COLORADO GENERAL ASSEMBLY
JOINT BUDGET COMMITTEE

FY 2011-12 STAFF BUDGET BRIEFING

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
(Medicaid Mental Health Community Programs)

-AND-

DEPARTMENT OF HUMAN SERVICES
(Mental Health and Alcohol and Drug Abuse Services)

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

Prepared By:
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December 10, 2010

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FY 2011-12 BUDGET BRIEFING
STAFF PRESENTATION TO THE JOINT BUDGET COMMITTEE
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
(Medicaid Mental Health Community Programs)
-AND-
DEPARTMENT OF HUMAN SERVICES
(Mental Health and Alcohol and Drug Abuse Services)

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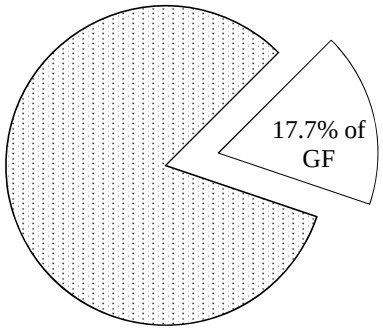
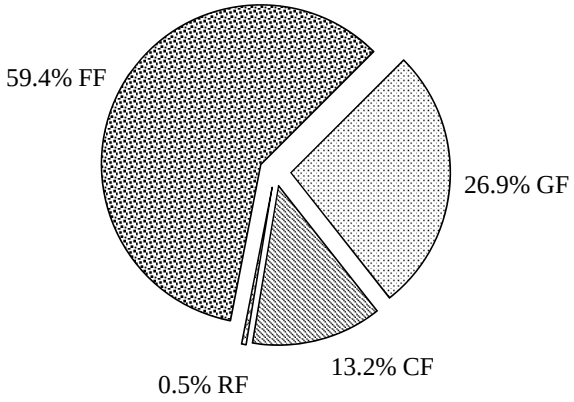
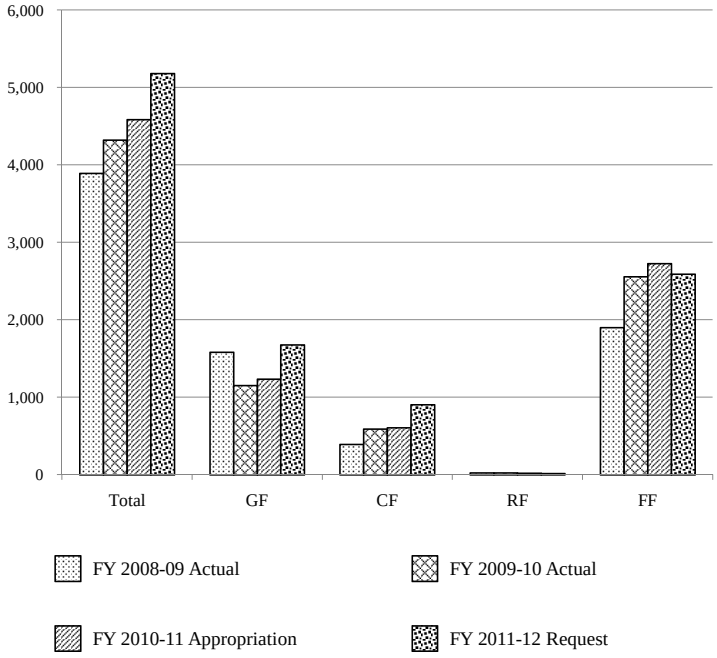


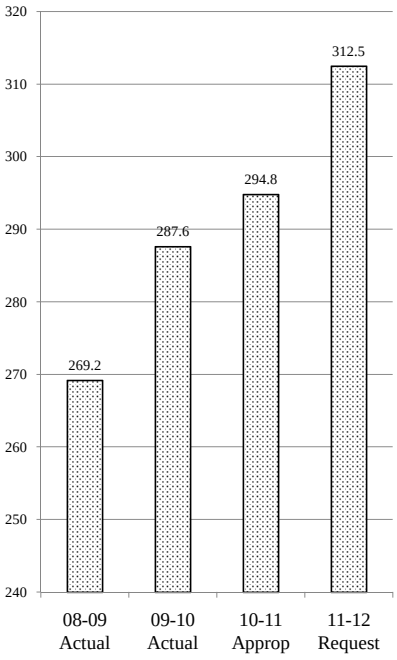
Department Funding Sources



Budget History
(Millions of Dollars)



FTE History

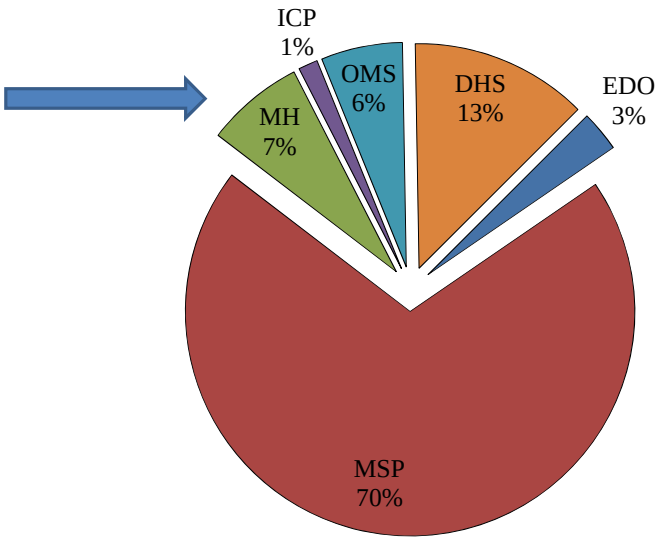


Unless otherwise noted, all charts are based on the FY 2010-11 appropriation.

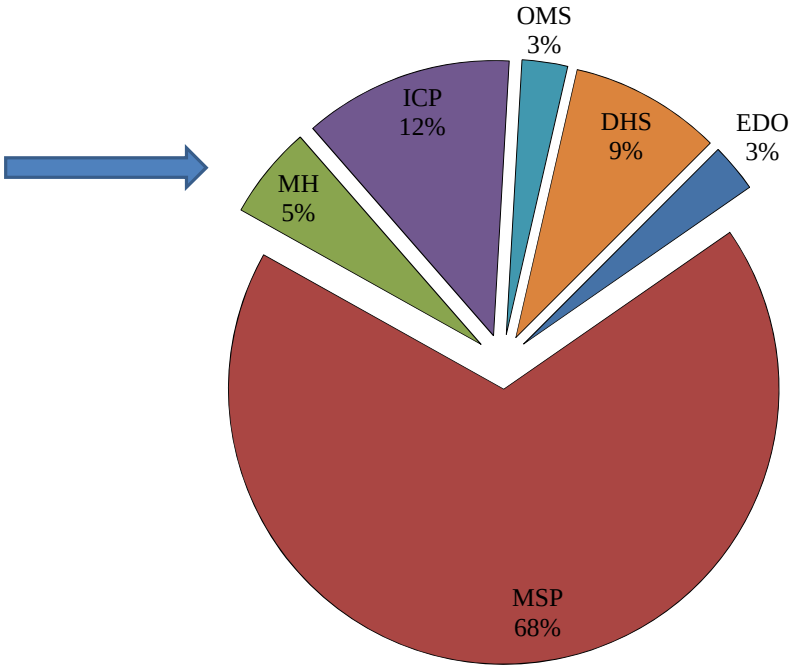
FY 2011-12 Joint Budget Committee Staff Budget Briefing
Department of Health Care Policy and Financing

GRAPHIC OVERVIEW

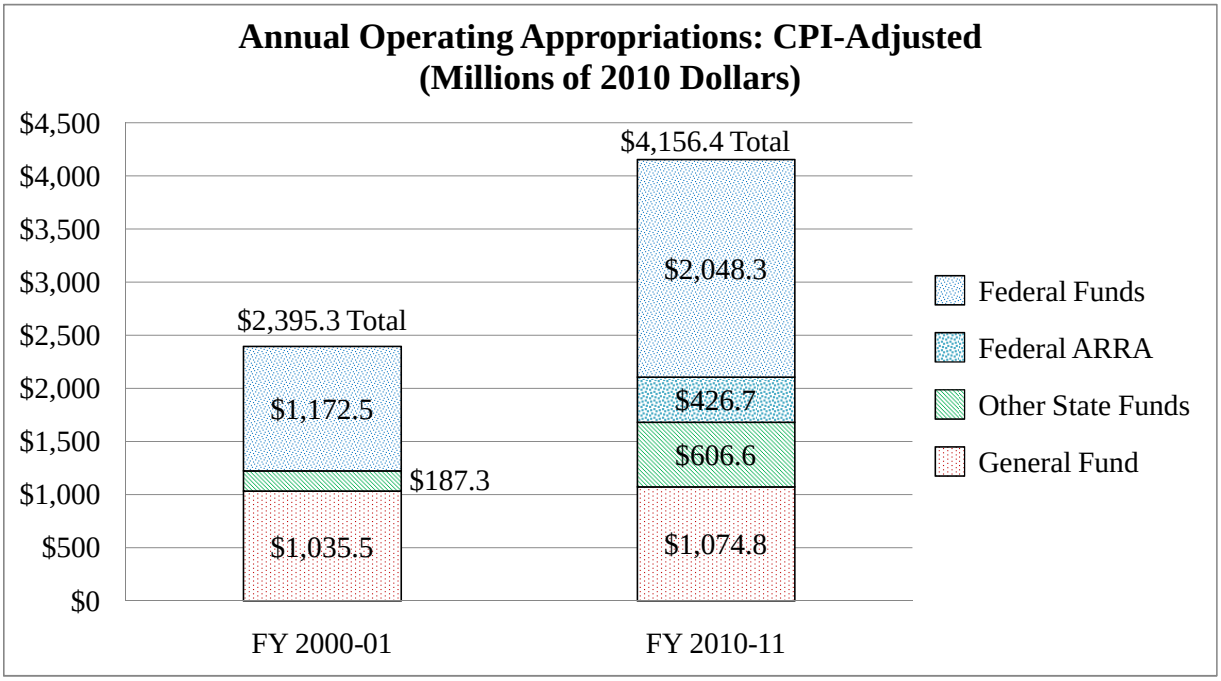
Distribution of General Fund by Division

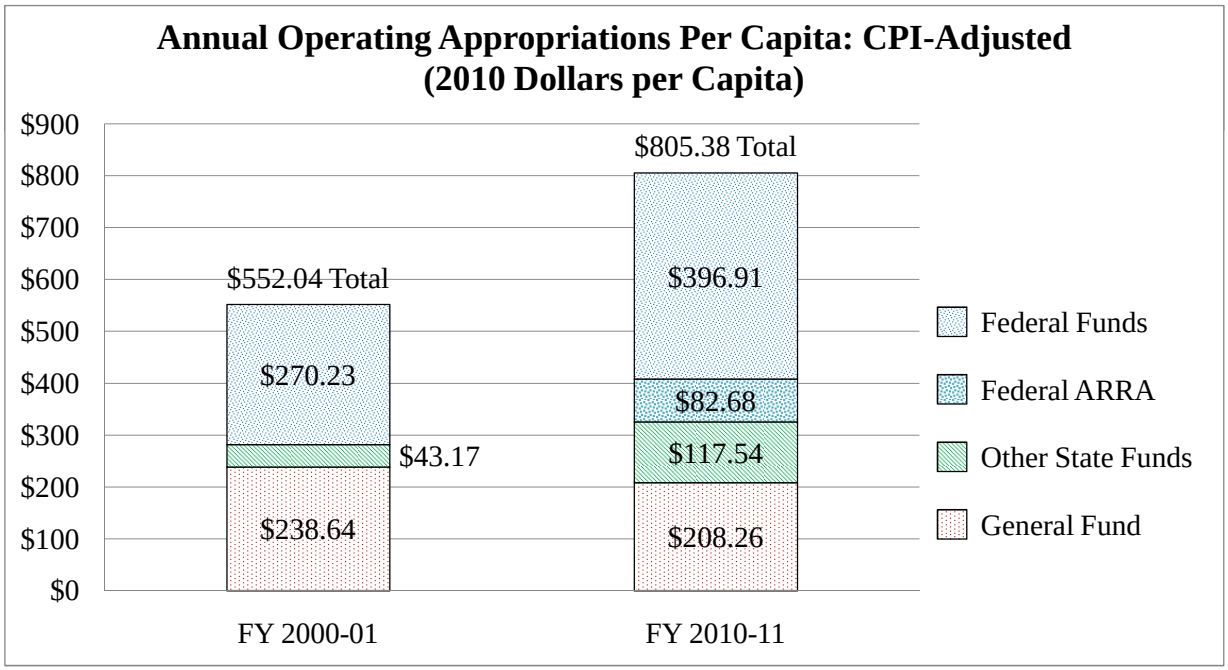


Distribution of Total Funds by Division



FY 2011-12 Joint Budget Committee Staff Budget Briefing
Department of Health Care Policy and Financing
COMPARISON OF FY 2000-01 AND FY 2010-11 APPROPRIATIONS





NOTES: (1) All appropriations above *exclude* duplicate appropriations (i.e., these appropriations exclude reappropriated funds for FY 2010-11 and, for FY 2000-01, exclude amounts that would have been classified as reappropriated funds). Additionally, in this department the appropriations do not reflect the amount of Medicaid funding transferred to the Department of Human. However, the FY 2000-01 appropriation has been adjusted to reflect the Medicaid Mental Health program in order to more accurately compare to the FY 2010-11 appropriation for HCPF administered programs.

(2) For the purpose of providing comparable figures, FY 2000-01 appropriations are adjusted to reflect changes in the Denver-Boulder-Greeley consumer price index (CPI) from 2000 to 2010. Based on the Legislative Council Staff September 2010 Economic and Revenue Forecast, the CPI is projected to increase 21.9 percent over this period.

(3) In the per capita chart, above, appropriations are divided by the Colorado population (for 2000 and 2010, respectively). Based on the Legislative Council Staff September 2010 Economic and Revenue Forecast, Colorado population is projected to increase by 18.9 percent over this period.

FY 2011-12 Joint Budget Committee Staff Budget Briefing
Department of Health Care Policy and Financing
(Medicaid Mental Health Community Programs)

DEPARTMENT OVERVIEW

Key Responsibilities (Medicaid Mental Health Community Programs Only)

- ❏ Administers the State's Medicaid mental health capitation (managed care) program. Under the terms of the program, the State pays regional entities, known as Behavioral Health Organizations (BHOs), a contracted capitation rate (per member per month) for eligible Medicaid clients with the geographic boundaries of the BHO. The BHO is then required to provide appropriate mental health services to all Medicaid-eligible persons needing such services.

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

Factors Driving the Budget (Medicaid Mental Health Community Programs Only)

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 - 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 then required to provide appropriate mental health services to all Medicaid-eligible persons needing such services as provided by the contract.

The rate paid to each BHO is based on each category of Medicaid client eligible for mental health services (e.g., children in foster care, low-income children, elderly, disabled) in each geographic region. Currently, the state is divided into five unique geographic regions covering the following aid categories:

- ❏ Adults 65 and Older (OAP-A)
- ❏ Disabled Adults 60 to 64 (OAP-B)
- ❏ Disabled Individuals to 59 (AND/AB)
- ❏ Categorically Eligible Low-Income Adults (AFDC-A)
- ❏ Expansion Adults
- ❏ Baby Care Program-Adults
- ❏ Eligible Children (AFDC-C/ BC)
- ❏ Foster Care

❑ Breast and Cervical Cancer Program

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 overall state appropriations for mental health services. For FY 2010-11, capitation payments represent 98.8 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 2007-08 to the FY 2011-12 request, expenditures/appropriations have grown by 35.9 percent while caseload has grown by 57.5 percent.

	FY 07-08 Actual	FY 08-09 Actual	FY 09-10 Actual	FY 10-11 Appropriation	FY 11-12 Request
Medicaid Mental Health Capitation Funding	$196,011,033	$215,860,937	$223,368,053	$247,616,458	$266,299,165
Annual Dollar Change	$11,370,465	$19,849,904	$7,507,116	$24,248,405	$18,682,707
Annual Dollar Percent Change	6.2%	10.1%	3.5%	10.9%	7.5%
Individuals Eligible for Medicaid Mental Health Services (Caseload)	373,557	417,750	479,185	532,724	588,188
Annual Caseload Change	(562)	44,193	61,435	53,539	55,464
Annual Caseload % Change	-0.2%	11.8%	14.7%	11.2%	10.4%

Medicaid Mental Health Fee-for-Service Payments

Medicaid Mental Health Fee-for-Service Payments is a separate budget line item in the Medicaid Mental Health Community Programs Division. The appropriation allows Medicaid clients not enrolled in a behavioral health organization to receive mental health services or enrolled Medicaid clients to receive mental health services not covered by the behavioral health organizations (outside of the scope of the State's contract with the behavioral health organizations). 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 Medicaid Mental Health Fee for Service Payments. As is illustrated, from FY 2007-08 to the FY 2011-12 request, expenditures/appropriations have grown by 149.7 percent.

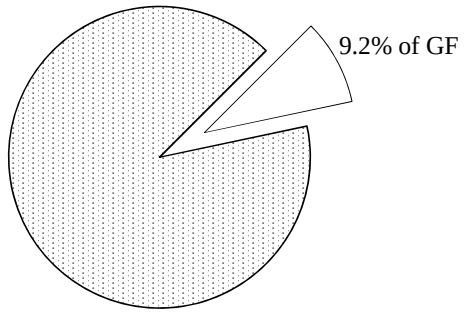
	FY 07-08 Actual	FY 08-09 Actual	FY 09-10 Actual	FY 10-11 Appropriation	FY 11-12 Request
Medicaid Mental Health Capitation Funding	$1,335,736	$1,776,253	$2,587,662	$2,965,758	$3,334,850
Annual Dollar Change	($32,131)	$440,517	$811,409	$378,096	$369,092
Annual Dollar Percent Change	-2.3%	33.0%	45.7%	14.6%	12.4%

Much of the increase in Medicaid Mental Health Fee for Service Payments is due to increases in the outpatient category of services. The significant increase in fee-for-service expenditures that occurred in FY 2009-10 is currently under study by the Department to determine if this increase reflects a permanent shift in expenditure patterns or if it is an anomaly. The Department indicates that until data analysis can prove or disprove any theories, it will take the conservative view for forecasting purposes, assuming the increase fee-for-service expenditures will continue into the foreseeable future.

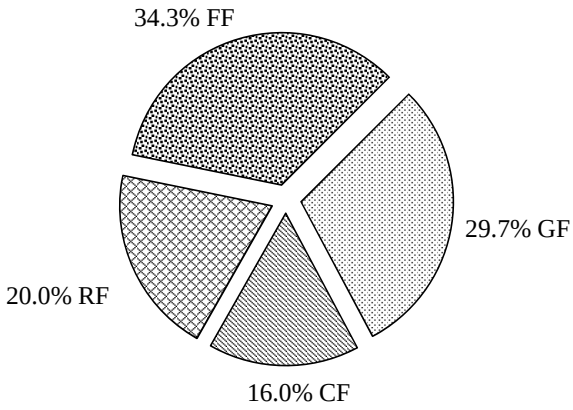
FY 2011-12 Joint Budget Committee Staff Budget Briefing
Department of Human Services

GRAPHIC OVERVIEW

Department's Share of Statewide General Fund

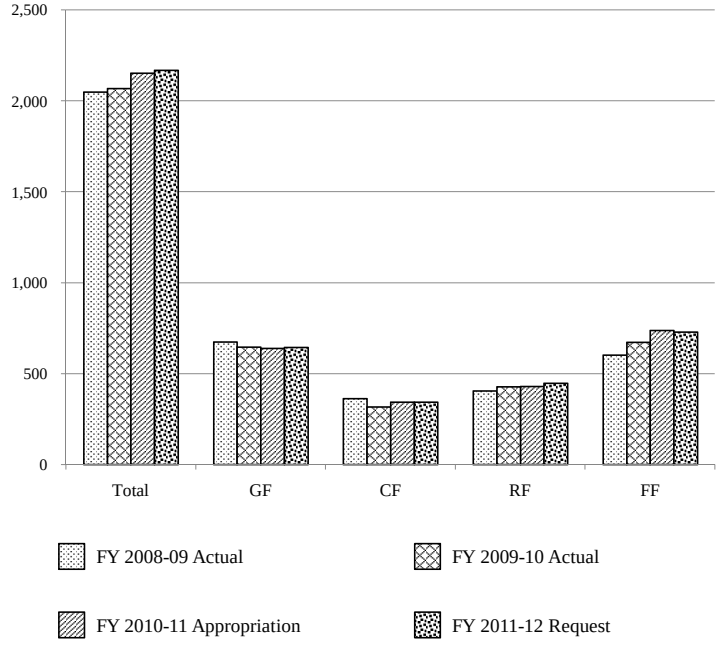


Department Funding Sources

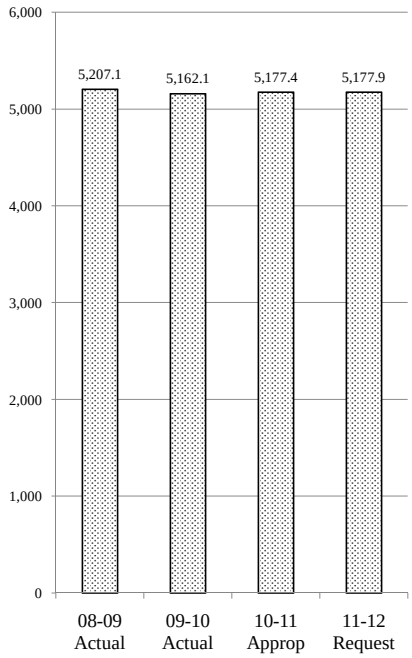


Note: If General Fund appropriated to the Department of Health Care Policy and Financing for human services programs were included in the graph above, the Department of Human Services' share of the total state General Fund would rise to 11.4%.

Budget History
(Millions of Dollars)

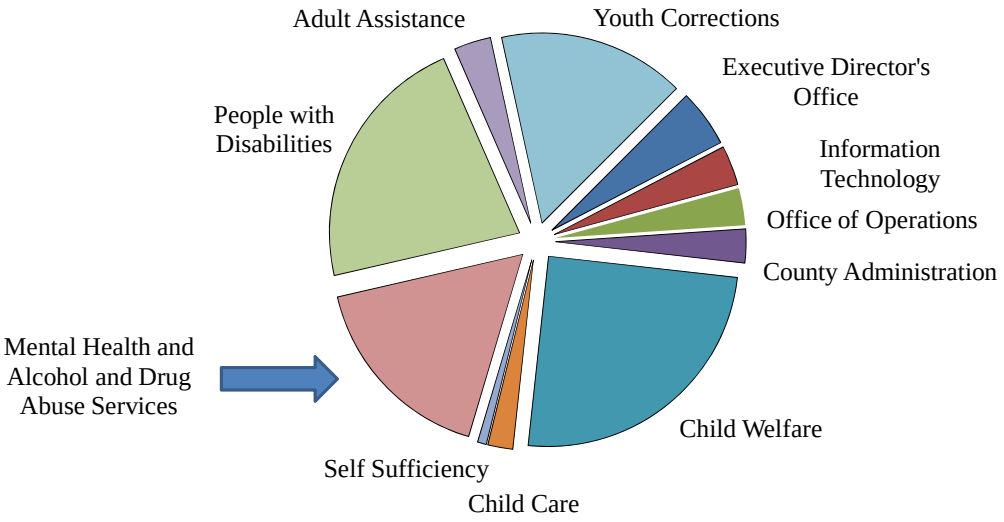


FTE History



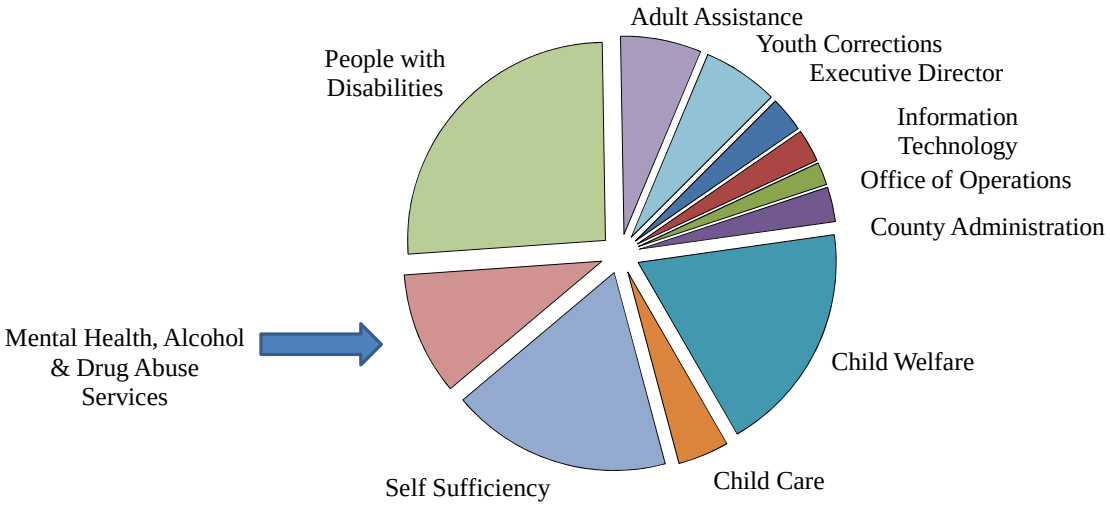
Unless otherwise noted, all charts are based on the FY 2010-11 appropriation.

