

**Schedule 13  
Funding Request for the 2013-14 Budget Cycle**

Department: Health Care Policy and Financing  
 Request Title: Substance Use Disorder Benefit  
 Priority Number: R-7  
 Dept. Approval by: John Bartholomew *JB* 10/26/12 Date  
 OSPB Approval by: [Signature] 10/30/12 Date

- Decision Item FY 2013-14
- Base Reduction Item FY 2013-14
- Supplemental FY 2012-13
- Budget Amendment FY 2013-14

Line Item Information		FY 2012-13		FY 2013-14		FY 2014-15
		1	2	3	4	5
	Fund	Appropriation FY 2012-13	Supplemental Request FY 2012-13	Base Request FY 2013-14	Funding Change Request FY 2013-14	Continuation Amount FY 2014-15
<b>Total of All Line Items</b>	<b>Total</b>	\$4,304,134,650	\$0	\$4,348,450,732	\$5,788,068	\$9,081,619
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	\$1,194,629,067	\$0	\$1,238,046,775	\$1,818,130	\$2,740,119
	GFE	\$312,202,624	\$0	\$312,202,624	\$0	\$0
	CF	\$665,268,289	\$0	\$640,200,403	\$42,035	\$97,407
	RF	\$3,215,340	\$0	\$1,215,340	\$0	\$0
	FF	\$2,128,819,330	\$0	\$2,156,785,590	\$3,927,903	\$6,244,092
<b>(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects</b>	<b>Total</b>	\$5,940,552	\$0	\$5,902,552	\$100,000	\$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	\$1,312,418	\$0	\$1,262,418	\$50,000	\$0
	GFE	\$0	\$0	\$0	\$0	\$0
	CF	\$437,500	\$0	\$468,500	\$0	\$0
	RF	\$0	\$0	\$0	\$0	\$0
	FF	\$4,190,634	\$0	\$4,171,634	\$50,000	\$0
<b>(2) Medical Services Premiums</b>	<b>Total</b>	\$3,985,613,386	\$0	\$4,026,532,673	\$415,440	(\$1,901,422)
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	\$1,050,603,677	\$0	\$1,092,869,207	(\$11,820)	(\$953,140)
	GFE	\$312,202,624	\$0	\$312,202,624	\$0	\$0
	CF	\$651,181,857	\$0	\$626,082,971	(\$282)	(\$33,883)
	RF	\$3,215,340	\$0	\$1,215,340	\$0	\$0
	FF	\$1,968,409,888	\$0	\$1,994,162,531	\$427,542	(\$914,399)
<b>(3) Medicaid Mental Health Community Programs; Mental Health Capitation Payments</b>	<b>Total</b>	\$312,580,712	\$0	\$316,015,507	\$5,272,628	\$10,983,040
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	\$142,712,972	\$0	\$143,915,150	\$1,779,950	\$3,693,259
	GFE	\$0	\$0	\$0	\$0	\$0
	CF	\$13,648,932	\$0	\$13,648,932	\$42,317	\$131,290
	RF	\$0	\$0	\$0	\$0	\$0
	FF	\$156,218,808	\$0	\$158,451,425	\$3,450,361	\$7,158,491

Letternote Text Revision Required? Yes: No:  If yes, describe the Letternote Text Revision:  
 (2) Medical Services Premiums: Of this amount, ~~\$482,144,867~~ \$482,111,758 shall be from the Hospital Provider Fee Cash Fund created in Section 25.5-4-402 3 (4), C.R.S.;  
 (3) Medicaid Mental Health Community Programs: a Of this amount, ~~\$13,614,743~~ \$13,656,881 (H) shall be from the Hospital Provider Fee Cash Fund created in Section 25.5-4-402 3 (4), C.R.S.

Cash or Federal Fund Name and COFRS Fund Number: CF: Hospital Provider Fee Cash Fund [24A], FF: Title XIX.

Reappropriated Funds Source, by Department and Line Item Name:  
 Approval by OIT? Yes: No: Not Required:   
 Schedule 13s from Affected Departments:  
 Other Information:



# DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

John W. Hickenlooper  
Governor

FY 2013-14 Funding Request  
November 1, 2012

Susan E. Birch  
Executive Director

  
Signature

  
Date

*Department Priority: R-7  
Substance Use Disorder Benefit*

Summary of Incremental Funding Change for FY 2013-14	Total Funds	General Fund	FTE
Substance Use Disorder Benefit	\$5,788,068	\$1,818,130	0.0

### Request Summary:

The Department of Health Care Policy and Financing and the Department of Human Services are submitting a series of coordinated requests to strengthen Colorado's behavioral health system. Collectively, the Departments are submitting requests to expand the Medicaid substance use disorder benefit; establish a comprehensive statewide behavioral health crisis care system for persons, families, and communities; expand community services for individuals with behavioral health needs to help avoid institutional placement; and, increase the number of available beds for individuals who have determined by the court to be Incompetent to Proceed (ITP). Collectively, these requests address current and serious unmet needs in the state's behavioral health system.

