STATE OF COLORADO

JOINT BUDGET COMMITTEE
LEGISLATIVE SERVICES BUILDING
200 EAST 14TH AVENUE, 3RD FLOOR
DENVER, CO 80203
TELEPHONE 303-866-2061
http://leg.colorado.gov/agencies/joint-budget-committee

March 12, 2021

Senator Jeff Bridges, Chair
Joint Technology Committee
200 East Colfax Avenue
Denver, CO 80203

Dear Senator Bridges,

The Joint Budget Committee respectfully requests that the Joint Technology Committee review the Department of Health Care Policy and Financing's (HCPF's) FY 2021-22 operating budget request *R23 Behavioral Health Eligibility and Claims System Consolidation.* This request would integrate eligibility determinations, claims processing, and data reporting for various behavioral health programs statewide. The proposal attempts to leverage existing systems used by HCPF in order to serve programs operated by other departments. There is a related capital construction request from the Department of Human Services. HCPF says the requests can move independently, but the Department of Human Services request includes at least $2.4 million capital construction funds that would be necessary for the HCPF request to reach full effectiveness. In particular, the Joint Budget Committee is interested in the Joint Technology Committee's feedback on whether HCPF has accurately estimated the scope and cost of the project and whether HCPF has a reasonable plan to manage the project. Thank you for your assistance. If you have any questions concerning this request, please contact Eric Kurtz of the JBC staff at 303-866-4952.

Sincerely,

Dominik Moreno
Chair, Joint Budget Committee

cc:
Louisa Altman, Joint Technology Committee Staff
Joshua Block, Department of Health Care Policy and Financing
Carolyn Kampamn, JBC Staff Director

Enclosures:
Department of Health Care Policy and Financing R23 narrative
Excerpt from the JBC Staff figure setting recommendation
Excerpt from the Department of Health Care Policy and Financing hearing responses

Schedule 13

Department of Health Care Policy and Financing

Funding Request for The FY 2021-22 Budget Cycle

Request Title

R-23 Behavioral Health Claims and Eligibility Processing

Dept. Approval By:

OSPB Approval By:

	Supplemental FY 2020-21
	Budget Amendment FY 2021-22
X	Change Request FY 2021-22

Summary Information	Fund	FY 2020-21 Initial Appropriation	FY 2020-21 Supplemental Request	FY 2021-22 Base Request	FY 2021-22 Change Request	FY 2022-23 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$174,907,625**	**$0**	**$179,234,713**	**$7,466,780**	**$2,052,479**
	FTE	520.4	0.0	521.2	0.0	0.0
	GF	$38,329,420	$0	$40,420,323	$7,488,276	$2,073,975
	CF	$17,207,991	$0	$17,694,424	$0	$0
	RF	$2,570,836	$0	$2,198,408	$0	$0
	FF	$116,799,378	$0	$118,921,558	($21,496)	($21,496)

Line Item Information	Fund	FY 2020-21 Initial Appropriation	FY 2020-21 Supplemental Request	FY 2021-22 Base Request	FY 2021-22 Change Request	FY 2022-23 Continuation
01. Executive Director's Office, (A) General Administration, (1) General Administration - Personal Services	**Total**	**$41,276,479**	**$0**	**$41,080,782**	**$1,585,701**	**$1,650,278**
	FTE	520.4	0.0	521.2	0.0	0.0
	GF	$14,487,249	$0	$14,650,129	$1,607,197	$1,671,774
	CF	$3,911,124	$0	$3,939,903	$0	$0
	RF	$2,305,357	$0	$1,892,777	$0	$0
	FF	$20,572,749	$0	$20,597,973	($21,496)	($21,496)
01. Executive Director's Office, (A) General Administration, (1) General Administration - Health, Life, and Dental	**Total**	**$5,264,801**	**$0**	**$6,826,728**	**$230,966**	**$230,966**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,342,322	$0	$2,480,588	$230,966	$230,966
	CF	$548,313	$0	$573,987	$0	$0
	RF	$138,532	$0	$173,157	$0	$0
	FF	$3,235,634	$0	$3,598,996	$0	$0

Line Item Information	Fund	FY 2020-21 Initial Appropriation	FY 2020-21 Supplemental Request	FY 2021-22 Base Request	FY 2021-22 Change Request	FY 2022-23 Continuation
	Total	**$72,366**	**$0**	**$71,148**	**$2,399**	**$2,497**
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (A) General Administration, (1) General Administration - Short-term Disability	GF	$26,778	$0	$26,526	$2,399	$2,497
	CF	$5,695	$0	$5,510	$0	$0
	RF	$1,607	$0	$1,644	$0	$0
	FF	$38,286	$0	$37,468	$0	$0
	Total	**$2,188,905**	**$0**	**$2,223,320**	**$70,570**	**$73,444**
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (A) General Administration, (1) General Administration - Amortization Equalization Disbursement	GF	$810,157	$0	$828,912	$70,570	$73,444
	CF	$172,037	$0	$172,189	$0	$0
	RF	$48,635	$0	$51,380	$0	$0
	FF	$1,158,076	$0	$1,170,839	$0	$0
	Total	**$2,188,905**	**$0**	**$2,223,320**	**$70,570**	**$73,444**
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (A) General Administration, (1) General Administration - Supplemental Amortization Equalization Disbursement	GF	$810,157	$0	$828,912	$70,570	$73,444
	CF	$172,037	$0	$172,189	$0	$0
	RF	$48,635	$0	$51,380	$0	$0
	FF	$1,158,076	$0	$1,170,839	$0	$0
	Total	**$2,356,365**	**$0**	**$2,248,313**	**$130,019**	**$21,850**
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (A) General Administration, (1) General Administration - Operating Expenses	GF	$954,547	$0	$919,906	$130,019	$21,850
	CF	$214,413	$0	$200,711	$0	$0
	RF	$13,297	$0	$13,297	$0	$0
	FF	$1,174,108	$0	$1,114,399	$0	$0
	Total	**$73,227,142**	**$0**	**$76,228,440**	**$3,153,555**	**$0**
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (C) Information Technology Contracts and Projects, (1) Information Technology Contracts and Projects - MMIS Maintenance and Projects	GF	$9,703,222	$0	$10,490,362	$3,153,555	$0
	CF	$6,312,421	$0	$6,757,984	$0	$0
	RF	$12,204	$0	$12,204	$0	$0
	FF	$57,199,295	$0	$58,967,890	$0	$0

Line Item Information	Fund	FY 2020-21 Initial Appropriation	FY 2020-21 Supplemental Request	FY 2021-22 Base Request	FY 2021-22 Change Request	FY 2022-23 Continuation
	Total	**$48,332,662**	**$0**	**$48,332,662**	**$2,223,000**	**$0**
01. Executive Director's Office, (C) Information Technology Contracts and Projects, (1) Information Technology Contracts and Projects - Colorado Benefits Management Systems, Operating & Contracts	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$10,194,988	$0	$10,194,988	$2,223,000	$0
	CF	$5,871,951	$0	$5,871,951	$0	$0
	RF	$2,569	$0	$2,569	$0	$0
	FF	$32,263,154	$0	$32,263,154	$0	$0

