



COLORADO

**Department of Health Care
Policy & Financing**

**Department of Health Care Policy and Financing
Behavioral Health Community Programs**

FY 2016-17, FY 2017-18, and FY 2018-19 Budget Request

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TABLE OF CONTENTS

BEHAVIORAL HEALTH COMMUNITY PROGRAMS..... 2

 History and Background Information 2

 Program Administration..... 4

 Medicaid Anti-Psychotic Pharmaceuticals 4

BEHAVIORAL HEALTH CAPITATION PAYMENTS AND MEDICAID BEHAVIORAL HEALTH FEE-FOR-SERVICE PAYMENTS 5

Exhibit AA - Calculation of Current Total Long Bill Group Impact 7

Exhibit BB - Calculation of Fund Splits 8

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..... 13

Exhibit FF - Behavioral Health Retroactivity Adjustment and Partial Month Adjustment Multiplier 13

 Retroactivity Adjustment Multiplier..... 14

 Partial Month Adjustment Multiplier..... 14

Exhibit GG - Behavioral Health Capitation Rate Trends and Forecasts 15

Exhibit HH - Forecast Model Comparisons 16

 Final Forecasts 16

 Capitation Trend Models 16

Exhibit II – Reconciliations..... 19

Exhibit JJ – Alternative financing populations 20

Exhibit KK - Medicaid Behavioral Health Fee-for-Service Payments 21

Exhibit LL - Global Reasonableness Test for Behavioral Health Capitation Payments 23

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

FY 2017-18 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 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.
- HB 14-1045, “Continuation of the Breast and Cervical Cancer Prevention and Treatment Program”, extends 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 was only available for one year (FY 2014-15).
- For the most recent rate setting cycle, rates effective July 1, 2016 to June 30, 2017, the Department experienced a significant drop in rates in a few eligibility categories for most BHOs. This is the result of BHO encounter data not supporting the current level of

FY 2017-18 BUDGET REQUEST: BEHAVIORAL HEALTH COMMUNITY PROGRAMS NARRATIVE

rates, specifically in the Individuals with Disabilities, MAGI Adults, Expansion Parents & Caretakers, and Foster Care eligibility categories. New rates will be set for FY 2017-18, July 1, 2017 to June 30, 2018, 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 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 R-2 and FY 2017-18 S-2A

FY 2016-17

- Primarily Caseload updates for a few eligibility categories that contribute about a \$18.8 million decrease.
 - Individuals with Disabilities caseload forecast decreased by 10,848 or 1.05% member months.
 - Low-income Adults caseload forecast decreased by 343,500 or 13.70% member months.
 - Expansion Parents caseload forecast decreased by 163,116 or 13.74% member months.
 - MAGI Adults caseload forecast decreased by 22,308 or 0.51% member months.
 - Children caseload forecast decreased by 181,680 or 2.74% member months.
- The Department updated its estimate of payments made to the BHOs as a result of the system overpayment issue. Due to system limitations, eligibility categories are incorrectly assigned for a subset of the population. Expansion parents are being incorrectly

FY 2017-18 BUDGET REQUEST: BEHAVIORAL HEALTH COMMUNITY PROGRAMS NARRATIVE

classified as MAGI Adults which leads to paying about \$30.00 more per member per month. The Department projects paying out a net of \$6.3 million in FY 2016-17 due to timing of prior period recoupments while continuing to pay the incorrect rate. The November request assumed recouping \$18.9 million in FY 2016-17. See Exhibit II and the narrative below for more detail.

- The Department has also paid additional capitation payments for children that were incorrectly classified as Individuals with Disabilities, resulting in an estimated \$3.1 million overpayment. The November request assumed these payments would be recouped in FY 2016-17, but instead will actually be recovered in FY 2017-18. Please see Exhibit II and narrative below for additional information on this issue.

FY 2017-18

- The changes in caseload and the IBNR factor for FY 2017-18 from the R-2 to the S-2A are primarily the result of flow through of the changes in FY 2016-17.
- The changes to the rates in FY 2017-18 from the November R-2 request are attributed to two primary reasons: 1) the implementation of the federal managed care regulations, which ultimately decreases rates, and 2) a small inflation factor to account for natural increases in costs.
- The Department expects to recover the remaining overpayments from FY 2016-17 for the expansion parent overpayment system issue. That estimate is \$25.3 million.
- 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 assumptions are no longer being used.
- The Department has also paid additional capitation payments for children that were incorrectly classified as Individuals with Disabilities, resulting in an estimated \$3.1 million overpayment. These payments will be recouped in FY 2017-18. Please see Exhibit II and narrative below for additional information on this issue.