Distribution of Net General Fund by Division*
FY 2010-11 Appropriation $797.2 million

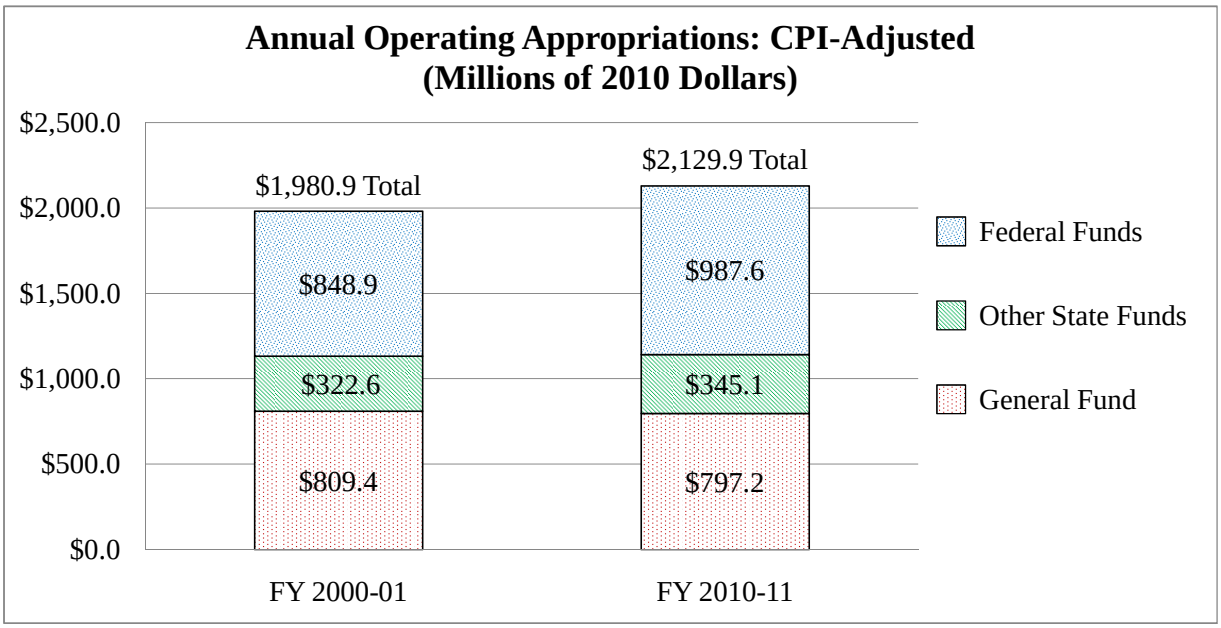


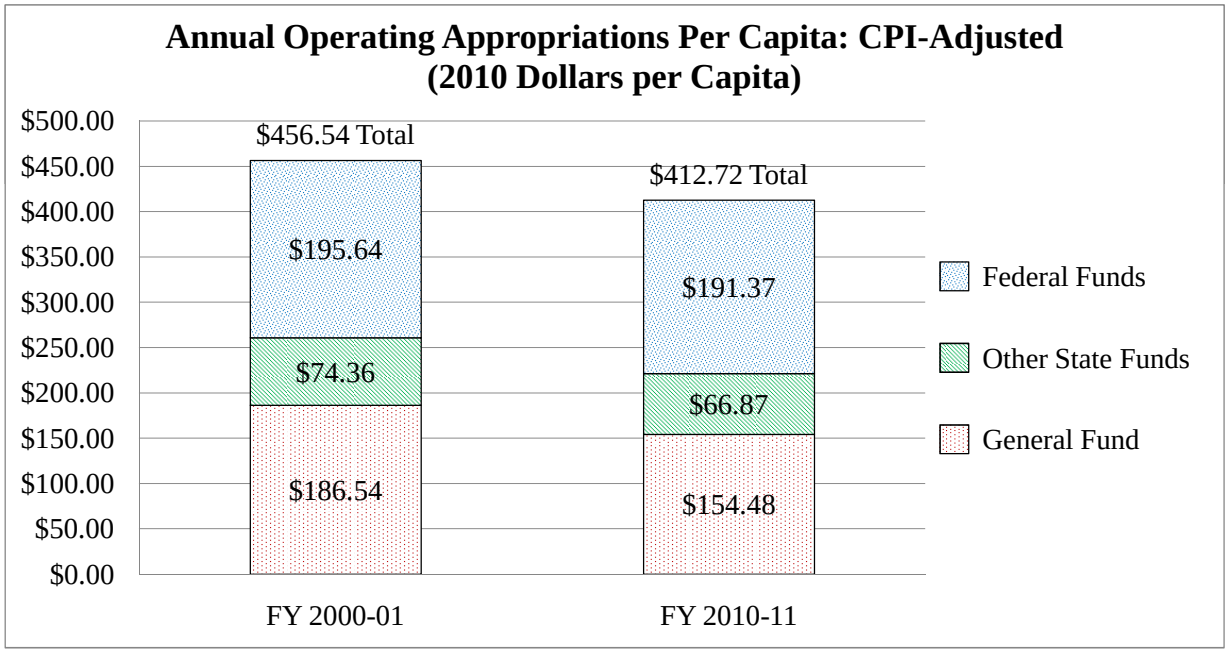
*Net General Fund includes General Fund appropriated to the Department of Human Services and General Fund appropriated to the Department of Health Care Policy and Financing for human services programs.

Distribution of Total Funds by Division
FY 2010-11 Appropriation $2,153.1 million



FY 2011-12 Joint Budget Committee Staff Budget Briefing
Department of Human Services
COMPARISON OF FY 2000-01 AND FY 2010-11 APPROPRIATIONS





NOTES: (1) All appropriations above *exclude* duplicate appropriations (i.e., these appropriations exclude reappropriated funds for FY 2010-11 and, for FY 2000-01, exclude amounts that would have been classified as reappropriated funds). For this department, the majority of reappropriated funds are for transfers from the Department of Health Care Policy and Financing. In this chart, these amounts are shown as General Fund and federal funds in the Department of Human Services, based on how the funds are initially appropriated in the Department of Health Care policy and Financing, and are excluded from the Department of Health Care Policy and Financing appropriation. Other duplicate appropriations in the Department of Human Services are entirely excluded from the chart. This includes transfers from the Department of Education to support vocational rehabilitation programs, transfers from the Department of Corrections for facility support services on the Department of Human Services' Pueblo campus, and funds transferred within the Department of Human Services for administrative support services, among other items.

(2) For the purpose of providing comparable figures, FY 2000-01 appropriations are adjusted to reflect changes in the Denver-Boulder-Greeley consumer price index (CPI) from 2000 to 2010. Based on the Legislative Council Staff September 2010 Economic and Revenue Forecast, the CPI is projected to increase 21.9 percent over this period.

(3) In the per capita chart, above, appropriations are divided by the Colorado population (for 2000 and 2010, respectively). Based on the Legislative Council Staff September 2010 Economic and Revenue Forecast, Colorado population is projected to increase by 18.9 percent over this period.

FY 2011-12 Joint Budget Committee Staff Budget Briefing
Department of Human Services
(Mental Health and Alcohol and Drug Abuse Services)

DEPARTMENT OVERVIEW

Key Responsibilities

- ❑ The **Division of Behavioral Health** provides overall policy development, coordination of services, management and administrative oversight for the delivery of mental health and alcohol and drug abuse community services to Colorado's non-Medicaid eligible population. Additionally, the Division is designated as the State Mental Health Authority and the State Substance Abuse Authority. As such, it collects nearly $30 million in block grant funding from the federal government.

- ❑ The **Mental Health Institute Division** operates the State's two mental health institutes at Fort Logan and Pueblo. The institutes serve all indigent citizens in the State of Colorado who require inpatient services to manage serious mental illness. In addition, the Pueblo facility houses the only forensic psychiatric hospital in the state. The Institute for Forensic Psychiatry (IFP) dedicates 310 beds to adults who are found not guilty by reason of insanity or incompetent to proceed (defendants unable to assist in their own defense). IFP is also the clearinghouse for all criminal court-related evaluations for individuals across the state.

- ❑ The **Division of Supportive Housing and Homeless Programs** administers Colorado's second largest rental assistance program. All of the programs in the Division are specifically targeted to persons with special needs, including those with physical, mental, developmental, and substance abuse disabilities. The Division partners with over 1,000 private landlords and approximately 70 community-based service organizations to provide 3,500 housing units.

Factors Driving the Budget

Division of Behavioral Health

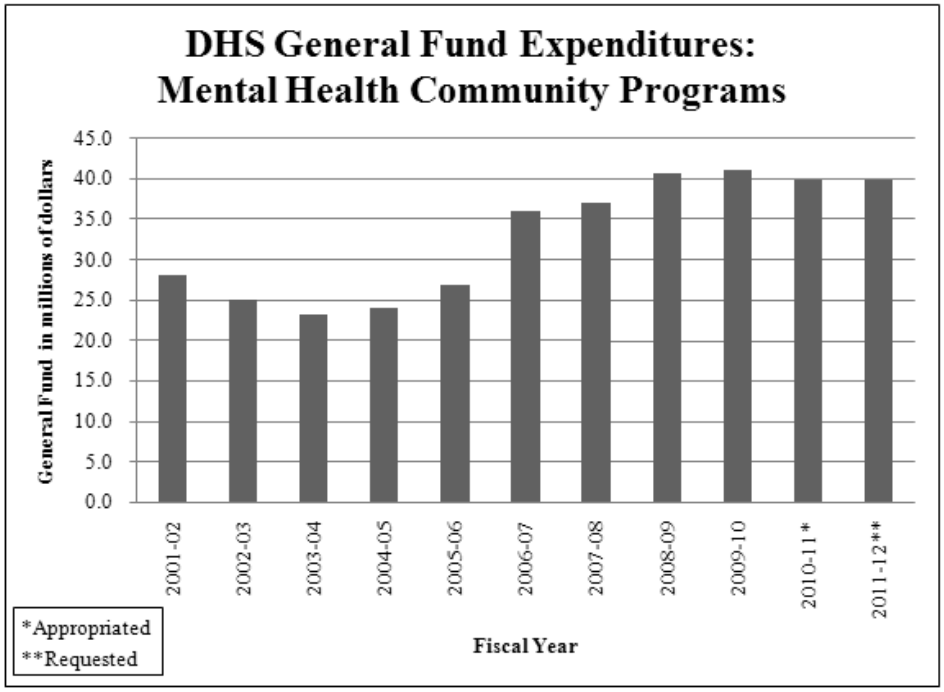
The Division's budget is driven by the contracts it enters into with community providers to deliver mental health and substance abuse treatment and prevention community services to eligible clients. To ensure that community provider arrangements are viable over the long term, the General Assembly has regularly adjusted community provider rates to account for inflationary changes. The rate changes each year are determined by the Joint Budget Committee in a common policy decision. The table below shows the rate changes for community provider programs in the Division from FY 2007-08 through the FY 2011-12 Department request.

Changes in Community Provider Rates						
	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11	FY 2011-12*
Rate Change	3.25%	1.5%	1.5%	0.0%	(2.0%)	0.0%

*Department request.

Historically, the General Assembly has adjusted appropriations to community providers of mental health and substance abuse treatment and prevention services outside of the provider rate inflationary common policy process, as well. For example, the FY 2003-04 appropriation included a decrease of $3.6 million General Fund as part of a reduction in services for non-Medicaid individuals with mental illnesses and the elimination of various pilot programs designed to assist targeted populations as part of the Statewide revenue shortfall. Conversely, the FY 2006-07 appropriation included an increase of $4.4 million General Fund to serve more non-Medicaid individuals with mental illnesses and the FY 2007-08 appropriation included an increase of $1.4 million General Fund for the same purpose.

The tables below summarizes General Fund spending by the Division on mental health community programs.



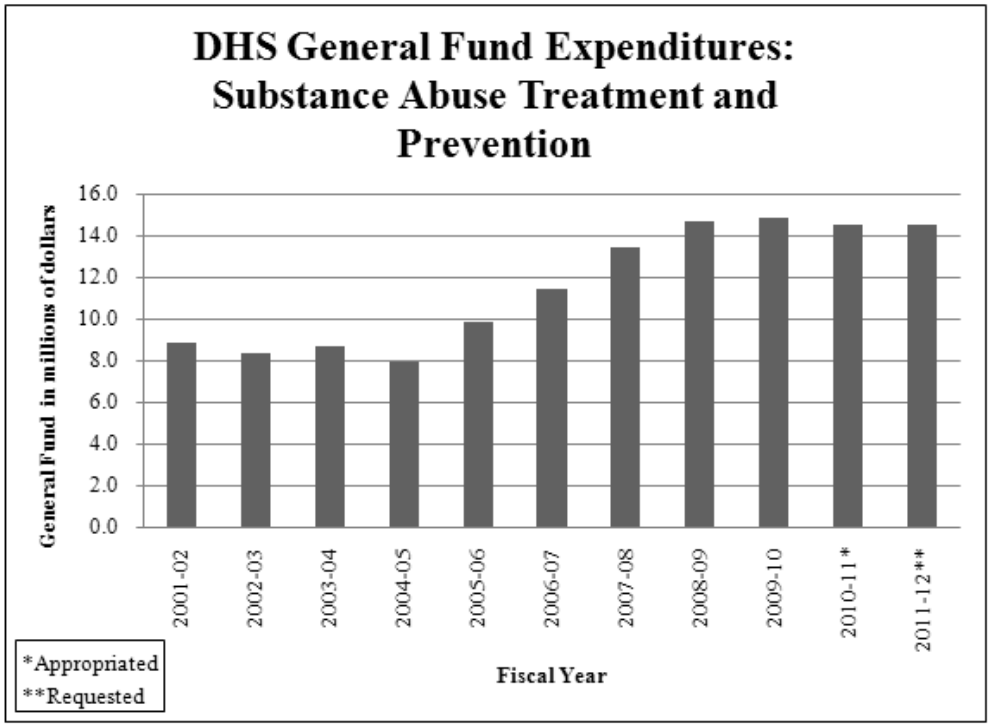
In addition to General Fund appropriations, the Division is appropriated cash funds and federal funds. As the designated "State Mental Health Authority," the Division receives federal funding from the Mental Health Services Block Grant administered by the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA). In FY 2010-11 the Block Grant provided the State with $6.5 million. The moneys are provided to

community mental health centers for the provision of services, and appropriated to the Division for administrative purposes and research.

The Division receives cash funds from tobacco litigation settlement moneys for the provision of mental health services. The Offender Mental Health Services Fund receive 12 percent of tier two settlement moneys for the purchase of mental health services from community mental health centers for juvenile and adult offenders who have mental health problems and are involved in the criminal justice system. For FY 2011-12, the Division received an appropriation of $3.8 million from the Offender Mental Health Services Fund for this purpose.

The Division of Behavioral Health's General Fund appropriations for community-based substance usage disorders treatment and prevention services totaled approximately 65 percent less than the General Fund appropriations for community-based mental health services for FY 2010-11. Substance usage disorders treatment and prevention services received increases in total General Fund appropriations in FY 2005-06 through FY 2008-09 due to the expansion of speciality programs, such as the Short-term Intensive Residential Rehabilitation Program (STIRRT), and the establishment of speciality programs, such as the Provider Performance Monitoring System. Outside of inflationary provider rate increases, core substance usage disorders treatment and prevention services have not received General Fund increases in the past ten years.

The tables below summarizes General Fund spending by the Division on substance usage disorders treatment and prevention services.

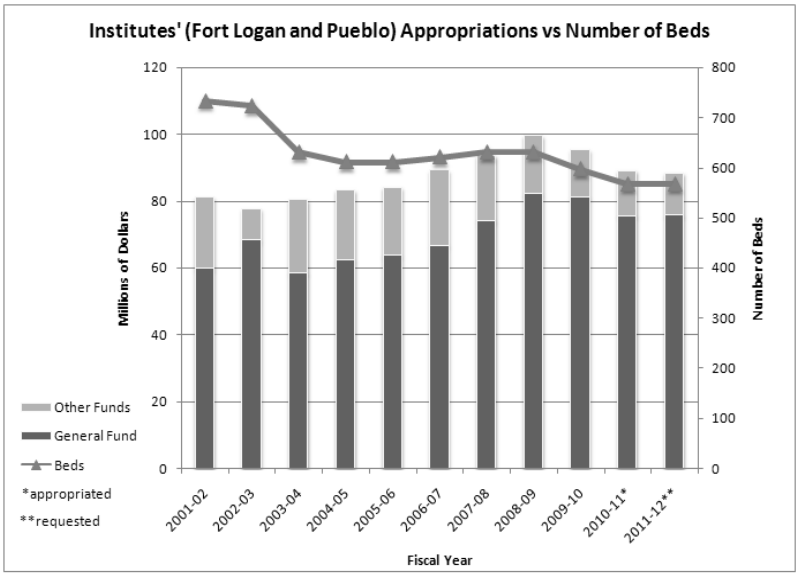


In addition to General Fund appropriations for community-based substance use disorders, the Division is appropriated cash funds and federal funds. As the designated "State Substance Abuse Authority," the Division receives federal funding from the Substance Abuse Prevention and Treatment Block Grant administered by SAMHSA. In FY 20101-11 the Block Grant provided the State with $23.5 million. The moneys are provided to substance usage disorders treatment and prevention service providers, and appropriated to the Division for administrative purposes and research.

The Division receives cash funds from tobacco litigation settlement moneys for the provision of mental health services. The Alcohol and Drug Abuse Community Prevention and Treatment Fund receives three percent of tier two settlement moneys for the purchase of community prevention and treatment services from community providers. For FY 2011-12, the Division received an appropriation of $0.9 million from the Alcohol and Drug Abuse Community Prevention and Treatment Fund for this purpose.

Mental Health Institute Division

The Department of Human Services operates the State's two mental health institutes in Denver and Pueblo. Over the past ten years (FY 2001-02 through FY 2011-12), the total number of inpatient beds has decreased from 734 to 568. 310 of the 568 beds currently available for treatment services are dedicated to the Institute for Forensic Psychiatry at the Colorado Mental Health Institute at Pueblo. The remaining 258 beds, commonly referred to as "civil beds," are spread between Pueblo (144 beds) and the Colorado Mental Health Institute at Fort Logan (114). The FY 2010-11 appropriation for the institutes is $89.1 million. In FY 2008-09, the average cost per bed across the institutes for civil beds was $265,587, including $$259,872 at Fort Logan and $271,663 at the Mental at the Pueblo facility. The average cost per bed at the Institute for Forensic Psychiatry was $$194,258 during the same fiscal year. The table below summarizes the yearly appropriations for the two institutes (combined) for the past ten years along with the number of inpatient treatment beds available for each year.



Despite the decline in inpatient beds, General Fund appropriations increased at the mental health institutes from FY 2004-05 through FY 2008-09. The increases are attributable to salary increases, compression pay, and the transition to and operation of the new High Security Forensic Institute Institute at Pueblo. Beginning in FY 2009-10, General Fund appropriations have declined as a result of the closure of the geriatric, adolescent, and children's treatment divisions at Fort Logan.

Division of Supportive Housing and Homeless Programs

The division is 100 percent federally funded from the United States Department of Housing and Urban Development via multiple funding streams. The program was appropriated $20.1 million and 19.0 FTE for FY 2010-11.

FY 2011-12 Joint Budget Committee Staff Budget Briefing
Department of Health Care Policy and Financing
(Medicaid Mental Health Community Programs)

DECISION ITEM PRIORITY LIST
Mental Health Community Programs Only

Decision Item	GF	CF	RF	FF	Total	FTE
2	$2,607,274	$9,251,400	($12,180)	$10,474,416	$22,320,910	0.0

Medicaid Mental Health Community Programs

Medicaid Mental Health Community Programs. Estimated base increase to the Medicaid Community Mental Health Programs line items. The request is based on the anticipated growth in the Medicaid caseload. *Statutory authority: Sections 25.5-5-408 and 25.5-5-411, C.R.S.*

FY 2011-12 Joint Budget Committee Staff Budget Briefing
Department of Health Care Policy and Financing
(Medicaid Mental Health Community Programs)

BASE REDUCTION ITEM PRIORITY LIST
Medicaid Mental Health Community Programs Only

	Reduction Item	GF	CF	RF	FF	Total	FTE
2		($4,598)	$0	$0	($4,597)	($9,195)	0.0
	Medicaid Fee-For-Service Payment Delay **Medicaid Mental Health Community Programs.** The Department proposes a permanent three week delay before paying fee-for-service claims. This request also includes the repayment of the FY 2010-11 three-week delay proposed in the Department's request ES-2, "Fee-for-Service Delay in FY 2010-11." *Statutory authority: Section 25.5-4-401, C.R.S.*						
5		(2,252,098)	(240,613)	0	(2,516,126)	(5,008,837)	0.0
	Medicaid Reductions **Medicaid Mental Health Community Programs.** For this reduction, the Department would make permanent the two percent reduction that is effective January 1, 2011 in the Mental Health Capitation Payments program. The Department estimates that the policy would reduce capitation program expenditures by $5,008,837 total funds, $2,252,098 General Fund in FY 2011-12, and annualize to a reduction of $5,380,493 total funds, $2,419,204 General Fund in FY 2012-13. *Statutory authority: 25.5-4-401 (1) (a), C.R.S.*						
6		(657,293)	(70,080)	0	(727,374)	(1,454,747)	0.0
	Delay Managed Care Payments **Medicaid Mental Health Community Programs.** the Department proposes to move managed care service providers from a concurrent payment methodology (services paid for during the month in which they are delivered) to a retrospective payment methodology (services paid for in the month following delivery). This request continues the implementation of the managed care delay requested as part of FY 2010-11 budget balancing, in request ES-3. *Statutory authority: Section 25.5-4-401, C.R.S.*						
Total		**($2,913,989)**	**($310,693)**	**$0**	**($3,248,097)**	**($6,472,779)**	**0.0**

FY 2011-12 Joint Budget Committee Staff Budget Briefing
Department of Human Services
(Mental Health and Alcohol and Drug Abuse Services)

DECISION ITEM PRIORITY LIST
Mental Health and Alcohol and Drug Abuse Services Only

Decision Item	GF	CF	RF	FF	Total	Net GF*	FTE
5	0	0	(548,765)	0	(548,765)	0	(5.0)

Transfer of Sol Vista Youth Services Center FTE to the Division of Youth Corrections

Division of Youth Corrections. The request is to transfer 5.0 FTE for Sol Vista clinical staff from the Colorado Mental Health Institute at Pueblo (CMHIP) appropriation to the appropriation for the Division of Youth Corrections (DYC). The change would also eliminate $548,765 reappropriated funds spending authority for funds currently transferred from DYC to CMHIP. Sol Vista is a 20-bed DYC facility for committed youth with severe mental health needs and is located on the CMHIP campus. Sol Vista clinical staff were previously employed by CMHIP under an agreement with DYC. The proposal would shift the clinical staff to direct employment with DYC. *Statutory authority: Section 19-2-403 (1), C.R.S.*.

* These amounts are shown for informational purposes only. A large portion of the Department's reappropriated funds are Medicaid-related transfers from the Department of Health Care Policy and Financing (HCPF). Roughly half of the corresponding HCPF appropriations are General Fund. Net General Fund equals the direct GF appropriation shown, plus the GF portion of the HCPF transfer.

FY 2011-12 Joint Budget Committee Staff Budget Briefing
Department of Human Services
(Mental Health and Alcohol and Drug Abuse Services)

NON PRIORITIZED CHANGE LIST
Mental Health and Alcohol and Drug Abuse Services Only

Base Reduction Item	GF	CF	RF	FF	Total	Net GF*	FTE
NP-2	0	0	(7,551)	0	(7,551)	(3,775)	0.0
HCPF BRI-2 Medicaid Fee-For-Service Payment Delay **Mental Health Institutes.** The Department of Health Care Policy and Financing proposes to implement a permanent three-week delay in the payment of fee-for-service Medicaid claims. The amount shown is the impact on Department of Human Services Medicaid-funded programs. *Statutory authority: Section 25.5-4-401, C.R.S. (requires statutory change to implement request).*							
NP-4	(253,018)	0	(16,525)	0	(269,543)	(261,281)	0.0
2% Across the Board Personal Services Reduction (DHS Impact) **Mental Health and Alcohol and Drug Abuse Services.** The proposal is for a one-time 2.0 percent reduction to the General Fund portion of all personal services appropriations. The reduction is to be achieved through vacancies or alternative personal services actions departments feel are necessary to implement the reduction. *Statutory authority: Sections 24-37-301 and 34-37-304 (d), C.R.S..*							
NP-7	(1,235,447)	(116,094)	(115,141)	(67,948)	(1,534,630)	(1,262,851)	0.0
Statewide PERA adjustment **Mental Health and Alcohol and Drug Abuse Services.** The request is for a continuation of S.B. 10-146, which decreased the State's PERA contribution rate by 2.5 percent of staff salaries and increased the employee contribution by a corresponding 2.5 percent. *Statutory authority: Section 24-51-401 (1.7) (a), C.R.S. (requires modification to implement request).*							
Total	**($1,488,465)**	**($116,094)**	**($139,217)**	**($67,948)**	**($1,811,724)**	**($1,527,907)**	**0.0**

* These amounts are shown for informational purposes only. A large portion of the Department's reappropriated funds are Medicaid-related transfers from the Department of Health Care Policy and Financing (HCPF). Roughly half of the corresponding HCPF appropriations are General Fund. Net General Fund equals the direct GF appropriation shown, plus the GF portion of the HCPF transfer.

FY 2011-12 Joint Budget Committee Staff Budget Briefing
Department of Health Care Policy and Financing
(Medicaid Mental Health Community Programs)

OVERVIEW OF NUMBERS PAGES

The following table summarizes the total change, in dollars and as a percentage, between the Department's FY 2010-11 appropriation and its FY 2011-12 request for the portion of the Department of Health Care Policy and Financing addressed in this briefing packet.

TOTAL Health Care Policy and Financing Divisions in this Briefing:
Requested Change, FY 2010-11 to FY 2011-12 (millions of dollars)

Category	GF	CF	RF	FF	Total
FY 2010-11 Appropriation	$87.1	$9.6	$0.0	$153.9	$250.6
FY 2011-12 Request	114.0	21.0	0.0	134.7	269.7
Increase / (Decrease)	$26.9	$11.4	$0.0	($19.2)	$19.1
Percentage Change	30.9%	118.8%	n/a	-12.5%	7.6%

The following table highlights the individual changes contained in the Department's FY 2011-12 budget request, as compared with the FY 2010-11 appropriation, for the portion of the Department covered in this briefing packet. For additional detail, see the numbers pages in Appendix A.

