

Schedule 13

Funding Request for the FY 2015-16 Budget Cycle

Department of Health Care Policy and Financing

PB Request Number R-02

Request Titles

R-02 Behavioral Health Request

Dept. Approval By:	Josh Block		<input checked="" type="checkbox"/>	Supplemental FY 2014-15
			<input type="checkbox"/>	Change Request FY 2015-16
			<input type="checkbox"/>	Base Reduction FY 2015-16
OSPB Approval By:			<input type="checkbox"/>	Budget Amendment FY 2015-16

Line Item Information	Fund	FY 2014-15		FY 2015-16		FY 2016-17
		Appropriation	Request	Base Request	FY 2015-16	Continuation
	Total	\$555,208,663	\$0	\$555,383,534	\$72,784,265	\$144,951,962
	FTE	-	-	-	-	-
Total of All Line Items	GF	\$174,504,409	\$0	\$173,825,571	\$19,340,878	\$33,906,979
	CF	\$4,534,586	\$0	\$4,500,945	\$467,470	\$1,205,483
	RF	\$0	\$0	\$0	\$0	\$0
	FF	\$376,169,668	\$0	\$377,057,018	\$52,975,917	\$109,839,500

Line Item Information	Fund	FY 2014-15		FY 2015-16		FY 2016-17
		Appropriation	Request	Base Request	FY 2015-16	Continuation
	Total	\$548,101,614	\$0	\$548,263,817	\$72,061,853	\$143,626,497
	CF	\$4,534,586	\$0	\$4,500,945	\$383,939	\$1,115,475
03. Behavioral Health Community Programs - Behavioral Health Capitation Payments	FF	\$372,562,308	\$0	\$373,428,468	\$51,399,974	\$107,856,328
	GF	\$171,004,720	\$0	\$170,334,404	\$20,277,940	\$34,654,694
	Total	\$7,107,049	\$0	\$7,119,717	\$722,412	\$1,325,465
	CF	\$0	\$0	\$0	\$83,531	\$90,008
03. Behavioral Health Community Programs - Behavioral Health Fee-for-Service Payments	FF	\$3,607,360	\$0	\$3,628,550	\$1,575,943	\$1,983,172
	GF	\$3,499,689	\$0	\$3,491,167	(\$937,062)	(\$747,715)

Letternote Text Revision Required?	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	If Yes, describe the Letternote Text Revision: See Exhibit BB
Cash or Federal Fund Name and CORE Fund Number:	Hospital Provider Fee (Fund 24A0); Breast and Cervical Cancer Prevention and Treatment fund (Fund 15D0); Federal Funds: Title XIX				
Reappropriated Funds Source, by Department and Line Item Name:	N/A				
Approval by OIT?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Not Required: <input checked="" type="checkbox"/>
Schedule 13s from Affected Departments:	N/A				
Other Information:	N/A				



COLORADO

**Department of Health Care
Policy & Financing**

Department of Health Care Policy and Financing
Behavioral Health Community Programs

FY 2014-15, FY 2015-16, and FY 2016-17 Budget Request

November 1, 2014

TABLE OF CONTENTS

BEHAVIORAL HEALTH COMMUNITY PROGRAMS..... 2

 History and Background Information 2

 Program Administration..... 4

 Medicaid Anti-Psychotic Pharmaceuticals 4

 Significant Changes to Forecast.....4

BEHAVIORAL HEALTH CAPITATION PAYMENTS AND MEDICAID BEHAVIORAL HEALTH FEE-FOR-SERVICE PAYMENTS6

Exhibit AA - Calculation of Current Total Long Bill Group Impact 8

Exhibit BB - Calculation of Fund Splits 9

Exhibit CC - Behavioral Health Community Programs Summary 11

Exhibit DD - Behavioral Health Caseload, Per Capita, and Expenditure History..... 11

Exhibit EE - Estimate and Request by Eligibility Category 12

 Incurred but not Reported Estimates..... 14

Exhibit FF - Behavioral Health Retroactivity Adjustment and Partial Month Adjustment Multiplier 15

 Retroactivity Adjustment Multiplier..... 15

 Partial Month Adjustment Multiplier..... 16

Exhibit GG - Behavioral Health Capitation Rate Trends and Forecasts..... 16

Exhibit HH - Forecast Model Comparisons 18

 Final Forecasts 18

 Capitation Trend Models 19

 Trend Justification.....22

Exhibit II – MAGI Adults Reconciliation..... 222

Exhibit JJ – Alternative Financing Populations 23

Exhibit KK - Medicaid Behavioral Health Fee-for-Service Payments 25

Exhibit LL - Global Reasonableness Test for Behavioral Health Capitation Payments 27

