DEPARTMENT OF HUMAN SERVICES
(Office of Behavioral Health[1])

FY 2014-15 JOINT BUDGET COMMITTEE HEARING AGENDA

Tuesday, December 17, 2013
9:30 am – Noon

9:30-9:40 INTRODUCTIONS AND OPENING COMMENTS

9:40-10:30 QUESTIONS RELATED TO FY 2014-15 BUDGET PRIORITIES

(R10) Outside Medical Expenses

1. What is driving recent increases in outside medical costs? How much of the increase is attributable to an aging population?

   In FY 2012-13, the Department provided care for 14 patients (ages 22-64) who required high cost care, six of which were catastrophic. The medical conditions requiring the most care included respiratory failure, renal failure, brain infection, leukemia, chronic pneumonia and an aortic aneurysm. Of the 14 patients, six were civil commitments, and eight were forensic commitments. As of December 17, 2013, six of the patients have been discharged.

   The recent increases in outside medical costs are not directly attributed to an aging population, but rather due to the increased complexity and severity of the medical conditions of the patients.

   The Department has been challenged with on-going high costs of outside medical care, as they are based on the highly variable, specific medical needs of the patients. In January 2013, the JBC approved the Department's supplemental request to increase CMHIP's personal services line item by $646,400 (this was funded by decreasing appropriations to the CMHIP Pharmaceutical line item). In June 2013, the JBC approved the Department's emergency supplemental request to increase the Institutes' personal services lines by $1,433,900 (CMHIP $617,800 and CMHIFL $816,100). The emergency supplemental was also funded by decreasing appropriations to the Institutes' Pharmaceutical lines, and included an appropriation to repay a Medicaid audit.

   Since outside medical expenses are paid out of the Personal Services allocation, the Department is under stress to hold Institute staff positions vacant in order to remain within the spending authority. This impacts one of the Department's goals, "To promote quality and effective behavioral health practices to strengthen the health, resiliency and recovery of Coloradans."

[1] This section of the budget includes: Community behavioral health administration; Mental health community programs; Substance use treatment and prevention; Co-occurring behavioral health services; and the Mental health institutes.

2. How are other states handling the costs of providing inpatient psychiatric care, including medical care, for an aging population?

Institutions for Mental Disease (IMDs) are inpatient facilities of more than 16 beds whose patient roster is more than 51% people with severe mental illness. Federal Medicaid matching payments are prohibited in IMDs for the patient population between the ages of 22 and 64. IMDs are permitted as a state option, for persons under age 22 or over age 64, to draw federal Medicaid matching funds. Colorado makes use of this state option, whenever possible. Most state hospitals fall under the IMD exclusion.

If a patient is temporarily transferred from an IMD to another medical facility for other in-patient or out-patient medical treatment, under current Federal policy (CMS directives and Federal Case law), the patient is still considered IMD patient. Accordingly, providers who are treating IMD patients on an outpatient basis may not bill Medicaid for these services. Likewise, if an IMD patient is transferred to another hospital for medical treatment, hospital may not bill Medicaid for the services provided.

3. How are the rates paid by the Department to outside medical providers determined?

The Department negotiates rates with medical providers. Reimbursements to hospitals are through contractual agreements and vary based on whether the patient is in observation or inpatient status, emergency room, or Intensive Care Unit (ICU) and vary by hospital. Currently, the Department pays 60%, 70%, 75%, 78% or 85% of the invoiced amount. There are also stop-loss agreements of $35,000 for inpatient care as well as per diem rates for invoices less than $35,000, for those patients in ICU or same day surgery.

When a patient requiring outside medical care (hospitalization), does not have private insurance, Medicare or Medicaid benefits and is solely financially responsible, local hospitals can assist the patient in applying for Colorado Indigent Care Program (CICP) funds, or other hospital based charity programs. Conversely, if a patient has private insurance or other financial resources, the Department will bill the patient as applicable.

In several catastrophic cases, the Department has successfully negotiated additional discounts with the local hospitals; specifically, 33% of billed charges and 50% of billed charges on two separate occasions of services over $300,000 each in FY 2012-13. The Department is currently evaluating all hospital contracts and will actively re-negotiate rates for the next fiscal year.

The outside medical provider (physicians, non-hospital) negotiated reimbursement rate is 160% of the current Medicare rates. Outside medical providers (physicians, non-hospitals) include such providers as orthopedic surgeons, arthritis specialists, oncologist, allergy-immunologist, cardiovascular specialist, OB/GYN, dermatologist, ear nose and throat specialist, endocrinologist, ophthalmologist, gastroenterologist, cardiologist,

hematologist, nephrologist, pulmonologist, neurologist, pain management specialist, pathologist, radiologist, general surgery, diagnostic lab, podiatrist, opticians, infectious diseases, and optometrists.