Auxiliary Data			
Requires Legislation?	NO		
Type of Request?	Department of Health Care Policy and Financing Prioritized Request	**Interagency Approval or Related Schedule 13s:**	Requires OIT Approval

Department Priority: R-23
Request Detail: Behavioral Health Claims and Eligibility Processing

Summary of Funding Change for FY 2021-22				
	Totals		Incremental Change	
	FY 2020-21 Appropriation	FY 2021-22 Base	FY 2021-22 Request	FY 2022-23 Request
Total Funds	$174,907,625	$179,234,713	$7,466,780	$2,052,479
FTE	520.4	521.2	0.0	0.0
General Fund	$38,329,420	$40,420,323	$7,488,276	$2,073,975
Cash Funds	$17,207,991	$17,694,424	$0	$0
Reappropriated Funds	$2,570,836	$2,198,408	$0	$0
Federal Funds	$116,799,378	$118,921,558	($21,496)	($21,496)

Summary of Request:

The Department requests funding in order to establish an eligibility system, a claims processing and submission system, and a data reporting system to serve all of the State's behavioral health programs. This request includes funding for contractor work and temporary staff to manage design, development, and implementation. The Department would leverage the State's existing Medicaid infrastructure to create these systems; rather than building new systems from the ground up, the Department would integrate the State's behavioral health programs into the existing infrastructure, which would reduce administrative cost and provide significant efficiencies over both the current model and any alternative which would build new systems that did not integrate with Medicaid. In addition, the Department requests rollforward authority for the appropriations in order to prevent delays in implementation.

The Department believes that the work of the Task Force is on Step 3 of the Evidence Continuum, "Assess Outcomes." The Task Force has provided detailed evidence demonstrating the shortcomings and lack of effectiveness of the current system, including the poor behavioral health outcomes on the current population. With a more comprehensive framework, the outcomes could be measured and compared, which would then assist in attaining evidence and demonstrating causal evidence for these programs.

Current Program:

On April 8, 2019, Gov. Jared Polis directed the Colorado Department of Human Services to spearhead Colorado's Behavioral Health Task Force ("Task Force").[1] The mission of the task force is to evaluate and set the roadmap to improve the current behavioral health system in the state. This includes developing Colorado's "Behavioral Health Blueprint" by the fall of 2020, with anticipated implementation of recommendations starting in late 2020. The executive committee is composed of the Lt. Governor, three members of Governor Polis' cabinet, the Commissioner of the Division of Insurance, and the Deputy County Manager for Douglas County. The BHTF itself is composed of 25 members, including legislators, providers, representatives of Colorado's tribes, and other stakeholders. There are three subcommittees with 25 members each.

In September 2020, the Task Force published its blueprint[2]: "Behavioral Health in Colorado: Putting People First. A Blueprint for Reform" ("the Blueprint"). The Blueprint identifies a path to providing a comprehensive, equitable, effective continuum of behavioral health services that meets the needs of all Coloradans in the right place at the right time to achieve whole person health and wellbeing. The Blueprint identifies six pillars of a strong behavioral health system: access; affordability; workforce and support; accountability; consumer and local guidance; and, whole person care.

To instigate reform, the Task Force is focusing on these key pillars that represent the fundamentals for a strong behavioral health system. The Task Force prioritized 19 actional recommendations across the six pillars. They are:

Access

1. Develop a single point of entry (with "no wrong door") to help individuals navigate the full continuum of behavioral health services.
2. Expand and enhance the crisis services system including co-responder and explore alternatives to reduce reliance on police for non-threatening behavioral health emergencies.
3. Address the bifurcation between mental health and substance use disorder.
4. Have an adequate, equitable, and complete continuum of behavioral health services, and address current disparities.

Affordability

5. Ensure adequate rates of payments and reimbursement, by all payers and payment sources, for the full continuum of services.
6. Streamline and consolidate funding streams that include maximizing federal dollars.
7. Prioritize the community investment funding available from not-for-profit hospitals to support implementation of the BHTF recommendations.

[1] https://www.colorado.gov/pacific/cdhs/colorado-behavioral-health-task-force
[2] https://drive.google.com/file/d/1lWVIG3IHPM8OUgVFgLuqWFn8waqgUseZ/view

Workforce and Support

8. Expand the capacity for a culturally competent licensed and unlicensed workforce.
9. Support and fund the use of non-traditional workforce, especially peers.
10. Reduce the administrative burden for providers.

Accountability

11. Research, develop, and publish population-specific standards of care and reasonable outcomes to measure quality.
12. Address high suicide incidences and disparities in care access, delivery, and outcomes for specific and marginalized populations.
13. Designate a single fiscal management system to be used to account for all publicly funded services to improve allocations.

Consumer and Local Guidance

14. Collaboratively identify local, regional and systemic service gaps and solutions.
15. Form and engage advisory groups to continuously provide input and guidance on system improvements.
16. Identify and provide sustainable, flexible funding streams for local communities to prioritize primary prevention and invest in solutions to mental wellness disparities.

Whole Person Care

17. Offer and expand care coordination services to address social determinants of health.
18. Expand high-intensity case management with treatment for individuals being discharged from a psychiatric hospital.
19. Create planned and facilitated education opportunities on behavioral health and cognitive disabilities for law enforcement, first responders, judges and court officials, and other partners.

Problem or Opportunity:

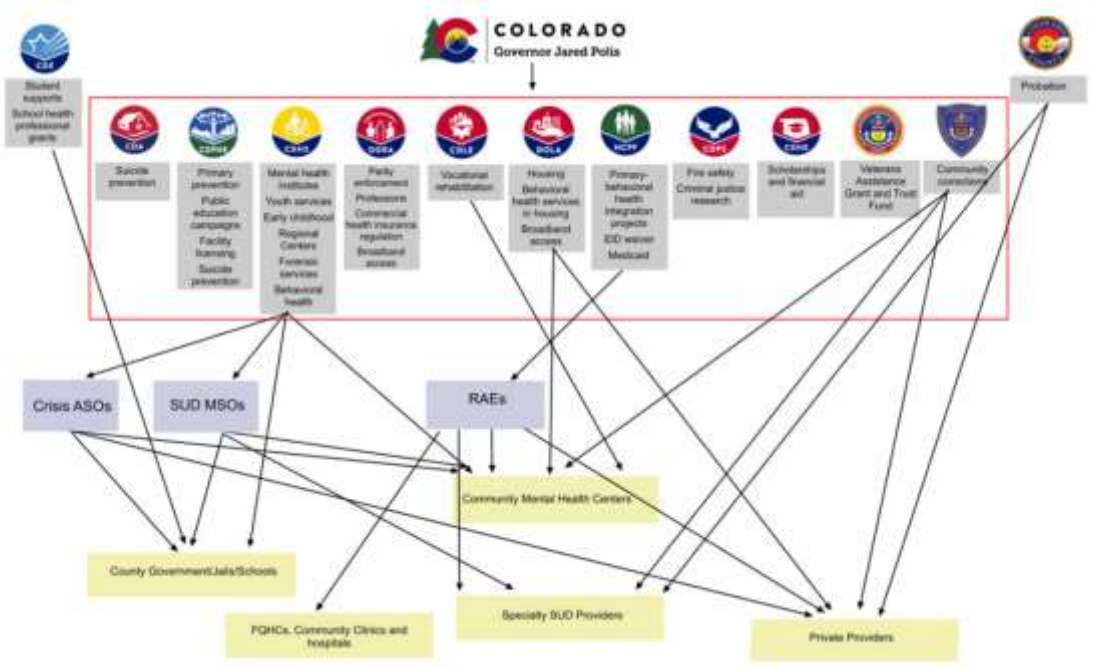
Colorado is well regarded as a healthy state with comparatively low obesity rates and a reputation for active residents. While these perceptions hold true, Colorado is not without its challenges, some less visible than others. When it comes to behavioral health and our State's ability to serve the needs of its residents, there is room for improvement. Colorado has historically struggled to consistently and equitably meet the overarching community needs for mental health and substance use services. Colorado's behavioral health system adequately serves some, but far from all of its constituents. The State ranks in the bottom half of states (29th) for prevalence of mental illness and access to care for adults and children.[3] In 2018, Colorado had the 7th highest suicide rate in

