

Schedule 13

Funding Request for the FY 2018-19 Budget Cycle

Department of Health Care Policy and Financing

Request Title R-02 Behavioral Health Programs

Dept. Approval By:  11/1/17 Supplemental FY 2017-18
 OSPB Approval By:  Change Request FY 2018-19
 Budget Amendment FY 2018-19

Summary Information	Fund	FY 2017-18		FY 2018-19	FY 2019-20	
		Initial Appropriation	Supplemental Request	Base Request	Change Request Continuation	
Total		\$625,797,571	\$0	\$651,114,866	\$38,797,903	\$61,490,745
FTE		0.0	0.0	0.0	0.0	0.0
Total of All Line Items Impacted by Change Request	GF	\$174,446,202	\$0	\$181,371,789	\$7,713,920	\$16,825,045
	CF	\$26,190,535	\$0	\$27,072,406	\$5,186,815	\$12,509,519
	RF	\$0	\$0	\$0	\$0	\$0
	FF	\$425,160,834	\$0	\$442,670,671	\$25,897,168	\$32,156,181

Line Item Information	Fund	FY 2017-18		FY 2018-19	FY 2019-20	
		Initial Appropriation	Supplemental Request	Base Request	Change Request Continuation	
Total		\$616,836,053	\$0	\$642,141,782	\$38,547,986	\$60,895,415
FTE		0.0	0.0	0.0	0.0	0.0
03. Behavioral Health Community Programs -- Behavioral Health Capitation Payments	GF	\$172,509,947	\$0	\$179,433,035	\$7,667,357	\$16,616,777
	CF	\$25,816,287	\$0	\$26,697,675	\$5,130,051	\$12,343,220
	RF	\$0	\$0	\$0	\$0	\$0
	FF	\$418,509,819	\$0	\$436,011,072	\$25,750,578	\$31,935,418

Total		\$8,961,518	\$0	\$8,973,084	\$249,917	\$595,330
FTE		0.0	0.0	0.0	0.0	0.0
03. Behavioral Health Community Programs -- Behavioral Health Fee-for-Service Payments	GF	\$1,936,255	\$0	\$1,938,754	\$46,563	\$208,268
	CF	\$374,248	\$0	\$374,731	\$56,764	\$166,299
	RF	\$0	\$0	\$0	\$0	\$0
	FF	\$6,651,015	\$0	\$6,659,599	\$146,590	\$220,763

CF Letternote Text Revision Required?	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	If Yes, see schedule 4 fund source detail.
RF Letternote Text Revision Required?	Yes	<input type="checkbox"/>	No	<input checked="" type="checkbox"/>	
FF Letternote Text Revision Required?	Yes	<input type="checkbox"/>	No	<input checked="" type="checkbox"/>	
Requires Legislation?	Yes	<input type="checkbox"/>	No	<input checked="" type="checkbox"/>	
Type of Request?	Department of Health Care Policy and Financing Prioritized Request				
Interagency Approval or Related Schedule 13s:	None				



COLORADO

**Department of Health Care
Policy & Financing**

Department of Health Care Policy and Financing
Behavioral Health Community Programs

FY 2017-18, FY 2018-19, and FY 2019-20 Budget Request

November 2017

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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 again procured 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. In July 2014, the Department went through another competitive bid process to reprocure the contractors of the five behavioral health regions. As a result of this reprocurement, four of the five prior behavioral health organizations won their respective rebids. The only change was in the northeast region. Access Behavioral Care Northeast began providing services in this region effective July 1, 2014.

Each behavioral health organization is responsible for providing or arranging medically necessary mental health services to Medicaid-eligible adults 65 and older, individuals with disabilities through 64, MAGI parents and caretakers, MAGI adults, 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, physician care, substance use disorder; 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