4. Please discuss the current Long Bill appropriation structure for the Mental Health Institutes, and any impacts this structure has on your ability to manage the two Institutes. Would approval of R10 provide the Institutes with sufficient management flexibility while providing the General Assembly with transparent and readily available information concerning expenditures at each Institute?

Yes, the approval of R10 would provide the Department with sufficient management flexibility while providing the General Assembly with transparent and readily available information concerning expenditures at each Institute. R10 will create a new Contract Medical Expense line, removing the outside medical expenses from the Personal Services allocation, and would improve management flexibility. The Department would clearly identify costs attributed to the outside medical costs at each Institute, and would be able to provide detail regarding transfers made within the authority of the request. The transfer authority would allow the Department to proactively manage fund balances.

However, there are other mechanisms to manage the budget given potentially unknown costs, i.e. outside medical expenses, which may include transfer authority for like line items between the two Mental Health Institutes.

The General Assembly divided the Mental Health Institutes (Fort Logan and Pueblo) appropriation into three distinct line items in the FY 2012-13 Long Bill: Personal Services, Operating Expenses, and Pharmaceuticals. FY 2012-13 included 5% transfer authority between the three lines at each Institute.

The FY 2013-14 Long Bill does not include transfer authority within the Institute lines. In Fiscal Year 2012-13, the Colorado Mental Health Institute at Fort Logan (CMHIFL) experienced significant cost savings in the Pharmaceutical line due to the utilization of generic medications. Concurrently, CMHIFL had several patients who incurred very high cost (catastrophic) medical expenses, resulting in a deficit within the Personal Services line. The Department was unable to transfer the projected excess funds from the Pharmaceutical line to the Personal Services line without submitting an official funding request (supplemental) since it exceeded the 5% transfer limit. This example was also duplicated at the Colorado Mental Health Institute at Pueblo (CMHIP).

The Personal Services line at each hospital pays for employee wages and benefits, in addition to contract services and outside medical services. The volatility of the medical services needed from one month to the next places an extreme hindrance to the hospital's ability to make staffing and other managerial decisions that are funded within Personal Services.

The inability to transfer between lines within each hospital appropriation is also difficult within Operating Expenses. As an example, both Institutes experienced unforeseen expenses, such as broken equipment, required safety modifications and repairs that were

outside of the current allocation. A projected positive balance within other budgetary lines (specifically Pharmaceuticals in FY 2012-13) was unable to be utilized without an official funding request.

(R11) Mental Health Institutes Electronic Health Record System

5. Please provide an overview of this initiative, including the capital and operating requests for FY 2014-15, as well as projected capital and operating expenditures for the subsequent two fiscal years.

The Department accepted the Office of the State Auditor's May 2011 recommendation to pursue the implementation of an electronic health record system and replace the legacy pharmacy system to address problems identified in medication prescribing and monitoring, as well as improve clinical decision-making, reduce medical errors, and increase the efficiency of clinical operations. A fully-integrated electronic health record will automatically tie patient treatments to patient outcomes (e.g., specific medications and therapies can be tied to specific improvements in each patient's condition), and will directly assist clinical efforts to address the patients' mental illnesses and aggression that drive assaults, the need for seclusion and restraint, and length of hospitalization.

The Department, in cooperation with the Governor's Office of Information Technology (OIT), is requesting funds to replace the existing electronic health information and billing systems for its two State-operated, acute-care, inpatient psychiatric hospitals at Fort Logan and Pueblo with a comprehensive and integrated Electronic Health Record (EHR), inclusive of lab, pharmacy, and dietary systems. This project would result in the implementation of a modern, comprehensive, fully-automated EHR that is fully integrated with all necessary clinical, operations and financial modules and systems and is compliant with the meaningful-use requirements established by the U.S. Department of Health and Human Services.

Since the EHR replaces the paper chart, access to medical information must be immediate, continuous and convenient, and therefore includes funds to establish a secure wireless network on both campuses. The request also includes electronic tablets to be used by physicians and other clinicians (to allow real-time order entry, chart updating, and medical information access while conducting groups and interacting with patients), as well as bar code scanning and labeling equipment to interface with the pharmacy and EHR system and eliminate medication transcription errors. Also included are point-of-care documentation for active treatment and implementation of an individualized care plan, and a system for historical records retention.

The request is for a fully-hosted and web-based solution, wherein the EHR and the integrated systems reside securely off-site, without the need for OIT resources or support of application servers.

