DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2018-19 JOINT BUDGET COMMITTEE HEARING AGENDA

OFFICE OF COMMUNITY LIVING AND MEDICAID BEHAVIORAL HEALTH PROGRAMS

Thursday, December 14, 2017

9:00 a.m. – 12:00 p.m.

MEDICAID BEHAVIORAL HEALTH COMMUNITY PROGRAMS

10:45-10:55 INTRODUCTIONS AND OPENING COMMENTS

10:55-11:10 BEHAVIORAL HEALTH SERVICE DELIVERY SYSTEM

27 **Provide a chart or graphic that describes the criteria for determining whether an individual is eligible to receive behavioral health services through the Department of Health Care Policy and Financing, the Department of Human Services, or both. Please include information about criteria that may apply differently depending on the individual (e.g., age, whether one is pregnant, diagnoses, etc.), the type or level of service, or the service setting.**

RESPONSE

Criteria for determining whether an individual is eligible for Medicaid services offered by the Department of Health Care Policy and Financing, include the following:

1. The individual must be Medicaid eligible and enrolled;
2. The services being sought must be traditional medical, state plan services or alternative, community-based services approved under a waiver; and
3. The service must be medically necessary.

The following table shows covered behavioral health services available to a Medicaid enrolled individual:

Behavioral Health Funding Mechanism	Available Services	Population-Special Criteria	Service Eligibility*
Behavioral Health Capitation	• Alcohol/Drug Screen Counseling • Assertive Community Treatment • Behavioral Health Assessment • Clubhouses • Crisis Services • Drop-in Centers • Emergency Services • Inpatient Psychiatric Hospital • Intensive Case Management • Medication Assisted Treatment • Outpatient Day Treatment • Outpatient Hospital • Pharmacological Management • Physician Services • Prevention/Early Intervention • Psychosocial Rehabilitation • Psychotherapy • Residential (Mental Health) • Respite Care • School-Based Mental Health Services • Social Ambulatory Detoxification • Substance Use Disorder Assessment • Vocational Services	**Children** – under federal EPSDT, all members under the age of 21 may receive any service considered medically necessary. Any benefit coverage limitations with regard to number of services and frequency do not apply if the service is medically necessary.	The member is enrolled in a BHO and is seeking treatment for a BHO covered diagnosis.
Fee-For-Service	• Behavioral Health Assessment • Psychotherapy • Pharmacological Management • Outpatient Day Treatment • Emergency Services • Crisis Services • Substance Use Disorder Assessment • Social Ambulatory Detoxification • Medication Assisted Treatment	**Children** – under federal EPSDT, all members under the age of 21 may receive any service considered medically necessary. Any benefit coverage limitations would not apply if the service is medically necessary.	The member is not enrolled in a BHO or the member is enrolled in a BHO but is seeking treatment for a diagnosis not covered by the BHO.
Limited Fee-For-Service	Exclusively available to pregnant women can be outpatient or residential		Pregnant or within one year after delivery (only women who were in

Behavioral Health Funding Mechanism	Available Services	Population-Special Criteria	Service Eligibility*
	depending on a woman's level of risk. Services include: • Case management • Group health education with other pregnant women • Group substance abuse counseling with other pregnant women • In-depth risk screening • Individual substance abuse counseling • Referral to appropriate aftercare and ongoing support • Urine screening and monitoring		Special Connections before they delivered are eligible for Special Connections services after they deliver) and who are at risk of having an unhealthy pregnancy and unhealthy baby because of alcohol and/or drug abuse problems.
Office of Behavioral Health	Services that are not offered under Medicaid or services for members who do not meet Medicaid's medical necessity criteria.		The member meets the criteria specified in OBH response.

*Must meet Medicaid medical necessity criteria

28 **Describe how recent increases in the number of individuals eligible for the Medicaid program have impacted the behavioral health service delivery system.**

- **a. Do service providers have the capacity to meet the behavioral health needs of Medicaid clients?**
- **b. Has the pace of the caseload increases affected the scope or quality of services?**
- **c. With respect to behavioral health organizations, how have the significant recoupments and reconciliations over the last several years affected their administrative operations or service capacity?**

RESPONSE

a) One measure the Department monitors as an indicator of whether the delivery system is maintaining and expanding its capacity to treat members is the number of clients receiving a service, or penetration rate. Based on the comparison of penetration rates prior to Medicaid expansion and after expansion, there is no indication that the increases in the number of Medicaid enrolled individuals have created capacity issues. As shown in the chart below, the percentage of

members receiving behavioral health services through the Behavioral Health Organizations (BHOs) has increased even as the client count has increased.

Fiscal Year	Total Member Months	Client Count	Clients Receiving a Service	Penetration Rate
FY 2012-13	8,114,627	676,418	93,707	13.85%
FY 2015-16	15,255,255	1,268,848	183,707	14.48%

While overall the BHOs appear to be maintaining the system's capacity to meet the majority of client needs, the Department and the BHOs are aware that there are different capacity issues throughout the state. Some of these are systemic, such as the statewide shortages of psychiatrists, child psychiatrists and psychologists, and nurse practitioners and other disciplines licensed to dispense psychiatric medications. Other capacity issues are regional, such as there is no psychiatrist available to provide publicly funded treatment for the southeastern region of the state, and the known shortage of properly trained and licensed psychotherapists in Park and Teller counties, among others. The Department, BHOs and Regional Care Coordination Organizations (RCCOs) continue to collaborate on how to address provider availability issues.

b) To assess the quality of services, the Department uses the Center for Medicare and Medicaid Services (CMS) required evaluation of the BHOs' compliance with quality assessment and performance improvement work that is performed by the Department's external quality review organization. In FY 2012-13 the BHOs were collectively 99 percent compliant within the area of quality assessment and performance improvements; this score was 100 percent in FY 2015-16. Furthermore, the Department has not experienced a significant increase in member or provider complaints about the behavioral health system and services provided.

c) Recoupments and reconciliations create a significant administrative burden for both the Department and for the BHOs. The primary concern raised by the BHOs is that reconciliations create financial uncertainty so they cannot make or plan for capital investments and other infrastructure building.

The reconciliation related to the expansion population risk corridor has had the most significant monetary impact. Because the needs of the expansion population were unknown at the time the rates were established, this reconciliation resulted in significant recoupments because capitation rates were initially higher than necessary to purchase the amount of services provided through the BHOs. The risk corridor is no longer necessary and has been removed because the Department has several years of experience with the population. The removal of the risk corridor will drastically reduce the amount of reconciliation and recoupments going forward. It is also important to note that under the expansion population risk corridor, the BHOs kept a portion of the overpayment which allowed for additional investment in building service capacity.

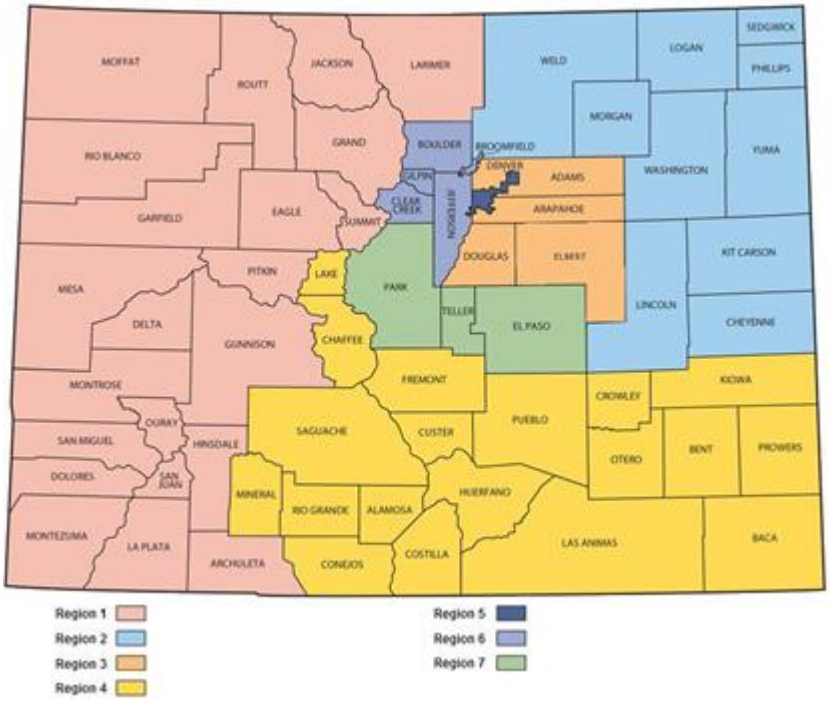
29 **Describe the origin of the existing behavioral health organization regions and the new regions proposed for regional accountable entities. If a county would like to change its assigned region, how can it seek such a change?**

RESPONSE

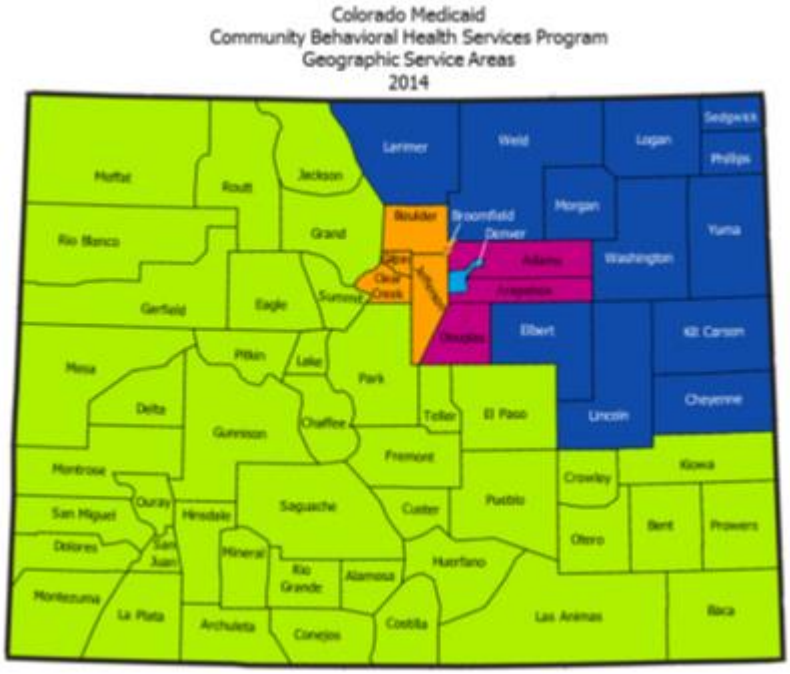
When initially designing the Medicaid managed behavioral health care program, Community Mental Health Centers (CMHCs) and the Department of Human Services (DHS) worked to build regions based on the existing CMHC infrastructure. Initially, CMHCs and DHS identified eight regions across the state. In 2004, the administration of the behavioral health program moved from DHS to the Department of Health Care Policy and Financing (the Department). The Department placed enhanced focus on managed care best practices, quality and improving performance. The increase in requirements prompted the existing behavioral health organizations (BHOs) to request a reduction in the number of regions from eight to five, in order to ensure that each BHO has the infrastructure and capacity to meet enhanced requirements. This change was made in 2005.

The regions proposed for the regional accountable entities (RAEs) in ACC Phase II align with the seven regions of the Accountable Care Collaborative (ACC) except that Elbert County will be a part of Region 3 rather than Region 7. The regions for the ACC were established in 2011 with the implementation of the program and are based on stakeholder feedback, examination of other regional maps and Department analysis of service utilization patterns. The Department considered the five behavioral health care regions when developing the ACC regions, but stakeholder engagement and feedback indicated that having more than five regions was important for ensuring opportunity for local partners, providing quality health care, to participate in the ACC.

ACC Phase II: Regional Accountable Entity Map



BHO Regional Map



Counties do not have the option to change ACC regions. However, clients are able to seek care outside of the county where they live. The RAEs will be responsible for contracting with a robust network of primary care and behavioral health providers that meet the service needs of their enrolled population and that meets compliance with access standards in their contract. In addition, the RAE is responsible for participating in and/or developing community-based infrastructure to engage the full range of Medicaid providers and non-medical community services to improve member health.

30 **Given the complexity of the behavioral health service delivery system, how do individuals access the correct services at the correct time? How do service providers determine the appropriate program or funding source for a particular client or service? What ideas should the General Assembly consider to improve the ability of individuals, communities, and service providers to understand and navigate the system?**

RESPONSE

The Department provides Medicaid members several resources to help them access the correct behavioral health services at the correct time. One resource, the Health First Colorado (Colorado's Medicaid Program) member handbook, is available on the Department's website and can be mailed upon request. The member handbook provides information about what services, including behavioral health services, are covered under Medicaid. The member handbook directs members to resources that will assist them in accessing behavioral health services, including how to access crisis services which are available 24 hours a day. Colorado Crisis Service also provides follow-up to ensure coordinated care. The Behavioral Health Organizations (BHOs) and the Regional Care Collaborative Organizations (RCCOs) also provide information, guidance and care coordination to members. Care coordination responsibilities include identifying, providing, or arranging for services and coordinating with other agencies to ensure that members receive the health care and supportive services that will allow them to remain in the community.