[3] Overall Ranking. Mental Health America. (n.d.) Accessed August 28, 2020. https://www.mhanational.org/issues/ranking-states

the nation[4] and suicide is the second leading cause of death among Colorado youth. With approximately one million residents in need of behavioral health services,[5] a comprehensive system that puts people first is critical.

Currently, the State's Behavioral Health System is fragmented. It is confusing for consumers, administratively burdensome for behavioral health providers, and exasperating to Coloradans who are trying to support their loved ones. The Behavioral Health Task Force heard from hundreds of Coloradans who have shared their personal experiences, or those of a loved one, about the challenges they faced in our current behavioral health system. Common themes emerged, and highlighted the need to boldly change behavioral health delivery in Colorado to put people first.

In early 2020, a financial analysis was done that found that Colorado has $1.4 billion in behavioral health funding, spread across at least 10 different agencies and over 75 programs. Over $825 million of those dollars are non-Medicaid community behavioral health funds. Over half of the programs are less than $10 million, meaning that the State dedicates significant administrative overhead to administer relatively small programs. Coloradans will benefit when public monies are used more efficiently, eventually leading to more funding for direct service delivery. The current system looks like this:



[4] National Center for Health Statistics. Stats of the State - Suicide Mortality. Centers for Disease Control and Prevention. Updated April 29, 2020. Accessed May 22, 2020. https://www.cdc.gov/nchs/pressroom/sosmap/suicide-mortality/suicide.htm

[5] Reinert M, Nguyen T, Fritze D. The State of Mental Health in America 2020. Mental Health America. 2019. Accessed August 28, 2020: 28. https://mhanational.org/sites/default/files/State%20of%20Mental%20Health%20in%20America%20-%202020.pdf

To combat this fragmentation, this request addresses the following recommendations:

- Develop a single point of entry (with "no wrong door") to help individuals navigate the full continuum of behavioral health services.
- Reduce the administrative burden for providers.
- Designate a single fiscal management system to be used to account for all publicly funded services to improve allocations.

As identified in the Behavioral Health Task Force Subcommittee Report,[6] a new governance structure is needed. The new structure should streamline an individual's access to services regardless of payer (i.e., reduces the 60+ "wrong doors"), ensures timely access, offers centralized system navigation services and establishes a core set of essential services that are readily available across the State. Numerous subcommittee recommendations addressed the difficulty for providers and individuals to determine program eligibility, coordinate between programs, and see and review data that would provide information about the effectiveness of the program.

Currently, there is no single eligibility or claims framework for the State's behavioral health programs. Over 75 programs, scattered across various state agencies, use different methodologies and procedures for determining eligibility and paying for services. As a result, the system is fragmented. This creates a myriad of complex problems which not only prevent individuals from receiving comprehensive care, but also drive excess administrative costs. As examples: individuals must be determined eligible for each program individually; there is no reporting to providers or care coordinators about the services that have been delivered; and, there is no management between systems to ensure that services have not been duplicated. This fragmentation leads to preventable problems that drive State cost. For example, the lack of data reporting, particularly for marginalized populations, hides behavioral health disparities and level of need.

Coloradans are not receiving quality care across all services because there is not a standardized process to publicly share data for the purpose of transparency. Providers are spending an inordinate amount of time on data submissions, reports, and other paperwork because the different funding sources do not share a standardized platform for data collection. Colorado must address the disparities in care access, delivery, and outcomes for marginalized populations.

A systemic approach to collecting, reporting, and analyzing data and demographics can help identify inequities that need to be addressed. A single fiscal-management system can be used to account for all publicly funded services. Without additional investment in this area, the State would be unable to consolidate the various disparate eligibility and claims processes, which would

[6] https://drive.google.com/file/d/16SGHGkjtC7ZfsCG_aOQXFJPrdLNnOdNm/view

inhibit the State from achieving the vision of the Task Force and meetings the behavioral health needs of its citizens.

Proposed Solution:

The Department requests $7,466,780 total funds, including $7,488,276 General Fund and a reduction of $21,496 federal funds in FY 2021-22 and $2,052,479 total funds, including $2,073,975 General Fund and a reduction of $21,496 federal funds in FY 2022-23, in order to establish an eligibility system, a claims processing and submission system, and a data reporting system to serve all of the State's behavioral health programs. This request includes funding for contractor work and temporary staff to manage design, development, and implementation. The Department would leverage the State's existing Medicaid infrastructure to create these systems; rather than building new systems from the ground up, the Department would integrate the State's behavioral health programs into the existing infrastructure, which would reduce administrative cost and provide significant efficiencies over both the current model and any alternative which would build new systems that did not integrate with Medicaid.

Further, the Department requests that appropriations made for this request be given rollforward authority in the Long Bill through FY 2022-23, to allow for the funding to remain available through the completion of the project. This is preferable to individual appropriations in each year because system development and implementation timelines will not perfectly be known in advance. Segmenting appropriations across fiscal years may cause unnecessary delayed in project implementation.

Proposed Changes to Eligibility, Claims, and Data Systems

This proposed solution is composed of three connected efforts: eligibility processing; claims and encounter processing; and, data reporting.

Eligibility Processing

The Department requests funding to integrate eligibility processing for the State's behavioral health programs into the Colorado Benefits Management System (CBMS) and the Colorado Program and Eligibility Application Kit (PEAK). With the requested funding, the Department would modify its systems to allow for Coloradans to have eligibility determined for all programs simultaneously. This would replace the current framework where program eligibility is determined on a case-by-case basis for each individual program. In lieu of sending individuals to their county offices, providers would be given the ability to enter application information to help streamline and expedite the process.

Claims and Encounter Processing

The Department requests funding to integrate claims processing for the State's behavioral health programs with the current Medicaid Management Information System (MMIS, also known as "interChange"). With the requested funding, the Department would develop a framework for

providers to submit claims and encounter information through a standard format, consistent with existing industry standards, that would enable claim adjudication, payment, and data reporting. This request would not change how providers are paid; in many cases, providers are not currently reimbursed a per visit or per encounter rate, and this system would not mandate programs moving to a fee-for-service environment. Rather, the data submitted would be used by program managers to validate that services were provided to eligible individuals and show the distribution of services across various providers; this would inform how existing funding is distributed under current methodologies. This would also help maintain expenditures within existing appropriations, as most of the State's behavioral health programs have a fixed annual appropriation that cannot be exceeded.

