JOINT BUDGET COMMITTEE

STAFF BUDGET BRIEFING
FY 2018-19

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

(Medicaid Behavioral Health Community Programs)

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

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DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

DEPARTMENT OVERVIEW

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

"Behavioral health" services include prevention and promotion of emotional health, prevention and treatment services for mental health and substance use disorders, and recovery support.[1] Most behavioral health services are provided to Medicaid-eligible clients through a statewide managed care or "capitated" program through which the Department contracts with regional entities to provide or arrange for medically necessary behavioral health services to Medicaid-eligible clients. Each entity (currently a "behavioral health organization" or BHO) receives a pre-determined monthly amount for each client who is eligible for Medicaid behavioral health services. In addition to funding for capitation payments to BHOs, a separate appropriation covers fee-for-service payments for behavioral health services provided to clients who are not enrolled in a BHO and for the provision of behavioral health services that are not covered by BHO contracts.

DEPARTMENT BUDGET: RECENT APPROPRIATIONS

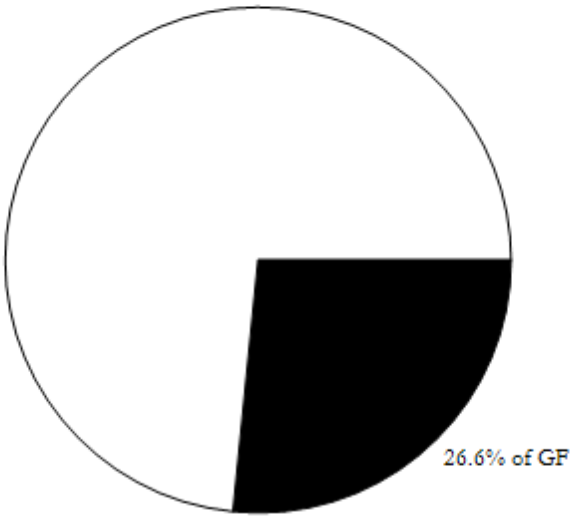
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING				
FUNDING SOURCE	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19 *
General Fund	$2,500,545,586	$2,629,494,550	$2,822,800,583	$2,921,024,097
Cash Funds	1,167,365,312	1,022,925,553	1,217,646,986	1,275,831,686
Reappropriated Funds	17,072,325	15,426,584	77,268,980	77,446,493
Federal Funds	5,438,943,180	5,409,785,027	5,837,486,131	6,008,917,056
TOTAL FUNDS	**$9,123,926,403**	**$9,077,631,714**	**$9,955,202,680**	**$10,283,219,332**
Full Time Equiv. Staff	422.2	435.8	458.5	495.2

*Requested appropriation.

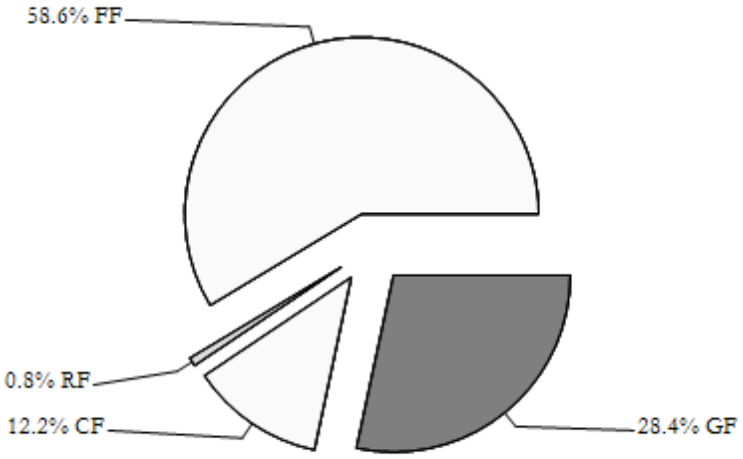
[1] Senate Bill 17-242 modernized statutory terminology related to behavioral health. For more information, see the description of this bill in Appendix B.

DEPARTMENT BUDGET: GRAPHIC OVERVIEW

Department's Share of Statewide General Fund

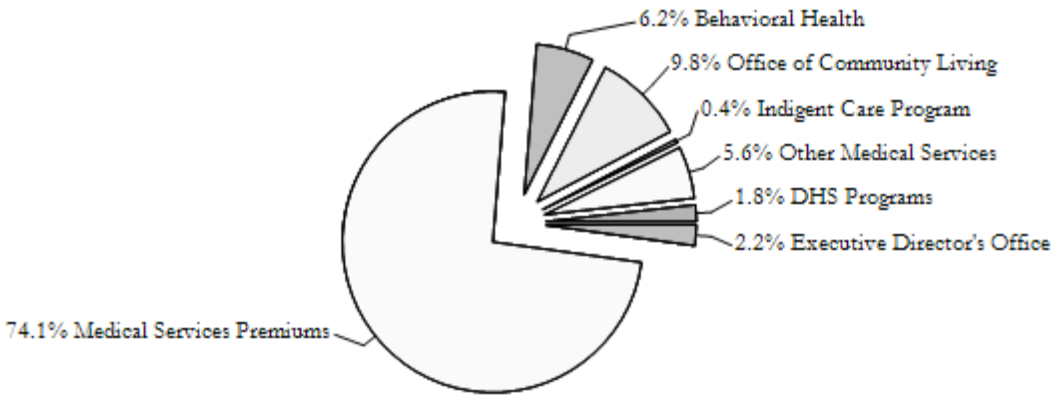


Department Funding Sources

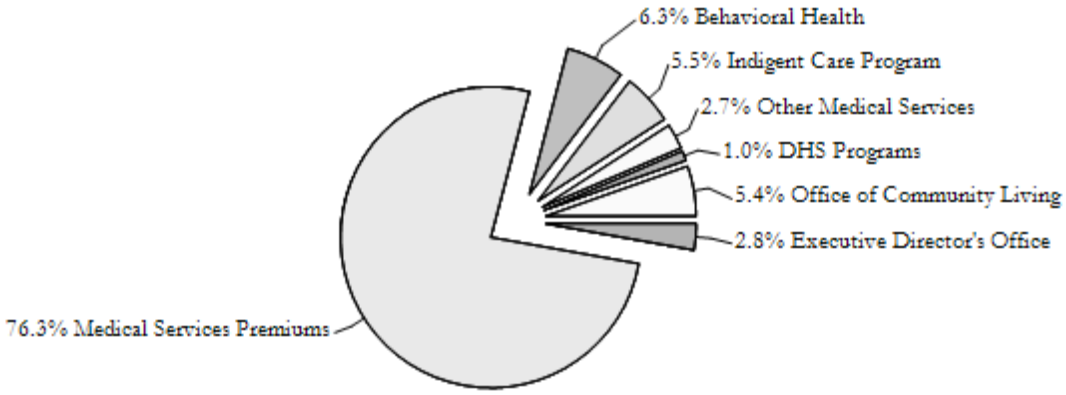


All charts are based on the FY 2017-18 appropriation.

Distribution of General Fund by Division



Distribution of Total Funds by Division



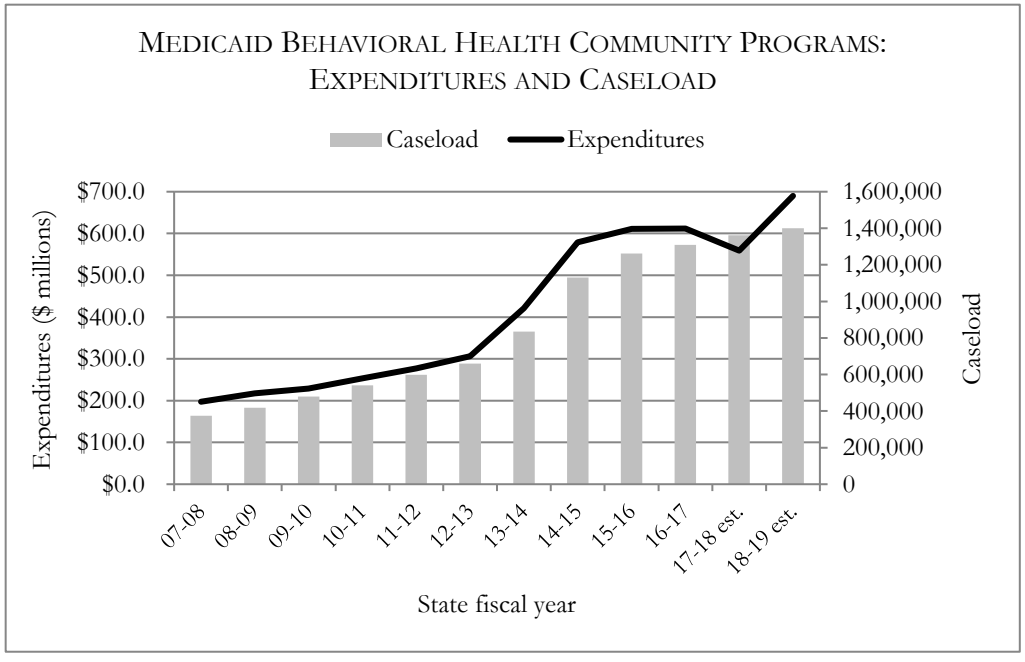
All charts are based on the FY 2017-18 appropriation.

GENERAL FACTORS DRIVING THE BUDGET

The Medicaid program provides health insurance to people with low incomes and to people needing long-term care. The financing, administration, and policy-making responsibilities for the program are shared between the federal and state governments. Medicaid generally operates as an entitlement program, meaning the people deemed eligible have a legal right to the plan benefits. As a result, the most significant factor affecting overall Medicaid expenditures is *enrollment*. Medicaid enrollment has increased significantly in recent years, due to increases in the state population, economic conditions that affect the number of people who meet the income eligibility criteria, and state and federal policy changes.

Expenditures of State funds are affected by the *federal match rate* for the Medicaid program. The federal medical assistance percentage (FMAP) can vary based on economic conditions in the state, the type of service provided, and the population receiving services. For state fiscal year 2017-18, the FMAP for most Colorado Medicaid expenditures is 50.0 percent. However, for adults newly eligible under the federal Affordable Care Act, Colorado receives a 95 percent federal match for calendar year 2017; this federal match is scheduled to decrease annually until it reaches 90 percent in calendar year 2020.

Most appropriations for Medicaid clients' *behavioral health services* are included in the "Behavioral Health Community Programs" section of the Department's budget. Funding in this section consists of 67.9 percent federal Medicaid funds, 27.9 percent General Fund, and 4.2 percent cash funds. Cash fund sources include the Healthcare Affordability and Sustainability Fee Cash Fund, and the Breast and Cervical Cancer Prevention and Treatment Fund. The following chart depicts annual expenditures for all line items within the Behavioral Health Community Programs section and the total number of Medicaid clients eligible for behavioral health services each year.



Caseload and expenditure increases that began in FY 2013-14 reflect the expansion of Medicaid eligibility and the expansion of substance use disorder benefits covered by Medicaid; both expansions became effective in January 2014. In addition, FY 2014-15 expenditures include $5.3 million of one-time funding for school-based prevention and early intervention services for youth. The significant decrease in expenditures anticipated for FY 2017-18 is largely due to recoupments and reconciliations that relate to services that were provided in previous fiscal years. *See the first issue brief for more details concerning these adjustments.*

BEHAVIORAL HEALTH CAPITATION PAYMENTS

Behavioral health services are generally provided to Medicaid clients through a statewide managed care or "capitated" program. The Department contracts with regional entities, currently known as behavioral health organizations (BHOs), to provide or arrange for behavioral health services for clients within their geographic region who are enrolled in the Medicaid program. All Medicaid clients who are eligible for medical benefits are also eligible for behavioral health services except for two populations: (1) non-citizens; and (2) adults who are eligible for both Medicaid and Medicare but for whom the Medicaid benefit is limited to payment of Medicare premiums and co-insurance payments. In order to receive services through a BHO, a client must have a covered diagnosis and receive a covered service or procedure that is medically necessary.

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

Capitated behavioral health program expenditures are thus affected by changes in the number of individuals who are eligible for Medicaid, client utilization and the associated costs of providing behavioral health services, and changes to the Medicaid State Plan or waiver program that affect the diagnoses, services, and procedures that are covered for Medicaid clients. The State's share of expenditures is also affected by changes in the federal match rate for various eligibility categories. Tables 1 through 3 show the year-over-year changes projected for FY 2018-19 in Medicaid enrollment, payments through the capitation program, and expenditures per capita by enrollment category.

TABLE 1: BEHAVIORAL HEALTH CAPITATION PROGRAM - ENROLLMENT				
CATEGORY	FY 17-18 REVISED	FY 18-19 REQUEST	DIFFERENCE	PERCENT
Children to 147% FPL	535,090	540,205	5,115	1.0%
Adults w/out Dependent Children to 138% FPL	380,104	393,958	13,854	3.6%
Parents/Caretakers to 68% FPL; Pregnant Adults to 200% FPL	202,411	210,047	7,636	3.8%
Parents/Caretakers 69% to 138% FPL	91,246	98,254	7,008	7.7%
Individuals with Disabilities to age 64 (to 450% FPL)	87,235	90,748	3,513	4.0%
Adults age 65+ (to SSI)	45,242	45,993	751	1.7%
Foster Care to 26 years	20,584	20,746	162	0.8%
Breast & Cervical Cancer to 250% FPL	117	62	(55)	-47.0%
TOTAL	**1,362,029**	**1,400,013**	**37,984**	**2.8%**

TABLE 2: BEHAVIORAL HEALTH CAPITATION PROGRAM - ANNUAL EXPENDITURES				
CATEGORY	FY 17-18 REVISED	FY 18-19 REQUEST	DIFFERENCE	PERCENT
Children to 147% FPL	$127,628,007	$133,572,660	$5,944,653	4.7%
Adults w/out Dependent Children to 138% FPL	213,348,404	233,354,896	20,006,492	9.4%
Parents/Caretakers to 68% FPL; Pregnant Adults to 200% FPL	71,677,122	78,536,559	6,859,437	9.6%
Parents/Caretakers 69% to 138% FPL	16,184,888	18,227,678	2,042,790	12.6%
Individuals with Disabilities to age 64 (to 450% FPL)	141,127,521	148,849,871	7,722,350	5.5%
Adults age 65+ (to SSI)	10,026,332	10,681,853	655,521	6.5%
Foster Care to 26 years	30,013,966	30,727,499	713,533	2.4%
Breast & Cervical Cancer to 250% FPL	39,816	21,683	(18,133)	-45.5%
Risk corridor and other payment adjustments for prior fiscal years	(66,033,726)	0	66,033,726	n/a
Health insurance provider fee payments	5,891,487	0	(5,891,487)	n/a
Estimated incentive payments (for previous year)	0	26,717,069	26,717,069	n/a
TOTAL	**$549,903,817**	**$680,689,768**	**$130,785,951**	**23.8%**

TABLE 3: BEHAVIORAL HEALTH CAPITATION PROGRAM - ANNUAL PER CAPITA EXPENDITURES				
CATEGORY	FY 17-18 REVISED	FY 18-19 REQUEST	DIFFERENCE	PERCENT
Children to 147% FPL	$239	$247	$9	3.7%
Adults w/out Dependent Children to 138% FPL	561	592	31	5.5%
Parents/Caretakers to 68% FPL; Pregnant Adults to 200% FPL	354	374	20	5.6%
Parents/Caretakers 69% to 138% FPL	177	186	8	4.6%
Individuals with Disabilities to age 64 (to 450% FPL)	1,618	1,640	22	1.4%
Adults age 65+ (to SSI)	222	232	11	4.8%
Foster Care to 26 years	1,458	1,481	23	1.6%
Breast & Cervical Cancer to 250% FPL	340	350	9	2.8%
TOTAL (excluding adjustments and payments associated with previous fiscal years)	**$448**	**$467**	**$19**	**4.3%**

OTHER DEPARTMENT BEHAVIORAL HEALTH EXPENDITURES

Please note that some behavioral health-related expenditures for Medicaid clients are funded through line item appropriations that are not part of the behavioral health community programs section of the budget. Specifically, the Medical Services Premiums line item appropriation covers:

- expenditures for the provision of *inpatient medical treatment* for clients with acute medical conditions that include a substance use disorder diagnosis (an estimated $182.9 million in FY 2016-17);

- behavioral health-related *pharmaceutical expenditures* (an estimated $58.1 million after rebates in FY 2015-16[2], including $31.3 million related to antipsychotic drugs); and

- *inpatient substance use disorder treatment for children and youth* under age 21 provided under the early and periodic screening, diagnostic and treatment benefit ($1.5 million in FY 2016-17).

In addition, Medicaid covers residential substance use disorder treatment for pregnant women through the "Special Connections Program", which is administered by the Department of Human Services with Medicaid funding transferred from HCPF ($1.1 million in FY 2016-17). Finally, administrative expenses related to behavioral health programs are funded through various line items in HCPF's Executive Director's Office.

[2] Actual expenditure data for pharmaceuticals for FY 2016-17 is not yet available due to some challenges with the reporting tools within the new Colorado Medicaid Management Innovation and Transformation Project (COMMIT).

SUMMARY: FY 2017-18 APPROPRIATION & FY 2018-19 REQUEST

TABLE 4: DEPARTMENT OF HEALTH CARE POLICY AND FINANCING						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2017-18 APPROPRIATION:						
SB 17-254 (Long Bill)	$625,797,571	$174,446,202	$26,190,535	$0	$425,160,834	0.0
Other legislation	0	0	0	0	0	0.0
TOTAL	**$625,797,571**	**$174,446,202**	**$26,190,535**	**$0**	**$425,160,834**	**0.0**
FY 2018-19 REQUESTED APPROPRIATION:						
FY 2017-18 Appropriation	$625,797,571	$174,446,202	$26,190,535	$0	$425,160,834	0.0
R2 Behavioral health forecast	38,797,903	7,713,920	5,186,815	0	25,897,168	0.0
R9 Provider rates	59,938	13,099	2,463	0	44,376	0.0
Annualize prior year budget actions	25,317,295	6,925,587	881,871	0	17,509,837	0.0
TOTAL	**$689,972,707**	**$189,098,808**	**$32,261,684**	**$0**	**$468,612,215**	**0.0**
INCREASE/(DECREASE)	$64,175,136	$14,652,606	$6,071,149	$0	$43,451,381	0.0
Percentage Change	10.3%	8.4%	23.2%	0.0%	10.2%	0.0%

R2 BEHAVIORAL HEALTH FORECAST: The request includes an increase of $38.8 million total funds, including $7.7 million General Fund, for projected caseload and expenditure changes in both the capitation and fee-for-service Medicaid behavioral health programs. *[For more information, see the first issue brief.]*

R9 PROVIDER RATES: The request includes an increase of $59,938 total funds, including $13,099 General Fund, for an across-the-board increase of 1.0 percent for community providers. This proposed rate increase applies to fee-for-service payments made for behavioral health services, but it does not apply to payments made through the statewide capitation program.

ANNUALIZE PRIOR YEAR BUDGET ACTIONS: The request includes an increase of $25.3 million total funds, including $6.9 million General Fund, to reflect the second-year impact of 2017 legislation and two FY 2017-18 budget actions. The most significant change is an increase of $26.7 million total funds for performance-based incentive payments to behavioral health organizations related to FY 2017-18 measurements of innovation and quality.

TABLE 5: ANNUALIZE PRIOR YEAR BUDGET ACTIONS					
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FEDERAL FUNDS	FTE
Annualize HB 17-1353 Delivery and payment initiatives	$26,717,069	$7,215,319	$1,090,836	$18,410,914	0.0
Annualize FY 17-18 Provider rates	11,566	2,499	483	8,584	0.0
Annualize HB 16-1321 Waiver buy-in	2,711	(4,546)	5,903	1,354	0.0
Annualize FY 17-18 R6 Delivery system & payment reform (incentive payments to BHOs)	(1,414,051)	(287,685)	(215,351)	(911,015)	0.0
TOTAL	**$25,317,295**	**6,925,587**	**$881,871**	**$17,509,837**	**0.0**

ISSUE: OVERVIEW OF DEPARTMENT'S FY 2018-19 REQUEST FOR BEHAVIORAL HEALTH COMMUNITY PROGRAMS (R2)

The Department's most recent projections for Medicaid behavioral health community programs indicate that the General Assembly will need to increase General Fund appropriations by $0.8 million in the current fiscal year and by another $13.9 million for FY 2018-19.

SUMMARY

- Compared to existing FY 2017-18 appropriations, the Governor's budget request for FY 2018-19 reflects an overall increase of $93.6 million total funds (10.1 percent) for behavioral health programs administered by the Department of Health Care Policy and Financing (HCPF) and the Department of Human Services (DHS). This includes an increase of $64.2 million (10.3 percent) for HCPF programs and $29.4 million (9.9 percent) for DHS programs.

- For FY 2017-18, HCPF estimates that existing appropriations for Medicaid behavioral health programs can be decreased by $66.9 million total funds, but the General Fund share of the appropriation will need to increase slightly. This overall reduction is primarily due to higher than anticipated recoupments from behavioral health organizations (BHOs) for payments related to services provided in FY 2015-16 and FY 2016-17.