BEHAVIORAL HEALTH COMMUNITY PROGRAMS

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

History and Background Information

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

The structure of managed care has changed over time. In 1995, implementation of the Behavioral Health Capitation Program in 51 counties of the State was complete, with the remaining 12 counties added in 1998. A 64th county was added when Broomfield became a county in November 2001. Through a competitive bid process, eight behavioral health assessment and service agencies were awarded contracts to be service providers in the program. Again through competitive procurement, the Department reduced the number of regions from eight to five and awarded managed care contracts to five behavioral health organizations effective January 1, 2005. The five behavioral health organizations were reprocured through a competitive bid process effective July 1, 2009. As a result of the reprocurement, the same five organizations won their respective contract bids, leaving the program unchanged. 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 bids. 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, disabled individuals 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, and physician care; and non-hospital residential care as it pertains to behavioral health. The capitation program also includes alternatives to institutionalization. The Department is required to make monthly capitation payments to contracted behavioral health organizations for services for each eligible Medicaid recipient. Payments vary across each behavioral health organization, as well as each eligibility category.

Since the inception of the Behavioral Health Community Programs, the Department has been responsible for oversight and contracting with the managed care organizations. The budget projections, day-to-day operations, and administration of the program were the

FY 2015-16 BUDGET REQUEST: BEHAVIORAL HEALTH COMMUNITY PROGRAMS NARRATIVE

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:

- SB 11-008, “Aligning Medicaid Eligibility for Children,” will expand Medicaid eligibility from 100% to up to 133% of the federal poverty level for children ages six through 18. The bill shifts impacted children from the Children’s Basic Health Plan (CHP+) to Medicaid beginning January 1, 2013. The Department assumes the expenditure for these children will continue to receive a 65% federal match rate, which is the rate for CHP+. SB 11-250, “Eligibility for Pregnant Women in Medicaid,” will expand Medicaid eligibility from 133% to 185% of the federal poverty level for all pregnant women. Similar to SB 11-008, this bill shifts impacted women from CHP+ to Medicaid on January 1, 2013. The Department assumes the expenditure for these women will continue to receive the enhanced federal match rate in FY 2014-15, but effective August 1, 2015, expenditure for these women will receive the standard Medicaid match.
- SB 13-200, “Expanding Medicaid Eligibility in Colorado,” extends Medicaid eligibility to up to 133% of the FPL for parents of Medicaid eligible children and adults without dependent children, effective January 1, 2014. The Department assumes that the expenditure for parents from 60% to 133% FPL and all adults without dependent children will receive a 100% federal match rate, while adults up to 60% FPL will receive the standard Medicaid match.
- As of January 1, 2014, the Medicaid benefit for the Behavioral Health Community Programs also includes a substance use disorder benefit. This expands the range of services that will be covered under Medicaid for disorders relating to substance use for currently enrolled members.

FY 2015-16 BUDGET REQUEST: BEHAVIORAL HEALTH COMMUNITY PROGRAMS NARRATIVE

- HB 14-1045, “Continuation of the Breast and Cervical Cancer Prevention and Treatment Program”, will extend the repeal date by five years for the program, through June 30, 2019. One hundred percent of the State’s share will come from the Breast and Cervical Cancer Prevention and Treatment fund.
- SB 14-215, “Disposition of Marijuana Revenue”, expands on the current school-based prevention and early intervention benefit within the BHO contract as well as creates a grant program that extends this benefit beyond just the Medicaid population. The expansion within the BHOs and the grant program provides additional resources in schools to target at risk youth as a result of the legalization of marijuana. This funding is currently only available for one year (FY 2014-15).

Program Administration

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

Medicaid Anti-Psychotic Pharmaceuticals

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

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

Significant Changes between FY 2014-15 S-2A and FY 2015-16 R-2

FY 2014-15

- For the Disabled Individuals category, the rate estimate decreased by \$8.25 per member per month (PMPM), causing a \$7.6 million decrease from prior forecast.

