COLORADO GENERAL ASSEMBLY
JOINT BUDGET COMMITTEE

FY 2013-14 STAFF BUDGET BRIEFING

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

(Medicaid Mental Health Community Programs Only)

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

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DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

The Department of Health Care Policy and Financing provides health care services to over 900,000 Colorado residents through the Medicaid medical and mental health programs, the Colorado Indigent Care program (CICP), the Children's Basic Health Plan (CBHP), and the Old Age Pension Medical program. The Medicaid, CICP, and CBHP programs are federal and State partnerships. The State receives approximately $2.8 billion in federal matching funds for these programs. The Department transfers over 8.0 percent of its appropriation to other State agencies, primarily the Department of Human Services, that administer programs eligible for Medicaid funding.

The Department's budget is comprised of (1) Executive Director's Office; (2) Medical Services Premiums; (3) Medicaid Mental Health Community Programs; (4) Indigent Care Program; (5) Other Medical Services; and (6) Department of Human Services Medicaid-Funded Programs.

Department Overview

This Joint Budget Committee staff budget briefing document includes the Medicaid Mental Health Community Programs executed by the Department of Health Care Policy and Financing. The Department:

- Administers the State's Medicaid mental health capitation (managed care) program. Under the terms of the program, the State pays regional entities a contracted capitation rate (per-member-per-month) for eligible Medicaid clients; and

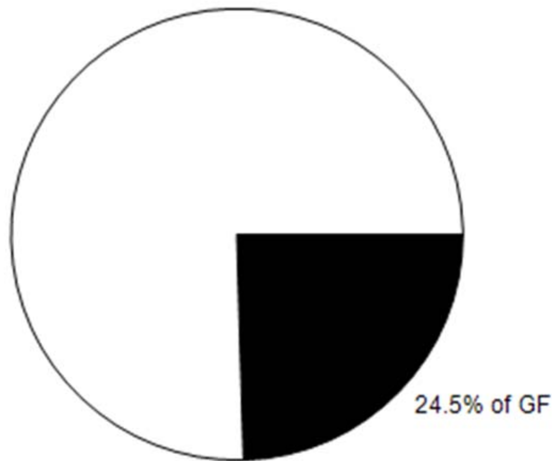
- Administers the State's Medicaid fee-for-service mental health program. The program allows Medicaid clients not enrolled in managed care to receive mental health services. It also provides funds for Medicaid clients to receive mental health services not covered by the managed care.

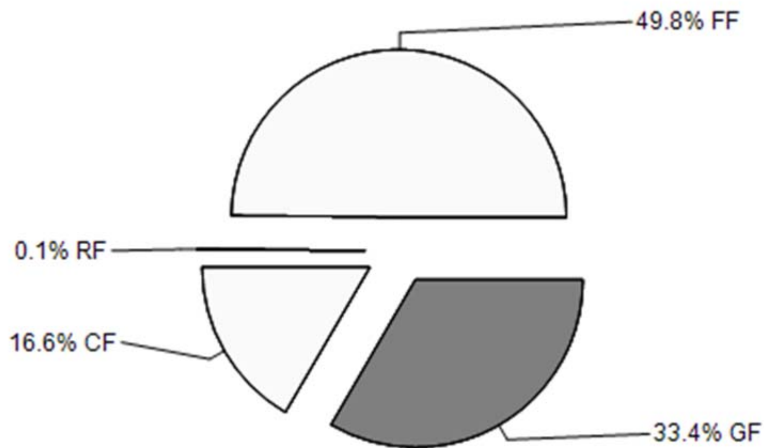
Department Budget: Recent Appropriations

Funding Source	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14 *
General Fund	$1,278,711,042	$1,698,937,482	$1,857,115,475	$2,031,840,028
Cash Funds	785,202,148	879,632,546	925,374,919	916,573,919
Reappropriated Funds	18,526,832	8,576,440	8,170,248	5,929,334
Federal Funds	2,810,778,210	2,579,167,123	2,770,497,473	3,082,378,760
Total Funds	**$4,893,218,232**	**$5,166,313,591**	**$5,561,158,115**	**$6,036,722,041**
Full Time Equiv. Staff	294.8	312.5	326.2	338.2

*Requested appropriation.

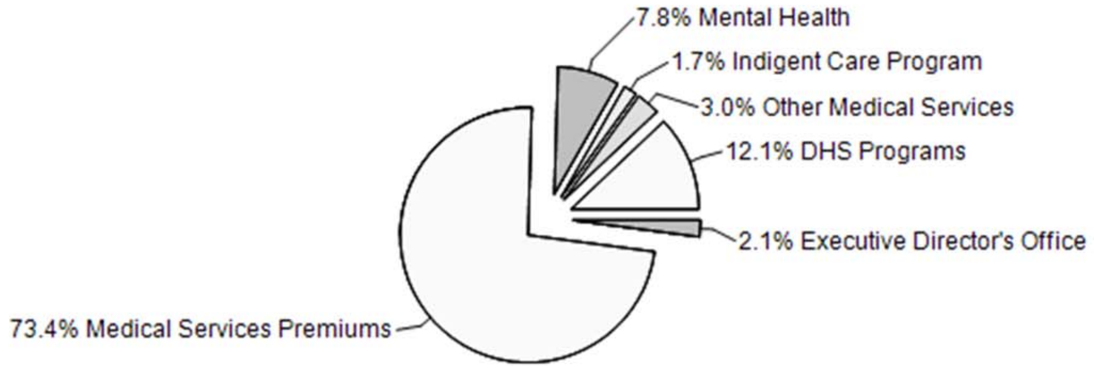
Department Budget: Graphic Overview



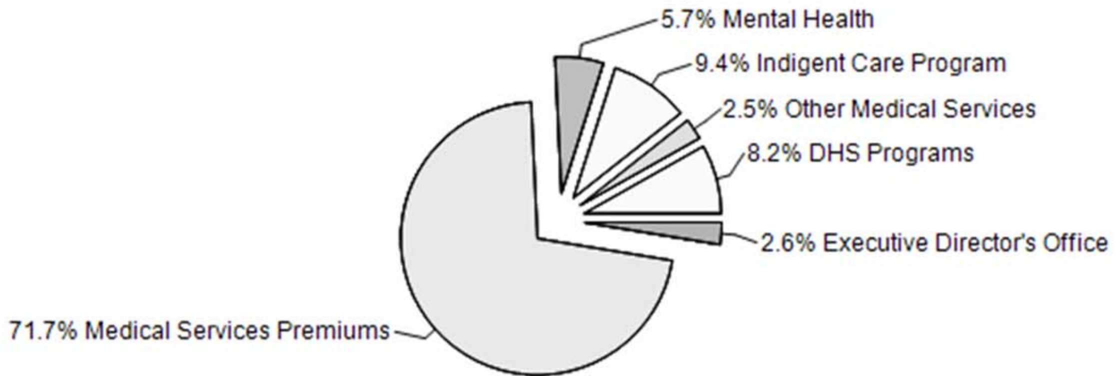


All charts are based on the FY 2012-13 appropriation.