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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 17-1353, “Implement Medicaid Delivery & Payment Initiatives”, authorized the Department to implement performance-based payments for medical providers. The payments are designed to incentivize BHOs to achieve performance based goals regarding improving health outcomes, coordinating care, and containing costs. The bill also implemented the integration of behavioral health and physical health services under the new Regional Accountability Entity (RAE). Starting in July 2018, the Department will be working with the new RAEs instead of the BHOs. Although care will be integrated between behavioral health and physical health services under one entity, the Department will still pay actuarially sound capitation rates for behavioral health services, therefore there will be no changes to the forecasting methodology.
- For the most recent rate setting cycle for rates effective July 1, 2017 to June 30, 2018, the Department experienced a significant drop in a few eligibility categories for most BHOs. This decrease in capitations was anticipated and requested in the Department’s FY 2017-18 R-6 “Delivery and Payment Reform.” The Department decreased capitation rates to comply with new federal managed care regulations, which require rates to be set to an actuarially determined point rather than negotiated upon within an actuarially set range. In most cases the actuarially set point was lower than the rate that was negotiated within the actuarially sound range. New rates will be set for FY 2018-19, and current BHO encounter data will be analyzed to assess the rates. Adjustments will be made as data supports.

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

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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).

Significant Changes between FY 2017-18 S-2A and FY 2018-19 R-2

FY 2017-18

- Major changes in the caseload and rate forecasts for a few eligibility categories contribute to about a \$62.4 million decrease.
 - MAGI Adults rate forecast decreased by \$8.02 or 14.6%
 - Foster Care rate forecast decreased by \$7.48 or 5.79%
 - Children rates forecast decreased by \$.40 or 2.0%
 - Individuals with Disabilities rates forecast decreased by \$7.80 or 5.5%
 - Eligible Children caseload forecast decreased by 160,992 or 2.5% member months
 - MAGI Adult caseload forecast decreased by 112,344 or 2.4% member months
 - Low-income Adults caseload forecast decreased by 71,832 or 2.9% member months
- The Department estimates that it will recoup \$48.3 million for the MAGI Adult and Expansion Parent risk corridor reconciliations for services that occurred in FY 2016-17. The prior forecast did not include the impact of this reconciliation.
- The Department updated its estimate of payments made to the BHOs because of a system overpayment issue. Due to system limitations in the old MMIS, eligibility categories were incorrectly assigned for a subset of the population. Expansion parents were being incorrectly classified as MAGI Adults which leads to paying about \$30.00 more per member per month than the contracted amount for that population. The Department projects recouping \$17.8 million in FY 2017-18 in the current forecast versus \$25.3 million in the prior forecast. See Exhibit II for more detail.

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- The Department estimates that it will pay \$1.9 million dollars for an eligibility issue that caused clients that should have been placed onto transitional Medicaid, which is a subset of low income adults, to be classified as Expansion Parents and Caretakers instead. This resulted in the Department paying a lower capitation rate for these clients than would have been paid if they were classified correctly as low income adults. This led to BHOs being paid approximately \$7.00 to \$13.00 less per member per month than the contracted amount for that population. The issue impacted capitations paid in FY 2015-16 and FY 2016-17.
- The Department estimates that it will pay \$5.9 million for the Health Insurance Provider Fee (HIPF) to Foothills Behavioral Health Partners (FBHP) and Colorado Health Partnerships (CHP) for services that occurred in FY 2016-17 due to an ACA mandate that charges a fee to covered entities that provide health insurance, based on the amount of revenue that the provider earns. The ACA mandates that the HIPF be paid for based upon the insurer's market share. This mandate excludes insurers that have a certain percentage of revenue that is publicly funded and provides other exclusions based on the amount of premiums taken into an account¹.
- The Department paid additional capitation payments for children that were incorrectly classified as Individuals with Disabilities, resulting in about a \$1.8 million overpayment. These payments will be recouped in FY 2017-18. Please see Exhibit II and the caseload narrative for additional information on this issue.

FY 2018-19

- The changes in caseload, rates, and the IBNR factor for FY 2018-19 from the S-2A to the R-2 are primarily the result of flow through of the caseload and rate forecast changes in FY 2017-18.
- The Department does not expect to make other reconciliations on an on-going basis related to the risk corridor because current rates are supported by actual historical data, and a risk corridor is no longer required to develop actuarially certified rates.

BEHAVIORAL HEALTH CAPITATION PAYMENTS AND MEDICAID BEHAVIORAL 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.

¹ <https://www.irs.gov/businesses/corporations/affordable-care-act-provision-9010>

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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. Effective July 1, 2014, the behavioral health services contracts were up for reprocurement through a competitive bid process. Four of the five BHOs from the previous rebid won their respective regions with the exception of the northeast region. That region is now managed by Access Behavioral Health – Northeast.