FY 2015-16 BUDGET REQUEST: BEHAVIORAL HEALTH COMMUNITY PROGRAMS NARRATIVE

- For the Low Income Adults category, the caseload estimate increased by approximately 27,000 per month (PM), causing an \$8.9 million increase from prior forecast. A significant portion of this increase is attributed to the 0-68% FPL group (General Fund is used for the state contribution for this population).
- For the Eligible Children category, the rate estimate increased by \$0.57 PMPM, causing a \$3.0 million increase from prior forecast. Also within this category, the caseload estimate increased by about 38,000 PM, causing an \$8.5 million increase from prior forecast.
- For the MAGI Adults category, the caseload estimate increased by approximately 60,000 PM, causing a \$60 million increase from prior forecast. The rate estimate for this category decreased by approximately \$23.00 PMPM, causing a \$46.0 million decrease from prior forecast. Due to the large changes in the two components, compounding effects contributed a \$21.0 million decrease from the prior forecast.
- For the Foster Care category, the caseload estimate increased by approximately 2,500 PM, causing a \$5.0 million increase from prior forecast. Rates also increased by about \$28.00 PMPM, causing a \$6.2 million increase from the prior forecast.
- SB 14-215 “Disposition of Marijuana Related Revenue”
 - The Department was appropriated \$4.3 million within the Behavioral Health Capitation line to enhance the school-based substance abuse prevention and early intervention program by providing additional resources in schools.
 - The Department was also appropriated \$2.0 million for a grant program designed to bridge the gap between prevention and early intervention services for the Medicaid and non-Medicaid populations (not included in current request).
- HB 14-1045 “Continuation of BCCP Program” reauthorized the Breast and Cervical Cancer Prevention and Treatment Program through June 30, 2019. The program was set to end June 30, 2014.
- The retroactivity policy was changed effective Jan 1, 2014 from 18 months to 3 months. The policy change results in paying less claims from prior periods in the current period, and as a result increases our incurred but not reported (IBNR) factor. The increase to the IBNR factor means that we are paying more claims in the period in which they were incurred and thus getting to payment completion quicker for each period.

FY 2015-16

- The caseload changes from the prior forecast to the current followed a similar pattern to FY 2014-15 with the exception of Eligible Children and Magi Adults, which grew at a fast pace in FY 2015-16 Q3 and Q4. Also, rate changes from the prior forecast to the current followed a similar pattern to FY 2014-15 but to a lesser degree.

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

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

The eligible behavioral health populations are:

- Adults 65 and Older
- Disabled Individuals Through 64
- Low Income Adults
- 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 is the Colorado Financial Reporting System (COFRS). The drawback was the COFRS provided total expenditures, but not by eligibility category. The exception was the Breast and Cervical Cancer Treatment Program eligibility category, which was reported separately in the COFRS. Since an allocation had to be calculated to determine the amount of actual expenditures across the other eligibility categories, a ratio was calculated for each eligibility category by dividing the MMIS eligibility category expenditures (less the Breast and Cervical Cancer Treatment Program eligibility category) by the total MMIS expenditures (less the Breast and Cervical Cancer Treatment Program eligibility category). The ratio for each category was multiplied by the total expenditures (less the Breast and Cervical Cancer Treatment Program eligibility category) from the COFRS. This calculation estimated actual COFRS expenditures across each eligibility category. Variance between the two systems was less than 0.67%. Beginning July 1, 2014, the Department is using a new financial reporting tool. The Colorado Operations Resource Engine (CORE) will be used in place of COFRS and the same overlay methodology will be 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

FY 2015-16 BUDGET REQUEST: BEHAVIORAL HEALTH COMMUNITY PROGRAMS NARRATIVE

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 clients, the state receives the standard Medicaid federal match with the State's share coming from General Fund. In FY 2014-15 the federal match is 50.76%. Payments for clients in the Breast and Cervical Cancer Program receive an enhanced federal match rate, which in FY 2014-15 is 65.53% and is described separately below. Capitation expenditures are split between traditional clients and expansion clients. Expansion clients are funded from Hospital Provider Fee funds with the exception of the parents and caretakers from 69% to 133% FPL and MAGI Adults, which are 100% federally funded. Finally, the reconciliation from prior years for behavioral health capitation overpayments, retractions for capitations paid for clients later determined to be deceased, and the addition of the marijuana tax money appropriation are also presented (see Exhibit II for reconciliation calculations). A summary of applicable FMAP rates for each of the forecast years is provided below:

FY 2015-16 BUDGET REQUEST: BEHAVIORAL HEALTH COMMUNITY PROGRAMS NARRATIVE

Population	FY 2014-15 Match Rate	FY 2015-16 Match Rate	FY 2016-17 Match Rate
Standard Medicaid	50.76%	51.01%	51.01%
Former CHP+ Children	65.53%	82.96%	88.71%
Former CHP+ Prenatal	65.53%	52.24%	51.01%
Expansion Adults	100.00%	100.00%	100.00%
BCCP	65.53%	65.71%	65.71%

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 clients also receive the standard Medicaid federal match with the State’s share coming from General Fund. In FY 2014-15 the federal match is 50.76%. 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 clients in the Breast and Cervical Cancer Program is managed through the capitation contracts with the behavioral health organizations. Therefore, the budget is based on the behavioral health caseload that includes the Breast and Cervical Cancer Program eligibility category. For this reason, they are shown as a separate eligibility category where appropriate.

