Schedule 13
Funding Request for the 2014-15 Budget Cycle

Department: Health Care Policy and Financing
Request Title: Behavioral Health Request
Priority Number: S-2A, BA-2

Dept. Approval by: Josh Block
Date

OSPB Approval by:
Date

- ☐ Decision Item FY 2014-15
- ☐ Base Reduction Item FY 2014-15
- ☑ Supplemental FY 2013-14
- ☑ Budget Amendment FY 2014-15

Line Item Information		FY 2013-14		FY 2014-15		FY 2015-16
		1	2	3	4	5
	Fund	Appropriation FY 2013-14	Supplemental Request FY 2013-14	Base Request FY 2014-15	Funding Change Request FY 2014-15	Continuation Amount FY 2015-16
Total of All Line Items	**Total**	385,638,470	20,759,122	461,739,445	59,467,174	67,075,541
	FTE	-	-	-	-	-
	GF	153,461,111	(1,033,311)	155,827,511	8,928,282	8,054,679
	GFE	-	-	-	-	-
	CF	2,033,883	(242,990)	12,646,178	788,280	1,785,637
	RF	-	-	-	-	-
	FF	230,143,476	22,035,423	293,265,757	49,750,612	57,235,225
(3) Behavioral Health Community Programs; Behavioral Health Capitation Payments	**Total**	380,837,424	20,148,529	456,935,528	58,743,432	66,076,263
	FTE	-	-	-	-	-
	GF	151,060,588	(1,338,607)	153,425,552	8,619,365	7,630,882
	GFE	-	-	-	-	-
	CF	2,033,883	(242,990)	12,646,178	788,280	1,785,637
	RF	-	-	-	-	-
	FF	227,742,953	21,730,126	290,863,799	49,335,787	56,659,744
(3) Behavioral Health Community Programs; Medicaid Mental Health Fee for Services Payments	**Total**	4,801,046	610,593	4,803,917	723,742	999,278
	FTE	-	-	-	-	-
	GF	2,400,523	305,296	2,401,959	308,917	423,797
	GFE	-	-	-	-	-
	CF	-	-	-	-	-
	RF	-	-	-	-	-
	FF	2,400,523	305,297	2,401,958	414,825	575,481

Letternote Text Revision Required? **Yes:** ☑ **No:** ☐ **If yes, describe the Letternote Text Revision:**
See Exhibit BB for cash funds splits.

Cash or Federal Fund Name and COFRS Fund Number: Hospital Provider Fee (Fund 24A); Breast and Cervical Cancer Prevention and Treatement fund (Fund 15D); Federal Funds: Title XIX

Reappropriated Funds Source, by Department and Line Item Name: N/A

Approval by OIT? **Yes:** ☐ **No:** ☐ **Not Required:** ☑

Schedule 13s from Affected Departments: N/A

Other Information: N/A

Department of Health Care Policy and Financing
Behavioral Health Community Programs

FY 2013-14, FY 2014-15, and FY 2015-16 Budget Request

February 7, 2014

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BEHAVIORAL HEALTH COMMUNITY PROGRAMS

The following is a description of the budget projection for the Behavioral Health Community Programs.

History and Background Information

In 1993, under Section 1915 (b) and Section 1902 (a) of Title XIX of the Social Security Act, the Centers for Medicare and Medicaid Services (CMS) granted the State waivers that allowed the State to implement a pilot managed care mental health program. The pilot program operated until 1995. In 1995, SB 95-078 directed the Department and the Department of Human Services to implement a statewide capitated mental health managed care program. In 1997, SB 97-005 authorized the Department to provide behavioral health services through a managed care program.

The structure of managed care has changed over time. In 1995, implementation of the Behavioral Health Capitation Program in 51 counties of the State was complete, with the remaining 12 counties added in 1998. A 64th county was added when Broomfield became a county in November 2001. Through a competitive bid process, eight behavioral health assessment and service agencies were awarded contracts to be service providers in the program. Again through competitive procurement, the Department reduced the number of regions from eight to five and awarded managed care contracts to five behavioral health organizations effective January 1, 2005. The five behavioral health organizations were reprocured through a competitive bid process effective July 1, 2009. As a result of the reprocurement, the same five organizations won their respective contract bids, leaving the program unchanged.

Each behavioral health organization is responsible for providing or arranging medically necessary mental health services to Medicaid-eligible adults 65 and older, disabled individuals through 64, low-income adults, adults without dependent children, eligible children, foster care children, and Breast and Cervical Cancer Program adults enrolled with a behavioral health organization. Services provided by those organizations include, but are not limited to: inpatient hospitalization, psychiatric care, rehabilitation, and outpatient care; clinic services, case management, medication management, and physician care; and non-hospital residential care as it pertains to behavioral health. The capitation program also includes alternatives to institutionalization. The Department is required to make monthly capitation payments to contracted behavioral health organizations for services for each eligible Medicaid recipient. Payments vary across each behavioral health organization, as well as each eligibility category.

Since the inception of the Behavioral Health Community Programs, the Department has been responsible for oversight and contracting with the managed care organizations. The budget projections, day-to-day operations, and administration of the program were the responsibility of the Department of Human Services. In 2004, the administration and programmatic duties were transferred from the Department of Human Services to the Department. These duties include budget projections and accounting for the program, site reviews of the institutions, and contract negotiations. The transfer resulted in a new Long Bill group for the Department in the FY 2004-05 Long

Bill (HB 04-1422). Subsequently, SB 05-112 transferred: (1) the Mental Health Administration appropriation for Personal Services, Operating Expenses, and External Quality Review Organization Mental Health from Behavioral Health Community Programs – Program Administration to the Executive Director's Office Long Bill group; (2) Single Entry Point case management services from Medicaid Mental Health Fee-for-Service Payments to Medical Services Premiums; and (3) services for the developmentally disabled from the Colorado Department of Human Services for People with Disabilities – Community Services and Regional Centers to Non-Emergency Medical Transportation, Medical Services Premiums, and Mental Health Fee-for-Service appropriations within the Department. As a result, only the Behavioral Health Community Programs expenditures are addressed in this section.

The recent history of the Behavioral Health Community Programs is summarized as follows:

- HB 02-1420 provided funding for three alternative programs in the Behavioral Health Community Programs: Alternatives to Inpatient Hospitalization at the Mental Health Institute at Pueblo, Alternatives to Inpatient Hospitalization at the Mental Health Institute at Fort Logan, and Alternatives to the Fort Logan Aftercare Program. Each of these programs was the result of reductions in institutional care. Contracting through mental health assessment and service agencies, community mental health centers offered to provide services through managed care at a much lower cost. Initially part of the Behavioral Health Capitation Payments line, separate appropriations were made in the FY 2004-05 Long Bill (HB 04-1422) and the FY 2004-05 Long Bill Add-On (SB 05-209). Funding for Alternatives to Inpatient Hospitalization at the Mental Health Institute at Pueblo, Alternatives to Inpatient Hospitalization at the Mental Health Institute at Fort Logan, and Alternatives to the Fort Logan Aftercare Program was incorporated into the capitation base during the request for proposal process for contracts effective January 1, 2005. Due to this new contractual provision with behavioral health organizations, separate appropriations were no longer needed as of FY 2005-06.

- In FY 2002-03, budget reductions were implemented and capitation payments were reduced significantly for FY 2002-03 through FY 2003-04. This led to a reduction of services provided by the behavioral health organizations. Increasing caseload for Behavioral Health Community Programs and incorporating funding for alternative programs to inpatient hospitalization tempered the effect reductions had on the capitation budget.

- Due to a temporary federal change, the Medicaid federal financial participation match was enhanced for the last quarter of FY 2002-03 through FY 2003-04 to 52.95% (up from 50%), while the State's share was reduced to 47.05%. The federal financial participation match rate returned to 50% for FY 2004-05.

- SB 03-196 mandated the Department to move from accrual-based accounting to cash-based accounting for the Medical Services Premiums and the Medicaid-funded services in the Department of Human Services' budget. This resulted in a one-time savings of approximately $70 million in Medical Services Premiums and $7 million in the Department of Human Services' Medicaid-funded services during FY 2002-03. With cash-based accounting, all expenditures became based on the date of payment, regardless of

when the date of service occurred, thus eliminating the six-month accounts payable period maintained under accrual-based accounting. Ideally, all prior expenditure history for behavioral health services would have been rebuilt on a cash basis for historical comparison purposes, using both the Colorado Financial Reporting System and the Medicaid Management Information System data. However, the Department's prospective per-capita budget methodology did not require the use of historical data prior to FY 2002-03.

- SB 03-282 gave the Department and the Department of Human Services' Medicaid-funded programs a one-time appropriation of $1,000,000 in FY 2003-04, wherein $500,000 was from the Tobacco Litigation Settlement Cash Fund, and the remaining $500,000 was from federal funds for behavioral health capitation and performance incentive awards.