- Compared to the revised estimate for FY 2017-18, HCPF's request for FY 2018-19 represents a $131.1 million (23.5 percent) increase in total funds, including an increase of $13.9 million General Fund. The Department's projections for FY 2018-19 are based on moderate growth in caseload and per capita rates. The primary reason for the large year-over-year increase is due the elimination of recoupments and reconciliations totaling $66.0 million in FY 2017-18.

DISCUSSION

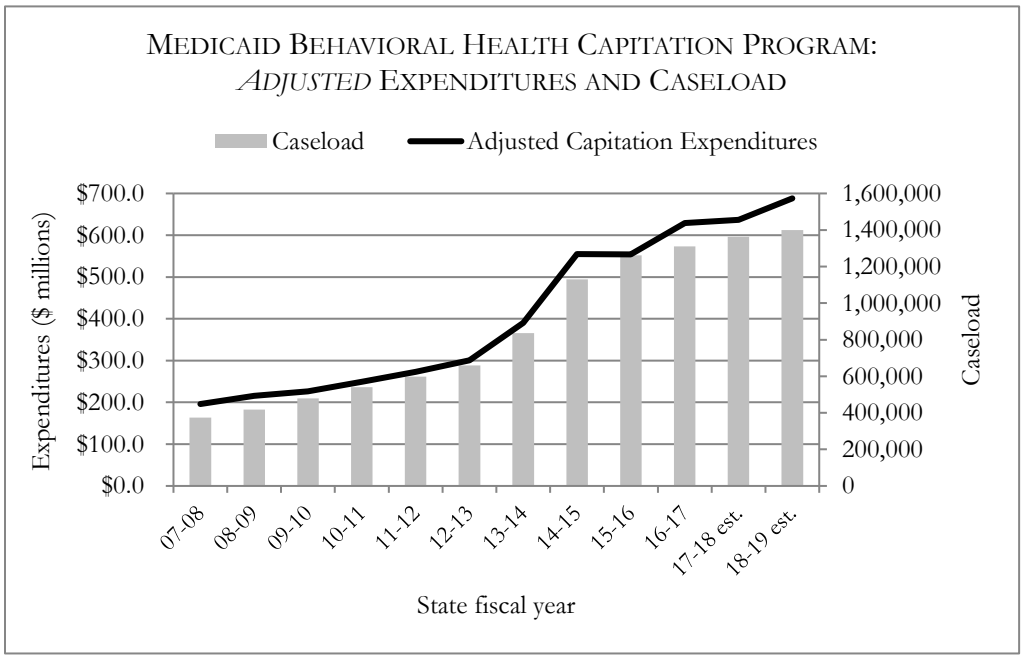
OVERALL FUNDING REQUEST FOR BEHAVIORAL HEALTH PROGRAMS FOR FY 2018-19

The majority of publicly funded behavioral health services in Colorado are funded through two program areas: HCPF's Behavioral Health Community Programs section, and the Office of Behavioral Health within DHS. The FY 2018-19 budget requests for these two program areas propose an overall increase of $93.6 million (10.1 percent) compared to existing appropriations, including a $42.5 million (11.6 percent) increase in General Fund appropriations. As detailed in Table 6, the overall increase includes $64.2 million for HCPF programs and $29.4 million for DHS programs. This issue brief provides an overview of the components of the HCPF share of the FY 2018-19 request and the underlying trends affecting the request.

TABLE 6: TOTAL APPROPRIATIONS FOR BEHAVIORAL HEALTH PROGRAMS - FY 2017-18 AND FY 2018-19						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2017-18 Appropriation						
Department of Human Services (DHS), Office of Behavioral Health	$297,735,126	$190,612,813	$44,667,927	$21,483,631	$40,970,755	1,316.7
Department of Health Care Policy and Financing (HCPF), Behavioral Health Community Programs	625,797,571	174,446,202	26,190,535	0	425,160,834	0.0
TOTAL	**$923,532,697**	**$365,059,015**	**$70,858,462**	**$21,483,631**	**$466,131,589**	**1,316.7**
FY 2018-19 Request						
DHS, Office of Behavioral Health	$327,139,408	$218,475,364	$45,786,140	$21,842,246	$41,035,658	1,344.0
HCPF, Behavioral Health Community Programs	689,972,707	189,098,808	32,261,684	0	468,612,215	0.0
TOTAL	**$1,017,112,115**	**$407,574,172**	**$78,047,824**	**$21,842,246**	**$509,647,873**	**1,344.0**
DHS: Increase/(Decrease)	$29,404,282	$27,862,551	$1,118,213	$358,615	$64,903	27.3
Percentage Change	*9.9%*	*14.6%*	*2.5%*	*1.7%*	*0.2%*	*2.1%*
HCPF: Increase/(Decrease)	$64,175,136	$14,652,606	$6,071,149	$0	$43,451,381	0.0
Percentage Change	*10.3%*	*8.4%*	*23.2%*	*n/a*	*10.2%*	*n/a*
TOTAL: Increase/(Decrease)	**$93,579,418**	**$42,515,157**	**$7,189,362**	**$358,615**	**$43,516,284**	**27.3**
Percentage Change	*10.1%*	*11.6%*	*10.1%*	*1.7%*	*9.3%*	*2.1%*

BEHAVIORAL HEALTH CAPITATION PROGRAM EXPENDITURE TRENDS

The following chart depicts expenditure and caseload changes for the Medicaid Behavioral Health Capitation Program since FY 2007-08. The amounts for FY 2017-18 and FY 2018-19 are based on HCPF's most recent expenditure estimates.

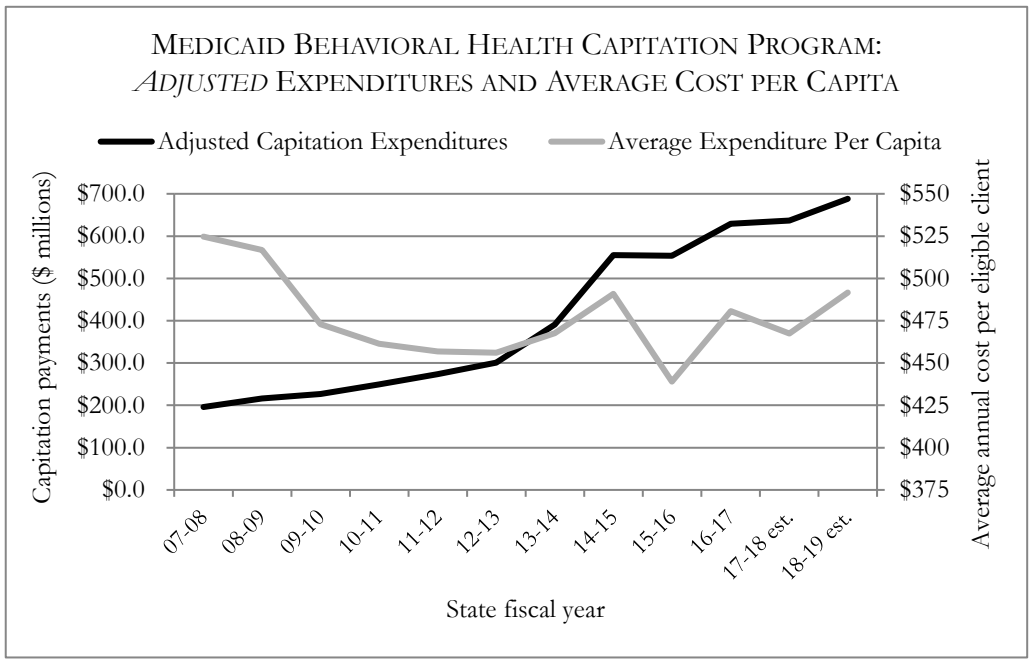


In contrast to the chart that is included in the General Factors Driving the Budget section of this document, the above chart:

- excludes annual behavioral health fee-for-service payments and one-time expenditures in FY 2014-15 for substance use prevention programs and contract reprocurement; and

- reflects expenditures related to Capitation reconciliations, recoupments, health insurance provider fee payments, and incentive payments in the fiscal year associated with dates of service, rather than in the fiscal year in which they were made (these adjustments are detailed in Table 8, followed by narrative descriptions to follow).

The next chart includes the same adjusted Capitation expenditures as the above chart, but it provides a second trend line to depict the average expenditure per eligible Medicaid client. This chart clearly illustrates that the overall increases in expenditures for Medicaid behavioral health services has primarily been driven by increases in the number of individuals eligible for these services. In fact, the average expenditure per eligible Medicaid client has decreased over time from $525 in FY 2007-08 to a low of $439 in FY 2015-16.



There are three primary reasons for recent changes in the average cost per capita:

- First, the size and composition of the population eligible for Medicaid has changed, and significant caseload increases occurred in eligibility categories that are less expensive to serve. From FY 2007-08 through FY 2012-13, due to the economic recession, the number of Children and Parents/Caretakers with low incomes increased faster than other eligibility categories for which behavioral health expenditures are highest (e.g., Individuals with Disabilities, and Individuals in or Formerly in Foster Care). Over the last five years, the most significant caseload increases have occurred in the new Adults Without Dependent Children eligibility category, which is projected to comprise 27.9 percent of the total caseload in FY 2017-18. This eligibility category is more expensive to serve than Children or Parents/Caretakers, and thus the overall average cost per capita has increased since expansion began in 2014.

- Second, the Capitation rates that were initially established for the adult populations that became eligible for Medicaid in January 2014 proved to be too high based on actual costs and service utilization. Capitation rates for these "expansion" populations declined significantly starting in FY 2015-16.

- Third, new federal managed care regulations impose more federal scrutiny on HCPF's rate setting process, resulting in a loss of flexibility for the State and reductions in come Capitation rates starting in FY 2017-18.

HCPF November 2017 Caseload and Expenditure Forecast

The Department's most recent caseload and expenditure forecast includes adjustments for both FY 2017-18 and FY 2018-19. As indicated below, the Department anticipates submitting a supplemental request for a significant mid-year adjustment to FY 2017-18 appropriations. The following table splits out the requested changes by fiscal year to provide a more informative overview of the request.

TABLE 7: BEHAVIORAL HEALTH COMMUNITY PROGRAMS
SUMMARY OF REQUESTED INCREASE BY FISCAL YEAR AND FUND SOURCE

	Total Funds	General Fund	Cash Funds	Federal Funds
Appropriation for FY 2017-18	$625,797,571	$174,446,202	$26,190,535	$425,160,834
Changes reflected in most recent Medicaid forecast for FY 2017-18	(66,932,236)	789,428	(693,784)	(67,027,880)
Subtotal: FY 2017-18 Estimate	**$558,865,335**	**$175,235,630**	**$25,496,751**	**$358,132,954**
Annualize prior year budget actions	25,317,295	6,925,587	881,871	17,509,837
R2 Behavioral health forecast	38,797,903	7,713,920	5,186,815	25,897,168
R9 Provider rates	59,938	13,099	2,463	44,376
Total FY 2018-19 Request	**$689,972,707**	**$189,098,808**	**$32,261,684**	**$468,612,215**
Increase/(Decrease)	**$131,107,372**	**$13,863,178**	**$6,764,933**	**$110,479,261**
Percent change	*23.5%*	*7.9%*	*26.5%*	*30.8%*

FY 2017-18 Budget Estimate

The FY 2017-18 appropriation for Medicaid behavioral health community programs currently provides a total of $625.8 million total funds for the provision of services to a projected membership of 1,380,362. The Department is now projecting a lower rate of caseload growth in FY 2017-18, resulting in a projected membership that is 18,333 lower than previously anticipated (1,362,029). The most significant reductions are reflected in the Children and Adults Without Dependent Children eligibility categories.

The Department has also lowered its estimates of FY 2017-18 per capita rates. The most significant rate decreases were for the Individuals with Disabilities and the Adults Without Dependent Children eligibility categories. The Department's projections also reflect larger than anticipated reconciliations and recoupments in FY 2017-18, all of which related to services that were provided in previous fiscal years. Appendix E details the caseload and rate data that underlie the Department's revised Capitation payment estimates for FY 2017-18, including the anticipated reconciliations and recoupments. Table 8 details the various reconciliations that occurred in FY 2016-17 and are expected to occur in FY 2017-18 and the next two fiscal years. For each adjustment, Table 8 also indicates the relevant fiscal year in which the associated services were provided. Following the table, staff has provided a description of each type of adjustment.

TABLE 8: SUMMARY OF CAPITATION RECONCILIATIONS - FY 2016-17 THROUGH FY 2019-20						
FISCAL YEAR IN WHICH PAYMENT/ RECOUPMENT OCCURRED	DATES OF SERVICE					TOTAL
	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	
FY 2016-17						
Risk corridor reconciliation	($17,524,964)	$0	$0	$0	$0	($17,524,964)
Expansion parent rate reconciliation	0	(19,040,337)	0	0	0	(19,040,337)
Parent indicator issue	0	0	12,376,983	0	0	12,376,983
Total: FY 2016-17	**(17,524,964)**	**(19,040,337)**	**12,376,983**	**0**	**0**	**(24,188,318)**
FY 2017-18						
Risk corridor reconciliation	0	(48,266,117)	0	0	0	(48,266,117)
Adjustment for children incorrectly placed in disability eligibility category	0	(1,848,939)	0	0	0	(1,848,939)
Adjustment for parents/caretakers eligible for Transitional Medicaid	0	934,784	932,577	0	0	1,867,361
Expansion parent rate reconciliation	0	0	(17,786,031)	0	0	(17,786,031)
Health insurance provider fee payment	0	0	5,891,487	0	0	5,891,487
Total: FY 2017-18	**0**	**(49,180,272)**	**(10,961,967)**	**0**	**0**	**(60,142,239)**
FY 2018-19						
BHO incentive payments (HB 17-1353)	0	0	0	26,717,069	0	26,717,069
Health insurance provider fee payment	0	0	0	0	0	0
Total: FY 2018-19	**0**	**0**	**0**	**26,717,069**	**0**	**26,717,069**
FY 2019-20						
RAE incentive payments (HB 17-1353)	0	0	0	0	28,131,120	28,131,120
Health insurance provider fee payment	0	0	0	0	6,092,303	6,092,303
Total: FY 2019-20	**0**	**0**	**0**	**0**	**34,223,423**	**34,223,423**
TOTALS	**($17,524,964)**	**($68,220,609)**	**$1,415,016**	**$26,717,069**	**$34,223,423**	**($23,390,065)**

- *Risk corridor reconciliation:* Due to the uncertainty of the cost of serving the newly eligible Adults Without Dependent Children and Parents/Caretakers (69% to 138% FPL) populations, the Department placed a "risk corridor" on the associated Capitation rates to protect both the State and BHOs from undue risk. The recoupments in the above table are due to the rates paid in FY 2014-15 and FY 2015-16 being set higher than actual costs.

- *Expansion parent rate reconciliation:* These recoupments are due to payments made in FY 2015-16 and FY 2016-17 for some individuals in the Parents/Caretakers (69% to 138% FPL) category. These payments were incorrectly based on the higher Adults Without Dependent Children category rate due to system limitations in the previous Medicaid Management Information System (MMIS) payment system.

- *Parent indicator issue:* This payment issue is essentially the reverse of the above reconciliation item, but it occurred upon implementation of the new Colorado interChange payment system that was

implemented in March 2017. The new system initially made payments for a group of adults with low incomes based on the lower Parents/Caretakers (69% to 138% FPL) category rate, rather than the rate for Adults Without Dependent Children. The Department identified and corrected this issue within FY 2016-17, the same year that the associated services were provided.

- *Adjustment for children incorrectly placed in disability eligibility category:* This recoupment was needed for payments made in FY 2015-16 for some children that were incorrectly categorized and paid based on the Individuals with Disabilities category rate.

- *Adjustment for parents/caretakers eligible for Transitional Medicaid*: These payments are due to a group of adults with low incomes who should have been placed on Transitional Medicaid in FY 2015-16 and FY 2016-17. These payments were incorrectly based on the lower Parents/Caretakers (69% to 138% FPL) category rate.

- *Health insurance provider fee payment:* Under the federal Affordable Care Act, a fee is charged to covered entities that provide health insurance. This fee only applies to for profit insurers, and it is based on the insurer's market share. This mandate was waived for calendar year 2017. The $5.9 million fee that the Department paid for FY 2016-17 was on behalf of two behavioral health organizations (BHOs): Foothills Behavioral Health Partners, LLC, and Colorado Health Partnerships, LLC. The Department's estimates for FY 2019-20 assume that this fee will continue to be required for some of the regional accountable entities. Any payments for CY 2018 will be paid in FY 2019-20.

- *BHO/RAE incentive payments (HB 17-1353):* BHOs are eligible to receive incentive payments in FY 2018-19 based on services provided in FY 2017-18 (and related performance measures). The new regional accountable entities (RAEs) will be eligible for incentive payments in FY 2019-20 based on services provided in FY 2018-19.

FY 2018-19 BUDGET ESTIMATE

The Department's FY 2018-19 budget request includes $690.0 million total funds for the provision of services to a projected membership of 1,400,013. Compared to the revised estimate for FY 2017-18, the request represents a $131.1 million (23.5 percent) year-over-year increase in total funds, and a $13.9 million (7.9 percent) increase in General Fund [see Table 7]. The projection is based on a 2.8 percent overall caseload increase, and an average increase of 4.3 percent in Capitation rates.

The primary reason for the large year-over-year increase in the appropriation is due to the elimination of reconciliations totaling $66.0 million in FY 2017-18 – all of which actually pertain to services in previous fiscal years. In addition, the FY 2018-19 request includes $26.7 million for potential incentive payments to BHOs for services provided in FY 2017-18. These increases are slightly offset by the elimination of $5.9 million for health insurance provider payments, as these are not required for calendar year 2017. Table 9 provides a side-by-side comparison of HCPF's revised estimates for Medicaid Behavioral Health Community Programs for FY 2017-18 and FY 2018-19. The far right column identifies annual changes in caseload and expenditures for each eligibility category or type of expenditure/recoupment. *See Appendix F for the detailed caseload and rate data that underlies the Department's capitation payments request for FY 2018-19.*

TABLE 9: FY 2018-19 MEDICAID BEHAVIORAL HEALTH COMMUNITY PROGRAMS BUDGET OVERVIEW

DESCRIPTION	FY 2017-18 REVISED		FY 2018-19 REQUEST		ANNUAL CHANGE	
	CASELOAD	FUNDING	CASELOAD	FUNDING	CASELOAD	FUNDING
Capitation Payments						
Eligibility Categories						
Adults age 65+ (to SSI)	45,242	$10,026,332	45,993	$10,681,853	751	$655,521
Adults:						
Parents/ Caretakers (to 68% FPL) and Pregnant Adults (to 200% FPL)	202,411	71,677,122	210,047	78,536,559	7,636	6,859,437
Parents/ Caretakers (69% to 138% FPL)*	91,246	16,184,888	98,254	18,227,678	7,008	2,042,790
Adults without Dependent Children (to 138% FPL)*	380,104	213,348,404	393,958	233,354,896	13,854	20,006,492
Breast and Cervical Cancer Program (to 250% FPL)	117	39,816	62	21,683	(55)	(18,133)
Individuals With Disabilities to age 64 (to 450% FPL)	87,235	141,127,521	90,748	148,849,871	3,513	7,722,350
Children (to 147% FPL)	535,090	127,628,007	540,205	133,572,660	5,115	5,944,653
Individuals In/ Formerly In Foster Care (up to age 26)	20,584	30,013,966	20,746	30,727,499	162	713,533
Subtotal	1,362,029	610,046,056	1,400,013	653,972,699	37,984	43,926,643
Adjustments:						
Risk corridor reconciliation		(48,266,117)		0		48,266,117
Expansion parent rate reconciliation		(17,786,031)		0		17,786,031
Adjustment for children incorrectly placed in disability eligibility category		(1,848,939)		0		1,848,939
Adjustment for parents/caretakers eligible for transitonal Medicaid		1,867,361		0		(1,867,361)
Health insurance provider fee payment		5,891,487		0		(5,891,487)
Estimated incentive payments		0		26,717,069		26,717,069
Total Capitation Payments	**1,362,029**	**$549,903,817**	**1,400,013**	**$680,689,768**	**37,984**	**$82,519,834**
Fee-for-service Payments						
Inpatient		$439,551		$455,316		$15,765
Outpatient		8,498,335		8,803,143		304,808
Physician		23,632		24,490		858
Total Fee-for-Service Payments		**$8,961,518**		**$9,282,949**		**$321,431**
GRAND TOTAL	**1,362,029**	**$558,865,335**	**1,400,013**	**$689,972,717**	**37,984**	**$82,841,265**
Incremental Percentage Change					***2.8%***	***23.5%***

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

Please note that it is anticipated that in January 2018 the Department will submit a supplemental request for FY 2017-18 based on the caseload and expenditure data in the relevant columns above. Subsequently, in February 2018 the Department will submit an updated caseload and expenditure forecast for both FY 2017-18 and FY 2018-19 that incorporates data through December 2017. Thus, the Committee will have updated information available when it makes decisions in March 2018 concerning the FY 2017-18 and FY 2018-19 budgets.