Distribution of General Fund by Division



Distribution of Total Funds by Division



All charts are based on the FY 2012-13 appropriation.

General Factors Driving the Budget

Mental Health Capitation Payments

Medicaid mental health community services throughout Colorado are delivered through a managed care or "capitated" program. Under capitation, the State pays a regional entity, known as a Behavioral Health Organization (BHO), a contracted amount (per-member-per-month) for each Medicaid client eligible for mental health services in the entity's geographic area. The BHO is required to provide appropriate mental health services to all Medicaid eligible persons needing such services as provided by the contract.

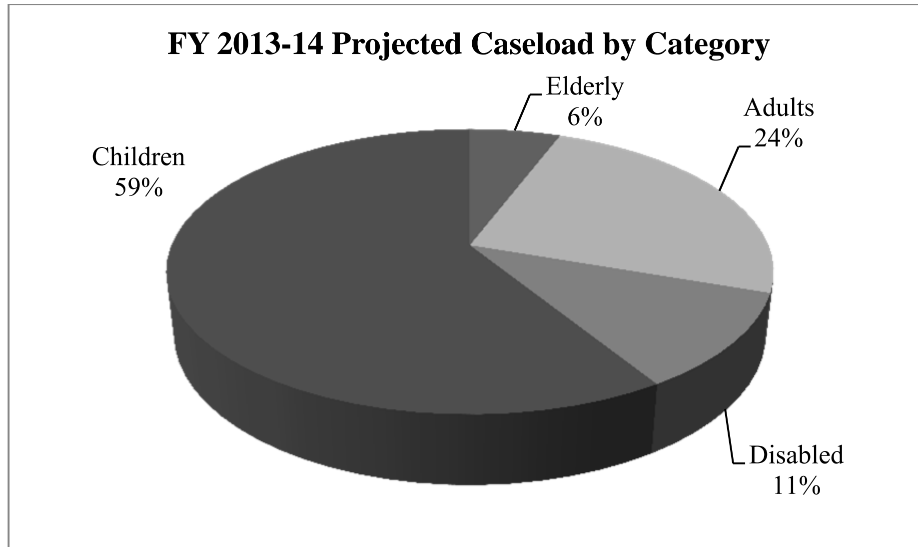
The rate paid to a BHO is based on the category of Medicaid client eligibility for mental health services (e.g. children) in each geographic region. Currently, the state is divided into five unique geographic regions covering the elderly, adult (including adults without dependent children), disabled, and children (including foster care) aid categories. Under the capitated mental health system, changes in rates paid, changes in overall Medicaid eligibility, and case-mix (mix of clients within aid categories) are important drivers in State appropriations for mental health services.

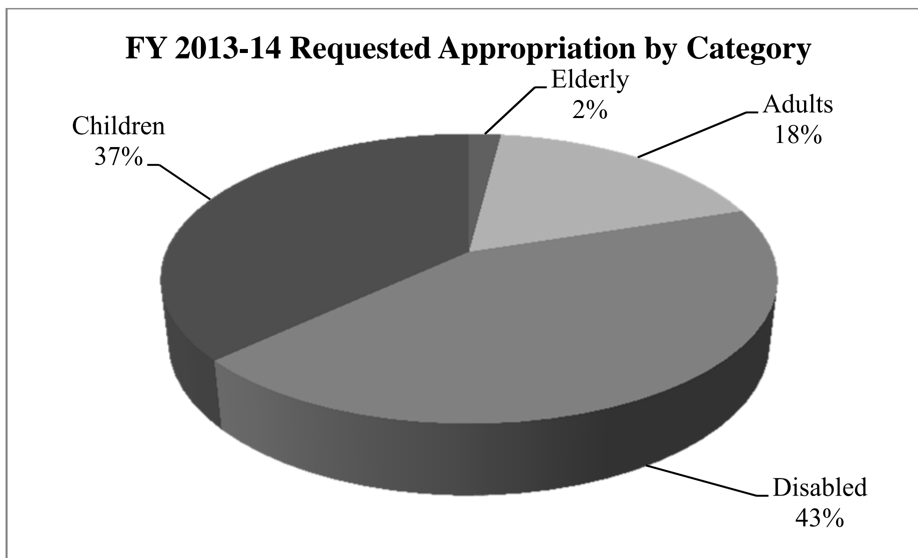
For FY 2012-13, capitation payments represent 98.6 percent of the total funds appropriated for Medicaid Mental Health Community Programs. The following table provides information on the recent expenditures and caseload for Medicaid Mental Health Capitation Payments. As is illustrated, from FY 2008-09 to the FY 2013-14 request, expenditures/appropriations have increased by 61.1 percent while caseload has increased by 70.6 percent.

