds	534,032	3,282,155	3,047,400	3,000,000	
SUBTOTAL - (F) Behavioral Health Services - Medicaid Funding	2,527,843	7,379,092	8,139,680	8,127,750	(0.1%)
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	1,255,361	3,439,156	4,005,537	4,056,952	1.3%
Federal Funds	1,272,482	3,939,936	4,134,143	4,070,798	(1.5%)

NOTE: An asterisk (*) indicates that the FY 2016-17 request for the line item is affected by one or more decision items.

Appendix B:
Recent Legislation Affecting Department Budget

2015 Session Bills

S.B. 15-167 (Modify FY 2014-15 Appropriations from Marijuana Revenue): Aligns FY 2014-15 appropriations from and transfers related to the Marijuana Tax Cash Fund (MTCF) with actual marijuana tax revenue collected in FY 2013-14. With respect to the Department of Health Care Policy and Financing, the act reduces the General Fund appropriation for the School-based Substance Abuse Prevention and Intervention Grant Program by $1,081,344 (from $2,000,000 to $918,656). The act also reduces the associated statutory transfer from the General Fund to the MTCF by $1,151,631 (from $4,260,000 to $3,108,369).

S.B. 15-228 (Medicaid Provider Rate Review): Establishes an annual process for the Department of Health Care Policy and Financing to review Medicaid provider rates, creates an advisory committee, and requires reporting to the Joint Budget Committee. Provides $539,823 total funds, including $269,912 General Fund and $269,911 federal funds, and 4.0 FTE to implement the rate review process.

H.B. 15-1186 (**Services for Children with Autism**): For the Children with Autism waiver program, the act:

- expands eligibility to add children ages six to eight;
- allows children who begin receiving services before age eight to receive a full three years of services;
- allows General Fund support and eliminates the current enrollment cap of 75 children;
- eliminates the annual statutory $25,000 per child expenditure cap on services and allows the cap to be adjusted through the budget process; and
- provides for an annual evaluation of the effectiveness of services for people with autism.

To implement these changes, the act provides $10.6 million, including $367,564 General Fund, to the Department of Health Care Policy and Financing in FY 2015-16. The table below summarizes the projected costs over the next three years. The source of cash funds is tobacco settlement moneys deposited in the Autism Treatment Cash Fund.

Children with Autism Waiver Expansion			
	FY 15-16	FY 16-17	FY 17-18
Total	$10,616,568	$19,042,713	$22,726,738
General Fund	367,564	8,830,589	10,567,929
Cash Funds	4,840,203	508,566	577,333
Federal Funds	5,408,801	9,703,558	11,581,476

H.B. 15-1368 (Cross-system Response Pilot Intellectual and Developmental Disabilities): Establishes the Cross-system Response for Behavioral Health Crises Pilot Program (Pilot Program) to provide crisis intervention, stabilization, and follow-up services to individuals who:

- have both an intellectual or developmental disability and a mental health or behavioral disorder;
- require services not available through an existing Medicaid waiver; and
- are not covered under the Colorado behavioral health care system.

Requires the Pilot Program to begin on or before March 1, 2016, and consist of multiple sites that represent different geographic areas of the state. The Pilot Program must:

- provide access to intensive coordinated psychiatric, behavioral, and mental health services as an alternative to emergency department care or in-patient hospitalization;
- offer community-based, mobile supports to individuals with dual diagnoses and their families;
- offer follow-up supports to individuals with dual diagnoses, their families, and their caregivers to reduce the likelihood of future crises;
- provide education and training for families and service agencies;
- provide data about the cost of providing such services throughout the state; and
- provide data to inform changes to existing regulatory or procedural barriers to the authorized use of public funds across systems, including the Medicaid state plan, home- and community-based service Medicaid waivers, and the capitated mental health system.

Requires the Department of Health Care Policy and Financing (HCPF) to conduct a cost-analysis study related to the services that would need to be added to eliminate service gaps and ensure that individuals with intellectual and developmental disabilities are fully included in the Colorado behavioral health system. Also, requires HCPF to provide recommendations for eliminating the service gap. Authorizes the Department of Human Services and HCPF to examine the feasibility of allowing a Community Centered-Board to use a vacant Regional Center group home for the Pilot Program. Appropriates $1,695,000 cash funds from the Intellectual and Developmental Disabilities Services Cash Fund to the Cross-system Response for Behavioral Health Crises Pilot Program Fund and authorizes HCPF to spend these moneys in FY 2015-16.

Relevant Bills From Previous Sessions

S.B. 14-215 (Disposition of Legal Marijuana Related Revenue): Creates the Marijuana Tax Cash Fund (MTCF) and directs that all sales tax moneys collected by the state starting in FY 2014-15 from retail and medical marijuana be deposited in the MTCF instead of the Marijuana Cash Fund. Specifies permissible uses of moneys in the MTCF, including increasing the availability of school-based prevention, early intervention, and health care services and programs to reduce the risk of marijuana and other substance use and abuse by school-aged children. Creates the School-based Substance Abuse Prevention and Intervention grant program in the Department of Health Care Policy and Financing (HCPF) to award competitive grants to entities to provide school-based prevention and intervention programs for youth, primarily focused on reducing marijuana use, but including strategies and efforts to reduce alcohol use and

prescription drug misuse. With respect to HCPF, appropriates a total of $6,363,807 for FY 2014-15, including: $2,000,000 General Fund for the newly created grant program; and $4,363,807 (including $2,000,000 General Fund and $2,363,807 federal Medicaid funds) for school-based prevention and intervention substance use disorder services to be provided by behavioral health organizations. Directs the State Treasurer to transfer $4,260,000 from the MTCF to the General Fund to offset the General Fund appropriations to HCPF.

S.B. 13-200 (Expand Medicaid Eligibility): Expands Medicaid eligibility from 100 percent of the federal poverty level (FPL) to 133 percent for parents and caretaker relatives with dependent children (parents) and adults without dependent children (AWDC). Pursuant to the provisions of the 2010 federal Affordable Care Act, Colorado is eligible for an enhanced federal match rate for certain populations as a result of the eligibility expansion authorized in S.B. 13-200. For Colorado, the enhanced federal match rate applies to AWDC with incomes from zero percent through 133 percent of the FPL, and to parents with incomes from 61 percent through 133 percent of the FPL. The enhanced federal match rate is 100 percent from 2014 through 2016 and then it declines incrementally until it reaches 90 percent in 2020. The act authorizes the Hospital Provider Fee to pay the State share of costs for the newly eligible populations when the enhanced federal match rate is reduced. Adjusts appropriations for FY 2013-14 as detailed in the following table, based on the eligibility expansions going into effect January 1, 2014.