Data Reporting

The Department requests funding to integrate the eligibility and claims information into its' current data reporting system, known as the Business Intelligence and Data Management (BIDM) system. The BIDM is a data warehouse that collects, consolidates, and organized data from multiple sources, and fully integrates with eligibility and claims data for reporting, analytics, and decision support. BIDM is able to provide reports to program administrators and providers about the amount, frequency, and scope of services being provided to members. With the requested funding, the Department would update the BIDM to accept the new data from the State's behavioral health programs, develop reports that can be distributed to providers, the public, and the General Assembly, and ultimately inform outcome evaluation and decision making about the future of the programs.

Expected Expenditures

The Department would use the requested funding primarily to increase existing contracts for CBMS, PEAK, MMIS, and BIDM to allow for system design, development, and implementation. Because the vendors for these systems are already in place, the Department would be able to begin work quickly, as opposed to issuing new procurements for new systems. Further, the Department would require 23 temporary staff to serve as project managers and design experts to lead the system change development and implementation. The Department cannot reassign existing staff to this project without incurring a significant cost. Costs for existing system development staff at the Department are paid largely by the federal government through grants for the Medicaid program, frequently at a 75% or 90% federal matching rate. As this project creates systems for a non-Medicaid program, federal funding is not available for support. Therefore, any time that a state employee works on this development, the State must backfill those costs with General Fund (or another cash fund source). In addition, reallocating staff to this project would delay other needed improvements to the Department's systems.

Evidence Continuum

The Department believes that the work of the Task Force is on Step 3 of the Evidence Continuum, "Assess Outcomes." The Task Force, through its large membership and multiple subcommittees,

has provided detailed evidence demonstrating the shortcomings and lack of effectiveness of the current system, including the poor behavioral health outcomes on the current population. The proposal to create a shared eligibility, claims, and data reporting framework is theory-informed in that there is a multitude of evidence demonstrating the inefficiencies of the current system. With a more comprehensive framework, the Department and the Task Force would able to build comprehensive data on which outcomes could be measured and compared, which would then assist in attaining evidence and demonstrating causal evidence for these programs.

Anticipated Outcomes:

This request aligns to Governor's Health Cabinet Wildly Important Goal to "Implement Behavioral Health Task Force Recommendations.[7]" By creating a shared eligibility, claims processing, and data reporting framework, the Department will enable additional work to be completed by the Task Force to improve the state's behavioral health system. Building these shared systems is a necessary precursor to many of the Task Force's recommendations, particularly those recommendations where data is needed to find and address health disparities and inequities. Even in isolation, these systems would enable significant improvements and efficiencies in the behavioral health system. Providers would reduce the amount of time they spend in eligibility determination and billing, which reduces their overhead costs. Program managers, including State staff, may be able to be repurposed to more beneficial activities and program management, instead of manual processing of eligibility, invoices, and claims. In addition, the state would be able to report data and outcomes out across the entirety of the behavioral health system, informing policy makers and stakeholders about where gaps and disparities exist, which will enable better and more targeted policy interventions designed to improve the lives of Coloradans.

The Department anticipates that financial efficiencies gained by implementing these shared systems will offset the cost of maintenance and ongoing operations in the future, to at least some degree. At this time, these future costs and savings are unclear; the Department would use the regular budget process in a future budget cycle to request necessary funding adjustments when more information is available.

Assumptions and Calculations:

The Department estimates that system development and implementation would take between 18 and 24 months, depending on how quickly contract amendments can be executed and staff can be hired. The implementation timeline depends on the development of detailed system requirements, coding, user acceptance testing, provider outreach and testing, and error checking to ensure that the system changes do not adversely impact other programs. Because of the uncertainty in the timeline, the Department is requesting rollforward authority on all appropriations through FY 2022-23.

[7] https://www.colorado.gov/pacific/sites/default/files/HCPF%202020-2021%20Performance%20Plan.pdf

The Department assumes that it would begin hiring processes immediately after funding was approved by the Joint Budget Committee in order to have staff available on July 1, 2021 to begin implementation. The temporary staff hired for this project would be required to sign to contracts that limits their term to a maximum two years; these staff would not receive retention rights under the State Personnel System. The Department estimates that it would require the equivalent of 23 full time staff to implement this project, although most positions would not be employed for the full two-year period. Instead, the Department would bring on staff as needed at the right time in the project; for example, the Department may employ a project manager for the duration, while business analysts developing system requirements may only be needed at the beginning, and user acceptance testers may only be needed at the end. The Department's request allows for flexibility to bring on appropriate expertise to support the project on an as-needed basis. As the personnel in the project would change over time, the Department estimated all the personnel costs using the Administrator IV classification, with benefits; the Department would manage expenditures within the requested amounts to ensure the cost does not exceed available appropriations. The Department also assumes that current staff would have to provide some level of support to the temporary staff throughout the project. The Department estimates that seven management level staff with an average salary of about $122,000 would spend about 5% of their time providing support. Because staff would be working on non-Medicaid programs, that time would not be eligible for federal financial participation (FFP).

The Department's detailed estimates for system costs and staff are contained in Appendix A.

R-23 Behavioral Health Claims and Eligibility Processing
Appendix A: Assumptions and Calculations

Table 1.1
Summary by Line Item
FY 2021-22

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	(1) Executive Director's Office; (A) General Administration; Personal Services	$1,585,701	0.0	$1,607,197	$0	$0	($21,496)	0.00%	Table 3; Sum of Salary, PERA, and Medicare
B	(1) Executive Director's Office; (A) General Administration; Health, Life, and Dental	$230,966	0.0	$230,966	$0	$0	$0	0.00%	Table 3, Health-Life-Dental
C	(1) Executive Director's Office; (A) General Administration; Short-term Disability	$2,399	0.0	$2,399	$0	$0	$0	0.00%	Table 3, STD
D	(1) Executive Director's Office; (A) General Administration; S.B. 04-257 Amortization Equalization Disbursement	$70,570	0.0	$70,570	$0	$0	$0	0.00%	Table 3, AED
E	(1) Executive Director's Office; (A) General Administration; S.B. 06-235 Supplemental Amortization Equalization	$70,570	0.0	$70,570	$0	$0	$0	0.00%	Table 3, SAED
F	(1) Executive Director's Office; (A) General Administration; Operating Expenses	$130,019	0.0	$130,019	$0	$0	$0	0.00%	Sum of Table 3, Operating Expenses
G	(1) Executive Director's Office; (C) Information Technology Contracts and Projects; MMIS Maintenance and Projects	$3,153,555	0.0	$3,153,555	$0	$0	$0	0.00%	Table 2.1, Row G
H	(1) Executive Director's Office; (C) Information Technology Contracts and Projects; Colorado Benefits Management Systems, Operating and Contract Expenses	$2,223,000	0.0	$2,223,000	$0	$0	$0	0.00%	Table 2.1, Row H
I	**Total Request**	**$7,466,780**	**0.0**	**$7,488,276**	**$0**	**$0**	**($21,496)**	**NA**	**Sum of Rows A through H**

Note: The Department is requesting rollforward authority for all appropriations in FY 2021-22.