Requested Changes, FY 2010-11 to FY 2011-12

Medicaid Mental Health Community Programs	GF	CF	RF	FF	Total
FY 2010-11 Current Appropriation	**$87,070,304**	**$9,555,600**	**$12,046**	**$153,944,266**	**$250,582,216**
FMAP Adjustment (ES #1)	4,266,730	383,395	0	(4,650,125)	0
Fee-for-Service Delay (ES #2)	(41,650)	0	0	(48,599)	(90,249)
Managed Care Delay (ES #3)	(7,903,646)	(993,035)	(1,004)	(11,737,020)	(20,634,705)
Caseload Forecast (S #1)	(2,110,115)	719,223	1,980	(2,334,672)	(3,723,584)
Requested FY 2010-11 Appropriation	**$81,281,623**	**$9,665,183**	**$13,022**	**$135,173,850**	**$226,133,678**
Annualize Prior Year Budget Actions	10,799,873	375,891	(842)	16,098,997	27,273,919
ARRA Adjustment	22,006,239	1,977,412	0	(23,983,651)	0
FY 2011-12 Base Request	**$114,087,735**	**$12,018,486**	**$12,180**	**$127,289,196**	**$253,407,597**

Medicaid Mental Health Community Programs	GF	CF	RF	FF	Total
Medicaid Mental Health Community Programs Caseload (DI #2)	2,796,419	9,251,400	(12,180)	10,663,558	22,699,197
FY 2011-12 Base Request + Caseload	**$116,884,154**	**$21,269,886**	**$0**	**$137,952,754**	**$276,106,794**
Medicaid Fee-For-Service Payment Delay (BRI #2)	(4,598)	0	0	(4,597)	(9,195)
Medicaid Reductions (BRI #5)	(2,252,098)	(240,613)	0	(2,516,126)	(5,008,837)
Delay Managed Care Payments (BRI #6)	(657,293)	(70,080)	0	(727,374)	(1,454,747)
Total FY 2011-12 Request	**$113,970,165**	**$20,959,193**	**$0**	**$134,704,657**	**$269,634,015**
Change from FY 2010-11 Current Appropriation	**$26,899,861**	**$11,403,593**	**($12,046)**	**($19,239,609)**	**$19,051,799**
Percent Change	**30.9%**	**119.3%**	**-100.0%**	**-12.5%**	**7.6%**
Change from Requested FY 2010-11 Appropriation	**$32,688,542**	**$11,294,010**	**($13,022)**	**($469,193)**	**$43,500,337**
Percent Change	**40.2%**	**116.9%**	**-100.0%**	**-0.3%**	**19.2%**

FY 2011-12 Joint Budget Committee Staff Budget Briefing
Department of Human Services
(Mental Health and Alcohol and Drug Abuse Services)

OVERVIEW OF NUMBERS PAGES

The following table summarizes the total change, in dollars and as a percentage, between the Department's FY 2010-11 appropriation and its FY 2011-12 request for the portion of the Department of Human Services addressed in this briefing packet. A large portion of the Department's reappropriated funds are Medicaid-related transfers from the Department of Health Care Policy and Financing (HCPF). Roughly half of the corresponding HCPF appropriations are General Fund. Net General Fund equals the direct GF appropriation shown, plus the GF portion of the HCPF transfer.

TOTAL Human Services Division in this Briefing:
Requested Change, FY 2010-11 to FY 2010-12 (millions of dollars)

Category	GF	CF	RF	FF	Total	Net GF	FTE
FY 2010-11 Appropriation	$131.6	$16.3	$10.3	$57.8	$216.0	$133.7	1,268.8
FY 2011-12 Request	131.8	15.9	9.6	57.8	215.1	134.5	1,263.3
Increase / (Decrease)	$0.2	($0.4)	($0.7)	$0.0	($0.9)	$0.8	(5.5)
Percentage Change	0.2%	-2.5%	-6.8%	0.0%	-0.4%	0.6%	-0.4%

The following table highlights the individual changes contained in the Department's FY 2010-11 budget request, as compared with the FY 2009-10 appropriation, for the portion of the Department covered in this briefing packet. For additional detail, see the numbers pages in Appendix A.

Requested Changes, FY 2010-11 to FY 2011-12

Category	GF	CF	RF	FF	Total	Net GF	FTE
Annualize Prior Year Budget Actions	$1,675,291	($224,248)	$11,703	$43,453	$1,506,199	$2,264,375	0.0
HCPF BRI #2 Medicaid Fee-For-Service Payment Delay (NP #2)	0	0	(7,551)	0	(7,551)	(3,775)	0.0
2% Across the Board Personal Services Reduction (NP #4)	(253,018)	0	(16,525)	0	(269,543)	(261,281)	0.0
Transfer Sol Vista Youth Services Center FTE to Division of Youth Corrections (DI #5)	0	0	(548,765)	0	(548,765)	0	(5.0)

Category	GF	CF	RF	FF	Total	Net GF	FTE
Statewide PERA Adjustment (NP #7)	(1,235,447)	(116,094)	(115,141)	(67,948)	(1,534,630)	(1,262,851)	0.0
Total	**$186,826**	**($340,342)**	**($676,279)**	**($24,495)**	**($854,290)**	**$736,468**	**(5.0)**

FY 2011-12 Joint Budget Committee Staff Budget Briefing
Department of Health Care Policy and Financing
(Medicaid Mental Health Community Programs)

BRIEFING ISSUE

ISSUE: Significant Actions Taken from FY 2007-08 to FY 2010-11 to Balance the Budget

From FY 2007-08 to FY 2010-11, total appropriations to the Department of Health Care Policy and Financing increased by over $1.0 billion. This increase resulted mainly from: (1) caseload growth of 41.2 percent in the Medicaid program and of 31.8 percent in the Children's Basic Health Plan; and (2) the enactment of provider fee reimbursement programs for hospitals and nursing facilities. In order to mitigate the impact of high Medicaid caseload growth during the economic downturn, the United States Congress and the General Assembly enacted several budget actions. The most notable action occurred when Congress passed the American Recovery and Reinvestment Act (ARRA) of 2009. The total federal relief provided under ARRA for the Medicaid program was over $1.0 billion from FY 2008-09 through FY 2010-11. The General Assembly also refinanced General Fund with other cash funds, and reduced Medicaid reimbursement rates to balance the budget. As a result of both the federal and State actions, the General Fund appropriation to the Department decreased by $249.5 million during this period.

SUMMARY:

- **Medicaid Mental Health Community Programs:** The General Assembly has decreased General Fund by $7.9 million (8.3 percent) from FY 2007-08 to FY 2010-11. The decrease in General Fund is due to provider reimbursement changes, cost savings initiatives, such as accellerated recoupments, and federal relief from ARRA.

DISCUSSION:

From FY 2007-08 to FY 2010-11, total appropriations to the Department of Health Care Policy and Financing (HCPF) increased by approximately 28.4 percent ($1.0 billion). The majority of this growth was related to increased caseload and the enactment of provider fee programs for hospitals and nursing facilities. Although total appropriations for the Department grew, this growth was absorbed by federal or cash fund sources. The General Fund appropriation actually fell by approximately 16.8 percent ($249.5 million) from FY 2007-08 to FY 2010-11 resulting from: (1) offsetting General Fund with federal relief under ARRA; (2) refinancing General Fund expenditures with cash funds; and (3) program reductions, including but not limited to reimbursement reductions for the Medicaid program. These decreases were partially offset by increased General Fund for caseload and cost growth.

The majority of the cash and federal fund increases can be explained by caseload growth and the refinancing of General Fund (either from ARRA or State law changes) to cash and federal funding

sources. In addition, both cash and federal funds grew as a result of the enactment of provider fee programs. Finally, the increase in cash and federal funds were partially offset by program reductions, including but not limited to reimbursement reductions.

Appropriations to the Department of Health Care Policy and Financing for FY 2007-08 through FY 2010-11 are illustrated in the bar chart and detailed in Table 1 below.

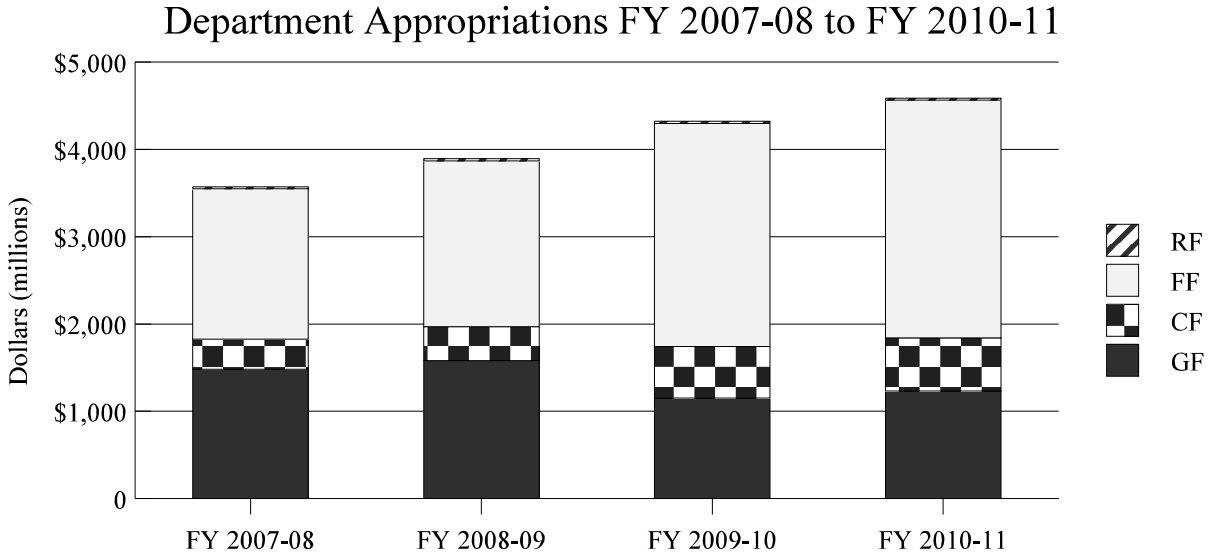


Table 1: Department of Health Care Policy and Financing
Appropriations FY 2007-08 to FY 2010-11

	Total Funds	General Fund	Cash Funds	Federal Funds	Reappropriated Funds
FY 2007-08 /1	$3,571,189,627	$1,481,718,670	$343,816,470	$1,721,062,814	$24,591,673
FY 2008-09	3,892,474,674	1,579,411,116	389,157,525	1,900,242,415	23,663,618
FY 2009-10	4,320,001,681	1,150,198,522	590,847,026	2,554,512,628	24,443,505
FY 2010-11	4,584,093,812	1,232,196,603	607,038,213	2,723,969,690	20,889,306
Increase/(Decrease.) /2	$1,012,904,185	($249,522,067)	$263,221,743	$1,002,906,876	($3,702,367)
Percent Change /2	28.4%	(16.8)%	76.6%	58.3%	(15.1)%

1/ FY 2007-08 Appropriations have been adjusted to reflect the same "cash funds" and "reappropriated funds" format implemented in FY 2008-09. Source: Page 128 of the FY 2008-09 Appropriations Report, plus 2009 legislation affecting FY 2007-08 appropriations (S.B. 09-187 and S.B. 09-259).
2/ Increase/(Decrease) and Percent Change compare FY 2007-08 and FY 2010-11.

Medicaid Mental Health Community Programs

This division provides mental health services through the purchase of services from five regional Behavioral Health Organizations (BHOs), which manage service delivery for eligible Medicaid recipients in a capitated, risk-based model. The division also contains funding for Medicaid mental health fee-for-service programs for those services not covered within the capitation contracts and rates. The funding for this budgetary section is mainly General Fund and federal funds. The major source of the cash funds is the Health Care Expansion Fund.

Medicaid Mental Health Community Programs Appropriations FY 2007-08 to FY 2010-11					
	Total Funds	**General Fund**	**Cash Funds**	**Federal Funds**	**Reappropriated Funds**
FY 2007-08 /1	$198,163,710	$94,964,787	$5,518,058	$97,673,482	$7,383
FY 2008-09	217,149,561	101,878,130	7,086,591	108,176,302	8,538
FY 2009-10	226,359,076	79,774,854	7,175,530	139,397,859	10,833
FY 2010-11	250,582,216	87,070,304	9,555,600	153,944,266	12,046
Increase/(Decrease) /2	$52,418,506	($7,894,483)	$4,037,542	$56,270,784	$4,663
Percent Change /2	26.5%	(8.3)%	73.2%	57.6%	63.2%

1/ FY 2007-08 Appropriations have been adjusted to reflect the same "cash funds" and "reappropriated funds" format implemented in FY 2008-09. Source: Page 128 of the FY 2008-09 Appropriations Report, plus 2009 legislation affecting FY 2007-08 appropriations (S.B. 09-187 and S.B. 09-259).
2/ Increase/(Decrease) and Percent Change compare FY 2007-08 and FY 2010-11.

Background on Budget Trends

As reflected in the table above, the overall budget for this section has increased by 26.5 percent since FY 2007-08, based on increases in cash funds and federal funds, offset by a General Fund reduction of 8.3 percent. The changes have been driven by four actions:

- ❏ Caseload and cost forecast adjustments totaling an increase of $64.1 million total funds, including $50.5 million General Fund, $8.2 million cash funds, and $5.5 million federal funds;
- ❏ Provider reimbursement changes, including benefit reductions and provider rate reductions, totaling a decrease of $6.6 million total funds, including $3.0 million General Fund and $3.3 million federal funds;
- ❏ Cost saving initiatives, including accelerated recoupments (capitated payments made for clients later found to be ineligible for Medicaid), totaling a decrease of $2.8 million total funds, including $1.6 million General Fund and $1.4 million federal funds; and
- ❏ The passage of ARRA, which temporarily increased the federal match rate (FMAP) for the Medicaid program, resulting in a decrease of $50.3 million General Fund, $4.5 million cash funds, and an increase of $54.8 million federal funds.

FY 2011-12 Joint Budget Committee Staff Budget Briefing
Department of Human Services
(Mental Health and Alcohol and Drug Abuse Services)

BRIEFING ISSUE

ISSUE: Significant Actions Taken from FY 2007-08 to FY 2010-11 to Balance the Budget

If General Fund appropriations to the Department of Health Care Policy and Financing that are transferred to the Department of Human Services are included, the General Fund appropriation to the Department of Human Services decreased by $43.2 million (5.1 percent) from FY 2007-08 to FY 2010-11. However, total appropriations to the Department of Human Services have increased since FY 2007-08, based primarily on federal funds increases. Since the most recent economic downturn started in 2008, increases for caseloads have been limited, provider rates have declined, beds in state facilities have been closed, and staff compensation has been restricted. However, federal funds increases, including federal funds temporarily available under the American Recovery and Reinvestment Act, have offset General Fund reductions and helped to limit the depth of cuts.

SUMMARY:

- **Mental Health and Alcohol and Drug Abuse Services:** The General Assembly has increased General Fund appropriations by $6.2 million (4.9 percent) from FY 2007-08 to FY 2010-11. The net General Fund has increased by $5.5 million in the same time period. Cash funds appropriations decreased by 14.4 percent ($2.7 million) from FY 2007-08 to FY 2010-11, while reappropriated funds appropriations declined by 25.4 percent ($3.5 million) in the same period. The increase in General Fund appropriations in the Division occurred as a result of the expansion of community-based behavioral healthcare services and the transition to the new Institute for Forensic Psychiatry facility.

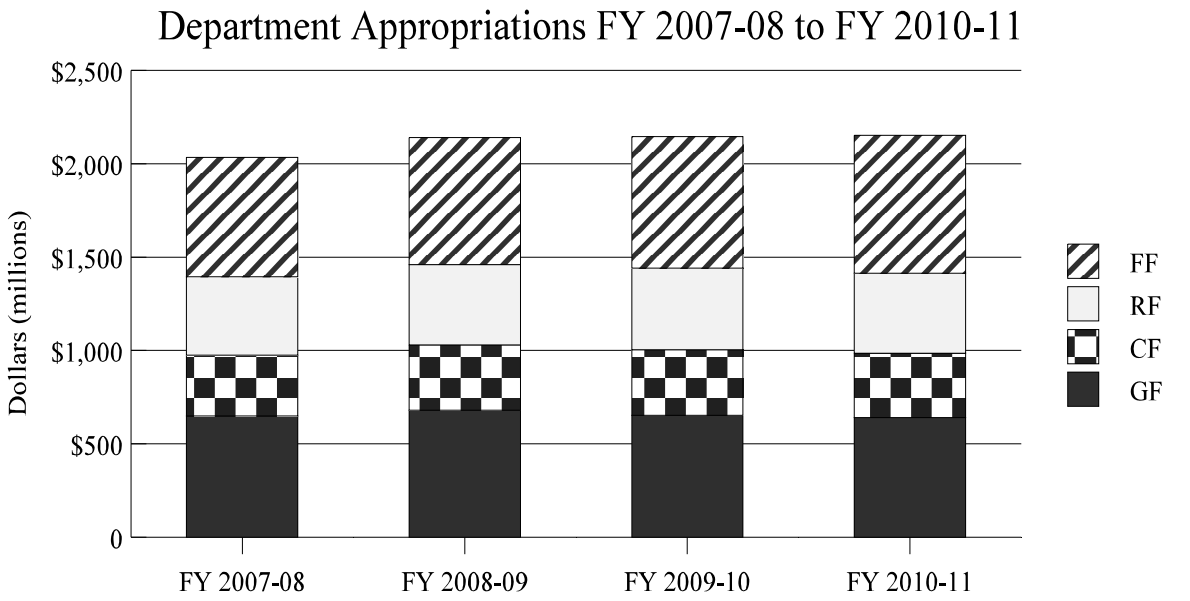
DISCUSSION:

FY 2007-08 to FY 2010-11, total appropriations to the Department of Human Services increased by approximately 5.9 percent ($119 million). Most of this increase ($99 million) was provided through federal funds, including technical adjustments to show $44 million in federal funds not previously reflected in the Long Bill. If these technical adjustments are excluded, appropriations to the Department increased by 3.7 percent ($75 million), including $55 million federal funds. The Department appropriation also increased by $19 million cash funds (primarily local and client share amounts) and $11 million reappropriated funds (primarily Medicaid funds).

These increases were partially offset by a decrease of $10 million General Fund. If General Fund amounts transferred from the Department of Health Care Policy and Financing are included, appropriations to the Department of Human Services that originate as General Fund decreased by $43 million (5.1 percent). This General Fund decrease was largely attributable to a temporary

increase to the Federal Medicaid Assistance Percentage (FMAP), which offset General Fund otherwise required in FY 2010-11.

Appropriations to the Department of Human Services for FY 2007-08 through FY 2010-11 are illustrated in the bar chart and detailed in the table below. As illustrated in the bar chart, General Fund and total appropriations increased in FY 2008-09. Since then, General Fund appropriations have declined while total appropriations have increased just 0.6 percent in the three years ($13.2 million) from FY 2008-09 to FY 2010-11. "Net" General Fund (shown in the table but not the chart) includes General Fund appropriated directly to the Department of Human Services *and* the General Fund portion of Medicaid funds that support Human Services programs.



Department of Human Services Appropriations FY 2007-08 to FY 2010-11						
	Total Funds	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**"Net" General Fund /a**
FY 2007-08 /b	$2,033,711,435	$649,483,006	325,981,045	$418,626,692	$639,620,692	*$840,401,436*
FY 2008-09	2,139,923,470	680,013,238	350,103,548	429,630,630	680,176,054	*877,648,618*
FY 2009-10	2,144,727,107	651,948,502	351,463,783	438,101,302	703,213,520	*811,376,049*
FY 2010-11 /c	2,153,111,241	639,803,262	344,632,848	429,957,794	738,717,337	*797,219,689*
Increase/(Decrease)/d	$119,399,806	($9,679,744)	$18,651,803	$11,331,102	$99,096,645	*($43,181,747)*
Percent Change /d	5.9%	(1.5)%	5.7%	2.7%	15.5%	*(5.1)%*

a/ "Net" General Fund includes General Fund appropriated directly to the Department of Human Services (DHS) and the General Fund portion of Medicaid funds appropriated to Department of Health Care Policy and Financing and transferred to DHS.
b/ FY 2007-08 Appropriations have been adjusted to reflect the same "cash funds" and "reappropriated funds" format implemented in FY 2008-09. Source: Page 200 of the FY 2008-09 Appropriations Report, plus 2009 legislation affecting FY 2007-08 appropriations (S.B. 09-189).

c/ The FY 2010-11 federal funds appropriation includes the addition of $35,279,032 for county child care and child welfare TANF reserves and $9,044,825 for federal refugee services that were not previously reflected in the Long Bill. If these adjustments are excluded, federal funding grew by 8.6 percent and total funding by 3.7 percent between FY 2007-08 and FY 2010-11.
d/ Increase/(Decrease) and Percent Change compare FY 2007-08 and FY 2010-11.

Overall funding trends reflect:

- ❑ Increases in FY 2008-09 and FY 2009-10 related to caseload growth (for developmental disability placements, child welfare services, and mental health services), and increases in General Fund appropriations to cover fixed facility costs when alternative sources are not available (such as for the mental health institutes).

- ❑ Efforts to offset caseload and General Fund cost increases in FY 2009-10 and FY 2010-11 by reducing provider reimbursements and closing units in institutional facilities (the mental health institutes and regional centers for people with developmental disabilities).

- ❑ Use of cash and federal funds to temporarily refinance General Fund (most notable in child welfare and developmental disability services) or to temporarily enhance spending (most notable in self-sufficiency programs). Funding available under ARRA reduced the General Fund portion of child welfare appropriations and the General Fund portion of Medicaid funds transferred from the Department of Health Care Policy and Financing for Human Services programs. It also provided large, temporary increases in funding for child care, subsidized employment, and housing supports.

Mental Health and Alcohol and Drug Abuse Services

This section of the budget includes appropriations for the Supportive Housing and Homeless Program, non-Medicaid community mental health services, the State's two mental health institutes, and substance usage disorders detoxification, treatment, and prevention services.

Mental Health and Alcohol and Drug Abuse Services Appropriations FY 2007-08 to FY 2010-11						
	Total Funds	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**"Net" General Fund**
FY 2007-08	$215,864,570	$125,433,294	19,007,990	$13,766,384	$57,656,902	*$128,258,786*
FY 2008-09	227,267,533	139,844,737	17,485,845	12,184,320	57,752,631	*142,602,519*
FY 2009-10	223,570,154	136,729,335	17,642,662	11,432,114	57,766,043	*138,962,504*
FY 2010-11	215,936,670	131,616,695	16,271,537	10,266,773	57,781,665	*133,745,018*
Increase/(Decrease)	$72,100	$6,183,401	($2,736,453)	($3,499,611)	$124,763	*$5,486,232*
Percent Change	0.0%	4.9%	(14.4)%	(25.4)%	0.2%	*4.3%*

Background on Budget Trends

As reflected in the table above, the overall budget for this section has remained constant since FY 2007-08, based on increases in General Fund offset by a cash funds and reappropriated funds reduction. General Fund appropriations since FY 2007-08 have been driven by:

- ❏ Salary increases totaling $6.6 million General Fund;
- ❏ Expanding the mental health community services contracts by $3.0 million General Fund to provide services to additional indigent mentally ill clients;
- ❏ An increase of $1.4 million General Fund to transition to the new High-Security Forensics Institute at the Colorado Mental Health Institute at Pueblo;
- ❏ An increase of $1.0 million General Fund to provide compression pay to nurses at the State's two mental health institutes; and
- ❏ Expansion of the Short-term Intensive Residential Remediation (STIRRT) program by $0.7 million General Fund; and
- ❏ An increase of $0.3 million General Fund for mental health and substance usage disorders services for juveniles and adults at risk of becoming or currently involved in the criminal justice system.

Major Budget Balancing Actions/Revenue Increases from FY 2007-08 to FY 2010-11

These increases in General Fund appropriations were partially offset by budget reduction actions made by the General Assembly. General Fund appropriations decreases occurred as a result of:

- ❏ The closure of General Hospital at the Colorado Mental Health Institute at Pueblo totaling a decrease of $4.6 million General Fund;
- ❏ The closure of three treatment divisions (geriatric, adolescent, and childrens) at the Colorado Mental Health Institute at Fort Logan totaling a decrease of $4.5 million General Fund;
- ❏ A decrease in the provider rate for community-based mental health services by $0.8 million General Fund;
- ❏ A decrease in the provider rate for community-based substance usage disorders services by $0.3 million General Fund;

FY 2011-12 Joint Budget Committee Staff Budget Briefing
Department of Health Care Policy and Financing / Department of Human Services
(Medicaid Mental Health Community Programs /
Mental Health and Alcohol and Drug Abuse Services)

BRIEFING ISSUE

ISSUE: Behavioral Healthcare Need in Colorado

The Colorado Population in Need 2009 study indicates that during FY 2006-07, 169,751 adults and 49,364 children and adolescents in Colorado had a serious behavioral health disorder and were living at or below 300 percent of the federal poverty level. Of the adults, 54 percent were male, 63 percent were white, 28 percent were hispanic, and 31 percent were in the 25 to 34 year old age group. The penetration rate for behavioral health services was 42.0 percent for adults, children, and adolescents with a serious behavioral health disorder living at or below 300 percent of the federal poverty level.

SUMMARY:

- In 2009, the Western Interstate Commission for Higher Education (WICHE) conducted a legislatively-authorized study (Colorado Population in Need 2009) of the behavioral healthcare need in Colorado for individuals at or below 300 percent of the federal poverty level in FY 2006-07.

- The Colorado Population in Need 2009 study indicates that amongst adults living at or below 300 percent of the federal poverty level, 89,803 had a serious mental illness, 65,990 had a substance use disorder, and 13,958 had a co-occurring serious mental illness and substance use disorder in FY 2006-07.

- The study indicates that amongst children and adolescents living at or below 300 percent of the federal poverty level, 49,364 had a serious emotional disturbance in FY 2006-07.

- The study indicates that 42.0 percent of adults, children, and adolescents with a serious behavioral health disorder living at or below 300 percent of the federal poverty level sought services funded by the Department of Health Care Policy and Financing or the Department of Human Services in FY 2006-07.

RECOMMENDATION:

Staff recommends that the Joint Budget Committee determine what measures the Department of Health Care Policy and Financing and the Department of Human Services are undertaking to increase the penetration rate of behavioral health services for individuals living at or below 300 percent of the federal poverty level.