Department	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
Health Care Policy and Financing	$315,141,256	($123,209)	($154,578,421)	$0	$469,842,886	19.0
Corrections	(2,471,751)	(2,471,751)	0	0	0	0.4
Human Services	(651,875)	(651,875)	0	0	0	0.0
Law	24,910	0	0	24,910	0	0.0
Personnel	12,122	0	0	12,122	0	0.0
Total	$312,054,662	($3,246,835)	($154,578,421)	$37,032	$469,842,886	19.4

Appendix C:
Update on Long Bill Footnotes & Requests for Information

Long Bill Footnotes

17 **Department of Health Care Policy and Financing, Department of Human Services Medicaid-funded Programs, Behavioral Health Services - Medicaid Funding, High Risk Pregnant Women Program** -- This appropriation is intended to include sufficient funding for the Department of Health Care Policy and Financing to implement the following provider rate increases for this program: (a) a $13.98 (91.3 percent) increase in the outpatient group rate; (b) a $31.26 (20.0 percent) increase in the per diem rate; plus (c) an overall rate increase of 1.7 percent.

Comment: The Department indicates that the above rate increases have not yet been implemented. The federal Centers for Medicare and Medicaid Services (CMS) has not yet approved the State Plan Amendment (Clinical Services SPA) that would allow the Department to implement the increase. The Department submitted the Amendment on June 3, 2015. The Department does not currently have an estimated approval date from CMS. When CMS does approve the rate, we will be able to implement it retroactively back to July 1, 2015.

Requests for Information

Requests Applicable to Multiple Departments

3. **Department of Health Care Policy and Financing, Behavioral Health Community Programs; and Department of Human Services, Behavioral Health Services** -- The Department of Human Services is requested to work with the Department of Health Care Policy and Financing and any other relevant state agencies to provide a report to the Joint Budget Committee by November 1, 2015, concerning substance use disorder (SUD) treatment and prevention services for adolescents and pregnant women. The report is requested to include the following information: (a) a brief description of each state program that provides SUD prevention or treatment services for adolescents or pregnant women; (b) actual expenditures for SUD prevention or treatment services for adolescents and pregnant women in FY 2014-15, by program and fund source; and (c) information indicating whether there is a need for additional state funding to meet the SUD prevention and treatment needs of adolescents or pregnant women.

Comment: This request for information is discussed in Carolyn Kampman's staff budget briefing presentation concerning the Department of Human Services, Behavioral Health Services, dated December 9, 2015.

Requests Applicable to the Department of Health Care Policy and Financing

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

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

Appendix D: FY 2014-15 SMART Act Annual Performance Report and FY 2015-16 Performance Plan

Pursuant to Section 2-7-205 (1) (b), C.R.S., the Department of Health Care Policy and Financing is required to publish an Annual Performance Report by November 1 of each year. This report is to include a summary of the Department's performance plan and most recent performance evaluation. For consideration by the Joint Budget Committee in prioritizing the budget request submitted by the Department, the FY 2014-15 report can be found at the following link:

https://drive.google.com/file/d/0B8ztIiGduUWbSlI3UkVmQ05VY28/view

Pursuant to Section 2-7-204 (3) (a) (I), C.R.S., the Department of Health Care Policy and Financing is required to develop a performance plan and submit that plan to the Joint Budget Committee and appropriate Joint Committee of Reference by July 1 of each year. For consideration by the Joint Budget Committee in prioritizing the budget request submitted by the Department, the FY 2015-16 plan can be found at the following link:

https://drive.google.com/folderview?id=0BzIopKKDzSSTfnRpV1JXYTA1Z051THJWbmhHTkpJLVNvOXJkSm5qbWlJM1ZRSUVyTEhJTmM&usp=drive_web

Appendix E: FY 2015-16 Behavioral Health Capitation Payments Calculation

Description	Eligibility Category								
	Adults Age 65+ (to SSI)	Individuals With Disabilities up to age 64 (to 450% FPL)	Parents/ Caretakers (to 68% FPL); Pregnant Adults (to 200% FPL)	Parents/ Caretakers (69% to 138% FPL)*	Adults without Dependent Children (to 138% FPL)*	Children (to 147% FPL)	Individuals In/ Formerly In Foster Care (up to age 26)	Breast and Cervical Cancer Program (to 250% FPL)	Total
Estimated Weighted Capitation Rate (per member, per month):									
First 6 months	$14.75	$128.42	$25.55	$20.74	$61.28	$19.67	$174.57	$25.55	
Second 6 months	$14.93	$137.89	$26.14	$21.22	$62.68	$20.13	$194.56	$26.14	
Estimated Monthly Caseload:									
First 6 months	42,046	83,835	194,598	81,084	288,584	525,198	19,861	312	1,235,518
Second 6 months	42,388	85,747	201,821	84,708	297,598	543,264	19,983	253	1,275,762
Full year	42,217	84,792	198,211	82,896	293,091	534,231	19,922	283	1,255,642
Total Capitated Payments (per member, per month rate X monthly caseload):									
First 6 months	$3,721,071	$64,596,544	$29,831,873	$10,090,093	$106,106,565	$61,983,868	$20,802,809	$47,830	$297,180,653
Second 6 months	3,797,117	70,941,923	31,653,606	10,785,023	111,920,656	65,615,426	23,327,355	39,681	318,080,785
Full year	$7,518,188	$135,538,467	$61,485,479	$20,875,116	$218,027,221	$127,599,294	$44,130,164	$87,510	$615,261,438
Estimated Expenditures:									
First 6 months									
Claims paid in current period	$3,705,070	$64,460,891	$29,649,899	$9,972,039	$105,321,376	$61,791,718	$20,777,846	$47,624	$295,726,463
Claims from prior periods	29,592	299,542	346,260	383,178	1,408,473	372,203	63,043	455	2,902,746
Second 6 months									
Claims paid in current period	3,780,789	70,792,945	31,460,519	10,658,838	111,092,381	65,412,018	23,299,362	39,510	316,536,362
Claims from prior periods	32,373	271,305	366,932	237,117	1,580,988	384,300	49,927	416	2,923,358
Total Estimated Expenditures	$7,547,824	$135,824,683	$61,823,610	$21,251,172	$219,403,218	$127,960,239	$44,190,178	$88,005	$618,088,929
Estimated date of death retractions	(192,935)	(690,805)	(32,332)	(14,439)	(255,630)	(14,439)	(39,737)	(1,445)	(1,241,762)
Subtotal: Expenditures including date of death retractions	**$7,354,889**	**$135,133,878**	**$61,791,278**	**$21,236,733**	**$219,147,588**	**$127,945,800**	**$44,150,441**	**$86,560**	**$616,847,167**
Adjustments:									
Adults without dependent children risk corridor reconciliation									($20,613,732)
Adults without dependent children rate reconciliation									3,700,000
Total Revised Estimate of Behavioral Health Capitation Payments									**$599,933,435**

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

The above data reflects the Department's most recent caseload and expenditure forecast for Behavioral Health Capitation Payments.