ISSUE: RESIDENTIAL AND INPATIENT SUBSTANCE USE DISORDER TREATMENT (HB 17-1351)

There is currently a gap in Medicaid coverage for adults with substance use disorder. This gap is partially filled with state and federal funds appropriated to the Department of Human Services.

SUMMARY

- Colorado's Medicaid benefit currently covers lower intensity services for individuals with substance use disorders through the behavioral health Capitation program, and it covers the highest level of inpatient care for these individuals through the Fee-for-service program. For most adults, there is a coverage gap because Medicaid does not cover residential care.

- House Bill 17-1351 requires the Department of Health Care Policy and Financing to submit a report concerning the feasibility of closing this coverage gap and the potential costs and savings that would result. This report was prepared by the Colorado Health Institute (CHI) and submitted by the Department in early November.

- The Opioid and Other Substance Use Disorders Interim Study Committee recently approved a bill that would add residential and inpatient substance use disorder treatment as a Medicaid benefit. The initial Legislative Council Staff fiscal note for this bill estimates annual State expenses of $48 million upon implementation, but does not yet quantify potential offsetting savings.

RECOMMENDATION

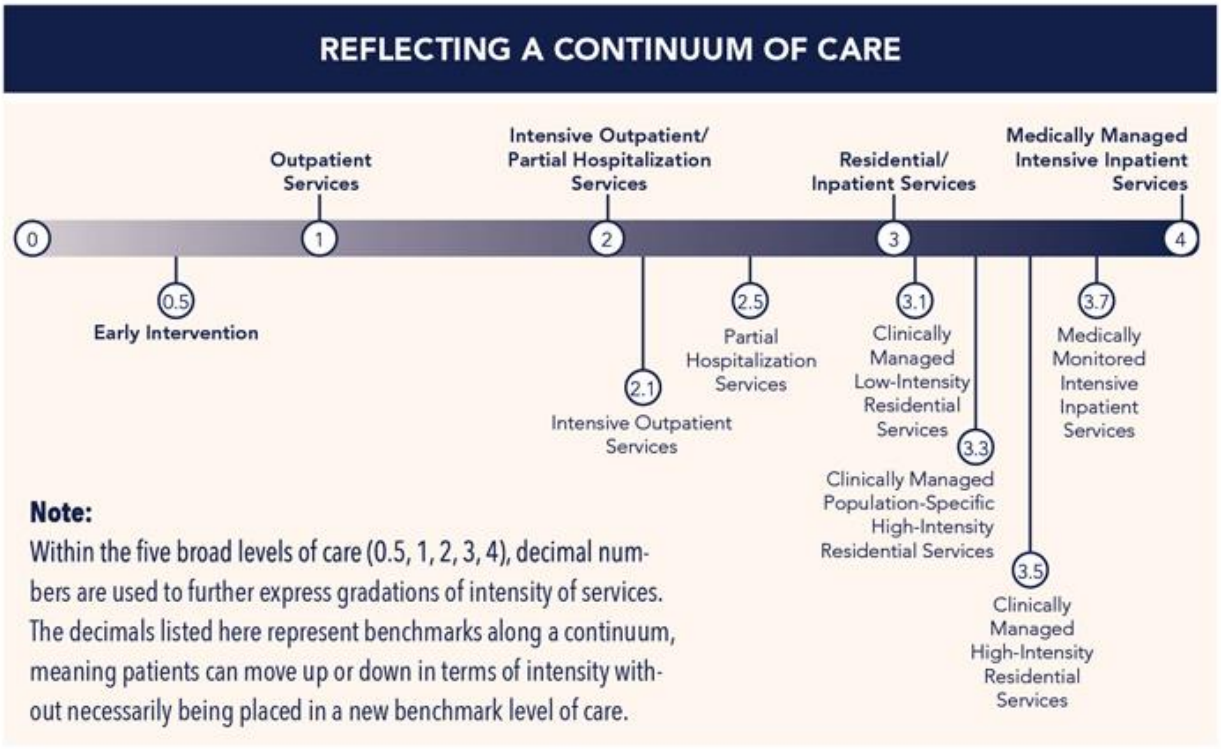
Staff recommends that the Committee ask the Department to discuss the CHI report, including the following related topics:

- What is the current status of the Department's existing federal 1915(b)(3) waiver for the behavioral health Capitation program, and what changes are necessary for the Department to implement Phase II of the Accountable Care Collaborative as planned on July 1, 2018? Would this waiver need to be amended if the Medicaid benefit is expanded to include the full continuum of substance use disorder (SUD) treatment? Should this waiver include the highest level of inpatient care?
- How do existing federal requirements related to institutions for mental disease (IMD) affect the ability of the Capitation program to provide a full continuum of mental health and SUD services?
- What would be the benefit of applying for a federal 1115 waiver in order to expand the continuum of SUD services? Should such a waiver application seek to address the IMD restrictions related to both mental health disorder and SUD services?
- How does the Department plan to estimate the cost savings that would result from an expanded SUD Medicaid benefit in light of the significant savings that are already assumed for clients with a SUD based on the implementation of H.B. 17-1353? Does the Department's ongoing Rocky Mountain Health Plans Prime pilot provide any useful data for estimating potential savings related to both efforts?
- Describe existing efforts to expand the number of licensed SUD treatment facilities eligible to receive Medicaid reimbursement. To what extent can the State determine criteria for these facilities and SUD treatment professionals to enroll as Medicaid providers?

DISCUSSION

BACKGROUND INFORMATION: CONTINUUM OF CARE FOR SUBSTANCE USE DISORDER

As noted at the beginning of this document, behavioral health services include a range of services spanning from prevention to treatment to recovery. Substance use disorder, alcohol use disorder, and other substance-related and addictive disorders are included within a class of mental disorders defined in the Diagnostic and Statistical Manual of Mental Disorders[3]. The American Society of Addiction Medicine (ASAM) is a professional medical society representing physicians, clinicians, and associated professionals in the field of addiction medicine. The ASAM describes treatment as a continuum of care for these disorders to include early intervention and four broad levels of service. Within these five broad levels of care, the ASAM defines services at varying levels of intensity. The following graphic illustrates key service levels within this continuum of care.[4]



The Colorado Medicaid behavioral health benefit for individuals with a substance use disorder (SUD) currently covers lower intensity services, including early intervention (0.5) through partial hospitalization services (2.5). This benefit also includes the highest level of care (4.0) when warranted by a medical diagnosis[5].

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[3] According to the dsm.psychiatryonline.org website, the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM), "is a classification of mental disorders with associated criteria designed to facilitate more reliable diagnoses of these disorders."

[4] Source: http://asamcontinuum.org/knowledgebase/what-are-the-asam-levels-of-care/

[5] Please note that the Medicaid benefit does not cover inpatient psychiatric hospital services for an individual for whom the primary diagnosis is a substance use disorder. However, the Department does cover inpatient psychiatric service costs during the assessment period of a client's hospitalization even if the primary diagnosis is ultimately determined to be a substance use disorder.

Prior to January 2014, Medicaid delivered certain outpatient SUD benefits under the Fee-for-service program. In January 2014, these outpatient benefits were expanded to include intensive outpatient (2.1) and partial hospitalization (2.5) services. These benefits were also shifted into the Capitation program. This change has allowed behavioral health organizations to increase access to low- and mid-level SUD services and mitigate the need for more intensive services.

Colorado's Medicaid program does not generally cover the levels of care that fall within the third service level in the above chart. Exceptions include the following:

- Children and young adults up to age 20 who are eligible for Medicaid may receive residential care (3.1, 3.3, or 3.5) under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program.
- Pregnant women and post-partum women who are eligible for Medicaid may receive residential SUD services through the Special Connections program. This program is funded by Medicaid but administered by the Department of Human Services.

A recent study by the Colorado Health Institute, which is described in detail in the next section of this issue brief, included the following table to provide more information about the five most intensive levels of care depicted in the above ASAM chart.

Level of Care	Title	Inpatient/ Residential	Staffing and Care	Current Covered Benefit under Health First Colorado?
3.1	Clinically Managed Low-Intensity Residential	Residential	24-hour structure with trained personnel; at least five hours of clinical service/week	No
3.3	Clinically Managed Population-Specific High-Intensity Residential	Residential	24-hour care with trained counselors to stabilize multidimensional imminent danger. Less intense milieu and group treatment for those with cognitive or other impairments.	No
3.5	Clinically Managed High-Intensity Residential	Residential	24-hour care with trained counselors to stabilize and prepare for outpatient treatment.	No
3.7	Medically Monitored Intensive Inpatient	Inpatient	24-hour nursing care with physician availability for significant problems in Dimensions 1, 2 or 3.* Sixteen hour/day counselor ability.	No
4.0	Medically Managed Intensive Inpatient	Inpatient	24-hour nursing care and daily physician care for severe, unstable problems in Dimensions 1, 2 or 3. Counseling available to engage patient in treatment.	Yes *Note: This is medical detox coverage for people with severe and acute medical needs that may result from SUD.*

HOUSE BILL 17-1351 (STUDY INPATIENT SUBSTANCE USE DISORDER TREATMENT)

This act requires the Department of Health Care Policy and Financing (HCPF), with assistance from the Office of Behavioral Health in the Department of Human Services (OBH), to prepare a written report concerning the feasibility of providing *residential* and *inpatient* SUD treatment as part of the Medicaid program or as a state-funded program. The act directs HCPF to consider and report on the following:

- The prevalence of opioid addiction and other SUDs in Colorado;
- Evidence-based best practices for the treatment of SUDs;
- Implementation issues, including any federal authorization necessary to include residential and inpatient SUD treatment services as a Medicaid benefit and existing provider capacity to provide this treatment;
- Estimates of the number of Medicaid clients who may be eligible for these services, and the treatment and administrative costs for providing these services; and
- Information concerning potential cost savings for the Medicaid program or other public assistance programs if these services are included as part of the Medicaid program (e.g., emergency room visits, hospital stays, county law enforcement contacts and jail expenses, etc.).

The act directs the two departments to include recommendations concerning:

- an implementation time frame;
- any necessary statutory changes;
- any changes to training requirements for certified addiction counselors; and
- effective use of state and federal funding and improvement of coordination among state agencies that administer SUD programs.

Finally, the act appropriates $37,500 General Fund to HCPF for FY 2017-18 to prepare the report, and it is anticipated that HCPF could spend $37,500 federal funds for the same purpose. The General Fund appropriation is offset by the transfer of $37,500 cash funds from the Marijuana Tax Cash Fund to the General Fund on June 30, 2018.

REPORT PREPARED BY COLORADO HEALTH INSTITUTE

The Department contracted with the Colorado Health Institute (CHI) to prepare the required report. The report was submitted on November 7, 2017, to the Joint Budget Committee, the Opioid and Other Substance Use Disorders Interim Study Committee, and the relevant House and Senate committees of reference. CHI utilized published research, data analysis, and interviews with stakeholders (providers, consumer advocates, insurers, and state agency staff) to produce the report. CHI indicates that five states[6] have federally approved "1115" Medicaid waivers to offer residential and inpatient SUD treatment services, and another seven states have waiver applications pending. For the purposes of the report, CHI focused on Virginia as the most relevant example for Colorado. Staff has provided a summary of the findings below, including several excerpts from the report. *[Page*

[6] California, Maryland, Massachusetts, Virginia, and West Virginia have existing 1115 waivers that include residential or inpatient substance use disorder treatment. Details of four of these waivers are listed in Appendix E of the report. The report indicates that California was the first to have its waiver approved and services started in July 2016; West Virginia was the most recent state to receive approval in October 2017. None of these states has released a report on costs, savings, or efficacy.

references refer to the CHI report titled: "Exploring Options for Residential and Inpatient Treatment of Substance Use Disorder in Health First Colorado".[7] *]*

PREVALENCE OF SUBSTANCE USE DISORDERS (SUDS)

- "An estimated half a million Coloradans are dependent on alcohol or have used illicit drugs, and about 142,000 of them are enrolled in Health First Colorado. Alcohol remains the most abused substance in Colorado, but a surge of overdose deaths by people who use opioids has focused attention on SUD. Data also show that Medicaid enrollees have slightly higher rates of SUD than non-Medicaid enrollees." *[Page 6]*

- "In 2016, a record 912 Coloradans died of a drug overdose, according to the Colorado Department of Public Health and Environment. The rate of overdoses has increased over time: In 2000, there were 7.8 deaths per 100,000 residents, and in 2016, 16.1 Coloradans per 100,000 residents died due to a drug overdose." *[Page 9]*

- The northeast part of the state and the metro Denver area and surrounding counties have the highest rates of both alcohol and illicit drug dependence or abuse. *[Pages 10 and 11]*

EVIDENCE-BASED BEST PRACTICES FOR THE TREATMENT OF SUDS

- "Helping a person with SUD sustain recovery is a lifelong process that requires close collaboration with his or her multidisciplinary care team… It typically takes a year or more of treatment to recover from SUD. For example, a person might begin in a medically managed withdrawal program, defined here as inpatient treatment, then move into residential treatment, followed by an intensive outpatient program and finally a traditional outpatient program. The person may cycle between levels of care as the severity of the SUD improves or worsens." *[Pages 17-18]*

- "Residential treatment is typically used for people with SUD or SUD and co-occurring mental health issues that need more structured care. Treatment occurs in non-hospital settings and provides a safe housing and recovery environment." *[Page 19]*

- "Under ASAM criteria for placement into residential treatment, an enrollee must not be experiencing withdrawal, and the independent assessor must determine that the enrollee's symptoms can be safely managed in a non-acute setting. In addition, the criteria consider whether candidates for residential treatment have safe or stable home environments to support recovery or whether they have severe mental, cognitive or behavioral problems that require 24-hour residential settings." *[Page 22]*

Staff comment: The General Assembly has increased investments in providing supportive housing options for individuals with SUDs through appropriations to the Department of Local Affairs for the Fort Lyon Supportive Residential Community Program and for affordable housing and supportive services for individuals with behavioral health disorders. To the extent that these investments provide safe and stable home environments to support recovery, they may reduce the number of individuals who require a residential or inpatient level of SUD treatment (or the length of time that individuals require such services).

[7] The report can be accessed at: https://www.colorado.gov/pacific/sites/default/files/HCPF%202017%20Inpatient%20SUD%20Treatment%20Report.pdf

- "ASAM criteria recommends inpatient treatment for patients with severe or unstable SUD symptoms that can be complicated by additional medical issues such as kidney disease or diabetes. Inpatient treatment is for people who require access to a wide range of medical interventions that can only be delivered in a 24-hour medically managed setting." *[Page 22]*

- "A systematic review of the evidence basis for residential treatment found that there are significant methodological challenges with many existing studies but that it can be effective for certain types of patients. The authors of the review concluded that there is a moderate level of evidence of effectiveness, meaning there was either an improvement or no difference in outcomes depending on the study." *[Page 19]*

Staff comment: Through S.B. 16-202, the General Assembly authorized the Department of Human Services (DHS) to contract for an evaluation of the effectiveness of intensive residential treatment of SUD services provided through managed service organizations. DHS and HCPF are required to collaborate with the contractor on the design of the evaluation so that the data and the analyses will be of maximum benefit for evaluating whether the Medicaid behavioral health benefit should be expanded to include intensive residential treatment for SUD. The final report is due to the Joint Budget Committee and the relevant House and Senate committees of reference by February 1, 2019. DHS selected JSI Research and Training Institute, Inc. (JSI) as the contractor to conduct the analysis. Preliminary findings are due to the Department by June 1, 2018.

CAPACITY AND WORKFORCE ISSUES

- "…it is likely that current facility capacity would be unable to meet the estimated demand for beds that a new residential benefit would create. However, it is likely that existing inpatient capacity would be able to absorb the small number of additional enrollees estimated to take advantage of a new inpatient benefit, as those who require medically managed inpatient services are already receiving them — either in a bed designated for substance use or in a general hospital." *[Page 12]*

- "Even if the number of current beds were sufficient to accommodate the number of clients who might need these services, their availability is not widespread enough to serve people in rural parts of the state… Twenty-eight counties do not have OBH-licensed residential and inpatient SUD treatment facilities, community mental health centers, opioid treatment programs, medication-assisted treatment providers or Special Connections providers. These counties include areas of the San Luis Valley, southeast Colorado and northern Colorado." *[Page 12]*

Staff comment: Through S.B. 16-202, the General Assembly has increased state resources available statewide to increase access to effective SUD treatment. These investments are designed to increase system capacity, and many regions are using this funding to increase access to residential treatment.

- "The Department and OBH should continue to work together on outreach to and enrollment of eligible OBH facilities into Medicaid. The Department and the new Regional Accountable Entities (RAEs) would need to contract with and reimburse only for residential or inpatient services that are delivered in qualified OBH-licensed facilities that also meet the conditions of participation in Medicaid." *[Pages 14 and 15]*

- "Colorado's addictions professionals who may be providing services in residential and inpatient settings also would need to meet the criteria to enroll as Health First Colorado providers,

potentially requiring additional training, graduate-level education and licensure for those who currently have only a bachelor's degree and certification….". *[Page 6]*

IMPLEMENTATION ISSUES

- "In order to draw down matching federal funds for an added residential or additional inpatient SUD treatment to Health First Colorado's benefits, the Department would need to seek a Section 1115 [of the federal Social Security Act] waiver from the federal government….Successful pursuit of a waiver, including implementation of the benefit, is likely to require at least two years, with multiple steps and analyses to perform." *[Pages 6 and 7]*

- "Under Section 1115 guidance, the waiver must be budget neutral to the federal government over the span of the demonstration period and any subsequent extensions. This means that actual service expenditures plus any new expenditures authorized under the waiver cannot be greater than projected 'without waiver' expenditures. Other states are predicting budget neutrality by off-setting medical services or by including this expanded SUD treatment option as part of broader payment or delivery-system reform efforts that could help drive down costs over the life of the waiver." *[Page 24]*

- "If Health First Colorado is authorized to pursue a waiver to use federal money for inpatient or residential treatment, the Centers for Medicare & Medicaid Services (CMS) states that ASAM criteria should be used in developing a residential or inpatient treatment benefit and that a full continuum of care should be available to all enrollees." *[Page 22]*

- "The state can also continue funding residential treatment under OBH using block grant, cash fund or General Fund dollars, and can expand access by adding more state funding. This could prove to be the more flexible and faster path forward, due to less stringent provider and education requirements as well as the estimated timeline for pursuing and receiving approval for the waiver." *[Page 23]*

COST ESTIMATES AND POTENTIAL SAVINGS

- CHI constructed a financial model to estimate the costs and benefits of offering these services, and model concludes that it could increase spending by Health First Colorado over a ten year time frame. However, CHI was not able to use claims-level data for Colorado due to privacy restrictions, and data is not yet available from other states with approved waivers. "A more detailed actuarial analysis may point to additional savings that could help offset the costs and support a cost-neutral estimate, as required by the federal waiver that would be needed to add residential and additional inpatient treatment for SUD to Health First Colorado." *[Page 8]*

- CHI estimates that a benefit potentially could be implemented as soon as July 1, 2020. CHI estimates that State expenses, net of savings related to reduced medical expenses, could increase by $34 million in the first year to serve approximately 17,000 Medicaid enrollees[8] and by up to $43 million by year five to serve 20,800 people. *[Pages 7 and 45]*

[8] CHI estimates that 11 percent of Health First Colorado enrollees with an SUD diagnosis would receive inpatient or residential treatment under the new benefit. *[Page 47]*

- The estimated savings in medical expenses are based on the results of a 2006 study finding that patients receiving residential treatment for SUD had lower medical costs compared to those that did not received treatment. The rates of cost reductions included: 63 percent for emergency department visits, 47 percent for hospitalizations, and 57 percent for physician services. However, CHI cautions that "if recent state efforts to reduce ED utilization have resulted in lower costs for SUD-related ED visits already, then the cost reduction may be smaller". *[Pages 45 and 48]*

- "…reports on different state and county programs found high rates of alcohol and drug use and mental illness among Colorado's prison population. The state prison system reported up to 72 percent of inmates had a SUD in 2014, and a statewide jail program showed nearly half of inmates who were screened had some type of SUD" *[Page 21]*

- "Studies of how residential treatment more broadly impacts prisoners suggest that treatment can reduce the risk of an overdose following release, as well as potentially reduce recidivism rates and criminal behavior." *[Page 21]*

Opioid and Other Substance Use Disorders Interim Study Committee Bill

This interim committee approved six bills for introduction in 2018, including a bill that would add residential and inpatient treatment as a benefit under the Colorado Medicaid program. The bill would limit participation to persons who meet nationally recognized, evidence-based level of care criteria for residential and inpatient treatment. The implementation of the benefit would be contingent on federal authorization and federal matching dollars. The bill also states that if the benefit is implemented, managed care organizations shall reprioritize the use of money allocated from the Marijuana Tax Cash Fund pursuant to S.B. 16-202 to assist in providing treatment, including residential and inpatient treatment, to persons who are not otherwise covered by public or private insurance.