To determine the appropriate program or funding source, providers should check the member's Medicaid eligibility at the time of service to determine if Medicaid is the payer. To assist providers, the Department's website contains detailed information on Medicaid covered services and benefits, as well as guidance on how to bill Medicaid. In addition to resources on the Department's website, RCCOs and BHOs (and in the future the Regional Accountable Entities), are contractually required to provide education and assistance on Medicaid billing policies to network providers.

The General Assembly has appropriated significant funding for behavioral health. The Office of State Planning and Budgeting produced a funding map outlining the various state agencies that receive funding for behavioral health. The graphic is included in Appendix A.

Specific to the Department of Health Care Policy and Financing, to improve the ability of individuals, communities, and service providers to understand and navigate the system, we request that the General Assembly continue to support the Department in the implementation of ACC Phase II as the Department moves toward a more integrated health care system. By combining the administration of physical and behavioral health services under one entity, Medicaid members will more easily and efficiently access the services they need, including behavioral health. In addition to the changes made in ACC Phase II, we request

the General Assembly continue to support the programs provided through the Departments of Human Services and Public Health and Environment. As health focused state agencies all three Departments are committed to working collaboratively to align programs and policies and ensure that Colorado residents are able to access needed behavioral health services.

11:10-11:30 BEHAVIORAL HEALTH BENEFITS COVERED BY MEDICAID

Federal "Institution for Mental Disease" (IMD) Exclusion

31 **Describe the federal prohibition on using Medicaid funds for services provided in an "institution for mental disease (IMD)".**

- **a. What is the origin or purpose of the prohibition, and has it changed over time?**
- **b. Describe the types of state and private behavioral health facilities that fall under this definition and those that do not.**

RESPONSE

The federal prohibition on using Medicaid funds for services provided in an Institution for Mental Disease (IMD) is codified in the Social Security Act and title 42 of the Code of Federal Regulations. It precludes federal Medicaid funding for any services to individuals between 21 and 65 years of age who reside in an institution with more than 16 beds and where more than 50 percent of residents require residential care and treatment for a mental disease, including substance use disorders.

The IMD exclusion existed in the Social Security Act prior to the establishment of Medicaid and was later codified in the original Medicaid statute in 1965. The primary purpose of the exclusion is to clearly delineate that the federal government is not responsible for funding inpatient psychiatric services, particularly the obsolete practice of warehousing individuals with mental illness in large institutions. Instead, the federal government chose to fund and promote active, community-based treatment for individuals with mental illness, leading to the rise of Community Mental Health Centers across the country. Until recently, the only exemptions that have been made to the IMD exclusion were to allow federal funding for children under 21 years of age and for institutions with fewer than 17 beds. In the last two years, CMS has provided two important opportunities: 1) states can receive federal funding for up to 15 days of inpatient residential treatment paid for under a capitated payment model; and 2) states may waive the IMD exclusion when implementing a comprehensive substance use disorder (SUD) treatment program through an 1115 waiver.

State and private hospitals, nursing facilities, and residential institutions with more than 16 beds are subject to the federal IMD regulations.

32 **How do existing federal IMD requirements affect the ability of the capitation program to provide a full continuum of mental health and substance use disorder (SUD) services?**

RESPONSE

Federal IMD requirements affect the ability of the capitation program to provide a full continuum of behavioral health services by preventing the state from paying for inpatient and residential treatment for mental health and substance use disorders beyond 15 days.

Federal Exclusions for Individuals in the Criminal Justice System

33 **Describe any federal prohibitions related to the use of Medicaid funds for the provision of medical and behavioral health services to individuals who are in the custody of a county jail, the Department of Corrections, or in the custody of the Colorado Mental Health Institute at Pueblo but being served through the RISE Program within the Arapahoe county jail.**

RESPONSE

Federal regulations (42 CFR 435.1008-10) prohibit the use of Medicaid funds to pay for services rendered to individuals who are involuntarily confined to a public institution, including correctional facilities. However, there is an exception to the Medicaid funding prohibition when an inmate is admitted as an inpatient in a hospital for greater than 24 hours. Under that exception, Medicaid may pay for Medicaid covered hospital and physician services, drugs, and durable medical equipment rendered and provided during that qualifying inpatient stay. With the implementation of the Affordable Care Act, the Department officially adopted this policy in 2014 and began to pay for these services for all Medicaid-eligible inmates.

In accordance with state law and to streamline the payment of services provided during an inpatient hospitalization, the Department implemented a functionality within CBMS and Colorado interChange that allows that allows Medicaid-eligible inmates to enroll in Medicaid and receive a limited-benefits package during their incarceration. This limited-benefits package pays for only those Medicaid covered services, including hospital costs, physician services, and medications, delivered during an inpatient hospitalization of 24 hours or more.

All other services provided in a public institution must be reimbursed through other funding streams, including facility budgets or independent sources.

It is the Department's understanding that individuals in the custody of the Colorado Mental Health Institute at Pueblo, but being served the in the RISE program within the Arapahoe County jail (like those in the custody of a county jail or the Department of Corrections), are considered incarcerated and therefore would be eligible only for the limited-benefit package described above.

Residential and Inpatient Substance Use Disorder Treatment (H.B.17-1351)

34 **Discuss the Colorado Health Institute report that was submitted pursuant to H.B. 17-1351, including the following related topics:**

- **a. What is the current status of the Department's existing federal 1915(b)(3) waiver for the behavioral health capitation program, and what changes are necessary for the Department to implement Phase II of the Accountable Care Collaborative as planned on July 1, 2018?**
- **b. Would the 1915(b)(3) waiver need to be amended if the Medicaid benefit is expanded to include the full continuum of SUD treatment?**
- **c. Under current law, do behavioral health organizations or hospitals have a financial incentive to prevent utilization of medically managed intensive inpatient services? Should the 1915(b)(3) waiver include this level of care to create appropriate financial incentives to increase access to less expensive levels of care?**
- **d. What would be the benefit of applying for a federal 1115 waiver in order to expand the continuum of SUD services? Should such a waiver application seek to address the IMD restrictions related to both mental health disorder and SUD services?**
- **e. How does the Department plan to estimate the cost savings that would result from an expanded SUD Medicaid benefit in light of the significant savings that are already assumed for clients with a SUD based on the implementation of H.B. 17-1353? Does the Department's ongoing Rocky Mountain Health Plans Prime pilot provide any useful data for estimating potential savings related to both efforts?**
- **f. Describe existing efforts to expand the number of licensed SUD treatment facilities eligible to receive Medicaid reimbursement. To what extent can the State determine criteria for these facilities and SUD treatment professionals to enroll as Medicaid providers?**
- **g. Does the Department support moving forward with an application for a federal 1115 waiver to expand the Medicaid behavioral health benefit to include residential and medically managed inpatient services?**

RESPONSE

a) What is the current status of the Department's existing federal 1915(b)(3) waiver for the behavioral health capitation program, and what changes are necessary for the Department to implement Phase II of the Accountable Care Collaborative as planned on July 1, 2018?

CMS has approved an extension of the Department's existing 1915(b) waiver for the behavioral health capitation program for the period of July 1, 2017 through June 30, 2019. Following the guidance from CMS, the Department will be establishing a new 1915(b) waiver for the Accountable Care Collaborative that will cover the period from July 1, 2018 through June 30, 2023 and ending the current 1915(b) waiver on June 30, 2018. The new Accountable Care Collaborative 1915(b) waiver will include the same (b)(3) authority for the current behavioral health capitation program. The new Accountable Care Collaborative 1915(b)

waiver will reflect the fact that one entity will be responsible for both behavioral and physical health and will enable the department to enroll all eligible clients into the Accountable Care Collaborative.

b) Would the 1915(b)(3) waiver need to be amended if the Medicaid benefit is expanded to include the full continuum of SUD treatment?

The Department would not be able to utilize the 1915(b) waiver to expand the Medicaid benefit to include the full continuum of SUD treatment, specifically residential treatment for greater than 15 days. Rather, an 1115 demonstration waiver would be required to waive the restriction on federal funding for residential treatment in excess of 15 days.

c) Under current law, do behavioral health organizations or hospitals have a financial incentive to prevent utilization of medically managed intensive inpatient services? Should the 1915(b)(3) waiver include this level of care to create appropriate financial incentives to increase access to less expensive levels of care?

As the Behavioral Health Organizations (BHOs) (and in the future the Regional Accountable Entities [RAEs]) are at financial risk for the covered services they provide, they have financial incentives to try to treat behavioral health conditions in the most cost-effective manner that prevents utilization of more expensive, higher acuity care. While the BHOs are not currently at risk for costs associated with medically managed intensive inpatient services, it is still in their financial interest to support clients' health by providing services in the community and preventing the use of high-cost intensive outpatient services following a hospitalization. In addition, the Department recently established additional financial incentives for BHOs to avoid inpatient services by attaching pay-for-performance payments to measures such as increasing engagement in SUD outpatient treatment and reducing emergency department utilization for a substance use disorder. Hospitals do not have the same financial risk or pay-for-performance arrangements and therefore may not have a clear financial incentive to prevent utilization of medically managed intensive inpatient services. If a hospital had a significant number of beds available, there could be a financial incentive to provide medically managed intensive inpatient services.

The reason to expand behavioral health benefits to include medically managed intensive inpatient services would be to support the full continuum of SUD services. Implementing medically managed intensive inpatient services through the 1915(b) waiver separate from other benefits, such as extended residential treatment, would likely provide little to no incentive for the RAEs to provide a lower level of care. Strong incentives already exist for the BHOs and RAEs to provide both SUD and mental health care in the least restrictive environment. Furthermore, it is unclear from the research whether medically managed intensive inpatient services on their own would improve client outcomes. Instead the Department, wants to explore the best approaches for making the full continuum of SUD services available to its members in order to increase the likelihood of achieving recovery.

d) What would be the benefit of applying for a federal 1115 waiver in order to expand the continuum of SUD services? Should such a waiver application seek to address the IMD restrictions related to both mental health disorder and SUD services?

If given the authority from the General Assembly, the benefit of applying for a federal 1115 waiver would be to enable the Department to offer the full continuum of SUD services. The 1115 waiver is the only option CMS has currently made available for states to waive the IMD exclusion for inpatient and residential SUD treatment beyond 15 days.

The Department is not aware of any indication from CMS that the 1115 waiver could be used to waive the IMD restrictions for mental health disorders. CMS has designed a specific 1115 demonstration initiative to enable states to implement comprehensive SUD treatment programs.

e) How does the Department plan to estimate the cost savings that would result from an expanded SUD Medicaid benefit in light of the significant savings that are already assumed for clients with a SUD based on the implementation of H.B. 17-1353? Does the Department's ongoing Rocky Mountain Health Plans Prime pilot provide any useful data for estimating potential savings related to both efforts?

The Department estimated savings for the implementation of ACC Phase II based on the change of the delivery system to entities that are accountable for both physical and behavioral health. That is distinct from savings that may accrue due to changing to a more comprehensive benefit package that includes residential and inpatient SUD services.

Few studies have estimated cost savings specifically related to residential or inpatient treatment of SUD, although there is emerging recognition that treatment in general can produce significant savings, as described in this State Medicaid Director letter on new service delivery opportunities for individuals with a substance use disorder[1]. The report submitted in response to HB 17-1351 incorporated savings to emergency room, inpatient hospital, and other services costs starting in the second year, based on two studies of substance use treatment. One study[2] found savings in these areas, although only the reduction in emergency room visits was statistically significant. The other study found savings to physician services[3]. Neither was specific to adding residential and inpatient treatment.

Additionally, the Department previously expanded access to SUD treatment in 2014 when outpatient treatment benefits were moved from fee-for-service to the Behavioral Health Organizations. Given that members already have access to outpatient treatment options, and due to the lack of concrete evidence of short-term savings, the Department would not assume any savings in the short term from implementing

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[1] https://www.medicaid.gov/federal-policy-guidance/downloads/SMD15003.pdf

[2] Ettner, S.L., Huang, D., et al. (2006). "Benefit-Cost in the California Treatment Outcome Project: Does Substance Abuse Treatment 'Pay for Itself?" Health Services Research. 41(1). Pages 192-213, Table 2. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1681530/

[3] Gerson, L.W., et al. (2001). "Medical Care Use by Treated and Untreated Substance Abusing Medicaid Patients." Journal of Substance Abuse Treatment. 20, 115-120. Page 116, Table 1.

an expanded inpatient and residential SUD benefit package. Savings that accrue in the long term would be adjusted through the regular budget process.