Annual designations of General Fund contributions to program costs are specified in sections 25.5-5-308(9), C.R.S. (2014). Exhibit BB details funds splits for the Behavioral Health Community Programs Capitations line. The funding for the clients enrolled in the program,

FY 2015-16 BUDGET REQUEST: BEHAVIORAL HEALTH COMMUNITY PROGRAMS NARRATIVE

is 34.47% cash funds from the Breast and Cervical Cancer Prevention and Treatment Fund, and 65.53% federal funds in FY 2014-15. 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.

Behavioral Health Services for Hospital Provider Fee Expansion Clients

HB 09-1293 established a funding mechanism for a series of expansion clients. The first set of expansion clients that are funded through the bill was parents with income up to 100% of the Federal Poverty Limit (FPL). Services for these clients were funded through the Hospital Provider Fee cash fund. These clients are assumed to be similar to other adult clients and expenditure for these clients is therefore calculated using the same per capita rate as other adult clients (see Exhibit JJ). Starting in FY 2011-12, additional expansion populations also received funding through the Hospital Provider Fee cash fund. These include disabled individuals with income limits up to 450% of the federal poverty level and MAGI Adults, both of which received services through the BHOs as part of their benefit package. The disabled individuals with income limits up to 450% are assumed to be similar to other disabled clients, and expenditure for these clients is therefore calculated using the same per-capita rate as other disabled clients (see exhibit JJ). For MAGI Adults, the BHOs will be reimbursed at a separate capitation rate than other eligibility categories. The Department estimated expenditure for this population using preliminary assumptions about the rate that will be set for MAGI Adults and the reconciliation method that will be used to ensure that the Department adequately pays the BHOs to serve this new population. See exhibits EE, GG, II, and JJ for more detailed explanations of these assumptions.

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

SB 11-008, "Aligning Medicaid Eligibility for Children," extended Medicaid eligibility to up to 133% of the federal poverty level (FPL) for all children under the age of 19. Formerly, the eligibility limit for children ages six through 18 was 100% of the FPL and 133% of the FPL for children five and under. The bill shifted impacted children from CHP+ to Medicaid beginning January 1, 2013. The Department assumes that the expenditure for these children will continue to receive the enhanced federal match rate, which in FY 2014-15 is 65.53%.

SB 11-250, "Eligibility for Pregnant Women in Medicaid," extended Medicaid eligibility from 133% to 185% of the FPL for all pregnant women. This bill shifted impacted women from CHP+ to Medicaid on January 1, 2013. The Department assumes that the expenditure for these women will continue to receive the enhanced federal match rate, which is 65.53% in FY 2014-15, but effective August 1, 2015, the federal match will drop to the standard Medicaid Match of 51.01%.

FY 2015-16 BUDGET REQUEST: BEHAVIORAL HEALTH COMMUNITY PROGRAMS NARRATIVE

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 Hospital Provider Fee cash fund, and all parents from 69% - 133% FPL and newly eligible MAGI Adults will receive a 100% federal match rate, while adults up to 60% FPL and non-newly eligible MAGI Adults will continue to receive the standard Medicaid match.

EXHIBIT CC - BEHAVIORAL HEALTH COMMUNITY PROGRAMS SUMMARY

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

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

Exhibit DD contains the caseload, per-capita, and expenditure history for each of the 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 seven 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 clients and non-citizens and ties to the caseload presented in the Request for Medical Services Premiums, Section E, Exhibit B. Please see the Medicaid Caseload section of the Medical Services Premiums narrative for further discussion of Medicaid caseload projections. The caseload numbers are used in numerous exhibits throughout the Behavioral Health Community Programs exhibits and narrative.

Behavioral Health Community Programs Per-Capita Historical Summary

As with caseload, Behavioral Health Community Programs per-capita is displayed in two tables. The first table sets forth total per-capita for 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-

FY 2015-16 BUDGET REQUEST: BEHAVIORAL HEALTH COMMUNITY PROGRAMS NARRATIVE

capita is shown in those categories and will not mathematically be the same as dividing each individual category expenditure by the caseload. Figures for fiscal years up to the present fiscal year are actual per-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, other than the Breast and Cervical Cancer Treatment Program, 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. The Breast and Cervical Cancer Treatment Program expenditures are carved out of both totals before the calculations are done, since this is the only category that does not need to be estimated. Once the overall expenditures by eligibility category are determined, they may be divided by the actual average monthly caseload for each eligibility category to determine the actual per capita for each eligibility category.