The preliminary Legislative Council Staff fiscal note for this bill was prepared prior to the release of the H.B. 17-1351 report. The fiscal note assumed that the benefit would begin July 1, 2020. Based on information that was available at that time, the fiscal note identified the following fiscal impact for the bill:

Fiscal Impact Summary	FY 2018-2019	FY 2019-2020	FY 2020-2021
State Revenue			
State Expenditures	**$491,569**	**$477,860**	**$173,032,786**
General Fund	154,469	147,779	47,948,589
Cash Funds	81,254	77,735	4,402,240
Federal Funds	235,722	225,514	120,655,125
Centrally Appropriated Funds	20,124	26,832	26,832
FTE Position Change	1.5 FTE	2.0 FTE	2.0 FTE
Appropriation Required: $471,445 - Department of Health Care Policy and Financing (FY 2018-19).			
Future Year Impacts: Ongoing expenditure increase.			

The fiscal impact was based on the following assumptions:

- 149,200 adults on Medicaid in FY 2020-21 will have a diagnosed SUD;
- of this group, 13 percent (19,400 clients) will be eligible and choose to seek inpatient or residential treatment; and
- the average cost for persons using the inpatient substance use treatment benefit will be $8,900 per year (based on the experience of West Virginia implementing a similar benefit).

The fiscal note indicated that the actual costs of the benefit will vary depending on the exact terms of the benefit (i.e., allowable numbers of days in treatment, provider rates, prior authorization process, etc.). The fiscal note also indicated that the benefit may reduce other Medicaid expenses (e.g., repeat instances of substance use treatment, emergency care associated with overdose, and long-term medical costs associated with substance use disorders). At the time the fiscal note was prepared, no estimates of these potential savings was available.

CONCLUSIONS AND POTENTIAL NEXT STEPS

The CHI report indicates that experts agree that the Medicaid program has a gap in the range of covered SUD services. This coverage gap is challenging to address, however, due to the federal prohibition on using federal Medicaid funds for care provided in mental health and SUD residential facilities, otherwise known as "institutions for mental disease" (IMDs)[9]. The CHI report indicates that the State would need to pursue a federal 1115 waiver to expand the benefit, and that application would need to be budget neutral to the federal government for over the span of the demonstration project. Cost savings estimates from CHI are not sufficient to offset the projected costs of the expanded service options. However, CHI did not have access to claims-level data and the report indicates that a more detailed actuarial analysis may result in a higher level of savings.

The CHI report indicates that other states are predicting budget neutrality of off-setting medical services or by including the expanded SUD services as part of a broader payment or delivery system reform efforts that could help reduce costs over the course of the waiver time frame.

As described more fully in the next issue brief, the HCPF budget request for FY 2018-19 includes fairly significant reductions in the Medical Services Premiums line item based on savings that will result from the payment and service delivery system reform initiative that was proposed through R6 last year. The Department's savings estimates related to better coordination of physical and behavioral health care under the implementation of H.B. 17-1353 and the new regional accountable entities (RAEs) were based on studies that documented reduced use of emergency department and inpatient hospital services by clients with severe and persistent mental illness (SPMI) and clients with SUDs. Of the total savings estimated by HCPF related to healthcare coordination, 71.8 percent was based on savings associated with clients with SUDs ($42.2 million total funds in FY 2018-19 for a half-year impact and $85.6 million total funds in FY 2019-20).

The CHI study anticipates savings for this same group of Medicaid clients if benefits are expanded to include residential and inpatient services. This raises the question of whether there is some overlap between the two savings estimates, and whether the authorization of residential and inpatient SUD

[9] An IMD facility: has more the 16 beds; is licensed as a psychiatric facility; is maintained primarily for the care of people with mental diseases; and has more than 50 percent of its patients admitted based on mental disease diagnosis.

services would further improve care for these clients and enhance the likely cost savings related to lower uses of inpatient, residential, and physician services.

Staff notes that in FY 2016-17, an estimated $182.9 million was spent (in the Medical Services Premium line item) for the provision of inpatient medical treatment for clients with an SUD diagnosis and acute medical conditions. Another $380,126 was spent on inpatient services that are funded through the Behavioral Health Fee-for-service Payments line item. None of these expenditures are part of the Capitation managed care program. Thus, neither BHOs nor hospitals have a financial incentive to prevent the use of these inpatient services.

In contrast, under the Capitation program BHOs are fully at risk for the full continuum of mental health disorder services – including residential and inpatient psychiatric care. The State has a federal 1915 (b)(3) waiver to pay for clients to receive necessary inpatient hospitalization services at psychiatric facilities that would be considered IMDs[10]. If the Capitation program could be expanded (and the associated federal 1915 (b)(3) waiver amended) to include the full continuum of SUD services, the RAEs would have a financial incentive to increase access to clinically appropriate, cost-effective services for clients with SUDs.

Staff recommends that the Committee ask the Department to discuss the CHI report at their budget hearing, including addressing the following topics:

- What is the current status of the Department's existing federal 1915(b)(3) waiver for the behavioral health Capitation program, and what changes are necessary for the Department to implement Phase II of the Accountable Care Collaborative as planned on July 1, 2018? Would this waiver need to be amended if the Medicaid benefit is expanded to include the full continuum of substance use disorder (SUD) treatment? Should this waiver include the highest level of inpatient care?

- How do existing federal requirements related to institutions for mental disease affect the ability of the Capitation program to provide a full continuum of both mental health and SUD services?

- What would be the benefit of applying for a federal 1115 waiver in order to expand the continuum of SUD services? Should such a waiver application seek to address the IMD restrictions related to both mental health disorder and SUD services?

- How does the Department plan to estimate the cost savings that would result from an expanded SUD Medicaid benefit in light of the significant savings that are already assumed for clients with a SUD based on the implementation of H.B. 17-1353? Does the Department's ongoing Rocky Mountain Health Plans Prime pilot provide any useful data for estimating potential savings related to both efforts?

- Describe existing efforts to expand the number of licensed SUD treatment facilities eligible to receive Medicaid reimbursement. To what extent can the State determine criteria for these facilities and SUD treatment professionals to enroll as Medicaid providers?

[10] Please note that the CHI report indicates that due to a recent change in federal managed care regulations, Medicaid now only pays for 15 days of services in an IMD. Staff does not yet understand how this recent change has affected the BHO contracts and their ability to provide residential or inpatient psychiatric care. This issue is relevant for both mental health and substance use-related services.

ISSUE: ACCOUNTABLE CARE COLLABORATIVES, PHASE II

The Department of Health Care Policy and Financing has announced the entities that it will contract with starting July 1, 2018, to manage the health needs of Medicaid enrollees, including both primary and behavioral health care.

SUMMARY

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

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

- In April 2015, HCPF announced that the administrative functions of the RCCOs and the BHOs will be integrated into a single regional accountable entity (RAE) in each of seven state regions, beginning July 1, 2017. HCPF, however, will pay directly for all clinical services, including behavioral health services. In February 2016, HCPF announced two important changes to this proposal: (a) a one year delay in implementation to July 1, 2018; and (2) retention of a capitation payment methodology for core behavioral health services.

- The Department's FY 2017-18 budget request included a decision item related to ACC Phase II, reflecting modest increase in funding for FY 2017-18 and significant savings starting in FY 2018-19. The Joint Budget Committee sponsored H.B. 17-1353, which authorizes elements to be featured in ACC Phase II, including performance-based incentive payments to behavioral health providers.

- HCPF recently announced that the protest period associated with the request for proposal process for the next phase of the ACC has ended. The proposals from each of the entities that were awarded RAE contracts are now available online. The Department is in the process of negotiating contracts that will go into effect July 1, 2018.

DISCUSSION

BACKGROUND INFORMATION: MEDICAID BEHAVIORAL HEALTH CAPITATION PROGRAM

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

Each BHO receives a pre-determined monthly amount for each Medicaid client who is eligible for behavioral health services within its geographic area. The "per-member-per-month" rates paid to each BHO are unique for each Medicaid eligibility category in each geographic region. These rates are adjusted annually based on client utilization and BHO expenditures. The BHOs function as fully at-risk managed care organizations; they assume the risk of more clients than expected needing care or needing more intensive services than anticipated, and they are incentivized to ensure appropriate levels of care are provided while not exceeding anticipated cost and utilization rates. BHOs share this risk with the not-for-profit community mental health centers (Centers) in their region, providing sub-capitated payments based on the number of clients in their area. In fact, in three of the five regions Centers are part owners of the BHO[11]. As described in the first issue brief, per capita costs under the Capitation program have remained relatively flat.

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

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

ACCOUNTABLE CARE COLLABORATIVE PROGRAM

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

- Regional collaborative care organizations (RCCOs), which are responsible for network development, provider support, care coordination, and accountability and reporting;

[11] These BHOs include: Behavioral Healthcare, Inc. (equally owned by the three Centers that serve Adams, Arapahoe, and Douglas counties and the City of Aurora); Foothills Behavioral Health Partners (equally owned by the two Centers that serve Boulder, Broomfield, Clear Creek, Gilpin, and Jefferson counties and by Beacon Health Options); and Colorado Health Partnerships (equally owned by the eight Centers that serve the 43 counties in southern and western Colorado and by Beacon Health Options).

- Primary care medical providers (PCMPs), which serve as a "medical home" for ACC members; and
- A statewide data and analytics contractor, which provides operational support and data to HCPF, RCCO staff, and PCMPs.

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

ACC Phase II and Regional Accountable Entities

In April 2015, HCPF announced that the administrative functions of the RCCOs and BHOs will be integrated into a single "regional accountable entity" (RAE) in each of seven state regions. HCPF indicates that the goals of the next phase are to: (1) improve health and life outcome for members; and (2) use state resources wisely. The objectives of phase II include the following:

- Join physical and behavioral health under one accountable entity;
- Strengthen coordination of services by advancing team-based care and health neighborhoods;
- Promote member choice and engagement;
- Pay providers for the increased value they deliver; and
- Ensure greater accountability and transparency.

In November 2016 HCPF released a draft request for proposals for phase II. HCPF solicited feedback on the draft RFP from clients, families, advocates, health care providers, vendors, legislators, and the public. HCPF released the final RFP in the Spring of 2017. The resulting contracts will go into effect July 1, 2018, and are anticipated to cover a seven year period (compared to five year term that has been used for BHO contracts).

Some key behavioral health-related changes in Phase II include:

- Functions of the BHOs and the RCCOs will be merged into the new RAEs. Capitation payments will be paid to RAEs, who will be responsible for managing the health needs of Medicaid enrollees in their region.
- The Capitation payment will continue to support a full continuum of behavioral health services, from outpatient therapy to alternative community services to crisis response and hospitalization. This continuum will continue to include the list of alternative services covered by the current capitation program and the associated federal 1915(b)(3) waiver.
- Clients seeking behavioral health services will continue to need to meet standards of "medical necessity". A client will also continue to need to have a "covered diagnosis" for Medicaid to pay for emergency department visits, inpatient hospitalization, and laboratory tests. However, requirements that a client have a covered diagnosis to receive behavioral health services will be relaxed to allow clients to receive limited therapies in a physical health setting.
- New performance incentives will reward increased behavioral health screening and the co-location of physical health and behavioral health services.
- RCCO and BHO regions would be realigned, affecting two counties. *Elbert County* would move from the region that includes El Paso, Teller, and Park counties to the region that includes Douglas, Arapahoe, and Adams counties. Behavioral health services for *Larimer County* would move to the region that includes all the western counties. *[See Appendix G for a map of current BHO*

regions, Appendix H for a map of the current RCCO regions, and Appendix I for a map of the proposed RAE regions.]

- Clients would be attributed to RAEs based on the location of their primary care provider, rather than their own address, to reduce the number of RAEs that a primary care provider might need to contract with.

HOUSE BILL 17-1353 (IMPLEMENT MEDICAID DELIVERY & PAYMENT INITIATIVES)

The HCPF budget request for FY 2017-18 included a decision item (R6) concerning the ACC. Overall, HCPF requested a net increase of $3.2 million total funds (including a decrease of $200,342 General Fund), for a number of changes that the Department characterized as delivery system and payment reforms. HCPF proposed taking a portion of the money currently paid to certain providers and transforming it into incentive payments based on health outcomes and performance. With respect to behavioral health, incentive payments would be financed using the savings from further projected decreases (estimated at 4.0 percent) in behavioral health capitation rates. The behavioral health performance payments related to FY 2017-18 would not be paid out until FY 2018-19, resulting in a one-time savings in FY 2017-18. These savings offset funding requests for administrative expenses and continuation of the "primary care rate bump".

The Joint Budget Committee sponsored legislation last session to provide a statutory framework for the existing ACC. House Bill 17-1353 also authorizes elements that will be featured in phase II of the ACC, authorizes performance-based payments to providers, and places guidelines and reporting requirements on these initiatives. *[For a more complete description of the act, see Appendix B.]*

The act was not expected to have any fiscal impact on FY 2017-18 expenditures, but the act was anticipated to result in costs and savings beginning in FY 2018-19. Anticipated costs and savings related to behavioral health programs are highlighted in Table 10.

TABLE 10:
ACCOUNTABLE CARE COLLABORATIVE/PERFORMANCE-BASED PAYMENTS LEGISLATION

	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FEDERAL FUNDS	FTE
FY 2018-19					
Accountable Care Collaborative (ACC)					
Administrative staff	$268,092	$134,046	$0	$134,046	3.7
Mandatory enrollment	29,183,877	11,177,425	1,138,171	16,868,281	
Increase PMPM by $1	15,086,585	5,778,162	588,377	8,720,046	
Savings - Mandatory enrollment	(50,830,650)	(21,621,473)	(1,882,759)	(27,326,418)	
Savings - Physical-behavioral health coordination	(57,785,147)	(15,364,614)	(1,897,370)	(40,523,163)	
Subtotal - ACC	*($64,077,243)*	*($19,896,454)*	*($2,053,581)*	*($42,127,208)*	*3.7*
Performance payments					
Rate analyst	$66,999	$33,499	$0	$33,500	0.9
Primary care	58,062,151	20,231,923	1,159,202	36,671,026	
Federally Qualified Health Centers	0	0	0	0	
Behavioral Health	26,717,069	7,215,319	1,090,836	18,410,914	
Subtotal - Performance payments	*$84,846,219*	*$27,480,741*	*$2,250,038*	*$55,115,440*	*0.9*
TOTAL FY 2018-19	**$20,768,976**	**$7,584,287**	**$196,457**	**$12,988,232**	**4.6**

TABLE 10:
ACCOUNTABLE CARE COLLABORATIVE/PERFORMANCE-BASED PAYMENTS LEGISLATION

	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FEDERAL FUNDS	FTE
FY 2019-20					
Accountable Care Collaborative (ACC)					
Administrative staff	$271,907	$135,953	$0	$135,954	4.0
Mandatory enrollment	26,169,379	10,022,872	1,020,606	15,125,901	
Increase PMPM by $1	15,379,665	5,890,412	599,807	8,889,446	
Savings - Mandatory enrollment	(95,391,901)	(41,260,953)	(3,155,463)	(50,975,485)	
Savings - Physical-behavioral health coordination	(117,205,890)	(31,164,084)	(4,909,831)	(81,131,975)	
Subtotal – ACC	*($170,776,841)*	*($56,375,801)*	*($6,444,881)*	*($107,956,159)*	**4.0**
Performance payments					
Contract performance evaluator	$150,000	$75,000	$0	$75,000	
Rate analyst	67,977	33,988	0	33,989	1.0
Primary care	59,055,014	20,577,889	1,492,346	36,984,779	
Federally Qualified Health Centers	0	0	0	0	
Behavioral Health	28,131,120	7,503,004	1,306,187	19,321,929	
Subtotal - Behavioral health	*$87,404,111*	*$28,189,881*	*$2,798,533*	*$56,415,697*	*1.0*
TOTAL FY 2018-19	**($83,372,730)**	**($28,185,920)**	**($3,646,348)**	**($51,540,462)**	**5.0**

- *Savings.* HCPF anticipates that better coordination of physical and behavioral health care will lead to improved clinical outcomes. The Department's related savings estimates in R6 were based on several studies that identified net cost savings associated with integrating primary and behavioral healthcare. These documented savings, however, pertain only to clients with severe and persistent mental illness (SPMI) and clients with substance use disorders (SUDs). The savings for both populations primarily relate to reduced use of emergency department and inpatient hospital services, and thus primarily affect the Medical Services Premiums line item rather than any appropriations in the Behavioral Health section. Specifically, HCPF estimated the following savings:
  - Savings of $16.6 million in FY 2018-19 (for six months) and $33.6 million in FY 2019-20 based on monthly savings of $44.96 per client with SPMI. These projected savings include $5.4 million General Fund in FY 2018-19 and $11.1 million General Fund in FY 2019-20.
  - Savings of $42.2 million in FY 2018-19 (for six months) and $85.6 million in FY 2019-20 based on monthly savings of $77.03 per client with SUD. These projected savings include $10.2 million General Fund in FY 2018-19 and $20.6 million General Fund in FY 2019-20.

- *Performance Payments.* The Department proposes making incentive payments to providers based on performance measures related to improved health outcomes and lower costs. As anticipated, HCPF's FY 2018-19 budget request for behavioral health programs includes $26.7 million to make incentive payments to behavioral health organizations for services provided in FY 2017-18.

OUTCOME OF PROCUREMENT PROCESS

The Department recently announced that that the protest period associated with the Request for Proposal for the RAEs for the next iteration of the ACC has ended. The following table lists the entities that will be awarded RAE contracts, along with the existing behavioral health organizations (BHOs) and regional accountable collaborative entities (RCCOs).

CURRENT AND FUTURE VENDORS FOR MEDICAID BEHAVIORAL HEALTH CAPITATION				
REGION	COUNTIES (BASED ON REVISED RAE REGIONS)	CURRENT BHO	CURRENT RCCO	RAE AWARDEE
1	Archuleta, Delta, Dolores, Eagle, Garfield, Grand, Gunnison, Hinsdale, Jackson, La Plata, *Larimer*, Mesa, Moffat, Montezuma, Montrose, Ouray, Pitkin, Rio Blanco, Routt, San Juan, San Miguel, and Summit	Colorado Health Partnerships	Rocky Mountain Health Plans	Rocky Mountain Health Plans
2	Adams, Arapahoe, and Douglas	Behavioral Healthcare, Inc.	Colorado Access	Northeast Health Partners
3	Cheyenne, *Elbert*, Kit Carson, Lincoln, Logan, Morgan, Phillips, Sedgwick, Washington, Weld, and Yuma	Colorado Access	Colorado Access	Colorado Access
4	Alamosa, Baca, Bent, Chaffee, Conejos, Costilla, Crowley, Custer, Fremont, Huerfano, Kiowa, Lake, Las Animas, Mineral, Otero, Prowers, Pueblo, Rio Grande, and Saguache	Colorado Health Partnerships	Integrated Community Health Partners	Health Colorado, Inc.
5	Denver	Colorado Access	Colorado Access	Colorado Access
6	Boulder, Broomfield, Clear Creek, Gilpin, and Jefferson	Foothills Behavioral Health Partners	CO Community Health Alliance	CO Community Health Alliance
7	El Paso, Elbert, Park, and Teller	Colorado Health Partnerships	Community Care of Central Colorado	CO Community Health Alliance

The Department has made available online the proposals from each of the awarded entities on CO.gov/HCPF/ACCPhase2. The Department indicates that it is continuing to prepare for the implementation of the next phase of the ACC and will be immediately focusing on contract negotiations with the new vendors. In early 2018, the Department will begin sharing more detailed information and plans to help providers and stakeholders prepare for the program transition. The Department prepared the following graphic to illustrate major implementation milestones.

In addition to being eligible to receive incentive payments in FY 2018-19 related to services provided in FY 2017-18, BHOs are contractually required to perform certain activities after June 30, 2018, including:

- continuing to paying claims for services provided in FY 2017-18;
- resolving outstanding grievances and appeals;
- participating in any State Fair Hearings;
- submitting audited financial statements;
- submitting encounter data; and
- providing other financial reports such as TPL, Waiver Services, and Graduate Medical Education.

The Department indicates that all BHOs have all submitted closeout plans, which will continue to be developed over the next few months to ensure that the plans are sound and attainable. Additionally, the BHO contracts are being amended to require that the BHOs maintain records for at least 10 years, as opposed to six, to comply with various regulations at the State and Federal levels.