Table 1.2
Summary by Line Item
FY 2022-23

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	(1) Executive Director's Office; (A) General Administration; Personal Services	$1,650,278	0.0	$1,671,774	$0	$0	($21,496)	0.00%	Table 3; Sum of Salary, PERA, and Medicare
B	(1) Executive Director's Office; (A) General Administration; Health, Life, and Dental	$230,966	0.0	$230,966	$0	$0	$0	0.00%	Table 3, Health-Life-Dental
C	(1) Executive Director's Office; (A) General Administration; Short-term Disability	$2,497	0.0	$2,497	$0	$0	$0	0.00%	Table 3, STD
D	(1) Executive Director's Office; (A) General Administration; S.B. 04-257 Amortization Equalization Disbursement	$73,444	0.0	$73,444	$0	$0	$0	0.00%	Table 3, AED
E	(1) Executive Director's Office; (A) General Administration; S.B. 06-235 Supplemental Amortization Equalization	$73,444	0.0	$73,444	$0	$0	$0	0.00%	Table 3, SAED
F	(1) Executive Director's Office; (A) General Administration; Operating Expenses	$21,850	0.0	$21,850	$0	$0	$0	0.00%	Sum of Table 3, Operating Expenses
G	(1) Executive Director's Office; (C) Information Technology Contracts and Projects; MMIS Maintenance and Projects	$0	0.0	$0	$0	$0	$0	0.00%	Table 2.2, Row G
H	(1) Executive Director's Office; (C) Information Technology Contracts and Projects; Colorado Benefits Management Systems, Operating and Contract Expenses	$0	0.0	$0	$0	$0	$0	0.00%	Table 2.2, Row H
I	**Total Request**	**$2,052,479**	**0.0**	**$2,073,975**	**$0**	**$0**	**($21,496)**	**NA**	**Sum of Rows A through H**

Table 2.1
Summary by Initiative
FY 2021-22

Row	Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	**Temporary Staff Costs**	**$2,090,225**	**0.0**	**$2,090,225**	**$0**	**$0**	**$0**	**0.00%**	**Sum of Rows B through D**
B	*Salary, PERA, Medicare*	*$1,585,701*	*0.0*	*$1,585,701*	*$0*	*$0*	*$0*	*0.00%*	*Table 3*
C	*AED, SAED, STD and HLD*	*$374,505*	*0.0*	*$374,505*	*$0*	*$0*	*$0*	*0.00%*	*Table 3*
D	*Operating Expenses*	*$130,019*	*0.0*	*$130,019*	*$0*	*$0*	*$0*	*0.00%*	*Table 3*
E	Funding Adjustment for Existing Staff	$0	0.0	$21,496	$0	$0	($21,496)	N/A	Table 6, Row C
F	**System Change Costs**	***$5,376,555***	***0.0***	***$5,376,555***	***$0***	***$0***	***$0***	***0.00%***	**Sum of Rows G through H**
G	*MMIS*	*$3,153,555*	*0.0*	*$3,153,555*	*$0*	*$0*	*$0*	*0.00%*	*Table 4, Row M*
H	*CBMS / PEAK*	*$2,223,000*	*0.0*	*$2,223,000*	*$0*	*$0*	*$0*	*0.00%*	*Table 5, Row G*
I	**Total Costs**	**$7,466,780**	**0.0**	**$7,488,276**	**$0**	**$0**	**($21,496)**		**Row A + Row E + Row F**

Note: The Department is requesting rollforward authority for all appropriations in FY 2021-22.

Table 2.2
Summary by Initiative
FY 2022-23

Row	Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	**Temporary Staff Costs**	**$2,052,479**	**0.0**	**$2,052,479**	**$0**	**$0**	**$0**	**0.00%**	**Sum of Rows B through D**
B	*Salary, PERA, Medicare*	*$1,650,278*	*0.0*	*$1,650,278*	*$0*	*$0*	*$0*	*0.00%*	*Table 3 + Table 6, Row C*
C	*AED, SAED, STD and HLD*	*$380,351*	*0.0*	*$380,351*	*$0*	*$0*	*$0*	*0.00%*	*Table 3*
D	*Operating Expenses*	*$21,850*	*0.0*	*$21,850*	*$0*	*$0*	*$0*	*0.00%*	*Table 3*
E	Funding Adjustment for Existing Staff	$0	0.0	$21,496	$0	$0	($21,496)	N/A	Table 6, Row C
F	**System Change Costs**	***$0***	***0.0***	***$0***	***$0***	***$0***	***$0***	***0.00%***	**Sum of Rows G through H**
G	*MMIS*	*$0*	*0.0*	*$0*	*$0*	*$0*	*$0*	*0.00%*	*No System Change Costs in FY 2022-23*
H	*CBMS / PEAK*	*$0*	*0.0*	*$0*	*$0*	*$0*	*$0*	*0.00%*	*No System Change Costs in FY 2022-23*
H	**Total Costs**	**$2,052,479**	**0.0**	**$2,073,975**	**$0**	**$0**	**($21,496)**		**Row A + Row E + Row F**

R-23 Behavioral Health Claims and Eligibility Processing
Appendix A: Assumptions and Calculations

Table 3 - FTE Calculation Assumptions:

Operating Expenses -- Base operating expenses are included per FTE for $500 per year. In addition, for regular FTE, annual telephone costs assume base charges of $450 per year.

Standard Capital Purchases -- Each additional employee necessitates the purchase of a Personal Computer ($900), Office Suite Software ($330), and office furniture ($3,473).

General Fund FTE -- Beginning July 1, 2019, new employees will be paid on a bi-weekly pay schedule; therefore **new full-time General Fund positions are reflected in Year 1 as 0.9615 FTE** to account for the pay-date shift (25/26 weeks of pay). **This applies to personal services costs only; operating costs are not subject to the pay-date shift.**

Expenditure Detail		FY 2021-22		FY 2022-23	
Personal Services:					
Classification Title	Biweekly Salary	FTE		FTE	
ADMINISTRATOR IV	$2,456	22.1	$1,411,394	23.0	$1,468,872
PERA			$153,842		$160,107
AED			$70,570		$73,444
SAED			$70,570		$73,444
Medicare			$20,465		$21,299
STD			$2,399		$2,497
Health-Life-Dental			$230,966		$230,966
Subtotal		**22.1**	**$1,960,206**	**23.0**	**$2,030,629**
Subtotal Personal Services		22.1	**$1,960,206**	23.0	**$2,030,629**
Operating Expenses:					
		FTE		FTE	
Regular FTE Operating	$500	23.0	$11,500	23.0	$11,500
Telephone Expenses	$450	23.0	$10,350	23.0	$10,350
PC, One-Time	$1,230	23.0	$28,290	-	
Office Furniture, One-Time	$3,473	23.0	$79,879	-	
Subtotal Operating Expenses			**$130,019**		**$21,850**
TOTAL REQUEST		22.1	**$2,090,225**	23.0	**$2,052,479**