- Within the appropriation for Behavioral Health Community Programs, the FY 2004-05 Long Bill (HB 04-1422) provided funding for the Mental Health Institute Rate Refinance Adjustment. This funding was necessary because in 2001 it was discovered the capitation-based payment for Medicaid clients did not cover bed costs at mental health institutes. Separate appropriations for the Mental Health Institutional Rate Refinance Adjustment were made in the FY 2004-05 Long Bill (HB 04-1422) and the FY 2004-05 Long Bill Add-on (SB 05-209). New contracts with behavioral health organizations effective January 1, 2005, began fully covering the negotiated bed cost at the mental health institutes in new capitation rates via payments withheld from behavioral health organizations and made directly to the Mental Health Institute. Therefore, a separate appropriation for the Mental Health Institute Rate Refinance Adjustment was no longer needed as of FY 2005-06.

- HB 04-1422 reorganized the Behavioral Health Community Programs Long Bill group into the following sections:

  1. Behavioral Health Capitation Payments, which included Capitation Base Payments, Behavioral Health Services for Breast and Cervical Cancer Patients, Mental Health Institute Rate Refinance Adjustment, Alternatives to Inpatient Hospitalization at the Mental Health Institute at Pueblo, and the Mental Health Institute at Fort Logan and Alternatives to the Fort Logan Aftercare Program. SB 05-209 consolidated these line items into one Behavioral Health Capitation Payments line item in FY 2005-06.

  2. Other Behavioral Health Payments, which included Medicaid Mental Health Fee-for-Service Payments, Child Placement Agency, and Anti-Psychotic Pharmaceuticals. Child Placement Agency and Anti-Psychotic Pharmaceuticals were listed under Other Behavioral Health Payments for informational purposes only. Detailed explanations of the Child Placement Agency and Anti-Psychotic Pharmaceuticals programs and appropriations can be found in the Department of Human Services Child Welfare section and the Department's Medical Services Premiums section, respectively. SB 05-209 did not change these line items. However, in November 2004, the Department received an order from CMS to cease making Child Placement Agency payments since they were considered supplemental payments outside the scope of the existing waiver. Payments were discontinued in December, and the line item has been removed from the Department budget.

- HB 05-1262, known as the Tobacco Tax bill, established two funds that provide capitated behavioral health benefits to an increasing population of Medicaid clients. Increased caseload funded by the Health Care Expansion Fund, administered by the Department, and the Prevention, Early Detection, and Treatment Fund, administered by the Department of Public Health and Environment, are included in both the current year and the out-year requests and are elaborated below.

- The Joint Budget Committee approved the Department's September 20, 2006 1331 Supplemental Request to transfer funding from the Department of Human Services to the Department. This transfer allowed for the inclusion of the Goebel enhanced services in the Behavioral Health Capitation rates and eliminated the need to classify and track them separately.

  The Goebel Lawsuit Settlement line item was created in FY 2003-04 to fund specialized and enhanced behavioral health services for approximately 1,600 Medicaid and non-Medicaid clients with mental illness in northwest Denver. The Goebel lawsuit claimed that residents of northwest Denver with chronic mental illness were being denied services. The FY 2003-04 Supplemental Bill (HB 04-1320) established the Goebel Lawsuit Settlement as a separate line item in the Department's Department of Human Services Medicaid-Funded Programs Long Bill group and paid it separately from Behavioral Health Community Programs payments.

  On March 31, 2006, the Goebel lawsuit was dismissed. After consultation with the Department's contracted actuary and review of the Goebel-specific encounter and eligibility data, it was determined an actuarially certified payment would become part of the Behavioral Health Capitation Payments line item. An adjustment was made for the inclusion and it began being included in the FY 2006-07 capitations.

- SB 07-002 and SB 08-099 expanded Medicaid eligibility for foster care children up to age 21.

- HB 08-1320 designated Cash Funds Exempt as cash funds and Reappropriated Funds, in effect moving the Health Care Expansion Fund from Cash Funds Exempt to cash funds and clearly distinguishing transfers from the Department of Human Services to the Department as Reappropriated Funds.

- HB 08-1373 continued and extended the Breast and Cervical Cancer Treatment Program to July 1, 2014. The bill designated funding sources for the program: a) for FY 2008-09, 100% of the State costs for the Program were appropriated from the Breast and Cervical Cancer Prevention and Treatment Fund; and b) for FY 2009-10 through FY 2013-14, 50% of State costs for the Program shall be appropriated from the Breast and Cervical Cancer Prevention and Treatment Fund and 50% shall be from the General Fund.

- SB 09-262 shifted state funding for the Breast and Cervical Cancer Program from 50% General Fund and 50% Breast and Cervical Cancer Prevention and Treatment Fund to 100% Breast and Cervical Cancer Prevention and Treatment Fund, effective until FY

2011-12. Beginning FY 2012-13, State funding for the Breast and Cervical Cancer Program was shifted back to 50% General Fund and 50% Breast and Cervical Cancer Prevention and Treatment Fund.

- Effective January 1, 2009, the Department issued, and the Behavioral Health Organizations (BHOs) actuarially certified, a new set of rates above the actuarial midpoint of the rate setting range. Rates are set using a combination of historical rate experience and recent encounter data. Under direction from CMS, the Department has gradually put more weight on the encounter data per-member per-month (PMPM). FY 2005-06 was the first year of rate setting that used a combination of historical rate experience and recent encounter data. These capitation rates were calculated using 5% encounter data and 95% of the historical rate experience. During the rate setting process resulting in the January 2009 rates, the Department altered the weight to 35% encounter and 65% historical. However, the Department found estimated service expenditures to be generally valued at an amount less than expected, relative to the BHO's audited financial statements. The Department believes there are two primary reasons for this discrepancy. First, the non-traditional, federally waivered (b)(3) service data was newly included in the FY 2006-07 encounter data used for rate setting and appeared to not be completely reported. Additionally, inconsistencies in coding and accounting practices caused some difficulties in the encounter pricing methodology. To offset the discrepancy, the Department paid its behavioral health rates at 3% above the actuarial midpoint. See description of Exhibit GG for additional information.

- HB 09-1293, the "Colorado Health Care Affordability Act," provided health care coverage for more than 100,000 uninsured Coloradans. The bill was implemented in April 2010 when the Department began collecting the hospital provider fee. Behavioral health services were subsequently expanded to parents up to 100% of the federal poverty level using the Hospital Provider Fee cash fund to cover the additional expenses. Behavioral health services were expanded further in FY 2011-12 to adults without dependent children with income up to 100% of the federal poverty level and disabled individuals with income up to 450% of the federal poverty level. For more detail, please see Exhibit J in the Medical Services Premiums Request.

- The June 22, 2009 General Revenue forecast indicated additional General Fund cuts would be necessary in FY 2009-10. On August 24, 2009, the Department released a series of early supplemental requests (ES), which affected the Department's behavioral health programs in the following ways:

  1. As a part of FY 2010-11 ES-2 "Medicaid Program Reductions," the Department reduced the reimbursement rate for the behavioral health capitation program by 2.5%, effective September 1, 2009, and accounted for the recoupment of net overpayments on prior years' behavioral health capitation payments.

  2. As a part of NP-ES-5 "Close Beds at the Mental Health Institutes," the Department of Human Services proposed that specific beds at the mental health institutes be closed as of January 1, 2010. These bed closures impacted the Department by immediately making those displaced from the mental health institutes clients available for the capitated behavioral health program. While

treated at the institutes, Department of Human Services funding preempted Medicaid payment, with Medicaid being the "payer of last resort." Displacing these clients allowed them to be eligible to receive Medicaid funded benefits and increased expenditure for mental health services.

- Effective January 1, 2010, the Department calculated a new set of behavioral health rates and set them below the actuarial midpoint. Three of the Behavioral Health Organizations (BHOs) were paid 2.5% below the actuarially set midpoint of the new set of rates. Two of the contracted Behavioral Health Organizations (BHOs) were unable to actuarially certify that they could operate at the new payment schedule. In January 2010, the Joint Budget Committee voted to appropriate funds to continue paying these two BHOs at the previously set rates (the rates from the last rate setting process, with the 2.5% cut from September 2009). These rates remained in effect through CY 2010. See the description of Exhibit GG for additional information.

- Effective January 1, 2011, the Department calculated a new set of behavioral health rates for calendar year 2011. The new rates implicitly included the 2.5% reductions taken by the BHOs, as the rate cuts were part of the historical and encounter data used in the rate-setting methodology. In addition, the rates were set at 1.71% below the point estimate rates in order to achieve an appropriated savings of $2,170,355. The Department worked with the BHOs in order to ensure they were able to certify the rates and continue to provide quality services to their clients, even while their rates were being reduced. The result of that negotiation process was to begin a series of rate reforms, the first of which was to include a new component in the rate called a "case rate" adjustment that was applied to the CY 2011 rates. The case rate is the BHO statewide average cost by diagnosis category. The case rate allows the Department to comply with CMS's direction by increasing the weight of the encounter data in the rate-setting process. The BHOs can accept the increased weight of encounter data because the case rate allows for any savings achieved to be spread across the entire system, rather than directly reducing the rate of the BHO responsible for generating savings. Incorporating the case rate serves to better align the rate-setting process with the Department's goals by incentivizing the BHOs to be more efficient without sacrificing the quality of the care provided to their clients.