Appendix A: Number Pages

	FY 2015-16 Actual	FY 2016-17 Actual	FY 2017-18 Appropriation	FY 2018-19 Request	Request vs. Appropriation
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING					
Tom Massey, Interim Executive Director					
(3) BEHAVIORAL HEALTH COMMUNITY PROGRAMS					
This section provides funding for the purchase of behavioral healthcare services from five regional behavioral health organizations (BHOs). Each BHO manage mental health and substance use disorder services for eligible Medcaid clients through a capitated, risk-based funding model. This section also provides funding for Medicaid behavioral health fee-for-service programs for those mental health and substance use disorder services not covered within the capitation contracts and rates. This section is primarily supported by federal Medicaid funds, General Fund, and the Colorado Healthcare Affordability and Sustainability Cash Fund.					
Behavioral Health Capitation Payments	603,218,669	603,888,726	616,836,053	680,689,768 *	
General Fund	166,102,477	157,456,205	172,509,947	187,100,392	
Cash Funds	9,773,437	17,292,866	25,816,287	31,827,726	
Reappropriated Funds	0	0	0	0	
Federal Funds	427,342,755	429,139,655	418,509,819	461,761,650	
Behavioral Health Fee-for-service Payments	8,086,839	7,793,562	8,961,518	9,282,939 *	
General Fund	1,881,329	1,762,029	1,936,255	1,998,416	
Cash Funds	71,017	189,409	374,248	433,958	
Federal Funds	6,134,493	5,842,124	6,651,015	6,850,565	
TOTAL - (3) Behavioral Health Community Programs	611,305,508	611,682,288	625,797,571	689,972,707	10.3%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	167,983,806	159,218,234	174,446,202	189,098,808	8.4%
Cash Funds	9,844,454	17,482,275	26,190,535	32,261,684	23.2%
Reappropriated Funds	0	0	0	0	0.0%
Federal Funds	433,477,248	434,981,779	425,160,834	468,612,215	10.2%

An asterisk (*) indicates that the FY 2018-19 request for a line item is affected by one or more decision items.

APPENDIX B
RECENT LEGISLATION AFFECTING DEPARTMENT BUDGET

2016 SESSION BILLS

H.B. 16-1407 (EXTEND MEDICAID PAYMENT REFORM & INNOVATION PILOT): Extends the Medicaid Payment Reform and Innovation Pilot Program (established through H.B. 12-1281) that allows contractors to work with providers and managed care entities to develop a payment reform project and submit a proposal to the Department. Removes statutory dates concerning the selection of and completion of payment reform projects, allowing projects that have been approved to continue beyond June 30, 2016, and allowing the Department to continue selecting new projects for the Pilot Program. Amends associated evaluation and reporting requirements. Appropriates $245,639 General Fund to the Department of Health Care Policy and Financing for FY 2016-17, and states that the appropriation is based on the assumptions that the Department will require an additional 1.0 FTE and that the Department will receive $347,064 federal funds to implement the act. This funding essentially reinstates full funding for the Department to evaluate proposals that are submitted, validate and certify provider rates, review managed care contracts, evaluate the payment reform projects that are approved, and prepare the required reports.

2017 SESSION BILLS

S.B. 17-242 (MODERNIZING BEHAVIORAL HEALTH TERMINOLOGY): Updates and modernizes terminology in the Colorado Revised Statutes related to behavioral health, mental health, alcohol abuse, and substance abuse. Based on specific contexts, the new terminology refers to behavioral health disorders, mental health disorders, alcohol use disorders, or substance use disorders. Outdated references to a certain "unit" in the Department of Human Services that administers behavioral health programs and services are updated to specify the "Office of Behavioral Health". The key definitions that were added or amended are excerpted below:

- *"Alcohol use disorder"* means a condition by which a person habitually lacks self-control as to the use of alcoholic beverages or uses alcoholic beverages to the extent that his or her health is substantially impaired or endangered or his or her social or economic function is substantially disrupted. Nothing in this subsection (1) precludes the denomination of a person with an alcohol use disorder as intoxicated by alcohol or incapacitated by alcohol. [Behavioral Health: Section 27-81-102 (1), C.R.S.]
- *"Behavioral health"* refers to an individual's mental and emotional well-being and actions that affect an individual's overall wellness. Behavioral health problems and disorders include substance use disorders, serious psychological distress, suicide, and other mental health disorders. Problems ranging from unhealthy stress or subclinical conditions to diagnosable and treatable diseases are included in the term "behavioral health". The term "behavioral health" is also used to describe service systems that encompass prevention and promotion of emotional health, prevention and treatment services for mental health and substance use disorders, and recovery support. [General Assembly: Section 2-4-401 (1), C.R.S.; also Behavioral Health: Sections 27-60-100.3 (1) and 27-61-101.5 (1), C.R.S.]

- *"Biologically based mental health disorder"* means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder. [Insurance: Section 10-16-104 (5.5)(a)(IV)(B), C.R.S.]
- *"Mental health disorder"* includes one or more substantial disorders of the cognitive, volitional, or emotional processes that grossly impairs judgment or capacity to recognize reality or to control behavior. An intellectual or developmental disability is insufficient to either justify or exclude a finding of a mental health disorder pursuant to the provisions of this article 65. [Behavioral Health: Section 27-65-102 (11.5), C.R.S.]
- *"Substance use disorder"* means a physical or psychological dependence on a controlled substance that develops following the use of the controlled substance on a periodic or continuing basis and is demonstrated by appropriate observation and tests by a person licensed to practice medicine pursuant to Article 36 of Title 12. [Behavioral Health: Section 27-80-203 (23.3), C.R.S.]

S.B. 17-267 (SUSTAINABILITY OF RURAL COLORADO): With respect to behavioral health programs, the act repeals the Hospital Provider Fee and creates the Healthcare Affordability and Sustainability (HAS) Fee as part of an enterprise for purposes of the Taxpayer's Bill of Rights (TABOR) such that the revenue from the HAS Fee does not count against the state fiscal year spending limit (Referendum C cap).

For FY 2017-18, the act replaces $597,380,996 in cash fund appropriations to the Department of Health Care Policy and Financing from the Hospital Provider Fee with cash fund appropriations from the Healthcare Affordability and Sustainability Fee Cash Fund (HAS Fee CF). In addition, the appropriation includes for the Department of Health Care Policy and Financing $264,100,000 from the HAS Fee CF and an anticipated like amount of federal funds, which is the amount of provider fees from hospitals that was restricted in S.B. 17-256. The appropriation also reduces the Department of Health Care Policy and Financing by $1,818,901 total funds, including $320,035 General Fund, $64,835 cash funds, and $1,434,031 federal funds based on the projected fiscal impact of the increase in Medicaid copayments.

H.B. 17-1351 (STUDY INPATIENT SUBSTANCE USE DISORDER TREATMENT): Requires the Department of Health Care Policy and Financing (HCPF), with assistance from the Department of Human Services' Office of Behavioral Health, to prepare a written report concerning the feasibility of providing residential and inpatient substance use disorder treatment as part of the Medicaid program or as a state-funded benefit. Requires HCPF to submit the report to several legislative committees by November 1, 2017. Requires the State Treasurer to transfer $37,500 cash funds from the Marijuana Tax Cash Fund to the General Fund on June 30, 2018. Appropriates $37,500 General Fund to HCPF for FY 2017-18, and states that this appropriation is based on the assumption that HCPF will receive $37,500 federal funds to implement the act.

H.B. 17-1353 (IMPLEMENT MEDICAID DELIVERY & PAYMENT INITIATIVES): Provides a statutory framework for the existing Accountable Care Collaborative (ACC), authorizes elements that will be featured in phase II of the ACC, authorizes performance-based payments to providers, and places guidelines and reporting requirements on these initiatives. With regard to the Accountable Care Collaborative, the act:

- Lists elements that must be included in the ACC, such as providing a primary care medical home for all Medicaid clients and integrating the delivery of behavioral health and physical health services
- Requires the creation of stakeholder advisory committees

- Requires an annual report on the ACC. The statutory annual report combines elements of an existing statutory report and an annual request for information submitted by the JBC.
- Requires a report outlining changes required to align state statute with a new federal rule regarding managed care
- Clarifies that the Medical Services Board has oversight and must promulgate rules to implement the ACC

Regarding performance-based payments, the bill:

- Authorizes the Department to implement performance-based payments and specifically authorizes performance payments for:
    - Primary care providers
    - Federally qualified health centers
    - Providers of long-term services and supports
    - Behavioral health providers
- Requires that prior to implementing performance payments the Department must submit to the Joint Budget Committee:
    - Either:
        i. Evidence that the payments are designed to achieve budget savings, or
        ii. A budget request for costs associated with the performance-based payments
    - The estimated performance-based payments compared to total reimbursements for the affected service
    - A description of the stakeholder engagement process and the Department's response to stakeholder feedback
- Requires an annual report on performance payments including factors such as the evidence for the performance payments, the expected outcomes, the stakeholder engagement process, and evaluation results

The act is not expected to have any fiscal impact on FY 2017-18 expenditures, but there are projected costs and savings associated with different elements beginning in FY 2018-19 as summarized in the table below.

ACCOUNTABLE CARE COLLABORATIVE/PERFORMANCE-BASED PAYMENTS LEGISLATION					
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FEDERAL FUNDS	FTE
FY 2018-19					
Accountable Care Collaborative (ACC)					
Administrative staff	$268,092	$134,046	$0	$134,046	3.7
Mandatory enrollment	29,183,877	11,177,425	1,138,171	16,868,281	
Increase PMPM by $1	15,086,585	5,778,162	588,377	8,720,046	
Savings - Mandatory enrollment	(50,830,650)	(21,621,473)	(1,882,759)	(27,326,418)	
Savings - Physical-behavioral health	(57,785,147)	(15,364,614)	(1,897,370)	(40,523,163)	
Subtotal - ACC	*($64,077,243)*	*($19,896,454)*	*($2,053,581)*	*($42,127,208)*	*3.7*
Performance payments					
Rate analyst	$66,999	$33,499	$0	$33,500	0.9
Primary care	58,062,151	20,231,923	1,159,202	36,671,026	
Federally Qualified Health Centers	0	0	0	0	
Behavioral Health	26,717,069	7,215,319	1,090,836	18,410,914	
Subtotal - Performance payments	*$84,846,219*	*$27,480,741*	*$2,250,038*	*$55,115,440*	*0.9*
TOTAL FY 2018-19	**$20,768,976**	**$7,584,287**	**$196,457**	**$12,988,232**	**4.6**

ACCOUNTABLE CARE COLLABORATIVE/PERFORMANCE-BASED PAYMENTS LEGISLATION					
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FEDERAL FUNDS	FTE
FY 2019-20					
Accountable Care Collaborative (ACC)					
Administrative staff	$271,907	$135,953	$0	$135,954	4.0
Mandatory enrollment	26,169,379	10,022,872	1,020,606	15,125,901	
Increase PMPM by $1	15,379,665	5,890,412	599,807	8,889,446	
Savings - Mandatory enrollment	(95,391,901)	(41,260,953)	(3,155,463)	(50,975,485)	
Savings - Physical-behavioral health	(117,205,890)	(31,164,084)	(4,909,831)	(81,131,975)	
Subtotal - ACC	*($170,776,841)*	*($56,375,801)*	*($6,444,881)*	*($107,956,159)*	**4.0**
Performance payments					
Contract performance evaluator	$150,000	$75,000	$0	$75,000	
Rate analyst	67,977	33,988	0	33,989	1.0
Primary care	59,055,014	20,577,889	1,492,346	36,984,779	
Federally Qualified Health Centers	0	0	0	0	
Behavioral Health	28,131,120	7,503,004	1,306,187	19,321,929	
Subtotal - Behavioral health	*$87,404,111*	*$28,189,881*	*$2,798,533*	*$56,415,697*	*1.0*
TOTAL FY 2018-19	**($83,372,730)**	**($28,185,920)**	**($3,646,348)**	**($51,540,462)**	**5.0**

APPENDIX C
FOOTNOTES AND INFORMATION REQUESTS

UPDATE ON LONG BILL FOOTNOTES

The FY 2017-18 Long Bill does not include any footnotes that directly pertain to the Behavioral Health Community Programs section.

UPDATE ON REQUESTS FOR INFORMATION

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

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

APPENDIX D
DEPARTMENT ANNUAL PERFORMANCE REPORT

Pursuant to Section 2-7-205 (1)(a)(I), C.R.S., by November 1 of each year, the Office of State Planning and Budgeting is required to publish an **Annual Performance Report** for the *previous fiscal year* for the Department of Health Care Policy and Financing. This report is to include a summary of the Department's performance plan and most recent performance evaluation for the designated fiscal year. In addition, pursuant to Section 2-7-204 (3)(a)(I), C.R.S., the Department of Health Care Policy and Financing is required to develop a **Performance Plan** and submit the plan for the *current fiscal year* to the Joint Budget Committee and appropriate Joint Committee of Reference by July 1 of each year.

As of the date the of this briefing, the Department of Health Care Policy and Financing's FY 2016-17 Annual Performance Report has not been made available by the Office of State Planning and Budgeting. The Department's the FY 2017-18 Performance Plan can be found at the following link:

https://www.colorado.gov/pacific/performancemanagement/department-performance-plans

APPENDIX E
FY 2017-18 BEHAVIORAL HEALTH CAPITATION PAYMENTS CALCULATIONS

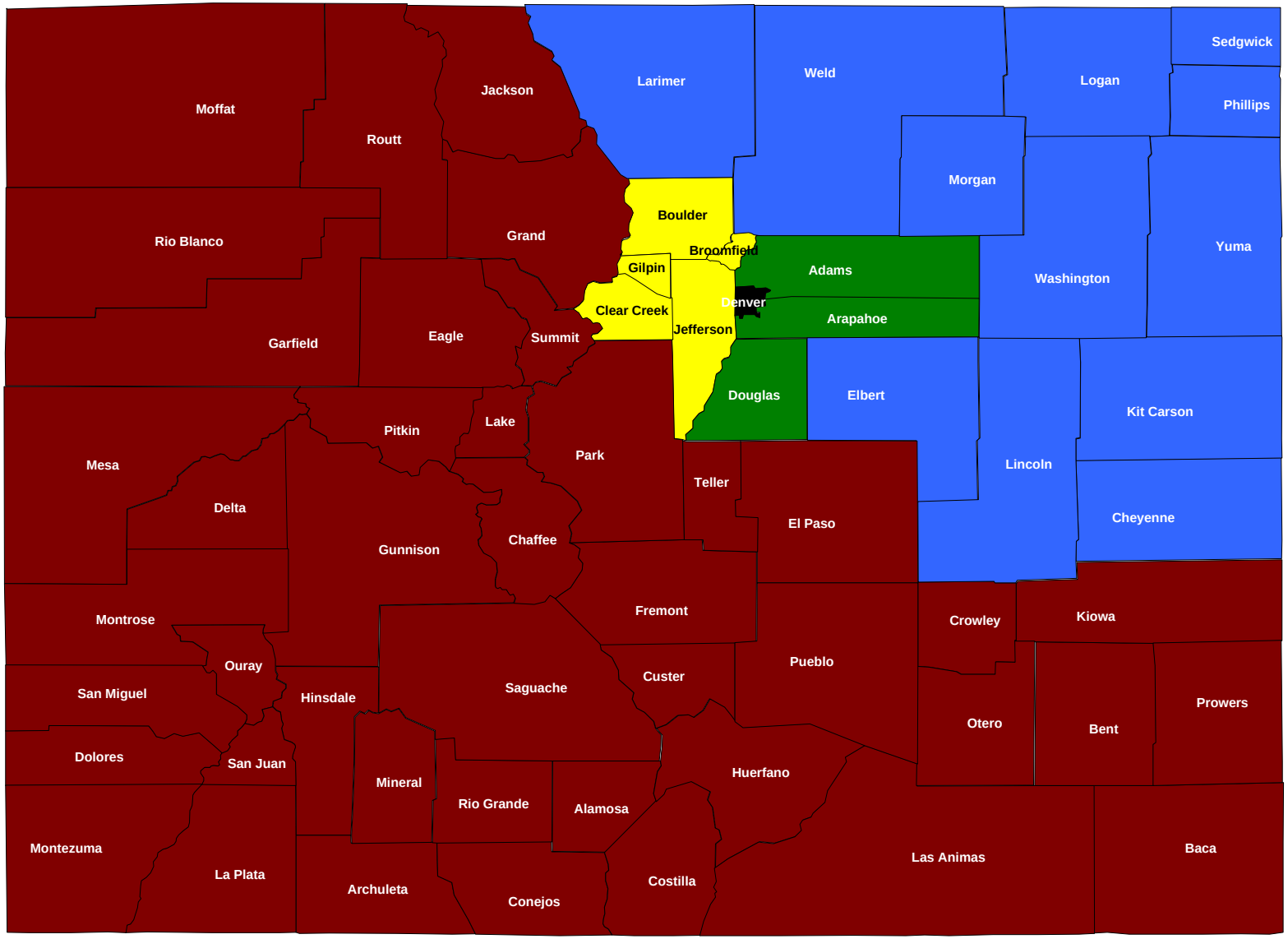
	Eligibility Category								
Description	Adults Age 65+ (to SSI)	Individuals With Disabilities up to age 64 (to 450% FPL)	Parents/ Caretakers (to 68% FPL); Pregnant Adults (to 200% FPL)	Parents/ Caretakers (69% to 138% FPL)*	Adults without Dependent Children (to 138% FPL)*	Children (to 147% FPL)	Individuals In/ Formerly In Foster Care (up to age 26)	Breast and Cervical Cancer Program (to 250% FPL)	Total
Weighted capitation rate (per member, per month)	$18.86	$135.45	$29.54	$14.67	$46.88	$19.88	$121.70	$29.54	
Estimated monthly caseload	45,242	87,235	202,411	91,246	380,104	535,090	20,584	117	1,362,029
Number of months rate is effective	12	12	12	12	12	12	12	12	
Total estimated capitated payments	**$10,239,169**	**$141,791,769**	**$71,750,651**	**$16,062,946**	**$213,831,306**	**$127,651,070**	**$30,060,874**	**$41,474**	**$611,429,260**
Estimated expenditures:									
Claims paid in current period	$10,203,332	$141,508,185	$71,513,874	$15,958,537	$213,018,747	$127,344,707	$30,027,807	$41,424	$609,616,613
Claims from prior periods	32,638	282,386	198,862	237,193	816,531	301,696	33,033	100	1,902,439
Estimated date of death retractions	(209,638)	(663,050)	(35,614)	(10,842)	(486,874)	(18,396)	(46,874)	(1,708)	(1,472,996)
Total expenditures after retractions	$10,026,332	$141,127,521	$71,677,122	$16,184,888	$213,348,404	$127,628,007	$30,013,966	$39,816	$610,046,056
Other payment adjustments:									
Risk corridor reconciliation	$0	$0	$0	($4,546,673)	($43,719,444)	$0	$0	$0	($48,266,117)
Expansion parent rate reconciliation	0	0	0	(17,786,031)	0	0	0	0	(17,786,031)
Adjustment for children incorrectly placed in disability eligibility category	0	(1,848,939)	0	0	0	0	0	0	(1,848,939)
Adjustment for parents/caretakers eligible for transitional Medicaid	0	0	1,867,361	0	0	0	0	0	1,867,361
Health insurance provider fee payment	74,157	1,236,770	527,425	527,873	2,001,905	1,158,211	363,925	1,221	5,891,487
NET EXPENDITURES	**$10,100,489**	**$140,515,352**	**$74,071,908**	**($5,619,943)**	**$171,630,865**	**$128,786,218**	**$30,377,891**	**$41,037**	**$549,903,817**
Annual per capita expenditure (excluding payment adjustments)	**$221.62**	**$1,617.79**	**$354.12**	**$177.38**	**$561.29**	**$238.52**	**$1,458.12**	**$340.31**	**$447.90**

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

APPENDIX F
FY 2018-19 BEHAVIORAL HEALTH CAPITATION PAYMENTS CALCULATIONS

	Eligibility Category								
Description	Adults Age 65+ (to SSI)	Individuals With Disabilities up to age 64 (to 450% FPL)	Parents/ Caretakers (to 68% FPL); Pregnant Adults (to 200% FPL)	Parents/ Caretakers (69% to 138% FPL)*	Adults without Dependent Children (to 138% FPL)*	Children (to 147% FPL)	Individuals In/ Formerly In Foster Care (up to age 26)	Breast and Cervical Cancer Program (to 250% FPL)	Total
Weighted capitation rate (per member, per month)	$19.70	$137.25	$31.18	$15.48	$49.47	$20.61	$123.60	$31.18	
Estimated monthly caseload	45,993	90,748	210,047	98,254	393,958	540,205	20,746	62	1,400,013
Number of months rate is effective	12	12	12	12	12	12	12	12	
Total estimated capitated payments	**$10,872,745**	**$149,461,956**	**$78,591,186**	**$18,251,663**	**$233,869,227**	**$133,603,501**	**$30,770,467**	**$23,198**	**$655,443,943**
Estimated expenditures:									
Claims paid in current period	$10,834,690	$149,163,032	$78,331,835	$18,133,027	$232,980,524	$133,282,853	$30,736,619	$23,170	$653,485,750
Claims from prior periods	35,837	283,584	236,777	104,409	812,559	306,363	33,067	50	1,812,646
Estimated date of death retractions	(188,674)	(596,745)	(32,053)	(9,758)	(438,187)	(16,556)	(42,187)	(1,537)	(1,325,697)
Total expenditures after retractions	$10,681,853	$148,849,871	$78,536,559	$18,227,678	$233,354,896	$133,572,660	$30,727,499	$21,683	$653,972,699
Other payment adjustments:									
Risk corridor reconciliation	$0	$0	$0	$0	$0	$0	$0	$0	$0
Expansion parent rate reconciliation	0	0	0	0	0	0	0	0	0
Adjustment for children incorrectly placed in disability eligibility category	0	0	0	0	0	0	0	0	0
Adjustment for parents/caretakers eligible for transitional Medicaid	0	0	0	0	0	0	0	0	0
Health insurance provider fee payment	0	0	0	0	0	0	0	0	0
Estimated incentive payments	336,290	5,608,581	2,391,800	2,393,829	9,078,360	5,252,324	1,650,350	5,535	26,717,069
NET EXPENDITURES	**$11,018,143**	**$154,458,452**	**$80,928,359**	**$20,621,507**	**$242,433,256**	**$138,824,984**	**$32,377,849**	**$27,218**	**$680,689,768**
Annual per capita expenditure (excluding payment adjustments)	**$232.25**	**$1,640.26**	**$373.90**	**$185.52**	**$592.33**	**$247.26**	**$1,481.13**	**$349.73**	**$467.12**

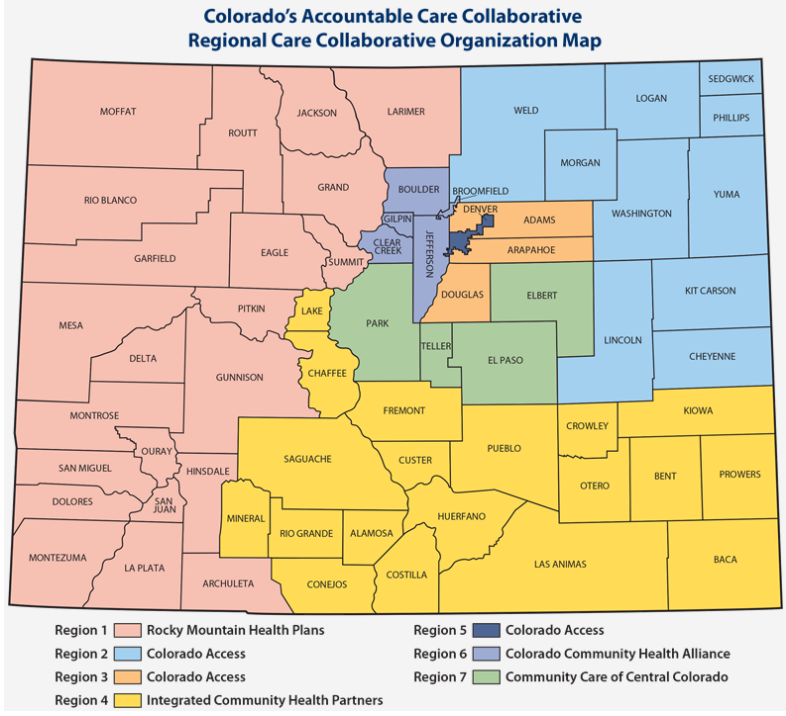
* These are new eligibility categories authorized by S.B. 13-200.