The Department requests \$5,788,068 total funds, \$1,818,130 General Fund in FY 2013-14 and \$9,081,619 total funds, \$2,740,119 General Fund in FY 2014-15 to enhance its existing substance use disorder benefit by administering services through Behavioral Health Organizations (BHO), expanding limitations on current services and adding appropriate services to create a more robust program. A high percentage of individuals with mental health disorders have a co-occurring

substance use disorder. Integrating substance use disorder services with the BHO benefit would provide clients with better care coordination and ensure they receive services necessary for recovery. Under the current fee-for-service structure, substance use disorder services are unmanaged and providers are unable to design comprehensive treatment programs as a result of the limited benefit offered by the Department. By expanding these services, the BHOs would be able to create a complete care program to aid clients in their recovery from addiction.

### Problem or Opportunity:

The current Medicaid substance use disorder benefit operates in a fee-for-service environment which offers little client support outside of the acute care provider as the client recovers. In addition, providers are very limited in the services that can be offered to clients under the current benefit. Many of the substance use disorder services have caps on the number of units that can be provided and the services available for treatment are not inclusive of many evidence-based successful benefits such as medication assisted treatment and peer support. The Department believes that moving the substance use disorder benefit under the BHO managed care framework, while also increasing

limits on services and adding appropriate services, would better treat substance use disorders and improve the overall health of the client.

**Brief Background:**

Prior to FY 2006-07 the Department offered substance use disorder treatment on a limited basis to pregnant women and recent mothers, up to one year postpartum, and clients who needed substance use disorder treatment when it was medically necessary to treat another covered condition. In 2005 the General Assembly passed HB 05-1015, which amended the Colorado Medical Assistance Act, section 25.5-5-202(1)(s)(I), C.R.S. (2012), and added substance use disorder treatment as a basic service available to all Medicaid clients.

In FY 2011-12 the Department spent \$2,931,529 on substance use disorder services for approximately 6,786 clients. This was an increase in expenditure of approximately 33% from FY 2010-11. The Department anticipates the utilization of these services will continue to grow as clients become more aware of service availability and with the addition of the Adults without Dependent Children (AwDC) population which expanded the number of adults on Medicaid by 10,000 clients in FY 2011-12.

**Proposed Solution:**

The Department requests to move the existing substance use disorder benefit under the scope of the BHO contracts, increase the limit on the current services offered, and expand the services available to clients. The Department would increase limits on: assessments; detoxification services; behavioral health counseling; group counseling; case management; safety assessments; drug screenings; and provision of daily living needs. The Department would also add medication assisted treatment and peer advocate services to the list of covered benefits. A complete description of the services and proposed changes are shown in appendix A, table 4. Many of the services currently offered do not allow providers to create an effective treatment

plan because they have unit caps which limit provider recommendations. The Department also believes that adding services to the benefit would better enable providers to treat clients and potentially create savings by improving the overall health of the client.

**Anticipated Outcomes:**

The Department believes moving the substance use disorder benefit to a full risk managed care program through the BHO contracts would result in a larger provider network and the addition of valuable care management for this population. Ensuring that clients have access to appropriate services and assistance in navigating the behavioral health system should result in increasing treatment of substance use disorders which could improve the overall health of the client.

In a study conducted by the Office of the State Auditor, a comparison was done between substance use disorder service costs and other medical costs for the same clients in FY 2006-07 through FY 2008-09. The auditors saw a reduction in medical costs for clients who had received substance use disorder services, but were not, however, able to determine whether the reduction in costs was a result of the treatment or other factors. While this study was not able to prove that substance use disorder treatment directly reduces other medical costs, the Department believes that providing treatment greatly improves the overall health of the client as it reduces clients' risks for a variety of health conditions and accidents and could therefore reduce costs. This view is supported by research from the National Center for Addiction and Substance Abuse at Columbia University, which has found that untreated addiction alone causes or contributes to more than 70 other diseases requiring hospitalization. In Washington, substance use disorder treatment was shown to save \$311 per month in medical costs for Medicaid members. In California, substance use disorder treatment reduced ER visits by 39%, hospital stays by 35% and total medical costs by

26% (Substance Abuse and Mental Health Services Administration (SAMHSA)).