- The Department requested to continue to apply the 1.71% reduction to the BHO rates in the current and request years in FY 2011-12 BRI-5 "Medicaid Reductions." The reduction was appropriated in the FY 2011-12 Long Bill.

- The FY 2011-12 Long Bill transferred $616,044 from the Division of Youth Corrections appropriation, which is administered by the Department of Human Services, to the appropriation for Behavioral Health Community Programs to fund behavioral health services provided to children living at the Ridge View Youth Services Center. In FY 2009-10, the Ridge View Youth Services Center in the Denver-Aurora area was granted a change of license to be classified as an unlocked, non-secure, community residential facility. The new type of license allowed Ridge View to be considered a community facility in which residents may qualify for Medicaid. Each resident at Ridgeview is viewed by Medicaid as being a low-income family of one, since the residents generally have no independent income. Thus, the residents at Ridgeview qualify under the same category of eligibility as foster care children.

Prior to FY 2011-12, the expenditure for behavioral health services provided to Ridge View clients was transferred from the appropriation for Behavioral Health Community Programs and into the appropriation for the Division of Youth Corrections. Its appropriation was transferred to the behavioral health long bill line to streamline the process and avoid manually transferring expenditure. Since the Ridge View clients have been incorporated in the caseload data since FY 2009-10, the Department assumes that the impact of these clients on behavioral health expenditures will be captured in the caseload forecasts and does not need to be added as a bottom line impact to Exhibit BB.

- SB 11-008, "Aligning Medicaid Eligibility for Children," will expand Medicaid eligibility from 100% to up to 133% of the federal poverty level for children ages six through 18. The bill shifts impacted children from the Children's Basic Health Plan (CHP+) to Medicaid beginning January 1, 2013. The Department assumes the expenditure for these children will continue to receive a 65% federal match rate, which is the rate for CHP+. SB 11-250, "Eligibility for Pregnant Women in Medicaid," will expand Medicaid eligibility from 133% to 185% of the federal poverty level for all pregnant women. Similar to SB 11-008, this bill shifts impacted women from CHP+ to Medicaid on January 1, 2013. The Department assumes the expenditure for these women will continue to receive a 65% federal match rate.

- SB 13-200, "Expanding Medicaid Eligibility in Colorado," extends Medicaid eligibility to up to 133% of the FPL for parents of Medicaid eligible children and adults without dependent children, effective January 1, 2014. The Department assumes that the expenditure for parents from 60% to 133% FPL and all adults without dependent children will receive a 100% federal match rate, while adults up to 60% FPL will receive the standard Medicaid match.

- Beginning January 1, 2014, the Medicaid benefit for the Behavioral Health Community Programs will also include a substance use disorder benefit. This expands the range of services that will be covered under Medicaid for disorders relating to substance use for currently enrolled members.

Program Administration

In FY 2005-06, SB 05-112 transferred all of Behavioral Health Community Programs - Program Administration expenditures into the Executive Director's Office Long Bill group and is reflected in the lines for Personal Services, Operating Expenses, and Mental Health External Quality Review Organization. The current year and out-year requests for Program Administration are included in the Executive Director's Office Long Bill group.

Medicaid Anti-Psychotic Pharmaceuticals

Prior to FY 2008-09, as part of the Long Bill, estimated expenditures for anti-psychotic pharmaceuticals were appropriated to this Long Bill group as Cash Funds Exempt. This was an informational-only line item; the costs for these drugs were and are paid in the Department's Medical Services Premiums Long Bill group, and no actual transfer took place. Because there was no corresponding decrease to the Medical Services Premiums Long Bill group, this double counted the funding for these drugs.

In its November 1, 2007 Budget Request, the Department officially requested the removal of the Medicaid Anti-Psychotic Pharmaceuticals line item and subsequently received approval. The Department continues to report expenditure for anti-psychotics in its Budget Request (such as in Exhibit F of the exhibits for Medical Services Premiums, and/or the Strategic Plan).

BEHAVIORAL HEALTH CAPITATION PAYMENTS AND MEDICAID MENTAL HEALTH FEE-FOR-SERVICE PAYMENTS

The Behavioral Health Capitation Payments line item reflects the appropriation that funds behavioral health services throughout Colorado through managed care providers contracted by the Department. As a result of competitive procurement, five behavioral health organizations were awarded contracts with updated capitation rates and services effective January 1, 2005. Payments for Mental Health Institute Rate Refinance Adjustment, Alternatives to Inpatient Hospitalization at the Mental Health Institute at Pueblo, Alternatives to Inpatient Hospitalization at the Mental Health Institute at Fort Logan, and Alternatives to the Fort Logan Aftercare Program were separate payments prior to FY 2005-06 and incorporated into the Behavioral Health Capitation Payments line item in FY 2005-06. Effective July 1, 2009, the five behavioral health organizations were reprocured through a competitive bid process. As a result of the reprocurement, the same five organizations won their respective contract bids, leaving the program unchanged.

The behavioral health organizations are responsible for providing or arranging all medically necessary behavioral health services to Medicaid-eligible clients within a specified geographic location for a pre-determined capitation rate. The Department pays actuarially certified rates to each behavioral health organization for each Medicaid client in each Medicaid eligibility category. Amounts are prorated for partial months of service and retroactive eligibility is covered. Payments vary across behavioral health organizations, as well as eligibility categories.

The Medicaid populations that are eligible for behavioral health services covered by capitation rates are combined into seven categories, as indicated below. Partial dual-eligible clients and non-citizens are ineligible for behavioral health services.

The eligible behavioral health populations are:

- Adults 65 and Older (OAP-A)
- Disabled Individuals Through 64 (AND/AB, OAP-B)
- Low Income Adults
- Adults without Dependent Children
- Eligible Children (AFDC-C/BC)
- Foster Care
- Breast and Cervical Cancer Prevention and Treatment Program

Analysis of Historical Expenditure Allocations across Eligibility Categories

At the beginning of a contract cycle, behavioral health organization capitation rates were entered in the Medicaid Management Information System (MMIS). Monthly payments were paid based on eligibility categories. The MMIS provided detailed expenditures by behavioral health organization and eligibility category but did not include offline transactions and accounting adjustments. The only source that included all actual expenditure activity is the Colorado Financial Reporting System (COFRS). The drawback was the COFRS provided total expenditures, but not by eligibility category. The exception was the Breast and Cervical Cancer Treatment Program eligibility category, which was reported separately in the COFRS. Since an allocation had to be calculated to determine the amount of actual expenditures across the other eligibility categories, a ratio was calculated for each eligibility category by dividing the MMIS eligibility category expenditures (less the Breast and Cervical Cancer Treatment Program eligibility category) by the total MMIS expenditures (less the Breast and Cervical Cancer Treatment Program eligibility category). The ratio for each category was multiplied by the total expenditures (less the Breast and Cervical Cancer Treatment Program eligibility category) from the COFRS. This calculation estimated actual COFRS expenditures across each eligibility category. Variance between the two systems was less than 0.67%

Description of Transition to New Methodology

Member month methodology was used prior to 2005 when the administration of Behavioral Health Community Programs was transferred from the Department of Human Services to the Department. Historical expenditures were divided by the capitation rates for the region served by each behavioral health assessment and service agency (now known as behavioral health organizations) to estimate the number of member months for which capitation payments were made. Behavioral health caseload growth rates were applied to these member months to calculate projected member months. Member months were multiplied by the capitation rates for the upcoming year to determine the projected capitation base payments. The problem with this system was that member months, which reflected the impact

of retroactive payments, were not equivalent to the Medicaid caseloads used in Medical Services Premiums, which did not include retroactivity. This methodology was used until February 15, 2005.

From February 2005 until the present Request, the Department had been transitioning towards a per-capita methodology. Previous year actual amounts were trended forward by eligibility category, generating an estimated per capita. Prior to this Request, the Joint Budget Committee had asked the Department to explore the possibility of projecting budgets by behavioral health organization as well as by eligibility category. The Department has determined that such a projection is not yet possible due to the following: a) the recent (FY 2005-06) consolidation of eight behavioral health assessment and service agencies into five behavioral health organizations, b) the disproportionate impact of Goebel driven expenditures into one behavioral health organization's capitation rate, and c) the volatile nature of specific capitation rates as compared to the overall trend of capitation rate increases within respective eligibility categories. However, the Department will continue to explore this methodology as new data becomes available.

As part of its ongoing efforts to continuously improve the projections, as well as to provide access to information more specific than overall per-capita rates, the Department moved to a capitation trend forecast model for the FY 2008-09 Estimate and FY 2009-10 Request. In short, the methodology examines the trend in capitation rates across each eligibility category and applies that trend to the average per-claim, incurred expense rate. By examining the capitation rate trends directly, rather than through a per-capita methodology, future expenditures are forecasted directly through the primary cost drivers: the actuarially agreed-upon capitation rate and caseload. By tying forecasts directly to capitation rates, the methodology may provide more accurate estimates of expenditures by eligibility category, rather than simply in aggregate, as well as provide an additional window of transparency into the forecasting process by presenting a clear link between total expenditure and the rates being paid to behavioral health organizations.