Appendix F: FY 2016-17 Behavioral Health Capitation Payments Calculation

Description	Eligibility Category								
	Adults Age 65+ (to SSI)	Individuals With Disabilities up to age 64 (to 450% FPL)	Parents/ Caretakers (to 68% FPL); Pregnant Adults (to 200% FPL)	Parents/ Caretakers (69% to 138% FPL)*	Adults without Dependent Children (to 138% FPL)*	Children (to 147% FPL)	Individuals In/ Formerly In Foster Care (up to age 26)	Breast and Cervical Cancer Program (to 250% FPL)	Total
Estimated Weighted Capitation Rate (per member, per month):									
First 6 months	$14.93	$137.89	$26.14	$21.22	$62.68	$20.13	$194.56	$26.14	
Second 6 months	$15.11	$140.96	$26.94	$21.87	$64.60	$20.59	$200.24	$26.94	
Estimated Monthly Caseload:									
First 6 months	42,691	87,794	208,139	86,629	301,819	555,160	19,985	183	1,302,400
Second 6 months	42,968	89,956	213,803	87,266	304,862	562,447	19,900	122	1,321,324
Full year	42,830	88,875	210,971	86,948	303,341	558,804	19,943	153	1,311,862
Total Capitated Payments (per member, per month rate X monthly caseload):									
First 6 months	$3,824,260	$72,635,488	$34,479,673	$83,011,342	$83,011,342	$47,997,113	$23,329,690	$28,702	$348,317,609
Second 6 months	3,895,479	76,081,187	35,735,607	83,011,342	83,011,342	52,985,405	20,339,379	19,720	355,079,461
Full year	$7,719,739	$148,716,675	$70,215,280	$166,022,684	$166,022,684	$100,982,518	$43,669,069	$48,422	$703,397,070
Estimated Expenditures:									
First 6 months									
Claims paid in current period	$3,807,816	$72,482,953	$32,445,389	$10,900,558	$112,668,130	$66,844,363	$23,301,694	$28,579	$322,479,482
Claims from prior periods	33,035	297,956	389,339	253,448	1,667,617	406,816	55,986	345	3,104,542
Second 6 months									
Claims paid in current period	3,878,728	75,921,417	34,348,306	11,317,068	117,290,222	69,269,299	23,879,966	19,635	335,924,641
Claims from prior periods	33,271	305,069	401,528	259,196	1,691,271	415,724	55,991	250	3,162,300
Total Estimated Expenditures	$7,752,850	$149,007,395	$67,584,562	$22,730,270	$233,317,240	$136,936,202	$47,293,637	$48,809	$664,670,965
Estimated date of death retractions	(173,642)	(621,725)	(29,099)	(12,995)	(230,067)	(12,995)	(35,763)	(1,301)	(1,117,587)
Subtotal: Expenditures including date of death retractions	**$7,579,208**	**$148,385,670**	**$67,555,463**	**$22,717,275**	**$233,087,173**	**$136,923,207**	**$47,257,874**	**$47,508**	**$663,553,378**
Decision Items:									
NP5 (DPHE R4) Cervical cancer eligibility expansion									16,512
Total Request									**$663,569,890**

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

Appendix G: Legislative History of Behavioral Health Capitation Program[15]

Mental Health Services Prior to Capitation Program
Prior to 1995, most Medicaid beneficiaries in Colorado received mental health benefits through a fee-for-service system. Medicaid beneficiaries who were not enrolled in health maintenance organizations (HMOs) received mental health services from a variety of Medicaid-enrolled providers, such as community mental health centers, clinics, hospitals, psychiatrists, psychologists, and social workers. These health care providers billed the Medicaid Program for each covered service provided to Medicaid beneficiaries. There was no central "gatekeeper" determining the need for services and no single clinician or case manager coordinating all aspects of an individual's mental health care. Medicaid beneficiaries were free to seek services from any Medicaid-enrolled provider.

Medicaid beneficiaries who were enrolled in HMOs received a limited amount of inpatient and outpatient mental health services through these HMOs. If a beneficiary received the maximum mental health benefits available through the HMO, additional necessary mental health services could be received through the Medicaid fee-for-service system described above.

Legislation Creating the Mental Health Capitation Program
Since 1992, there have been four significant legislative changes that affected the delivery of mental health services to Medicaid clients:

- **House Bill 92-1306** required the Department of Social Services (Department) to promulgate rules to establish a managed care system, defined as a system for providing health care services which "integrates both the delivery and the financing of health care services in an attempt to provide access to medical services while containing the cost and use of medical care". The act authorized the Department to enter into contracts with vendors to provide medical services based on a fixed rate of reimbursement per recipient if the Department determined that a capitated contract would reduce the cost of providing medical benefits. The act also authorized the Department to work with the Department of Institutions to conduct a feasibility study concerning a prepaid capitated single entry point system for providing comprehensive mental health services. If the Department determined that the implementation of such a program would be cost-effective, the act authorized it to implement a two-year pilot program.

- **Senate Bill 95-078** included a legislative finding that, "preliminary indications from other states show that prepaid capitated systems for providing mental health services to medical assistance recipients result in cost-savings to the State". The act extended the pilot program to July 1997, and expanded the pilot program reporting requirements to include:
  - benefits to recipients and their access to mental health services;
  - the overall impact of the program on recipients, providers, and the mental health system;
  - recommendations concerning the feasibility of proceeding with statewide a capitated system; and

[15] This Appendix is based on information provided by the Department of Health Care Policy and Financing, and the Colorado Behavioral Healthcare Council.

- recommendations concerning the role of community mental health centers (Centers) under a capitated system, including "plans to protect the integrity of the state mental health system and to ensure that [Centers] are not exposed to undue financial risks under the prepared capitated system…based on the unique and historical role the [Centers] have assumed in meeting the mental health needs of communities throughout the state".

The act directed the Departments of Health Care Policy and Financing and Human Services to implement a statewide prepaid mental health managed care program by July 1, 1998, or six months after receipt of the necessary federal waivers. The act directed the Departments to revise the waiver request to allow HCPF to limit a recipient's freedom of choice with respect to a provider of mental health services and to restrict reimbursements to providers.