EXHIBIT EE - ESTIMATE AND REQUEST BY ELIGIBILITY CATEGORY

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

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

FY 2015-16 BUDGET REQUEST: BEHAVIORAL HEALTH COMMUNITY PROGRAMS NARRATIVE

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

The Department has broken down the current fiscal year and the request year into two components: a first and second quarter estimate (Q1 and Q2) and a third and fourth quarter estimate (Q3 and Q4). This accounts for the fact that the Department makes rate adjustments on a calendar year basis. As such, the Q1 and Q2 capitation rate is known and is the point estimate rate from the previous two quarters (the first two quarters of the calendar year). Typically, for the Department's November requests, the current year's Q1 and Q2 rates are known and the remaining rates are estimated. In the February supplemental, the rates for the current year and the first half of the request year are known and only the final two quarters of the request year are estimated. By the time February numbers are presented, the Department has completed its most recent rate setting process, adding to the known set of data. Because BHO contracts were rebid for FY 2014-15, the rate setting process was different than previous years. For the new contract, an 18-month actuarially sound capitation rate was set for the BHO's and their respective winning bids would be their rate in effect for 12 months, so through FY 2014-15. This differs from previous practices because of it being a rebid year. Therefore in this request, FY 2014-15 point estimate rates are known and FY 2015-16 and FY 2016-17 are estimates. In January 2015, a six month rate will be negotiated between the Department and BHOs for FY 2015-16 Q1 & Q2 to allow for rate setting to take place again on a calendar year basis in 2016. As presented in Exhibit EE, the estimated capitation rate is multiplied by the monthly caseload and then multiplied by the number of months the rate will be in effect.

In order to adjust the calculations for cash accounting, the Department makes two adjustments to the calculation: first, the Department subtracts the incurred amount estimated to be paid in subsequent periods; then, the Department adds the claims incurred in prior periods expected to be paid in the forecast period. These adjustments transform the estimated incurred expenditure to a cash-based figure. The basis for these adjustments is described in this narrative below and is shown starting on page 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 clients in FY 2009-10; this activity resulted in retraction of payments originally made between FY 2004-05 and FY 2008-09 and reduced prior period dates of service expenditure. The Department is continuing to identify these claims and retracts payments twice a year. For the current year, the retractions are estimated as a 10% reduction in the total amount retracted in the previous year. For the request year, the retractions are estimated as a

10% reduction in the estimated amount that will be retracted in the current year. The retractions are expected to decline, as there is a smaller pool of historical clients from which to retract and current processes of identification become more effective.

Incurred-but-not-Reported Estimates

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

The Department examined historical data from the last five fiscal years and determined the prior fiscal years would provide a representative model for the likelihood of claims being paid in the year in which they are incurred. Pages 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.

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

It is of note that beginning January 1, 2014, the Department instituted a policy of denying retroactive capitation claims that are from a period beyond three months prior to the payment month. For those clients with retroactive claims beyond three months who are found to have received services, the Department will reimburse the BHOs through a fee-for-service payment. Since capitations are calculated to pay for actual services delivered by spreading that cost to caseload regardless of whether services are received, the net effect of eliminating cap payments and reimbursing for services may be cost neutral. The Department will monitor this policy change, and, should there be any expenditure fluctuations, the Department will seek to adjust through future budget requests.

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

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

Retroactivity Adjustment Multiplier

For the purpose of adjusting the forecasted capitation rate to capture the omission of retroactivity from caseload, the Department analyzed the last 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 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. The Department analyzed the data, however, and determined the amount of retroactivity in the claims incurred each period is steadily changing over time and has trended downward

FY 2015-16 BUDGET REQUEST: BEHAVIORAL HEALTH COMMUNITY PROGRAMS NARRATIVE

for all eligibility categories except for disabled individuals. 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. As such, the Department analyzed FY 2013-14 Q3 & Q4 for actual retroactivity and used those percentages as the basis for the factor.

Partial Month Adjustment Multiplier

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

As presented on page 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 comparison of any trend in claims-based rates as compared to capitation rates. The percentages are similar across years, indicating claims-based trends are matching capitation trends. The Department analyzed the data, however, and determined the amount of partial months paid each period is steadily changing over time within each eligibility category. For this reason, the Department assumes the most recent period with adequate time for run out of claims is the best representation of how much partial-month payments will affect the claims-based rate in the current and request years.

EXHIBIT GG - BEHAVIORAL HEALTH CAPITATION RATE TRENDS AND FORECASTS

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

Beginning in January 2009, the Department switched its rate-setting cycle from a state fiscal year cycle to a calendar year cycle. Capitation rates are now effective from January 1 through December 31. Therefore, the Department now presents its forecasted rates

FY 2015-16 BUDGET REQUEST: BEHAVIORAL HEALTH COMMUNITY PROGRAMS NARRATIVE

in six-month blocks to account for the rate change occurring in the middle of a state fiscal year. As mentioned above, FY 2014-15 rates were set on a state fiscal year basis, due to the BHO contract reprocurement, but will be switching back to a calendar year basis in 2016.

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

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

It is important to note the overall weighted 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.