Additionally, the Department has incorporated an incurred but not reported methodology similar to other portions of this Request submitted by the Department (e.g., Nursing Facilities; see Section E, Exhibit H). The Department is adjusting its request to capture the reality that some behavioral health claims incurred in any one fiscal year may not be paid during that same fiscal year. Similarly, some portion of expenditure in any fiscal year will be payments on claims incurred in prior fiscal years.

The following narrative describes in greater detail the assumptions and calculations used in developing the current year and out-year requests for Behavioral Health Community Programs. It should be noted that the data and values in many of the exhibits are contained and/or calculated in one or more other exhibits which may come before or after the exhibit being described. When this occurs, the source exhibit will be noted.

EXHIBIT AA - CALCULATION OF CURRENT TOTAL LONG BILL GROUP IMPACT

Effective with the November 2, 2009 Budget Request, in this exhibit the Department sums the total spending authority by fund source, including the Long Bill and any special bills which have appropriations that affect the Department. The total spending authority is compared to the total projected estimated current year expenditures from Exhibit BB. The difference between the two figures is the Department's Supplemental Request for the current fiscal year.

Exhibit AA now presents a concise summary of spending authority affecting the Behavioral Health Programs. In previous budget requests, the Department presented historical expenditure and caseload figures in graphical form. This information can be found in table form in Exhibit DD (see below).

For the request year, the Department starts with the prior year's appropriation including special bills and adds in any required annualizations. This total is the Base Amount for the Request year. The total Base Amount is compared to the total projected estimated request year expenditure from Exhibit BB. The difference between the two figures is the Department's Funding Request in the November Budget Request and the Department's Budget Amendment in the February Supplemental Budget Request.

EXHIBIT BB - CALCULATION OF FUND SPLITS

Exhibit BB details fund splits for all Behavioral Health Community Programs budget lines for the current fiscal year Supplemental and the out-year Budget Request. For all of the capitation payments except the Breast and Cervical Cancer Program, the funding is 50% State funds and 50% federal funds. Payments for clients in the Breast and Cervical Cancer Program receive a 65% federal match rate and are described separately below. Capitation expenditures are split between traditional clients and expansion clients funded from Hospital Provider Fee funds. Finally, the recoupments from prior years for behavioral health capitation overpayments, retractions for capitations paid for clients later determined to be deceased, and the Substance Use Disorder benefit are also presented (see Exhibit II for recoupment calculations).

In the capitation base for both years, most clients are paid for with 50% General Fund and 50% federal funds. Expansion clients funded through HB 09-1293 receive State share funding from the Hospital Provider Fee Cash Fund. These clients also receive a 50% federal match.

Medicaid Mental Health Fee-for-Service Payments also receive 50% General Fund and 50% federal funds. The sum of the capitations and the fee-for-service payments comprise the Department's request.

Behavioral Health Services for Breast and Cervical Cancer Program Adults

SB 01S2-012 created the Breast and Cervical Cancer Prevention and Treatment Program. SB 05-209 and HB 08-1373 incorporated funding for the Breast and Cervical Cancer patients into the appropriation for Behavioral Health Community Programs Capitation Payments, effective with the FY 2005-06 budget. Behavioral health care for clients in the Breast and Cervical Cancer Program is managed through the capitation contracts with the behavioral health organizations. Therefore, the budget is based on the behavioral health caseload that includes the Breast and Cervical Cancer Program eligibility category. For this reason, they are shown as a separate eligibility category where appropriate.

Annual designations of General Fund contributions to program costs are specified in sections 25.5-5-308(8), (9), and (10) C.R.S. (2012). Exhibit BB details funds splits for the Behavioral Health Community Programs Capitations line. The funding for the clients already enrolled in the program, called "traditional clients," is 17.5% General Fund, 17.5% cash funds from the Breast and Cervical Cancer Prevention and Treatment Fund, and 65% federal funds in FY 2013-14. In addition, the Department received funding from the Tobacco Tax Bill (HB 05-1262) to enroll more clients in the Breast and Cervical Cancer Program. These clients, called the "expansion clients," are funded by the Prevention, Early Detection, and Treatment Fund administered by the Department of Public Health and Environment and the Tobacco Tax Bill (see the explanation below and Exhibit JJ, which shows all Tobacco Tax impacts, for a full explanation). The funding for the expansion clients was 35% reappropriated funds and 65% federal funds. The program sunsets at the end of FY 2013-14, with the potential to extend the program through new legislation.

Behavioral Health Services for Hospital Provider Fee Expansion Clients

HB 09-1293 established a funding mechanism for a series of expansion clients. The first set of expansion clients that are funded through the bill was parents with income up to 100% of the Federal Poverty Limit (FPL). Services for these clients are funded through the Hospital Provider Fee cash fund. These clients are assumed to be similar to other adult clients and expenditure for these clients is therefore calculated using the same per capita rate as other adult clients (see Exhibit JJ). Starting in FY 2011-12, additional expansion populations also received funding through the Hospital Provider Fee cash fund. These include disabled individuals with income limits up to 450% of the federal poverty level and adults without dependent children, both of which received services through the BHOs as part of their benefit package. The disabled individuals with income limits up to 450% are assumed to be similar to other disabled clients, and expenditure for these clients is therefore calculated using the same per-capita rate as other disabled clients (see exhibit JJ). For the adults without dependent children, the BHOs will be reimbursed at a separate capitation rate than other eligibility categories. The Department estimated expenditure for this population using preliminary assumptions about the rate that will be set for adults without dependent children and the reconciliation method that will be used to ensure that the Department adequately pays the BHOs to serve this new population. See exhibits EE, GG, II, and JJ for more detailed explanations of these assumptions.

Behavioral Health Services for Expansion Populations in SB 11-008 and SB 11-250

SB 11-008, "Aligning Medicaid Eligibility for Children," extended Medicaid eligibility to up to 133% of the federal poverty level (FPL) for all children under the age of 19. Formerly, the eligibility limit for children ages six through 18 was 100% of the FPL and 133% of the FPL for children five and under. The bill shifted impacted children from the CHP+ to Medicaid beginning January 1, 2013. The Department assumes that the expenditure for these children will continue to receive a 65% federal match rate, which is the rate for CHP+.

SB 11-250, "Eligibility for Pregnant Women in Medicaid," extended Medicaid eligibility from 133% to 185% of the FPL for all pregnant women. This bill shifted impacted women from CHP+ to Medicaid on January 1, 2013. The Department assumes that the expenditure for these women will continue to receive a 65% federal match rate.

Behavioral Health Services for Expansion populations in SB 13-200

SB 13-200, "Expanding Medicaid Eligibility in Colorado," extends Medicaid eligibility to up to 133% of the FPL parents of Medicaid eligible children and adults without dependent children, effective January 1, 2014. The Department assumes that the expenditure for parents from 60% to 133% FPL and all adults without dependent children will receive a 100% federal match rate, while adults up to 60% FPL will receive the standard Medicaid match.

EXHIBIT CC - BEHAVIORAL HEALTH COMMUNITY PROGRAMS SUMMARY

Exhibit CC presents a summary of behavioral health caseload and capitation expenditures itemized by eligibility category as well as a summary of the rest of the Behavioral Health Community Programs. The net capitation payments include the impacts of actions with perpetual effect, such as the decrease in payment rates by 1.7%, as well as caseload driven impacts such as the various recoupments and retractions for clients determined to be ineligible. Exhibit EE illustrates the build to the final expenditure estimates presented in this exhibit.

EXHIBIT DD - BEHAVIORAL HEALTH CASELOAD, PER CAPITA, AND EXPENDITURE HISTORY

Exhibit DD contains the caseload, per-capita, and expenditure history for each of the 11 eligibility categories. Each of the tables that comprise Exhibit DD is described below.

Behavioral Health Community Programs Caseload

Behavioral Health Community Programs caseload is displayed in two tables. The first table shows total caseload for the combined disabled categories as well as the combined adult categories. The second table displays caseload by all behavioral health eligibility categories. Figures for fiscal years up to the present fiscal year are actual caseloads, while the current fiscal year and the request year caseloads are estimates. The behavioral health caseload excludes the caseload for partial dual eligible clients and non-citizens and ties to the caseload presented in the Request for Medical Services Premiums, Section E, Exhibit B. Please see the Medicaid Caseload section of the Medical Services Premiums narrative for further discussion of Medicaid caseload projections. The caseload numbers are used in numerous exhibits throughout the Behavioral Health Community Programs exhibits and narrative.

Behavioral Health Community Programs Per Capita Historical Summary

As with caseload, Behavioral Health Community Programs per capita is displayed in two tables. The first table sets forth total per capita for the combined disabled categories as well as the combined adult categories. The second table displays per capita by all behavioral health eligibility categories. However, since the actual per capita from the first table is the same for both disabled categories, and the four adult categories have a single per capita, the true per capita is shown in those categories and will not mathematically be the same as dividing each individual category expenditure by the caseload. Figures for fiscal years up to the present fiscal year are actual per capitas, while the current fiscal year and the request year per capitas are estimates.

Behavioral Health Community Programs Expenditures Historical Summary

The history of expenditures includes combined category and expanded category tables as well as total expenditures for both capitation and fee-for-service expenditures. For fee-for-service expenditure, service categories are listed separately.