The behavioral health organizations are responsible for providing or arranging all medically necessary behavioral health services to Medicaid-eligible members 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 eight categories, as indicated below. Partial dual-eligible members and non-citizens are ineligible for behavioral health services.

The eligible behavioral health populations are:

- Adults 65 and Older
- Individuals with Disabilities
- Low Income Adults
- Expansion Parents & Caretakers
- MAGI Adults
- Eligible Children
- 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 was 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

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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. Beginning July 1, 2014, the Department is using a new financial reporting tool. The Colorado Operations Resource Engine (CORE) is used in place of COFRS and the same overlay methodology is used between CORE and the MMIS.

Description of Methodology

The Department utilizes a capitation trend forecast model. 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 forecast utilizes 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 adjusts 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 Community 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 for the base traditional members, the state receives the standard Medicaid federal match with the State's share coming from General Fund. In FY 2017-18 the federal match is 50.00%. Payments for members in the Breast and Cervical Cancer Program receive an enhanced federal match rate, which in FY 2017-18 is 65.00% and is described separately below. Capitation expenditures are split between traditional members and expansion members. Expansion members are funded from Healthcare Affordability and Sustainability Fee funds. Finally, the reconciliation from prior years for behavioral health capitation overpayments, retractions for capitations paid for members later determined to be deceased, and system issues are also presented (see Exhibit II for reconciliation calculations). A summary of applicable FMAP rates for each of the forecast years is provided below:

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Population	FY 2017-18 Match Rate	FY 2018-19 Match Rate	FY 2019-20 Match Rate
Standard Medicaid	50.00%	50.00%	50.00%
Former CHP+ Children	88.00%	88.00%	70.75%
Former CHP+ Prenatal	88.00%	88.00%	70.75%
Expansion Adults	94.50%	93.50%	91.50%
BCCP	65.00%	65.00%	65.00%

The Department also calculates the fund splits for the fee-for-service expenditure in Exhibit BB. The make-up of the fee-for-service population is the same as the capitation program and therefore the same funding mechanisms are used for the same populations mentioned above in the fee-for-service environment (see Exhibit JJ and Exhibit KK for fee-for-service calculations).

Medicaid Behavioral Health Fee-for-Service base traditional members also receive the standard Medicaid federal match with the State’s share coming from General Fund. In FY 2017-18 the federal match is 50.00%. Similar to the populations within the capitation payments line, as of July 1, 2014, the Department is breaking out the fee-for-service expenditure by funding source according to population so that it may claim the correct federal match associated with who is obtaining services. 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 members 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(9), C.R.S. (2015). Exhibit BB details funds splits for the Behavioral Health Community Programs Capitations line. The funding for the members enrolled in the

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program is 35.00% cash funds from the Breast and Cervical Cancer Prevention and Treatment Fund and 65.00% federal funds in FY 2017-18. The program was reauthorized in FY 2014-15 and sunsets at the end of FY 2018-19, with the potential to extend the program through new legislation. Beginning in FY 2016-17, the Breast and Cervical Cancer Prevention and Treatment Program expanded the age of eligibility for women being screened for cervical cancer from 39 to 21, which impacts the caseload forecast.

Behavioral Health Services for Healthcare Affordability and Sustainability Fee Expansion Members

HB 09-1293 established a funding mechanism for a series of expansion members. The first set of expansion members that are funded through the bill was parents with income up to 100% of the Federal Poverty Limit (FPL). Services for these members were funded through the Healthcare Affordability and Sustainability Fee cash fund. Starting in FY 2011-12, additional expansion populations also received funding through the Healthcare Affordability and Sustainability Fee cash fund. These include individuals with disabilities with income limits up to 450% of the federal poverty level and MAGI Adults, both of which received services through the BHOs as part of their benefit package. Individuals with disabilities with income limits up to 450% are assumed to be similar to other members with disabilities, and expenditure for these members is therefore calculated using the same per-capita rate as other members with disabilities (see exhibit JJ). For MAGI Adults, the BHOs are reimbursed at a separate capitation rate than other eligibility categories. The Department is currently using actual expenditure and utilization data for the MAGI Adult population to set rates and now that the Department has a few years of data, a risk corridor is no longer necessary and final reconciliations for prior year risk corridors will take place in FY 2017-18. 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