The Department anticipates that moving the substance use disorder benefit to the BHO contracts would improve health outcomes and recovery success through outreach and benefits management. These organizations specialize in behavioral health and are well trained and equipped to define and carry out substance use disorder outreach and treatment plans with clients. All Medicaid clients have access to behavioral health services through the BHOs. By providing substance use disorder services through these organizations, not only would more clients be referred to treatment through regular BHO visits, but care coordination would improve through case management. Clients would also be able to receive care in one location for multiple issues. The Department believes that concurrently treating underlying conditions leads to better outcomes than individual treatment of symptoms.

In addition to a more managed structure, the Department requests to increase the availability of current services and expand the substance use disorder benefit to include new services better aligned to serve the needs of clients. The Department has already received a number of recommendations for program improvements through a focused study conducted by Signal Behavioral Health Network in 2010 designed to make program recommendations for the AwDC population. This study included 24 subject matter experts, some of which currently act as providers for the Department. The recommendations primarily discussed ways to improve the substance use disorder service package by expanding the current benefit and proposed new services that would improve client outcomes.

By expanding current limitations on benefits and adding services to better meet the need of the clients, the Department anticipates the BHOs would create care plans to sufficiently aid clients in recovery. A more robust program would overcome some of the service limitation issues

that current fee-for-service providers experience. For example, allowing 52 urinalysis units, as opposed to the current benefit of 36, would allow the BHOs to monitor substance use on a weekly basis. This change could help improve client accountability and success in the recovery process.

The Department intends to utilize the Benefits Collaborative process, as well as the Signal recommendations to encourage further stakeholder involvement in creating an effective substance use disorder benefit. The Benefits Collaborative serves as the Department's formal coverage standard development process. The Benefits Collaborative is a stakeholder driven process for ensuring that benefit coverage standards are: based on the best available clinical evidence; outline the appropriate amount, duration, and scope of Medicaid services; set reasonable limits upon those services; and, promote the health and functioning of Medicaid clients.

Beyond direct health outcomes, research by the National Center for Addiction and Substance Abuse at Columbia University has found that health-related costs represent only 26 cents of every dollar spent on substance use disorder. The other 74 cents goes to Justice, Education, Child/Family Services and other costs. By providing treatment to individuals with substance use disorders, the overall burden to State government for related costs may be reduced.

#### **Alternatives:**

The Department considered substance use disorder service limitation and additional benefits in the fee-for-service environment. However, given other states' experience and recommendations from stakeholders, the Department believes a managed care structure through the BHOs would result in overall better health outcomes and lower total costs of care for these clients.

### **Assumptions for Calculations:**

The Department assumes the benefit would be implemented January 1, 2014. To be consistent with annual BHO rate setting and to allow the Department enough time to update the 1915(b) waiver and make appropriate rule changes the Department believes this timeline to be the most appropriate for implementing this request.<sup>1</sup>

The Department requests \$100,000 for actuarial consulting services to assist the Department in calculating an add-on substance use disorder treatment rate that is actuarially sound. Adding the existing fee-for-service substance use disorder benefit and two new services to the BHO contract, as well as expanding the limits of existing services, will require the Department to calculate an actuarially sound rate using existing data, data collected by the Division of Behavioral Health, and other sources. The Department will require actuarial assistance in developing a rate setting model and a risk sharing mechanism, validating the existing data, identifying supplemental data sources if needed, calculating the anticipated utilization increase, calculating trend, and certifying a substance use capitation rate.

The Department would utilize the Benefits Collaborative process to determine actual benefit changes. However, in order to estimate costs associated with the request, the Department utilized benefit recommendations from the stakeholders involved in the Signal report. The Department believes that these assumptions are reasonable to approximate the final benefit.

Should the Department obtain differing information from the Benefits Collaborative

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<sup>1</sup> Please note that because the BHO contracts are scheduled to be reproced in July 2014, it may not be possible to add this benefit to the BHO contracts prior to that date. If so, the Department assumes that it would administer an enhanced SUD benefit through the current fee-for-service delivery system until the benefit can be added to the BHO contracts. The Department would work with stakeholders to determine the best course of action, and use the regular budget process to account for any necessary changes to the implementation assumed in this request.

process and determine the change would require an adjustment to the budget, the Department would request funding through the normal budget process. The Department does, however, intend to design a program limited to the fiscal bounds of this request. While the details of the revised program may differ from the request, the Department does not anticipate the difference to be so great as to require additional funding. The BHOs have already demonstrated competencies in managing a statewide Medicaid benefit under significant budget constraints and the Department anticipates that they would be able to ensure that care is managed within established limits. The current BHO contracts contain an option clause to make substance use disorder a covered benefit; the Department would not need to use the procurement process to add this benefit to the contracts.

The Department anticipates that adding the substance use disorder benefit to the BHO contract would increase both the number of clients using services and the number of services each client receives. Providing case management through the BHOs would better align clients' needs for a more successful recovery program. Some of these needs would be met through increasing the maximum number of units allowed by the Department for particular services.