Actual expenditures are only available from the Colorado Financial Reporting System (COFRS). Expenditures by eligibility category, other than the Breast and Cervical Cancer Treatment Program, are not available from the COFRS. The Medicaid Management Information System (MMIS) does provide expenditures by eligibility category but does not include offline transactions and accounting adjustments. The two systems typically have minor discrepancies in reported expenditure, often due to accounting adjustments made to the COFRS as fiscal periods close. Because the variance is minor, data from the MMIS can be used to distribute total expenditures from the COFRS across eligibility categories.

A ratio is calculated for each eligibility category by dividing the MMIS eligibility category expenditures by the total MMIS expenditures. The ratio is multiplied by the total expenditures from the COFRS. This calculation estimates actual COFRS expenditures across each eligibility category. The Breast and Cervical Cancer Treatment Program expenditures are carved out of both totals before the

calculations are done, since this is the only category that does not need to be estimated. Once the overall expenditures by eligibility category are determined, they may be divided by the actual average monthly caseload for each eligibility category to determine the actual per capita for each eligibility category.

EXHIBIT EE - ESTIMATE AND REQUEST BY ELIGIBILITY CATEGORY

Exhibit EE provides capitation expenditure calculations for the current fiscal year and the request year.

The Department has adopted a methodology based on forecasting a capitation rate, multiplying that rate by monthly caseload, multiplying again by the number of months that the forecasted rate will be in effect, and then adjusting for incurred claims that will be paid in subsequent years as well as for claims from former years that will be paid in the year of the request. The methodology is a zero-based budget tool that allows the Department to examine projected expenditures each year without building in inappropriate assumptions, estimates, or calculations from preceding years.

The forecasted capitation rate is derived from exhibits FF through HH and will be presented in more detail below. The caseload is the same as presented in Medicaid Medical Services Premiums, Section E, Exhibit B (excepting partial dual eligible clients and non-citizens, as discussed above).

The Department has broken down the current fiscal year and the request year into two components: a first and second quarter estimate (Q1 and Q2) and a third and fourth quarter estimate (Q3 and Q4). This accounts for the fact that the Department makes rate adjustments on a calendar year basis. As such, the Q1 and Q2 capitation rate is known and is the point estimate rate from the previous two quarters (the first two quarters of the calendar year). For the Department's November requests, the current year's Q1 and Q2 rates are known and the remaining rates are estimated. In the February supplemental, the rates for the current year and the first half of the request year are known and only the final two quarters of the request year are estimated. By the time February numbers are presented, the Department has completed its most recent rate setting process, adding to the known set of data. As presented in Exhibit EE, the estimated capitation rate is multiplied by the monthly caseload and then multiplied by the number of months the rate will be in effect.

In order to adjust the calculations for cash accounting, the Department makes two adjustments to the calculation: first, the Department subtracts the incurred amount estimated to be paid in subsequent periods; then, the Department adds the claims incurred in prior periods expected to be paid in the forecast period. These adjustments transform the estimated incurred expenditure to a cash-based figure. The basis for these adjustments is described in this narrative below and is shown starting on page EE-3.

After calculating total expenditure, the anticipated date-of-death retractions for each fiscal year are estimated and added to total expenditure. The Department began an aggressive retraction of payments for deceased clients in FY 2009-10; this activity resulted in

retraction of payments originally made between FY 2004-05 and FY 2008-09 and reduced prior period dates of service expenditure. The Department is continuing to identify these claims and retracts payments twice a year. For the current year, the retractions are estimated as a 10% reduction in the total amount retracted in the previous year. For the request year, the retractions are estimated as a 10% reduction in the estimated amount that will be retracted in the current year. The retractions are expected to decline, as there is a smaller pool of historical clients from which to retract and current processes of identification become more effective.

Incurred-but-not-Reported Estimates

In order to estimate the necessary adjustments to convert the projection to a cash basis, the Department estimates monthly incurred-but-not-reported (IBNR) adjustments based on historical data. Monthly adjustments are required because, for example, claims incurred in July of the current fiscal year have 11 more months of the fiscal year in which the claims can be paid; however, claims incurred in June of the fiscal year only have the remainder of that month in which to be paid before the payment becomes part of the next fiscal year's expenditure.

The Department examined historical data from the last five fiscal years and determined the prior fiscal years would provide a representative model for the likelihood of claims being paid in the year in which they are incurred. Pages F.EE-4 through F.EE-5 presents the percentage of claims paid in a six-month period that come from that same period and those which come from previous periods. The previous four years of expenditure experience were examined and the average was applied to the forecast.

Historically, for each eligibility category except disabled individuals through 64, over 99% of incurred claims are paid by the end of the fiscal year in which the claims were incurred. For the disabled individuals, it takes a full 18 months for 99% of claims to be paid. This is likely due to the relative difficulty in determining and documenting disability as opposed to criteria such as age or income. Hence, a larger percentage of claims from previous periods exist for this category of clients.

It is of note that beginning November 1, 2009, the Department instituted a policy of denying retroactive capitation claims that are from a period beyond 18 months prior to the payment month. For those clients with retroactive claims beyond 18 months who are found to have received services, the Department will reimburse the BHOs through a fee-for-service payment. Since capitations are calculated to pay for actual services delivered by spreading that cost to caseload regardless of whether services are received, the net effect of eliminating cap payments and reimbursing for services may be cost neutral. The Department will monitor this policy change, and, should there be any expenditure fluctuations, the Department will seek to adjust through future budget requests.

On pages F.EE-9 through F.EE-11, the Department calculates the estimated outstanding expenditure from claims remaining from previous period by aid category. The sums are then carried forward to the calculations on pages F.EE-1, F.EE-2, and F.EE-3.

Actuarially Certified Capitation Rates

Capitated rates for the behavioral health organizations are required to be actuarially certified and approved by CMS, thus actuarially certified rate increases could reasonably be expected to be good predictors of future costs. As such, the Department used trends on the historically certified capitation rates to derive the capitation rate presented in Exhibit EE. The methodology for determining the forecasted capitation rate is the subject of Exhibits FF through HH.

EXHIBIT FF - BEHAVIORAL HEALTH RETROACTIVITY ADJUSTMENT AND PARTIAL MONTH ADJUSTMENT MULTIPLIER

Capitations are paid for clients from the date the client's eligibility is effective, resulting in claims paid retroactively. As such, any projection which derives expenditure by using non-retroactive caseload must take into account these retroactive claims. Since expenditures are calculated as the estimated capitation rate multiplied by the non-retroactive caseload, an adjustment for retroactivity can be applied to either the forecasted capitation rate or the caseload figure. In order to maintain the uniform presentation of caseload across all Departmental estimates and requests, the Department chose to make its retroactivity adjustment to the forecasted capitation rate itself.

Additionally, claims-based data (as it is derived from literally the money spent on each claim) is the actual driver of expenditure. Examining the capitation rate for forecasting allows the Department and policy makers to see the relationship of the capitation payments paid to the behavioral health organizations to total expenditure. Forecasting based on trends in the capitation rate will only be as accurate as the relationship between that capitation trend and any trends in the rates of per-claim expenditure. These two rates can (and indeed do) trend similarly, but any difference in trends needs to be captured in order to ensure the accuracy of the forecast. The different trends are usually related to the incidence of payments for partial months of eligibility, which fluctuate for reasons unrelated to the Behavioral Health Capitation program. This difference is captured through a partial-month adjustment multiplier.

Retroactivity Adjustment Multiplier

For the purpose of adjusting the forecasted capitation rate to capture the omission of retroactivity from caseload, the Department analyzed the last five years of claims and caseload data. Page F.FF-1 presents the average monthly claims as compared to the average monthly caseload for those years across eligibility categories. The relatively steady percentage values across each respective eligibility category suggest the ratio is indeed systemic (as created by retroactivity) rather than a unique circumstance. The Department analyzed the data, however, and determined the amount of retroactivity in the claims incurred each period is steadily changing over time and has trended downward for all eligibility categories except for disabled individuals. For this reason, the Department assumes the most recent

period with adequate time for run-out of claims is the best representation of how much retroactivity will affect the claims-to-caseload ratio in the current and request years.

Partial Month Adjustment Multiplier

To derive the partial month adjustment multiplier for the purpose of capturing any difference in trends between the capitation rate trends and the trends on per-claim expenditure, the last five years of data were examined. Prior to FY 2006-07, capitation rates were radically adjusted to capture systemic changes including, but not limited to, shifting to the Department the bulk of Medicaid program responsibility from the Department of Human Services, the consolidation to five behavioral health organizations from eight, and program and financing adjustments resulting from the Goebel lawsuit. Due to these adjustments, the volatility of capitation rates prior to FY 2006-07 would not be a quality indicator of any future comparisons to claims paid.