- **Senate Bill 97-005** required HCPF (subject to the receipt of federal waivers) to implement a plan to result in 75 percent of Colorado's Medicaid recipients to be in a managed care plan by July 1, 2000. The plan was to include the following:
  - Acute and long-term care pilot program;
  - Limited enrollment managed care contracts;
  - Managed mental health services; and
  - Program of all-inclusive care for the elderly.

  The act delineated the required features of the managed care system and the criteria the Department must use to measure quality, and authorized the Department to institute a program of competitive bidding to provide medical services in a managed care program. The act also required the Department to make prepaid capitation payments to managed care organizations based upon a defined scope of services. The act required the capitation rates to include risk adjustments, reinsurance, or stop-loss funding methods, and indicated that payments to plans may vary when it is shown that certain populations are expected to cost more or less than the capitated population as a whole. The act required the Department to compile data on health outcomes and to evaluate the cost-efficiency of the state's managed care programs. The act also required the General Assembly to appropriate any savings achieved through the implementation of a managed care system to: (a) cover the related administrative costs; and (b) pay for programs to expand access to services for the medically indigent population.

- **House Bill 04-1265** transferred the Medicaid mental health community program operations from the Department of Human Services to HCPF (with the exception of funding related to the *Goebel* lawsuit settlement). According to HCPF, this change allowed for more cohesive management of the entire continuum of Medicaid services and administrative contracts. In addition, this shift also allows HCPF to be more aware of gaps between physical and mental health care and to better serve Medicaid beneficiaries by having one administrative agency responsible for the provision of their Medicaid services.

Federal Waivers

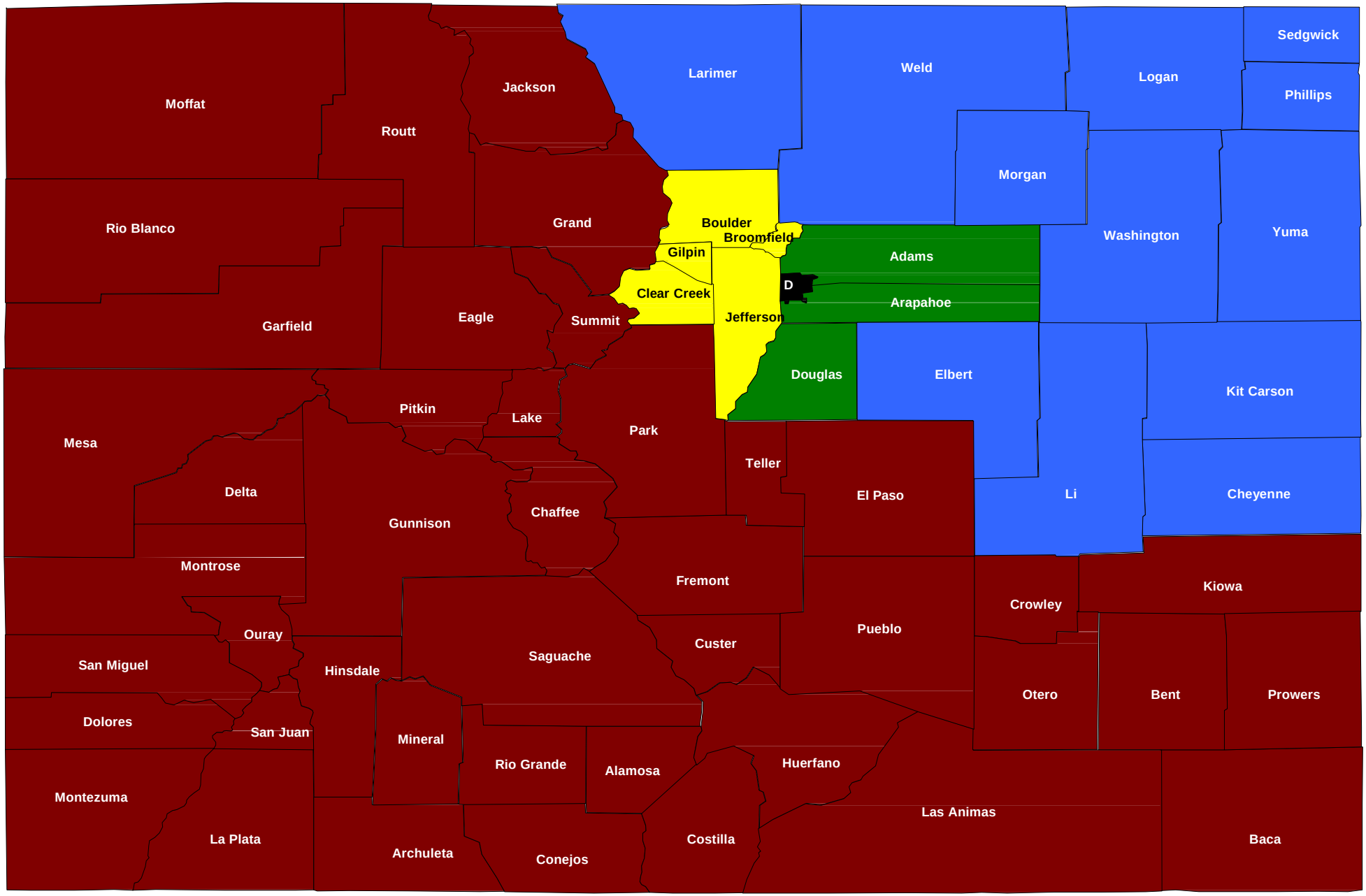
In 1993, the federal Health Care Financing Administration (HCFA) granted the State waivers under Section 1915 (b) and Section 1902 (a) of Title XIX of the Social Security Act. These waivers allowed the State to implement a managed mental health program for a two-year period, from July 1, 1995, through June 30, 1997. These initial waivers were subsequently extended by HCFA approximately every

two years through the current renewal which expires December 31, 2015. The federal Centers for Medicare and Medicaid Services (CMS) is currently reviewing the next extension of the waiver which would be in effect from January 1, 2016 through June 30, 2017.

Program Implementation
The Colorado Medicaid Mental Health Capitation and Managed Care Program was implemented in 51 counties in 1995, and in the remaining 12 counties (that existed at that time) in 1998. From 1998 through 2004, eight contractors operated the Program. In 2005, the Department reconfigured the counties into five geographic service areas. Each contractor operates the Program in a specific geographic area, and only one contractor operates in any given area.