In addition, administering the program through the BHOs would not only increase utilization by providing outreach to potential clients but also by offering a larger provider network once a client is referred to the program. In FY 2009-10 the Department implemented the Screening, Brief Intervention and Referral to Treatment (SBIRT) program designed to identify clients with potential substance use disorders and refer them to treatment. Currently, primary care physicians must identify local substance use disorder treatment providers when they identify a need through SBIRT or otherwise. By moving treatment for substance use disorders to the BHO contracts, the referral becomes much easier for the providers and for the clients as they would be

assigned a case manager at the beginning of the treatment process.

Due to the unique nature of this request the Department was unable to find specific information from other states' experience to help determine utilization assumptions of moving the substance use disorder benefit from the fee-for-service structure to managed care under the BHO contracts. As a result, the Department has made some broad assumptions about utilization. In estimating the impact of moving the substance use disorder services to the BHO contracts the Department assumes a 100% increase in utilization. The Department assumes that not all of the growth in clients utilizing services would be new clients. Many existing clients would remain in the program as they are allowed a larger mix of services for a longer time.

The Department assumes a 20% increase in the number of units per client as a result of this request. The Department believes that coordination through the BHO's case managers would increase the number of services each client receives as case managers assist in constructing treatment plans.

The Department assumes two new services would be added as a result of this request: medication-assisted treatment and peer support services. Medication-assisted treatment is the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders. Research shows that when treating substance use disorders, a combination of medication and behavioral therapies is most successful. Medication-assisted treatment is clinically driven with a focus on individualized patient care. To estimate costs for this service the Department estimated current per utilizer costs for medication-assisted treatment and estimated an increase in utilization, ramping up to twice as much as the current benefit in FY 2014-15.

Peer support services are an integral component of a recovery-oriented system of care (ROSC).

Traditionally, recovery-oriented services have been viewed as activities that occur after a formal substance use treatment episode. However, this view has changed and recovery-oriented activities and approaches are part of the full continuum of care in partnership with other disciplines, such as mental health and primary care. Recovery management is shifting the substance use disorder treatment world from an acute care model, which treats medical conditions in an intensive short-term manner, to a chronic care approach reflecting a commitment to long-term supports and wellness. Recovery-oriented activities include providing a menu of traditional treatment services and alternative therapies, such as peer support services.

Providing medication-assisted treatment and peer support services aligns with best practices, SAMHSA supported treatment models, and SAMHSA sponsored state activities such as the Access to Recovery (ATR) and Bringing Recovery Support Systems to Scale (BRSS TACS) projects managed by the Office of Behavioral Health. To estimate costs for peer support services the Department assumed approximately one-third of clients would utilize the service at an average of 26 hours per year.

While the Department believes that there could be savings achieved through this proposal, the Department did not include savings associated with the request. The Department believes that providing substance use disorder treatment improves clients' overall health by reducing their risk for serious disease and accidents. However, because many diseases take years to develop and are unique to each person, the Department does not anticipate any short term savings from the substance use disorder benefit changes.

**Consequences if not Funded:**

If this request is not funded the Department would continue to operate the substance use disorder treatment program under a fee-for-service structure. However, Medicaid members will not benefit from the advantages of coordinated, whole-person care for substance use

disorders, and Colorado would not benefit from the potential improvements in client health, productivity, quality of life, and cost effectiveness offered by expanding and managing the benefit.

**Impact to Other State Government Agency:**

The Department is actively working with the Office of Behavioral Health (OBH) on the expansion of Medicaid’s substance use disorder benefit. By adding a more robust substance use disorder treatment benefit to the BHO program, a number of OBH programs may be affected. OBH currently funds substance use disorder services to non-Medicaid populations with its federal block grant and other state funds, as well as certain substance use disorder services not covered by Medicaid as a wraparound benefit to Medicaid members.

OBH believes that shifting coverage of certain substance use disorder services to Medicaid may permit block grant or other state funding to be repurposed to serve additional individuals within gap populations such as the non-Medicaid populations. It would also allow block grant funds to be used for gap services (such as recovery services and residential treatment) not included in Medicaid’s expanded benefit or eligible to receive federal financial participation. While these changes would require planning and collaboration with both OBH and the Department, contractors, clients and advocates, OBH sees the expansion of Medicaid’s substance use disorder benefit and management through the BHO program as an opportunity to create a statewide recovery-oriented system of care, and expand support recovery services for beneficiaries. The implementation of an expanded Medicaid substance use disorder benefit would not have a financial impact on OBH because its primary source of funding is a block grant.