The Rocky Mountain Health Plans Prime pilot does not cover SUD treatment, therefore it does not have useful information to estimate the savings for expanding SUD treatment.

f) Describe existing efforts to expand the number of licensed SUD treatment facilities eligible to receive Medicaid reimbursement. To what extent can the State determine criteria for these facilities and SUD treatment professionals to enroll as Medicaid providers?

The Department is collaborating with the Office of Behavioral Health in implementing key efforts to expand the number of licensed SUD treatment facilities eligible to receive Medicaid reimbursement:

- Ensuring licensed SUD treatment facilities have a licensed practitioner on staff under which services can be rendered. This change enables SUD treatment facilities to become eligible for enrollment as a Medicaid provider.
- Enacting a State Plan Amendment with CMS so that masters-level licensed addiction counselors are an approved provider type for the full continuum of behavioral health services. This change allows licensed addiction counselors to oversee the rendering of services in a licensed SUD treatment facility, thereby expanding the potential number of treatment facilities eligible to enroll as a Medicaid provider.
- Updating the State Plan in alignment with the Office of Behavioral Health rule that enables licensed behavioral health practitioners to provide SUD services under their defined scope of practice. This change is designed to increase the number of providers eligible to provide SUD treatment.

As the single state authority for behavioral health, the Office of Behavioral Health is responsible for establishing state criteria for SUD treatment facilities and providers. Within these established criteria, the Department needs to further ensure facilities and providers meet certain qualifications and training in order to comply with CMS requirements around medical necessity.

g) Does the Department support moving forward with an application for a federal 1115 waiver to expand the Medicaid behavioral health benefit to include residential and medically managed inpatient services?

Based on the findings from the report submitted in response to HB 17-1351, the Department supports pursuing the option of utilizing a federal 1115 waiver to enhance the current SUD benefit. The report identifies some important findings that will require further work by the state, particularly the likelihood of increased state expenses and the inconclusive findings about the benefits of some forms of treatment. The report serves as a strong framework with which the Department can pursue development of a residential and inpatient SUD benefit if the Department is given the appropriate authority and resources. Some of the steps that will need to be taken are: ensuring the appropriate administrative structure is in place to effectively manage any new benefits; targeting individual benefits to the appropriate clients; building a qualified workforce; and designing a budget action.

35 **Provide information related to detoxification services, including the following:**

a. **Where do these services fall along the continuum of care for SUD *[utilizing the ASAM scale on page 17 of the staff briefing document]*?**

b. **What types of costs are covered through the Capitation Program, and what costs are covered by other sources of state and federal revenue? Are available state and federal revenues sufficient to cover the costs of providing this service?**

c. **What types of financial, geographic, and regulatory barriers exist that make it difficult to establish and maintain these services statewide?**

RESPONSE

a) Detoxification services are not classified along the ASAM Continuum of Care. Detoxification services, also known as withdrawal management, are classified in relation to the level of withdrawal management required. The scale depicted on Page 6 of Appendix B, "What's New in ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions[4]" outlines the levels ranging from Outpatient Services (Level 1 Withdrawal Management [WM]) to Medically Managed Intensive Inpatient (Level 4 WM). Level 1 WM is the least restrictive level of withdrawal management and can be performed in outpatient settings without extended on-site monitoring. Level 4 WM is the most intensive level of withdrawal management.

b) The Medicaid behavioral health capitation program covers Clinically Managed Residential Withdrawal Management (level 3.2 WM) which is commonly referred to as social, ambulatory detoxification. These services are rendered to members whose intoxication or withdrawal signs and / or symptoms are severe enough to require a 24-hour structured program. These services are not provided to members who require hospitalization for their intoxication or withdrawal symptoms.

Medicaid reimbursed services are provided by a facility that is licensed by the Office of Behavioral Health (OBH) at an ASAM level of 3.2 and has 16 or fewer beds. Since Medicaid cannot pay for per diem services outside of a hospital or nursing facility, Colorado Medicaid reimburses licensed facilities for the individual service components including: physical assessment of detoxification progression (i.e., vital signs monitoring); safety assessment (i.e., suicidal ideation and other behavioral health issues); level of motivation assessment for treatment evaluation; and, the provision of daily living needs (i.e., hydration, nutrition, cleanliness, and toiletry). Any room and board costs associated with the detoxification stay are reimbursed by OBH. OBH also covers Medically Monitored High Intensity Inpatient detoxification services (level 3.7 WM).

[4] http://www.naadac.org/assets/1959/meelee_asam_criteria.pdf

The Department has heard from providers of level 3.2 WM services that the reimbursement amounts are not sufficient and that the bifurcated payment structure is overly burdensome as it requires the unbundling of services for Medicaid payment and the payment of room and board by the OBH.

c) In order to be licensed by OBH and to enroll in Medicaid, facilities must maintain staffing levels that are appropriate to the level of care that is needed, regardless of the number of individuals being served at any given time. The staffing requirements for 24-hour facilities combined with the fact that Medicaid can only pay facilities for the services they provide members can sometimes make it difficult for facilities to generate enough revenue to cover administrative costs. Facilities have also expressed concern that it is overly burdensome to split billing between Medicaid for services and OBH for room and board expenses. These challenges are often exacerbated in rural areas of the state where facilities may not be able to maintain a high enough census to cover expenses. Additionally, there are workforce challenges in Colorado that make it difficult for these facilities to retain properly credentialed staff.

36 **The Department recently changed rules related to prescribing and dispensing opioids to Medicaid clients. Can the Department quantify any cost savings (within the Department or within other impacted state agencies) that may result from these regulatory changes?**

RESPONSE

The Department instituted a new opioid policy on August 1, 2017 for members who have not received any opioids in the past 12 months. These members are termed "opioid treatment naïve" and this policy applies only to them. The policy allows up to eight pills per day and up to a seven-day supply (56 pills) for up to three fills. A prior authorization is required for continuation. The new policy does not apply to those who have been receiving opioids chronically or for patients in palliative care. When the Department implemented the policy, it did not anticipate any significant fiscal impact.

The Department manages the pharmacy benefit and makes routine changes such as preference for more cost-effective medications over others, coverage policies to ensure appropriate use (based on evidence of safety and efficacy), and utilization management strategies relating to dosing, pill quantities, or days' supply. The Department has authority to make these changes as part of its standard process under the Colorado Code of Regulations and the State Plan with CMS. The standard process includes gaining input from stakeholders and independent advisory groups such as the Drug Utilization Review Board.

Long acting opioids (used by patients with chronic pain) will not be allowed for an opioid treatment naïve member. If their use is needed, the case will be evaluated via a prior authorization. Exceptions may be granted for certain clinical settings (for example: newly diagnosed cancer patients, post-operative surgery, etc). The Department also contracts with a pain management specialist who can conduct peer to peer consultations for difficult cases.

The main goal of the opioid naïve policy is to reduce the possibility of a member transitioning to chronic therapy with an opioid from an acute pain scenario (i.e. surgical procedure, trauma) when it is not medically needed and potentially becoming addicted. The correlation of a longer days' supply of the initial fill of an opioid prescription to longer-term opioid use has been shown in a large Morbidity and Mortality Weekly Report (MMWR)[5] population analysis. The authors noted from their findings, "The rate of long-term use was relatively low (6.0% on opioids 1 year later) for persons with at least 1 day of opioid therapy, but increased to 29.9% when the first episode of use was for ≥31 days."

There are other states and programs that are implementing similar limited day supply policies. Arizona[6], for instance, has a state-wide implementation of a 7-day prescription limit on the initial fill and refill of an opioid. CVS[7] has also recently released plans to make a similar policy change. Seventeen states have implemented or plan to implement an opioid-limiting policy.[8]

11:30-12:00 BEHAVIORAL HEALTH CAPITATION PROGRAM

Utilization, Rates, and Expenditures

37 **Provide data concerning trends in behavioral health service utilization and costs, including:**

- **a. the number and percentage of Medicaid clients that utilize mental health and substance use-related services;**
- **b. a breakdown of utilization rates for each eligibility category; and**
- **c. the relative cost of providing behavioral health services for various eligibility or demographic groups.**

RESPONSE

The following table shows the number of enrolled members, the number of members receiving services and penetration rates (distinct utilizers as a percentage of the total number of potential utilizers) for FY 2015-16.

[5] MMWR Morb Mortal Wkly Rep 2017;66:265–269. DOI: http://dx.doi.org/10.15585/mmwr.mm6610a1
[6] https://pharmacy.az.gov/sites/default/files/documents/files/ahcccsMedicalPolicyManual310V_0.pdf
[7] http://www.cnn.com/2017/09/22/health/cvs-prescription-restrictions-opioids-bn/index.html
[8] https://www.washingtonpost.com/politics/with-drug-overdoses-soaring-states-limit-the-length-of-painkiller-prescriptions/2017/08/09/4d5d7e0c-7d0f-11e7-83c7-5bd5460f0d7e_story.html?utm_term=.61d408d615e9

FY 2015-16 Penetration Rates by Population - Any Behavioral Health or Substance Use Disorder Service			
Population	**BHO Members**	**Clients Receiving a Service**	**Penetration Rate**
Adults 65 and Older (OAP-A)	41,566	3,809	9.16%
Disabled Adults 60 - 64 (OAP-B)	10,817	2,971	27.47%
Disabled Individuals to 59 (AND/AB)	68,090	23,853	35.03%
Parents and Caretakers	157,265	24,122	15.34%
Children	503,508	47,642	9.46%
Foster Care	20,004	6,342	31.70%
Prenatal	13,975	2,489	17.81%
SB 11-008 Eligible Children	20,438	639	3.13%
MAGI Adults and BCCP	427,100	69,187	16.20%
Adult Buy-in	5,040	1,566	31.07%
Children Buy-in	1,042	207	19.86%
Total	**1,268,845**	**182,827**	**14.41%**

Historical information on the relative differences in per capita costs by population can be found in Exhibit DD of the FY 2018-19 R-2: "Behavioral Health Community Programs" in Appendix C. The table can also be found on the Department's website.[9]

38 **Describe how frequently capitation per-member-per-month rates are adjusted based on actual utilization and cost data. Please include information about recent practices as well as the Department's plans for the future.**

RESPONSE

Managed care rates are typically set on an annual basis. Due to the rigorous regulatory federal framework around managed care rate setting, the process is an expensive, highly resource intensive process for both the state and the managed care entities; setting rates more frequently than annually creates administrative and budgetary challenges. That said, there are instances where rates need to be reset on a six-month basis; this is generally limited to cases where the data used to set rates is potentially unreliable. There are also occasions where rates are updated due to policy changes that were not included in the original rate setting process.

Recent practice is to set rates on an annual basis. There was only one exception in the most recent year, for one behavioral health organization, where six-month rates were used. It is the Department's intent to set all rates on an annual basis moving forward.

[9]https://www.colorado.gov/pacific/sites/default/files/HCPF%2C%20FY%2019%2C%20R-2%20BH%20Exhibit%20DD.pdf.

39 **Describe why the Department is required to pay Health Insurance Provider Fees to the federal government on behalf of certain entities with which it contracts. Please include:**

a. A reference to the federal legal or regulatory requirement; and

b. A list of payments made by the Department to date for behavioral health organizations (BHOs) and any other affected vendors.

RESPONSE

a) Federal regulations at 42 CFR § 438.5(e) require managed care rates to reflect certain non-benefit costs, which include taxes. The Health Insurance Providers Fee, established by section 9010 of the Affordable Care Act, is a federal tax which falls under the scope of this requirement as clarified in an FAQ issued by The Centers for Medicare & Medicaid Services.[10] The managed care entities pay the tax directly to the federal government, but are compensated for the cost through managed care rates paid by the state.

b) The table below summarizes the Health Insurance Provider Fee costs incurred due to contracting with for-profit managed care entities.

[10] https://www.medicaid.gov/federal-policy-guidance/downloads/faq-10-06-2014.pdf

Summary of Insurer Fee Payments To-Date			
Year	**Program**	**Managed Care Entity**	**Fee Payment**
2014	BHO	NBHP	$127,175
2014	BHO	CHP	$1,637,143
2014	BHO	FBHP	$263,124
2014	HMO	RMHP	$1,103,129
2014	CHP+	Co Choice	$127
2014	CHP+	Delta Dental	$62,710
2014	CHP+	DH	$72,559
2014	CHP+	RMHP	$131,267
2015	BHO	CHP	$4,018,051
2015	BHO	FBHP	$1,132,150
2015	HMO	RMHP	$277,753
2015	CHP+	CO Choice	$6,527
2015	CHP+	Delta Dental	$83,333
2015	CHP+	DH	$52,517
2015	CHP+	RMHP	$125,605
2015	CHP+	KP	$139,398
2016	BHO	CHP	$4,467,690
2016	BHO	FBHP	$1,423,798
2016	HMO	RMHP	$1,332,415
2016	CHP+	CO Choice	$12,767
2016	CHP+	Delta Dental	$69,141
2016	CHP+	RMHP	$112,952
2016	CHP+	KP	$106,264
Total			**$16,757,595**

Accountable Care Collaboratives, Phase II

40 **Describe the performance measures the Department is using in FY 2017-18 to evaluate BHOs' service delivery, and any additional measures the Department plans to use for the new regional accountable entities (RAEs). How do these measures relate to improved health outcomes for Medicaid clients?**

RESPONSE

In FY 2017-18 Behavioral Health Organizations (BHO) will be eligible for incentive payments if they demonstrate improvement on care coordination performance measures or quality and access to care process measures. The following table includes all measures in place for FY 2017-18.