DISCUSSION:

Background

The Department of Human Services' (DHS) Division of Behavioral Health contracted with the Western Interstate Commission for Higher Education (WICHE) to study the unmet need and disparities in care among Coloradans with serious behavioral health disorders who cannot afford to pay (living in households at or below 300.0 percent of the federal poverty level) for mental health and/or substance abuse treatment services. The team investigated adults with serious mental illness, adults with substance use disorders, adults with co-occurring serious mental illness and substance use disorders, and children and adolescents with severe emotional disturbance (children and adolescents with co-occurring severe emotional disturbance and substance use disorders are included in the severe emotional disturbance category of behavioral health disorders). The results of the study were published as the Colorado Population in Need 2009 report.

Core Data

The data generated for the study can be broken into three categories. The first category, prevalence estimates, refers to the total number of individuals with a serious behavioral disorder in the study population of individuals living in a household at or below 300.0 percent of the federal poverty level during the study time period of FY 2006-07. The estimate was generated by taking national prevalence rates from epidemiological studies and applying them to Colorado census data.

The second category of data, service utilization, details the number of individuals living in households at or below 300.0 percent of the federal poverty level who accessed behavioral health services funded by the Department of Health Care Policy and Financing (HCPF) or DHS in the study time period.

The third category, unmet need, illustrates the number of individuals who qualified for, but did not access HCPF and/or DHS funded behavioral health services in FY 2006-07. From the data collected in these three groups, it is possible to determine the percentage of qualified individuals who accessed services (penetration rate) funded by DHS and HCPF across the state. The table below provides a summary of the findings contained in the Colorado Population in Need 2009 report.

Colorado Population in Need 2009 Study Findings, FY 2006-07				
Population Category	**Prevalence (unique individuals)**	**Service Utilization (unique individuals)**	**Unmet Need (unique individuals)**	**Penetration Rate (%)**
Adults - Serious Mental Illness only	89,803	30,358	59,445	33.8%
Adult - Substance Use Disorder	65,990	28,599	37,391	43.3%
Adults - Co-occurring	13,958	2,298	11,660	16.5%
Adolescents and Children - Severe Emotional Disturbance	49,364	30,839	18,525	62.5%
Total	**219,115**	**92,094**	**127,021**	**42.0%**

Demographic Characteristics

The table to the right outlines the general demographic characteristics for adults with a behavioral health disorder (serious mental illness, substance use disorder, or co-occurring disorder) living at or below 300 percent of the federal poverty level. The typical individual meeting these conditions is a white male between the ages of 25 to 34. In terms of unmet need for behavioral health treatment services, the demographic characteristics mirror that of the general prevalence data. When examining the childrens and adolescent population, the prevalence is nearly equal across age categories 0 to 5, 6 to 11, and 12 to 17 and across race/ethnicity. The largest unmet needs presents itself in ages 0 to 5, male gender, and hispanic race/ethnicity. Highlighting race/ethnicity, only four percent of all hispanic children and adolescents with a behavioral health need and living at or below 300 percent of the federal poverty level are accessing behavioral health services. Comparatively, 63 percent of white children and adolescents and 91 percent of African American children and adolescents with a behavioral health need sought out and received services in FY 2006-07.

Prevalence of Behavioral Health Disorders		
Age Group		
	18-20	8%
	21-24	17%
	25-34	31%
	35-44	22%
	45-54	12%
	55-64	5%
	65+	4%
Gender		
	Female	46%
	Male	54%
Race/Ethnicity		
	White	63%
	African American	5%
	Other	4%
	Hispanic	28%

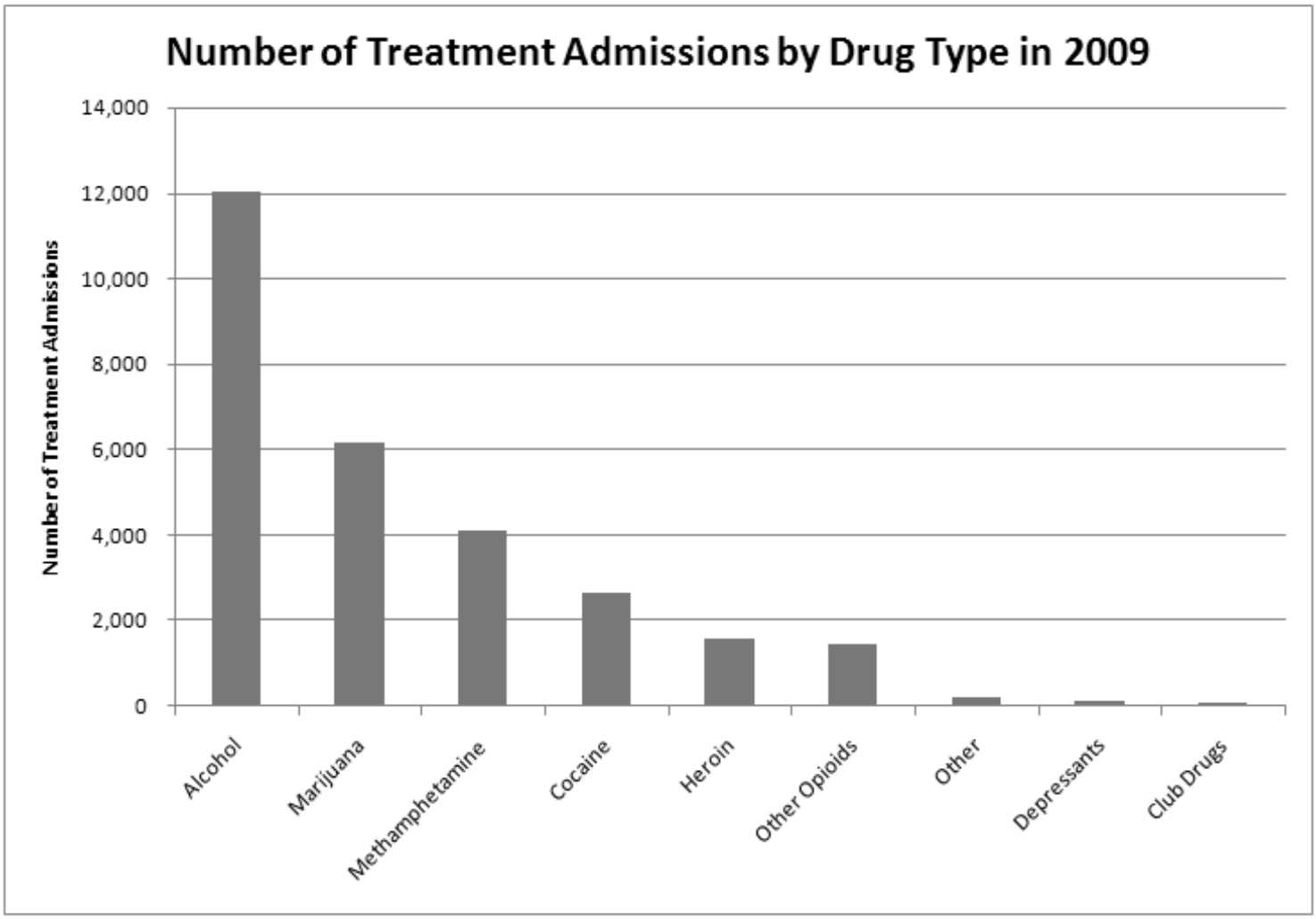
Frequently Presenting Disorders

In FY 2009-10, anxiety disorders, often cited as the most prevalent psychiatric illnesses in the general community, were the most frequently presented disorders to community providers of mental health services. Anxiety disorders, defined as a subjective sense of unease, dread, or foreboding, can indicate a primary psychiatric condition or can be a component of, or reaction to, a primary medical disease. The second most prevalent diagnosis during the FY 2009-10 timeframe was bipolar. Bipolar disorder involves periods of excitability (mania) alternating with periods of depression. The mood swings between mania and depression can be very abrupt. Finally, the third most common diagnosis during the time period was major depression. Major depression is when a person has five or more symptoms of depression for at least 2 weeks.

FY 2010 Diagnosis Categories	
Anxiety	12.5%
Bipoloar	12.3%
Major Depression	11.8%
Other	11.5%
Adjustment Disorder	8.9%
Mood Disorder	6.2%
Schizophrenia	5.6%
ADD-Hyperactivity	5.5%
Schizoaffective Disorder	5.3%
Depressive Disorder	5.0%

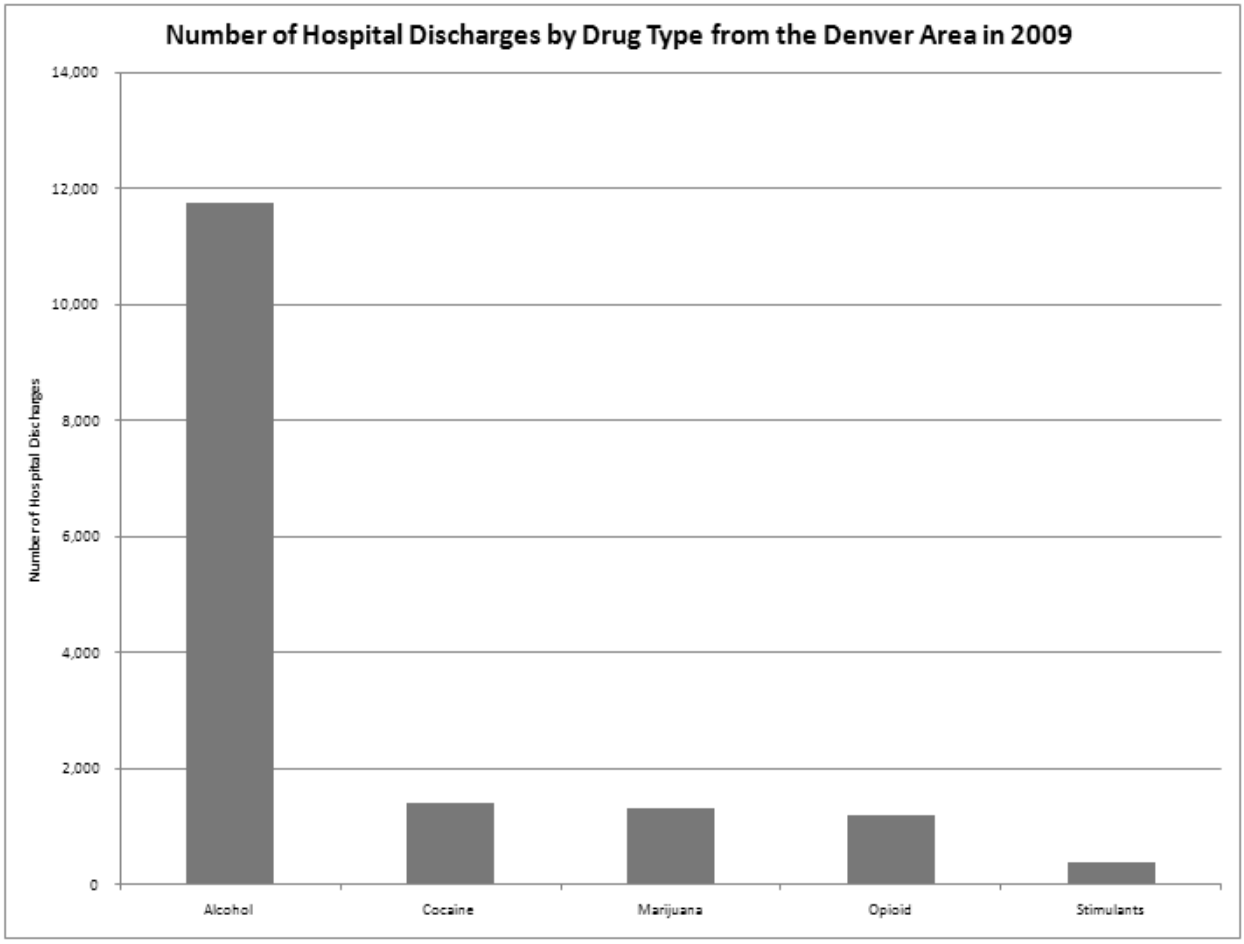
These symptoms include feeling sad, hopeless, worthless, or pessimistic. In addition, people with major depression often have behavior changes, such as new eating and sleeping patterns.

In terms of substance use disorders, the Patterns and Trends in Drug Abuse in Denver and Colorado: 2009 report indicates that alcohol disorders led the way in 2009 with 42 percent of the treatment admissions, nearly doubling the next closest disorder, marijuana usage. Excluding alcohol, marijuana abuse has continued to result in the highest number of treatment admissions in Colorado annually since 2000. After decreasing from 40 to 35 percent from 2002 to 2007, statewide marijuana treatment admissions increased to 37 percent (excluding alcohol) in 2009. The table below summarizes the number of treatment admissions by drug type in 2009.



Individuals with substance use disorders receive treatment in emergency settings, as well. In 2009, nearly 12,000 individuals in the Denver area were discharged from hospitals as a result of an alcohol

abuse disorder. The table below summarizes the number of drug-related hospital discharges in 2009 from Denver area hospitals.



FY 2011-12 Joint Budget Committee Staff Budget Briefing
Department of Health Care Policy and Financing / Department of Human Services
(Medicaid Mental Health Community Programs /
Mental Health and Alcohol and Drug Abuse Services)

BRIEFING ISSUE

ISSUE: General Overview of the Behavioral Healthcare System in Colorado

The State of Colorado primarily provides (or arranges for the provision of) mental health and substance use disorders services through the Department of Health Care Policy and Financing (HCPF) and the Department of Human Services (DHS). HCPF contracts with a series of regional entities to administer the State's managed care mental health services program and distributes Medicaid payments on a fee-for-service basis to substance usage disorders service providers. DHS operates the State's two mental health institutes, contracts with community mental health centers to provide mental health services to non-Medicaid eligible individuals, and contracts with a series of managed service organizations to arrange for the provision of substance usage disorders services.

SUMMARY:

- ❑ The Department of Health Care Policy and Financing (HCPF) contracts with five regional entities, known as Behavioral Health Organizations (BHOs), to provide mental health treatment services in a managed care setting to Medicaid enrollees. HCPF provides substance abuse insurance coverage for Medicaid members under a fee-for-service model.

- ❑ The Department of Human Services (DHS) contracts with 17 community mental health centers (CMHC's) across the state to provide a variety of mental health treatments including inpatient, outpatient, emergency and crisis, and consultative and educational services. DHS contracts with managed service organizations (MSOs) for the provision of substance use disorders detoxification and treatment services.

- ❑ DHS operates two State mental health institutes providing inpatient hospitalization for individuals with serious mental illness. The Colorado Mental Health Institute at Fort Logan has 114 inpatient beds, while the Colorado Mental Health Institute at Pueblo (CMHIP) has at total of 452 beds. Included in CMHIP's 454 bed total is 310 beds in its Institute for Forensic Psychiatry (IFP).

RECOMMENDATION:

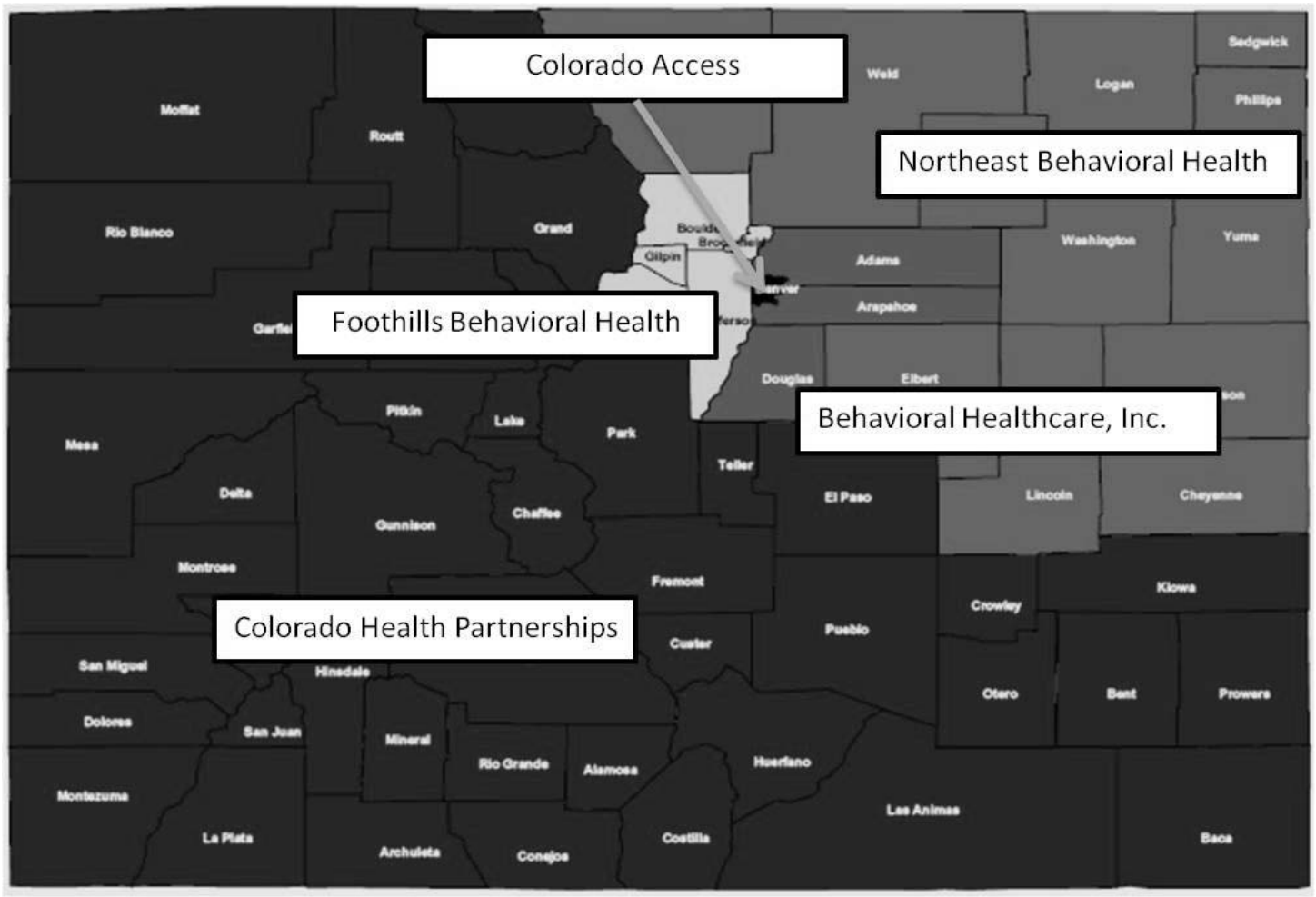
Staff recommends that the Joint Budget Committee determine what measures HCPF and DHS are undertaking to increase the penetration rate of behavioral health services for individuals living at or below 300 percent of the federal poverty level.

DISCUSSION:

HCPF - Behavioral Health Organizations

In 1993, the Centers for Medicare and Medicaid Services (CMS) granted the State waivers to implement a pilot managed care mental health program. The pilot program operated until 1995. In 1995, S.B. 95-078 (Rizzuto/Anderson) directed HCPF and DHS to implement a statewide capitated mental health managed care program. The Medicaid Mental Health Capitation Program quickly grew to fifty-one counties, with the remaining twelve counties added in 1998 (a sixty-fourth county was added when Broomfield became a county in November 2001).

Through a competitive bid process in 1995, eight Mental Health Assessment and Service Agencies (MHASAs) were awarded contracts to be service providers in the program. Again through competitive procurement, HCPF reduced the number of regions from eight to five and awarded managed care contracts to five Behavioral Health Organizations (BHOs) effective January 1, 2005. The five BHOs were reprocured through a competitive bid process effective July 1, 2009. As a result of the reprocurement, the same five BHOs won their respective contract bids, leaving the program unchanged. The map below depicts the five BHO geographic regions.



HCPF has been responsible for the oversight and contracting with managed care organizations from the beginning of the Medicaid Mental Health Capitation Program in 1995. Prior to 2004, the budget projections, day-to-day operations, and administration of the program were the responsibility of the DHS. In 2004, the administration and programmatic duties were transferred from DHS to HCPF.

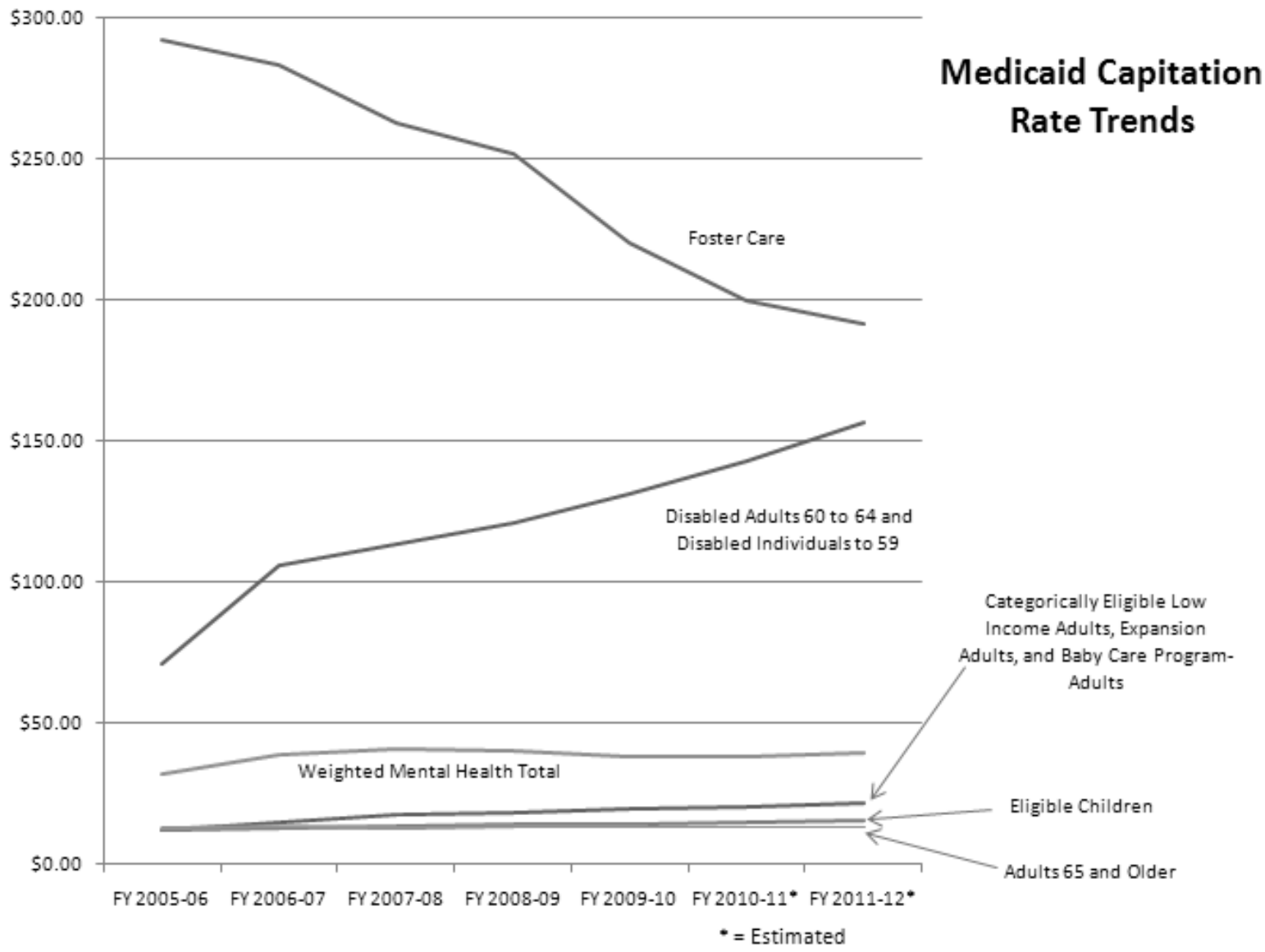
Each BHO is responsible for providing or arranging medically necessary mental health services to all Medicaid-eligible individuals enrolled with a behavioral health organization in the following categories:

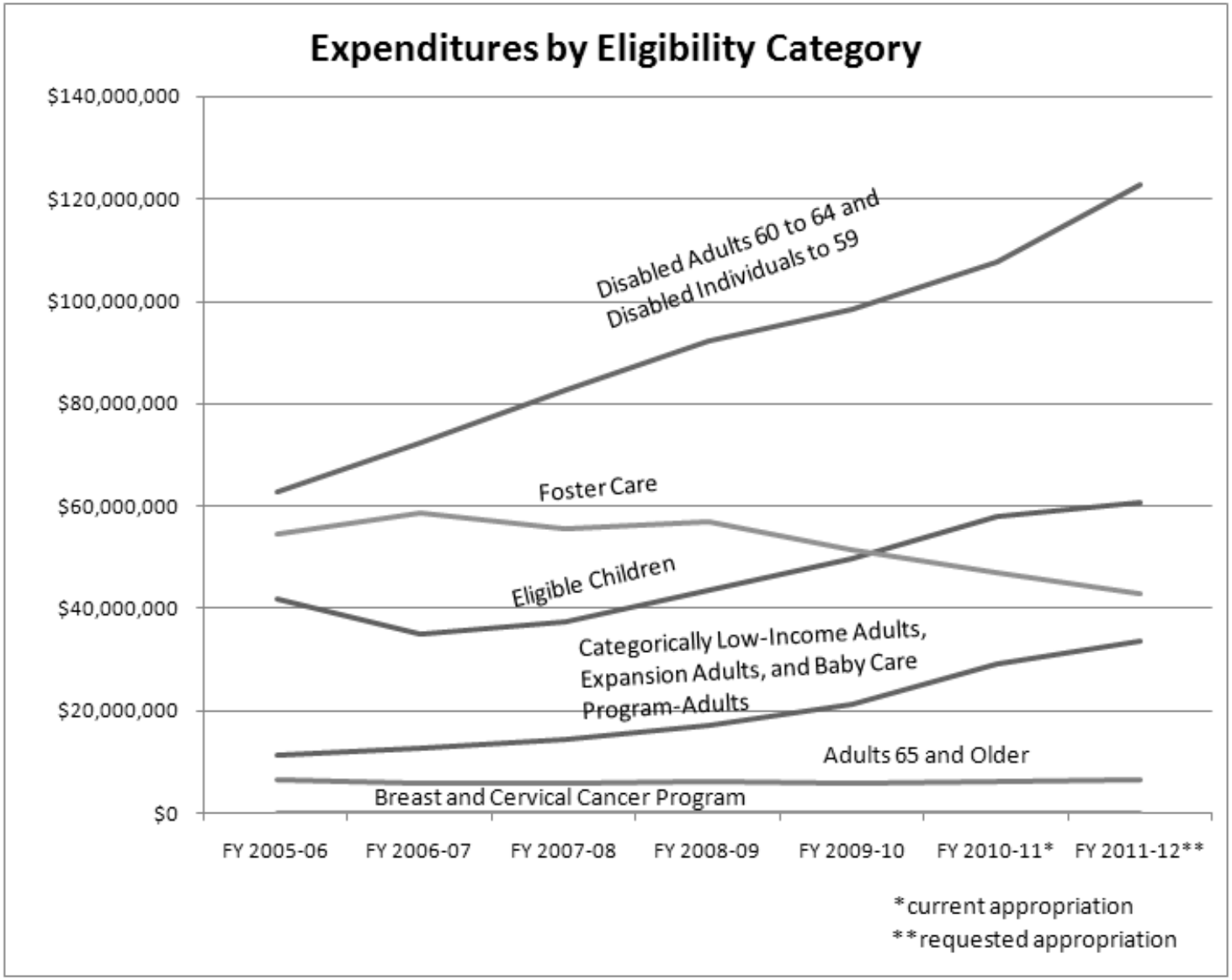
- ❑ Adults 65 and Older (OAP-A)
- ❑ Disabled Adults 60 to 64 (OAP-B)
- ❑ Disabled Individuals to 59 (AND/AB)
- ❑ Categorically Eligible Low-Income Adults (AFDC-A)
- ❑ Expansion Adults
- ❑ Baby Care Program-Adults
- ❑ Eligible Children (AFDC-C/ BC)
- ❑ Foster Care
- ❑ Breast and Cervical Cancer Program