The Department requested and was granted the authority to expand the Medicaid substance use disorder benefit and to incorporate the benefit into the BHO managed care delivery system. The objective was to provide a more integrated and robust service package for clients with behavioral health needs. The expanded benefit does not, however, include residential or inpatient substance use disorder treatment.

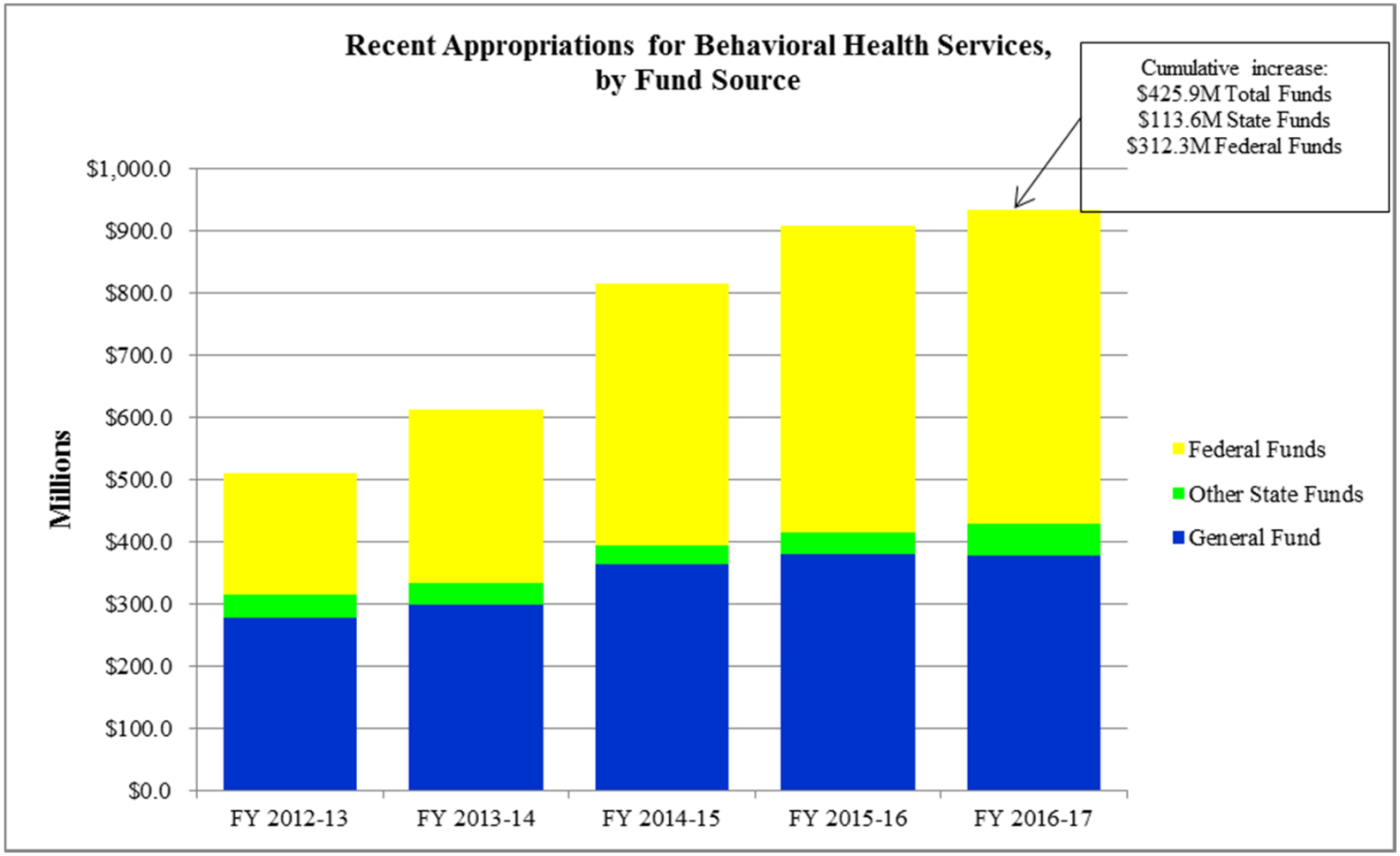
Current Law
The current Statewide Managed Care System is authorized and governed by Section 25.5-5-401 *et seq.*, C.R.S. The Department is required to "establish cost-effective, capitated rates for community mental health services in a manner that includes cost containment mechanisms". The Department is authorized to limit a recipient's freedom of choice with respect to a provider of mental health services and to restrict reimbursements for mental health services to designated and contracted agencies. This section also states that the administration of the State's mental health institutes shall remain the responsibility of the Department of Human Services.