The Department also believes that there may be future savings to other state agencies; substance use disorder is a contributing factor in many arrests and incarcerations. Reducing the rate of substance use disorder may also result in

reductions to the number of individuals who are arrested and incarcerated, providing some relief for many aspects of the criminal justice system. While the Department does not assume any short term savings to other state agencies (such as the Department of Corrections), it is possible that a more robust Medicaid substance use disorder treatment benefit would help mitigate growth in the criminal justice system over the long term.

**Cash Fund Projections:**

This request includes Cash Funds from the Hospital Provider Fee Cash Fund. For information on associated revenues, expenditures, and cash fund balance, please see the Schedule 9 “Cash Funds Report” in Section O of this Budget Request.

**Relation to Performance Measures:**

This request will assist the Department in meeting its performance measures to improve health outcomes and better integrate physical and mental health services. Many studies have shown that providing substance use disorder treatment improves health outcomes of people by reducing their propensity for accident and serious disease. By expanding the substance use disorder benefit, the Department would improve clients’ likelihood for recovery and potentially prevent health ailments over time. Further, providers would be able to refer clients to the BHOs to aid in substance use disorder recovery which, in turn, would enable clients to receive other mental health services.

**Current Statutory Authority or Needed Statutory Change:**

Colorado Medical Assistance Act, section 25.5-5-202, C.R.S. (2012). Basic services for the categorically needy - optional services

(1) Subject to the provisions of subsection (2) of this section, the following are services for which federal financial participation is available and which Colorado has selected to provide as optional services under the medical assistance program:

- (s) (I) Outpatient substance abuse treatment

R-7 - Medicaid Substance Use Disorder Benefit  
Appendix A: Calculations and Assumptions

<b>Table 1.1 - Summary of Request FY 2013-14</b>					
<b>Summary of Request FY 2013-14</b>	<b>Total Funds</b>	<b>General Fund</b>	<b>Cash Funds</b>	<b>Reappropriated Funds</b>	<b>Federal Funds</b>
<b>Total Request</b>	<b>\$5,788,068</b>	<b>\$1,818,130</b>	<b>\$42,035</b>	<b>\$0</b>	<b>\$3,927,903</b>
(1) Executive Director's Office	\$100,000	\$50,000	\$0	\$0	\$50,000
(2) Medical Services Premiums	\$415,440	(\$11,820)	(\$282)	\$0	\$427,542
(3) Medicaid Mental Health Community Programs; Mental Health Capitation Payments	\$5,272,628	\$1,779,950	\$42,317	\$0	\$3,450,361

<b>Table 1.2 - Summary of Request FY 2014-15</b>					
<b>Summary of Request FY 2014-15</b>	<b>Total Funds</b>	<b>General Fund</b>	<b>Cash Funds</b>	<b>Reappropriated Funds</b>	<b>Federal Funds</b>
<b>Total Request</b>	<b>\$9,081,619</b>	<b>\$2,740,119</b>	<b>\$97,407</b>	<b>\$0</b>	<b>\$6,244,092</b>
(1) Executive Director's Office	\$0	\$0	\$0	\$0	\$0
(2) Medical Services Premiums	(\$1,901,422)	(\$953,140)	(\$33,883)	\$0	(\$914,399)
(3) Medicaid Mental Health Community Programs; Mental Health Capitation Payments	\$10,983,040	\$3,693,259	\$131,290	\$0	\$7,158,491

R-7 - Medicaid Substance Use Disorder Benefit  
Appendix A: Calculations and Assumptions

<b>Table 2.1 - FY 2013-14 Impact by Component</b>						
<b>FY 2013-14</b>	<b>Total Funds</b>	<b>General Fund</b>	<b>Cash Funds</b>	<b>Reappropriated Funds</b>	<b>Federal Funds</b>	<b>Source</b>
<b>Total Request</b>	<b>\$5,788,068</b>	<b>\$1,818,130</b>	<b>\$42,035</b>	<b>\$0</b>	<b>\$3,927,903</b>	
<b>(1) Executive Director's Office</b>	<b>\$100,000</b>	<b>\$50,000</b>	<b>\$0</b>	<b>\$0</b>	<b>\$50,000</b>	
Actuarial Certification Costs to set Behavioral Health Organization Rates	\$100,000	\$50,000	\$0	\$0	\$50,000	Narrative
<b>(2) Medical Services Premiums</b>	<b>\$415,440</b>	<b>(\$11,820)</b>	<b>(\$282)</b>	<b>\$0</b>	<b>\$427,542</b>	
Move Substance Use Disorder Benefit from Medical Services Premiums	(\$1,989,373)	(\$808,844)	(\$19,230)	\$0	(\$1,161,299)	Table 5.1
Add Medication Assisted Treatment Service (non-AwDC Populations)	\$2,174,819	\$884,243	\$21,022	\$0	\$1,269,554	Table 4
Add Medication Assisted Treatment Service (AwDC Populations)	\$444,514	\$0	\$0	\$0	\$444,514	Table 6
Offset for Current Medication Assisted Treatment Service	(\$214,520)	(\$87,219)	(\$2,074)	\$0	(\$125,227)	Table 5.2
<b>(3) Medicaid Mental Health Community Programs; Mental Health Capitation Payments</b>	<b>\$5,272,628</b>	<b>\$1,779,950</b>	<b>\$42,317</b>	<b>\$0</b>	<b>\$3,450,361</b>	
Add Substance Use Disorder Benefit to Behavioral Health Organization Contracts and Expand Current Benefit Limits	\$3,116,907	\$1,267,278	\$30,129	\$0	\$1,819,500	Table 4
Add Peer Support Services	\$1,260,929	\$512,672	\$12,188	\$0	\$736,069	Table 4
Add Adults without Dependent Children Population	\$894,792	\$0	\$0	\$0	\$894,792	Table 6