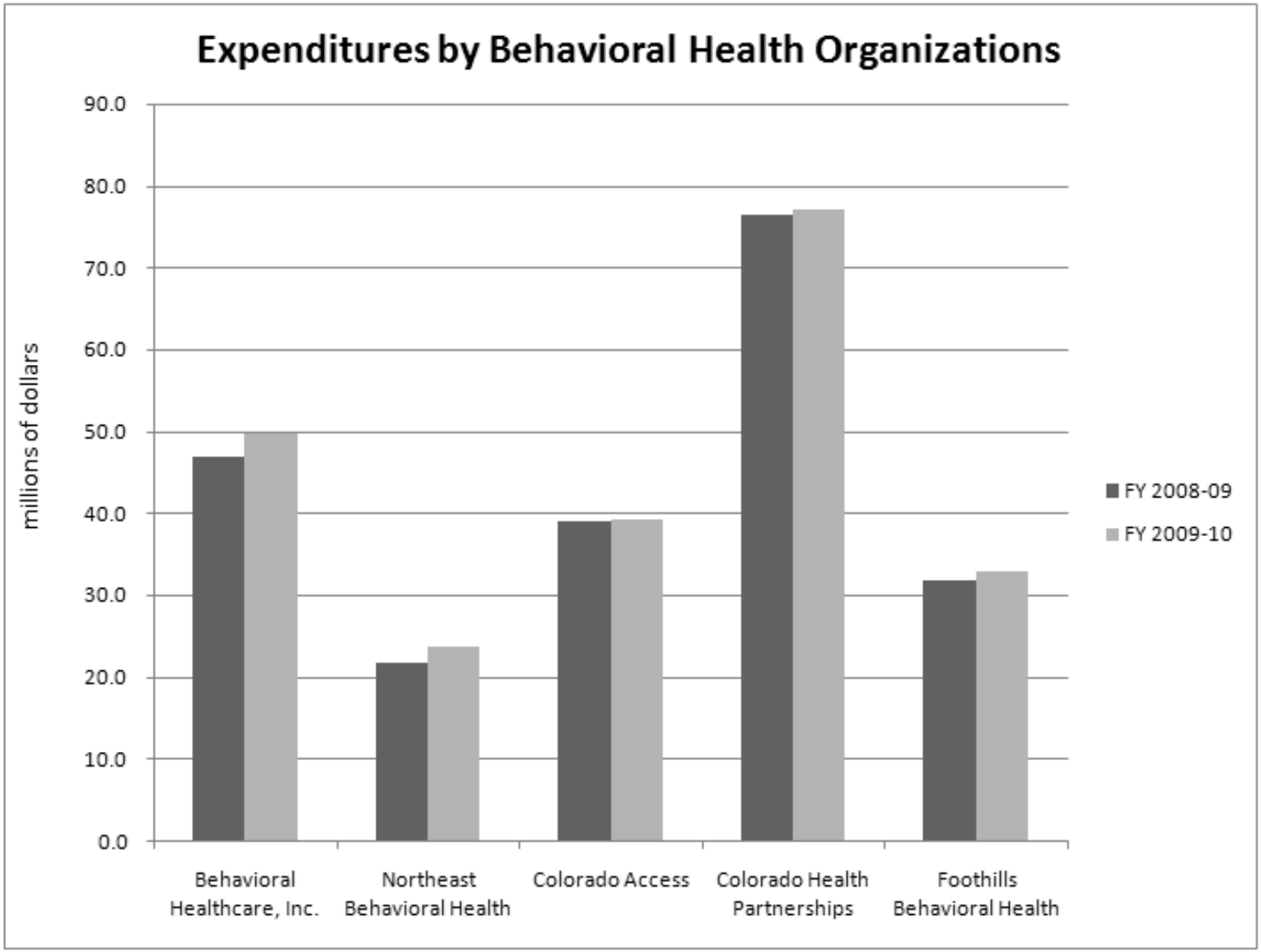
Services provided by the BHOs include, but are not limited to:

- ❑ Inpatient hospitalization;
- ❑ Psychiatric care;
- ❑ Rehabilitation and outpatient care;
- ❑ Individual and group therapy;
- ❑ Clinic services;
- ❑ Case management;
- ❑ Medication management and physician care;
- ❑ Emergency services;
- ❑ Assertive community treatment;
- ❑ Respite services;
- ❑ Clubhouse and drop-in centers;
- ❑ Non-hospital residential care as it pertains to mental health; and
- ❑ Alternatives to institutionalization.

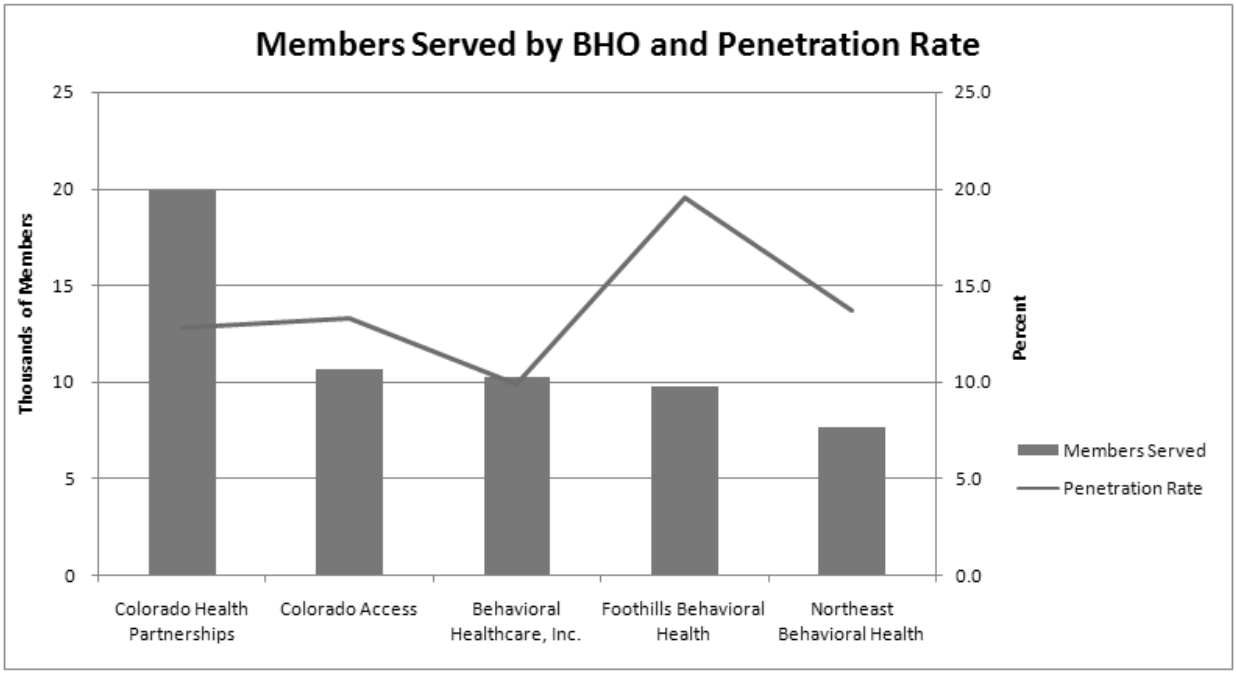
HCPF makes monthly capitation payments to the five BHOs for services for each eligible Medicaid recipient. Payments vary across each BHC, as well as each eligibility category. The charts below summarize capitation rates by eligibility category, total capitation expenditures/appropriations by eligibility category, and total capitation expenditures by BHO region.


Medicaid Capitation Rate Trends
$300.00
$250.00
$200.00
$150.00
$100.00
$50.00
$0.00
Foster Care
Disabled Adults 60 to 64 and Disabled Individuals to 59
Categorically Eligible Low Income Adults, Expansion Adults, and Baby Care Program-Adults
Weighted Mental Health Total
Eligible Children
Adults 65 and Older
FY 2005-06
FY 2006-07
FY 2007-08
FY 2008-09
FY 2009-10
FY 2010-11*
FY 2011-12*
* = Estimated

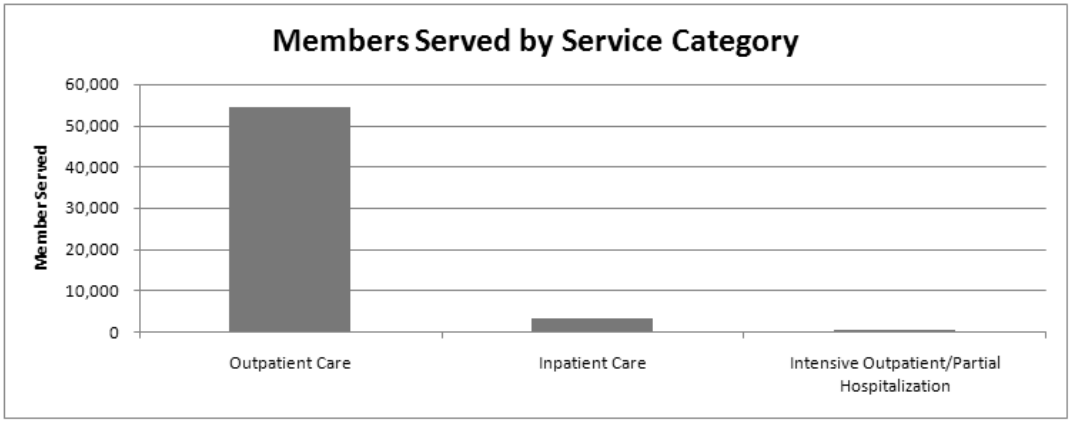

Expenditures by Eligibility Category
$140,000,000
$120,000,000
$100,000,000
$80,000,000
$60,000,000
$40,000,000
$20,000,000
$0
Disabled Adults 60 to 64 and Disabled Individuals to 59
Foster Care
Eligible Children
Categorically Low-Income Adults, Expansion Adults, and Baby Care Program-Adults
Adults 65 and Older
Breast and Cervical Cancer Program
FY 2005-06
FY 2006-07
FY 2007-08
FY 2008-09
FY 2009-10
FY 2010-11*
FY 2011-12**
*current appropriation
**requested appropriation


Expenditures by Behavioral Health Organizations
millions of dollars
90.0
80.0
70.0
60.0
50.0
40.0
30.0
20.0
10.0
0.0
Behavioral Healthcare, Inc.
Northeast Behavioral Health
Colorado Access
Colorado Health Partnerships
Foothills Behavioral Health
FY 2008-09
FY 2009-10

Not each and every member enrolled in a BHO seeks and receives mental health services from (or arranged by) the BHO. Much like private sector insurance, some members use certain services while others do not. The table below captures penetration rate data by BHO for FY 2008-09. The penetration rate is a calculation of the percentage of consumers served by the respective BHO out of all Medicaid-eligible individuals within the BHO service area.



As mentioned above, the BHOs arrange for the provision of a variety of mental health services depending on the healthcare needs of the member. The chart below groups the variety of services into three categories: inpatient care, intensive outpatient or partial hospitalization, and outpatient care. As is seen in the chart below, outpatient care consumed the majority of services delivered in FY 2008-09.



HCPF - Substance Usage Disorders Medicaid Program

House Bill 05-1015 (Romanoff/Johnson) added outpatient substance abuse treatment as an optional service to the State's Medicaid program. Prior to the passage of H.B. 05-1015, only two Medicaid-covered substance abuse treatment options existed. First, detoxification services were available to Medicaid enrollees if an accompanying medical condition was present. Second, pregnant, substance abusing women were eligible for substance usage disorders services up until 60 days postpartum.

Note, the State Auditor is statutorily required to submit a report to the Legislative Audit Committee analyzing the costs and savings to the Medicaid program as a result of adding outpatient substance abuse treatment as a benefit. The report is scheduled to be presented to the Audit Committee on December 13, 2010. On or before March 31, 2011, based upon the audit report, if the Audit Committee finds that providing outpatient substance abuse treatment resulted in an overall increase in Medicaid expenditures, the service is repealed.

Medicaid supported substance abuse treatment services are administered in a fee-for-service model whereby providers render Medicaid-eligible services and HCPF reimburses the providers. The list of Medicaid-eligible substance usage disorders services increased with the passage of H.B. 10-1033 (Massey/Boyd), which added "Screening, Brief Intervention, and Referral to Treatment (SBIRT) to the list of Medicaid optional services. The bill allows HCPF to reimburse existing providers for providing SBIRT services.

The appropriation for the Medicaid-eligible substance usage disorders services is located in HCPF's Medical Services Premiums division.

DHS - Mental Health Services for Indigent Individuals

DHS contracts with 17 community mental health centers (CMHC's) across the state to provide a variety of mental health treatments including inpatient, outpatient, emergency, and consultative and educational services to medically indigent individuals. The medically indigent are individuals whose income is less than 300.0 percent of the federal poverty level, are not eligible for Medicaid, and do not receive mental health services from any other system.

While there is statutory authority for the General Assembly to appropriate funds for medically indigent individuals with a need for mental health services, it is not an individual entitlement nor is the appropriation driven by caseload. The amount of available funding appropriated by the General Assembly determines the number of people who receive services. The State's contracted rate for the medically indigent population is a little over $3,000 per person. The number of clients served through DHS contracts with the CMHCs has hovered around the 10,000 individuals level for the past few fiscal years. The number of indigent clients contracted for service does not include the number of clients served with other State funding sources, such as Medicaid payments made on behalf of individuals enrolled in BHOs.

The contracts that DHS enters into with the CMHCs require the CMHCs to provide services to a targeted number of indigent individuals across age categories. The table below presents the FY 2009-10 base contract numbers for each CMHC by targeted age category.

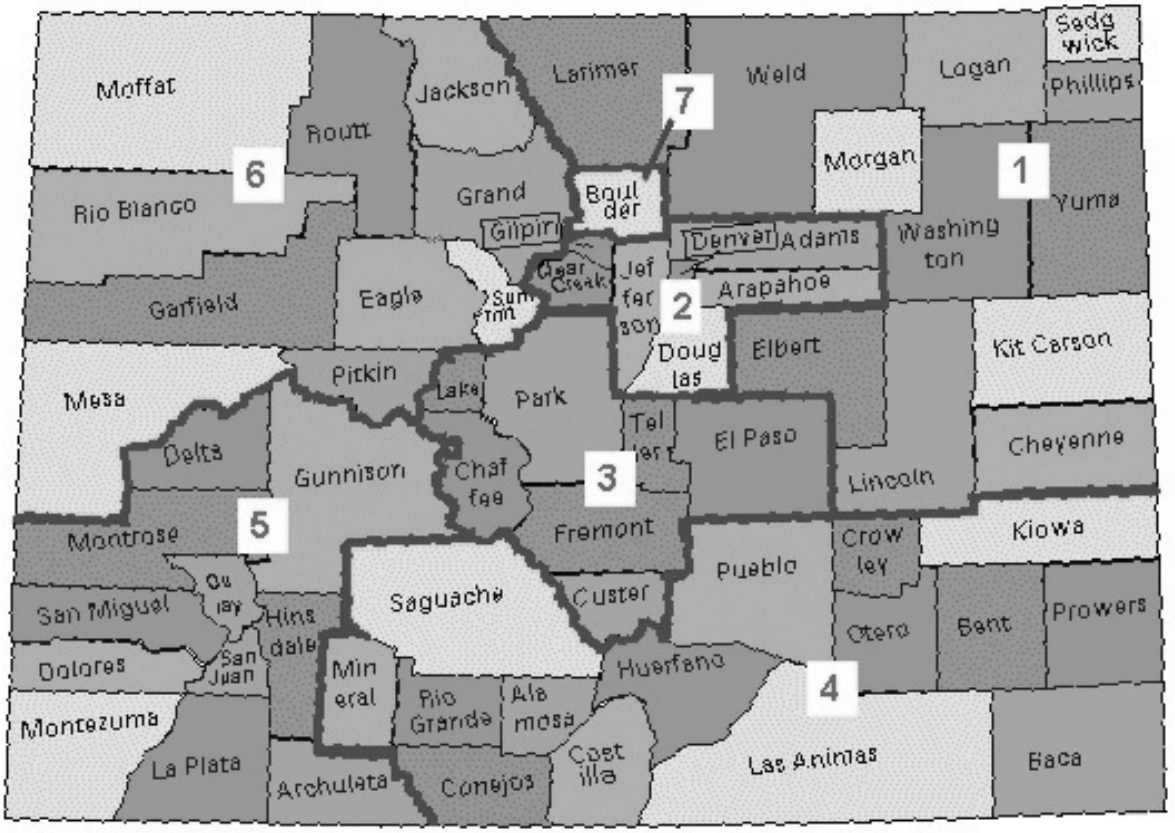
FY 2010 Contracted Service Levels by Target Age Category						
Mental Health Center	**Counties Served**	**Children**	**Adolescents**	**Adults**	**Older Adults**	**Total**
Community Reach Center	Adams	76	67	419	39	601
Arapahoe/Douglas Mental Health Network	Douglas and Arapahoe (except the City of Aurora)	73	65	372	40	550
Asian Pacific	N/A	3	3	17	2	25
Aurora Mental Health Center	Adams and Arapahoe	55	50	304	22	431
Mental Health Center Serving Boulder and Broomfield Counties	Boulder and Broomfield	30	30	246	21	327
Centennial Mental Health Center	Logan, Sedgwick, Phillips, Yuma, Washington, Morgan, Elbert, Lincoln, Kit Carson, and Cheyenne	46	51	250	39	386
Colorado West Regional Mental Health Center	Moffat, Rio Blanco, Garfield, Mesa, Pitkin, Eagle, Grand, Jackson, Routt, and Summit	65	61	432	48	606
Jefferson Center for Mental Health	Jefferson, Gilpin, and Clear Creek	107	114	617	92	930
Larimer Center for Mental Health	Larimer	49	46	380	37	512
Mental Health Center of Denver	City and County of Denver	180	177	1,311	135	1,803
Midwestern Colorado Mental Health Center	Gunnison, Delta, Montrose, San Miguel, Ouray, and Hinsdale	26	26	169	27	248
North Range Behavioral Health	Weld	83	79	486	45	693
AspenPointe, Inc.	El Paso, Teller, and Park	107	106	613	50	876
San Luis Valley Comprehensive Community Mental Health Center	Alamosa, Saguache, Mineral, Rio Grande, Conejos, and Costilla	30	34	166	16	246
Servicios De La Raza	N/A	5	5	32	4	46
Southeast Mental Health Services	Crowley, Kiowa, Otero, Bent, Prowers, and Baca	21	25	151	25	222
Axis Health System, Inc.	Dolores, San Juan, Montezuma, La Plata, and Archuleta	36	38	228	25	327
Spanish Peaks Mental Health Center	Pueblo, Huerfano, and Los Animas	48	57	305	47	457
West Central Mental Health Center	Fremont, Custer, Chaffee, and Lake	12	12	162	27	213
Total		**1,052**	**1,046**	**6,660**	**741**	**9,499**

CMHCs provide a variety of services to indigent individuals. The top five most frequently delivered services by CMHCs in 2008 were:

- ❑ Case Management (23 percent)
- ❑ Individual Therapy (19 percent)
- ❑ Assessment (16 percent)
- ❑ Med Management (15 percent)
- ❑ Group Therapy (6 percent)

DHS - Substance Use Disorders Services for Indigent Individuals

DHS has established seven Sub-State Planning Areas (SSPAs) to manage distribution of substance abuse treatment services in the state. Managed Service Organizations (MSOs) are assigned to each SSPA. MSOs are responsible for oversight, quality assurance, and contract compliance of funded substance abuse treatment providers. The map below depicts the seven SSPAs that cover the state.



DHS currently contracts with four MSOs to manage the delivery of substance use disorders services across the seven SSPAs. The MSOs arrange for detoxification, Short Term Intensive Residential Remediation Treatment (STIRRT), and traditional treatment services. The table below summarizes services delivered through the MSOs for FY 2009-10.

FY 2009-10 Modality Counts Across all MSOs	
Modality	**Count**
Detox	**52,069**
STIRRT	**1,467**
Treatment	
Clinical Assessment	1,360
Opioid Risk Tool	1,078
Outpatient	12,699
Residential	2,766
Day treatment	148
Minor in Possession	223
Total Treatment	**18,274**

Of State-funded substance use disorders treatment clients (including those served by the MSOs and those served in other State-funded systems), 42 percent had been referred for treatment by the criminal justice system (not related to driving under the influence). In FY 2009-10, 23,239 unique individuals were discharged from driving under the influence (DUI) treatment services (excluding detox services).

DHS - Colorado Mental Health Institutes

DHS operates two State mental health institutes providing inpatient hospitalization for individuals with serious mental illness. The Colorado Mental Health Institute at Fort Logan (Fort Logan), located in southwest Denver County, is organized into two treatment divisions (adult and Therapeutic Residential Child Care Facility) with 114 total beds. The Colorado Mental Health Institute at Pueblo (CMHIP) is organized into five treatment divisions (adolescent, adult, geriatric, co-occurring mental illness and substance abuse disorders, and forensics) with 454 total beds. 310 of the 454 beds at CMHIP are for forensic patients placed in the legal custody of DHS by the courts for competency evaluations and restoration to competency services. The forensics treatment division also provides services to individuals found not guilty by reason of insanity (NGRI). The treatment division is known as the Institute for Forensic Psychiatry (IFP).

DHS Operated Mental Health Institutes		
Institute	**Treatment Division**	**# of Beds**
Fort Logan		
	Adults	94
	Therapeutic Residential Childcare Facility (TRCCF)	20
	Total	**114**
Pueblo		
	Adolescents	20
	Adults	64
	Geriatrics	40
	CIRCLE	20
	Forensics	310
	Total	**454**
	Total All Institutes	**568**

The table below outlines the average occupancy rate for each treatment division. The occupancy rate is determined by comparing average daily attendance (ADA) figures with total capacity for each division. The adult treatment divisions at both Fort Logan and CMHIP, as well as the IFP, Geriatric,

and CIRCLE treatment divisions at CMHIP, consistently scored the highest occupancy rates of all treatment divisions across both institutes.

Occupancy Rates in Colorado Mental Health Institutes (%)					
	FY 2006-07	**FY 2007-08**	**FY 2008-09**	**FY 2009-10**	**FY 2010-11***
Fort Logan					
Children**	62.9%	63.2%	55.4%	48.8%	N/A
Adolescent**	65.8	60.4	61.1	41.9	N/A
TRCCF	84.1	85.0	77.4	51.3	60.9
Geriatric**	79.2	92.2	86.7	75.4	N/A
Adult	94.2	93.8	91.6	92.1	93.9
Total - Fort Logan	**85.0%**	**86.2%**	**82.7%**	**80.0%**	**88.1**
Pueblo					
Forensic	84.4%	89.1%	89.4%	90.3	90.5
Adolescent	64.3	65.0	60.0	56.1	58.4
Geriatric	90.9	93.4	88.9	85.7	89.3
Adult	94.7	96.4	98.0	90.8	85.0
Circle***	N/A	N/A	N/A	95.2	89.6
General Hospital**	46.0	50.6	35.5	15.5	N/A
Total - CMHIP	**84.5%**	**88.3%**	**87.5%**	**88.2%**	**88.2%**
Total - all Institutes	**84.6%**	**87.7%**	**86.2%**	**86.4%**	**88.2%**

*Based on first quarter data.
**Treatment division closed during FY 2009-10.
***Prior to FY 2009-10, Circle occupancy rates were included in the Adult treatment division.

In addition to high rates of occupancy in the adult treatment divisions at Fort Logan and CMHIP and the IFP, these divisions have high numbers of admissions each year. The following table summarizes the number of inpatient admissions for all treatment divisions at Fort Logan and CMHIP.

Inpatient Admissions (duplicated) at Colorado Mental Health Institutes					
Treatment Division	**FY 2006-07**	**FY 2007-08**	**FY 2008-09**	**FY2009-10**	**FY 2010-11***
Ft Logan					
Children**	263	229	223	85	N/A
Adolescents**	354	320	339	124	N/A

TRCCF	10	13	19	24	8
Geriatrics**	68	46	36	9	N/A
Adult	588	545	660	630	252
Total	**1,283**	**1,153**	**1,277**		
Pueblo					
Forensics	406	433	381	465	148
Adolescents	229	223	225	259	116
Geriatrics	93	74	68	67	18
Adult	498	529	475	480	228
Circle	86	97	93	92	38
General Hospital**	402	485	315	10	N/A
Total	**1,714**	**1,841**	**1,557**	**1,373**	**548**

*Based on data available through November 2010.
**Treatment division closed during FY 2009-10.