Behavioral Health Organization Incentive Program Performance Measures	
Care Coordination Performance Measures	**Quality and Access to Care Process Measures**
Suicide Risk Assessment for those receiving mental health or substance use disorder (SUD) evaluation	Mental health engagement
Documented care coordination agreements for specific vulnerable populations	SUD treatment engagement
Documented care plans for dual diagnosis service denials	Follow-up appointment after a hospital discharge for a mental health condition
	Emergency department utilization for a behavioral health condition

In FY 2018-19, the Regional Accountable Entities (RAEs) will be eligible for incentive payments if they demonstrate improvement in:

- SUD treatment rates
- Follow-up Appointment within 7 days after a hospital discharge for a behavioral health condition
- Child Welfare Screening (Foster Care Only) and Follow Up/Engagement
- Depression Screening and Follow Up/Engagement

For both FY 2017-18 and FY 2018-19, BHOs and RAEs only qualify for incentive payments if they meet minimum performance requirements related to submission of encounter data, completion of corrective action plans if applicable, and demonstrated accuracy in six documentation categories.

In addition to the behavioral health measures identified above, starting in FY 2018-19, RAEs will be eligible for incentive payments through the Key Performance Indicator (KPI) Incentive Program that supports health promotion activities, investments for the efficient, affordable delivery of Medicaid services, and appropriate coordination of care for members. While this component primarily focuses on performance related to physical health care, there are several that touch on improving access to care and improving behavioral health outcomes. FY 2018-19, KPIs include:

- Reducing potentially avoidable costs
- Reducing Emergency Department visits
- Increasing access to behavioral health services, both in fee-for-service and through the behavioral health capitation
- Increasing percentage of members who receive well visits
- Increasing percentage of pregnant women who receive prenatal care visits
- Increasing percentage of members who receive a dental visit within a year
- Increasing coordination of care between primary care, behavioral health, and specialty care providers

All of these measures are in place to improve performance and ensure focus and attention on measures that can improve health outcomes. For example, increased access to behavioral health services, particularly early in an acute episode, can improve both physical and mental health. Ensuring access to prenatal care can have positive impacts on both mothers and children.

41 **Explain why the Department plans to make incentive payments to BHOs and RAEs the year <u>after</u> services are provided.**

RESPONSE

Typically, incentive payments are made four to six months after the conclusion of the performance period. This ensures that there has been sufficient time for claims run-out, data collection and the calculation of vendor/provider performance. The incentive payment for an annual measure would be made up to six months after the end of the performance period.

42 **For those BHOs that will no longer be providing services for Medicaid clients as of July 1, 2018, describe how the Department plans to handle activities that need to occur after FY 2017-18. Specifically, what resources are expected to be available to cover the costs of close-out activities BHOs will be required to perform and any potential recoupments they are required to pay?**

RESPONSE

Medicaid Behavioral Health Organizations (BHOs) are required to be licensed by the Division of Insurance (DOI) as either a Limited Service Licensed Provider Network (LSLPN) or a Health Maintenance Organization (HMO). As part of their licensure, they are required to demonstrate that the entity is solvent and has the operational capacity to perform services consistent with the level of risk accepted under the contract. The

entity must maintain a specified level of financial reserves. The reserves and the administrative portion of their monthly capitation payments are intended to cover all administrative and client service responsibilities throughout the close-out period of the contract. The primary responsibilities during the close-out period include: paying provider claims for services and meeting other financial commitments; fulfilling all administrative activities under their contract, such as communicating with members and the provider community; and submitting state and federally required financial, performance and service encounter data and information.

43 **Describe the protest period related to the request for proposal process for RAEs and the outcome of that process. Further, describe any legal actions that may result from this process and any potential impact to the Department's plans to contract with the new RAEs beginning July 1, 2018.**

RESPONSE

Following the evaluation of any state procurement, the state agency notifies all bidders which bidder(s) will receive an award. Any bidder that did not receive a notice of intent to award has 10 business days to protest the decision to the state agency's procurement director. The state agency's procurement director has 10 business days to respond to the protest. If the state agency procurement director rules there is no merit in the protest and upholds the initial determination, the protesting bidder(s) may file an appeal with the state procurement director or may file in district court. For the RAE procurement, two bidders filed a total of three protests. The Department's procurement director upheld the initial determination and the protesting bidders indicated on or prior to November 21, 2017 (their final date to appeal to the state procurement director or file in district court) that they would not be pursuing further action. There is no opportunity for any new appeals or legal challenges in accordance with state procurement rules and the Department does not anticipate any impact to the contracting process timeline.

44 **Describe the ownership structure, for profit/not for profit status, and nature (e.g., hospital system, insurance company, federal qualified health center, community mental health center, etc.) of each of the entities that the Department will be contracting with as a RAE starting in FY 2018-19.**

RESPONSE

The table below shows the ownership structure of each of the Regional Accountable Entities (RAEs). Due to the complexity of the organizational structures of the RAEs, the Department does not yet have definitive information on the profit/not for profit status of the vendors. This is important as it relates to the Health Insurance Provider Fee, which is calculated by the Internal Revenue Service (IRS) after taxes are filed by the entities.

Region	Vendor	Ownership Structure	Business Affiliations
1	Rocky Mountain Health Plans	United HealthCare Services [Inc., a Minnesota corporation, which is a wholly owned subsidiary of UnitedHealth Group Incorporated, a Delaware corporation.]	• Rocky Mountain Health Plans is a regional insurance company that operates commercial and public plans

Region	Vendor	Ownership Structure	Business Affiliations
			• United HealthCare Services is a national insurance company that operates commercial and public plans
2	Northeast Health Partners	Corporate members: Plan de Salud de Valle Inc., North Range Behavioral Health, Centennial Mental Health Center, Sunrise Community Health (Own 25% each)	• All ownership partners are service providers (federally qualified health centers and community mental health centers)
3	Colorado Access	Corporate members: University of Colorado Health and University of Colorado Medicine (collectively, the University), Children's Hospital Colorado, and the Colorado Community Managed Care Network	• Colorado Access is a state insurance company that operates publicly-funded plans and serves as Single Entry Point • Corporate members are service providers or provider associations
4	Health Colorado, Inc.	Owners: Valley-Wide Health Systems, Inc., Health Solutions, Beacon Health Options Inc., San Luis Valley Behavioral Health Group, Solvista Health Group, Southeast Health Group (Own 16 2/3 percent each)	• Beacon Health Options is a national company offering behavioral health solutions for health plans • All other owners are service providers
5	Colorado Access	Corporate members: University of Colorado Health and University of Colorado Medicine (collectively, the University), Children's Hospital Colorado, and the Colorado Community Managed Care Network.	• Colorado Access is a state insurance company that operates publicly-funded plans and serves as Single Entry Point • Corporate members are service providers or provider associations
6	Colorado Community Health Alliance	Members: Colorado Community Health Alliance, LLC (a partnership between Physician Health Partners, LLC, Primary Physician Partners, LLC, and Centura Ventures, LLC), and Anthem Partnership Holding Company, LLC, a wholly owned subsidiary of Anthem, Inc.	• Colorado Community Health Alliance is a partnership of provider associations and health care providers • Anthem is a national insurance company that operates commercial and public plans
7	Colorado Community	Members: Colorado Community Health Alliance, LLC (a partnership between Physician Health Partners, LLC, Primary	• Colorado Community Health Alliance is a partnership of

Region	Vendor	Ownership Structure	Business Affiliations
	Health Alliance	Physician Partners, LLC, and Centura Ventures, LLC), and Anthem Partnership Holding Company, LLC, a wholly owned subsidiary of Anthem, Inc.	provider associations and health care providers • Anthem is a national insurance company that operates commercial and public plans

45 **Describe the Department's plans for monitoring and evaluating services provided and expenditures incurred by RAEs. Specifically, how will the Department track expenditures related to behavioral health services provided through the Capitation Program separately from behavioral health and medical services that are provided through various fee-for-service programs?**

RESPONSE

The Department has a number of strategies for monitoring and evaluating services provided and expenditures to members.

Capitated Behavioral Health Benefit. The RAEs will receive a single monthly payment (known as a "capitation") from which they will directly reimburse providers for the delivery of covered services. As the Department does not process claims for these services, the RAE is responsible for submitting encounter data to the Department on a monthly basis that details all of the services the RAE provided to clients. The Department processes the encounter data through the Colorado interChange and validates that the services are allowed Medicaid services. The Department then performs analytics on the encounter data to monitor penetration rates, utilization patterns, etc. One primary analysis that is performed to ensure compliance with federal regulations is the calculation of the total percentage of capitation dollars a RAE received that were spent on client services. At least one time annually, the Department will review the total utilization and set prices for the services provided. The total utilization and costs are then used to set the capitation rates for the individual RAEs.

Administrative Per-Member-Per-Month (PMPM) Payment. The Department will pay the RAEs a monthly administrative payment based on the number of enrolled members to support the RAEs' investments for the efficient, affordable delivery of care within their region and ensuring members have access to and receive appropriate care coordination. The RAE does not pay for the delivery of physical health services; rather, physical health providers will submit claims to the Department for reimbursement. As the RAE expenditures under the administrative PMPM cannot be reported as encounters, the Department is requiring that all RAEs submit a quarterly financial report. The financial report will describe all payments and expenditures broken out by type with discrete categories such as care coordination, practice support and administration. The Department will meet in-person with the RAEs each quarter to review their financial report.

In addition to the above approaches, the Department uses the MMIS and the Department's Business Intelligence and Data Management System (BIDM) to regularly run analytics on encounters and fee-for-service claims to monitor and evaluate services and performance. These regular analytics include:

- Monthly reports on Key Performance Indicators, such as well visits and utilization of outpatient behavioral health services; and other pay-for-performance measures;
- Quarterly and annual reports on national clinical quality measures that will be reported publicly on the Department's website;
- Monthly updates on all services paid for in the RAE region and by contracted providers.

The Department will also utilize a variety of contract management tools to monitor and evaluate services, such as:

- Review of the RAEs' behavioral health utilization management program to ensure items and services requested meet medical necessity guidelines;
- Quarterly reports by the RAEs on member grievances and appeals;
- Reports from the Department's utilization management vendor on services provided fee-for-service;
- Ongoing monitoring of fee-for-service expenditures by the Department's Benefit Management Unit.

46 **How will behavioral and physical care utilization be managed by the RAEs?**

a. **Will there be multiple care managers?**
b. **How does the concept of "conflict free case management" apply to RAEs?**

RESPONSE

For physical health care utilization, the RAE will have responsibility for creating a network of primary care medical providers, ensuring coordination of medical services and supporting the use of data and interventions that will promote use of the right services at the right time. The primary tool for the RAEs to manage physical health care utilization is utilization data from the Department and other locally organized data sharing arrangements. The RAEs can analyze this data to develop strategies that promote the use of preventive services among identified populations, as well as to identify and outreach to members who are accessing emergency services. For behavioral health services, as part of the capitated payment arrangement, the RAE will have a full utilization management program that will ensure services provided are medically necessary and provided in the most appropriate and least restrictive setting.

Some RAE members will have multiple care managers. Individuals who are served by home and community-based waivers will continue to have support from contracted case management agencies. In addition, many hospitals and community providers have care management programs. However, the move toward a single accountable entity will align the coordination of physical and behavioral health services and create a single point of contact for collaboration with other care managers that may be involved.

The concept of "conflict free case management" as defined by federal law and regulation does not apply to the RAE as it is specific to the provision of long-term services and supports. That said, the idea of conflict fee case management is vitally important. The Department has included protections in the RAE contract to reduce the perception and/or occurrence of conflicts of interest. For example, the Department has added several requirements that drive increased transparency related to utilization management practices, provider credentialing and acceptance into the network, and the RAE's overall governance structure. In addition to these transparency requirements, the RAEs will be held accountable for all potentially avoidable costs, which will decrease incentives to shift costs from one system to another.