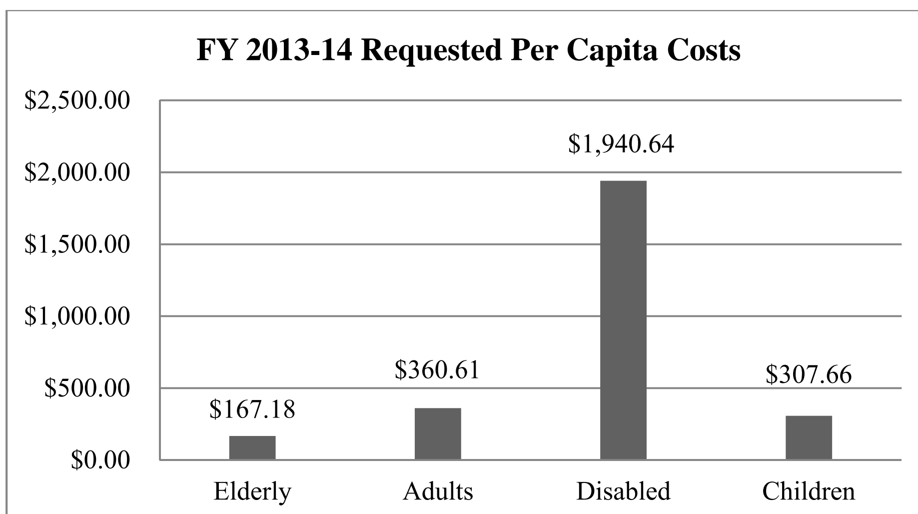
Medicaid Mental Health Capitation Funding						
	FY 2008-09 Actual	FY 2009-10 Actual	FY 2010-11 Actual	FY 2011-12 Actual	FY 2012-13 Appropriation	FY 2013-14 Request*
Capitation Funding	$215,860,937	$226,620,818	$249,352,665	$273,376,614	$312,580,712	$347,855,029
Annual Dollar Change	$19,849,904	$10,759,881	$22,731,847	$24,023,949	$39,204,098	$35,274,317
Annual Dollar % Change	10.1%	5.0%	10.0%	9.6%	14.3%	11.3%
Caseload	417,750	479,185	540,456	598,322	664,441	712,810
Annual Caseload Change	43,631	61,435	61,271	57,866	66,119	48,369
Annual Caseload % Change	11.8%	14.7%	12.8%	10.7%	11.1%	7.3%

*Does not include the request to add the substance use disorder benefit to the capitation program.

The pie charts on the following page highlight that costs for Medicaid community mental health services are driven in large part by children and the disabled population.


FY 2013-14 Projected Caseload by Category
Elderly 6%
Adults 24%
Children 59%
Disabled 11%


FY 2013-14 Requested Appropriation by Category
Elderly 2%
Adults 18%
Children 37%
Disabled 43%


FY 2013-14 Requested Per Capita Costs
$2,500.00
$2,000.00
$1,500.00
$1,000.00
$500.00
$0.00
$167.18
$360.61
$1,940.64
$307.66
Elderly
Adults
Disabled
Children

Medicaid Mental Health Fee-for-Service Payments

Fee-for-service payments are a separate budget line item in the Medicaid mental health services program. The appropriation allows Medicaid clients not enrolled in a BHO to receive mental health services or enrolled Medicaid clients to receive mental health services not covered by the BHO (outside of the scope of the State's contract with the BHOs). Medicaid mental health fee-for-service payments are expended across three categories: inpatient services, outpatient services, and physician services.

The following table provides information on the recent expenditures for fee-for-service payments. As is illustrated in the table below, from FY 2008-09 to the FY 2013-14 request, expenditures/appropriations have grown by 167.7 percent. Much of the increase in fee-for-service payments is due to rising costs in the outpatient category of services.

Medicaid Mental Health Fee-for-Service Funding						
	FY 2008-09 Actual	**FY 2009-10 Actual**	**FY 2010-11 Actual**	**FY 2011-12 Actual**	**FY 2012-13 Appropriation**	**FY 2013-14 Request**
Fee-for-Service Funding	$1,776,253	$2,587,662	$3,870,594	$3,864,984	$4,147,628	$4,755,308
Annual Dollar Change	$440,517	$811,409	$1,282,932	($5,610)	$282,644	$607,680
Annual Dollar Percent Change	33.0%	45.7%	49.6%	(0.1%)	7.3%	14.7%

Summary: FY 2012-13 Appropriation & FY 2013-14 Request

Department of Health Care Policy and Financing (Medicaid Mental Health Community Programs Only)	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
FY 2012-13 Appropriation:						
HB 12-1335 (Long Bill)	$316,728,340	$144,786,787	$13,648,932	$0	$158,292,621	0.0
TOTAL	**$316,728,340**	**$144,786,787**	**$13,648,932**	**$0**	**$158,292,621**	**0.0**
FY 2013-14 Requested Appropriation:						
FY 2012-13 Appropriation	$316,728,340	$144,786,787	$13,648,932	$0	$158,292,621	0.0
R-2: Mental health community programs	32,384,988	10,284,849	(1,313,268)	0	23,413,407	0.0
R-7: Substance use disorder benefit	5,272,628	1,779,950	42,317	0	3,450,361	0.0
R-13: Provider rate increase	62,214	31,107	0	0	31,107	0.0
Annualize prior year legislation	3,434,795	1,202,178	0	0	2,232,617	0.0
TOTAL	**$357,882,965**	**$158,084,871**	**$12,377,981**	**$0**	**$187,420,113**	**0.0**
Increase/(Decrease)	$41,154,625	$13,298,084	($1,270,951)	$0	$29,127,492	0.0
Percentage Change	13.0%	9.2%	(9.3%)	0.0%	18.4%	0.0%

Description of Requested Changes

R-2: Mental health community programs: The request includes an increase of $32.4 million total funds (including $10.3 million General Fund) for FY 2013-14 for caseload changes in the managed care and fee-for-service Medicaid mental health program. *For more information on this budget request, see staff's issue briefing in this document entitled "Medicaid Mental Health Caseload and Budget."*

R-7: Substance use disorder benefit: The request seeks to increase Department appropriations by $5.8 million total funds (including $1.9 million General Fund) for FY 2013-14 to enhance the existing substance use disorder benefit through the expansion of services offered, the addition of new service offerings, and the migration of the benefit from a fee-for-service model to a managed care model administered by Behavioral Health Organizations (BHOs). *For more information on this budget request, see staff's issue briefing in this document entitled "Substance Use Disorder Benefit."*

R-13: Provider rate increase: For the division covered in this staff budget briefing document, the request includes the addition of $62,214 total funds (including $31,107 General Fund) for FY 2013-14 to implement a 1.5 percent increase in community provider rates for fee-for-service mental health treatment.