The Department added a new rate cell in FY 2011-12 for the MAGI Adults population, which was funded through the Hospital Provider Fee Cash Fund initially, but with the passage of the Affordable Care Act will be funded entirely with federal funds. The MAGI Adults rate is based on data from Disabled Adults and Low-Income Adults rates. In prior budget requests, the Department assumed a large reconciliation component to be paid retroactively; this was, in part, due to the fact there were a great number of unknowns related to the rate setting process. With the new rate setting methodology used beginning July 1, 2014, the Department still expects a number of unknowns and therefore expects to continue the reconciliation process in FY 2014-15 and the foreseeable future. The Department is currently in the process of analyzing the data surrounding the MAGI Adults rate and the outcome of the reconciliation process should be completed prior to the February supplement request.

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). Typically, for Funding Requests, the rate applied to the first six months of the current year is known due to the calendar year rate setting cycle (see the description of Exhibit GG, above). The rate applied to the next six months of the current year is then estimated from a series of trend models and historical changes (see below). That same rate is then carried forward into the first six months of the request year due to the calendar year rate setting cycle. The rate for the last six months of the request year is estimated by taking the percent change in rates from the last known rate to the first forecasted rate and carrying that percentage change forward. Of note, for FY 2014-15 rates for the entire fiscal year are known as a result of the rates being set on a fiscal year basis due to the procurement of the BHO contracts. For FY 2015-16 Q1 & Q2, the Department will set a six month rate to allow rate setting to take place on a calendar year basis moving forward. The Department will utilize the prior methodology when it reverts back to calendar year rate setting in 2016.

Typically, for Supplemental Requests, the rate for the entirety of the current year and the first six months of the request year are known due to the calendar year rate setting cycle. The rate for the final six months of the request year is estimated using the various trend models and historical information described below. Similar to above, the FY 2014-15 supplemental request will differ because we will only know FY 2014-15 rates and no part of FY 2015-16 that the time of submittal.

The projected rate is then adjusted by any policy impacts. In accordance with the FY 2010-11 ES-2 budget action, beginning September 1, 2009, the Department paid rates that were 2.5% below the actuarial midpoint. This rate cut is now incorporated in the data used during the rate-setting process and is no longer included as an adjustment factor in exhibit HH. There are currently no additional policy changes that impact the rates and therefore the only other adjustments are those to the account for partial month and retroactive eligibility (see below).

FY 2015-16 BUDGET REQUEST: BEHAVIORAL HEALTH COMMUNITY PROGRAMS NARRATIVE

The forecasted rate is also 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.

Finally the claims-based rate is adjusted a third time, this time 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 period will see a change in the capitation rate that is the average of the last two changes in the capitation rate. The exponential growth model assumes the capitation rate is increasing faster as time moves forward (a best-fit exponential equation is applied to the historical data and trended into the future). The linear growth model is a regression model on time, fitting a linear equation line to the historical data and forecasting that line into the future. Each model in the exhibit also shows what the percent change would be from the prior period.

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

Capitation rates are required to be actuarially sound and are built from a blend of historical rates and recent year encounter data (provider expenditure on services). The trends models, as presented in this exhibit, are an attempt to predict the final outcome of this rate setting process. However, the use of historical, final rates as data points for predicting future rates is limited when future periods are likely to

FY 2015-16 BUDGET REQUEST: BEHAVIORAL HEALTH COMMUNITY PROGRAMS NARRATIVE

be fundamentally different than historical periods. Beginning with FY 2008-09 the Department has experienced unusual trends for the behavioral health capitation program. This program, in its present state, has never existed in an economic climate like the one currently being experienced. As such, the various rate estimating models' reliance on historical performance for predicting future performance is limited. The Department has used the trend models to establish a range of reasonable rate values and has selected trends by considering the various factors that impact the respective eligibility populations as well as the impact that encounter data will have on the rate setting process. As such, the Department believes the most recent years' experience is the most predictive of the likely current year and future year experiences. The following table shows the trends selected for the current and request years by eligibility category.

Aid Category	FY 2015-16 Q1 & Q2 Trend Selection	CY 2016 Trend Selection	CY 2017 Trend Selection
Adults 65 and Older	0.36%	1.96%	1.96%
	Trend is half of the projected percent growth for FY 2015-16 based on average annual percent growth from FY 2008-09 through FY 2014-15.	Trend is average annual percent growth from FY 2009-10 to FY 2011-12 and FY 2013-14.	Trend is average annual percent growth from FY 2009-10 to FY 2011-12 and FY 2013-14.
Disabled Individuals Through 64	1.87%	1.39%	1.39%
	Trend is half of the projected percent growth for FY 2015-16 based on average annual percent growth from FY 2008-09 through FY 2014-15.	Trend is average annual percent growth from FY 2011-12 through FY 2014-15.	Trend is average annual percent growth from FY 2011-12 through FY 2014-15.