Table 4
FY 2021-22 MMIS Changes

Row	Item	Amount	Notes/Calculations
System Design and Development - MMIS			
A	Estimated hours of work	15,600	10 FTE for 9 months of work
B	Hourly rate	$116	Vendor rate for FY 2021-22
C	**Total Cost**	**$1,809,600**	**Row A * Row B**
System Integration Testing - MMIS			
D	Estimated hours of work	5,200	10 FTE for 3 months of work
E	Hourly rate	$119	Vendor rate for FY 2022-23
F	**Total Cost**	**$616,356**	**Row D * Row E**
Call Center Support - MMIS			
G	Estimated hours of work	4,160	Estimate from vendor
H	Hourly rate	$31	Vendor rate for FY 2022-23
I	**Total Cost**	**$127,587**	**Row G * Row H**
BIDM Enhancements			
J	Estimated hours of work	3,600	Estimate from vendor
K	Hourly rate	$167	Vendor rate for FY 2021-22
L	**Total Cost**	**$600,012**	**Row J * Row K**
M	**Grand Total**	**$3,153,555**	**Sum of Rows C and F and I and L**

Table 5 FY 2021-22 CBMS / PEAK Changes			
Row	**Item**	**Amount**	**Notes/Calculations**
System Design and Development			
A	Estimated hours of work	13,000	Estimate from current vendor
B	Hourly rate	$138	Vendor rate for FY 2021-22
C	**Total Cost**	**$1,794,000**	**Row A * Row B**
System Integration Testing			
D	Estimated hours of work	3,000	Estimate from current vendor
E	Hourly rate	$143	Vendor rate for FY 2022-23
F	**Total Cost**	**$429,000**	**Row D * Row E**
G	**Grand Total**	**$2,223,000**	**Row C + Row F**

Table 6:
HCPF FTE Cost Allocation

Row	Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	Current Salaries - Full FFP	$42,993	0.0	$21,497	$0	$0	$21,496	50.00%	Assumes full Medicaid match
B	Current Salaries - GF-Only	$42,993	0.0	$42,993	$0	$0	$0	0.00%	Assumes 5% of time will be GF-only
C	**Total Costs**	**$0**	**0.0**	**$21,496**	**$0**	**$0**	**($21,496)**	**N/A**	**Row B - Row A**

EXTRACT from JBC Staff Figure Setting Recommendations

➔ R23 BEHAVIORAL HEALTH ELIGIBILITY AND CLAIMS SYSTEM CONSOLIDATION

REQUEST

The Department requests a net increase of $7.5 million total funds, including $7.5 million General Fund, to integrate eligibility determinations, claims processing, and data reporting for various behavioral health programs statewide. The proposal attempts to leverage existing systems used by the Department in order to serve programs operated by other departments, and so the Department of Health Care Policy and Financing is taking the lead on the request. The Governor's budget navigator identifies this as a strategic investment and stimulus in information technology to strengthen the state response to behavioral health needs.

Most of the costs are General Fund, because they are related to integrating non-Medicaid programs with Medicaid systems. There is a small decrease in federal funds due to the reallocation of existing staff who receive a federal match to this project that does not receive a federal match.

R23 BEHAVIORAL HEALTH CLAIMS AND ELIGIBILITY PROCESSING				
	UNITS		RATE	TOTAL FUNDS
Temporary staff (including benefits)	23	FTE	$90,879.35	$2,090,225
MMIS				
System design and development	15,600	hrs	$116.00	1,809,600
Testing	5,200	hrs	$118.53	616,356
Call center support	4,160	hrs	$30.67	127,587
BIDM enhancements	3,600	hrs	$166.67	600,012
CBMS				
System design and development	13,000	hrs	$138.00	1,794,000
Testing	3,000	hrs	$143.00	429,000
TOTAL				$7,466,780

The Department requests rollforward authority for the development funds to FY 22-23. The Department expects the project to take 18-24 months, but the exact timing of when payments to contractors will occur is not known. The Department requested funding for the temporary staff through FY 22-23. The Department says it would not necessarily hire 23 people continuously for two years, but rather the Department would staff up with the correct expertise as needed. The 23 FTE is an average of the estimated staff costs per year over the two years. The request does not include a budget for ongoing maintenance and operations, but it does include statements that the financial efficiencies gained by implementing the shared systems are anticipated to offset the costs of maintenance and ongoing operations, and that those costs would be addressed in a future budget submission.

There is a related capital construction request from the Department of Human Services. The Department says the requests can move independently, but the Department of Human Services request includes at least $2.4 million capital construction funds that would be necessary for this request to reach full effectiveness.

RECOMMENDATION

Staff does not recommend the request. This was a difficult request for the JBC staff to analyze and prioritize. On the one hand, the JBC staff has a hard time justifying this request before restoring benefit reductions made in FY 20-21 that the Department didn't even request, such as copays, the adult dental cap, and the senior dental program. The cost of restoring the copays is now estimated at

$954,930 General Fund, although the estimated cost would have been roughly double in November when the Governor submitted the original budget request. There is no General Fund cost to remove the adult dental cap. Restoring the senior dental program costs $1.0 million General Fund. All three benefit reductions combined cost less General Fund to restore than this request. On the other hand, the costs for restoring those benefit reductions are on-going and this request is one-time. Requests for one-time funding are exactly the thing that is most helpful in a year when there might be one-time money available, but there is considerable uncertainty and concern about future revenues.

Ultimately, the JBC staff decided not to recommend the request because the benefits appear primarily administrative. The Department makes a compelling case that the administration of behavioral health programs is fragmented, uncoordinated, and inefficient. This request would likely improve the lives of program administrators and providers, particularly around billing and data collection, and provide better data for analysis by policy makers. Whether that would translate to better services for the clients is an open question.

In a year when there is money this is probably a reasonable request to improve the effectiveness of government. However, the JBC staff is not certain the state budget is far enough out of the woods to justify this request, especially before restoring some of the benefit reductions implemented in FY 20-21.

The JBC staff found the Department's assertions that the request will improve the steering of clients to the right services unconvincing. Staff doubts the current referral process is as broken as the Department describes, as staff assumes most professionals in the field are familiar with the major state programs. Nor does staff believe CBMS is a panacea for getting people to the right services as there are plenty of anecdotal stories of CBMS coming up short for people with special needs, such as disabilities. Staff suspects in most cases it comes down to knowledgeable staff and advocacy, either from the client or allies or both, to get people in the right programs for their needs.

The ambiguous scope of the project is also concerning to the JBC staff. The Department submitted the request at a very early stage in the planning process. This raises concerns for the JBC staff about whether the Department has properly sized the project or fully understands the amount of work necessary. For work like this it is often impossible to know the full measure until you begin, but the JBC staff found the Department's description of the request, even after follow up questions, unusually vague.

BACKGROUND AND ANALYSIS

The request is one piece of a broader set of initiatives recommended by the Behavioral Health Task Force.[4] The Department argues the request would help get clients to the right services, reduce the administrative burden on both program staff and providers, and improve program oversight and coordination. Also, the Department considers this a necessary precursor to an effective Behavioral Health Administration, which the executive branch proposes creating in a separate piece of legislation that is not part of the budget process.