The former CHP+ populations that transferred to Medicaid with SB 11-008 (Eligible Children) and SB 11-250 (Eligible Pregnant Adults) receives the enhanced CHP+ FMAP of approximately 65.00%, with an additional 23 percentage point FMAP increase through September 30, 2019; the enhanced FMAP is expected to be 88.00% in FY 2017-18 and FY 2018-19, and 70.75% in FY 2019-20. The FMAP in FY 2019-20 is an estimated match rate that includes the 88.0% enhanced match rate for July 1, 2019 to September 30, 2019 and the standard match rate of 65.0% for October 1, 2019 to June 30, 2020.

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 MAGI Adults, effective January 1, 2014. The Department assumes that the expenditure for parents from 60% to 68% FPL will receive the standard Medicaid match rate, with the state share coming from Healthcare Affordability and Sustainability Fee cash fund, and all parents from 69% - 133% FPL and newly eligible MAGI Adults will receive the expansion federal match rate, while adults up to 60% FPL will continue to receive the standard Medicaid match. The Department also estimates the non-newly eligible

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MAGI Adult population. Because some of these members may have been eligible prior to the expansion, the Department is unable to claim the expansion federal match. Therefore, the Department estimates that it can claim the expansion match on 75% percent of the population and the standard match on the other 25%. As such, the federal match percentage in FY 2017-18 is 88.38%. Beginning January 1, 2017, all expansion populations will begin a stepdown in federal matching. As a result, the match rate for those populations in FY 2017-18 will be 94.50%, 93.50% in FY 2018-19, and 91.50% in FY 2019-20.

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 caseload driven impacts such as the various reconciliations and retractions for members 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 13 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 each of the rate cells which the Department pays a capitation on. The second table displays caseload by all behavioral health eligibility categories that make up the eight rate cells. 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 members 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 each rate cell the Department pays a capitation on. The second table displays per-capita for all behavioral health eligibility categories. However, since the actual per capita from the first table for the combined 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

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for fiscal years up to the present fiscal year are actual per-capita, while the current fiscal year and the request year per-capita 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 Operations Resource Engine (CORE). Expenditures by eligibility category are not available from the CORE. 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 CORE as fiscal periods close. Because the variance is minor, data from the MMIS can be used to distribute total expenditures from the CORE 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 CORE. This calculation estimates actual CORE expenditures across each eligibility category. 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 members and non-citizens, as discussed above).

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

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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 E.EE-4.

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 members 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 members 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 E.EE-4 through E.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.

On pages E.EE-6 through E.EE-7, 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 E.EE-1, E.EE-2, and E.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 members 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 six months of claims and caseload data. Historically the Department would analyze the previous five years of data, but due to the policy change relating to retroactivity beginning January 1, 2014, that data would not provide an accurate depiction of retroactivity based on current policy. Page E.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. For this reason, the Department previously assumed 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. As a result of the retroactivity policy change noted above the Department has seen a substantial decline in retroactivity.

Partial Month Adjustment Multiplier

As presented on page E. 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

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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.

The weighted rate is presented along with the percentage change from the 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 for each BHO and eligibility type as the rate point estimate for each fiscal year.

It is important to note the overall weighted rate 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.

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 E.HH-1 and E.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 E.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 E.HH-1 and E.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 E.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 E.HH-3 (see below).

The forecasted rate is adjusted by the partial month adjustment multiplier, calculated on page E.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.

The claims-based rate is also adjusted by the retroactivity adjustment. From Exhibit FF, page E.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 E.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

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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 trend models, as presented in this exhibit, are an attempt to predict the final outcome of this rate setting process. 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.