Annualize prior year legislation: The request includes adjustments related to prior year legislation. For the division covered in this staff budget briefing document, the annualization of prior year legislation increase in funding is due to S.B. 11-008 (Boyd/Gerou) which specified that the income eligibility criteria for Medicaid that applies to children aged 5 and under and pregnant women shall also apply to children between the ages of 6 and 19 and S.B. 11-250 (Boyd/Ferrandino & Summers) which increased the upper income limit for Medicaid eligibility among pregnant women from 133 percent to 185 percent of federal poverty level in order to comply with federal law.

Issue: Medicaid Mental Health Caseload and Budget

The State provides Medicaid mental health community services to enrollees through a capitated managed care program. As of November 2012, the Department of Health Care Policy and Financing estimates a need for $315.8 million total funds for FY 2012-13 and $357.9 million total funds for FY 2013-14 for the Medicaid mental health services program due to caseload changes.

SUMMARY:

- Medicaid mental health community services in Colorado are delivered through a managed care model whereby the State contracts with regional entities to provide mental health services to all Medicaid-eligible persons needing such services;

- As of November 2012, caseload for Medicaid mental health community services is estimated to decrease by 1.0 percent in FY 2012-13 from the current FY 2012-13 appropriation and increase by 8.4 percent in FY 2013-14 compared to the FY 2012-13 projection;

- The current FY 2012-13 appropriation for Medicaid mental health community services is $316.7 million total funds (including $144.8 million General Fund). Based on estimates as of November 2012, the Department of Health Care Policy and Financing projects that an appropriation of $315.8 million total funds (including $143.1 million General Fund) is needed to cover expenses of Medicaid mental health community services due to caseload for FY 2012-13; and

- Based on estimates as of November 2012, the Department projects that an appropriation of $352.5 million total funds (including $156.3 million General Fund) is needed to cover the expenses of Medicaid mental health community services due to caseload for FY 2013-14.

DISCUSSION:

Background

Prior to 1995, Medicaid enrollees in Colorado received mental health services through either a fee-for-service system or health maintenance organizations (HMO). In 1995, the General Assembly authorized the State to provide mental health services to Medicaid enrollees through a capitated managed care program. Under the capitation model, the State pays a regional entity, known as a Behavioral Health Organization (BHOs), a contracted amount (per-member-per-month) for each Medicaid client in the entity's geographic area. The BHO is required to provide appropriate mental health services to all Medicaid-eligible persons needing such services.

The rate paid to each BHO is based on eligibility categories (e.g., elderly, adults, disabled, and children) in each geographic region. Under the capitated mental health system, changes in rates paid, changes in overall Medicaid eligibility, and case-mix (mix of types of clients within the population) are important drivers in overall State appropriations for mental health services.

FY 2012-13 Budget Projection

The current FY 2012-13 appropriation includes $316.7 million total funds (including $144.8 million General Fund) for the provision of services to a caseload of 664,441. The Department estimates that the current FY 2012-13 appropriation can be decreased by $0.9 million total funds (including $1.7 million General Fund) and still meet projected expenditures. The primary driver of the requested decrease is a caseload decrease of 1.0 percent over the appropriated caseload. Smaller fluctuations appear in the request due to date of death retractions and recoupment of payments for clients later deemed ineligible for Medicaid. *See Appendix E for staff's detailed calculations for the FY 2012-13 requested appropriation.*

The table below outlines the current FY 2012-13 appropriation compared to the projected FY 2012-13 appropriation request by aid category, as well as by capitation and fee-for-service payment categories. *Note, it is anticipated that the Committee will receive a revised request from the Department in January 2013 that uses more months of recent actuals to project caseload and corresponding expenditures. It is staff's recommendation that the Committee take action on the FY 2012-13 request during the figure setting process and include the action as a Long Bill Add-on to the FY 2013-14 Long Bill.*

FY 2012-13 Medicaid Mental Health Community Programs Budget Overview						
Cost	**FY 2012-13 Appropriation**		**FY 2012-13 Projection**		**Difference**	
Item	**Caseload**	**Appropriation**	**Caseload**	**Appropriation**	**Caseload**	**Appropriation**
Capitation Payments						
Aid Categories						
Adults 65 and Older (Elderly)	40,820	$6,734,583	40,364	$6,647,593	(456)	($86,990)
Low Income Adults (Adults)	153,880	44,169,121	152,840	43,754,714	(1,040)	(414,407)
Adults without Dependent Children (Adults)	10,000	9,443,024	10,000	13,481,055	0	4,038,031
Breast and Cervical Cancer Program (Adults)	679	195,362	621	178,530	(58)	(16,832)
Disabled Individuals Through 64 (Disabled)	73,254	135,666,988	72,197	132,555,546	(1,057)	(3,111,442)
Eligible Children (Children)	367,649	79,281,854	363,786	79,518,692	(3,863)	236,838
Foster Care (Children)	18,159	37,736,831	17,994	37,270,633	(165)	(466,198)
Aid Categories Subtotal	**664,441**	**$313,227,763**	**657,802**	**$313,406,763**	**(6,639)**	**$179,000**
Adjustments						
Recoupments	n/a	($1,672,249)	n/a	($1,240,550)	n/a	$431,699
Date of Death Retractions	n/a	(562,802)	n/a	(595,623)	n/a	(32,821)
Reconciliations	n/a	1,588,000	n/a	0	n/a	(1,588,000)
Adjustments Total	**n/a**	**($647,051)**	**n/a**	**($1,836,173)**	**n/a**	**($1,189,122)**
Capitation Payments Total	**664,441**	**$312,580,712**	**657,802**	**$311,570,590**	**(6,639)**	**($1,010,122)**
Fee-For-Service						
Inpatient	n/a	$678,379	n/a	$694,994	n/a	$16,615
Outpatient	n/a	3,288,417	n/a	3,368,955	n/a	80,538
Physician	n/a	180,832	n/a	185,261	n/a	4,429
Fee-For-Service Total	**n/a**	**$4,147,628**	**n/a**	**$4,249,210**	**n/a**	**$101,582**
Total Mental Health Community Programs	**664,441**	**$316,728,340**	**657,802**	**$315,819,800**	**(6,639)**	**($908,540)**
Incremental Percentage Change					**-1.0%**	**-0.3%**