[4] For a summary of the Behavioral Task Force's Phase One findings with budgetary impacts, see the November 20, 2020, briefing for the Department of Human Services:
http://leg.colorado.gov/sites/default/files/fy2021-22_humbrf3.pdf
For the full report of the Behavioral Health Task Force:
https://drive.google.com/file/d/1HWh6KxA94HH7FOeCWG7zazfuiGNY36vO/view

In support of R23 the Department cited analysis by the Colorado Health Institute that identified over 75 different behavioral health programs across 10 agencies. More than half of those programs have budgets of less than $10 million. For most of these programs eligibility, funding distributions, and performance metrics are tracked by email and spreadsheets.

ELIGIBILITY DETERMINATIONS

Eligibility for each program is currently determined individually, often by the providers using criteria from the state. This makes it likely that clients may get funneled to services that are less than ideal for their circumstances or may not find all the services for which they are eligible and would benefit. It also results in duplication of effort across programs and an administrative burden on both providers and program staff. The proposed solution is to consolidate eligibility determinations into the Colorado Benefits Management System (CBMS).

There is significant variation in the eligibility criteria for the different programs from relatively simple criteria based on diagnosis or status (e.g. in school, homeless, or involved in the criminal justice system) to relatively complicated criteria that may consider things like income, assets, or household size. Furthermore, there are inconsistent definitions of how things like income or family size are calculated across programs, for example does alimony get counted as income or is a mother-in-law living in the home part of the family.

The JBC staff asked the Department if consolidating eligibility in CBMS may actually increase, rather than decrease, the administrative burden for some applicants. For example, would a client have to provide detailed information about income, defined three different ways for different programs, where previously they merely had to meet some status or diagnosis criteria? When the state first implemented the health insurance exchange (Connect for Health Colorado) there were significant consumer complaints about the administrative burden on applicants of proving they are not eligible for Medicaid in order to qualify for federal tax credits available through the exchange. The JBC staff wonders if a consolidation of behavioral health eligibility determinations will result in similar concerns about extraneous and burdensome questions.

The Department replied that the eligibility system is dynamic so the number of questions applicants need to answer varies depending on their situation. Early screening questions will narrow down the available behavioral health benefits to minimize the number of irrelevant questions clients need to answer. Also, the Department says the focus of this request is on health care services, rather than on the primary prevention or early intervention programs that tend to have the simpler status-based eligibility criteria (see the discussion of the scope of the project below). Finally, the Department argues the time needed to answer the questions is worth the applicant's investment, because it helps identify what benefits they qualify for, including complimentary benefits that address social determinates of health such as food assistance, housing, etc.

The Department says it will involve clients in the design and testing of the eligibility determination integration and notes that the Department has experience engaging clients, advocates, and providers and incorporating their feedback in the final product. The Department says the CBMS vendor and the Office of Information Technology are incorporating the human centered design approach in the software development. Also, the Department says it will use the Member Experience Advisory Councils (MEAC) and the Member Contact Center (MCC) to obtain feedback on the project.

FUNDS DISTRIBUTION AND DATA REPORTING

The Department argues that the fragmented way money is distributed to providers and data is collected from providers, in small doses from lots of unique programs, is administratively inefficient. Just as significant, the fragmentation makes consolidating and analyzing information across programs challenging, creating problems when trying to do things like identify service gaps, reduce duplication of services, address disparities in care, or pay for performance.

The request would modify the Department's Medicaid Management Information System (MMIS), and the Business Intelligence and Data Management System (BIDM) that pulls management data out of the MMIS, to handle funds distribution and data reporting for the non-Medicaid behavioral health programs. Most of the smaller programs disburse funds through contracts or grants, rather than the typical Medicaid fee-for-service payment, but the MMIS can handle these types of payments. The proposal would not change the funding methodologies, rates, or allocations by provider for the various behavioral health programs. It would change where providers submit requests for payment and data to support eligibility for those payments.

The Department believes centralizing funds distribution and data reporting will reduce the administrative burden for both providers and program staff. Many providers participate in more than one publicly-financed behavioral health program and must navigate the unique characteristics of each to get the right information submitted to the right agency in the right format to get paid. Frequently the same information, or substantially similar information, is requested from multiple programs. The Department believes a centralized clearing house will be easier to navigate. Most of the behavioral health programs do not currently have mature and full-featured billing systems that can handle on-line data submissions, provider communication, data queries, etc. The lack of automation results in a lot of high touch, hands-on work by program staff.

While the Department's assertions of reduced administrative burden and better management information sound plausible, it is important to note there will be a potentially painful learning curve for providers and program staff. The Department of Human Services identified 649 providers. As of November 30, the Department of Health Care Policy and Financing had reviewed 110 of them and found 45 currently enrolled in Medicaid, suggesting a large portion of the behavioral health providers are not already familiar with the MMIS and will need to learn new procedures.

The Department notes providers were well represented on the Behavioral Health Task Force and there was unanimous support for recommendation #13 to designate a single fiscal management system to be used to account for all publicly funded services to improve allocations. The Department says select providers will participate in end-to-end testing.

SCOPE OF THE PROJECT

This project would address eligibility determinations, payment processing, and payment data. A related capital construction information technology request from the Department of Human Services would address, among other things, improved collection of clinical data from the behavioral health providers. The Department says it can do the modifications to the CBMS, MMIS, and BIDM independent of the capital construction information technology request from the Department of Human Services, but it would not achieve the full targeted reduction in the administrative burden for providers and program staff, because providers would still need to report clinical data and billing data separately to different state agencies, and because program staff would need to manually match the clinical and billing data. The relevant portion of the Department of Human Services' request includes at least the

$2.4 million for consolidated behavioral health data collection. It is unclear to the JBC staff whether the departments consider other portions of the Department of Human Services request as connected, such as the $2.4 million portion for Health Information Exchange investment or the $300,000 for capacity tracking and bed management.

When asked for a list of the specific programs where eligibility and funds distribution would be consolidated by the request, the Department responded:

> *[The Colorado Department of Human Services] CDHS has issued an Invitation to Negotiate (ITN) to engage a firm to develop and manage a comprehensive change management process. By June 30th, 2021, the firm is expected to have completed the following:*
>
> - *Conduct an analysis of all current behavioral health programs to understand current funding sources, budget, IT, staffing, data/reporting functions and outcomes*
> - *Provide recommendations on what programs and funding should be consolidated under the [Behavioral Health Administration] BHA*
> - *Complete an analysis of Medicaid and private insurance and provide recommendations for alignment with the BHA*
> - *Develop an implementation plan to establish the BHA to include the organizational structure, staffing needs, budget, IT, data integration, reporting systems, and billing systems.*
>
> *The implementation plan is expected to be a phased approach to establish the BHA between July 1, 2021 and June 30, 2022. It will be functional and operating on July 1, 2022.*

This response, combined with the Department's comments that the emphasis is on health care services, rather than on primary prevention or early intervention programs, leads the JBC staff to conclude that the Department does not yet know which of the 75 different identified behavioral health programs will be included in the consolidations of eligibility and claims systems. It may not make sense to consolidate all 75 programs. For example, it might create more problems than benefits to include prevention programs or programs specifically for incarcerated populations.