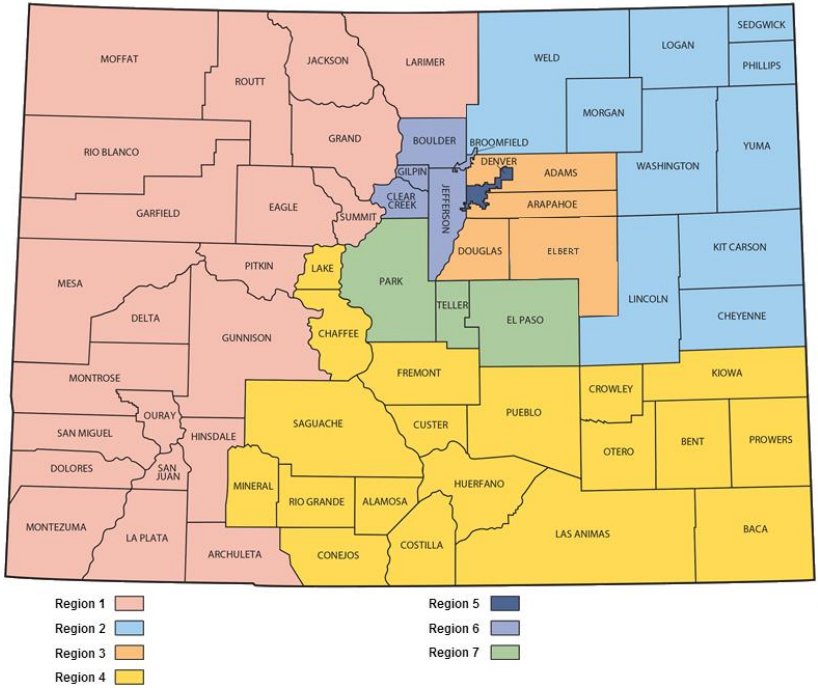
Colorado Medicaid Capitation Behavioral Health Organizations by Geographic Service Area

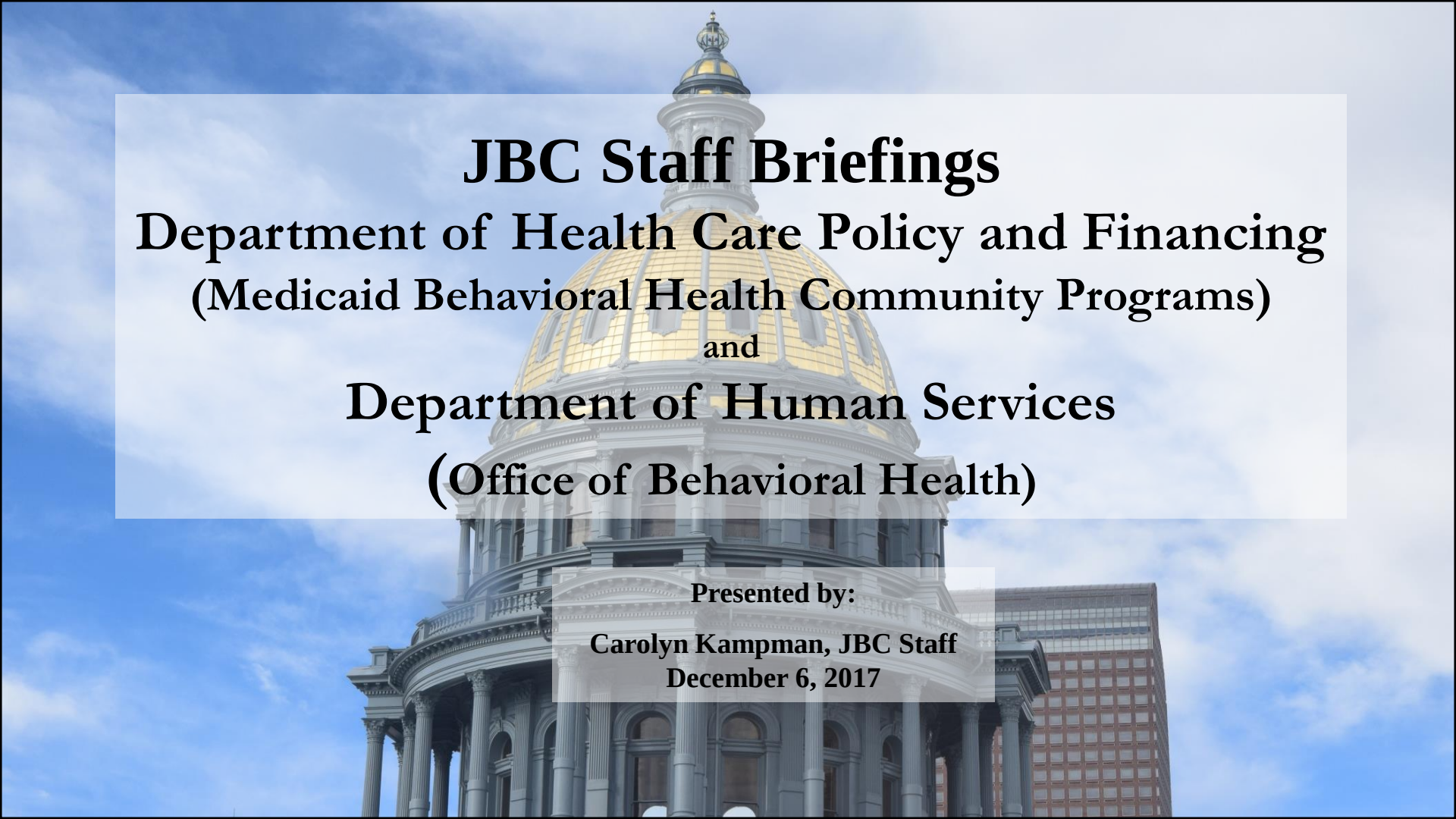
- Northeast: Access Behavioral Care (Colorado Access)
- Metro: Access Behavioral Care (Colorado Access)
- Metro West: Foothills Behavioral Health Partners, LLC
- Metro East: Behavioral Healthcare, Inc.
- Colorado Health Partnerships, LLC

ACC Phase I: Current RCCO Map



ACC Phase II: Regional Accountable Entity Map





JBC Staff Briefings

Department of Health Care Policy and Financing

(Medicaid Behavioral Health Community Programs)

and

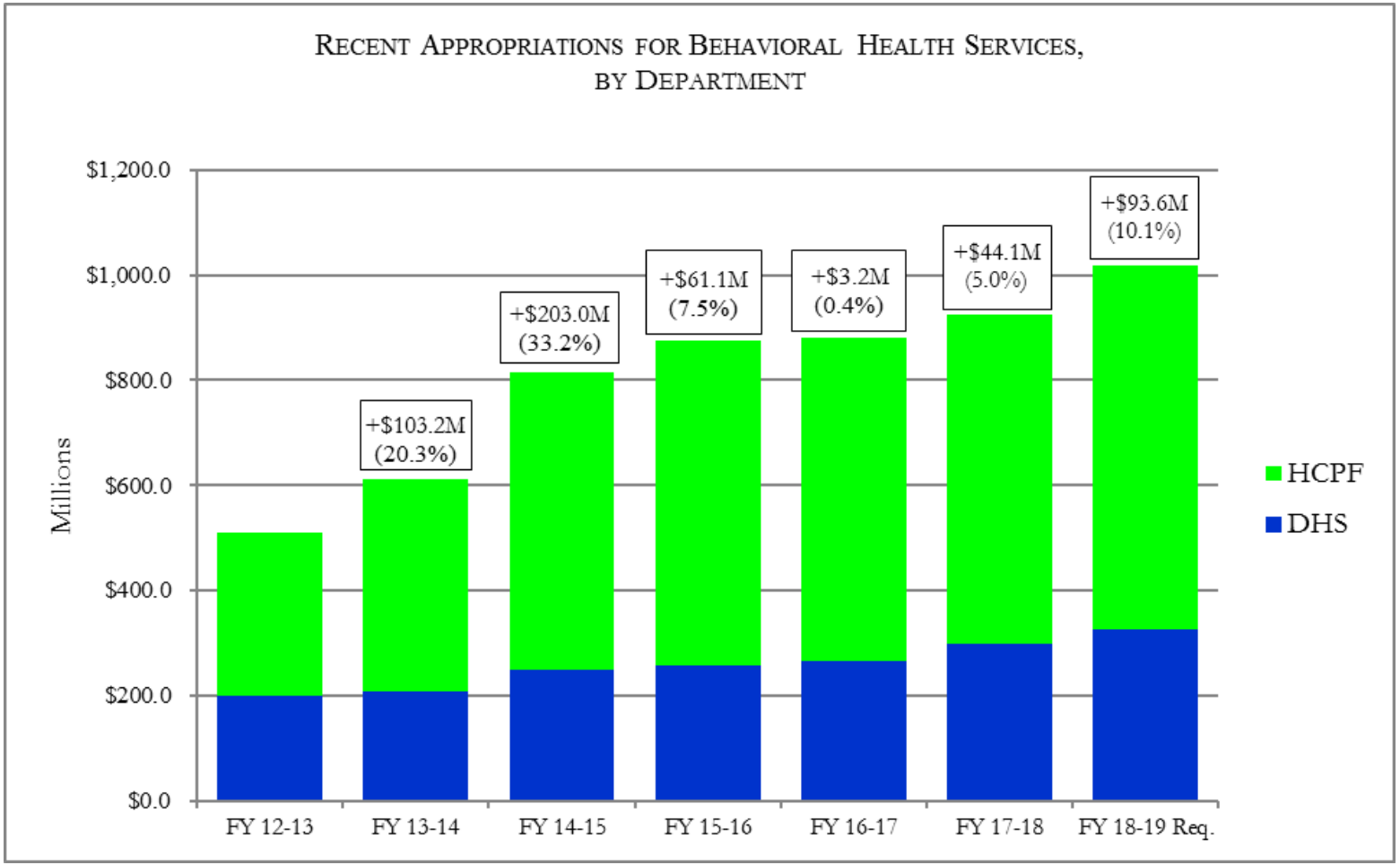
Department of Human Services

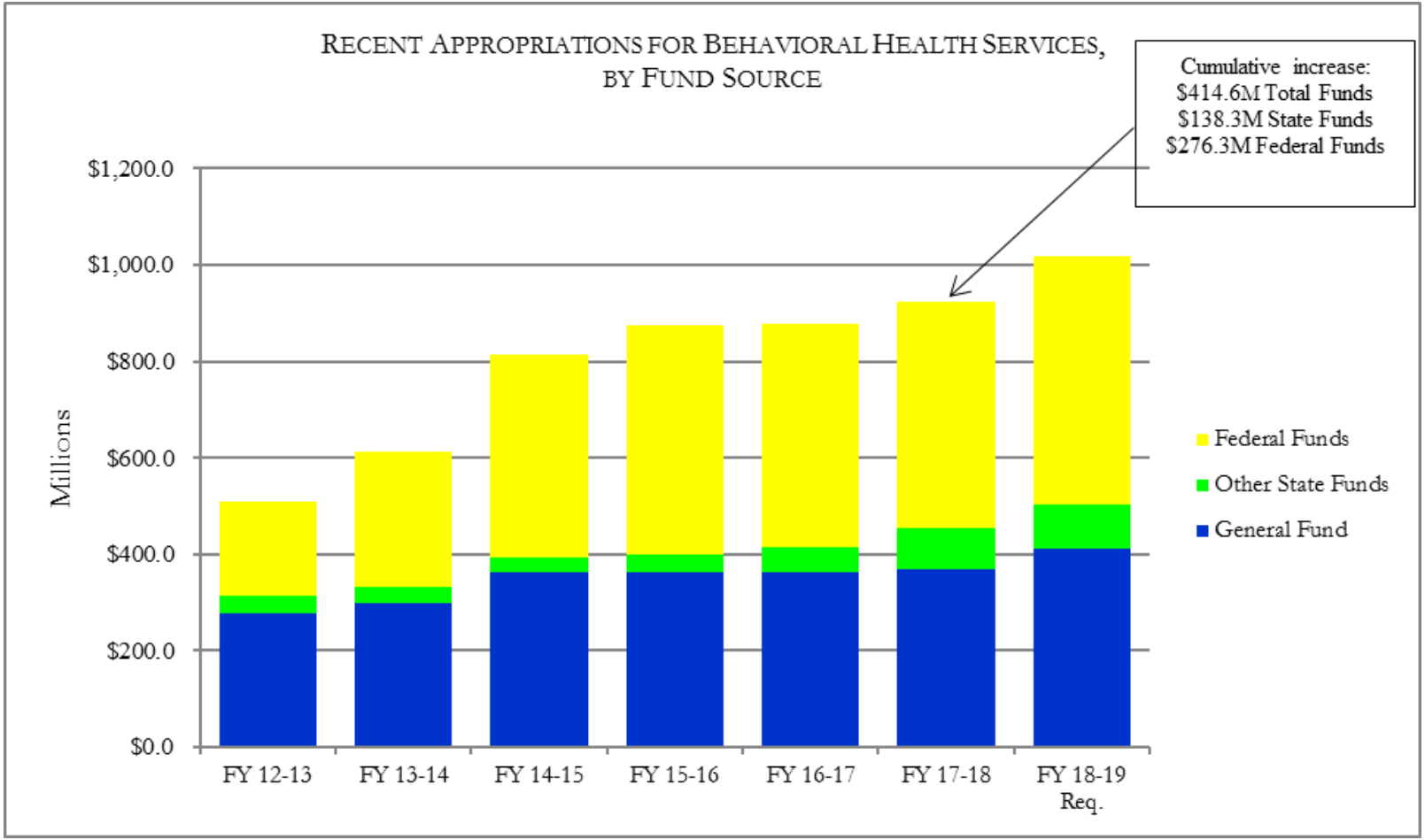
(Office of Behavioral Health)

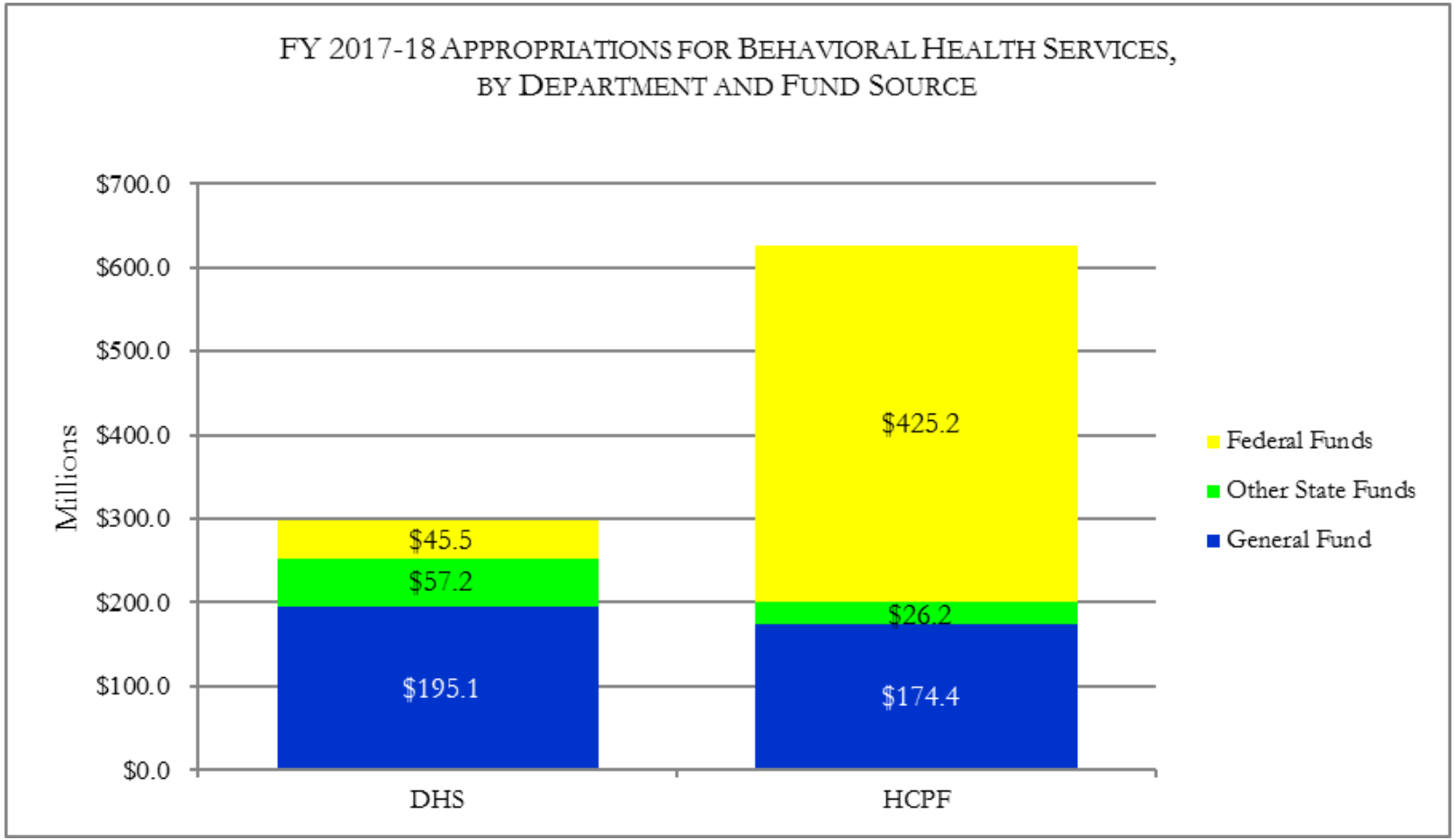
Presented by:

Carolyn Kampman, JBC Staff

December 6, 2017


RECENT APPROPRIATIONS FOR BEHAVIORAL HEALTH SERVICES, BY DEPARTMENT
$1,200.0
$1,000.0
$800.0
$600.0
$400.0
$200.0
$0.0
Millions
+$103.2M (20.3%)
+$203.0M (33.2%)
+$61.1M (7.5%)
+$3.2M (0.4%)
+$44.1M (5.0%)
+$93.6M (10.1%)
FY 12-13
FY 13-14
FY 14-15
FY 15-16
FY 16-17
FY 17-18
FY 18-19 Req.
HCPF
DHS