The table below provides inpatient average length of stay for discharged patients by treatment division for each fiscal year from FY 2006-07 to FY 2010-11. The data do not capture length of stay figures for individuals residing within treatment divisions who have not been discharged during the fiscal years shown.

Inpatient Average Length of Stay for Discharged Patients (days)					
	FY 2006-07	**FY 2007-08**	**FY 2008-09**	**FY 2009-10**	**FY 2010-11***
Fort Logan					
Children**	14.6	16.7	15.0	14.8	N/A
Adolescent**	13.4	13.1	13.4	10.4	N/A
TRCCF	367.5	371.0	487.8	192.4	192.3
Geriatric**	84.9	205.0	181.9	466.1	N/A
Adult	40.6	62.5	50.9	46.9	45.2
Pueblo					
Forensic	245.4	246.2	369.3	225.5	175.3
Adolescent	16.6	16.8	15.6	14.1	13.9
Geriatric	289.9	186.9	164.6	165.9	78.1
Adult	54.9	39.9	50.5	52.5	41.9
CIRCLE	78.5	73.8	73.6	75.7	71.1

General Hospital**	5.4	8.4	33.7	3.4	N/A

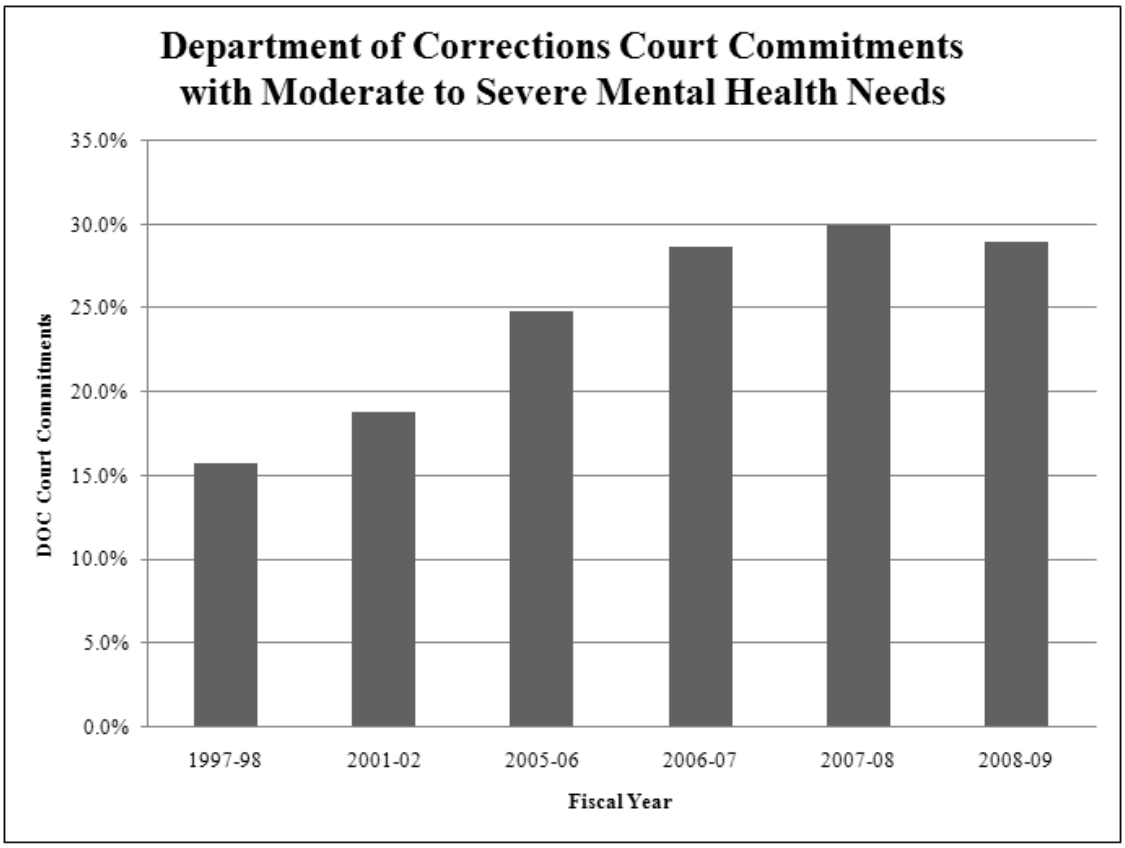
*Based on data available through November 2010.
**Treatment division closed during FY 2009-10.

The average length of stay at the institutes ranges from one to two days to up to 52.1 years. As of November 30, 2010, the IFP, for example, was providing mental health treatment services to 31 individuals who have been in the treatment division for 10 years or longer. The table below captures the length of stay for patients currently receiving services at Fort Logan and CMHIP.

Current Inpatient Length of Stay as of November 30, 2010		
Treatment Division	**Average (years)**	**Longest Tenure (years)**
Fort Logan		
TRCCF	0.4	0.6
Adult	1.6	27.1
Pueblo		
Forensic	4.5	52.1
Adolescent	0.1	0.3
Geriatric	5.0	39.4
Adult	0.2	5.8
CIRCLE	0.1	0.3

Receiving Services Outside of the State Mental Health System

As the Colorado Population in Need 2009 report illustrated, many Coloradans living in households at or below 300.0 percent of the federal poverty level are not receiving services in the State behavioral health system funded by DHS and HCPF. When these individuals do not receive treatment in the State's mental health system their behavioral healthcare needs do not cease to require care. Instead, individuals have increasingly received treatment in other venues, such as hospitals, community health clinics, non-profit organizations, emergency rooms, and criminal justice systems. For example, the table below illustrates the impact to the Department of Corrections (DOC) of individuals receiving treatment for mental health needs in the state criminal justice system.



The impact of providing mental health services within the criminal justice system is not limited to the State, but also impacts county governments across the state. The Denver Metro Area County Commissioners (Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, and Jefferson Counties) are currently studying the cost impact of providing mental health services in county jails. Data collected for 2009 indicates that the seven counties expended approximately $41.5 million dollars incarcerating and providing services to inmates with mental illness. The average cost per day for non-mentally ill inmates was $71.31, while the average cost per day for a mentally ill inmate was $90.58. The average length of stay for inmates with mental illness topped four times the rate of non-mentally ill inmates (97.5 days vs. 22.0 days).

RECOMMENDATION:

Staff recommends that the Joint Budget Committee determine what measures HCPF and DHS are undertaking to increase the penetration rate of behavioral health services for individuals living at or below 300 percent of the federal poverty level.

FY 2011-12 Joint Budget Committee Staff Budget Briefing
Department of Health Care Policy and Financing / Department of Human Services
(Medicaid Mental Health Community Programs /
Mental Health and Alcohol and Drug Abuse Services)

BRIEFING ISSUE

ISSUE: Proposed Service Reductions to Medicaid Mental Health Programs

The Joint Budget Committee (JBC) issued a formal request for information to the Department of Health Care Policy and Financing (HCPF) seeking recommended benefit or service reductions to Medicaid Mental Health programs in order to achieve a $2.2 million total funds savings between January 2011 and June 2011. As a result, HCPF submitted a plan to the JBC to adjust the rate-setting methodology in a manner that allows the two percent rate reduction to be enacted within the actuarially sound range in lieu of benefit or service reductions.

SUMMARY:

- ❏ The Department of Health Care Policy and Financing (HCPF) requested a two percent reduction to the Behavioral Health Organizations' (BHOs) rates for calendar year (CY) 2010 effective in July of 2010.

- ❏ In December 2009, two of the five BHOs could not certify the CY 2010 rates as actuarially sound, as is federally regulated and statutorily required. As a result, HCPF opted to extend previous rates for the two BHOs through December of 2010.

- ❏ The Long Bill for FY 2010-11 delayed the requested two percent reduction in rates until January of 2011 with the expectation that HCPF and the BHOs would work together to develop a plan to generate the two percent savings in FY 2010-11 without negatively impacting clients.

- ❏ HCPF submitted a plan to the JBC in early December of 2010 to adjust the rate-setting methodology in a manner that allows the two percent rate reduction to be enacted within the actuarially sound range in lieu of benefit or service reductions.

RECOMMENDATION:

The Department's rate reform proposal represents a step forward in the evolution toward capitation rates that generate savings without requiring significant declines in service delivery. Staff recommends that Committee explore what measures are being considered to ensure that cost savings and efficiencies are not introduced into the rate-setting methodology at the expense of positive health outcomes for the client.

DISCUSSION:

Background

HCPF submitted an early supplemental to the Committee for FY 2009-10 to implement a 2.5 percent decrease to BHO capitation rates beginning in September of 2009. The supplemental was approved by the Committee and the General Assembly, resulting in a $4.4 million total funds ($2.0 million General Fund) reduction in Mental Health Capitation Payments in FY 2009-10. In addition to the 2.5 percent decrease, HCPF proposed a two percent reduction ($2.2 million total funds) to the BHOs CY 2010 capitation rates effective July 2010. In December of 2009, however, two of the BHOs (Northeast Behavioral Health Partnership and Colorado Health Partnerships) could not certify the CY 2010 capitation rates as actuarially sound, as required by federal regulation and State statute. As a consequence, HCPF extended the two BHOs' September 2009 through December 2009 capitation rates through December of 2010. The FY 2010-11 Long Bill delayed the two percent CY 2010 capitation rate decrease until January 2011. The Committee used the request for information process to urge HCPF to work with BHOs during the summer and fall of 2010 to develop a plan to achieve the $2.2 million total funds reduction without negatively impacting client services and within a range of actuarial soundness. HCPF provided a report to the Committee on its plan in December of 2010.

Report from HCPF

The report from HCPF outlines a plan to achieve the $2.2 million total funds savings while providing long-term financial stability for the BHOs and minimizing client impact. The core of the HCPF plan is reliant on the addition of a component to the rate-setting methodology to capture case rate data. The case rate is the BHO statewide average cost per client by diagnosis category. The case rate is calculated using the priced BHO encounter data (see below for more information on capitation rate setting).

According to the report, HCPF has compared CY 2009 case rate data to CY 2009 case rate data and found that all BHOs have decreased their costs per client. This indicates that the BHOs have become more efficient since CY 2008 in service delivery. HCPF recommends allowing the BHOs to keep a portion of the efficiency savings (25 percent) to incentivize future costs per client savings and to remain actuarially sound in CY 2010. The Department advises that the case rate component of the rate-setting methodology become a permanent piece of the capitation determination model.

Understanding Capitation Rates

To fully understand HCPF's plan, it is necessary to have a general knowledge of the rate setting process. Rate-setting methodology currently consists two components, a per member per month cost component and a historical rate component. The per member per month cost component is based on the BHOs most recent year of encounter data. Encounter data shows the BHOs actual use rate and the service unit cost for a given year. Service unit costs are based on an established fee schedule, In practice, for example, encounter data reflects that BHO "X" provided 10 units of service "Y" at $25 per service for a total of $250. The second component, historical rates, is simply the established capitation rate.

HCPF has gradually put more weight on the encounter data in determining capitation rates. Increasing the weight of the encounter data, however, has created a ratchet effect whereby savings occurring in the base year as a result of service provision efficiencies is removed when the new encounter data is incorporated. This creates a financial environment for BHOs that jeopardizes their ability to remain actuarially sound, as occurred in December 2009.

To ensure that capitation rates are actuarially sound without negatively impacting client services, HCPF and the BHOs worked collaboratively to adjust the rate-setting methodology in a manner that produces savings and limits the negative impact on client services. By permanently adding the case rate component to the methodology of determining capitation rates, an efficiency gain is possible that produces savings to the State, savings to the BHOs, and without harm to clients.

Benefit of the Proposal

A key benefit of HCPF's rate reform proposal is that it incentivizes BHOs to achieve service delivery efficiencies to generate additional revenue rather than providing more expensive services to maximize reimbursements. For example, traditional Medicaid fee-for-service delivery models are potentially susceptible to providers furnishing services based on anticipated reimbursement levels rather than patient care or cost benefit to the entire behavioral healthcare system. Similarly, relying only on historical rates and encounter data to set rates in a managed care setting without allowing BHOs to share in efficiencies can provide an incentive for BHOs to keep their costs high to guard against drops in capitation rates. For example, if BHO "X" provides 10 units of service "Y" at $25 per unit, BHO "X" will be reimbursed for $250. In this model, BHO "X" has little motivation to provide service "Y" at less than $25 per unit because that would cause a decrease in the following year's capitation rates. By including the case rate in the rate-setting methodology, along with a financial efficiency gain, BHO's are motivated to provide services at rates lower than the statewide average cost so that they can retain a portion of the savings.

RECOMMENDATION:

In 2003, CMS revised regulations to require that all managed care rates be based on actuarially sound methodologies. This removed the requirement that rates be based on historical fee-for-service data and gave states flexibility to use alternative data sources, including service encounters. In November 2006, the State Auditor released the results of a performance audit that evaluated HCPF's rate setting methodology used to establish rates for services paid in the Medicaid mental health managed care program. Based on the findings of the audit, the State Auditor's Office made two specific recommendations on the Department's rate setting methodologies:

- ❑ Develop a standardized encounter reporting manual to ensure the accuracy and consistency of encounter data reported; and

- ❑ Initiate a cost study to assess and verify the fee schedule used to price encounters based on standard coding methods to allow for more accurate comparison to other states' fee schedules.

The Committee and General Assembly approved an additional appropriation of $325,000 for FY 2007-08 and FY 2008-09 to complete both the encounter coding manual and the cost study. This project led to significant reforms in the capitation program to enable more accurate outcomes from the rate setting process. Reforms include the implementation of consistent reporting across all BHOs and the development of a pricing methodology that no longer perpetuates broad rate disparities and possible inefficiencies across the state.

The Department's proposed plan to incorporate case rate into the rate-setting methodology represents the next step in the evolution of setting capitation rates that generate service delivery efficiencies, savings to the State, savings to BHOs, and are actuarially sound. Staff recommends that Committee have a conversation with HCPF to determine what measures are being considered to ensure that cost savings and efficiencies are not introduced into the rate-setting methodology at the expense of positive client outcomes. Staff believes that the Department's proposal is fiscally advantageous. However, it is necessary that safeguards be put in place to protect the BHO member from receiving less than adequate treatment services or levels or services.

FY 2011-12 Joint Budget Committee Staff Budget Briefing
Department of Health Care Policy and Financing / Department of Human Services
(Medicaid Mental Health Community Programs /
Mental Health and Alcohol and Drug Abuse Services)

BRIEFING ISSUE

ISSUE: The Future of the Colorado Mental Health Institutes

The Department of Human Services (DHS) operates the State's two mental health institutes with a requested FY 2011-12 budget of $88.4 million ($75.7 million General Fund) and 1,178 FTE. Since FY 1995-96, the bed count across the two institutes has dropped from 879 beds to 568 beds today. Colorado is currently ranked approximately 40th in the nation in the number of public psychiatric beds per capita.

SUMMARY:

- ❑ The Colorado Mental Health Institute at Pueblo opened as the Colorado State Insane Asylum on October 23, 1879. The Colorado Mental Health Institute at Fort Logan opened as the Fort Logan Mental Health Center in 1961 after the land was deeded to the State by the federal government.

- ❑ The two State mental health institutes serve individuals with serious mental illnesses who require a level of service that is not available (in most instances) in a community treatment setting.

- ❑ The number of beds across the institutes has dropped from 879 bed in FY 1995-96 to 568 in the current fiscal year. During the past two nationwide recessions (current and early 2000s), the institutes have closed a total of 187 beds.

- ❑ As a result of treatment division closures in FY 2009-10, the Colorado Mental Health Institute at Fort Logan is currently operating units for adults and a Therapeutic Residential Childcare Facility (TRCCF) with a total of 114 beds. The Colorado Mental Health Institute at Pueblo operates a total of 454 beds for geriatric, adult, adolescent, and forensic patients.

RECOMMENDATION:

Staff recommends that the Committee work with DHS to determine if the current alignment of public psychiatric beds across the two institutes is structured to meet the needs of individuals with serious mental illnesses in a manner that maximizes administrative efficiencies.

DISCUSSION:

Historical Background

The Colorado Mental Health Institute at Pueblo (Pueblo) opened as the Colorado State Insane Asylum in 1879 to provide services to 11 patients admitted from different counties across the state. By 1923, the census at the facility rose to over 2,000 patients and continued to grow until 1961 when the hospital had nearly 6,000 patients.

Fort Logan was born as an Army post for the federal government in 1887. The fort consisted of officers' quarters, a headquarters building, hospital, enlisted men's barracks, stables, and warehouses. The fort was officially closed in 1946, and the United States Veterans Administration (VA) used the hospital temporarily while the new VA hospital was constructed in Denver. Over 300 acres of the fort land was deeded to the State of Colorado in 1960 to establish a state hospital, which became the Fort Logan Mental Health Center.

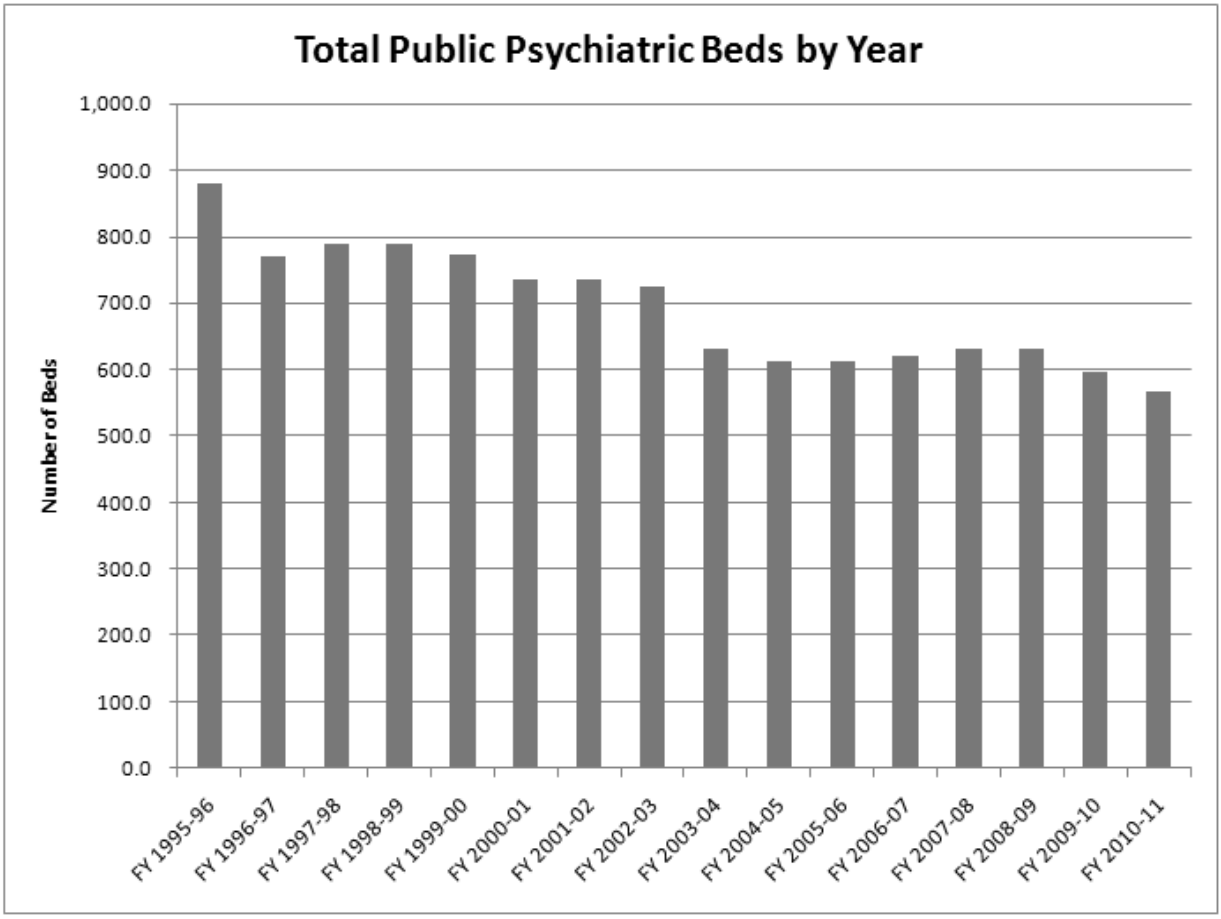
Colorado was part of the nationwide deinstitutionalization movement in the mid 1960s, as individuals with mental illness were targeted for treatment in the community rather than treatment in a public psychiatric facility. Several factors led to deinstitutionalization in the United States:

- ❑ Public psychiatric facilities were not considered a humane means for addressing mental illnesses.
- ❑ Pharmaceutical developments provided drugs that allowed individuals to manage mental illnesses while remaining in the community.
- ❑ The federal government implemented the Medicaid program, which did not provide funding for public psychiatric hospital care.
- ❑ Community-based mental health treatment services were part of federal policy.
- ❑ The public's perception of individuals with mental illness improved.
- ❑ State's saved money by providing funds for community-based mental health services rather than operating large numbers of public psychiatric hospital bed.

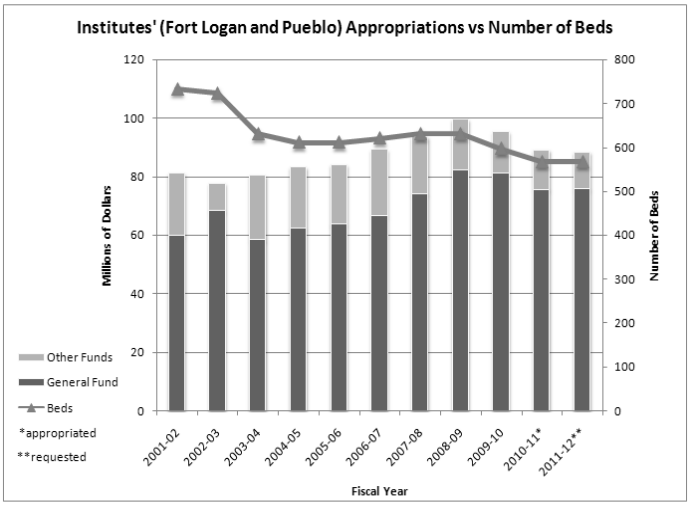
Recent History of the Institutes

Since the mid-1990s, expenditures for the State mental health institutes have been severely affected by a loss of patient-based revenue, stemming from a decline in the number of patient hospitalizations. Today, the average daily census across the two institutes is approximately 500 individuals (400 patients at Pueblo and 100 patients at Fort Logan). Since FY 1995-96, the bed count across the institutes has decreased by 35 percent (311 beds). The declining level of patient hospitalization over the past 15 years is attributable to two primary factors:

- ❑ The "deinstitutionalization" of clients into a community setting (see above); and
- ❑ The implementation of Medicaid managed care has resulted in fewer hospitalizations in the institutes as mental health providers seek to provide lower cost alternative services in the community, closer to home.



Despite this decline in census, the expenditures have increased at the mental health institutes until FY 2009-10. The increases are attributable to inflationary factors, including salaries, and the Neiberger and Zuniga lawsuit settlements (see below for more information on the lawsuits).



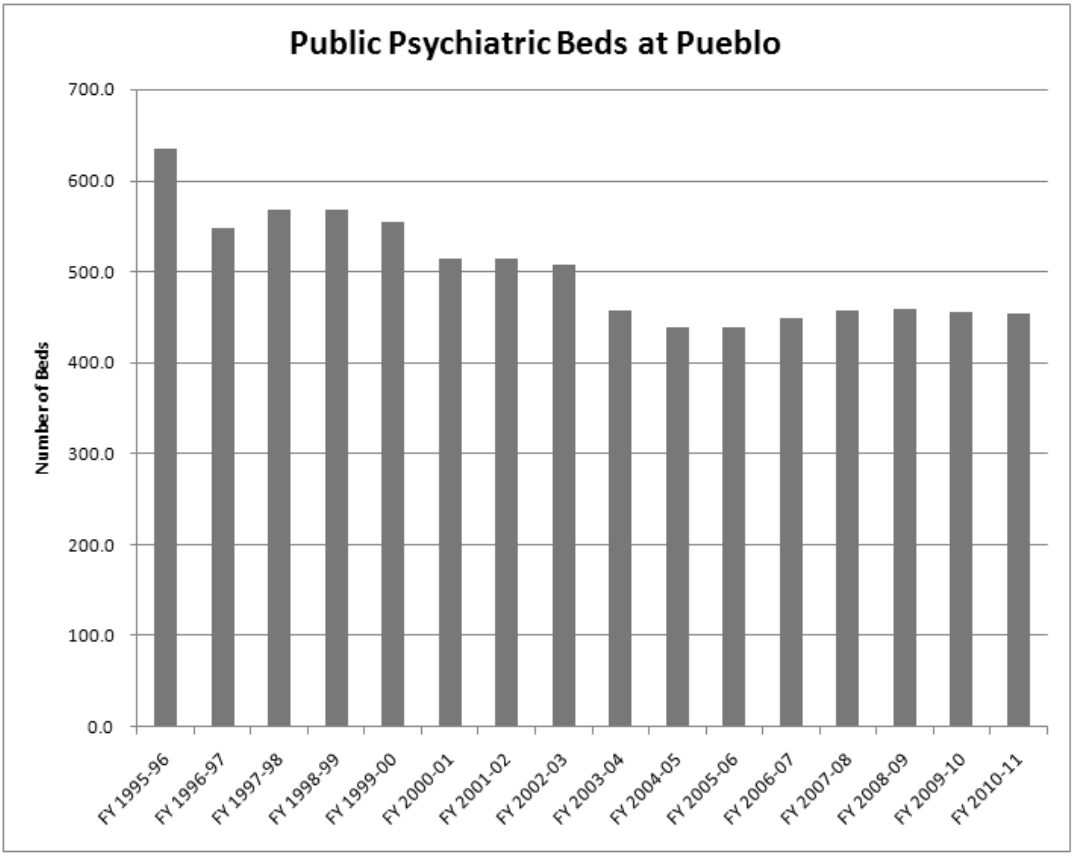
Pueblo and Fort Logan are both considered Institutions for Mental Disease (IMD) under federal law because both have more than 16 beds and are primarily engaged in providing diagnosis, treatment, or care of persons with mental health disorders, including medical attention, nursing care, and related services. Under the IMD exclusion, Medicaid will not reimburse the State for the inpatient hospitalization of an adult who is between 21 and 64-years-old at Fort Logan or Pueblo. Medicaid will pay for community mental health treatment services for an eligible adult between the ages of 21 and 64. However, when the same adult enters Fort Logan or Pueblo, the cost of his or her care is transferred entirely to the General Fund. Additionally, the 45-day Medicaid inpatient psychiatric benefit limit (implemented in FY 2003-04) has also put pressure on the institutes to reduce the length of stay for patients under age 21 and age 65 and over. In the absence of an alternative revenue stream, the care of patients age 21 and under and age 65 and over is covered by General Fund following the 45 -day limit. The table below indicates the percentage of inpatient admissions at Fort Logan and Pueblo who were Medicaid eligible at the time of admission between FY 2006-07 and the current fiscal year.