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Trend Selection

Aid Category	FY 2018-19 Trend	FY 2019-20 Trend
Adults 65 and Older (OAP-A)	4.41%	4.41%
	Trend is equal to the average growth from FY 2009-10 to FY 2017-18.	Trend is equal to the average growth from FY 2009-10 to FY 2017-18.
Individuals with disabilities Through 64 (AND/AB, OAP-B)	1.32%	1.32%
	Trend is equal to the average growth from FY 2009-10 to FY 2017-18.	Trend is equal to the average growth from FY 2009-10 to FY 2017-18.
Low Income Adults / Expansion Parents & Caretakers	5.53%	5.53%
	Trend is equal to the average growth from FY 2009-10 to FY 2017-18.	Trend is equal to the average growth from FY 2009-10 to FY 2017-18.
MAGI Adults	5.53%	5.53%
	Trend is equal to Low Income Adults.	Trend is equal to Low Income Adults.
Eligible Children (AFDC-C/BC)	3.64%	3.64%
	Trend is equal to the Average Growth from FY 2009-10 to FY 2017-18.	Trend is equal to the Average Growth from FY 2009-10 to FY 2017-18.
Foster Care	1.56%	1.56%
	The trend selection is based on the two-year moving average.	The trend selection is based on the two-year moving average.

Trend Justification

The rate setting methodology changed effective January 1, 2014. The previous rate setting process involved the actuaries setting rates that were actuarially sound in aggregate. The new methodology involves setting actuarially sounds rates for each aid category. The Department also changed its methodology for determining rates due to new managed care regulations. In FY 2017-18, federal regulations require the Department to set an actuarially certified rate point, rather than negotiating a rate within an actuarially certified rate range.

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The new regulations lead to an overall reduction in rates since most capitation rates that were previously negotiated were higher than the rates that were set to an actuarially sound point. Based on current analysis of the behavioral health organizations cost data, the Department expects that rates are representative of actual costs and expects a positive trend to the rates beginning in FY 2018-19 from expected inflation in national medical costs.

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

EXHIBIT II - MAGI ADULTS RECONCILIATION

Recoupments

Capitation payments are made on a monthly basis throughout the year in the Medicaid Management Information System (MMIS). When members are determined to be eligible for benefits retroactively, retroactive capitation payments are made to the behavioral health organizations through the MMIS. When members are determined to be ineligible for Medicaid benefits retroactively, a recoupment of the capitation payments is completed separately. When known, this exhibit also shows the impact of the reconciliation process surrounding all populations. For this request, as in years past, there is a risk corridor placed on the MAGI Adults and Expansion Parents and Caretaker rates due to the uncertainty of the true cost of these populations. The risk corridors allow the risk of not setting an accurate rate to be split between the Department and the BHOs. Depending on how far off the rate is from the actual encounter based rate, either the Department or the BHOs may receive money; for example, if the rates were set too high, the Department would recoup funding. Exhibit II summarizes the expected fiscal impacts.

The Department is expecting to make two reconciliations surrounding the MAGI Adults and Expansion Parents and Caretakers populations. The first is the reconciliation related to the risk corridor from FY 2015-16. The Department is estimating that it will recoup \$48.3 million for FY 2015-16 in FY 2017-18. The Department currently has enough data on the expansion populations to accurately set rates. Therefore, risk corridors will no longer be used for the Expansion Parents and MAGI Adults populations.

The Department also experienced a systems issue that resulted in paying some Expansion Parents and Caretakers the MAGI Adult rate, which is considerably higher. Therefore, a recoupment related to this issue is expected to be about a \$18.9 million. Because this involves a population that was 100% federally funded in the applicable time period, there is no impact to state funds. With the implementation of the new interchange, the Department is now able to correctly identify all populations and pay correctly so there will be no need to reconcile this in future years. The Department expects to make a recoupment with the BHOs of \$1.8 million in FY 2017-18 from a system issue that changed several members' eligibility from Eligible Children and CHP+ Children to the Individuals with disabilities category, which has a significantly higher rate than for Eligible Children. Please see caseload narrative for additional information. The

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Department also expects to make a payment to the BHOs of \$1.9 million for an eligibility issue that caused some individuals to be placed in Expansion Parents and Caretakers when they should have been placed into the Transitional Medicaid program, which is a subset of the Low Income Adults population and has a higher rate than for Expansion Parents and Caretakers.

EXHIBIT JJ – ALTERNATIVE FINANCING POPULATIONS

Exhibit JJ is a stand-alone exhibit designed to show the effect of the Colorado Health Care Affordability Act (HB 09-1293), Aligning Medicaid Eligibility for Children (SB 11-008), Eligibility for Pregnant Women in Medicaid (SB 11-250), and Expanding Medicaid Eligibility in Colorado (SB 13-200) to the Behavioral Health Community Programs fund splits. This exhibit presents projected caseload and costs itemized by eligibility category for the current year and the request year. The exhibit also separates out the funding source and the calculation of federal match associated with each category. Note the caseloads shown are the average monthly number over each year and will fluctuate throughout the year.