RECENT APPROPRIATIONS FOR BEHAVIORAL HEALTH SERVICES, BY FUND SOURCE
Cumulative increase:
$414.6M Total Funds
$138.3M State Funds
$276.3M Federal Funds
Millions
$1,200.0
$1,000.0
$800.0
$600.0
$400.0
$200.0
$0.0
FY 12-13
FY 13-14
FY 14-15
FY 15-16
FY 16-17
FY 17-18
FY 18-19 Req.
Federal Funds
Other State Funds
General Fund


FY 2017-18 Appropriations for Behavioral Health Services, by Department and Fund Source
$700.0
$600.0
$500.0
$400.0
$300.0
$200.0
$100.0
$0.0
Millions
$45.5
$57.2
$195.1
$425.2
$26.2
$174.4
DHS
HCPF
Federal Funds
Other State Funds
General Fund

JBC Staff Briefing

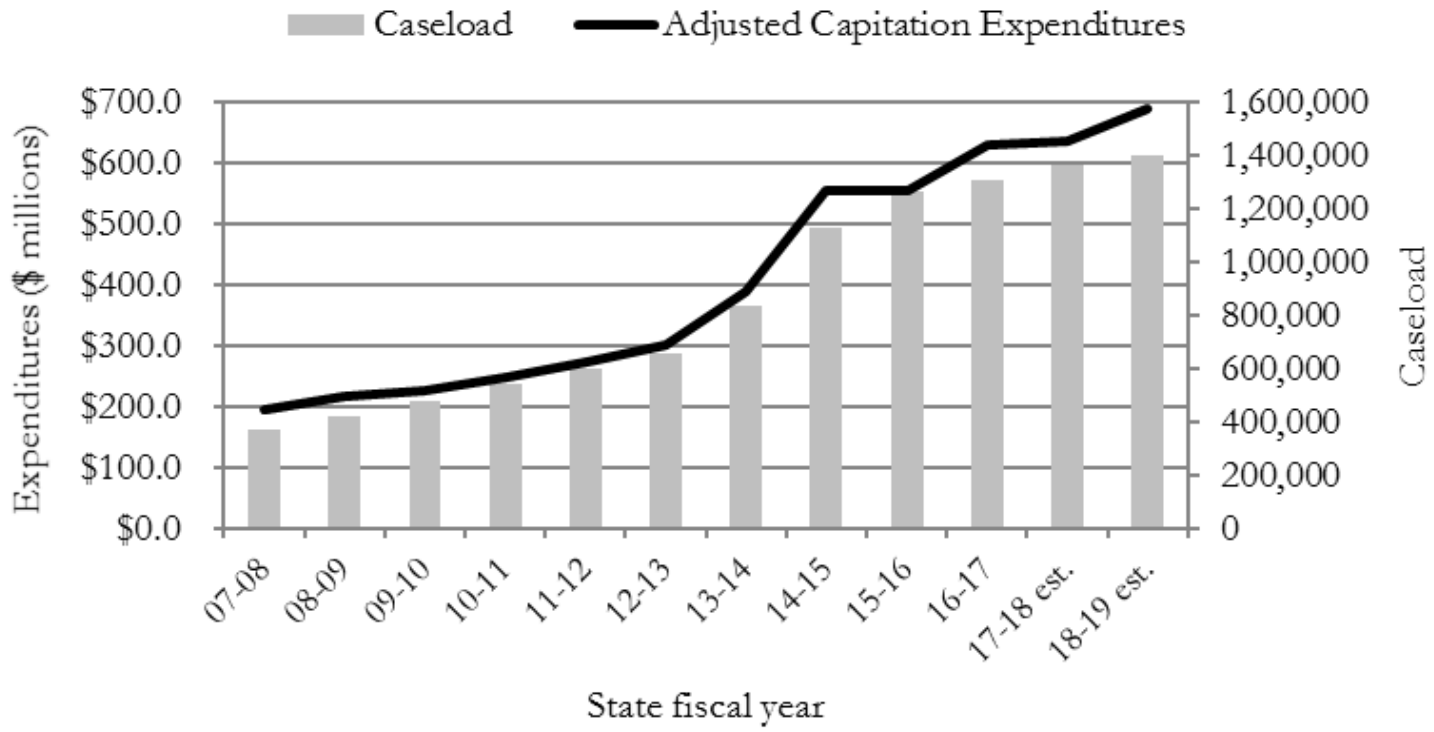
Department of Health Care Policy and Financing

(Medicaid Behavioral Health Community Programs)

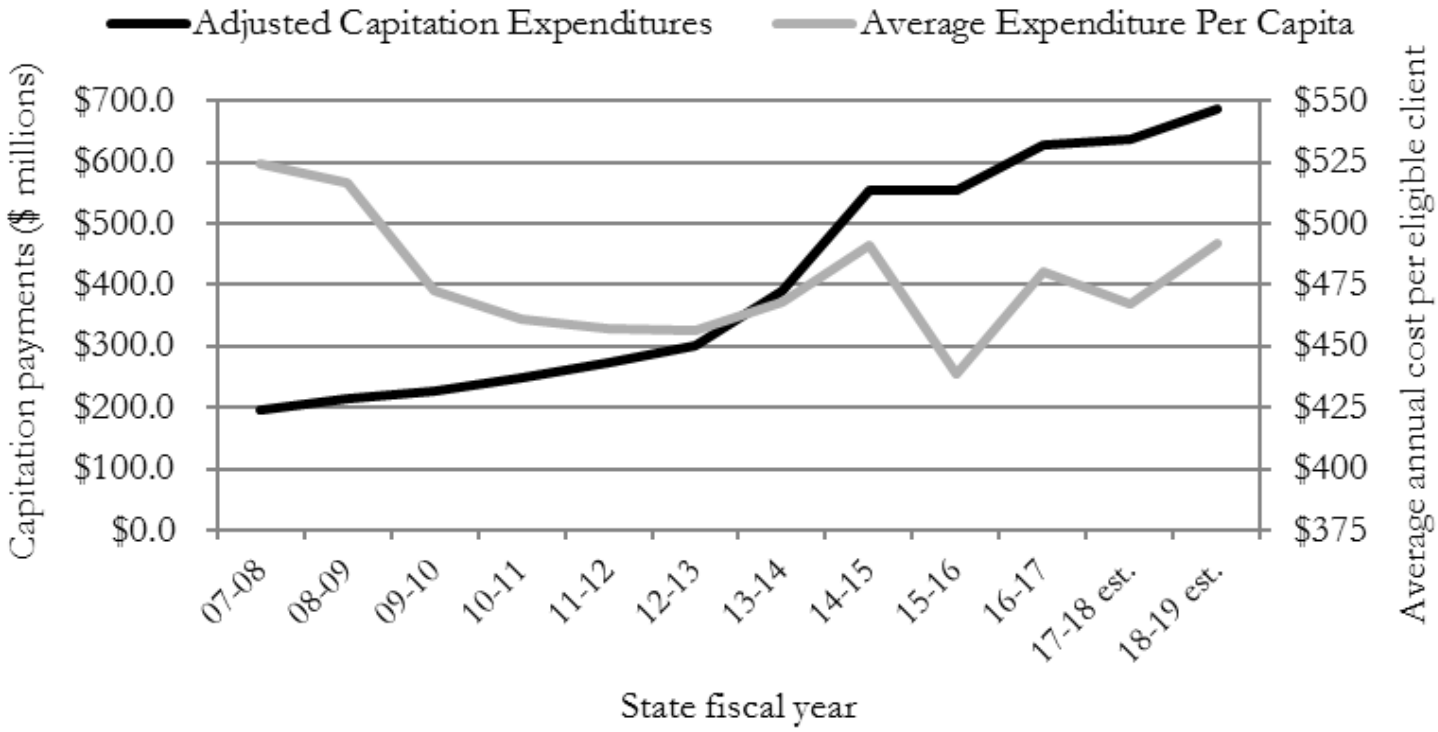
Presented by:

Carolyn Kampman, JBC Staff
December 6, 2017

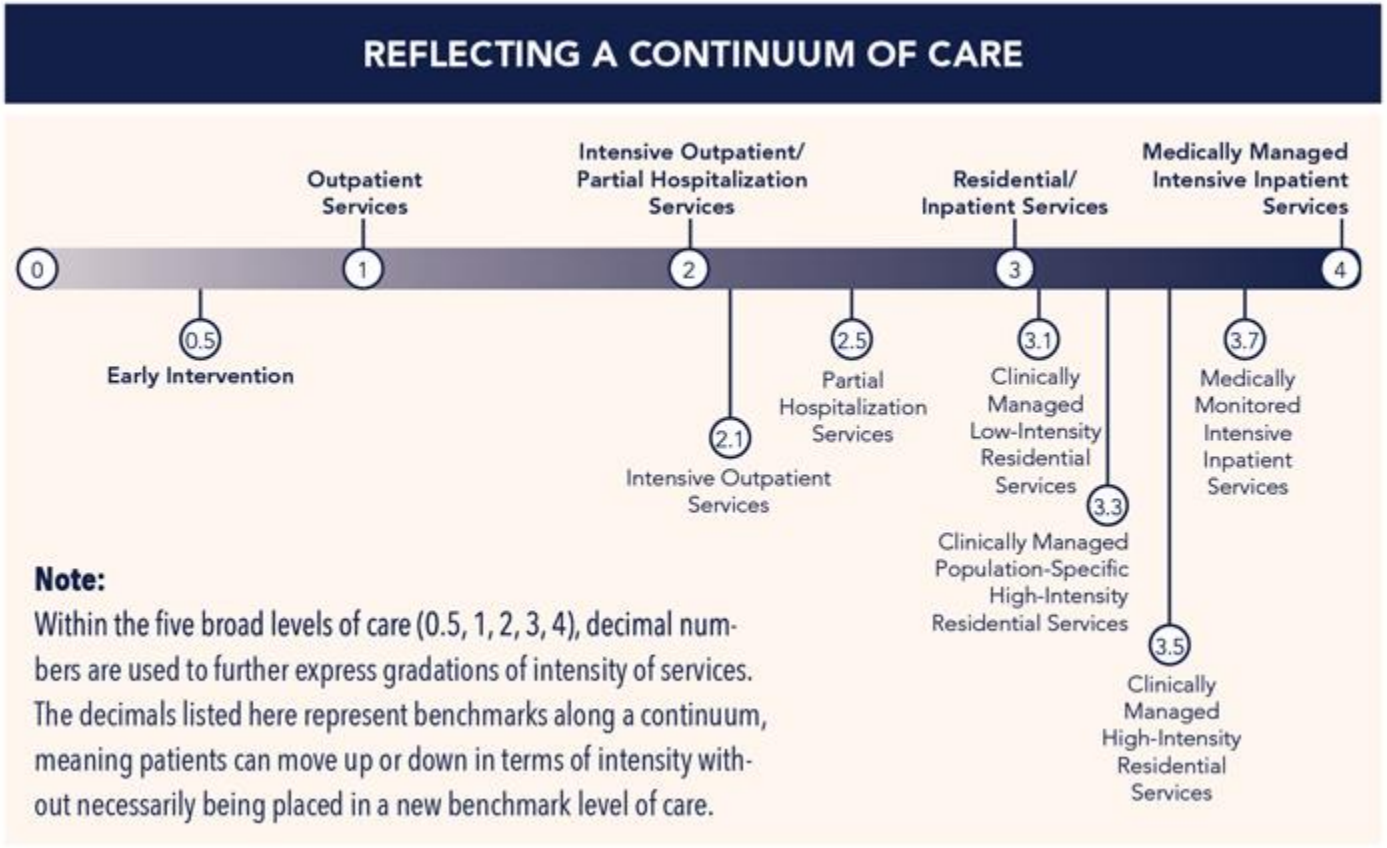
MEDICAID BEHAVIORAL HEALTH CAPITATION PROGRAM: *ADJUSTED* EXPENDITURES AND CASELOAD



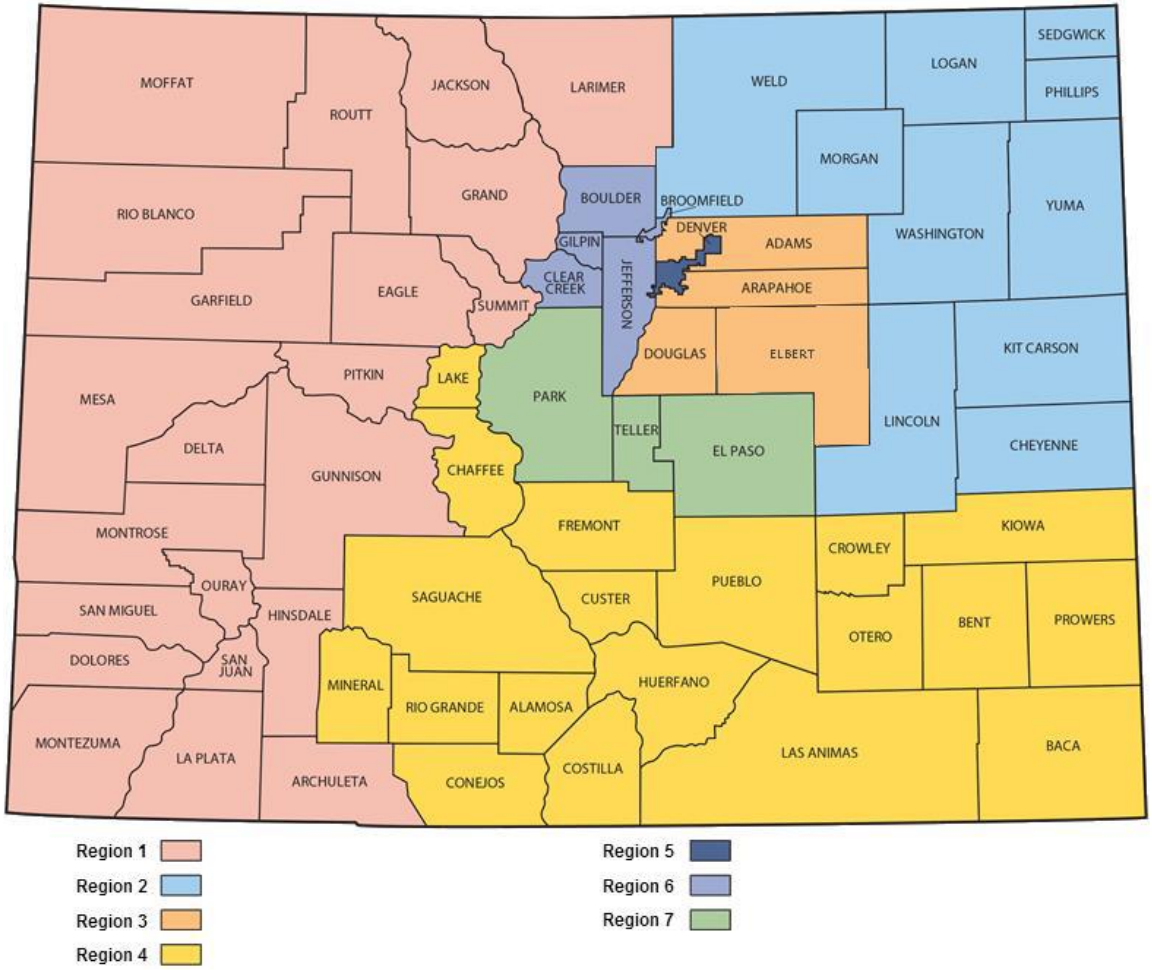
MEDICAID BEHAVIORAL HEALTH CAPITATION PROGRAM: *ADJUSTED* EXPENDITURES AND AVERAGE COST PER CAPITA

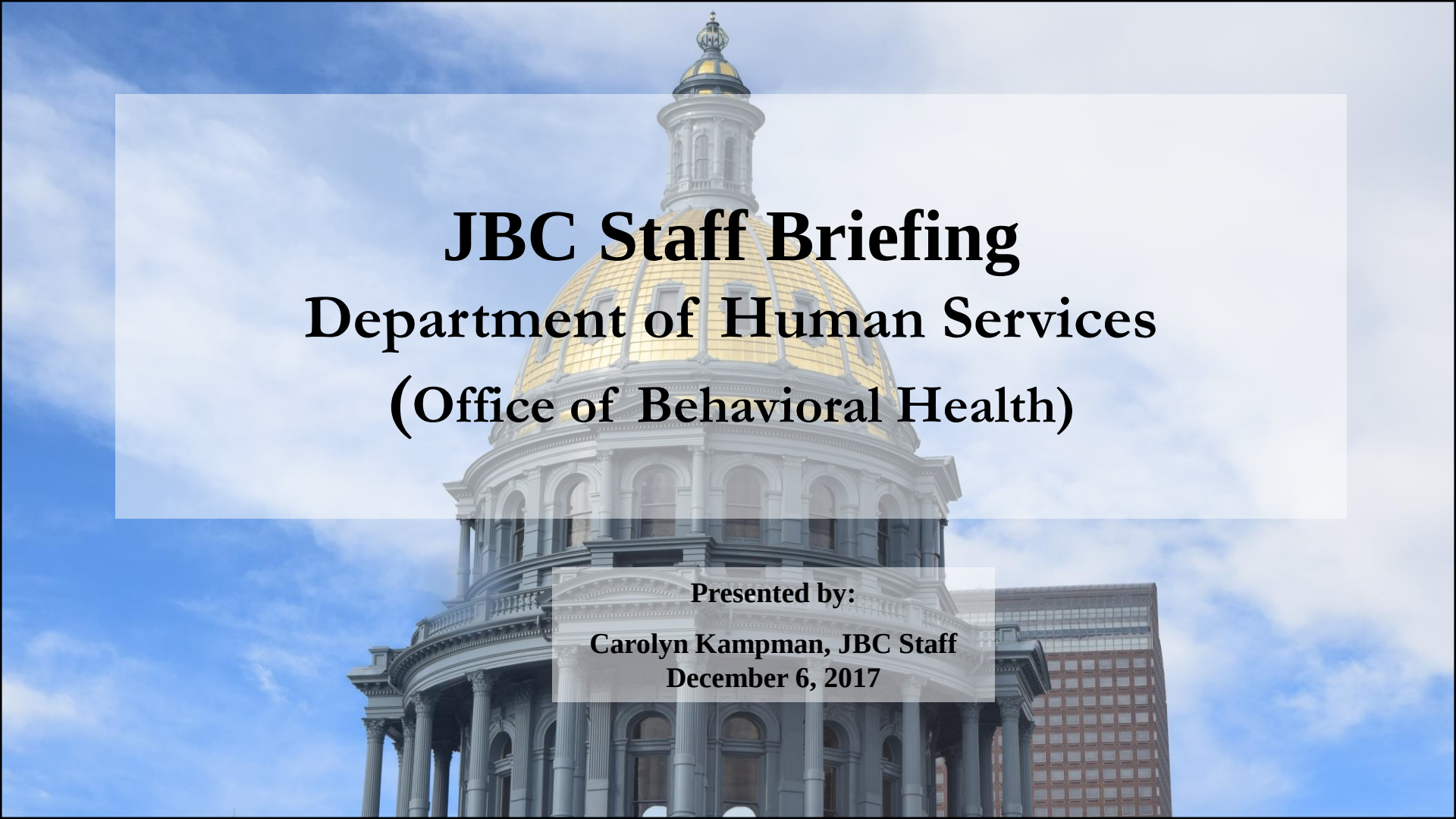


American Society of Addiction Medicine (ASAM) Levels of Care



Proposed Regional Accountable Entity (RAE) Regions





JBC Staff Briefing

Department of Human Services

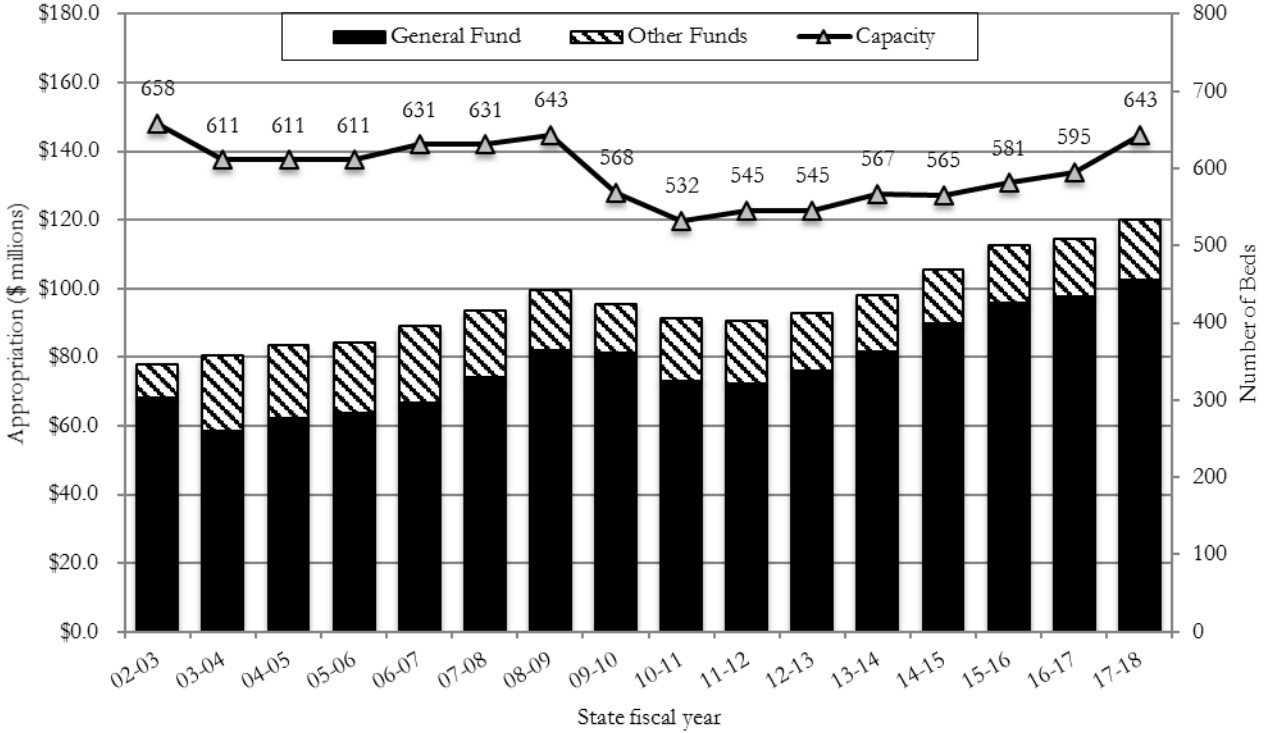
(Office of Behavioral Health)