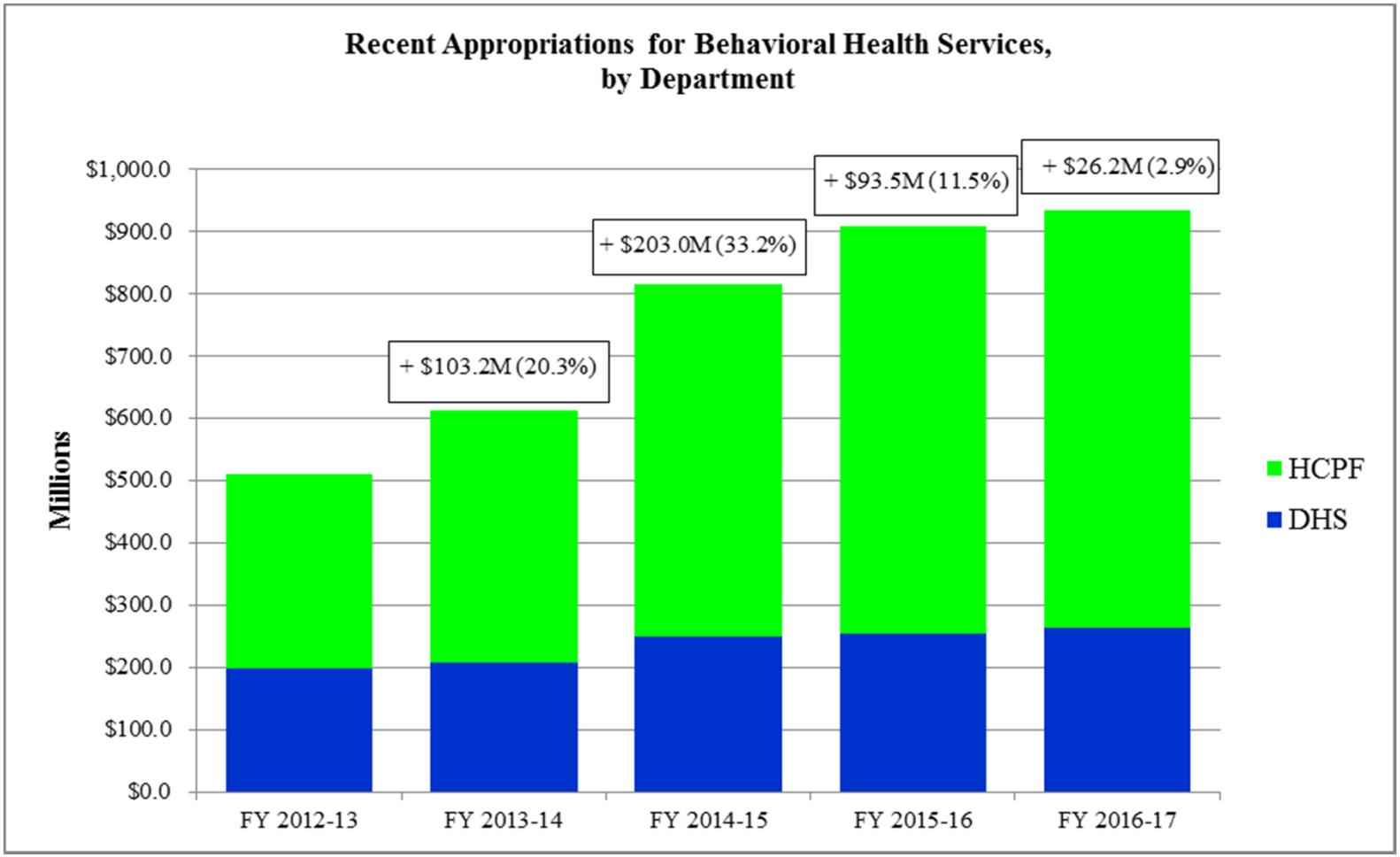


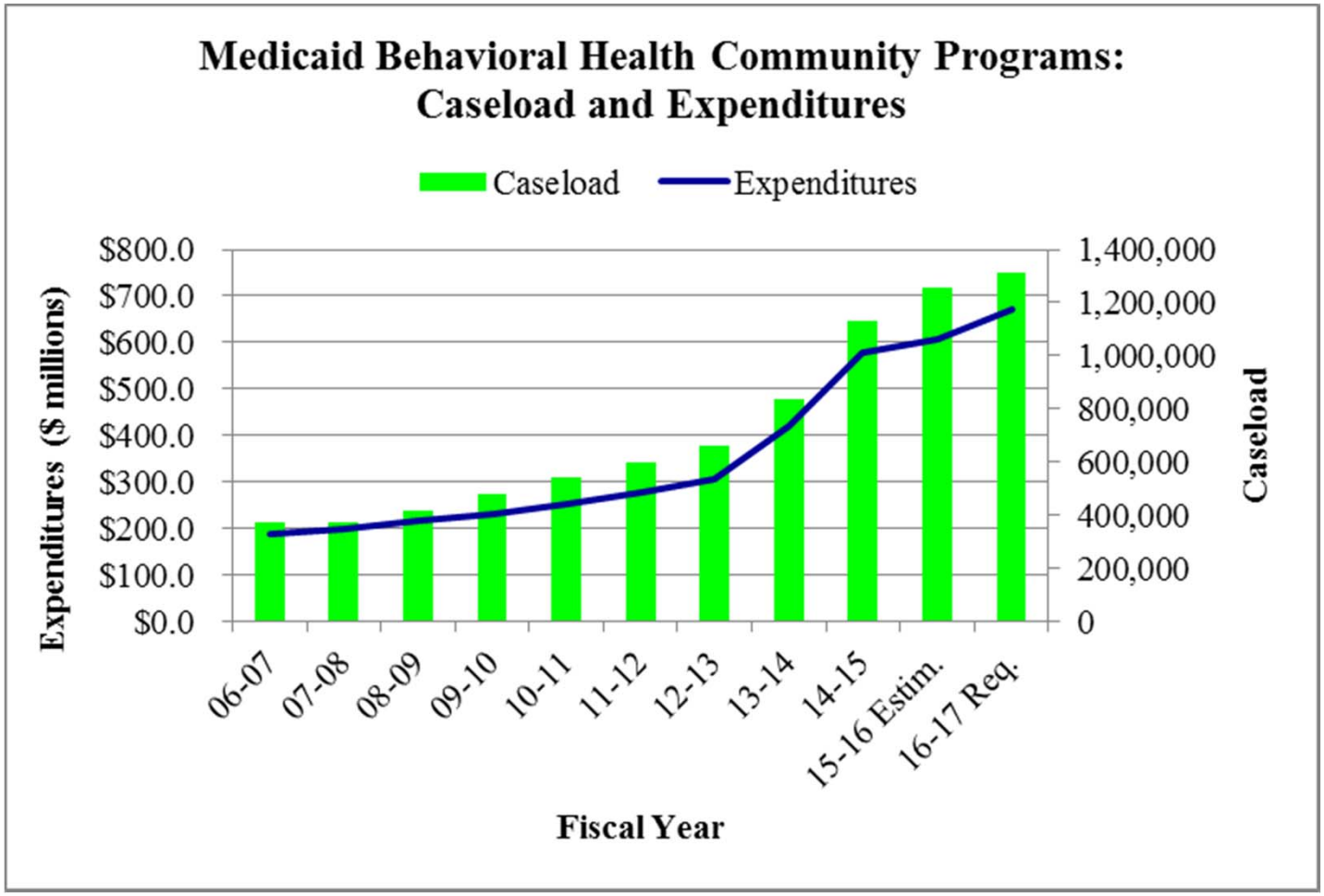
Colorado Medicaid Capitation
Behavioral Health Organizations
by Geographic Service Area