47 **Section 25.5-4-403, C.R.S., requires the Department to establish a price schedule annually with the Department of Human Services in order to reimburse each community mental health center and clinic provider for its "actual and reasonable cost of services". How does the Department plan to comply with this provision when the RAE contracts go into effect?**

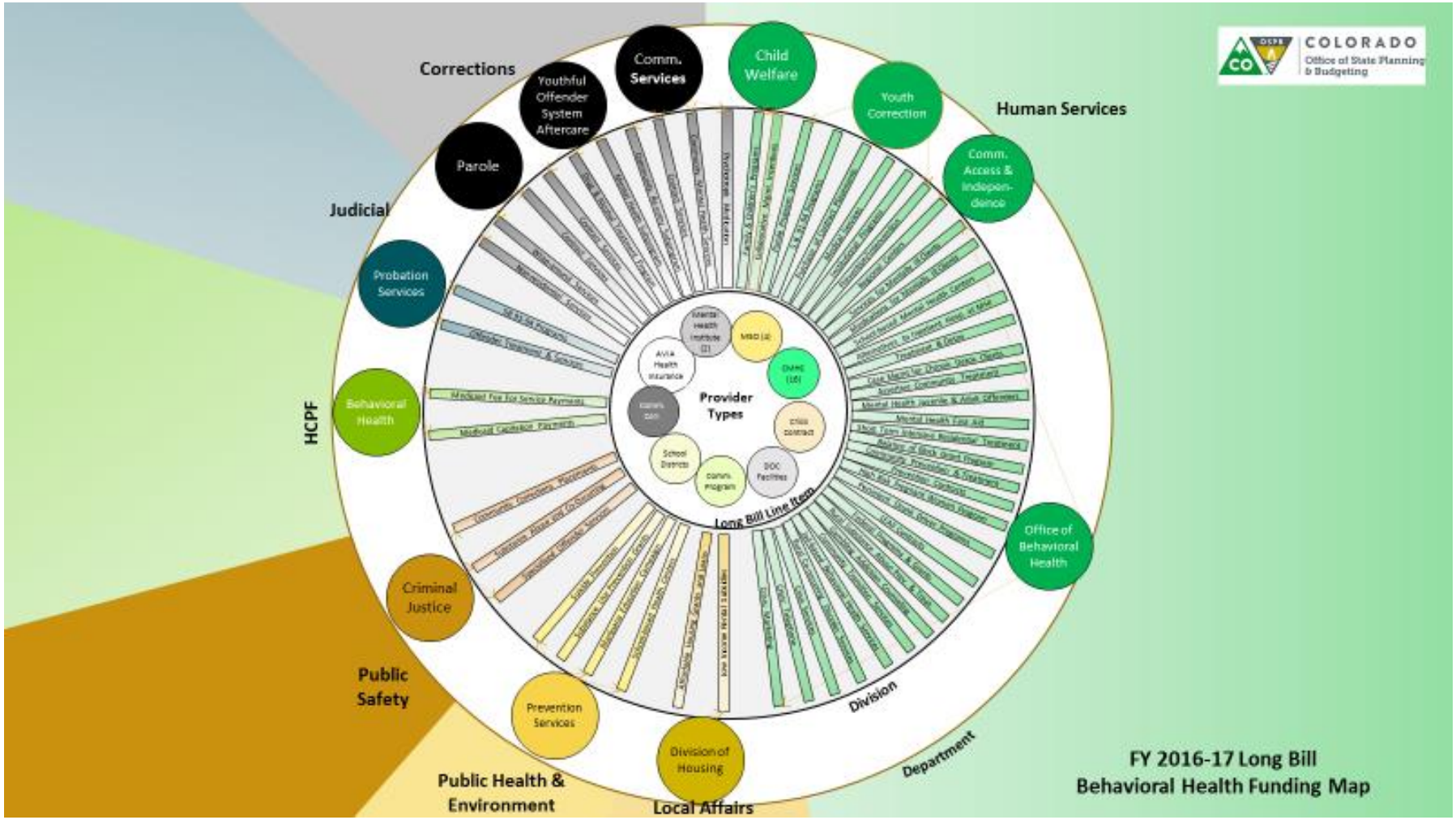
RESPONSE

The Department will comply with the requirement the same way it has historically. Community Mental Health Centers (CMHCs) submit a cost report annually that is used by the Department and the Office of Behavioral Health at the Department of Human Services to develop cost-based, provider specific fee schedules. The Medicaid program utilizes this provider specific fee schedule for CMHC reimbursement.

This statute does not govern how the Department pays managed care entities (Behavioral Health Organizations [BHOs] or Regional Accountable Entities [RAEs]) or how managed care entities pay the downstream provider network. In the two-decade history of the behavioral health managed care program, the Department has never directed the managed care entities to pay CMHCs the fee schedule and it is not the Department's intention to do so in the future.

There are checks and balances in managed care systems to ensure downstream providers receive a reasonable reimbursement rate. The Department assumes that the CMHCs will be able to negotiate a reasonable rate based on their current market share and the need for the managed care entities to achieve network adequacy standards.

APPENDIX A: FY 2016-17 LONG BILL BEHAVIORAL HEALTH FUNDING MAP



APPENDIX B: LEVELS OF CARE

Levels of Care

LEVEL OF CARE	ADOLESCENT TITLE	ADULT TITLE	DESCRIPTION
0.5	Early Intervention	Early Intervention	Assessment and education for at-risk individuals who do not meet diagnostic criteria for substance use disorder
1	Outpatient Services	Outpatient Services	Less than 9 hours of service/week (adults); less than 6 hours/week (adolescents) for recovery or motivational enhancement therapies/strategies
2.1	Intensive Outpatient	Intensive Outpatient	9 or more hours of service/week (adults); 6 or more hours/week (adolescents) to treat multidimensional instability
2.5	Partial Hospitalization	Partial Hospitalization	20 or more hours of service/week for multidimensional instability not requiring 24-hour care
3.1	Clinically Managed Low-Intensity Residential	Clinically Managed Low-Intensity Residential	24-hour structure with available trained personnel; at least 5 hours of clinical service/week
3.3	**This Level of Care not designated for adolescent populations*	Clinically Managed Population-Specific High-Intensity Residential	24-hour care with trained counselors to stabilize multidimensional imminent danger. Less intense milieu and group treatment for those with cognitive or other impairments unable to use full active milieu or therapeutic community
3.5	Clinically Managed Medium-Intensity Residential	Clinically Managed High-Intensity Residential	24-hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment. Able to tolerate and use full active milieu or therapeutic community
3.7	Medically Monitored High Intensity Inpatient	Medically Monitored Intensive Inpatient	24-hour nursing care with physician availability for significant problems in Dimensions 1, 2 or 3. Sixteen hour/day counselor ability
4	Medically Managed Intensive Inpatient	Medically Managed Intensive Inpatient	24-hour nursing care and daily physician care for severe, unstable problems in Dimensions 1, 2 or 3. Counseling available to engage patient in treatment
OTP (LEVEL 1)	**OTPs not specified here for adolescent populations, though information may be found in discussion of adult services*	Opioid Treatment Program (Level 1)	Daily or several times weekly opioid agonist medication and counseling available to maintain multidimensional stability for those with severe opioid use disorder

APPENDIX C: MEDICAID BEHAVIORAL HEALTH COMMUNITY PROGRAMS, CASELOAD

Exhibit DD - Medicaid Behavioral Health Community Programs, Caseload

Medicaid Behavioral Health Community Programs Average Monthly Caseload

Item	Adults 65 and Older (OAP-A)	Disabled Individuals	Low Income Adults	Expansion Parents and Caretakers	MAGI Adults	Eligible Children	Foster Care	Breast and Cervical Cancer Program	TOTAL BEHAVIORAL HEALTH
FY 2007-08 Actuals	36,284	56,079	59,761	-	-	204,022	17,141	270	373,557
FY 2008-09 Actuals	37,619	57,802	68,850	-	-	235,129	18,033	317	417,750
% Change from FY 2007-08	3.68%	3.07%	15.21%	0.00%	0.00%	15.25%	5.20%	17.41%	11.83%
FY 2009-10 Actuals	38,487	60,313	82,669	3,238	-	275,672	18,381	425	479,185
% Change from FY 2008-09	2.31%	4.34%	20.07%	0.00%	0.00%	17.24%	1.93%	34.07%	14.71%
FY 2010-11 Actuals	38,921	64,052	88,982	27,167	-	302,410	18,393	531	540,456
% Change from FY 2009-10	1.13%	6.20%	7.64%	739.01%	0.00%	9.70%	0.07%	24.94%	12.79%
FY 2011-12 Actuals	39,740	67,869	100,854	35,461	1,134	334,633	18,034	597	598,322
% Change from FY 2010-11	2.10%	5.96%	13.34%	30.53%	0.00%	10.66%	-1.95%	12.43%	10.71%
FY 2012-13 Actuals	40,827	71,859	107,760	41,545	10,634	368,079	17,777	623	659,104
% Change from FY 2011-12	2.74%	5.88%	6.85%	17.16%	837.74%	9.99%	-1.43%	4.36%	10.16%
FY 2013-14 Actuals	41,836	76,837	138,897	47,082	87,243	434,377	18,267	559	835,098
% Change from FY 2012-13	2.47%	6.93%	28.89%	13.33%	720.42%	15.30%	2.76%	-10.27%	26.70%
FY 2014-15 Actuals	41,817	80,641	178,328	71,989	241,392	495,836	20,036	400	1,130,439
% Change from FY 2013-14	-0.05%	4.95%	28.39%	52.90%	176.69%	16.84%	9.68%	-28.44%	35.37%
FY 2015-16 Actuals	42,403	85,546	179,514	86,964	320,374	526,694	19,935	322	1,261,752
% Change from FY 2014-15	1.40%	6.08%	0.67%	20.80%	32.72%	6.22%	-0.50%	-19.50%	11.62%
FY 2016-17 Actuals	43,941	85,111	176,318	101,059	347,848	534,843	20,310	295	1,309,725
% Change from FY 2015-16	3.63%	-0.51%	-1.78%	16.21%	8.58%	1.55%	1.88%	-8.39%	3.80%
FY 2017-18 Projections	45,242	87,235	202,411	91,246	380,104	535,090	20,584	117	1,362,029
% Change from FY 2016-17	6.70%	1.97%	12.75%	5.00%	19.00%	2.00%	3.00%	-64.00%	3.99%
FY 2018-19 Projections	45,993	90,748	210,047	98,254	393,958	540,205	20,746	62	1,400,013
% Change from FY 2017-18	1.66%	4.03%	3.77%	7.68%	3.64%	0.96%	0.79%	-47.00%	2.79%
FY 2019-20 Projections	46,770	94,786	215,305	102,381	401,763	544,835	20,929	61	1,426,830
% Change from FY 2018-19	1.69%	4.45%	2.50%	4.20%	1.98%	0.86%	0.88%	-2.00%	1.92%
FY 2017-18 Appropriation	44,144	88,158	208,397	80,982	389,466	548,506	20,456	253	1,380,362
Difference between the FY 2017-18 Appropriation and the FY 2017-18 Projection	1,098	(923)	(5,986)	10,264	(9,362)	(13,416)	128	(136)	(18,333)

Expanded Medicaid Average Monthly Caseload for Behavioral Health Community Programs