Percentage of Inpatient Admissions (duplicated) Medicaid Eligible at Admission					
Institute	**FY2006-07**	**FY 2007-08**	**FY2008-09**	**FY2009-10**	**FY 2010-11***
Fort Logan					
Children**	90.9%	91.3%	89.7%	92.9%	N/A
Adolescents**	83.6%	81.9%	86.7%	89.5%	N/A
TRCCF	80.0%	92.3%	94.7%	95.8%	100.0%
Geriatrics**	70.6%	78.3%	61.1%	66.7%	N/A
Adult	75.7%	71.4%	57.7%	83.8%	69.4%
Fort Logan Total	**80.7%**	**78.8%**	**71.7%**	**85.7%**	**70.4%**
Pueblo					
Forensics	7.6%	10.6%	10.2%	10.3%	10.1%
Adolescents	62.9%	75.8%	74.2%	89.2%	83.6%
Geriatrics	64.5%	43.2%	58.8%	47.8%	50.0%
Adult	50.6%	31.9%	49.5%	42.9%	33.3%
Circle	22.1%	22.7%	20.4%	16.3%	10.5%
General Hospital**	1.2%	0.8%	1.6%	N/A	N/A
Pueblo Total	**29.8%**	**24.0%**	**32.4%**	**38.7%**	**36.7%**
All Institutes Total	**51.6%**	**45.1%**	**50.1%**	**57.0%**	**47.5%**

*Based on data available through November 2010.
**Treatment division closed during FY 2009-10.

Colorado Mental Health Institute at Pueblo

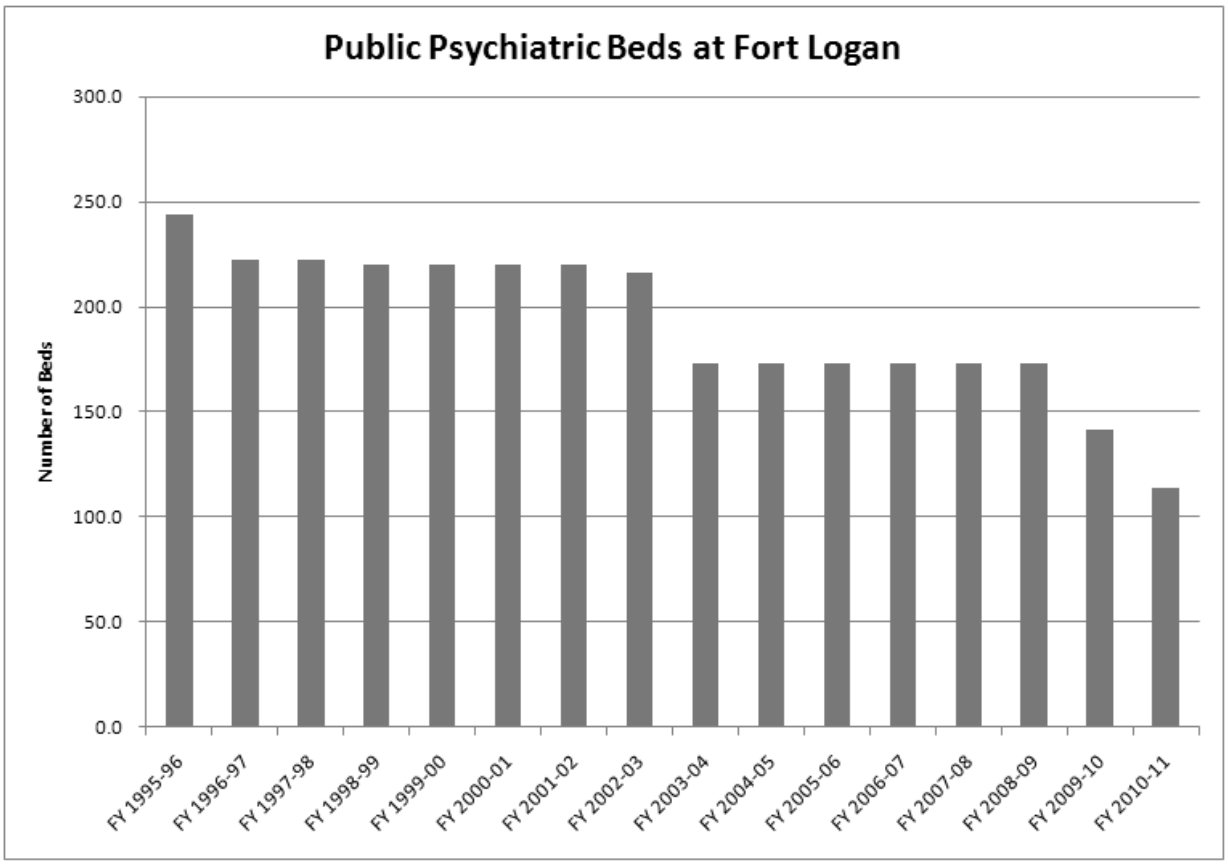
The bed count at Pueblo has dropped 28 percent in the last 15 years. However, two lawsuit settlements have greatly impacted the expenditures at the facility. First, the Neiberger lawsuit settlement required the forensics treatment division to comply with a number of requirements, including a 1.35-to-1 staff-to-patient ratio. As part of the settlement, the Department requested and eventually received moneys to construct a new high security forensic facility. The facility opened in June 2009 and houses 200 maximum and medium security patients. Second, a competency evaluation and restoration waiting list in the forensic treatment division triggered the Zuniga lawsuit. To comply with the settlement, the Department received supplemental funding from the General Assembly to open a 20 bed unit in the forensic treatment division to drastically reduce the waiting list.



Colorado Mental Health Institute at Fort Logan

The bed count at Fort Logan has dropped 53 percent in the last 15 years. The institute currently offers services to two populations:

- ❏ Adults with serious mental illnesses (94 beds); and
- ❏ Younger boys and girls (20 beds) referred by county departments of social services and the DHS' Division of Youth Corrections (DYC).



During FY 2009-10, the General Assembly approved the closure of the childrens, adolescent, and geriatric treatment divisions at Fort Logan (59 beds). The division closures resulted in a FY 2010-11 savings of $3.7 million General Fund across DHS and the Department of Health Care Policy and Financing (HCPF). As part of the closures, funds were appropriated to community providers for the provision of services for individuals displaced.

The closure of beds at Fort Logan has presented challenges for both the institutes and community providers. Individuals displaced from the treatment divisions in the lead up to the closures were difficult to place in the community. The geriatric population, in particular, has proved to be a placement challenge. Some patients were transferred to the geriatric treatment division at Pueblo, some patients were admitted into nursing homes, and some patients were transferred to the adult treatment division at Fort Logan. Unfortunately, capacity does not exist in the community at a level that supports the client needs for geriatric populations with serious mental illnesses. This will continue to be an issue as society enters a period of increased geriatric populations.

The Therapeutic Residential Childcare Facility (TRCCF) treatment division was originally slated for closure in FY 2010-11 as part of the Governor's Budget Reduction Proposal submitted to the Committee in August of 2009. Later, the Governor's Office reversed the August closure and requested that the TRCCF remain operational in FY 2010-11. While the TRCCF serves as a safety

net for hard to serve children, it is feasible that individuals currently receiving services in the treatment division could receive similar services in the community. In the second half of calendar year 2008, approximately 54.4 percent of the 1,699 TRCCF beds across the state were occupied. Currently, the Jefferson Hills TRCCF facility located in the Denver metro area, and within several miles of the Fort Logan facility, indicates that it has the capacity and the service options to provide services to individuals currently served by the Fort Logan TRCCF. Closing the treatment division would result in a General Fund savings of approximately $0.6 million.

RECOMMENDATION:

Despite the decrease in number, the State's public psychiatric beds continue to provide a valuable service in the continuum of mental health care for individuals with serious mental illnesses. Individuals served by the institutes are gravely disabled and represent a danger to themselves or others as a result of mental illness. While on the surface it appears that the State could save money by shuttering treatment divisions or an entire institute, it must be remembered that patients at the institutes receive treatment in that setting because they have been referred there by the community mental health centers due to the acuity of their illness and the lack of suitable treatment options outside of the public psychiatric hospital treatment setting. Rather than recommend additional treatment division closures at the institutes, staff recommends that the Committee work with DHS to determine if the current alignment of public psychiatric beds across the two institutes is structured to meet the needs of individuals with serious mental illnesses in a manner that maximizes administrative efficiencies.

FY 2011-12 Joint Budget Committee Staff Budget Briefing
Department of Health Care Policy and Financing / Department of Human Services
(Medicaid Mental Health Community Programs /
Mental Health and Alcohol and Drug Abuse Services)

BRIEFING ISSUE

ISSUE: Federal Healthcare Reform and What It Means for Behavioral Healthcare?

Federal healthcare reform will significantly impact the provision and management of behavioral health services in Colorado. Rules and regulations have not yet been established at the federal level to determine the full impact of reform initiatives, however it is feasible to identify the issues associated with the expansion of Medicaid and the evolution toward integrated physical and behavioral healthcare.

SUMMARY:

- ❑ The Patient Protection and Affordable Care Act (ACA) and its accompanying Reconciliation Act contained two key provisions that will impact the delivery and management of behavioral health services in the State of Colorado.

- ❑ First, raising the income limit to 133 percent of FPL across all Medicaid-eligibility categories will increase the number of individuals seeking behavioral services. It is unknown if the behavioral health benefit for the newly eligible population will be comprehensive or limited.

- ❑ Second, Federal healthcare reform is leading states toward integrated physical and behavioral healthcare models to leverage client care and financial benefits.

- ❑ The Department of Health Care Policy and Financing (HCPF) has taken steps to develop regional integrated models of healthcare delivery and management for Medicaid-eligible clients.

RECOMMENDATION:

Staff recommends that the Committee discuss how HCPF and DHS are building the policy infrastructure to support the expanded Medicaid-eligible population and migration toward integrated primary and behavioral healthcare put forth by federal healthcare reform.

DISCUSSION:

Background

Earlier this year, the federal government passed the Patient Protection and Affordable Care Act and its accompanying Reconciliation Act (referred to herein as ACA). While much of the focus of the

legislation has been on primary and physical healthcare, there are many components of the new law that will impact the provision of behavioral health services in the State of Colorado in the next several years. How the health reform law is implemented will largely depend upon regulations and guidance issued by federal agencies that will impact both the State-supported behavioral health programs and private sector behavioral health services.

Medicaid Expansion

The State-supported behavioral health programs administered by the Department of Health Care Policy and Financing (HCPF) and the Department of Human Services (DHS) will undergo extensive changes. First, as of January 1, 2014, ACA provides for an increase in the income level used to determine eligibility for Medicaid. Following the expansions contained in H.B. 09-1293 (Riesberg and Ferrandino/Keller and Boyd), most people in Colorado with incomes of up to 100 percent of the federal poverty level (FPL) for their family size now qualify for Medicaid. ACA raises the income limit to 133 percent of FPL across all eligibility categories (including children, parents, childless adults, and disabled persons), which will increase the number of people covered by the Medicaid mental health program.

It has yet to be determined if individuals newly eligible for Medicaid through this expansion will receive regular Medicaid benefits. The newly eligible population will receive a benefit that offers behavioral health services, however it is not known if the behavioral health benefit will be comprehensive or limited in scope. It is feasible that the newly eligible population will qualify for "benchmark plans" designed to have fewer benefits than traditional Medicaid clients currently receive. If the newly Medicaid-eligible population does not qualify for a comprehensive behavioral health benefit, it is anticipated that funds would be needed to manage the gap between covered service and needed service. For example, a newly Medicaid-eligible individual may only qualify for five units of behavioral service "X" during a one year span. If the individual requires ten units of service "X" during a one year span to manage their disorder properly, funds outside of Medicaid would be needed to cover the gap between the Medicaid benefit and service need. It is not envisioned that these gap funds would require an additional appropriation to HCPF or DHS. It is assumed that a portion of moneys currently appropriated to DHS for behavioral health services for indigent individuals could be used for this purpose. The unknown minimum Medicaid behavioral health benefit for the newly eligible population makes it difficult, if not impossible, to estimate the level of gap funds needed.

In summary, the following questions must be considered when studying how the Medicaid expansion associated with federal healthcare reform impacts future costs of behavioral healthcare:

- ❏ Will the Medicaid mental health benefit be comprehensive or limited in scope for the newly eligible population?

- ❏ Will the newly Medicaid-eligible population be folded into the current managed care system (BHOs) as the Medicaid mental health program exists today?

- ❑ Will the substance use disorder benefit be comprehensive or limited in scope for the newly eligible population?

- ❑ Will the newly Medicaid-eligible population receive substance use disorders services under the current fee-for-service model or will the entire Medicaid substance abuse disorders benefit migrate to a managed care setting administered by Managed Service Organizations (MSOs) or BHOs?

- ❑ Will there be a gap between the behavioral health Medicaid benefit for the newly eligible population and actual service need that will necessitate the appropriation of State moneys to ensure proper service provision?

- ❑ Medicaid expansion, the individual mandate requiring most people to obtain insurance, and the existence of behavioral health parity in law have potential to profoundly alter the need for traditional indigent behavioral healthcare moneys. Given this, will the State continue to receive nearly $30 million per year in federal block grants aimed at targeted, indigent populations with behavioral healthcare needs?

Integrated Care

Historically, mental health services and substance use disorders have not only been isolated from each other, but also from the primary care world, as well. Understanding the need to improve an individuals interrelated health outcomes, providers and managed care organizations across the state have begun to collaborate and develop formal partnerships to integrate primary care, mental health services, and substance use disorders services. For example, North Range Behavioral Health merged operations with local substance abuse disorders provider Island Grove Regional Treatment Center in 2008 to provide a complete range of integrated services for individuals with mental illnesses, substance use disorders, or both. In the same year, North Range Behavioral Health entered into a partnership with Sunrise Community Health Center (a Federally Qualified Health Center) to provide integrated primary care and behavioral health services.

Statewide there are several other examples of the integrated trend occurring organically to benefit the client. The list below summarizes the primary advantages realized in the migration to integrated care:

- ❑ Better coordination of care and communication between providers;
- ❑ Acknowledges that physical health is linked to behavioral health, and vice versa; and
- ❑ Provides the client with a process of care that is seamless and easier to navigate;

From a financial perspective, individuals with behavioral health issues are a costly contingent group of an insurance population because of the high rate of physical care required. Individuals with severe and persistent behavioral health illnesses often have co-morbid conditions that are intertwined, such as diabetes or heart disease. These individuals increase the cost of the total healthcare system and have shorter life spans on average than people without behavioral health illnesses.

Federal healthcare reform is leading states toward integrated care models to leverage client care and financial benefits. Beginning January 1, 2011, states can amend their Medicaid plan to provide coordinated care through a single-point (health home) to individuals with chronic illness. A health home (or medical home) is simply a strategy for helping individuals with chronic conditions manage those conditions better through the selection of a team of health care professionals to:

- ❑ Manage and coordinate all of the services the person receives from multiple providers;
- ❑ Help with transitions from one kind of service provision setting to another;
- ❑ Provide support to both the individual and family members; and
- ❑ Offer referrals to community and social support services.

HCPF has taken steps to implement the health home, integrated concept of healthcare delivery for its Medicaid clients. The Accountable Care Collaborative (ACC) initiative, slated to begin with a pilot in January of 2011 and cover 60,000 clients, is designed as a model in which providers take joint responsibility for keeping patients healthy while simultaneously controlling costs. A key component of the initiative is to coordinate clients' physical health, behavioral health, and long-term care. Success of the ACC is dependent upon:

- ❑ Providing a principal point of care (health home) for clients;
- ❑ Creating a statewide data and analytics function to provide a web-based, provider health information system;
- ❑ Coordinating care across care providers; and
- ❑ Developing accountability for clients health status and affordability through Regional Care Collaborative Organizations (RCCOs).

Several behavioral healthcare providers and managed care organizations have partnered with primary care providers in submitting proposals to the HCPF's ACC request for proposals for the initial pilot implementations of the model. Depending on the outcome of the pilots, the ACC model has potential to change the landscape of behavioral health service provision and management.

DHS has taken small steps toward integrating mental health and substance use disorders services. At an administrative level, the Department has merged the Division of Mental Health and the Alcohol and Drug Abuse Division into one division (Division of Behavioral Health). This allows for an enhanced level of direct communication between the two behavioral health services from a contract, grant seeking, and performance management perspective. Due to limited financial resources, however, challenges exist in creating incentives for mental health and substance use disorders providers to pilot and integrate their services in an expedited manner. DHS has targeted its limited funds to meeting the base need of behavioral health services. As the Colorado Population in Need 2009 (see staff briefing issue "Behavioral Healthcare Need in Colorado" above) study illustrated, there is a large unmet need in the state for base level behavioral health services.

RECOMMENDATION:

Staff recommends that the Committee discuss how HCPF and DHS are building the policy infrastructure to support the expanded Medicaid-eligible population and migration toward integrated primary and behavioral healthcare put forth by federal healthcare reform. Specifically, the Committee should determine the short, mid, and long-term vision that the departments share for coordinating the behavioral healthcare programs that they each administer.

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APPENDIX A: NUMBERS PAGES

	FY 2008-09 Actual	FY 2009-10 Actual	FY 2010-11 Appropriation	FY 2011-12 OSPB Request	Change Requests
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING **Executive Director: Joan Henneberry**					
(3) MEDICAID MENTAL HEALTH COMMUNITY PROGRAMS					
Mental Health Capitation Programs	215,860,937	223,368,053	247,616,458	266,299,165	DI #2, BRI #5
General Fund	86,769,471	79,359,784	85,931,156	112,302,740	BRI #6
Cash Funds	5,219,083	6,393,602	9,555,600	20,959,193	
Reappropriated Funds	7,330	10,833	12,046	0	
Federal Funds	123,865,053	137,603,834	152,117,656	133,037,232	
Medicaid Mental Health Fee for Service Payments	1,776,253	2,587,662	2,965,758	3,334,850	DI #2, BRI #2
General Fund	730,829	993,452	1,139,148	1,667,425	
Federal Funds	1,045,424	1,594,210	1,826,610	1,667,425	
					Request vs. Appropriation
TOTAL - (3) MEDICAID MENTAL HEALTH COMMUNITY PROGRAMS	217,637,190	225,955,715	250,582,216	269,634,015	7.6%
General Fund	87,500,300	80,353,236	87,070,304	113,970,165	30.9%
Cash Funds	5,219,083	6,393,602	9,555,600	20,959,193	119.3%
Reappropriated Funds	7,330	10,833	12,046	0	-100.0%
Federal Funds	124,910,477	139,198,044	153,944,266	134,704,657	-12.5%

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	FY 2008-09 Actual	FY 2009-10 Actual	FY 2010-11 Appropriation	FY 2011-12 OSPB Request	Change Requests
DEPARTMENT OF HUMAN SERVICES **Executive Director: Karen Bye**					
(8) MENTAL HEALTH AND ALCOHOL AND DRUG ABUSE SERVICES					
(A) Administration					
Personal Services	2,039,420	2,111,167	2,217,843	2,163,511	NP-4, NP-7
FTE	21.5	22.7	25.1	25.1	
General Fund	884,393	881,689	934,271	929,768	
Cash Funds	235,798	238,216	227,132	195,220	
Reappropriated Funds	322,923	300,460	325,996	323,886	
Federal Funds	596,306	690,802	730,444	714,637	
For Information Only					
Medicaid Reappropriated Funds	*322,923*	*300,460*	*325,996*	*323,886*	
Medicaid - General Fund therein	*161,461*	*150,230*	*162,998*	*161,936*	
Net General Fund	*1,045,854*	*1,031,919*	*1,097,269*	*1,091,704*	
Operating Expenses	91,299	87,351	93,846	92,750	
General Fund	26,944	27,392	25,847	25,847	
Cash Funds	5,777	5,777	5,777	4,681	
Reappropriated Funds	11,274	11,274	10,832	10,832	
Federal Funds	47,304	42,908	51,390	51,390	
For Information Only					
Medicaid Reappropriated Funds	*11,274*	*11,274*	*10,832*	*10,832*	
Medicaid - General Fund therein	*5,637*	*5,637*	*5,416*	*5,416*	
Net General Fund	*32,581*	*33,029*	*31,263*	*31,263*	
Federal Indirect Costs - FF	56,947	52,930	27,138	27,138	
Federal Programs and Grants - FF	1,291,254	708,275	2,518,447	2,517,892	NP-7
FTE	5.3	5.5	11.0	11.0	

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	FY 2008-09 Actual	FY 2009-10 Actual	FY 2010-11 Appropriation	FY 2011-12 OSPB Request	Change Requests
Supportive Housing and Homelessness	17,879,832	17,991,801	20,059,749	20,067,600	NP-7
FTE	23.2	16.3	19.0	19.0	
General Fund	0	0	0	0	
Cash Funds	1,330,030	0	0	0	
Reappropriated Funds	1,317	0	0	0	
Federal Funds	16,548,485	17,991,801	20,059,749	20,067,600	
					Request vs. Appropriation
TOTAL - (A) Administration	21,358,752	20,951,524	24,917,023	24,868,891	-0.2%
FTE	50.0	44.5	55.1	55.1	0.0%
General Fund	911,337	909,081	960,118	955,615	-0.5%
Cash Funds	1,571,605	243,993	232,909	199,901	-14.2%
Reappropriated Funds	335,514	311,734	336,828	334,718	-0.6%
Federal Funds	18,540,296	19,486,716	23,387,168	23,378,657	0.0%
For Information Only					
Medicaid Reappropriated Funds	*334,197*	*311,734*	*336,828*	*334,718*	*-0.6%*
Medicaid - General Fund therein	*167,098*	*155,867*	*168,414*	*167,352*	*-0.6%*
Net General Fund	*1,078,435*	*1,064,948*	*1,128,532*	*1,122,967*	*-0.5%*
(B) Mental Health Community Programs					
(1) Mental Health Services for the Medically Indigent					
Services for Indigent Mentally Ill Clients	39,608,620	39,650,775	39,170,328	39,170,328	
General Fund	33,447,748	33,443,723	32,774,850	32,774,850	
Reappropriated Funds	0	0	161,909	161,909	
Federal Funds	6,160,872	6,207,052	6,233,569	6,233,569	
Medications for Indigent Mentally Ill Clients - GF	1,713,993	1,713,993	1,713,993	1,713,993	

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	FY 2008-09 Actual	FY 2009-10 Actual	FY 2010-11 Appropriation	FY 2011-12 OSPB Request	Change Requests
Early Childhood Mental Health Services - GF	1,112,202	1,109,363	1,146,676	1,146,676	
Assertive Community Treatment Programs	1,316,734	1,316,734	1,290,400	1,290,400	
General Fund	658,367	658,367	645,200	645,200	
Cash Funds	658,367	658,367	645,200	645,200	
Reappropriated Funds	0	0	0	0	
Alternatives to Inpatient Hospitalization at a Mental Health Institute - GF	3,022,489	3,112,579	3,138,615	3,138,615	
Enhanced Mental Health Pilot Services for Detained Youth-GF	454,734	84,203	0	0	
Family Advocacy Demonstration Sites	149,271	142,545	196,154	0	
Cash Funds	149,271	142,545	196,154	0	
Reappropriated Funds	0	0	0	0	
Mental Health Services for Juvenile and Adult Offenders	4,111,734	4,136,840	3,812,463	3,812,463	
Cash Funds	4,111,734	4,136,840	3,812,463	3,812,463	
Reappropriated Funds	0	0	0	0	
Veteran Mental Health	52,488	47,106	0	0	
Cash Funds	52,488	47,106	0	0	
Reappropriated Funds	0	0	0	0	
					Request vs. Appropriation
Subtotal - (1) Mental Health Services for the Medically Indigent	51,542,265	51,314,138	50,468,629	50,272,475	-0.4%
General Fund	40,409,533	40,122,228	39,419,334	39,419,334	0.0%
Cash Funds	4,971,860	4,984,858	4,653,817	4,457,663	-4.2%
Reappropriated Funds	0	0	161,909	161,909	0.0%
Federal Funds	6,160,872	6,207,052	6,233,569	6,233,569	0.0%

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	FY 2008-09 Actual	FY 2009-10 Actual	FY 2010-11 Appropriation	FY 2011-12 OSPB Request	Change Requests
(2) Residential Treatment for Youth (H.B. 99-1116)	857,220	1,011,487	976,994	976,994	
General Fund	402,365	530,578	560,154	560,154	
Cash Funds	280,387	275,886	300,000	300,000	
Reappropriated Funds	174,468	205,023	116,840	116,840	
For Information Only					
Medicaid Reappropriated Funds	*174,468*	*205,023*	*116,840*	*116,840*	
Medicaid - General Fund therein	*79,106*	*47,636*	*44,878*	*58,420*	
Net General Fund	*481,471*	*578,214*	*605,032*	*618,574*	
					Request vs. Appropriation
TOTAL - (B) Mental Health Community Programs	52,399,485	52,325,625	51,445,623	51,249,469	-0.4%
General Fund	40,811,898	40,652,806	39,979,488	39,979,488	0.0%
Cash Funds	5,252,247	5,260,744	4,953,817	4,757,663	-4.0%
Reappropriated Funds	174,468	205,023	278,749	278,749	0.0%
Federal Funds	6,160,872	6,207,052	6,233,569	6,233,569	0.0%
For Information Only					
Medicaid Reappropriated Funds	*174,468*	*205,023*	*116,840*	*116,840*	*0.0%*
Medicaid - General Fund therein	*79,106*	*47,636*	*44,878*	*58,420*	*30.2%*
Net General Fund	*40,891,004*	*40,700,442*	*40,024,366*	*40,037,908*	*0.0%*
(C) Mental Health Institutes					
Mental Health Institutes	93,651,716	0	0	0	
FTE	1,200.2	0.0	0.0	0.0	
General Fund	78,728,712	0	0	0	
Cash Funds	6,174,965	0	0	0	
Reappropriated Funds	8,748,039	0	0	0	
For Information Only					
Medicaid Reappropriated Funds	*4,048,839*	*0*	*0*	*0*	
Medicaid General Fund	*1,726,081*	*0*	*0*	*0*	
Net General Fund	*80,454,793*	*0*	*0*	*0*	