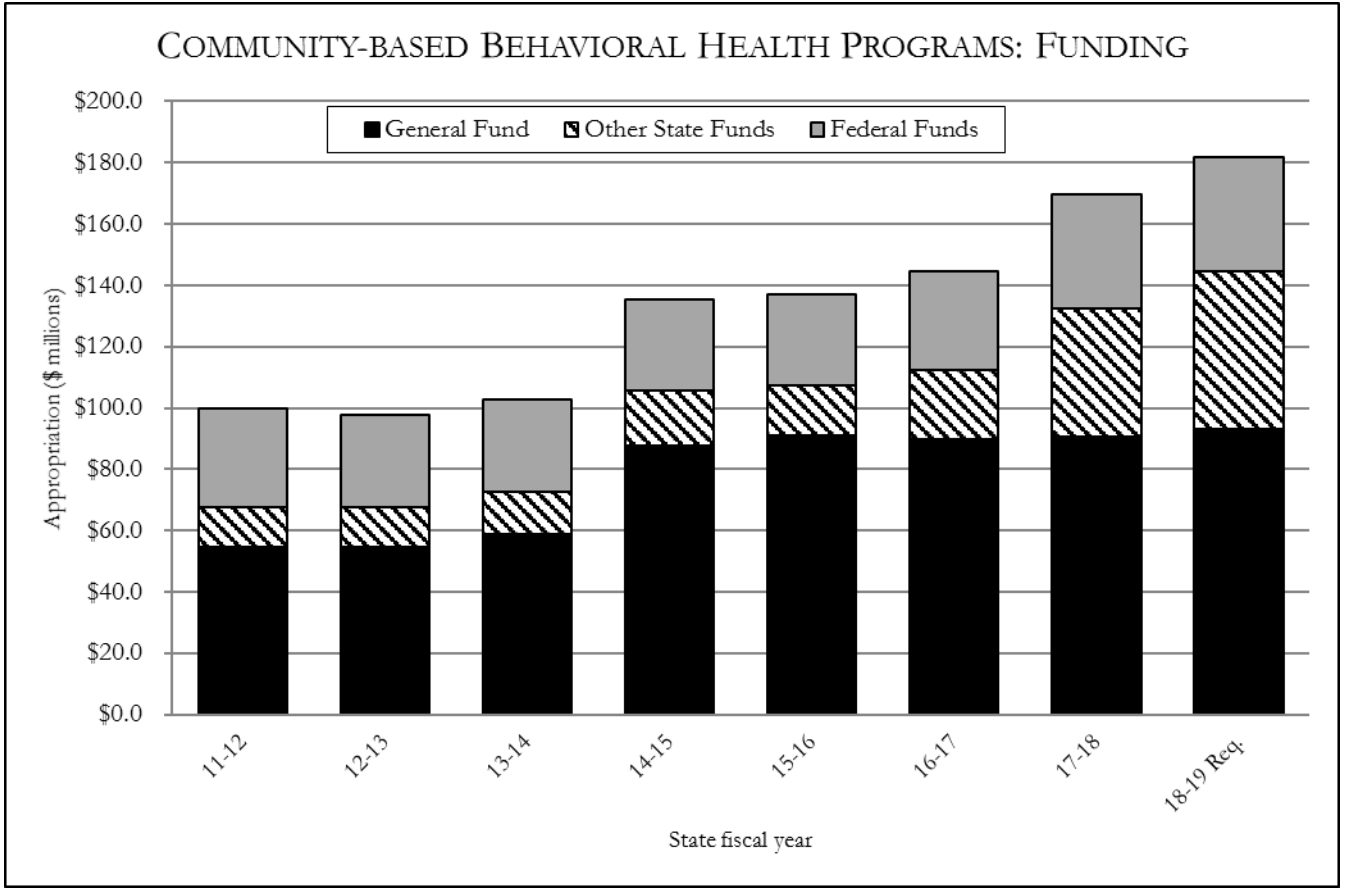
Presented by:

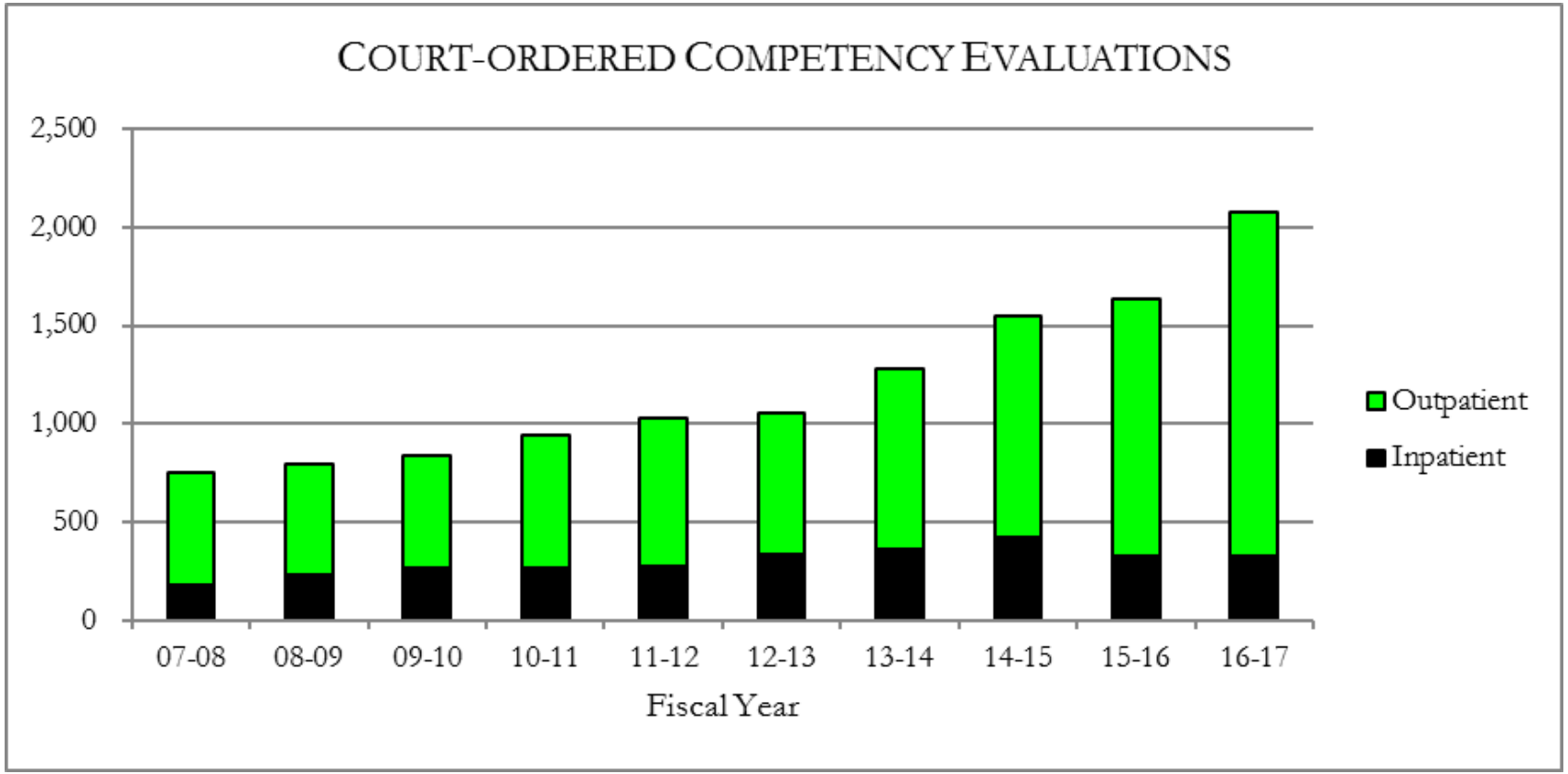
Carolyn Kampman, JBC Staff

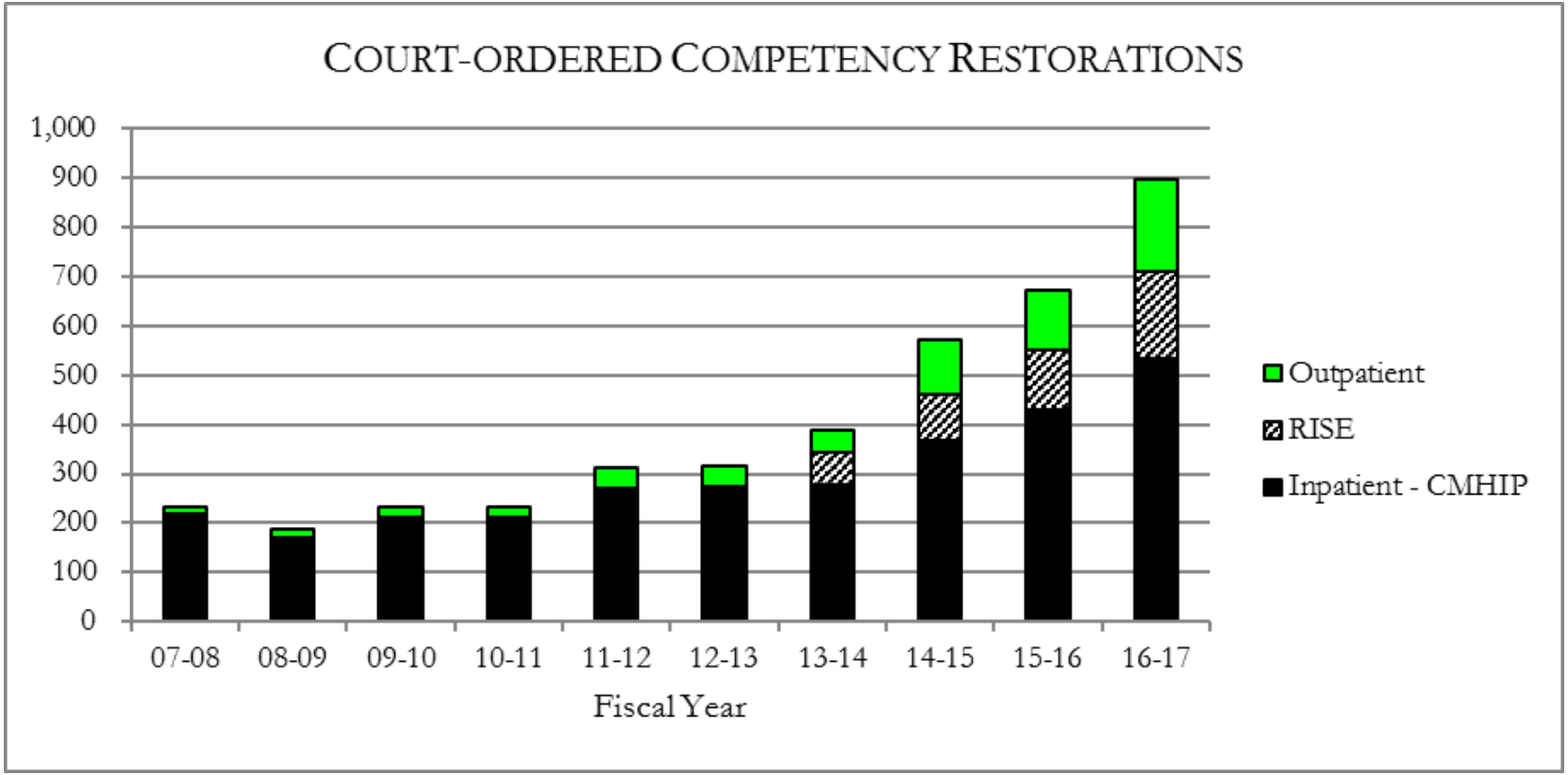
December 6, 2017

MENTAL HEALTH INSTITUTES: FUNDING AND CAPACITY

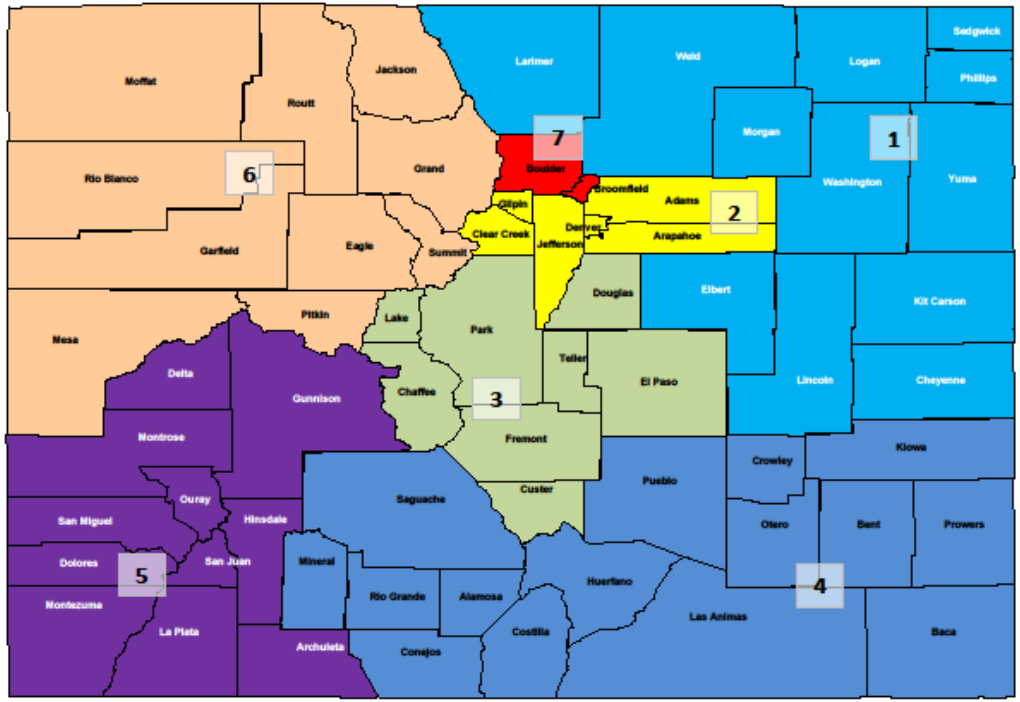



COMMUNITY-BASED BEHAVIORAL HEALTH PROGRAMS: FUNDING
$200.0
$180.0
$160.0
$140.0
$120.0
$100.0
$80.0
$60.0
$40.0
$20.0
$0.0
Appropriation ($ millions)
General Fund
Other State Funds
Federal Funds
11-12
12-13
13-14
14-15
15-16
16-17
17-18
18-19 Req.
State fiscal year


COURT-ORDERED COMPETENCY EVALUATIONS
2,500
2,000
1,500
1,000
500
0
07-08
08-09
09-10
10-11
11-12
12-13
13-14
14-15
15-16
16-17
Fiscal Year
Outpatient
Inpatient


COURT-ORDERED COMPETENCY RESTORATIONS
1,000
900
800
700
600
500
400
300
200
100
0
07-08
08-09
09-10
10-11
11-12
12-13
13-14
14-15
15-16
16-17
Fiscal Year
Outpatient
RISE
Inpatient - CMHIP

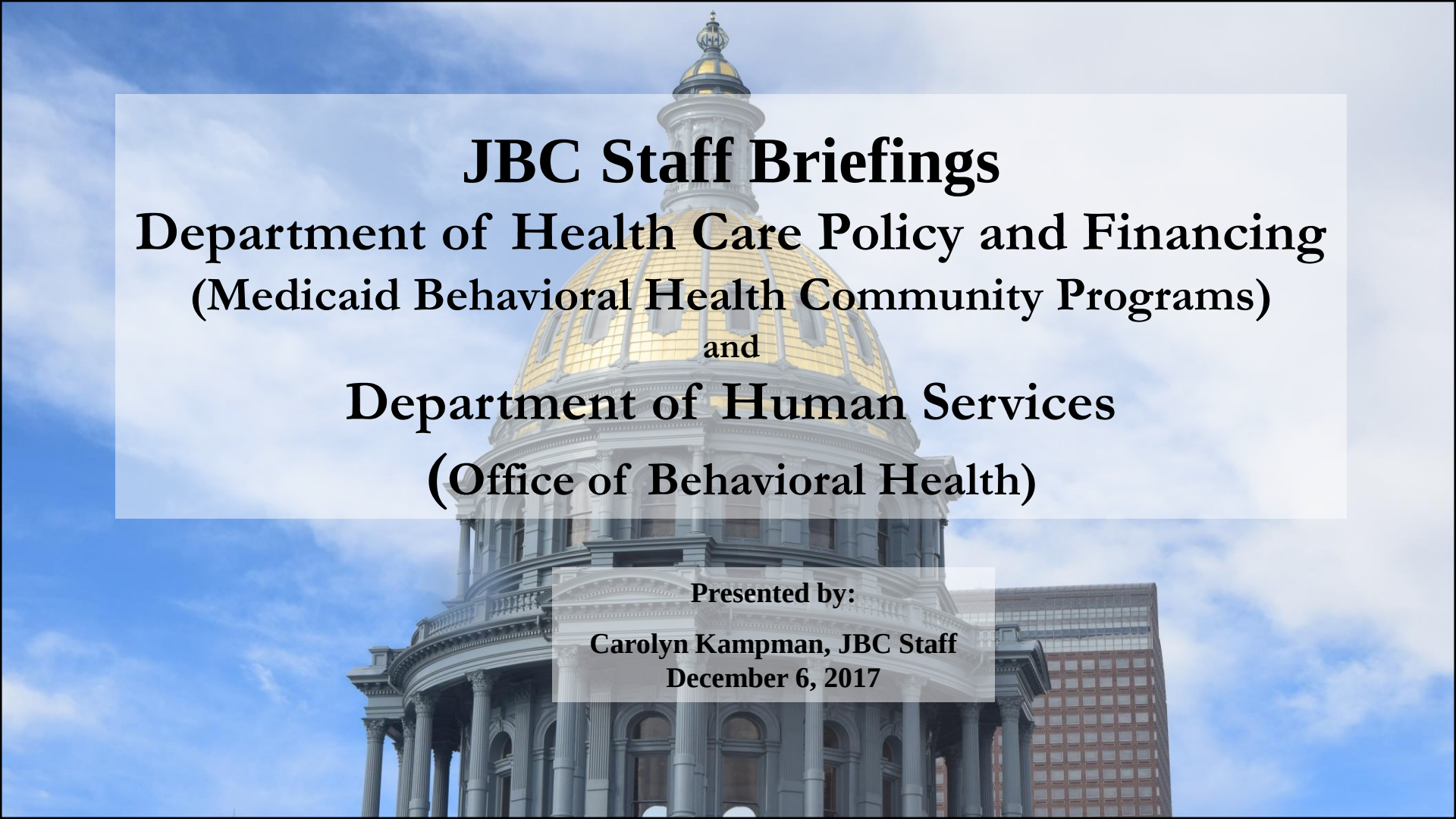
Managed Service Organization (MSO) Regions



Colorado Managed Service Organizations
Catchment Areas by Sub-State Planning Areas (SSPA)

MSO	SSPA
Mental Health Partners	7
AspenPointe	3
Signal Behavioral Health Network, Inc.	1 2 4
West Slope Casa, LLC	5 6

Source: Colorado Behavioral Healthcare Council



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Department of Health Care Policy and Financing

(Medicaid Behavioral Health Community Programs)

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December 6, 2017