R-7 - Medicaid Substance Use Disorder Benefit  
Appendix A: Calculations and Assumptions

<b>Table 2.2 - FY 2014-15 Impact by Component</b>						
<b>FY 2014-15</b>	<b>Total Funds</b>	<b>General Fund</b>	<b>Cash Funds</b>	<b>Reappropriated Funds</b>	<b>Federal Funds</b>	<b>Source</b>
<b>Total Request</b>	<b>\$9,081,619</b>	<b>\$2,740,119</b>	<b>\$97,407</b>	<b>\$0</b>	<b>\$6,244,092</b>	
<b>(1) Executive Director's Office</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	
Actuarial Certification Costs to set Behavioral Health Organization Rates	\$0	\$0	\$0	\$0	\$0	Narrative
<b>(2) Medical Services Premiums</b>	<b>(\$1,901,422)</b>	<b>(\$953,140)</b>	<b>(\$33,883)</b>	<b>\$0</b>	<b>(\$914,399)</b>	
Move Substance Use Disorder Benefit from Medical Services Premiums	(\$4,306,991)	(\$1,730,235)	(\$61,507)	\$0	(\$2,515,249)	Table 5.1
Add Medication Assisted Treatment Service (non-AwDC Populations)	\$2,420,574	\$972,410	\$34,568	\$0	\$1,413,596	Table 4
Add Medication Assisted Treatment Service (AwDC Populations)	\$471,185	\$0	\$0	\$0	\$471,185	Table 6
Offset for Current Medication Assisted Treatment Service	(\$486,189)	(\$195,315)	(\$6,943)	\$0	(\$283,931)	Table 5.2
<b>(3) Medicaid Mental Health Community Programs; Mental Health Capitation Payments</b>	<b>\$10,983,040</b>	<b>\$3,693,259</b>	<b>\$131,290</b>	<b>\$0</b>	<b>\$7,158,491</b>	
Add Substance Use Disorder Benefit to Behavioral Health Organization Contracts and Expand Current Benefit Limits	\$6,545,505	\$2,629,506	\$93,475	\$0	\$3,822,524	Table 4
Add Peer Support Services	\$2,647,951	\$1,063,754	\$37,815	\$0	\$1,546,383	Table 4
Add Adults without Dependant Children Population	\$1,789,584	\$0	\$0	\$0	\$1,789,584	Table 6

R-7 - Medicaid Substance Use Disorder Benefit  
Appendix A: Calculations and Assumptions

<b>Table 3.1 - Percentage Allocations for Fund Splits FY 2013-14</b>							
<b>Population</b>	<b>Proportion by Caseload</b>	<b>Total Funds</b>	<b>General Fund</b>	<b>Cash Funds: Hospital Provider Fee</b>	<b>Reappropriated Funds</b>	<b>Federal Funds</b>	<b>Fund Split Comments</b>
<b>Request Excluding AwDC</b>		<b>\$6,552,655</b>	<b>\$2,664,193</b>	<b>\$63,339</b>	<b>\$0</b>	<b>\$3,825,123</b>	
Categorically Eligible Populations	81.32%	\$5,328,387	\$2,664,193	\$0	\$0	\$2,664,194	
Expansion Adults to 100%	16.75%	\$1,097,590	\$0	\$0	\$0	\$1,097,590	100% FF
Disabled Buy-In (Adults)	1.93%	\$126,678	\$0	\$63,339	\$0	\$63,339	CF: Hospital Provider Fee
Percentage Allocations for Fund Splits			40.66%	0.97%	0.00%	58.38%	Based on Request Excluding AwDC