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

FY 2017-18 BUDGET REQUEST: BEHAVIORAL HEALTH COMMUNITY PROGRAMS NARRATIVE

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 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 Program eligibility category, which was reported separately in the COFRS. Since an allocation had to be calculated to determine the

FY 2017-18 BUDGET REQUEST: BEHAVIORAL HEALTH COMMUNITY PROGRAMS NARRATIVE

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.

FY 2017-18 BUDGET REQUEST: BEHAVIORAL HEALTH COMMUNITY PROGRAMS NARRATIVE

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 2016-17 the federal match is 50.20%. Payments for members in the Breast and Cervical Cancer Program receive an enhanced federal match rate, which in FY 2015-16 is 65.13% and is described separately below. Capitation expenditures are split between traditional members and expansion members. Expansion members are funded from Hospital Provider 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:

Population	FY 2016-17 Match Rate	FY 2017-18 Match Rate	FY 2018-19 Match Rate
Standard Medicaid	50.20%	50.00%	50.00%
Former CHP+ Children	88.13%	88.00%	88.00%
Former CHP+ Prenatal	88.13%	88.00%	88.00%
Expansion Adults	97.50%	94.50%	93.50%
BCCP	65.13%	65.00%	65.00%

FY 2017-18 BUDGET REQUEST: BEHAVIORAL HEALTH COMMUNITY PROGRAMS NARRATIVE

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 2016-17 the federal match is 50.20%. 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 program, is 34.87% cash funds from the Breast and Cervical Cancer Prevention and Treatment Fund, and 65.13% federal funds in FY 2016-17. 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 Hospital Provider 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 Hospital Provider Fee cash fund. Starting in FY 2011-12, additional expansion populations also received funding through the Hospital Provider 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

FY 2017-18 BUDGET REQUEST: BEHAVIORAL HEALTH COMMUNITY PROGRAMS NARRATIVE

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 2016-17. 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 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 2016-17 is 88.13%.

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 88.13% in FY 2016-17.

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 for 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 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 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 2016-17 is 85.68%. 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 2016-17 will be 97.50%, 94.50% in FY 2017-18, and 93.50% in FY 2018-19.

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 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.

FY 2017-18 BUDGET REQUEST: BEHAVIORAL HEALTH COMMUNITY PROGRAMS NARRATIVE

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 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

FY 2017-18 BUDGET REQUEST: BEHAVIORAL HEALTH COMMUNITY PROGRAMS NARRATIVE

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 a 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. The Department analyzed the data, however, and determined the amount of retroactivity in the claims incurred each period is steadily changing over time and has trended downward for all eligibility categories. 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 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.

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 is funded entirely with federal funds through January 1, 2017 at which point it will revert back to Hospital Provider Fee with an enhanced federal match. The MAGI Adults rate was based on data from Disabled Adults and Low-Income Adults rates. In prior budget requests, the Department assumed a large reconciliation component to be completed 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 2016-17. Beginning in FY 2016-17, the Department no longer has a risk corridor on either expansion population rates and does not expect to make these recoupments beyond FY 2016-17. The Department currently estimates that it will recover \$17.5 million for FY 2014-15 and \$6.6 million for FY 2015-16 dates of service.

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 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.

FY 2017-18 BUDGET REQUEST: BEHAVIORAL HEALTH COMMUNITY PROGRAMS NARRATIVE

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 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.

Trend Selection

Aid Category	FY 2017-18 Trend	FY 2018-19 Trend
Adults 65 and Older (OAP-A)	1.21%	1.21%
	Trend is the average growth from FY 2010-11 to FY 2014-15.	Trend is the average growth from FY 2010-11 to FY 2014-15.
Individuals with disabilities Through 64 (AND/AB, OAP-B)	2.23%	2.23%
	Trend is average of FY 2013-14 and FY 2014-15.	Trend is average of FY 2013-14 and FY 2014-15.

FY 2017-18 BUDGET REQUEST: BEHAVIORAL HEALTH COMMUNITY PROGRAMS NARRATIVE

Low Income Adults / Expansion Parents & Caretakers	2.30%	2.30%
	Trend is half of the average growth from FY 2008-09 to FY 2012-13.	Trend is half of the average growth from FY 2008-09 to FY 2012-13.
MAGI Adults	2.30%	2.30%
	Due to lack of available data, trend is equal to Low Income Adults.	Due to lack of available data, trend is equal to Low Income Adults.
Eligible Children (AFDC-C/BC)	2.30%	2.30%
	Trend is half of the average growth from FY 2010-11 to FY 2012-13.	Trend is half of the average growth from FY 2010-11 to FY 2012-13.
Foster Care	2.92%	2.92%
	Trend is growth from FY 2012-13 to FY 2013-14.	Trend is growth from FY 2012-13 to FY 2013-14.