The amorphous scope of the project also raises questions about whether the Department has appropriately sized and timed the request for funding. The Department anticipates system development and implementation would take 18-24 months. In the table below the temporary staff costs would continue into the second year, but the other costs are estimated totals for the life of the project and the Department requests roll-forward spending authority, since the exact timing of when payments to contractors would be due is unknown. The project is dealing exclusively with programs that are not part of Medicaid, and so the fiscal impact is all General Fund, except for a small $21,496 decrease in Federal Funds and increase in General Fund to reflect the reallocation of existing management staff time to support the project.

R23 BEHAVIORAL HEALTH CLAIMS AND ELIGIBILITY PROCESSING				
	UNITS		RATE	TOTAL FUNDS
Temporary staff (including benefits)	23	FTE	$90,879.35	$2,090,225
MMIS				
System design and development	15,600	hrs	$116.00	1,809,600
Testing	5,200	hrs	$118.53	616,356
Call center support	4,160	hrs	$30.67	127,587
BIDM enhancements	3,600	hrs	$166.67	600,012
CBMS				
System design and development	13,000	hrs	$138.00	1,794,000

R23 BEHAVIORAL HEALTH CLAIMS AND ELIGIBILITY PROCESSING			
	UNITS	RATE	TOTAL FUNDS
Testing	3,000 hrs	$143.00	429,000
TOTAL			$7,466,780

ONGOING MAINTENANCE AND OPERATIONS

The request does not include a budget for ongoing maintenance and operations, but it does include statements that the financial efficiencies gained by implementing the shared systems are anticipated to offset the costs of maintenance and ongoing operations, and that those costs would be addressed in a future budget submission.

All of the financial efficiencies gained will be in other departments, rather than the Department of Health Care Policy and Financing. Those efficiencies will be hard to quantify and could easily be reallocated to other program purposes in the departments that gain them. The JBC staff is skeptical of whether administrative savings will be identified and transferred to the Department for maintenance costs and the JBC staff does not know who would take the lead in birddogging those administrative savings. More likely, any administrative savings will be reallocated in the department that realizes the savings, hopefully to a higher purpose.

43. [Sen. Rankin] How will we know if administrative savings are achieved as a result of the behavioral health eligibility and claims system consolidation?

RESPONSE

Governor Polis's Behavioral Health Task Force identified over 60 funding streams for publicly-funded behavioral health services. Identifying and billing the right funding stream impacts providers' time to bill the correct program and state agency. It also impacts access as individuals struggle to navigate the system or find the appropriate service to meet their unique needs. This decision is supported by a November 2016 Office of State Planning and Budgeting behavioral health funding study.[45] One of the primary recommendations was that the Office of Behavior Health (OBH) should work with the Department to significantly reduce or eliminate the payment of indigent client funding to Community Mental Health Centers (CMHCs) for individuals who are Medicaid eligible and enrolled. By consolidating eligibility and claims payments systems between OBH and the Department, it will help to eliminate these duplicative payments. This same report identified that the requirement that providers use multiple methods for obtaining reimbursement for contracted services creates an administrative burden and requires more resources be directed to these administrative and billing activities when the resource may be better allocated toward providing services to members.

This request would reduce unnecessary burden on providers by consolidating eligibility for programs into a single structure using the Colorado Benefits Management System (CBMS), which will reduce fragmentation for members attempting to find resources for themselves or family members, and streamline billing and reimbursement for providers using the Department's billing system. Decreasing unnecessary administrative burden will not generate savings, but it can enable existing resources within the system to go further, enable state resources to be used more effectively, and potentially enable a greater percent of allocated resources to be spent on care (provider reimbursement) versus administration.

As a result of this effort, OBH and the Department will be able to report on cost, quality and outcomes for the behavioral health system. By leveraging the Department's existing systems and contractors, there are

[45] https://www.colorado.gov/cdhs/BHneeds2020

efficiencies to be gained instead of building, testing and rolling out all new systems to manage these behavioral health services. Consolidating data and enhanced analytics will allow for uniform reporting of the 60 funding streams that are supported with state funding as well. This is a significant step in improving insights to the pending Behavioral Health Administration in their quest to make continual, incremental improvements in Colorado's behavioral health system for years to come.

This consolidation Colorado's behavioral health program administration into the Department's administration structure enables the state to leverage the investments associated with our budgeted $950 million behavioral health spend to the betterment of much smaller programs that would face significant budget and technical challenges to implementing these improvements. This collaborative alignment of program administration also enables downstream benefits, like leveraging the RAE contracts or the same value-based reimbursements to align shared goals and interests across the industry, driving meaningful change to the betterment of prevention, health outcomes, system improvements, and affordability goals.

Maximizing the Department's administrative systems is just one of the many ways the Department is stepping up to be an active leader in the implementation and operations associated with the Behavioral Health Task Force Blueprint recommendations.

44. **[Sen. Rankin] Please respond to the JBC staff suggestion that maybe R23 Behavioral health eligibility and claims system consolidation should be phased or delayed to allow better analysis of the full scope of the work required. This seems like a great application of Agile. Is the Department using that software development methodology for this project? What are the things the Department would do first (the low hanging fruit)? Could the eligibility consolidation and the billing consolidation be separated into two projects? Provide a plan discussing these aspects of the project and process.**

RESPONSE

The implementation of the system changes will be a multiple phase project. The Department uses Agile, Waterfall, and a combination of the two system development lifecycles as needed. The eligibility consolidation and billing consolidation have been separate projects since they are implemented in separate systems. However, the implementation is integrated since the data must be exchanged between the systems. The high-level phases of the project include conducting an analysis of all of the eligibility requirements across programs for eligibility system (CBMS) changes, streamlined access for provider enrollment into the Department's claims processing system (MMIS), and developing and implementing requirements in the MMIS for benefits, providers, and services. For example, implementing the program eligibility within CBMS would be the first system implementation. This would allow providers to help determine if the patient is covered under Medicaid or another of the behavioral health programs. The high level requirements are known; however, a detailed project plan for each system that will be modified has not yet been developed.

45. **[Sen. Rankin] Please describe the involvement of the Joint Technology Committee and the Office of Information Technology with this project and the coordination of this project with the request from the Department of Human Services? What review has occurred to date, what is scheduled, and how has feedback received changed the planning?**

RESPONSE

As this project will leverage existing state systems, there was no capital request for a new system submitted to the Joint Technology Committee (JTC). The Governor's Office of Information Technology (OIT) will be engaged early to identify data conversion strategy and network and architecture strategy and development, as well as security reviews and approvals for data transfer and retention approval. Further, OIT will be involved in all system changes related to the Colorado Benefits Management System. The Department consulted with OIT prior to the request being released, and initiated project discussions with OIT starting in December 2020. The request was developed in collaboration with staff from the Office of Behavioral Health at the Department of Human Services. If requested by the JTC, the Department will provide updates if this budget request is approved.