Item	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	Breast & Cervical Cancer Program	TOTAL BEHAVIORAL HEALTH
FY 2007-08 Actuals	36,284	6,146	49,933	-	53,473	6,388	-	-	-	204,022	-	17,141	270	373,557
FY 2008-09 Actuals	37,619	6,447	51,355	-	61,874	6,976	-	-	-	235,129	-	18,033	317	417,750
% Change from FY 2007-08	3.68%	4.90%	2.85%	0.00%	15.71%	10.94%	0.00%	0.00%	0.00%	15.25%	0.00%	5.20%	17.41%	11.83%
FY 2009-10 Actuals	38,487	7,049	53,264	-	74,839	7,830	-	3,238	-	275,672	-	18,381	425	479,185
% Change from FY 2008-09	2.31%	9.34%	3.72%	0.00%	20.95%	12.24%	0.00%	0.00%	0.00%	17.24%	0.00%	1.93%	34.07%	14.71%
FY 2010-11 Actuals	38,921	7,767	56,285	-	81,114	7,868	-	27,167	-	302,410	-	18,393	531	540,456
% Change from FY 2009-10	1.13%	10.19%	5.67%	0.00%	8.38%	0.49%	0.00%	739.01%	0.00%	9.70%	0.00%	0.07%	24.94%	12.79%
FY 2011-12 Actuals	39,740	8,383	59,434	52	93,224	7,630	-	35,461	1,134	334,633	-	18,034	597	598,322
% Change from FY 2010-11	2.10%	7.93%	5.59%	0.00%	14.93%	-3.02%	0.00%	30.53%	0.00%	10.66%	0.00%	-1.95%	12.43%	10.71%
FY 2012-13 Actuals	40,827	9,051	61,920	888	99,392	8,024	344	41,545	10,634	359,843	8,236	17,777	623	659,104
% Change from FY 2011-12	2.74%	7.97%	4.18%	1607.69%	6.62%	5.16%	0.00%	17.16%	837.74%	7.53%	0.00%	-1.43%	4.36%	10.16%
FY 2013-14 Actuals	41,836	9,853	64,434	2,560	124,680	13,160	1,057	47,082	87,243	399,032	25,345	18,267	559	835,098
% Change from FY 2012-13	2.47%	8.86%	4.04%	188.29%	25.44%	64.01%	207.27%	13.33%	720.42%	10.89%	207.73%	2.76%	-10.27%	26.70%
FY 2014-15 Actuals	41,817	10,466	66,548	3,627	161,682	14,897	1,749	71,989	241,392	445,723	50,113	20,036	400	1,130,439
% Change from FY 2013-14	-0.05%	6.22%	3.30%	41.68%	29.68%	13.20%	65.47%	52.90%	176.69%	11.70%	97.72%	9.68%	-28.44%	35.37%
FY 2015-16 Actuals	42,403	10,529	68,800	6,217	163,342	14,413	1,759	86,964	320,374	467,193	59,501	19,935	322	1,261,752
% Change from FY 2014-15	1.40%	0.60%	3.38%	71.41%	1.03%	-3.25%	0.57%	20.80%	32.72%	4.82%	18.73%	-0.50%	-19.50%	11.62%
FY 2016-17 Actuals	43,941	11,241	67,619	6,251	160,991	13,311	2,016	101,059	347,848	469,906	64,937	20,310	295	1,309,725
% Change from FY 2015-16	3.63%	6.76%	-1.72%	0.55%	-1.44%	-7.65%	14.61%	16.21%	8.58%	0.58%	9.14%	1.88%	-8.39%	3.80%
FY 2017-18 Projections	45,242	11,681	67,743	7,811	188,617	11,429	2,365	91,246	380,104	466,328	68,762	20,584	117	1,362,029
% Change from	2.96%	3.91%	0.18%	24.96%	17.16%	-14.14%	17.31%	-9.71%	9.27%	-0.76%	5.89%	1.35%	-60.34%	3.99%
FY 2018-19 Projections	45,993	12,176	69,473	9,099	196,256	11,427	2,364	98,254	393,958	468,328	71,877	20,746	62	1,400,013
% Change from FY 2017-18	1.66%	4.24%	2.55%	16.49%	4.05%	-0.02%	-0.04%	7.68%	3.64%	0.43%	4.53%	0.79%	-47.01%	2.79%
FY 2019-20 Projections	46,770	12,712	71,706	10,368	201,516	11,425	2,364	102,381	401,763	470,392	74,443	20,929	61	1,426,830
% Change from FY 2018-19	1.69%	4.40%	3.21%	13.95%	2.68%	-0.02%	0.00%	4.20%	1.98%	0.44%	3.57%	0.88%	-1.61%	1.92%
FY 2017-18 Appropriation	44,144	11,659	69,085	7,414	192,463	14,131	1,803	80,982	389,466	479,307	69,199	20,456	253	1,380,362
Difference between the FY 2017-18 Appropriation and the FY 2017-18 Projection	1,098	22	(1,342)	397	(3,846)	(2,702)	562	10,264	(9,362)	(12,979)	(437)	128	(136)	(18,333)

Exhibit DD - Medicaid Behavioral Health Community Programs, Behavioral Health Capitation Payments Per Capita Historical Summary										
Behavioral Health Capitation Payments Per Capita History										
Item	**Adults 65 and Older (OAP-A)**	**Disabled Individuals**	**Low Income Adults**	**Expansion Parents & Caretakers**	**MAGI Adults**	**Eligible Children**	**Foster Care**	**Breast and Cervical Cancer Program**	**TOTAL PER CAPITA**
FY 2007-08 Actuals	$159.45	$1,473.28	$243.04	-	-	$184.13	$3,235.25	$222.88	$524.72
FY 2008-09 Actuals	$163.48	$1,593.93	$247.30	-	-	$185.92	$3,147.83	$230.52	$516.72
% Change from FY 2008-09	2.53%	8.19%	1.75%	-	0.00%	0.97%	-2.70%	3.43%	-1.52%
FY 2009-10 Actuals	$148.47	$1,632.73	$249.27	$198.60	-	$180.47	$2,792.78	$230.48	$472.93
% Change from FY 2008-09	-9.18%	2.43%	0.80%	0.00%	0.00%	-2.93%	-11.28%	-0.02%	-8.47%
FY 2010-11 Actuals	$160.97	$1,757.63	$263.96	$281.77	-	$191.64	$2,341.69	$253.28	$464.69
% Change from FY 2009-10	8.42%	7.65%	5.89%	41.88%	0.00%	6.19%	-16.15%	9.89%	-1.74%
FY 2011-12 Actuals	$163.61	$1,780.77	$269.34	$285.90	$80.46	$202.54	$2,152.46	$264.78	$453.78
% Change from FY 2010-11	1.64%	1.32%	2.04%	1.47%	0.00%	5.69%	-8.08%	4.54%	-2.35%
FY 2012-13 Actuals	$160.02	$1,764.19	$278.07	$284.16	$1,214.44	$207.94	$2,060.15	$244.53	$457.14
% Change from FY 2011-12	-2.19%	-0.93%	3.24%	-0.61%	1409.37%	2.66%	-4.29%	-7.65%	0.74%
FY 2013-14 Actuals	$162.40	$1,767.53	$305.75	$215.56	$1,061.53	$209.54	$2,130.75	$453.98	$498.07
% Change from FY 2012-13	1.49%	0.19%	9.96%	-24.14%	-12.59%	0.77%	3.43%	85.65%	8.95%
FY 2014-15 Actuals	$165.63	$1,756.35	$313.39	$436.95	$690.61	$232.36	$2,595.59	$337.31	$504.19
% Change from FY 2013-14	1.99%	-0.63%	2.50%	102.70%	-34.94%	10.89%	21.82%	-25.70%	1.23%
FY 2015-16 Actuals	$176.94	$1,478.28	$301.07	$622.13	$639.84	$225.39	$1,870.14	$385.86	$478.08
% Change from FY 2014-15	6.83%	-15.83%	-3.93%	42.38%	-7.35%	-3.00%	-27.95%	14.39%	-5.18%
FY 2016-17 Actuals	$204.81	$1,618.89	$334.45	$353.29	$603.51	$230.06	$1,446.41	$273.29	$461.08
% Change from FY 2015-16	15.75%	9.51%	11.09%	-43.21%	-5.68%	2.07%	-22.66%	-29.17%	-3.56%
FY 2017-18 Projections	$221.62	$1,617.79	$354.12	$177.38	$561.29	$238.52	$1,458.12	$340.31	$447.90
% Change from FY 2016-17	25.25%	9.44%	17.62%	-71.49%	-12.28%	5.82%	-22.03%	-11.81%	-2.86%
FY 2018-19 Projections	$232.25	$1,640.26	$373.90	$185.52	$592.33	$247.26	$1,481.13	$349.73	$467.12
% Change from FY 2017-18	4.80%	1.39%	5.59%	4.59%	3.67%	3.67%	1.58%	2.77%	4.29%
FY 2019-20 Projections	$232.76	$1,641.19	$374.00	$185.63	$592.61	$247.29	$1,481.37	$351.51	$469.45
% Change from FY 2018-19	0.22%	0.06%	0.03%	0.06%	0.05%	0.01%	0.02%	$0.01	0.50%

Expanded Medicaid Per Capita Summary for Behavioral Health Capitation Payments

Item	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Disabled Buy-In**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Pregnant Adults**	**SB 11-250 Eligible Pregnant Adults**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**MAGI Adults**	**Eligible Children (AFDC-C/BC)**	**SB 11-008 Eligible Children**	**Foster Care**	**Breast & Cervical Cancer Program**	**TOTAL PER CAPITA**
FY 2007-08 Actuals	$159.45	$1,400.04	$1,482.29	-	$243.96	$235.19	-	-	-	$184.13	-	$3,235.25	$222.88	$524.72
FY 2008-09 Actuals	$163.48	$1,511.57	$1,604.27	-	$250.59	$218.14	-	-	-	$185.92	-	$3,147.83	$230.52	$516.72
FY 2009-10 Actuals	$148.47	$1,537.50	$1,645.34	-	$254.25	$201.68	-	$198.60	-	$180.47	-	$2,792.78	$230.48	$472.93
% Change from FY 2008-09	-9.18%	1.72%	2.56%	0.00%	1.46%	-7.55%	0.00%	0.00%	0.00%	-2.93%	0.00%	-11.28%	-0.02%	-8.47%
FY 2010-11 Actuals	$160.97	$1,659.68	$1,771.15	-	$268.39	$218.28	-	$281.77	-	$191.64	-	$2,341.69	$253.28	$464.69
% Change from FY 2009-10	8.42%	7.95%	7.65%	0.00%	5.56%	8.23%	0.00%	41.88%	0.00%	6.19%	0.00%	-16.15%	9.89%	-1.74%
FY 2011-12 Actuals	$163.61	$1,693.76	$1,793.05	$1,763.06	$272.59	$229.60	-	$285.90	$80.46	$202.54	-	$2,152.46	$264.78	$453.78
% Change from FY 2010-11	1.64%	2.05%	1.24%	0.00%	1.56%	5.19%	0.00%	1.47%	0.00%	5.69%	0.00%	-8.08%	4.54%	-2.35%
FY 2012-13 Actuals	$160.02	$1,688.62	$1,771.11	$2,051.66	$281.45	$248.12	-	$284.16	$1,214.44	$212.70	-	$2,060.15	$244.53	$457.14
% Change from FY 2011-12	-2.19%	-0.30%	-1.22%	16.37%	3.25%	8.07%	0.00%	-0.61%	1409.37%	5.02%	0.00%	-4.29%	-7.65%	0.74%
FY 2013-14 Actuals	$162.40	$1,724.52	$1,766.62	$1,955.82	$311.47	$272.41	$46.13	$215.56	$1,061.53	$220.20	$41.67	$2,130.75	$453.98	$498.07
% Change from FY 2012-13	1.49%	2.13%	-0.25%	-4.67%	10.67%	9.79%	0.00%	-24.14%	-12.59%	3.53%	0.00%	3.43%	85.65%	8.95%
FY 2014-15 Actuals	$165.63	$1,720.12	$1,753.44	$1,914.25	$317.16	$264.72	$379.29	$436.95	$690.61	$225.15	$296.46	$2,595.59	$337.31	$504.19
% Change from FY 2013-14	1.99%	-0.26%	-0.75%	-2.13%	1.83%	-2.82%	722.22%	102.70%	-34.94%	2.25%	611.45%	21.82%	-25.70%	1.23%
FY 2015-16 Actuals	$176.94	$1,436.10	$1,471.07	$1,629.51	$304.54	$262.60	$294.03	$622.13	$639.84	$225.30	$226.09	$1,870.14	$385.86	$478.08
% Change from FY 2014-15	6.83%	-16.51%	-16.10%	-14.87%	-3.98%	-0.80%	-22.48%	42.38%	-7.35%	0.07%	-23.74%	-27.95%	14.39%	-5.18%
FY 2016-17 Actuals	$204.81	$1,594.24	$1,622.37	$1,625.52	$337.50	$298.26	$329.80	$353.29	$603.51	$227.60	$247.83	$1,446.41	$273.29	$461.08
% Change from FY 2015-16	15.75%	11.01%	10.29%	-0.24%	10.82%	13.58%	12.17%	-43.21%	-5.68%	1.02%	9.62%	-22.66%	-29.17%	-3.56%
FY 2017-18 Projections	$221.62	$1,617.79	$1,617.79	$1,617.79	$354.12	$354.12	$354.12	$177.38	$561.29	$238.52	$238.52	$1,458.12	$340.31	$447.90
% Change from FY 2016-17	25.25%	12.65%	9.97%	-0.72%	16.28%	34.85%	20.44%	-71.49%	-12.28%	5.87%	5.50%	-22.03%	-11.81%	-2.86%
FY 2018-19 Projections	$232.25	$1,640.26	$1,640.26	$1,640.26	$373.90	$373.90	$373.90	$185.52	$592.33	$247.26	$247.26	$1,481.13	$349.73	$467.12
% Change from FY 2017-18	4.80%	1.39%	1.39%	1.39%	5.59%	5.59%	5.59%	4.59%	5.53%	3.67%	3.67%	1.58%	2.77%	4.29%
FY 2019-20 Projections	$232.76	$1,641.19	$1,641.19	$1,641.19	$374.00	$374.00	$374.00	$185.63	$592.61	$247.29	$247.29	$1,481.37	$351.51	$469.45
% Change from FY 2018-19	0.22%	0.06%	0.06%	0.06%	0.03%	0.03%	0.03%	0.06%	0.05%	0.01%	0.01%	0.02%	0.51%	0.50%

Exhibit DD - Medicaid Behavioral Health Community Programs, Expenditures Historical Summary