As presented on page F.FF-2, for each eligibility category, the weighted average claims-based rate (weighted by proportion of total claims within an eligibility category covered by an individual behavioral health organization) was compared to the weighted capitation rate (similarly weighted). Then, the claims-based rate as a percentage of the capitation rate was calculated, providing a simple comparison of any trend in claims-based rates as compared to capitation rates. The percentages are similar across years, indicating claims-based trends are matching capitation trends. The Department analyzed the data, however, and determined the amount of partial months paid each period is steadily changing over time within each eligibility category. For this reason, the Department assumes the most recent period with adequate time for run out of claims is the best representation of how much partial-month payments will affect the claims-based rate in the current and request years.

EXHIBIT GG - BEHAVIORAL HEALTH CAPITATION RATE TRENDS AND FORECASTS

As presented above, the expenditure forecast was derived by examining the trend on the capitation rate and then applying that trend to the monthly cost per client (i.e., the claims-based rate). For the purpose of trend analysis, the weighted capitation rate (weighted by proportion of total claims within an eligibility category covered by an individual behavioral health organization) was examined. Exhibit GG presents historical data as well as the forecasted weighted rates.

Beginning in January of 2009, the Department switched its rate-setting cycle from a state fiscal-year cycle to a calendar-year cycle. Capitation rates are now effective from January 1 through December 31. Therefore, the Department now presents its forecasted rates in six-month blocks to account for the rate change occurring in the middle of a state fiscal year.

The weighted rate is presented along with the percentage change from the previous six months as well as from the average rate of the entire previous fiscal year. The multiple forecast trend models and the criteria for selecting the forecasted capitation rate point estimate are presented in Exhibit HH.

Based on the Department's calculations and rate-setting process and input from the behavioral health organizations, the Department's actuaries certify a capitation rate range for each BHO and eligibility type; the Department is permitted to pay any rate within this range and maintain an actuarially sound capitation payment. To develop the range, the actuaries calculate a single rate (the "point estimate") and the upper and lower bounds around this rate that maintain actuarial soundness.

It is important to note the overall weighted point estimate presented in the exhibit is weighted across two factors. First, the rate is weighted within an eligibility category (that is, weighted by the behavioral health organizations' proportion of claims processed within that eligibility category). Second, that rate is then weighted across all eligibility categories (with the weight derived from the total number of claims processed within an eligibility category as a percentage of total claims processed across all eligibility categories). Because caseload can be increasing or decreasing independently of any one capitation rate, the Weighted Behavioral Health Total rate may not be a clear indicator of the rate trends across all eligibility categories.

Exhibit GG presents the weighted point estimate rates, and the trend of those rates is used for forecasting. The weighted point estimates differ from paid rates, which can change within the upper and lower bounds of the established rate range in response to new rate-setting processes and budget reduction measures. The paid rates, which are discussed below, are not presented in Exhibit GG in order to allow for comparison across years and so as to not artificially inflate or deflate the rate trend and bias the estimated rate in future years.

From January 1, 2009, to June 30, 2009, the Department paid rates 3% above the actuarial midpoint due to a new rate-setting methodology. Beginning September 1, 2009, in accordance with FY 2010-11 ES-2, the Department paid rates that were 2.5% below the actuarial midpoint. New rates were established for the 2010 calendar year and set 2.5% below their certified midpoint rates. However, the Department's rate-setting process and federal regulation require that both the Department and the BHOs actuarially certify they will be able to operate at the proposed paid rates. With the January 1, 2010 rates, two BHOs were unable to certify. The Joint Budget Committee voted to appropriate funding to continue those two BHOs at a continuation of their most recent previously certified rates, the September 1, 2009 rates. These two BHOs continued to be paid their September 1, 2009 rates through CY 2010. The 2.5% reductions to the BHOs' rates will continue to be in effect through future fiscal years, as they are now part of the encounter and historical data used in the rate-setting process. In addition, the rates were reduced by 1.71% in CY 2011. This was originally requested in FY 2010-11 BRI-6 as a 2.0% cut to be effective July 2010. The Joint Budget Committee decided to delay this cut until January 2011 and appropriated it as a savings of $2,170,355 to be achieved in FY 2010-11. The Department determined it would be able to realize savings in FY 2010-11 in this amount by cutting the CY 2011 rates by 1.71%. This rate reduction will continue to be built into the rates in the current and request years, as requested in FY 2011-12 BRI-5.

The Department added a new rate cell in FY 2011-12 for the adults without dependent children expansion population, which will be funded through the Hospital Provider Fee Cash Fund. The rates for CY 2012 and CY 2013 for the adults without dependent children are actuarially certified at $100.81 and $101.87 respectively. The rates are based on data from Disabled Adults and Low-Income Adults rates. In prior budget requests, the Department assumed a large reconciliation component to be paid retroactively; this was, in part, due to the fact there were a great number of unknowns related to the rate setting process. Based on the current expenditure projections, however, the Department has removed the reconciliation component from its expenditure calculations.

EXHIBIT HH - FORECAST MODEL COMPARISONS

Exhibit HH produces the final capitation rate estimates that are used as the source of the expenditure calculations provided in Exhibit EE. Pages F.HH-1 and F.HH-2 present the final rate estimates in their entirety. The final rate estimates are a product of model selection (discussed below) and the necessary adjustments as presented in Exhibit FF.

On page F.HH-3, a series of forecast models are presented for each eligibility category. From the models or from historical changes, a point estimate is selected as an input into pages F.HH-1 and F.HH-2. Based on the point estimates, the adjustments presented in Exhibit FF are then applied and the final, adjusted point estimate is then used in the expenditure calculations of Exhibit EE.

Final Forecasts

Page F.HH-1 begins by presenting the known rates from those already set through the actuarial process and the remaining point estimates of each eligibility category's rate as selected on page F.HH-3 (see below). For Funding Requests, the rate applied to the first six months of the current year is known due to the calendar year rate setting cycle (see the description of Exhibit GG, above). The rate applied to the next six months of the current year is then estimated from a series of trend models and historical changes (see below). That same rate is then carried forward into the first six months of the request year due to the calendar year rate setting cycle. The rate for the last six months of the request year is estimated by taking the percent change in rates from the last known rate to the first forecasted rate and carrying that percentage change forward.

For Supplemental Requests, the rate for the entirety of the current year and the first six months of the request year are known due to the calendar year rate setting cycle. The rate for the final six months of the request year is estimated using the various trend models and historical information described below.

The projected rate is then adjusted by any policy impacts. In accordance with the FY 2010-11 ES-2 budget action, beginning September 1, 2009, the Department has paid rates that are 2.5% below the actuarial midpoint. This rate cut is now incorporated in the data used during the rate-setting process and is no longer included as an adjustment factor in exhibit HH. For Q3 and Q4 of FY 2010-11, the

Department reduced rates by an additional 1.71%. The Department requested this reduction in FY 2010-11 BRI-6, "Medicaid Reductions," for the full year but will be implemented for only two quarters of FY 2010-11, per instructions from the Office of State Planning and Budgeting. The 1.71% reduction will continue to be in effect in the current and request years.

The forecasted rate is also adjusted by the partial month adjustment multiplier, calculated on page F.FF-2. The multiplier is applied to adjust for the fact that the full capitation rate is not paid for every member month. The rate for paid claims is impacted by payments made for partial months of eligibility; this type of payment will not be for a "whole" capitation payment at the current fiscal period's capitation rate. Therefore, the multiplier is applied to convert capitation rates to a figure which is more likely to reflect actual expenditure.

Finally the claims-based rate is adjusted a third time, this time by the retroactivity adjustment. From Exhibit FF, page F.FF-1, this second adjustment is made to capture the retroactivity not captured by the caseload figures. As described in the narrative for Exhibit FF, since caseload does not capture retroactivity, and since projected total expenditure is equal to caseload times the projected rate, either the rate or the caseload must be adjusted to capture retroactivity. To keep behavioral health caseload matched to other caseload figures presented by the Department, the adjustment is made to the projected rate yielding the final forecasted rate, which is the rate used to drive the expenditure calculation presented in Exhibit EE. A similar methodology is applied to the rates in each eligibility category and for each fiscal period.

Capitation Trend Models

The forecasted capitation rates are the result of a point estimate selection from among several forecast trend models and historical information. These models are presented on page F.HH-3 and historical midpoint rates are presented in Exhibit GG.

For each eligibility category, four different trend model forecasts were performed: an average growth model, a two-period moving average model, an exponential growth model, and a linear growth model. The average growth model examines the rate of change in the capitation rate and applies the average rate of change to the forecast period. The two-period moving average model projects the forecast period will see a change in the capitation rate that is the average of the last two changes in the capitation rate. The exponential growth model assumes the capitation rate is increasing faster as time moves forward (a best-fit exponential equation is applied to the historical data and trended into the future). The linear growth model is a regression model on time, fitting a linear equation line to the historical data and forecasting that line into the future. Each model in the exhibit also shows what the percent change would be from the prior period.

The Department's decisions for trend factors are informed, in part, by preliminary calculations from the actual rate setting process. Because those calculations remain preliminary, the Department does not explicitly use them in estimating trend factors.