FY 2013-14 Budget Projection

The Department's FY 2013-14 budget request includes $352.5 million total funds (including $156.3 million General Fund) for the provision of services to a caseload of 712,810. The primary driver of the request is a caseload increase of 8.4 percent over the projected FY 2012-13 caseload. Smaller fluctuations appear in the request due to date of death retractions and recoupment of payments for clients later deemed ineligible for Medicaid. *See Appendix F for staff's detailed calculations for the FY 2013-14 requested appropriation.*

The table below outlines the requested FY 2012-13 appropriation compared to the requested FY 2013-14 appropriation need by aid category, as well as by capitation and fee-for-service payment categories. *Note, it is anticipated that the Committee will receive a revised request from the Department in January 2013 that uses more months of recent actuals to project caseload and corresponding expenditures.*

FY 2013-14 Medicaid Mental Health Community Programs Budget Overview						
Cost	**FY 2012-13 Projection**		**FY 2013-14 Request**		**Difference**	
Item	**Caseload**	**Appropriation**	**Caseload**	**Appropriation**	**Caseload**	**Appropriation**
Capitation Payments						
Aid Categories						
Adults 65 and Older (Elderly)	40,364	$6,647,593	41,195	$6,986,349	831	$338,756
Low Income Adults (Adults)	152,840	43,754,714	164,051	48,715,906	11,211	4,961,192
Adults without Dependent Children (Adults)	10,000	13,481,055	10,000	14,108,016	0	626,961
Breast and Cervical Cancer Program (Adults)	621	178,530	655	194,920	34	16,390
Disabled Individuals Through 64 (Disabled)	72,197	132,555,546	77,441	150,695,765	5,244	18,140,219
Eligible Children (Children)	363,786	79,518,692	401,411	92,247,200	37,625	12,728,508
Foster Care (Children)	17,994	37,270,633	18,057	36,825,069	63	(445,564)
Aid Categories Subtotal	**657,802**	**$313,406,763**	**712,810**	**$349,773,225**	**55,008**	**$36,366,462**
Adjustments						
Recoupments	n/a	($1,240,550)	n/a	($1,373,413)	n/a	($132,863)
Date of Death Retractions	n/a	(595,623)	n/a	(544,783)	n/a	50,840
Adjustments Total	**n/a**	**($1,836,173)**	**n/a**	**($1,918,196)**	**n/a**	**($82,023)**
Capitation Payments Total	**657,802**	**$311,570,590**	**712,810**	**$347,855,029**	**55,008**	**$36,284,439**
Fee-For-Service						
Inpatient	n/a	$694,994	n/a	$767,595	n/a	$72,601
Outpatient	n/a	3,368,955	n/a	3,720,885	n/a	351,930
Physician	n/a	185,261	n/a	204,614	n/a	19,353
Fee-For-Service Total	**n/a**	**$4,249,210**	**n/a**	**$4,693,094**	**n/a**	**$443,884**
Total Mental Health Community Programs	**657,802**	**$315,819,800**	**712,810**	**$352,548,123**	**55,008**	**$36,728,323**
Incremental Percentage Change					**8.4%**	**11.6%**

RELEVANCE OF BRIEFING ISSUE TO THE DEPARTMENT'S STRATEGIC PLAN:

The change request is driven by an increase in the number of Colorado citizens meeting the eligibility criteria to enroll in Medicaid. As such, it relates to the Department's overarching strategic plan goals of increasing the number of insured Coloradoans, improving health outcomes, increasing access to health care, and containing health care costs.

Issue: Substance Use Disorder Benefit

The Department of Health Care Policy and Financing currently funds the State's fee-for-service substance use disorder benefit accessed by nearly 7,000 Colorado residents. The Department's FY 2013-14 budget request includes an increase of $5.8 million total funds (including $1.8 million General Fund) to enhance the benefit by expanding existing service offerings, adding new service offerings, and changing the mode of administration from a fee-for-service model to a managed care model.

SUMMARY:

- The State's current substance use disorder (SUD) Medicaid benefit is underused due to limitations in service offerings;

- The Department of Health Care Policy and Financing (HCPF) requests $5.8 million total funds (including $1.8 million General Fund) for FY 2013-14 to enhance the benefit by expanding existing services, adding new services, and shifting the administration from a fee-for-service model to a managed care model; and

- The Department's plan to enhance the benefit is conceptually sound, yet key issues related to the benefit's service offerings and administration must be addressed before funding decisions are made by the Committee.

RECOMMENDATION:

Staff recommends that prior to making any funding decisions on this budgetary request the Committee explore the process for determining SUD treatment services to add or expand, the options for administering the program in a managed care environment that maximizes patient outcomes and fiscal prudence while leveraging existing expertise, and how the need for residential services as part of the treatment continuum will be met.

DISCUSSION:

Background
Prior to 2006, the State's Medicaid program offered SUD treatment on a limited basis to pregnant women (and recent mothers, up to one year post-partum) and to individuals in need of SUD treatment when it was medically necessary to treat another covered condition. House Bill 05-1015 (Romanoff/Johnson) added outpatient SUD as an optional service to the State's Medicaid program. As implemented by HCPF, the outpatient SUD benefit covers the following services:

- Assessment;
- Detoxification monitoring;
- Individual therapy;

- Group therapy;
- Case management; and
- Screening and monitoring.

SUD treatment services are currently administered in a fee-for-service model whereby providers render services to Medicaid-eligible clients and HCPF reimburses the providers. This is a different model than the Department of Human Services (DHS) uses to administer State and federal funding for substance abuse treatment for clients not eligible for Medicaid or consuming services not offered by Medicaid. The DHS model consists of a series of contracts with Managed Service Organizations (MSOs) that are responsible for contracting with providers and oversight, quality assurance, and contract compliance.

Issue
The treatment model for achieving positive health outcomes for individuals with an SUD has shifted from an acute care model whereby an individual needs short-term, intensive services in recovering from one or more episodes to a model that recognizes an SUD as a chronic condition requiring episode-based treatment in conjunction with recovery management that includes long-term supports and wellness. While the current benefit is adequate for many individuals seeking treatment, its limited service offerings and limited service durations do not provide individuals with a continuum of care that fosters chronic condition management that results in positive health outcomes and decreases in system costs.