Healthcare Affordability and Sustainability Fee Fund 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 members in May 2010. In SB 17-267, The Hospital Provider Fee was changed to the Healthcare Affordability and Sustainability Fee Fund which provides for the costs of the following populations that impact the Behavioral Health budget:

MAGI Parents/Caretakers 60% to 68% FPL

Historically, clients who fell under the Expansion Parents to 133% FPL eligibility category (any client over 60% FPL) were considered expansion clients and the State’s share of funding was provided through the Hospital Provider Fee Fund. The MAGI conversion has resulted in some clients with over 60% FPL falling into the MAGI Parents/Caretakers 60% to 68% FPL category. The State share of funding for these clients comes from the HAS Fee Fund, effective July 1, 2017, in compliance with statute.

The Department uses caseload figures from R-1 Medical Service Premiums, Exhibit J and per capita costs for Low Income Adults in Exhibit DD to forecast the total costs for this population.

MAGI Parents/Caretakers 69% to 133% FPL

The Health Care Expansion Fund originally provided funding for parents of children enrolled in Medicaid from approximately 24% to at least 60% of the federal poverty level. This expansion population receives standard Medicaid benefits. SB 13-200 extended this eligibility through 133% FPL, effective July 1, 2013; the Hospital Provider Fee Fund had funded this population up to 100% FPL in the interim before the Affordable Care Act’s 100% enhanced federal match began and the population expanded to 133% FPL on January 1, 2014. Beginning January 1, 2017, the enhanced federal match fell to 95%. On January 1, 2018, it falls to 94%, then on January 1, 2019,

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it falls to 93%, and on January 1, 2020 it falls to 90%, where it will remain. Effective July 1, 2017, this population is financed with the HAS Fee for the State share of expenditure.

The Department uses caseload figures from R-1 Medical Service Premiums, Exhibit J and per capita costs for Expansion Parents & Caretakers in Exhibit DD to forecast the total costs for this population.

MAGI Adults

With the advent of SB 13-200, effective July 1, 2013, MAGI Adults are covered up to 133% FPL as of January 1, 2014. Similar to MAGI Parents/Caretakers 69% to 133% FPL, the Hospital Provider Fee Fund had funded this population in the interim before the population expanded and the enhanced federal match began on January 1, 2014. Beginning January 1, 2017, the enhanced federal match fell to 95%. On January 1, 2018, it falls to 94%, and then to 93% on January 1, 2019 and 90% on January 1, 2020, where it will remain. Effective July 1, 2017, the State share of expenditure for this population is financed with the HAS Fee.

The Department uses caseload figures from R-1 Medical Service Premiums, Exhibit J and per capita costs for MAGI Adults in Exhibit DD to forecast the total costs for this population.

Non-Newly Eligible

Medicaid expansion clients who were eligible for Medicaid prior to 2009 are not eligible for the enhanced expansion federal medical assistance percentage (FMAP) that began January 1, 2014. Clients who may be eligible for Medicaid through Home- and Community-Based Services waivers due to a disability are required to provide asset information to be determined eligible for Medicaid waiver services. With Medicaid expansion, clients who may have been eligible but did not provide asset information can still be eligible under different eligibility categories, such as MAGI Adults. It is difficult for the State to prove whether these clients would have been eligible for Medicaid services prior to 2009, had they provided their asset information at that time. For this reason, some clients under expansion categories are not eligible for the full enhanced expansion FMAP. Instead, with the approval of a resource proxy for the non-newly eligible, 75% of expenditure receives expansion FMAP while the remaining 25% receives the standard FMAP, funded from the HAS Fee Fund. The Department has incorporated the resource proxy in this request.

The Department uses caseload figures from R-1 Medical Service Premiums, Exhibit J and per capita costs for MAGI Adults in Exhibit DD to forecast the total costs for this population.