FY 2015-16 BUDGET REQUEST: BEHAVIORAL HEALTH COMMUNITY PROGRAMS NARRATIVE

Low Income Adults	2.90%	5.51%	5.51%
	Trend is half of the projected percent growth for FY 2015-16 based on average annual percent growth from FY 2008-09 through FY 2014-15.	Trend is average annual percent growth in from FY 2011-12 through FY 2014-15.	Trend is average annual percent growth in from FY 2011-12 through FY 2014-15.
MAGI Adults	2.90%	5.51%	5.51%
	Trend is half of the projected percent growth for FY 2015-16 based on average annual percent growth from FY 2008-09 through FY 2014-15.	Trend is average annual percent growth from FY 2008-09 through FY 2014-15	Trend is average annual percent growth from FY 2008-09 through FY 2014-15
Eligible Children	2.12%	4.23%	4.23%
	Trend is half of the projected percent growth for FY 2015-16 based on average annual percent growth from FY 2008-09 through FY 2014-15.	Trend is average growth in rates from FY 2008-09 through FY 2014-15	Trend is average growth in rates from FY 2008-09 through FY 2014-15

FY 2015-16 BUDGET REQUEST: BEHAVIORAL HEALTH COMMUNITY PROGRAMS NARRATIVE

	1.58%	1.58%	1.58%
Foster Care	Trend is half of the projected percent growth for FY 2015-16 based on average annual percent growth from FY 2008-09 through FY 2014-15.	Trend is half of the percent growth from FY 2013-14 Q3 & Q4 to FY 2013-14 Q1 & Q2.	Trend is half of the percent growth from FY 2013-14 Q3 & Q4 to FY 2013-14 Q1 & Q2.

Trend Justification

The rate setting methodology has changed for rates effective January 1, 2014. The previous rate setting process involved the actuaries setting rates that were actuarially sound in aggregate. The new methodology now involves setting actuarially sound rates for each aid category. With a lack of data points to base the trend selection on the current models outputs, the trend selected for FY 2015-16 Q1 & Q2 is half of the projected growth in FY 2015-16 based on the average growth model. A six month rate will be negotiated with the BHO's to allow for the rate setting process to revert to calendar year in 2016. The six month rate must still fall within the 18-month actuarially sound rate range set July 1, 2014. The CY 2016 and CY 2017 trends were chosen because the Department predict how the new methodology is going to affect future rates and using a historical average provides a conservative estimate.

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 clients are determined to be eligible for benefits retroactively, retroactive capitation payments are made to the behavioral health organizations through the MMIS. When clients are determined to be ineligible for Medicaid benefits retroactively, a recoupment of the capitation payments is completed separately. When known, this exhibit also shows the impact of the reconciliation process surrounding

FY 2015-16 BUDGET REQUEST: BEHAVIORAL HEALTH COMMUNITY PROGRAMS NARRATIVE

the MAGI Adults population. For this request, as in years past, there is a risk corridor placed on the MAGI Adults rate due to the uncertainty of the true cost of this population. This risk corridor allows 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 reconciliation surrounding the payments made for FY 2013-14 have not been calculated by the Department to date, but will be updated once calculations have been made.

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

No recoupments were made during FY 2005-06 due to a computer programming change, and this has delayed the recoupment process. In FY 2006-07, recoupments from FY 2003-04 were processed. In FY 2007-08, no recoupments were processed as the Department sought to verify eligibility information provided by the behavioral health organizations. This process has proven to be complicated by the various reporting practices of the community behavioral health centers that provide services to clients. The Department collaborated with the Centers for Medicare and Medicaid Services (CMS) to develop a retrospective eligibility validation process which the Department implemented in FY 2009-10. Recoupments from FY 2005-06 through FY 2007-08 were processed in the latter half of FY 2009-10. In FY 2010-11, recoupments were collected for FY 2004-05. The Department recouped expenditure for FY 2008-09 ineligibles at the beginning of FY 2011-12. The recoupments from incurred expenses in FY 2008-09 were altered in their federal fund split due to the impact of the American Recovery and Reinvestment Act. Since those expenditures were made with enhanced federal funds, any recoupments will also see a disproportionate share of federal funds retrieved. Recoupments from FY 2009-10 were set for collection in FY 2012-13, but due to timely filing, requirements from CMS were collected in FY 2011-12. Recoupments for FY 2009-10 are altered by the enhanced federal match from the year the claims were processed. Due to timely filing issues raised by federal authorities, the Department will not be processing reconciliations for FY 2010-11. As a result, the Department estimates that reconciliations will be lower in FY 2012-13 than previously estimated. Reconciliations are anticipated to return to previous levels in subsequent years. Recoupments from FY 2011-12 will be collected in FY 2012-13, and those from FY 2012-13 as well as future recoupments will no longer be made by the Department due to issues related to timely filing; instead, capitation rates will be adjusted accordingly.