Annual Total Expenditures

Item		Adults 65 and Older (OAP-A)	Disabled Individuals	Low Income Adults	Expansion Parents & Caretakers	MAGI Adults	Eligible Children	Foster Care	Breast & Cervical Cancer Program	TOTAL BEHAVIORAL HEALTH
FY 2008-09	Capitations	$6,149,782	$92,132,599	$17,026,544	$0	$0	$43,714,042	$56,764,896	$73,074	$215,860,937
	Fee-for-Service									
	Inpatient Services	$22,235	$331,864	$107,478	$0	$0	$171,764	$8,913	$0	$642,254
	Outpatient Services	$9,657	$284,108	$300,557	$0	$0	$364,710	$103,091	$0	$1,062,123
	Physician Services	$285	$37,367	$12,386	$0	$0	$13,685	$8,153	$0	$71,876
	Sub-Total Fee-for-Service	$32,177	$653,339	$420,421	$0	$0	$550,159	$120,157	$0	$1,776,253
	Total FY 2008-09 Expenditures	**$6,181,959**	**$92,785,938**	**$17,446,965**	**$0**	**$0**	**$44,264,201**	**$56,885,053**	**$73,074**	**$217,637,190**
	% Change from FY 2007-08	**6.48%**	**11.60%**	**17.80%**	**0.00%**	**0.00%**	**16.64%**	**2.35%**	**21.43%**	**10.28%**
FY 2009-10 [1]	Capitations	$5,714,066	$98,475,008	$20,606,973	$643,078	$0	$49,749,580	$51,334,158	$97,955	$226,620,818
	Fee-for-Service									
	Inpatient Services	$36,707	$327,355	$23,679	$1,024	$0	$184,094	$23,702	$0	$596,561
	Outpatient Services	$18,805	$528,618	$598,850	$24,891	$0	$601,664	$139,423	$0	$1,912,251
	Physician Services	$61	$45,659	$6,338	$205	$0	$22,296	$4,291	$0	$78,850
	Sub-Total Fee-for-Service	$55,573	$901,632	$628,867	$26,120	$0	$808,054	$167,416	$0	$2,587,662
	Total FY 2009-10 Expenditures	**$5,769,639**	**$99,376,640**	**$21,235,840**	**$669,198**	**$0**	**$50,557,634**	**$51,501,574**	**$97,955**	**$229,208,480**
	% Change from FY 2008-09	**-6.67%**	**7.10%**	**21.72%**	**0.00%**	**0.00%**	**14.22%**	**-9.46%**	**34.05%**	**5.32%**
FY 2010-11 [1]	Capitations	$6,265,262	$112,579,810	$23,487,736	$7,654,920	$0	$57,953,130	$43,070,676	$134,493	$251,146,027
	Fee-for-Service									
	Inpatient Services	$26,281	$462,018	$54,952	$18,405	$0	$209,493	$31,297	$0	$802,446
	Outpatient Services	$19,668	$838,729	$805,357	$260,702	$0	$843,338	$204,022	$0	$2,971,816
	Physician Services	$44	$53,652	$10,651	$2,892	$0	$19,019	$10,074	$0	$96,331
	Sub-Total Fee-for-Service	$45,993	$1,354,399	$870,960	$281,999	$0	$1,071,850	$245,393	$0	$3,870,594
	Total FY 2010-11 Expenditures	**$6,311,255**	**$113,934,209**	**$24,358,696**	**$7,936,919**	**$0**	**$59,024,980**	**$43,316,069**	**$134,493**	**$255,016,621**
	% Change from FY 2009-10	**9.39%**	**14.65%**	**14.71%**	**1086.03%**	**0.00%**	**16.75%**	**-15.89%**	**37.30%**	**11.26%**
FY 2011-12	Capitations	$6,501,731	$120,858,807	$27,163,997	$10,138,129	$91,244	$67,777,256	$38,817,457	$158,074	$271,506,635
	Fee-for-Service									
	Inpatient Services	$21,297	$355,817	$48,185	$18,329	$0	$176,653	$11,869	$0	$632,151
	Outpatient Services	$19,808	$762,862	$898,679	$332,229	$13,232	$980,428	$156,434	$0	$3,163,672
	Physician Services	$0	$49,001	$13,561	$4,718	$0	$23,508	$5,786	$0	$96,575
	Sub-Total Fee-for-Service	$41,105	$1,167,680	$960,426	$355,276	$13,232	$1,180,589	$174,089	$0	$3,892,397
	Total FY 2011-12 Expenditures	**$6,542,836**	**$122,026,487**	**$28,124,363**	**$10,493,405**	**$104,476**	**$68,957,845**	**$38,991,546**	**$158,074**	**$275,399,032**
	% Change from FY 2010-11	**3.67%**	**7.10%**	**15.46%**	**32.21%**	**0.00%**	**16.83%**	**-9.98%**	**17.53%**	**7.99%**
FY 2012-13	Capitations	$6,533,297	$126,772,700	$29,964,300	$11,805,595	$12,914,408	$76,537,197	$36,623,205	$152,344	$301,303,046
	Fee-for-Service									
	Inpatient Services	$23,759	$667,573	$56,164	$5,318	$47,488	$147,305	$26,023	$0	$973,629
	Outpatient Services	$15,873	$746,068	$1,003,284	$301,289	$270,481	$1,035,757	$140,576	$0	$3,513,329
	Physician Services	$0	$61,602	$5,800	$2,561	$256	$9,712	$2,308	$0	$82,240
	Sub-Total Fee-for-Service	$39,632	$1,475,243	$1,065,248	$309,168	$318,226	$1,192,774	$168,907	$0	$4,569,198
	Total FY 2012-13 Expenditures	**$6,572,929**	**$128,247,943**	**$31,029,548**	**$12,114,763**	**$13,232,634**	**$77,729,971**	**$36,792,112**	**$152,344**	**$305,872,244**
	% Change from FY 2011-12	**0.46%**	**5.10%**	**10.33%**	**15.45%**	**12565.72%**	**12.72%**	**-5.64%**	**-3.62%**	**11.07%**
FY 2013-14	Capitations	$6,794,071	$135,811,614	$42,468,350	$10,148,824	$92,611,488	$88,922,742	$38,922,470	$253,774	$415,933,333
	Fee-for-Service									
	Inpatient Services	$12,637	$701,499	$138,091	$9,711	$199,734	$181,770	$33,646	$0	$1,277,088
	Outpatient Services	$10,423	$555,506	$1,039,616	$276,800	$1,113,265	$885,140	$75,378	$0	$3,956,127
	Physician Services	$50	$32,316	$7,787	$1,262	$9,088	$10,754	$1,877	$0	$63,135
	Sub-Total Fee-for-Service	$23,110	$1,289,321	$1,185,495	$287,773	$1,322,086	$1,077,664	$110,901	$0	$5,296,351
	Total FY 2013-14 Expenditures	**$6,817,181**	**$137,100,935**	**$43,653,845**	**$10,436,597**	**$93,933,574**	**$90,000,406**	**$39,033,371**	**$253,774**	**$421,229,684**
	% Change from FY 2012-13	**3.72%**	**6.90%**	**40.68%**	**-13.85%**	**609.86%**	**15.79%**	**6.09%**	**66.58%**	**37.71%**
FY 2014-15	Capitations	$6,926,061	$141,634,009	$55,885,779	$31,455,667	$166,708,082	$115,210,684	$52,005,193	$134,923	$569,960,398
	Fee-for-Service									
	Inpatient Services	$68,648	$419,127	$41,495	$8,711	$338,450	$117,114	$44,071	$0	$1,037,617
	Outpatient Services	$15,159	$578,816	$1,289,044	$386,626	$2,835,698	$1,206,136	$109,984	$0	$6,421,463
	Physician Services	$0	$40,084	$7,568	$909	$8,980	$7,396	$1,407	$0	$66,344
	Sub-Total Fee-for-Service	$83,807	$1,038,027	$1,338,106	$396,247	$3,183,128	$1,330,646	$155,462	$0	$7,525,424
	Total FY 2014-15 Expenditures	**$7,009,868**	**$142,672,036**	**$57,223,885**	**$31,851,914**	**$169,891,210**	**$116,541,330**	**$52,160,655**	**$134,923**	**$577,485,822**
	% Change from FY 2013-14	**2.83%**	**4.06%**	**31.09%**	**205.19%**	**80.86%**	**29.49%**	**33.63%**	**-46.83%**	**37.10%**
FY 2015-16	Capitations	$7,502,928	$126,461,139	$54,045,657	$54,103,151	$204,989,597	$118,710,699	$37,281,250	$124,247	$603,218,668
	Fee-for-Service									
	Inpatient Services	$196,797	$329,254	$24,417	$15,147	$371,092	$112,391	$35,382	$0	$1,084,479
	Outpatient Services	$14,779	$591,149	$1,409,045	$478,376	$3,016,043	$1,284,583	$139,439	$4,516	$6,937,930
	Physician Services	$117	$40,917	$9,413	$935	$8,821	$1,974	$2,254	$0	$64,431
	Sub-Total Fee-for-Service	$211,694	$961,320	$1,442,875	$494,457	$3,395,956	$1,398,948	$177,074	$4,516	$8,086,839
	Total FY 2015-16 Expenditures	**$7,714,622**	**$127,422,459**	**$55,488,532**	**$54,597,608**	**$208,385,553**	**$120,109,647**	**$37,458,324**	**$128,763**	**$611,305,507**
	% Change from FY 2014-15	**10.05%**	**-10.69%**	**-3.03%**	**71.41%**	**22.66%**	**3.06%**	**-28.19%**	**-4.57%**	**5.86%**
FY 2016-17	Capitations	$8,999,674	$137,785,026	$58,968,966	$35,703,386	$209,929,370	$123,045,127	$29,376,555	$80,621	$603,888,725
	Fee-for-Service									
	Inpatient Services	$31,244	$120,848	$9,033	$5,368	$107,847	$86,132	$19,653	$0	$380,126
	Outpatient Services	$15,718	$550,742	$1,423,199	$634,320	$3,154,639	$1,428,144	$137,585	$4,855	$7,349,403
	Physician Services	$0	$1,240	$4,962	$1,064	$10,463	$1,402	$1,250	$56	$20,437
	Sub-Total Fee-for-Service	$46,962	$672,830	$1,437,194	$640,953	$3,272,950	$1,515,679	$158,488	$4,911	$7,749,966
	Total FY 2016-17 Expenditures	**$9,046,637**	**$138,457,856**	**$60,406,160**	**$36,344,339**	**$213,202,320**	**$124,560,806**	**$29,535,043**	**$85,532**	**$611,638,691**
	% Change from FY 2015-16	**17.27%**	**8.66%**	**8.86%**	**-33.43%**	**2.31%**	**3.71%**	**-21.15%**	**-33.57%**	**0.05%**

[1] FY 2009-10 and FY 2010-11 have been adjusted for one-time recoupments.

Exhibit DD - Medicaid Behavioral Health Community Program: Expenditures Historical Summary