Capitation rates are required to be actuarially sound and are built from a blend of historical rates and recent year encounter data (provider expenditure on services). The trends models, as presented in this exhibit, are an attempt to predict the final outcome of this rate setting process. However, the use of historical, final rates as data points for predicting future rates is limited when future periods are likely to be fundamentally different than historical periods. Beginning with FY 2008-09 the Department has experienced unusual trends for the behavioral health capitation program. This program, in its present state, has never existed in an economic climate like the one currently being experienced. As such, the various rate estimating models' reliance on historical performance for predicting future performance is limited. The Department has used the trend models to establish a range of reasonable rate values and has selected trends by considering the various factors that impact the respective eligibility populations as well as the impact that encounter data will have on the rate setting process. As such, the Department believes the most recent years' experience is the most predictive of the likely current year and future year experiences. The following table shows the trends selected for the current and request years by eligibility category.

Aid Category	**CY 2015 Trend Selection**	**CY 2016 Trend Selection**	**Justification**
Adults 65 and Older (OAP-A)	3.17%	3.17%	The rate setting methodology has changed for rates effective 1/1/14. The previous rate setting process involved the actuaries setting rates that were actuarially sound in aggregate. The new methodology now involves setting actuarially sounds rates for each aid category. With a lack of data points to base our trend selection on our current models outputs, the trends selected for CY 2015 and CY 2016 are the average between the lower bound and the mid-point trends supplied by the actuaries. The trends are in effect for FY 2013-14 Q3 and Q4 through CY 2015.
	Average of lower bound and mid-point trend estimates supplied by actuaries	Average of lower bound and mid-point trend estimates supplied by actuaries	
Disabled Individuals Through 64 (AND/AB, OAP-B)	3.94%	3.94%	The rate setting methodology has changed for rates effective 1/1/14. The previous rate setting process involved the actuaries setting rates that were actuarially sound in aggregate. The new methodology now involves setting actuarially sounds rates for each aid category. With a lack of data points to base our trend selection on our current models outputs, the trends selected for CY 2015 and CY 2016 are the average between the lower bound and the mid-point trends supplied by the actuaries. The trends are in effect for FY 2013-14 Q3 and Q4 through CY 2015.
	Average of lower bound and mid-point trend estimates supplied by actuaries	Average of lower bound and mid-point trend estimates supplied by actuaries	

Low Income Adults	2.41%	2.41%	The rate setting methodology has changed for rates effective 1/1/14. The previous rate setting process involved the actuaries setting rates that were actuarially sound in aggregate. The new methodology now involves setting actuarially sounds rates for each aid category. With a lack of data points to base our trend selection on our current models outputs, the trends selected for CY 2015 and CY 2016 are the average between the lower bound and the mid-point trends supplied by the actuaries. The trends are in effect for FY 2013-14 Q3 and Q4 through CY 2015.
	Average of lower bound and mid-point trend estimates supplied by actuaries	Average of lower bound and mid-point trend estimates supplied by actuaries	
Adults without Dependent Children	2.90%	2.90%	The rate setting methodology has changed for rates effective 1/1/14. The previous rate setting process involved the actuaries setting rates that were actuarially sound in aggregate. The new methodology now involves setting actuarially sounds rates for each aid category. With a lack of data points to base our trend selection on our current models outputs, the trends selected for CY 2015 and CY 2016 are the average between the lower bound and the mid-point trends supplied by the actuaries. The trends are in effect for FY 2013-14 Q3 and Q4 through CY 2015.
	Average of trends for all eligibility types for the lower bound and mid-point ranges developed by the actuaries	Average of trends for all eligibility types for the lower bound and mid-point ranges developed by the actuaries	
Eligible Children (AFDC-C/BC)	2.84%	2.84%	The rate setting methodology has changed for rates effective 1/1/14. The previous rate setting process involved the actuaries setting rates that were actuarially sound in aggregate. The new methodology now involves setting actuarially sounds rates for each aid category. With a lack of data points to base our trend selection on our current models outputs, the trends selected for CY 2015 and CY 2016 are the average between the lower bound and the mid-point trends supplied by the actuaries. The trends are in effect for FY 2013-14 Q3 and Q4 through CY 2015.
	Average of lower bound and mid-point trend estimates supplied by actuaries	Average of lower bound and mid-point trend estimates supplied by actuaries	
Foster Care	3.10%	3.10%	The rate setting methodology has changed for rates effective 1/1/14. The previous rate setting process

	Average of lower bound and mid-point trend estimates supplied by actuaries	Average of lower bound and mid-point trend estimates supplied by actuaries	involved the actuaries setting rates that were actuarially sound in aggregate. The new methodology now involves setting actuarially sounds rates for each aid category. With a lack of data points to base our trend selection on our current models outputs, the trends selected for CY 2015 and CY 2016 are the average between the lower bound and the mid-point trends supplied by the actuaries. The trends are in effect for FY 2013-14 Q3 and Q4 through CY 2015.

The selected point estimates of the capitation rates are adjusted on pages F.HH-1 and F.HH-2, as described above, for use in the expenditure calculations presented in Exhibit EE.

EXHIBIT II - RECOUPMENTS AND RECONCILIATIONS

Recoupments

Capitation payments are made on a monthly basis throughout the year in the Medicaid Management Information System (MMIS). When clients are determined to be eligible for benefits retroactively, retroactive capitation payments are made to the behavioral health organizations through the MMIS. When clients are determined to be ineligible for Medicaid benefits retroactively, a recoupment of the capitation payments is completed separately. Exhibit II summarizes the expected fiscal impacts.

The Department has worked to reduce the payments to the behavioral health organizations for clients later deemed ineligible for Medicaid. Historically, monthly capitation payments were made on a prospective basis. In February 2004, the Department converted to concurrent capitation payments. FY 2004-05 was the first full year for monthly capitation payments on a concurrent basis.

No recoupments were made during FY 2005-06 due to a computer programming change, and this has delayed the recoupment process. In FY 2006-07, recoupments from FY 2003-04 were processed. In FY 2007-08, no recoupments were processed as the Department sought to verify eligibility information provided by the behavioral health organizations. This process has proven to be complicated by the various reporting practices of the community behavioral health centers that provide services to clients. The Department collaborated with the Centers for Medicare and Medicaid Services (CMS) to develop a retrospective eligibility validation process which the Department implemented in FY 2009-10. Recoupments from FY 2005-06 through FY 2007-08 were processed in the latter half of FY 2009-10. In FY 2010-11, recoupments were collected for FY 2004-05. The Department recouped expenditure for FY 2008-09 ineligibles at the beginning of FY 2011-12. The recoupments from incurred expenses in FY 2008-09 were altered in their federal fund split due to the impact of the American Recovery and Reinvestment Act. Since those expenditures were made with enhanced federal

funds, any recoupments will also see a disproportionate share of federal funds retrieved. Recoupments from FY 2009-10 were set for collection in FY 2012-13, but due to timely filling, requirements from CMS were collected in FY 2011-12. Recoupments for FY 2009-10 are altered by the enhanced federal match from the year the claims were processed. Due to timely filing issues raised by federal authorities, the Department will not be processing reconciliations for FY 2010-11. As a result, the Department estimates that reconciliations will be lower in FY 2012-13 that previously estimated. Reconciliations are anticipated to return to previous levels in subsequent years. Recoupments from FY 2011-12 will be collected in FY 2012-13, and those from FY 2012-13 as well as future recoupments will no longer be made by the Department due to issues related to timely filing; instead, capitation rates will be adjusted accordingly.

The most recent recoupment made by the Department was for FY 2009-10 ineligibles. The methodology used to calculate the recoupment for that year differs slightly from previous years. The data for that fiscal year is also more reliable than past fiscal years due to data standardization and verification efforts undertaken by the BHOs and the Department. For those reasons, the Department estimated future recoupments using the FY 2009-10 actual amount as a base and inflating it by the growth rate in caseload for that fiscal year. Beginning in FY 2012-13, the Department will no longer request recoupments for ineligibles.

EXHIBIT JJ - EXPANSION POPULATIONS

Exhibit JJ is a stand-alone exhibit designed to show the effect of the Colorado Health Care Affordability Act (HB 09-1293) and other bills to the Behavioral Health Community Programs. This exhibit presents projected caseload and costs itemized by eligibility category for the current year and the request year. Note the caseloads shown are the average monthly number over each year and will fluctuate throughout the year.

Tobacco Tax Bill:

HB 05-1262 established a number of funds, two of which provide funding to the Behavioral Health Community Programs line: the Health Care Expansion Fund administered by the Department; and the Prevention, Early Detection, and Treatment Fund administered by the Department of Public Health and Environment. The Health Care Expansion Fund provided capitated behavioral health funding for expansion adults, individuals eligible as a result of the removal of the Medicaid asset test, the expansions of the Children's Extensive Support and Children's Home and Community Based Services waiver programs, optional legal immigrants eligible for services as a result of HB 05-1086, and foster care clients eligible for services up to the age of 21 as a result of beginning SB 07-002. The Health Care Expansion Fund became insolvent in FY 2010-11. Any additional revenue that comes into the fund will be used to offset General Fund expenditure in Medical Services Premiums; effective in FY 2011-12, there are no longer any behavioral health services funded by the Health Care Expansion Fund.