<b>Table 3.2 - Percentage Allocations for Fund Splits FY 2014-15</b>							
<b>Population</b>	<b>Proportion by Caseload</b>	<b>Total Funds</b>	<b>General Fund</b>	<b>Cash Funds: Hospital Provider Fee</b>	<b>Reappropriated Funds</b>	<b>Federal Funds</b>	<b>Fund Split Comments</b>
<b>Request Excluding AwDC</b>		<b>\$11,614,030</b>	<b>\$4,665,669</b>	<b>\$165,858</b>	<b>\$0</b>	<b>\$6,782,503</b>	
Categorically Eligible Populations	80.35%	\$9,331,338	\$4,665,669	\$0	\$0	\$4,665,669	
Expansion Adults to 100%	16.80%	\$1,950,975	\$0	\$0	\$0	\$1,950,975	100% FF
Disabled Buy-In (Adults)	2.86%	\$331,717	\$0	\$165,858	\$0	\$165,859	CF: Hospital Provider Fee
Percentage Allocations for Fund Splits			40.17%	1.43%	0.00%	58.40%	Based on Request Excluding AwDC

"Categorically Eligible Population" includes Adults 65 and Older, Disabled Adults 60-65, Disabled Adults to 59, Categorically Low Income Adults, Expansion Adults to 60%, and Baby Care Program -Adults. Proportions are based on caseload estimated in the Department's FY 2013-14 request R-1 "Request from Medical Services Premiums".

R-7 - Medicaid Substance Use Disorder Benefit  
Appendix A: Calculations and Assumptions

Table 4 - Estimated Costs for a Substance Use Disorder Benefit													
Service	Procedure Code	Current Rate	Unit	Current Program Limit	Assumed Limitation Increases <sup>(1)</sup>	FY 2011-12 Clients Utilizing Services	FY 2013-14 Estimated Clients Utilizing Services with	FY 2014-15 Estimated Clients Utilizing Services with	Current Yearly Average Utilization per Utilizer	Estimated Yearly Average Utilization per Utilizer	FY 2013-14 Estimated Annual Cost per Service	FY 2013-14 Estimated Incurred Cost Per Service <sup>(2)</sup>	FY 2014-15 Estimated Annual Cost per Service
<b>Existing Services</b>													
Alcohol and/or drug assessment	H0001	\$95.79	1 session	3 sessions per SFY	2 annual assessments which may involve more than one session	2,159	4,318	4,534	1.17	1.40	\$579,798	\$289,899	\$608,788
Physical assessment of detoxification progression including vital signs monitoring	T1007	\$12.06	1 Unit	7 days	5 sessions of 3 days each	1,732	3,464	3,637	6.06	7.27	\$303,825	\$151,913	\$319,016
Behavioral health counseling and therapy, individual	H0004	\$13.14	1 Session/15 minutes	25 sessions at 15 mins/unit, no more than 4 units (1 hour) per SFY	35 sessions per SFY	2,660	5,320	5,586	16.96	20.35	\$1,422,620	\$711,310	\$1,493,752
Alcohol and/or drug services; group counseling by a clinician	H0005	\$28.17	1 Session	36 sessions (up to 3 hours) per SFY	36 sessions of both outpatient and intensive outpatient therapy	3,102	6,204	6,514	10.06	12.07	\$2,108,761	\$1,054,381	\$2,214,199
Alcohol and/or drug services; case management (targeted)	H0006	\$15.97	1 Contact/15 mins	36 Contacts per SFY	52 Contacts per SFY	1,311	2,622	2,753	6.96	8.36	\$349,973	\$174,986	\$367,472
Safety assessment including suicide ideation and other behavioral health issues	S3005	\$12.06	1 unit	7 days	5 sessions of 3 days each	1,780	3,560	3,738	5.63	6.76	\$290,077	\$145,038	\$304,581
Drug screening and monitoring	S9445	\$12.03	1 specimen	36 specimens	52 specimens	2,874	5,748	6,035	8.32	9.98	\$690,127	\$345,064	\$724,634
Provision of daily living needs including hydration, nutrition, cleanliness and toiletry for clients	T1019	\$12.06	1 unit	7 days	5 sessions of 3 days each	1,572	3,144	3,301	5.81	6.98	\$264,548	\$132,274	\$277,776
Level of motivation assessment for treatment evaluation	T1023	\$12.06	1 unit			1,435	2,870	3,014	5.40	6.47	\$224,084	\$112,042	\$235,289
<b>Subtotal Existing Services</b>											<b>\$6,233,814</b>	<b>\$3,116,907</b>	<b>\$6,545,505</b>
<b>New Services</b>													
Medication Assisted Treatment	NA	\$801.22	1 tab			417	4,524	4,750	1.00	1.20	\$4,349,638	\$2,174,819	\$4,567,120
Drug Rebates <sup>(3)</sup>	NA							0			\$0	\$0	(\$2,146,546)
Peer Advocate Service	NA	\$5.36	15 minutes			0	4,524	4,750		104.00	\$2,521,859	\$1,260,929	\$2,647,951
<b>Subtotal New Services</b>											<b>\$6,871,497</b>	<b>\$3,435,748</b>	<b>\$5,068,525</b>
<b>Total Estimated Costs</b>						<b>6,786</b>	<b>13,572</b>	<b>14,251</b>			<b>\$13,105,311</b>	<b>\$6,552,655</b>	<b>\$11,614,030</b>