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

FY 2015-16 BUDGET REQUEST: BEHAVIORAL HEALTH COMMUNITY PROGRAMS NARRATIVE

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.

Colorado Health Care Affordability Act

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

The Department also expanded eligibility to cover MAGI Adults, formally known as adults without dependent children in FY 2011-12. The program was initially limited to 10,000 clients. In February 2013, additional enrollees were added from the waitlist beginning in April through September 2013 because the Department had sufficient funding to support the addition. Beginning January 1, 2014, with the passage and implementation of SB 13-200 referenced below, that cap was lifted on the amount of clients served with the MAGI Adults population. This population received the full range of behavioral health services provided by the BHOs, and the BHOs are paid at a different capitation rate for these members than any of its other eligibility categories. The Department’s caseload projections for all expansion populations are provided in this Budget Request (see exhibit B in Medical Services Premiums).

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

SB 11-008, “Aligning Medicaid Eligibility for Children,” extended Medicaid eligibility to up to 133% of the FPL for all children under the age of 19. Formerly, the eligibility limit for children ages six through 18 was 100% of the FPL and 133% of the FPL for children five and under. The bill shifted impacted children from the CHP+ to Medicaid beginning January 1, 2013. The Department assumed the expenditure for these children will continue to receive a 65.53% federal match rate, which is the rate for CHP+. As with most of the Hospital Provider Fee populations, the Department assumed the per-capita costs for this expansion population would be the same as for the traditional population since the majority of behavioral health expenditure is paid through the capitation program.

SB 11-250, “Eligibility for Pregnant Women in Medicaid,” extended Medicaid eligibility from 133% to 185% of the FPL for all pregnant women. This bill shifted impacted women from CHP+ Medicaid on January 1, 2013. The Department assumes the expenditure for these women will continue to receive a 65.53% federal match rate and that the per-capita costs will be the same as for the traditional population.

FY 2015-16 BUDGET REQUEST: BEHAVIORAL HEALTH COMMUNITY PROGRAMS NARRATIVE

Expanding Medicaid Eligibility in Colorado

SB 13-200, "Expanding Medicaid Eligibility in Colorado," extends Medicaid eligibility to up to 133% of the FPL parents and caretakers of Medicaid eligible children and MAGI Adults, effective January 1, 2014. The Department assumes that the expenditure for parents and caretakers from 60% to 68% FPL will be funded with the standard Medicaid match, with the State's share coming from the Hospital Provider Fee fund. The Department assumes that parents and caretakers from 69% to 133% FPL and all MAGI Adults will receive a 100% federal match rate, while parents up to 60% FPL will receive the standard Medicaid match, with the State's share coming from General Fund.

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.

The Medicaid Behavioral Health Fee-for-Service Payments appropriation allows Medicaid clients not enrolled in a behavioral health organization to receive behavioral health services or enrolled Medicaid clients 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 clients enrolled in a behavioral health organization who are eligible for both Medicare and Medicaid.

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

History and Background Information

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

FY 2015-16 BUDGET REQUEST: BEHAVIORAL HEALTH COMMUNITY PROGRAMS NARRATIVE

the Department of Human Services to the Department's Behavioral Health Fee-for-Service Payments appropriation. The changes to case management services and behavioral health care for developmentally disabled clients are discussed below.

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

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

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

Current Calculations

The current fiscal year's total estimated expenditure is based on the actual expenditures from FY 2013-14, trended forward based upon the expected change in caseload from FY 2013-14 to FY 2014-15. The request year estimate is the result of a forward trend of the current-year estimate by the factor of the anticipated change in caseload, and this is then trended forward by the anticipated change in caseload for the out-year estimate.

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

FY 2015-16 BUDGET REQUEST: BEHAVIORAL HEALTH COMMUNITY PROGRAMS NARRATIVE

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.

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 2014-15 appropriation is 30.12% higher than FY 2013-14 actual expenditures, primarily due to caseload growth. The FY 2014-15 estimate incorporates increased caseload projections along with various rate adjustments and results in a 29.67% increase from FY 2013-14 actual expenditures and a -0.34% decrease from the current appropriation. The FY 2015-16 estimate is built on the FY 2014-15 estimate and presents a 13.57% expenditure increase. This increase is primarily due to: 1) increased caseload projections for traditional clients; 2) increased caseload due to the Colorado Health Care Affordability Act expansion populations; and 3) projected increases in capitation rates from CY 2013 to CY 2015. The FY 2015-16 request represents a 13.18% increase over the current FY 2014-15 appropriation. The FY 2016-17 Budget Request is built on the FY 2015-16 estimate and represents an 11.54% expenditure increase over the FY 2015-16 request and a 26.23% increase over the FY 2014-15 appropriation.