The Prevention, Early Detection, and Treatment Fund provides funding for cancer treatment through its Breast and Cervical Cancer Treatment program, and historically 30% of the Breast and Cervical Cancer Program caseload is paid for out of this fund. The Department requested a change to the allocation of traditional and expansion clients in FY 2012-13 in order to avoid overspending the amount appropriated to the Department of Public Health and Environment for transfer to the Department for Breast and Cervical Cancer Treatment. The Department of Public Health and Environment's appropriation for the Breast and Cervical Cancer Treatment program was $1,215,340. The Department requested $1,215,340 in reappropriated funds for Breast and Cervical Cancer Program expansion clients in request S-1, "Request for Medical Services Premiums." As this is the total balance of available reappropriated funds, the Department is requesting to fund all Breast and Cervical Cancer Program clients in the Behavioral Health Community Programs Long Bill Group from the Breast and Cervical Cancer Prevention and Treatment Fund and General Fund.

Colorado Health Care Affordability Act

HB 09-1293, the "Colorado Health Care Affordability Act" provided funding to provide health care coverage for uninsured Coloradans in FY 2009-10 and beyond. The Department began collecting fees from hospitals in April 2010 for the Hospital Provider Fee cash fund and started extending benefits to expansion clients in May 2010.

The first expansion population to be affected by HB 09-1293 was the expansion adult population with income limits up to 100% of the federal poverty level (FPL). The Department assumed that the costs for this population was the same as for the traditional population, as the vast majority of behavioral health services payments are made via capitation and do not change based on client utilization. An additional population has been added in FY 2011-12 consisting of working disabled adults with income up to 450% of the federal poverty level and disabled children with income up to 300% of the federal poverty level. As with adults, the Department assumes that the costs for this population will be the same as for the traditional population.

The Department also expanded eligibility to cover adults without dependent children in FY 2011-12. The program is initially limited to 10,000 clients. This population received the full range of behavioral health services provided by the BHOs, and the BHOs were paid at a different capitation rate for these members than any of its other eligibility categories. The Department's caseload projections for all HB 09-1293 expansion populations are provided in this Budget Request (see exhibit B in Medical Services Premiums).

Aligning Medicaid Eligibility for Children and Eligibility for Pregnant Women in Medicaid

SB 11-008, "Aligning Medicaid Eligibility for Children," extended Medicaid eligibility to up to 133% of the FPL for all children under the age of 19. Formerly, the eligibility limit for children ages six through 18 was 100% of the FPL and 133% of the FPL for children five and under. The bill shifted impacted children from the CHP+ to Medicaid beginning January 1, 2013. The Department assumed the expenditure for these children will continue to receive a 65% federal match rate, which is the rate for CHP+. As with most of the

Hospital Provider Fee populations, the Department assumed the per-capita costs for this expansion population would be the same as for the traditional population since the majority of behavioral health expenditure is paid through the capitation program.

SB 11-250, "Eligibility for Pregnant Women in Medicaid," extended Medicaid eligibility from 133% to 185% of the FPL for all pregnant women. This bill shifted impacted women from CHP+ Medicaid on January 1, 2013. The Department assumes the expenditure for these women will continue to receive a 65% federal match rate and that the per-capita costs will be the same as for the traditional population.

Expanding Medicaid Eligibility in Colorado

SB 13-200, "Expanding Medicaid Eligibility in Colorado," extends Medicaid eligibility to up to 133% of the FPL parents of Medicaid eligible children and adults without dependent children, effective January 1, 2014. The Department assumes that the expenditure for parents from 60% to 133% FPL and all adults without dependent children will receive a 100% federal match rate, while adults up to 60% FPL will receive the standard Medicaid match.

EXHIBIT KK - MEDICAID MENTAL HEALTH FEE-FOR-SERVICE PAYMENTS

Medicaid Mental Health Fee-for-Service Payments is a separate budget line item in Behavioral Health Community Programs. Expenditures for this line are shown in Exhibit KK. The data from Exhibit KK also appears in Exhibits AA, BB, and CC as well as the Schedule 13.

The Medicaid Mental Health Fee-for-Service Payments appropriation allows Medicaid clients not enrolled in a behavioral health organization to receive mental health services or enrolled Medicaid clients to receive mental health services not covered by the behavioral health organizations. The services are not covered either because the client is not enrolled in a behavioral health organization or the services are outside the scope of the behavioral health organization contract. Medicare crossover claims are included in the fee-for-service category; these are behavioral health organization covered services for clients enrolled in a behavioral health organization who are eligible for both Medicare and Medicaid.

Fee-for-service providers include, but are not limited to hospitals, psychiatrists, psychologists, primary care physicians, and behavioral health centers. The State also reimburses providers through fee-for-service if either the diagnosis or the procedure is not included in the behavioral health organization contract or the patient is not enrolled in a behavioral health organization.

History and Background Information

The nature of Medicaid Mental Health Fee-for-Service Payments has changed in recent years. Prior to FY 2002-03, Fee-for-Service Payments were included in the Behavioral Health Capitation base appropriation. During FY 2002-03, case management services provided by community mental health centers were included in the Mental Health Fee-for-Service Payments appropriation. During FY 2003-04, case management services were provided by Single Entry Point agencies and were still part of the Mental Health Fee-for-Service Payments appropriation, but they were moved to the Medical Services Premiums appropriation in FY 2004-05. Also during FY 2004-05, fee-for-service mental health care for developmentally disabled clients living in Regional Centers was transferred from the Department of Human Services to the Department's Mental Health Fee-for-Service Payments appropriation. The changes to case management services and mental health care for developmentally disabled clients are discussed below.

Historically, community mental health centers provided case management services to the Children's Home- and Community-Based Services for the Mentally Ill waiver clients on a fee-for-service basis. Effective July 1, 2003, the Department began utilizing contracted Single Entry Point agencies for these services instead of the community mental health centers. Funding for these case management services remained in the fee-for-service payments appropriation for FY 2003-04. However, since Single Entry Point contracts are customarily paid from the Medical Services Premiums, the Department requested these services be transferred to the Medical Services Premiums Long Bill group. The supplemental appropriation to the Department (SB 05-112) moved Single Entry Point case management from the Mental Health Fee-for-Service Payments line item to the Medical Services Premiums line item in FY 2004-05 and was effective July 1, 2004.

The supplemental appropriation to the Department (SB 05-112) also authorized the transfer of the fee-for-service mental health care for developmentally disabled clients living in Regional Centers from the Department of Human Services to the Department. This followed a September 3, 2004 1331 Supplemental which was approved by the Joint Budget Committee on September 21, 2004, for the transfer of funds from the Department of Human Services for Developmental Disability State Plan services. This action funded State Plan services provided to clients in the Developmentally Disabled waiver for Children's Home and Community Based Services as required by the Centers for Medicare and Medicaid Services, effective October 1, 2004.

The expenditures in Exhibit KK are broken out into the three major categories which make up Medicaid Mental Health Fee-for-Service: inpatient services, outpatient services, and physician services.

Current Calculations

The current fiscal year's total estimated expenditure is based on the actual expenditures made year to date, trended forward based upon the expected change in caseload from the first half of the year to the second half of the year. The request year estimate is the result of a

forward trend of the current-year estimate by the factor of the anticipated change in caseload, and this is then trended forward by the anticipated change in caseload for the out-year estimate.

No rate or utilization increases are forecasted, although the Department is currently investigating the feasibility and necessity of incorporating such adjustments. Mental health fee-for-service expenditure has increased drastically over previous years. The Department has been performing data analysis using fee-for-service claims in an attempt to determine what caused the increase and whether or not it will continue to grow in the future. In the process, the Department discovered there was an error in the MMIS in which certain services billed as fee-for-service claims for BHO-enrolled clients are paying when they should be denied by the MMIS and billed to the appropriate BHO. This error was corrected through a system change effective November 2011. Initial data analysis since November shows there was a decline in the expenditure paid as mental health fee-for-service due to the system change. The Department will continue to monitor its impact as more data becomes available over time and may request for a decrease in its appropriation if the expenditure decreases as expected through the standard budget process.

EXHIBIT LL - GLOBAL REASONABLENESS TEST FOR BEHAVIORAL HEALTH CAPITATION PAYMENTS

The Global Reasonableness Test presented in Exhibit LL compares the percent change between behavioral health capitation expenditures as reported in Exhibit DD and forecasted in Exhibit EE. The FY 2013-14 appropriation is 26.38% higher than FY 2012-13 actual expenditures, primarily due to caseload growth. The FY 2013-14 estimate incorporates increased caseload projections along with various rate adjustments for budget cutting initiatives and results in a 25.82% increase from FY 2012-13 actual expenditures and a -0.45% decrease from the current appropriation. The FY 2014-15 estimate is built on the FY 2013-14 estimate and presents a 28.10% expenditure increase. This increase is primarily due to: 1) increased caseload projections for traditional clients; 2) increased caseload due to the Colorado Health Care Affordability Act expansion populations; and 3) projected increases in capitation rates from CY 2012 to CY 2014. The FY 2014-15 request represents a 27.53% increase over the current FY 2013-14 appropriation. The FY 2015-16 Budget Request is built on the FY 2014-15 estimate and represents a 9.67% expenditure increase over the FY 2014-15 request and a 39.87% increase over the FY 2013-14 appropriation.