(1) The Department has assumed a benefit package in order to create an estimated cost for this proposal. However, the specific increases will be determined through the Department's Benefits Collaborative process. See the narrative for additional information.  
(2) The Department assumes the program would be implemented January 1, 2014 and has adjusted expenditure estimates to account for a half-year implementation in FY 2013-14.  
(3) The Department accounted for drug rebates by estimating that approximately 47% of expenditure would be returned to the Department. This estimate is consistent with the Department's FY 2011-12 rebate experience. The Department estimates that there is a six month lag between when expenditure is incurred and when rebates are collected; therefore, there is no rebate offset in FY 2013-14.

R-7 - Medicaid Substance Use Disorder Benefit  
Appendix A: Calculations and Assumptions

<b>Table 5.1 - Estimated Substance Use Disorder Benefit Expenditure without Benefit Expansion</b>				
<b>Item</b>	<b>FY 2011-12 Actuals</b>	<b>Estimated FY 2013-14</b>	<b>Estimated FY 2014-15</b>	<b>Source</b>
Percentage Selected to Trend Expenditure	33.00%	16.50%	8.25%	Growth in Substance Use Disorder Services from FY 2010-11 to FY 2011-12. The selected trend for FY 2013-14 is half of the FY 2011-12 trend, and the selected trend for FY 2014-15 is half of the FY 2013-14 trend.
Substance Use Disorder Total Expenditure Offset	(\$2,931,529)	<b>(\$1,989,373)</b>	<b>(\$4,306,991)</b>	FY 2013-14: [FY 2011-12 Total * (1+Trend) <sup>2</sup> ] * 0.5 FY 2014-15: [2 * FY 2013-14 Total] * (1+Trend)

<b>Table 5.2 - Estimated Medication Assisted Treatment without Benefit Expansion</b>				
<b>Item</b>	<b>FY 2011-12 Actuals</b>	<b>Estimated FY 2013-14</b>	<b>Estimated FY 2014-15</b>	<b>Source</b>
Percentage Selected to Trend Expenditure	13.32%	13.32%	13.32%	Growth in Prescription Drugs from FY 2010-11 to FY 2011-12
Substance Use Disorder Total Expenditure Offset	(\$334,107)	<b>(\$214,520)</b>	<b>(\$486,189)</b>	FY 2013-14: [FY 2011-12 Total * (1+Trend) <sup>2</sup> ] * 0.5 FY 2014-15: [2 * FY 2013-14 Total] * (1+Trend)

Note: Estimated in FY 2013-14 are reduced for a six month implementation.

<b>Table 6.1 - Adults without Dependent Children Substance Use Disorder Benefit Expansion Estimates for Non-Medication Assisted Treatment</b>				
<b>Row</b>	<b>Item</b>	<b>FY 2013-14</b>	<b>FY 2014-15</b>	<b>Source</b>
A	Estimated Total Expenditure	\$4,377,836	\$9,193,456	Table 3 (Total "Existing Services" and Peer Advocate Service)
B	Estimated Total Expenditure per Utilizer	\$322.56	\$645.13	Table 3 Total Costs / Estimated Utilizers
C	Estimated AwDC Utilizers	2,774	2,774	10,000 AwDC clients x 27.74% of homeless who self identified substance use in the 2012 Metro Denver Homeless Initiative (MDHI) Point-in-Time survey
D	Total Estimated <u>Non-Medication Assisted Treatment</u> AwDC Costs	\$894,792	\$1,789,584	Row B * Row C

<b>Table 6.2 - Adults without Dependent Children Substance Use Disorder Benefit Expansion Estimates for Medication Assisted Treatment</b>				
<b>Row</b>	<b>Item</b>	<b>FY 2013-14</b>	<b>FY 2014-15</b>	<b>Source</b>
A	Estimated Total Expenditure	\$2,174,819	\$2,420,574	Table 3 (Medication Assisted Treatment and Drug Rebate)
B	Estimated Total Expenditure per Utilizer	\$160.24	\$169.86	Table 3 Total Costs / Estimated Utilizers
C	Estimated AwDC Utilizers	2,774	2,774	10,000 x 27.74% of homeless who self identified substance use in the 2012 Metro Denver Homeless Initiative (MDHI) Point-in-Time survey
D	Total Estimated Medication Assisted Treatment AwDC Costs	\$444,514	\$471,185	Row B * Row C