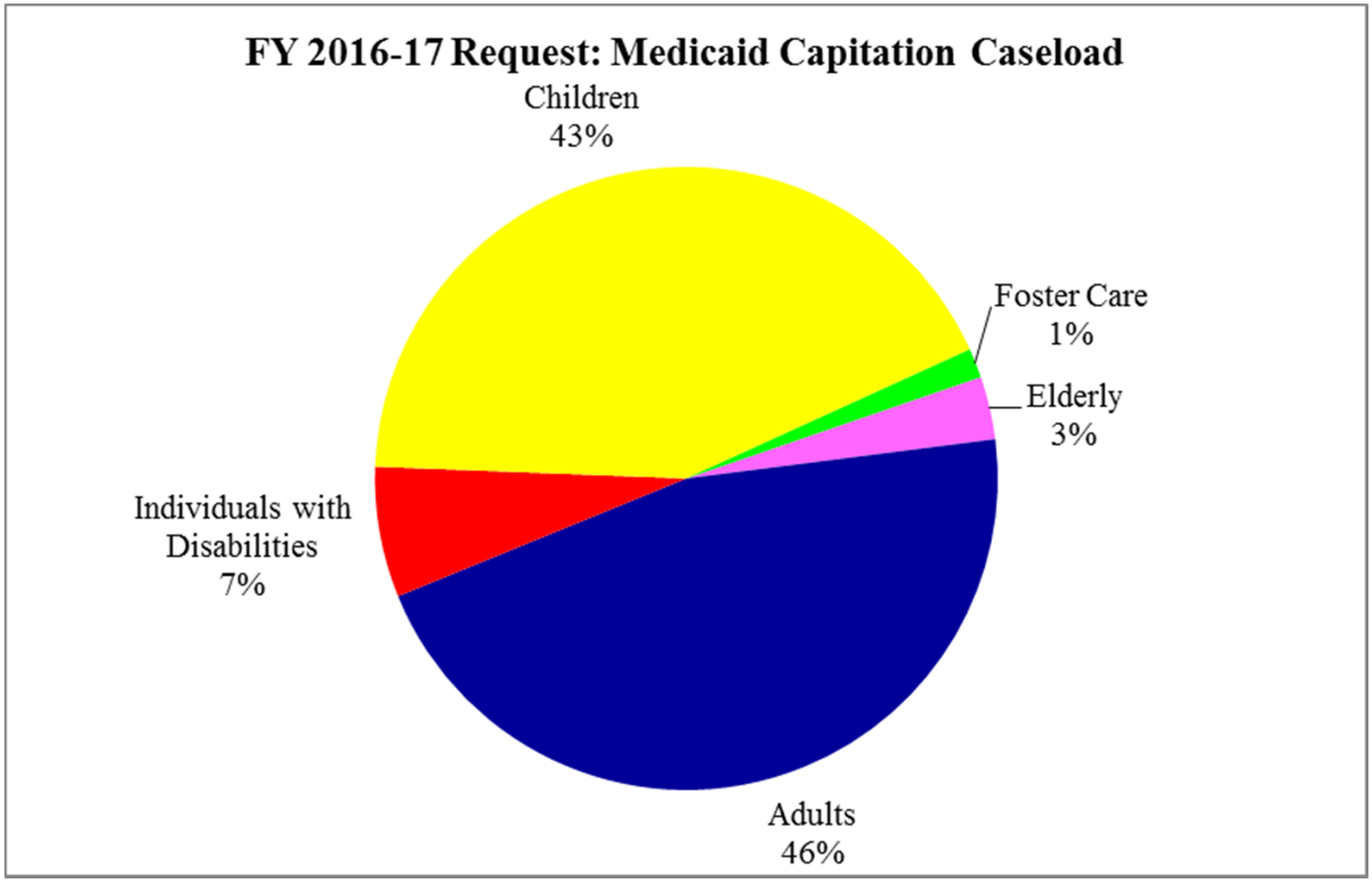
- Access Behavioral Care – Northeast (Colorado Access)
- Access Behavioral Care – Denver Metro (Colorado Access)
- Foothills Behavioral Health Partners, LLC
- Behavioral Healthcare, Inc.
- Colorado Health Partnerships, LLC

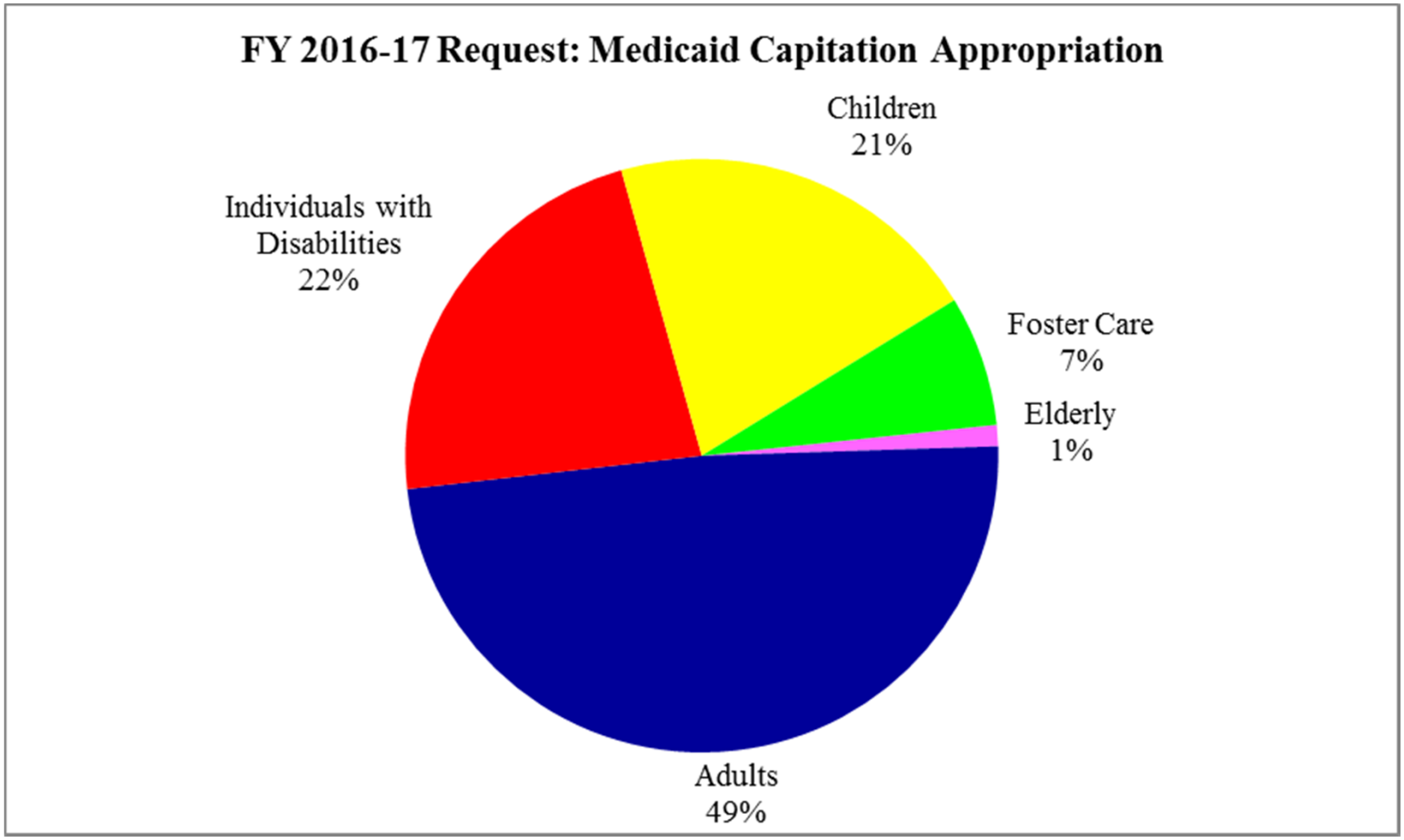
Prepared by Colorado Behavioral Healthcare Council