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 sound rates for each aid category. Based on current analysis of the behavioral health organizations cost data, the Department does not anticipate that rates will increase in FY 2017-18 beyond normal growth related to inflation. The rates are also based on more complete and accurate cost data provided by the BHOs. The Department expects that the new base rates are representative of actual costs and expects a positive trend to the rates in FY 2018-19 as well.

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 – RECONCILIATIONS

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's 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 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 January to June 2015 rates and all of FY 2015-16. The Department is estimating that it will recoup \$17.5 million as a result of capitation rates being set higher than actual costs for January to June 2015 and \$6.6 million for FY 2015-16. As mentioned above, 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. The Department anticipates with the implementation of the new MMIS, the correct rate will be paid beginning in March 2017. The prior request assumed that the Department would be able to recoup all overpayment within the fiscal year, but because the new MMIS implementation was moved back to March, the Department expects to overpay by about \$6.3 million in FY 2016-17 for dates of service through FY 2015-16 and all remaining overpayments from FY 2016-17 will be recouped in FY 2017-18. Therefore, a recoupment related to this issue in FY 2017-18 is expected to be about \$25.3 million. Because this involves a population that was 100% federally funded prior to January 1, 2017, there is minimal impact to state funds in FY 2017-18. With the implementation of the new MMIS, the Department will be able to correctly identify all populations and pay correctly so there will be no need to reconcile this in future years.

The Department also expects to make a recoupment with the BHOs of an estimated \$3.1 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. The Department is currently identifying a list of impacted clients and will work with the BHOs on the recoupment once the final impact is determined. Please see caseload narrative for additional information.

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.

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 members in May 2010.

The Department also expanded eligibility to cover MAGI Adults, formerly known as adults without dependent children in FY 2011-12. The program was initially limited to 10,000 members. 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 members 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. 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 have per-capita costs that will be the same as for the traditional population.

FY 2017-18 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 Expansion Parents and Caretakers from 69% to 133% FPL and all MAGI Adults will receive the enhanced federal match rate, while parents up to 60% FPL will receive the standard Medicaid match, with the State’s share coming from General Fund.

Other Populations

This exhibit also tracks expenditure and fund splits for Non Newly Eligible (NNE) and children eligible through the continuous eligibility (CE) policy. The NNE population are MAGI Adults who may have been eligible for Medicaid prior to expansion because of a disability, but signed up after Medicaid expansion. As a result, CMS does not allow this group to be financed with 100% federal financing. Therefore, the Department developed a methodology that assigns a blended FFP rate, which in FY 2016-17 was 85.68%. Children who retain eligibility through CE are financed with the Hospital Provider Fee cash fund, rather than General Fund and the Department tracks that financing mechanism in this exhibit.

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 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.

FY 2017-18 BUDGET REQUEST: BEHAVIORAL HEALTH COMMUNITY PROGRAMS NARRATIVE

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 members living in Regional Centers was transferred from 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 members 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 members 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 members 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 members 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 2015-16, trended forward based upon the expected change in caseload from FY 2015-16 to FY 2016-17. The request year estimate is the result of a forward trend of the

FY 2017-18 BUDGET REQUEST: BEHAVIORAL HEALTH COMMUNITY PROGRAMS NARRATIVE

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 also continues 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.

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 2016-17 appropriation is 13.19% higher than FY 2015-16 actual expenditures, primarily due to caseload growth. The FY 2016-17 estimate incorporates revised caseload projections along with various rate adjustments and results in a 4.91% increase from FY 2015-16 actual expenditures and an 7.31% decrease from the current appropriation. The FY 2017-18 estimate is built on the FY 2016-17 estimate and presents a 6.22% expenditure increase. This increase is primarily due to: 1) increased caseload projections for traditional members; 2) increased caseload due to the Colorado Health Care Affordability Act expansion populations; and 3) projected increases in capitation rates from FY 2016-17 to FY 2017-18. The FY 2017-18 request represents a 1.54% decrease over the current FY 2016-17 appropriation. The FY 2018-19 Budget Request is built on the FY 2017-18 estimate and represents a 10.93% expenditure increase over the FY 2017-18 request and a 9.21% increase over the FY 2016-17 appropriation.