Proposed Solution
The Department put forth a three-part plan to enhance the current SUD Medicaid benefit. First, the plan calls for expanding the limitations on current services to offer more client support outside of episode-based treatment. The request lays out the framework for expanding certain services (as well as adding new services) based on the recommendations contained in Signal Behavioral Health Network's "Recommendations for the New Medicaid Adults without Dependent Children Benefit" report, while leaving the formal definition of the exact parameters of individual service expansions to the stakeholder-driven Benefits Collaborative process. The framework in the request includes the following expansion options:

Framework SUD Benefit Existing Service Expansion		
Existing Service	**Current Limit (Per FY)**	**Proposed Limit (Per FY)**
Assessment	3 Sessions	2 Annually (may involve more than 1 session)
Detox Monitoring	7 Days	5 Sessions
Individual Therapy	25 Sessions	35 Sessions
Group Therapy	36 Sessions	36 Sessions (both outpatient and intensive)
Case Management	36 Contacts	52 Contacts
Screening and Monitoring	1 Specimen	52 Specimens

Second, the plan calls for the addition of services covered by the SUD Medicaid benefit. Similarly to the expansion of existing services, the request lays out the framework for adding services, while leaving the formal definition of the exact parameters of individual service additions to the stakeholder-driven Benefits Collaborative process. The framework in the request includes options for Medication Assisted Treatment (the use of medications, in combination with

counseling and behavioral therapies, known commonly as "MAT") and peer advocate services (bridge between providers and clients to help facilitate SUD treatment plan).

Third, the plan calls for shifting the SUD Medicaid benefit from its current fee-for-service model to a managed care model carried out through contracts with Behavioral Health Organizations (BHOs). The request indicates that better patient health outcomes can be attained in a managed care model due to the comprehensive network of behavioral health (mental health and substance use disorder) care providers established by the BHOs as part of their current contracts to manage the Medicaid mental health community services program, the use of dedicated care managers by the BHOs to assist in the development of treatment plans, and the ability to quickly refer mental health patients in the BHO network to SUD providers.

Proposed Budget
The Department's FY 2013-14 budget request seeks $5.8 million total funds (including $1.8 million General Fund) to implement the three initiatives discussed above. For FY 2014-15, the Department projects the program will require an appropriation of $9.1 million total funds (including $2.7 million General Fund). The FY 2013-14 request indicates that the BHO-administered SUD benefit will begin on January 1, 2014 (to coincide with the annual BHO rate setting) and fund care for an estimated 6,786 unique Medicaid enrollees. The estimated number of Medicaid enrollees accessing care is estimated to increase to 14,251 in FY 2014-15.

The client utilization and cost estimates generated by the Department for the request contain some broad assumptions necessitated by the lack of other states' experience in shifting the Medicaid SUD benefit from a fee-for-service model to a managed care model. The client utilization estimate assumes a 100 percent increase based on the ability of BHOs to conduct outreach to its existing network of mental health consumers in need of SUD treatment. The cost estimates assume a 20 percent increase based on the BHOs use of case managers to assist in creating treatment plans that attain positive health outcomes for the patients.

Analysis
It is staff's opinion that the need exists to modify the Medicaid SUD benefit to increase access to care and save State moneys in the long-term. The State of Colorado has over 100,000 individuals living in households at or below 300.0 percent of the federal poverty level who require behavioral health services, but do not access the needed care according to the Western Interstate Commission for Higher Education's (WICHE) "Colorado Population in Need 2009" report. Stakeholders (State agencies, managed care organizations, managed service organizations, and providers) responsible for the delivery of behavioral health care concur that the existing Medicaid SUD benefit does not include the necessary ingredients (service types and service durations) to provide access to care that yields quality patient outcomes to the more than 100,000 individuals in need of support. Stakeholders also concur that providing an appropriate level of care to individuals in need of SUD treatment can produce long-term financial benefit in the form of reduced physical health costs and reduced interactions with the criminal justice system. The State Auditor's 2010 performance audit of the Medicaid SUD benefit echoed the sentiment of the stakeholders in reporting that clients receiving $2.4 million in SUD treatment experienced a $3.5 million dollar reduction in medical costs during the three year period (FY 2006-07 through FY 2008-09) of service provision.

Staff agrees that the concepts contained in the Department's three part plan for enhancing the Medicaid SUD benefit will contribute to more Colorado citizens accessing the proper care for behavioral health care needs and save the State money in the long-term. The plan is conceptually strong, but key points must be taken into consideration by the Committee prior to making a funding decision on this request. Specifically:

- Creating a menu of treatment options that is in the best interest of the patient and fiscally prudent is essential. MSOs and SUD treatment providers are uniquely positioned as administrators of DHS-funded SUD treatment moneys to use their expertise to inform the design of the enhanced benefit.

- Migrating the benefit from a fee-for-service model to a managed care model is logical in Colorado due to the pre-existence of the managed care model for Medicaid services for mental health in the community, as administered by BHOs, and the managed service model for SUD treatment funding for the State's non-Medicaid eligible population, as administered by MSOs. It is unclear, however, how the performance monitoring and SUD provider network expertise of MSOs and the utilization management functions and mental health provider network expertise of BHOs can be integrated in a manner that does not create additional bureaucracy that negatively impacts providers, and consequently patients.

- A plan lacking residential treatment options to address severe SUD needs does not represent a comprehensive strategy for attaining positive patient health outcomes and ultimately decreasing costs. For a subset of individuals, outpatient SUD treatment is not sufficient. There are certain complications with using Medicaid moneys to pay for residential services (residential treatment for SUD may fall under the "IMD Exclusion," which prohibits the use of federal Medicaid moneys for individuals between the ages of 22 and 64 in facilities with more than 16 beds), so other options must be explored to fulfill this critical need. The Department indicates it has begun to collaborate with DHS to determine if a more robust outpatient Medicaid SUD benefit (as proposed in this request) will decrease the pressures on DHS' federal SUD treatment block grant moneys to a degree that would allow for expansion of the State's coverage of residential treatment services.

RELEVANCE OF BRIEFING ISSUE TO THE DEPARTMENT'S STRATEGIC PLAN:

This briefing issue is related to the Department's strategic plan goal of improving health outcomes and better integrating physical and behavioral health services. The Department is in the process of developing the methodology to measure the impact of an expanded substance use disorder benefit on physical and mental health expenditures in the Medicaid program.