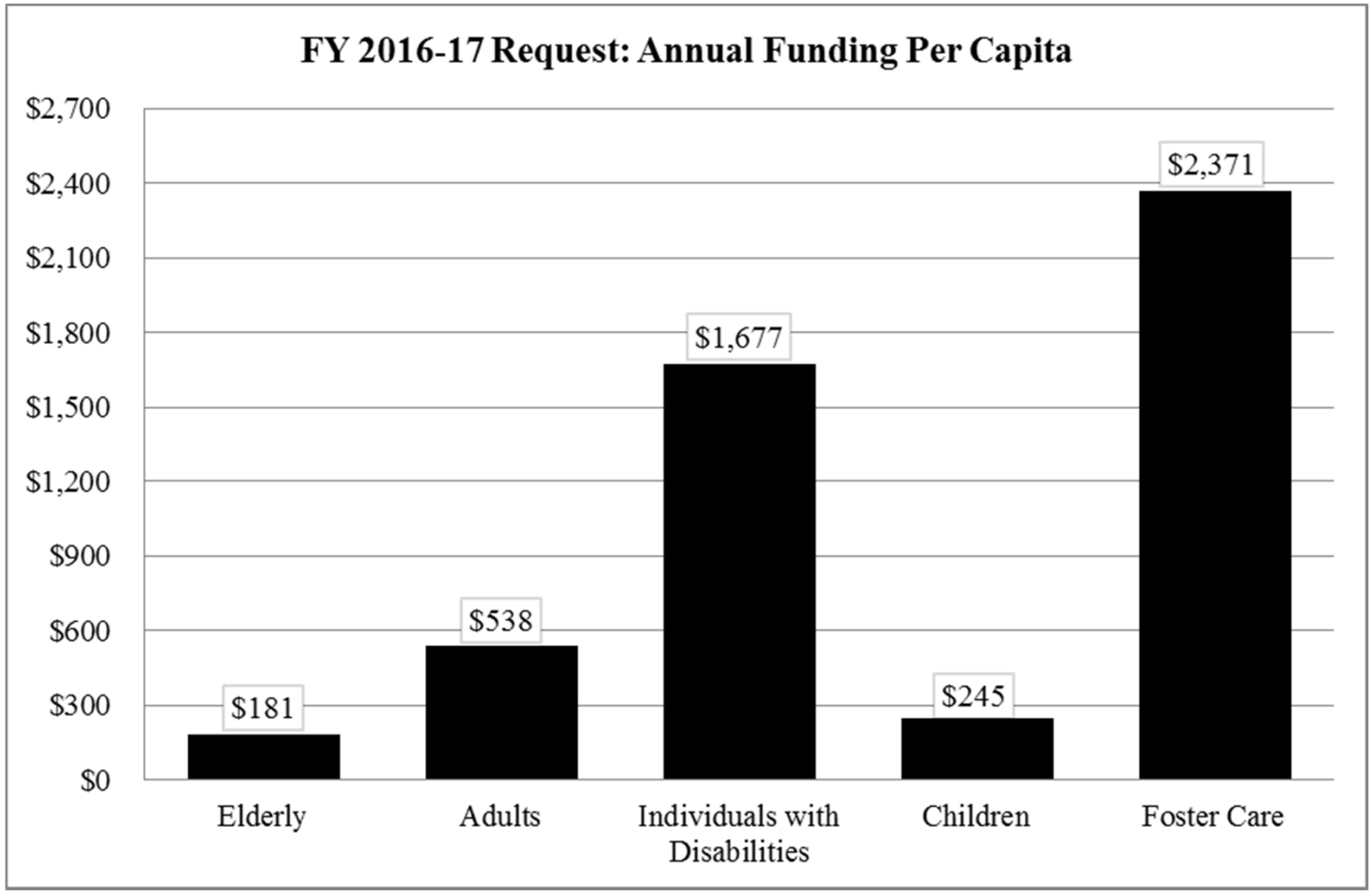

Recent Appropriations for Behavioral Health Services, by Fund Source
Cumulative increase:
$425.9M Total Funds
$113.6M State Funds
$312.3M Federal Funds
Millions
$1,000.0
$900.0
$800.0
$700.0
$600.0
$500.0
$400.0
$300.0
$200.0
$100.0
$0.0
FY 2012-13
FY 2013-14
FY 2014-15
FY 2015-16
FY 2016-17
Federal Funds
Other State Funds
General Fund


Recent Appropriations for Behavioral Health Services, by Department
Millions
$1,000.0
$900.0
$800.0
$700.0
$600.0
$500.0
$400.0
$300.0
$200.0
$100.0
$0.0
+ $103.2M (20.3%)
+ $203.0M (33.2%)
+ $93.5M (11.5%)
+ $26.2M (2.9%)
FY 2012-13
FY 2013-14
FY 2014-15
FY 2015-16
FY 2016-17
HCPF
DHS


Medicaid Behavioral Health Community Programs:
Caseload and Expenditures
Caseload
Expenditures
Expenditures ($ millions)
$800.0
$700.0
$600.0
$500.0
$400.0
$300.0
$200.0
$100.0
$0.0
1,400,000
1,200,000
1,000,000
800,000
600,000
400,000
200,000
0
Caseload
06-07
07-08
08-09
09-10
10-11
11-12
12-13
13-14
14-15
15-16 Estim.
16-17 Req.
Fiscal Year


FY 2016-17 Request: Medicaid Capitation Caseload
Children
43%
Foster Care
1%
Elderly
3%
Individuals with
Disabilities
7%
Adults
46%


FY 2016-17 Request: Medicaid Capitation Appropriation
Children
21%
Individuals with
Disabilities
22%
Foster Care
7%
Elderly
1%
Adults
49%


FY 2016-17 Request: Annual Funding Per Capita
$2,700
$2,400
$2,100
$1,800
$1,500
$1,200
$900
$600
$300
$0
$181
$538
$1,677
$245
$2,371
Elderly
Adults
Individuals with Disabilities
Children
Foster Care