Expanded Annual Total Expenditures

	Item	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	Breast & Cervical Cancer Program	TOTAL BEHAVIORAL HEALTH
FY 2008-09	Capitations	$6,149,782	$9,745,116	$82,387,483	$0	$15,504,797	$1,521,747	$0	$0	$0	$43,714,042	$0	$56,764,896	$73,074	$215,860,937
	Fee-for-Service														
	Inpatient Services	$22,235	$9,653	$322,211	$0	$107,478	$0	$0	$0	$0	$171,764	$0	$8,913	$0	$642,254
	Outpatient Services	$9,657	$19,613	$264,495	$0	$291,393	$9,164	$0	$0	$0	$364,710	$0	$103,091	$0	$1,062,123
	Physician Services	$285	$1,580	$35,787	$0	$10,873	$1,513	$0	$0	$0	$13,685	$0	$8,153	$0	$71,876
	Sub-Total Fee-for-Service	$32,177	$30,846	$622,493	$0	$409,744	$10,677	$0	$0	$0	$550,159	$0	$120,157	$0	$1,776,253
	Total FY 2008-09 Expenditures	**$6,181,959**	**$9,775,962**	**$83,009,976**	**$0**	**$15,914,541**	**$1,532,424**	**$0**	**$0**	**$0**	**$44,264,201**	**$0**	**$56,885,053**	**$73,074**	**$217,637,190**
	% Change from FY 2007-08	**6.48%**	**13.22%**	**11.41%**	**0.00%**	**19.44%**	**3.11%**	**0.00%**	**0.00%**	**0.00%**	**16.64%**	**0.00%**	**2.35%**	**21.43%**	**10.28%**
FY 2009-10 [1]	Capitations	$5,714,066	$10,837,828	$87,637,180	$0	$19,027,843	$1,579,130	$0	$643,078	$0	$49,749,580	$0	$51,334,158	$97,955	$226,620,818
	Fee-for-Service														
	Inpatient Services	$36,707	$0	$327,355	$0	$23,679	$0	$0	$1,024	$0	$184,094	$0	$23,702	$0	$596,561
	Outpatient Services	$18,805	$35,433	$493,185	$0	$575,312	$23,538	$0	$24,891	$0	$601,664	$0	$139,423	$0	$1,912,251
	Physician Services	$61	$631	$45,028	$0	$4,747	$1,591	$0	$205	$0	$22,296	$0	$4,291	$0	$78,850
	Sub-Total Fee-for-Service	$55,573	$36,064	$865,568	$0	$603,738	$25,129	$0	$26,120	$0	$808,054	$0	$167,416	$0	$2,587,662
	Total FY 2009-10 Expenditures	**$5,769,639**	**$10,873,892**	**$88,502,748**	**$0**	**$19,631,581**	**$1,604,259**	**$0**	**$669,198**	**$0**	**$50,557,634**	**$0**	**$51,501,574**	**$97,955**	**$229,208,480**
	% Change from FY 2008-09	**-6.67%**	**11.23%**	**6.62%**	**0.00%**	**23.36%**	**4.69%**	**0.00%**	**0.00%**	**0.00%**	**14.22%**	**0.00%**	**-9.46%**	**34.05%**	**5.32%**
FY 2010-11 [1]	Capitations	$6,265,262	$12,890,748	$99,689,062	$0	$21,770,317	$1,717,419	$0	$7,654,920	$0	$57,953,130	$0	$43,070,676	$134,493	$251,146,027
	Fee-for-Service														
	Inpatient Services	$26,281	$0	$462,018	$0	$54,952	$0	$0	$18,405	$0	$209,493	$0	$31,297	$0	$802,446
	Outpatient Services	$19,668	$54,047	$784,682	$0	$778,402	$26,955	$0	$260,702	$0	$843,338	$0	$204,022	$0	$2,971,816
	Physician Services	$44	$559	$53,093	$0	$8,634	$2,017	$0	$2,892	$0	$19,019	$0	$10,074	$0	$96,331
	Sub-Total Fee-for-Service	$45,993	$54,606	$1,299,792	$0	$841,988	$28,972	$0	$281,999	$0	$1,071,850	$0	$245,393	$0	$3,870,594
	Total FY 2010-11 Expenditures	**$6,311,255**	**$12,945,354**	**$100,988,854**	**$0**	**$22,612,305**	**$1,746,391**	**$0**	**$7,936,919**	**$0**	**$59,024,980**	**$0**	**$43,316,069**	**$134,493**	**$255,016,621**
	% Change from FY 2009-10	**9.39%**	**19.05%**	**14.11%**	**0.00%**	**15.18%**	**8.86%**	**0.00%**	**1086.03%**	**0.00%**	**16.75%**	**0.00%**	**-15.89%**	**37.30%**	**11.26%**
FY 2011-12	Capitations	$6,501,731	$14,198,785	$106,568,343	$91,679	$25,412,054	$1,751,883	$0	$10,138,129	$91,244	$67,777,256	$0	$38,817,457	$158,074	$271,506,635
	Fee-for-Service														
	Inpatient Services	$21,297	$12,590	$343,228	$0	$48,185	$0	$0	$18,329	$0	$176,653	$0	$11,869	$0	$632,151
	Outpatient Services	$19,808	$66,220	$696,219	$423	$873,401	$25,278	$0	$332,229	$13,232	$980,428	$0	$156,434	$0	$3,163,672
	Physician Services	$0	$580	$48,421	$0	$12,402	$1,159	$0	$4,718	$0	$23,508	$0	$5,786	$0	$96,575
	Sub-Total Fee-for-Service	$41,105	$79,389	$1,087,868	$423	$933,988	$26,438	$0	$355,276	$13,232	$1,180,589	$0	$174,089	$0	$3,892,397
	Total FY 2011-12 Expenditures	**$6,542,836**	**$14,278,174**	**$107,656,211**	**$92,102**	**$26,346,042**	**$1,778,321**	**$0**	**$10,493,405**	**$104,476**	**$68,957,845**	**$0**	**$38,991,546**	**$158,074**	**$275,399,032**
	% Change from FY 2010-11	**3.67%**	**10.30%**	**6.60%**	**0.00%**	**16.51%**	**1.83%**	**0.00%**	**32.21%**	**0.00%**	**16.83%**	**0.00%**	**-9.98%**	**17.53%**	**7.99%**
FY 2012-13	Capitations	$6,533,297	$15,283,706	$109,667,124	$1,821,870	$27,973,392	$1,990,908	$0	$11,805,595	$12,914,408	$76,537,197	$0	$36,623,205	$152,344	$301,303,046
	Fee-for-Service														
	Inpatient Services	$23,759	$89,128	$568,472	$9,972	$56,164	$0	$0	$5,318	$47,488	$147,305	$0	$26,023	$0	$973,629
	Outpatient Services	$15,873	$70,123	$667,130	$8,815	$977,747	$25,538	$0	$301,289	$270,481	$1,035,757	$0	$140,576	$0	$3,513,329
	Physician Services	$0	$355	$61,247	$0	$5,234	$566	$0	$2,561	$256	$9,712	$0	$2,108	$0	$82,240
	Sub-Total Fee-for-Service	$39,632	$159,606	$1,296,849	$18,788	$1,039,144	$26,104	$0	$309,168	$318,226	$1,192,774	$0	$168,907	$0	$4,569,198
	Total FY 2012-13 Expenditures	**$6,572,929**	**$15,443,312**	**$110,963,973**	**$1,840,658**	**$29,012,536**	**$2,017,012**	**$0**	**$12,114,763**	**$13,232,634**	**$77,729,971**	**$0**	**$36,792,112**	**$152,344**	**$305,872,244**
	% Change from FY 2011-12	**0.46%**	**8.16%**	**3.07%**	**1898.50%**	**10.12%**	**13.42%**	**0.00%**	**15.45%**	**12565.72%**	**12.72%**	**0.00%**	**-5.64%**	**-3.62%**	**11.07%**
FY 2013-14	Capitations	$6,794,071	$16,991,711	$113,813,015	$5,006,888	$38,834,657	$3,584,933	$48,760	$10,148,824	$92,611,488	$87,866,710	$1,056,032	$38,922,470	$253,774	$415,933,333
	Fee-for-Service														
	Inpatient Services	$12,637	$19,104	$626,179	$56,216	$138,091	$0	$0	$9,711	$199,734	$169,677	$12,092	$33,646	$0	$1,277,088
	Outpatient Services	$10,423	$38,587	$501,652	$15,268	$987,859	$49,120	$2,637	$276,800	$1,113,265	$820,427	$64,713	$75,178	$0	$3,956,127
	Physician Services	$50	$1,324	$30,834	$158	$6,611	$1,176	$0	$1,262	$9,088	$10,578	$176	$1,877	$0	$63,135
	Sub-Total Fee-for-Service	$23,110	$59,015	$1,158,665	$71,641	$1,132,562	$50,296	$2,637	$287,773	$1,322,086	$1,000,682	$76,982	$110,901	$0	$5,296,351
	Total FY 2013-14 Expenditures	**$6,817,181**	**$17,050,726**	**$114,971,680**	**$5,078,529**	**$39,967,219**	**$3,635,229**	**$51,397**	**$10,436,597**	**$93,933,574**	**$88,867,392**	**$1,133,014**	**$39,033,371**	**$253,774**	**$421,229,684**
	% Change from FY 2012-13	**3.72%**	**10.41%**	**3.61%**	**175.91%**	**37.76%**	**80.23%**	**0.00%**	**-13.85%**	**609.86%**	**14.33%**	**0.00%**	**6.09%**	**66.58%**	**37.71%**
FY 2014-15	Capitations	$6,926,061	$18,002,789	$116,688,242	$6,942,978	$51,278,862	$3,943,543	$663,374	$31,455,667	$166,708,082	$100,354,417	$14,856,267	$52,005,193	$134,923	$569,960,398
	Fee-for-Service														
	Inpatient Services	$68,648	$24,636	$391,086	$3,405	$41,495	$0	$0	$8,711	$338,450	$106,174	$10,940	$44,071	$0	$1,037,617
	Outpatient Services	$15,159	$52,567	$513,707	$12,542	$1,229,177	$53,357	$6,510	$386,626	$2,835,698	$916,742	$289,394	$109,984	$0	$6,421,463
	Physician Services	$0	$2,696	$37,013	$375	$6,170	$613	$786	$909	$8,980	$6,239	$1,156	$1,407	$0	$66,344
	Sub-Total Fee-for-Service	$83,807	$79,898	$941,806	$16,323	$1,276,841	$53,969	$7,296	$396,247	$3,183,128	$1,029,155	$301,491	$155,462	$0	$7,525,424
	Total FY 2014-15 Expenditures	**$7,009,868**	**$18,082,687**	**$117,630,048**	**$6,959,301**	**$52,555,703**	**$3,997,512**	**$670,670**	**$31,851,914**	**$169,891,210**	**$101,383,572**	**$15,157,758**	**$52,160,655**	**$134,923**	**$577,485,822**
	% Change from FY 2013-14	**2.83%**	**6.05%**	**2.31%**	**37.03%**	**31.50%**	**9.97%**	**0.00%**	**205.19%**	**80.86%**	**14.08%**	**0.00%**	**33.63%**	**-46.83%**	**37.10%**
FY 2015-16	Capitations	$7,502,928	$15,120,720	$101,209,755	$10,130,664	$49,743,555	$3,784,911	$517,191	$54,103,151	$204,989,597	$105,257,829	$13,452,870	$37,281,250	$124,247	$603,218,668
	Fee-for-Service														
	Inpatient Services	$196,797	$103,206	$224,056	$1,491	$24,417	$0	$0	$15,147	$371,092	$101,655	$10,736	$35,382	$0	$1,084,479
	Outpatient Services	$14,779	$58,715	$504,056	$28,379	$1,348,307	$56,200	$4,538	$478,376	$3,016,043	$1,067,081	$217,502	$139,439	$4,516	$6,937,930
	Physician Services	$117	$1,385	$39,249	$282	$3,924	$5,301	$187	$935	$8,821	$1,741	$233	$2,254	$0	$64,431
	Sub-Total Fee-for-Service	$211,694	$163,807	$767,361	$30,152	$1,376,648	$61,502	$4,725	$494,457	$3,395,956	$1,170,477	$228,471	$177,074	$4,516	$8,086,839
	Total FY 2015-16 Expenditures	**$7,714,622**	**$15,284,527**	**$101,977,116**	**$10,160,816**	**$51,120,203**	**$3,846,413**	**$521,916**	**$54,597,608**	**$208,385,553**	**$106,428,306**	**$13,681,341**	**$37,458,324**	**$128,763**	**$611,305,508**
	% Change from FY 2014-15	**10.05%**	**-15.47%**	**-13.31%**	**46.00%**	**-2.73%**	**-3.78%**	**-22.18%**	**71.41%**	**22.66%**	**4.98%**	**-9.74%**	**-28.19%**	**-4.57%**	**5.86%**
FY 2016-17	Capitations	$8,999,674	$17,920,858	$109,703,026	$10,161,142	$54,333,943	$3,970,150	$664,873	$35,703,386	$209,929,370	$106,951,722	$16,093,405	$29,376,555	$80,621	$603,888,725
	Fee-for-Service														
	Inpatient Services	$31,244	$12,197	$108,652	$0	$9,033	$0	$0	$5,368	$107,847	$86,132	$0	$19,653	$0	$380,126
	Outpatient Services	$15,718	$54,312	$496,430	$0	$1,351,952	$68,106	$3,142	$634,520	$3,154,639	$1,297,910	$130,235	$137,585	$4,855	$7,349,403
	Physician Services	$0	$1,240	$0	$0	$1,552	$3,070	$340	$1,064	$10,463	$26	$1,376	$1,250	$56	$20,417
	Sub-Total Fee-for-Service	$46,962	$67,749	$605,082	$0	$1,362,536	$71,176	$3,482	$640,953	$3,272,950	$1,384,068	$131,611	$158,488	$4,911	$7,749,966
	Total FY 2016-17 Expenditures	**$9,046,637**	**$17,988,607**	**$110,308,108**	**$10,161,142**	**$55,696,479**	**$4,041,326**	**$668,355**	**$36,344,339**	**$213,202,320**	**$108,335,790**	**$16,225,016**	**$29,535,043**	**$85,532**	**$611,638,691**
	% Change from FY 2015-16	**17.27%**	**17.69%**	**8.17%**	**0.00%**	**8.95%**	**5.07%**	**28.06%**	**-33.43%**	**2.31%**	**1.79%**	**18.59%**	**-21.15%**	**-33.57%**	**0.05%**

[1] FY 2009-10 and FY 2010-11 have been adjusted for one-time recoupments.