Buy-In for Disabled Individuals

This expansion allows for individuals with disabilities with income up to 450% of the federal poverty level to pay premiums to purchase Medicaid benefits. Eligibility for the working adults with disabilities with income up to 450% of the FPL began in March 2012, with

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eligibility to children with disabilities with income up to 300% of the FPL following in June 2012. The Department does not have an implementation timeframe for non-working adults with disabilities at this time.

The Department uses caseload figures from R-1 Medical Service Premiums, Exhibit J and per capita costs for Disabled Individuals in Exhibit DD to forecast the total costs for this population.

Continuous Eligibility for Children

HB 09-1293, the Colorado Health Care Affordability Act of 2009, established continuous eligibility for twelve months for children on Medicaid, even if the family experiences an income change during any given year, contingent on available funding. The Department implemented continuous eligibility for children in March 2014 and has the authority to use the HAS Fee Cash Fund to fund the state share of continuous eligibility for Medicaid children. Because this population is not an expansion population, it receives standard FMAP. Previously, the Department showed this adjustment in funding as a General Fund offset under Cash Funds Financing.

The Department uses caseload figures from R-1 Medical Service Premiums, Exhibit J and per capita costs for Eligible Children in Exhibit DD to forecast the total costs for this population.

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. As with most of the Healthcare Affordability and Sustainability 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 have per-capita costs that will be the same as for the traditional population.

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

Medicaid Behavioral Health Fee-for-Service Payments is a separate budget line item in Behavioral Health Community Programs. Expenditures for this line are calculated in Exhibit KK. The data from Exhibit KK also appear in Exhibit BB, where the fund splits relating to the fee-for-service payments are calculated.

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The Medicaid Behavioral Health Fee-for-Service Payments appropriation allows Medicaid members not enrolled in a behavioral health organization to receive behavioral health services or enrolled Medicaid members to receive behavioral 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 members 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.

Current Calculations

Due to payment delays from transitioning to the interChange payment system in March 2017, FY 2016-17 expenditure is artificially low and any trends applied to the FY 2016-17 expenditure would need to be artificially high to return fee-for-service costs to expected levels. To account for this, the current year's estimate is set equal to the FY 2017-18 appropriated amount. The request year estimate is the result of a forward trend of the appropriated amount 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.

Beginning July 1, 2014, the Department has changed the fund split methodology for fee-for-service expenditure. Previously, fee-for-service expenditure made up a significantly smaller portion of the behavioral health programs total expenditure and it was assumed that the Department would claim the standard Medicaid federal match on all expenditure. As the fee-for-service component continues to grow and expenditure for populations that receive a match other than the standard Medicaid match continue to grow and make up a larger portion of total fee-for-service expenditure, the Department felt it would be best to forecast expenditure for each population separately in order to better estimate the actual cost to the state.

The Departments current method for determining expenditure in the current year, request year, and out year is to apply the same proportion of total expenditure attributed to each population from the most recent complete fiscal year to the current estimated total fee-for-service expenditure in the years being forecasted. Although this method may not accurately forecast the correct proportions from one year to the next, the Department believes this will give the most accurate representation at this time. The Department will continue to evaluate the methodology in the future and make changes as more information becomes available. Fund splits for fee-for-service expenditure is broken out in more detail in Exhibit BB.

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No rate or utilization increases are forecasted, although the Department is currently investigating the feasibility and necessity of incorporating such adjustments. Behavioral health fee-for-service expenditure has increased 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. 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 2017-18 appropriation is 0.85% higher than FY 2016-17 actual expenditures, primarily due to caseload growth. The FY 2017-18 estimate incorporates increased caseload projections along with various rate adjustments and reconciliations and therefore results in a 10.09% decrease from FY 2016-17 actual expenditures and an 10.85% decrease from the current appropriation. The FY 2018-19 estimate is built on the FY 2017-18 estimate and presents a 23.78% expenditure increase. This increase is primarily due to: 1) decrease in reconciliations from the risk corridor; 2) the addition of the rate incentive program; and 3) projected increases in capitation rates from FY 2017-18 to FY 2018-19. The FY 2018-19 request represents a 10.35% increase over the current FY 2017-18 appropriation. The FY 2019-20 Budget Request is built on the FY 2018-19 estimate and represents a 3.43% expenditure increase over the FY 2019-20 request and a 14.14% increase over the FY 2017-18 appropriation.