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	FY 2008-09 Actual	FY 2009-10 Actual	FY 2010-11 Appropriation	FY 2011-12 OSPB Request	Change Requests
Colorado Mental Health Institute - Ft. Logan	0	23,896,703	19,882,955	19,944,981	NP-4, NP-7
FTE	0.0	270.6	252.2	252.2	
General Fund	0	20,536,761	17,885,983	17,980,425	
Cash Funds	0	2,919,019	1,201,092	1,181,589	
Reappropriated Funds	0	440,923	795,880	782,967	
For Information Only					
Medicaid Cash Funds	*0*	*345,126*	*0*	*0*	
Medicaid General Fund	*0*	*132,496*	*0*	*0*	
Net General Fund	*0*	*20,669,257*	*17,885,983*	*17,980,425*	
Colorado Mental Health Institute - Pueblo	0	69,983,188	68,827,749	68,146,208	DI-5, NP-2,
FTE	0.0	913.8	923.0	918.0	NP-4, NP-7
General Fund	0	58,269,153	57,671,404	57,733,170	
Cash Funds	0	5,159,092	5,617,894	5,528,170	
Reappropriated Funds	0	6,554,943	5,538,451	4,884,868	
For Information Only					
Medicaid Cash Funds	*0*	*3,597,183*	*2,916,208*	*2,853,318*	
Medicaid General Fund	*0*	*1,381,745*	*1,120,115*	*1,426,416*	
Net General Fund	*0*	*59,650,898*	*58,791,519*	*59,159,586*	
General Hospital	3,252,709	678,857	0	0	
FTE	34.2	1.2	0.0	0.0	
General Fund	3,252,709	678,857	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
For Information Only					
Medicaid Cash Funds	*0*	*0*	*0*	*0*	
Medicaid General Fund	*0*	*0*	*0*	*0*	
Net General Fund	*3,252,709*	*678,857*	*0*	*0*	

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	FY 2008-09 Actual	FY 2009-10 Actual	FY 2010-11 Appropriation	FY 2011-12 OSPB Request	Change Requests
Educational Programs	1,075,542	879,531	344,508	342,789	NP-4, NP-7
FTE	13.4	8.9	7.7	7.7	
General Fund	105,785	134,881	21,853	21,667	
Cash Funds	147,936	122,442	122,307	121,726	
Reappropriated Funds	459,868	263,256	200,348	199,396	
Federal Funds	361,953	358,952	0	0	
					Request vs. Appropriation
TOTAL - (C) Mental Health Institutes	97,979,967	95,438,279	89,055,212	88,433,978	-0.7%
FTE	1,247.8	1,194.5	1,182.9	1,177.9	-0.4%
General Fund	82,087,206	79,619,652	75,579,240	75,735,262	0.2%
Cash Funds	6,322,901	8,200,553	6,941,293	6,831,485	-1.6%
Reappropriated Funds	9,207,907	7,259,122	6,534,679	5,867,231	-10.2%
Federal Funds	361,953	358,952	0	0	N/A
For Information Only					
Medicaid Cash Funds	*4,048,839*	*3,942,309*	*2,916,208*	*2,853,318*	*-2.2%*
Medicaid - General Fund therein	*1,726,081*	*1,514,241*	*1,120,115*	*1,426,416*	*27.3%*
Net General Fund	*83,813,287*	*81,133,893*	*76,699,355*	*77,161,678*	*0.6%*
(D) Alcohol and Drug Abuse Division					
(1) Administration					
Personal Services	2,071,651	2,184,009	2,265,700	2,276,930	NP-4, NP-7
FTE	26.2	26.9	30.8	30.8	
General Fund	174,370	225,606	246,562	281,869	
Cash Funds	48,867	98,684	120,292	118,920	
Reappropriated Funds	490,089	489,957	496,446	489,725	
Federal Funds	1,358,325	1,369,762	1,402,400	1,386,416	
For Information Only					
Medicaid Reappropriated Funds	*53,136*	*53,135*	*53,136*	*51,466*	
Medicaid - General Fund therein	*26,568*	*26,567*	*26,568*	*25,728*	
Net General Fund	*200,938*	*252,173*	*273,130*	*307,597*	

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	FY 2008-09 Actual	FY 2009-10 Actual	FY 2010-11 Appropriation	FY 2011-12 OSPB Request	Change Requests
Operating Expenses	190,989	166,818	206,404	206,404	
General Fund	0	0	0	0	
Cash Funds	10,288	16,635	35,091	35,091	
Reappropriated Funds	4,992	886	4,992	4,992	
Federal Funds	175,709	149,297	166,321	166,321	
For Information Only					
Medicaid Reappropriated Funds	*952*	*0*	*952*	*952*	
Medicaid - General Fund therein	*476*	*0*	*476*	*476*	
Net General Fund	*476*	*0*	*476*	*476*	
Other Federal Grants - FF	216,157	211,245	457,383	457,383	
Indirect Cost Assessment	243,972	243,723	243,723	243,723	
Cash Funds	3,529	3,280	3,280	3,280	
Federal Funds	240,443	240,443	240,443	240,443	
					Request vs. Appropriation
Subtotal - (1) Administration	2,722,769	2,805,795	3,173,210	3,184,440	0.4%
FTE	26.2	26.9	30.8	30.8	0.0%
General Fund	174,370	225,606	246,562	281,869	14.3%
Cash Funds	62,684	118,599	158,663	157,291	-0.9%
Reappropriated Funds	495,081	490,843	501,438	494,717	-1.3%
Federal Funds	1,990,634	1,970,747	2,266,547	2,250,563	-0.7%
For Information Only					
Medicaid Reappropriated Funds	*54,088*	*53,135*	*54,088*	*52,418*	*-3.1%*
Medicaid - General Fund therein	*27,044*	*26,567*	*27,044*	*26,204*	*-3.1%*
Net General Fund	*201,414*	*252,173*	*273,606*	*308,073*	*12.6%*

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	FY 2008-09 Actual	FY 2009-10 Actual	FY 2010-11 Appropriation	FY 2011-12 OSPB Request	Change Requests
(2) Community Programs					
(a) Treatment Services					
Treatment and Detoxification Contracts	22,943,758	23,115,961	23,179,819	23,179,819	
General Fund	11,606,803	11,343,686	11,337,648	11,337,648	
Cash Funds	929,719	1,156,923	1,218,518	1,218,518	
Reappropriated Funds	275,706	267,405	275,706	275,706	
Federal Funds	10,131,530	10,347,947	10,347,947	10,347,947	
Case Management - Chronic Detox Clients	369,361	369,361	369,311	369,311	
General Fund	2,478	2,478	2,428	2,428	
Federal Funds	366,883	366,883	366,883	366,883	
Short-Term Intensive Residential Remediation Treatment	3,297,537	3,401,037	3,340,683	3,340,683	
General Fund	2,914,221	3,017,721	2,957,367	2,957,367	
Cash Funds	383,316	383,316	383,316	383,316	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	
High Risk Pregnant Women - RF	1,460,363	1,474,989	1,999,146	1,999,146	
For Information Only					
Medicaid Reappropriated Funds	*1,460,363*	*1,474,989*	*1,999,146*	*1,999,146*	
Medicaid General Fund therein	*626,952*	*566,543*	*767,872*	*999,573*	
Net General Fund	*626,952*	*566,543*	*767,872*	*999,573*	
					Request vs. Appropriation
Subtotal - (a) Treatment Services	28,071,019	28,361,348	28,888,959	28,888,959	0.0%
General Fund	14,523,502	14,363,885	14,297,443	14,297,443	0.0%
Cash Funds	1,313,035	1,540,239	1,601,834	1,601,834	0.0%
Reappropriated Funds	1,736,069	1,742,394	2,274,852	2,274,852	0.0%
Federal Funds	10,498,413	10,714,830	10,714,830	10,714,830	0.0%
For Information Only					
Medicaid Cash Funds	*1,460,363*	*1,474,989*	*1,999,146*	*1,999,146*	*0.0%*
Medicaid - General Fund therein	*626,952*	*566,543*	*767,872*	*999,573*	*30.2%*
Net General Fund	*15,150,454*	*14,930,428*	*15,065,315*	*15,297,016*	*1.5%*

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	FY 2008-09 Actual	FY 2009-10 Actual	FY 2010-11 Appropriation	FY 2011-12 OSPB Request	Change Requests
(b) Prevention and Intervention					
Prevention Contracts	3,812,374	3,831,628	3,886,951	3,886,951	
General Fund	31,154	34,061	33,649	33,649	
Cash Funds	23,132	5,000	27,072	27,072	
Reappropriated Funds	0	0	0	0	
Federal Funds	3,758,088	3,792,567	3,826,230	3,826,230	
Persistent Drunk Driver Programs	1,020,571	901,903	1,106,635	1,106,635	
Cash Funds	1,020,571	901,903	1,106,635	1,106,635	
Reappropriated Funds	0	0	0	0	
Law Enforcement Assistance Fund Contracts	213,934	213,216	255,000	255,000	
Cash Funds	213,934	213,216	255,000	255,000	
Reappropriated Funds	0	0	0	0	
					Request vs. Appropriation
Subtotal - (b) Prevention and Intervention	5,046,879	4,946,747	5,248,586	5,248,586	0.0%
General Fund	31,154	34,061	33,649	33,649	0.0%
Cash Funds	1,257,637	1,120,119	1,388,707	1,388,707	0.0%
Reappropriated Funds	0	0	0	0	N/A
Federal Funds	3,758,088	3,792,567	3,826,230	3,826,230	0.0%
(c) Other Programs					
Federal Grants	3,067,984	2,974,790	5,063,429	5,063,429	
Reappropriated Funds	0	0	195,500	195,500	
Federal Funds	3,067,984	2,974,790	4,867,929	4,867,929	
Balance of Substance Abuse Block Grant Programs	7,022,832	7,235,208	6,671,360	6,671,360	
General Fund	189,763	189,763	185,968	185,968	
Federal Funds	6,833,069	7,045,445	6,485,392	6,485,392	
Community Prevention and Treatment	1,063,321	990,115	905,871	905,871	
Cash Funds	1,063,321	990,115	905,871	905,871	
Reappropriated Funds	0	0	0	0	

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	FY 2008-09 Actual	FY 2009-10 Actual	FY 2010-11 Appropriation	FY 2011-12 OSPB Request	Change Requests
Gambling Addiction Counseling Services - RF	19,197	98,768	144,727	144,727	
Rural Substance Abuse Prevention and Treatment - CF	0	0	88,443	88,443	
					Request vs. Appropriation
Subtotal - (c) Other Programs	11,173,334	11,298,881	12,873,830	12,873,830	0.0%
General Fund	189,763	189,763	185,968	185,968	0.0%
Cash Funds	1,063,321	990,115	994,314	994,314	0.0%
Reappropriated Funds	19,197	98,768	340,227	340,227	0.0%
Federal Funds	9,901,053	10,020,235	11,353,321	11,353,321	0.0%
					Request vs. Appropriation
Subtotal - (2) Community Programs	44,291,232	44,606,976	47,011,375	47,011,375	0.0%
General Fund	14,744,419	14,587,709	14,517,060	14,517,060	0.0%
Cash Funds	3,633,993	3,650,473	3,984,855	3,984,855	0.0%
Reappropriated Funds	1,755,266	1,841,162	2,615,079	2,615,079	0.0%
Federal Funds	24,157,554	24,527,632	25,894,381	25,894,381	0.0%
For Information Only					
Medicaid Reappropriated Funds	*1,460,363*	*1,474,989*	*1,999,146*	*1,999,146*	*0.0%*
Medicaid - General Fund therein	*626,952*	*566,543*	*767,872*	*999,573*	*30.2%*
Net General Fund	*15,371,371*	*15,154,252*	*15,284,932*	*15,516,633*	*1.5%*
					Request vs. Appropriation
TOTAL - (D) Alcohol and Drug Abuse Division	47,014,001	47,412,771	50,184,585	50,195,815	0.0%
FTE	26.2	26.9	30.8	30.8	0.0%
General Fund	14,918,789	14,813,315	14,763,622	14,798,929	0.2%
Cash Funds	3,696,677	3,769,072	4,143,518	4,142,146	0.0%
Reappropriated Funds	2,250,347	2,332,005	3,116,517	3,109,796	-0.2%
Federal Funds	26,148,188	26,498,379	28,160,928	28,144,944	-0.1%
For Information Only					
Medicaid Reappropriated Funds	*1,514,451*	*1,528,124*	*2,053,234*	*2,051,564*	*-0.1%*
Medicaid - General Fund therein	*653,996*	*593,110*	*794,916*	*1,025,777*	*29.0%*
Net General Fund	*15,572,785*	*15,406,425*	*15,558,538*	*15,824,706*	*1.7%*

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(E) Co-occurring Behavioral Health Services					
(1) Behavioral Health Services for Juveniles and Adults at risk or involved in the Criminal Justice System (H.B. 10-1284)	0	0	334,227	334,227	
General Fund	0	0	334,227	334,227	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	
					Request vs. Appropriation
TOTAL - (8) MENTAL HEALTH AND ALCOHOL AND DRUG ABUSE SERVICES	218,752,205	216,128,199	215,936,670	215,082,380	-0.4%
FTE	1,324.0	1,265.9	1,268.8	1,263.8	-0.4%
General Fund	138,729,230	135,994,854	131,616,695	131,803,521	0.1%
Cash Funds	16,843,430	17,474,362	16,271,537	15,931,195	-2.1%
Reappropriated Funds	11,968,236	10,107,884	10,266,773	9,590,494	-6.6%
Federal Funds	51,211,309	52,551,099	57,781,665	57,757,170	0.0%
For Information Only					
Medicaid Reappropriated Funds	*6,071,955*	*5,987,190*	*5,423,110*	*5,356,440*	*-1.2%*
Medicaid - General Fund therein	*2,626,281*	*2,310,854*	*2,128,323*	*2,677,965*	*25.8%*
Net General Fund	*141,355,511*	*138,305,708*	*133,745,018*	*134,481,486*	*0.6%*

APPENDIX B: SUMMARY OF MAJOR LEGISLATION

- **S.B. 10-153 (Boyd/Frangas):** Creates the Behavioral Health Transformation Council, which is an advisory council to the Governor and his cabinet. By August 1, 2010, the Governor is required to designate one department to act as the lead agency to facilitate the council's work. The lead agency and the Governor are to determine the membership, tenure, and operations of the council. Council membership shall include representatives from executive agencies, the judicial branch, behavioral health providers, consumers, and other stakeholders. The bill sets the duties of the council for strategic planning, developing outcome measures, aligning services, annual reporting, and other tasks.

- **S.B. 10-169 (Boyd/Riesberg):** Allows the Hospital Provider Fee Cash Fund to offset General Fund expenditures in the amount of the additional federal revenue received under the American Recovery and Reinvestment Act (ARRA) Enhanced FMAP program for the Hospital Provider Fee Program once a transfer from the Health Care Expansion Fund to the General Fund pursuant to H.B. 10-1320 is repaid. In FY 2009-10, the Hospital Provider Fee is anticipated to offset $4.9 million in General Fund appropriations otherwise required and to repay the Health Care Expansion Fund through a transfer of $42.7 million. In FY 2010-11, the Hospital Provider Fee is anticipated to offset $46.3 million in General Fund appropriations otherwise required.

- **S.J.R. 10-010 (White/Ferrandino)**: Declares a state fiscal emergency for FY 2010-11, which allows Amendment 35 tobacco-tax revenues to be used in that year for any health-related purpose. See the description of H.B. 10-1381 for a list of related adjustments to appropriations (both in this Department and the Department of Public Health and Environment).

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APPENDIX B: SUMMARY OF MAJOR LEGISLATION

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- **S.B. 10-175 (Boyd/Riesberg):** The bill relocates several sections of statute concerning behavioral health, substance abuse treatment, and mental health facilities so that these sections are grouped together in Title 27 of the Colorado Revised Statutes.

- **H.B. 10-1032 (Frangas/Boyd):** Requires the Department of Human Services to review the state's current behavioral health crisis response system and to formulate a plan to address the lack of a coordinated crisis response system. Requires the Department to submit a report of the plan to the General Assembly on or before January 30, 2013.

- **H.B. 10-1284 (Massey and Summers/Romer and Spence):** Regulates medical marijuana by creating a state and local medical marijuana licensing authority. Amends the statute concerning the medical marijuana program to regulate the role of care givers. Includes an appropriation to the Department of Human Services of $334,227 General Fund for mental health and substance abuse services for juveniles and adults at risk of becoming or currently involved in the criminal justice system. For more information, see the "Summary of Major Legislation" section at the end of the Department of Revenue JBC staff briefing document.

- **H.B. 10-1369 (Scanlan and Pommer/Bacon):** Amends the "Public School Finance Act of 1994" to modify the funding for K-12 public schools in FY 2010-11. Includes a refinance of $13,439 reappropriated funds with $13,439 General Fund for educational programs at the state mental health institutes. For more information, see the "Recent Legislation" section at the end of the Department of Education.

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Department of Health Care Policy and Financing
(Medicaid Mental Health Community Programs)

APPENDIX C: UPDATE OF FY 2010-11 LONG BILL FOOTNOTES AND REQUESTS FOR INFORMATION

Long Bill Footnotes

The FY 2010-11 Long Bill did not contain footnotes for the Medicaid Mental Health Community Programs section.

Requests for Information

15 **Department of Health Care Policy and Financing, Medicaid Mental Health Community Program, Mental Health Capitation Payments --** The Department is requested to provide a report to the Joint Budget Committee by December 1, 2010 recommending benefit or service reductions to Medicaid Mental Health programs in order to achieve a $2,200,000 total fund savings between January 2011 and June 2011. In the report, the Department is requested to provide the following information:

(1) cost estimates for each of the benefit or service changes recommended;
(2) input from the behavioral health organizations on how such benefit and service reductions will be implemented;
(3) a description of any involvement that mental health advocacy groups had in providing input on the benefit or service changes recommended; and
(4) an analysis of whether rate reductions could be enacted within the actuary sound range in lieu of benefit or service reductions recommended or in combination therewith.

Comment: The Governor's Office of State Planning and Budgeting did not submit the report to the Committee by the December 1, 2010 deadline, however it was received by December 6th. See the staff briefing issue entitled "Proposed Service Reductions to Medicaid Mental Health Programs" for more information.

16 **Department of Health Care Policy and Financing, Medicaid Mental Health Community Programs, Mental Health Capitation Payments --** The Department is requested to report in their annual budget submission the amount of expenditures for each year for anti-psychotic pharmaceuticals.

Comment: The Department complied with the request, and provided anti-psychotic pharmaceuticals expenditure data for FY 2002-03 through FY 2009-10. The table below summarizes the expenditures.

Cash Based Actuals

ACUTE CARE Gross Antipsychotic Drugs Expenditure (For Information Only)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2002-03	$4,664,387	$916,979	$17,700,825	$519,527	$0	$2,839	$783,549	$3,789,992	$11,356	$0	$0	$28,389,454
FY 2003-04	$6,372,432	$1,298,397	$25,300,975	$1,057,440	$0	$3,389	$1,296,760	$5,340,219	$29,882	$0	$0	$40,899,694
FY 2004-05	$6,629,621	$1,760,042	$28,042,949	$1,378,076	$0	$3,654	$1,795,300	$6,321,954	$22,953	$0	$0	$45,954,548
FY 2005-06	$4,033,428	$1,685,933	$24,178,645	$1,633,973	$0	$326	$1,935,729	$7,189,609	$22,633	$0	$0	$40,680,277
FY 2006-07	$479,529	$1,222,769	$19,965,507	$2,000,023	$110,237	$183	$2,688,319	$7,814,333	$13,828	$0	$0	$34,294,729
FY 2007-08	$476,587	$1,416,439	$22,587,953	$2,257,237	$326,303	$7,201	$3,116,761	$8,901,950	$23,191	$0	$0	$39,113,622
FY 2008-09	$574,003	$1,594,319	$22,596,632	$3,156,992	$432,485	$13,539	$3,477,458	$8,956,851	$50,359	$0	$0	$40,852,638
FY 2009-10[11]	$624,336	$1,845,804	$23,477,770	$3,457,524	$853,198	$31,055	$3,652,240	$8,663,502	$61,246	$0	$0	$42,666,675

Percent Change in Cash Based Actuals

ACUTE CARE Gross Antipsychotic Drugs Expenditure (For Information Only)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2003-04	36.62%	41.62%	44.07%	103.54%	0.00%	19.36%	65.50%	40.90%	163.14%	0.00%	0.00%	44.07%
FY 2004-05	4.04%	35.53%	9.97%	30.32%	0.00%	7.85%	38.44%	18.38%	-23.19%	0.00%	0.00%	12.36%
FY 2005-06	-39.16%	-4.21%	-13.78%	18.57%	0.00%	-91.07%	7.82%	13.72%	-1.39%	0.00%	0.00%	-11.48%
FY 2006-07	-88.11%	-27.47%	-17.43%	22.40%	100.00%	-44.00%	38.88%	8.69%	-38.90%	0.00%	0.00%	-15.70%
FY 2007-08	-0.61%	15.84%	13.13%	12.86%	196.00%	3839.28%	15.94%	13.92%	67.71%	0.00%	0.00%	14.05%
FY 2008-09	20.44%	12.56%	0.04%	39.86%	32.54%	88.02%	11.57%	0.62%	117.13%	0.00%	0.00%	4.45%
FY 2009-10	8.77%	15.77%	3.90%	9.52%	97.28%	129.37%	5.03%	-3.28%	21.62%	0.00%	0.00%	4.44%

Per Capita Cost

ACUTE CARE Gross Antipsychotic Drugs Expenditure (For Information Only)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2002-03	$134.40	$168.84	$379.46	$12.73	$0.00	$60.40	$4.63	$271.35	$1.45	$0.00	$0.00	$85.56
FY 2003-04	$185.63	$234.07	$545.02	$22.23	$0.00	$32.27	$6.64	$358.07	$3.56	$0.00	$0.00	$111.27
FY 2004-05	$185.29	$289.39	$585.09	$24.12	$0.00	$42.01	$8.07	$400.25	$3.84	$0.00	$0.00	$113.18
FY 2005-06	$111.40	$279.04	$505.25	$27.75	$0.00	$1.74	$9.04	$436.79	$4.42	$0.00	$0.00	$101.14
FY 2006-07	$13.36	$201.81	$409.14	$39.46	$21.36	$0.80	$13.09	$467.25	$2.67	$0.00	$0.00	$87.44
FY 2007-08	$13.13	$230.47	$452.37	$50.66	$36.59	$26.67	$15.28	$519.34	$3.69	$0.00	$0.00	$99.79
FY 2008-09	$15.26	$247.30	$440.01	$64.24	$33.98	$42.71	$14.79	$496.69	$7.22	$0.00	$0.00	$93.52
FY 2009-10	$16.22	$261.85	$440.78	$59.96	$41.79	$73.07	$13.25	$471.33	$7.82	$0.00	$0.00	$85.54

Percent Change in Per Capita Cost

ACUTE CARE Gross Antipsychotic Drugs Expenditure (For Information Only)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2003-04	38.12%	38.63%	43.63%	74.63%	0.00%	-46.57%	43.41%	31.96%	145.52%	0.00%	0.00%	30.05%
FY 2004-05	-0.18%	23.63%	7.35%	8.50%	0.00%	30.18%	21.54%	11.78%	7.87%	0.00%	0.00%	1.72%
FY 2005-06	-39.88%	-3.58%	-13.65%	15.05%	0.00%	-95.86%	12.02%	9.13%	15.10%	0.00%	0.00%	-10.64%
FY 2006-07	-88.01%	-27.68%	-19.02%	42.20%	100.00%	-54.02%	44.80%	6.97%	-39.59%	0.00%	0.00%	-13.55%
FY 2007-08	-1.72%	14.20%	10.57%	28.38%	71.30%	3233.75%	16.73%	11.15%	38.20%	0.00%	0.00%	14.12%
FY 2008-09	16.22%	7.30%	-2.73%	26.81%	-7.13%	60.14%	-3.21%	-4.36%	95.66%	0.00%	0.00%	-6.28%
FY 2009-10	6.29%	5.88%	0.17%	-6.66%	22.98%	71.08%	-10.41%	-5.11%	8.31%	0.00%	0.00%	-8.53%

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APPENDIX C: UPDATE OF FY 2010-11 LONG BILL FOOTNOTES AND REQUESTS FOR INFORMATION

Long Bill Footnotes

2 **Department of Corrections, Management, Executive Director's Office Subprogram; Department of Human Services, Mental Health and Alcohol and Drug Abuse Services, Alcohol and Drug Abuse Division; and Division of Youth Corrections; Judicial Department, Probation and Related Services; and Department of Public Safety, Division of Criminal Justice; and Colorado Bureau of Investigation --** State agencies involved in multi-agency programs requiring separate appropriations to each agency are requested to designate one lead agency to be responsible for submitting a comprehensive annual budget request for such programs to the Joint Budget Committee, including prior year, request year, and three year forecasts for revenues into the fund and expenditures from the fund by agency. The requests should be sustainable for the length of the forecast based on anticipated revenues. Each agency is still requested to submit its portion of such request with its own budget document. This applies to requests for appropriation from the Drug Offender Surcharge Fund, the Offender Identification Fund, the Sex Offender Surcharge Fund, the Persistent Drunk Driver Cash Fund, and the Alcohol and Drug Driving Safety Program Fund, among other programs.

Comment: This footnote expresses legislative intent. The Department submitted a request to spend from the Drug Offender Surcharge Fund, the Persistent Drunk Driver Cash Fund, and the Alcohol and Drug Driving Safety Fund.

Requests for Information

No requests for information were made of the Division.