Appendix A: Number Pages

	FY 2010-11 Actual	FY 2011-12 Actual	FY 2012-13 Appropriation	FY 2013-14 Request	Request vs. Appropriation
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING					
Sue Birch, Executive Director					
(3) MEDICAID MENTAL HEALTH COMMUNITY PROGRAMS					
Primary functions: Provides mental health services and programs for eligible Medicaid clients.					
Mental Health Capitation for Medicaid Clients	249,352,665	273,376,614	312,580,712	353,127,657 *	
General Fund	95,057,227	131,782,602	142,712,972	155,707,217	
Cash Funds	9,559,892	5,791,948	13,648,932	12,377,981	
Reappropriated Funds	13,000	25,046	0	0	
Federal Funds	144,722,546	135,777,018	156,218,808	185,042,459	
Medicaid Mental Health Fee for Service Payments	3,870,594	3,894,039	4,147,628	4,755,308 *	
General Fund	1,532,590	1,917,565	2,073,815	2,377,654	
Federal Funds	2,338,004	1,976,474	2,073,813	2,377,654	
TOTAL - (3) Medicaid Mental Health Community Programs	253,223,259	277,270,653	316,728,340	357,882,965	13.0%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	96,589,817	133,700,167	144,786,787	158,084,871	9.2%
Cash Funds	9,559,892	5,791,948	13,648,932	12,377,981	(9.3%)
Reappropriated Funds	13,000	25,046	0	0	0.0%
Federal Funds	147,060,550	137,753,492	158,292,621	187,420,113	18.4%

*This line item contains a decision item.

Appendix B: Recent Legislation Affecting Department Budget

2011 Session Bills

S.B. 11-209 (Long Bill): General Appropriations Act for FY 2011-12.

H.B. 11-1242 (Medicaid provider integration of service): This bill requires the Department to study issues concerning the integrated delivery of mental and physical health. The Department, with input from behavior health organizations, community mental health centers, and other health care providers, is required to review existing regulations, reimbursement policies, barriers, and incentives that affect the integrated delivery of health care. The study is to be paid for with gifts, grants, and donations, and matching federal moneys. The Department is required to report its findings to the Joint Budget Committee and legislative committees. In FY 2011-12, the bill appropriates $113,500 total funds to the Department. Of this amount, $56,750 is cash funds from gifts, grants, and donations and $56,750 is federal funds.

2012 Session Bills

H.B. 12-1184 (Supplemental Bill): Supplemental appropriation to the Department of Health Care Policy and Financing to modify the FY 2011-12 appropriations contained in the FY 2011-12 Long Bill (S.B. 11-209).

H.B. 12-1281 (Medicaid payment reform pilot program): Creates the Medicaid Payment Reform and Innovation Pilot Program. Requires the Department of Health Care Policy and Financing to review proposals and select projects to pilot by July 1, 2013. Appropriates $213,079, ($106,540 General Fund and $106,539 federal funds), and 0.8 FTE to the Department of Health Care Policy and Financing in FY 2012-13 to evaluate payment projects and for reporting requirements.

H.B. 12-1335 (Long Bill): General Appropriations Act for FY 2012-13.

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

Long Bill Footnotes

The FY 2012-13 Long Bill did not contain any Long Bill Footnotes related to the programs covered in this JBC Staff Budget Briefing document.

Requests for Information

1 **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 and mental health capitation 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. This information is used by staff to track annual changes to rates for behavior health organizations.

Appendix D: Change Requests' Relationship to Performance Measures

This appendix shows how the Department of Health Care Policy and Financing indicates each change request in this section of the budget ranks in relation to the Department's top priorities, and what performance measures the Department is using to measure success of the request.

Change Requests' Relationship to Performance Measures

R	Change Request Description	Goals / Objectives	Performance Measures
2	Increase caseload in the Medicaid Mental Health Community Program.	The Medicaid Mental Health Community Program is an entitlement-based partnership between the State and the federal government. The change request is driven by an increase in the number of Colorado citizens meeting the eligibility criteria to enroll in Medicaid. As such, it relates to the Department's overarching goals of increasing the number of insured Coloradoans, improving health outcomes, increasing access to health care, and containing health care costs.	The Department measures the goals/objectives by determining the percentage of eligible people enrolled in Medicaid, determining the percentage of Medicaid enrollees accessing mental health services, analyzing per-member-per-month costs of the Program, and measuring the effectiveness of alternatives to inpatient hospitalization in delivering more cost effective, patient-centric treatment services.
7	Enhance the existing Medicaid substance use disorder benefit by administering services through Behavioral Health Organizations (BHOs), expanding limitations on current services, and adding appropriate services to create a more robust program.	Improve health outcomes and better integrate physical and behavioral health services.	The Department is in the process of developing the methodology to measure the impact of an expanded substance use disorder benefit on physical and mental health expenditures in the Medicaid program.

Appendix E: FY 2012-13 Mental Health Capitation Payments Calculations

Estimated PM/PM Rate - Q1/2	$13.53	$149.99	$23.53	$109.87	$17.80	$174.33	$23.53	
Estimated PM/PM Rate - Q3/4	$13.93	$158.51	$24.37	$114.96	$18.71	$170.80	$24.37	

FY 2012-13 Caseload by 6 Months	**Adults 65 and Older**	**Disabled Through 64**	**Low Income Adults**	**Adults w/o Dep. Children**	**Eligible Children**	**Foster Care**	**BCCP**	**Forecast**
First 6 Months	40,160	70,844	149,045	10,000	356,122	17,997	614	644,782
Second 6 Months	40,566	73,550	156,634	10,000	371,450	17,991	629	670,820
Full Year	40,363	72,197	152,840	10,000	363,786	17,994	622	657,801

FY 2012-13 Estimated Need Calculations	**Adults 65 and Older**	**Disabled Through 64**	**Low Income Adults**	**Adults w/o Dep. Children**	**Eligible Children**	**Foster Care**	**BCCP**	**Total**
First 6 Months								
Average Monthly Caseload	40,160	70,844	149,045	10,000	356,122	17,997	614	644,782
PM/PM Rate X Caseload Average	$3,260,189	$63,755,349	$21,042,173	$6,592,200	$38,033,830	$18,824,502	$86,685	$151,594,927
Second 6 Months								
Average Monthly Caseload	40,566	75,042	156,634	10,000	371,450	17,991	629	672,312
PM/PM Rate X Caseload Average	$3,390,506	$71,369,445	$22,903,023	$6,897,600	$41,698,977	$18,437,177	$91,972	$164,788,700
Estimated Need	**$6,650,695**	**$135,124,794**	**$43,945,197**	**$13,489,800**	**$79,732,807**	**$37,261,679**	**$178,657**	**$316,383,628**

FY 2012-13 Estimated Claims Paid	**Adults 65 and Older**	**Disabled Through 64**	**Low Income Adults**	**Adults w/o Dep. Children**	**Eligible Children**	**Foster Care**	**BCCP**	**Total**
First 6 Months								
Claims Paid in Current Period	$3,194,659	$59,821,644	$20,034,253	$6,460,356	$36,805,337	$18,641,904	$85,749	$145,043,902
Claims from Prior Periods	$65,173	$3,275,841	$918,593	$129,207	$1,142,714	$187,702	$868	$5,720,098
Second 6 Months								
Claims Paid in Current Period	$3,322,357	$65,634,519	$21,805,968	$6,759,648	$40,352,100	$18,258,336	$90,979	$156,223,907
Claims from Prior Periods	$65,404	$3,823,542	$995,900	$131,844	$1,218,541	$182,691	$934	$6,418,856
Total Claims Paid in FY 2012-13	**$6,647,593**	**$132,555,546**	**$43,754,714**	**$13,481,055**	**$79,518,692**	**$37,270,633**	**$178,530**	**$313,406,763**

FY 2012-13 Est. Date of Death Retractions	**Adults 65 and Older**	**Disabled Through 64**	**Low Income Adults**	**Adults w/o Dep. Children**	**Eligible Children**	**Foster Care**	**BCCP**	**Total**
12 Months	($108,718)	($448,801)	($9,537)	($9,537)	($5,471)	($12,897)	($662)	**($595,623)**

FY 2012-13 Pre-adjusted Request	**Adults 65 and Older**	**Disabled Through 64**	**Low Income Adults**	**Adults w/o Dep. Children**	**Eligible Children**	**Foster Care**	**BCCP**	**Total**
12 Months	**$6,538,875**	**$132,106,745**	**$43,745,177**	**$13,471,518**	**$79,513,221**	**$37,257,736**	**$177,868**	**$312,811,140**

FY 2012-13 Recoupment Adjustments	**Total**
12 Months	**($1,240,550)**

FY 2012-13 Total Requested Appropriation	**Total**
12 Months	**$311,570,590**

Appendix F: FY 2013-14 Mental Health Capitation Payments Calculations

Estimated PM/PM Rate - Q1/2	$13.93	$158.51	$24.37	$114.96	$18.71	$170.80	$24.37
Estimated PM/PM Rate - Q3/4	$14.35	$167.52	$25.24	$120.28	$19.67	$169.08	$25.24

FY 2013-14 Caseload by 6 Months	Adults 65 and Older	Disabled Through 64	Low Income Adults	Adults w/o Dep. Children	Eligible Children	Foster Care	BCCP	Forecast
First 6 Months	40,982	76,130	162,141	10,000	390,844	18,028	646	698,771
Second 6 Months	41,408	78,752	165,961	10,000	411,977	18,086	664	726,848
Full Year	41,195	77,441	164,051	10,000	401,411	18,057	655	712,810

FY 2013-14 Estimated Need Calculations	Adults 65 and Older	Disabled Through 64	Low Income Adults	Adults w/o Dep. Children	Eligible Children	Foster Care	BCCP	Total
First 6 Months								
Average Monthly Caseload	40,982	76,130	162,141	10,000	390,844	18,028	646	698,771
PM/PM Rate X Caseload Average	$3,425,276	$72,404,198	$23,708,257	$6,897,600	$43,876,147	$18,475,094	$94,458	$168,881,030
Second 6 Months								
Average Monthly Caseload	41,408	78,752	165,961	10,000	411,977	18,086	664	726,848
PM/PM Rate X Caseload Average	$3,565,229	$79,155,210	$25,133,134	$7,216,800	$48,621,526	$18,347,885	$100,556	$182,140,340
Estimated Need	**$6,990,504**	**$151,559,408**	**$48,841,391**	**$14,114,400**	**$92,497,673**	**$36,822,980**	**$195,014**	**$351,021,370**

FY 2013-14 Estimated Claims Paid	Adults 65 and Older	Disabled Through 64	Low Income Adults	Adults w/o Dep. Children	Eligible Children	Foster Care	BCCP	Total
First 6 Months								
Claims Paid in Current Period	$3,356,428	$67,936,859	$22,572,631	$6,759,648	$42,458,947	$18,295,886	$93,438	$161,473,837
Claims from Prior Periods	$67,641	$4,135,193	$1,084,029	$137,952	$1,330,018	$180,196	$992	$6,936,021
Second 6 Months								
Claims Paid in Current Period	$3,493,568	$74,271,334	$23,929,257	$7,072,464	$47,051,051	$18,169,911	$99,470	$174,087,055
Claims from Prior Periods	$68,712	$4,352,379	$1,129,989	$137,952	$1,407,184	$179,076	$1,020	$7,276,312
Total Claims Paid in FY 2012-13	**$6,986,349**	**$150,695,765**	**$48,715,906**	**$14,108,016**	**$92,247,200**	**$36,825,069**	**$194,920**	**$349,773,225**

FY 2013-14 Est. Date of Death Retractions	Adults 65 and Older	Disabled Through 64	Low Income Adults	Adults w/o Dep. Children	Eligible Children	Foster Care	BCCP	Total
12 Months	($99,438)	($410,494)	($8,723)	($8,723)	($5,004)	($11,796)	($605)	**($544,783)**

FY 2013-14 Pre-adjusted Request	Adults 65 and Older	Disabled Through 64	Low Income Adults	Adults w/o Dep. Children	Eligible Children	Foster Care	BCCP	Total
12 Months	**$6,886,911**	**$150,285,271**	**$48,707,183**	**$14,099,293**	**$92,242,196**	**$36,813,273**	**$194,315**	**$349,228,442**

FY 2013-14 Recoupment Adjustments	Total
12 Months	**($1,373,413)**

FY 2013-14 Total Requested Appropriation	Total
12 Months	**$347,855,029**