The current legacy health information systems that the Department uses at the Mental Health Institutes are not designed for the level of interoperability and flexibility required in modern healthcare. Over the past 20-years, the Institutes have incorporated

and operated from numerous system components (NetSmart's Avatar in 2004, Lagniappe's Pharmacy and MultiData's Laboratory in 1994, and Vision's web-based Carex dietary system in 2006). These systems were not designed for the quick and convenient sharing of clinical information that is fundamental to modern health systems, and that is required for clinical decision support. Specifically, the current systems primarily share only patient identifier data from Avatar to the others, so that records in the laboratory, pharmacy, dietary and ancillary systems can be tagged per the correct patient and also produce an accurate bill. By contrast, fully-integrated electronic health records are built to accommodate the association of any data within the whole system, so that automated actions are created easily to support safe medical decision-making.

The projected operating expenditures will fund personal services, operating expenses and contractual services to support the EHR system.

The following table details the overall project request, including both the Capital and Operating budget requests by fiscal year.

Request Year	*Capital Request*		*Operating Request*		*Total Capital & Operating Request*
	$	*CDHS FTE*	*$*	*CDHS FTE*	*$*
FY 2014-15	*$9,849,610*	*0.0*	*$350,396*	*4.5*	***$10,200,006***
FY 2015-16	*$4,863,145*	*0.0*	*$528,164*	*7.7*	***$5,391,309***
FY 2016-17 - Continuous	*$0*	*0.0*	*$2,734,592*	*8.0*	***$2,734,592***
Total	***$14,712,755***		***$3,613,152***		***$18,325,907***

6. Describe the existing information systems that the proposed Electronic Health Record (EHR) System would replace. Further, please explain how this request relates to a request that the Department submitted in FY 2012-13 for an electronic health record and pharmacy system feasibility study (R2).

The current legacy health and billing, laboratory, pharmacy, and dietary systems are used by both mental health institutes (Pueblo and Fort Logan) to track and bill for patient care. The separate systems are described in the following table:

Existing Systems in Use at the Mental Health Institutes

System Name	Function	Description of use
Avatar	Health and Billing	• Patient demographic information (patient name, ID#, housing unit, etc.) • date of admission, transfer, or release • diagnosis and treatment • legal status • seclusion and restraint data • payer information
Multidata Lab	Laboratory	Lab equipment is directly linked to the laboratory system that stores clinical results and transmits billing information to Avatar.
Carex	Dietary	The dietary system is used to plan and provide patient meals and includes dietary restrictions and preferences and food inventories. Meals are included and billed in the room rate through Avatar.
Lagniappe	Pharmacy	Pharmacy orders are manually transcribed and entered in the pharmacy system in order to dispense medications and bill patients for pharmaceuticals. The laboratory and pharmacy systems are built with the outdated text-based, or "green-screen," technologies.
Microsoft Access	Various	The Institutes also use multiple Microsoft Access databases for additional data capture and reporting, including but not limited to: clinic and outside medical referrals, lawsuit compliance tracking, critical incident reporting, patient privilege levels and safety checks, and discharge barriers.

Beyond the replacement of antiquated systems, the requested electronic health record (EHR) system will fully meet the expectations and needs of the modern healthcare environment.

The Department requested $75,000 in FY 2012-13 to hire a vendor to conduct a needs analysis for an EHR and pharmacy system, and the Joint Budget Committee denied the request. The Department used internal resources to research electronic health record system and platform options, and published a Request for Information in April 2013. Those efforts formed the basis of the current capital and operating budget requests.

7. Explain how the proposed EHR system would communicate with other state agencies, vendors, and care providers. Further, how would the Department ensure that the proposed system would comply with privacy and legal requirements related to medical records?

The requested electronic health record (EHR) system will communicate treatment and operations data via the Colorado Regional Health Information Organization (CORHIO) in compliance with all federal and state electronic health information security and privacy regulations. The EHR business requirements will stipulate the creation and

maintenance by the vendor of a secure and encrypted connection to the CORHIO for this purpose. Clinical and business operations data can be shared between the Department's Mental Health Institutes and other hospitals and providers, so long as the other entities are also securely connected to the CORHIO site, and dependent upon patients' approval.

The business requirements being developed for the requested EHR (in partnership with OIT and HIPAA Compliance staff) will stipulate that the EHR solution meets all HIPAA, Office for Civil Rights (OCR), and National Institute of Standards and Technology (NIST) standards for electronic health records systems, for data at rest and during transmission, as well as the standards stipulated by the U.S. Department Health and Human Services for EHR meaningful use by an inpatient hospital. Many existing EHR vendors meet these security, safety and encryption requirements.

(R14) Psychiatrist Base Salary Adjustment

8. Please clarify the status of psychiatrists who are employed by the Mental Health Institutes. Are they state employees or independent contractors?

Psychiatrists are employed as faculty of University of Colorado at Denver (UCD). The Department has a contract with UCD for psychiatrists to provide mental health services within the mental health institutes. Supervision of the psychiatrists is under the responsibility of the Department.

(R15) Mental Health First Aid (MHFA)

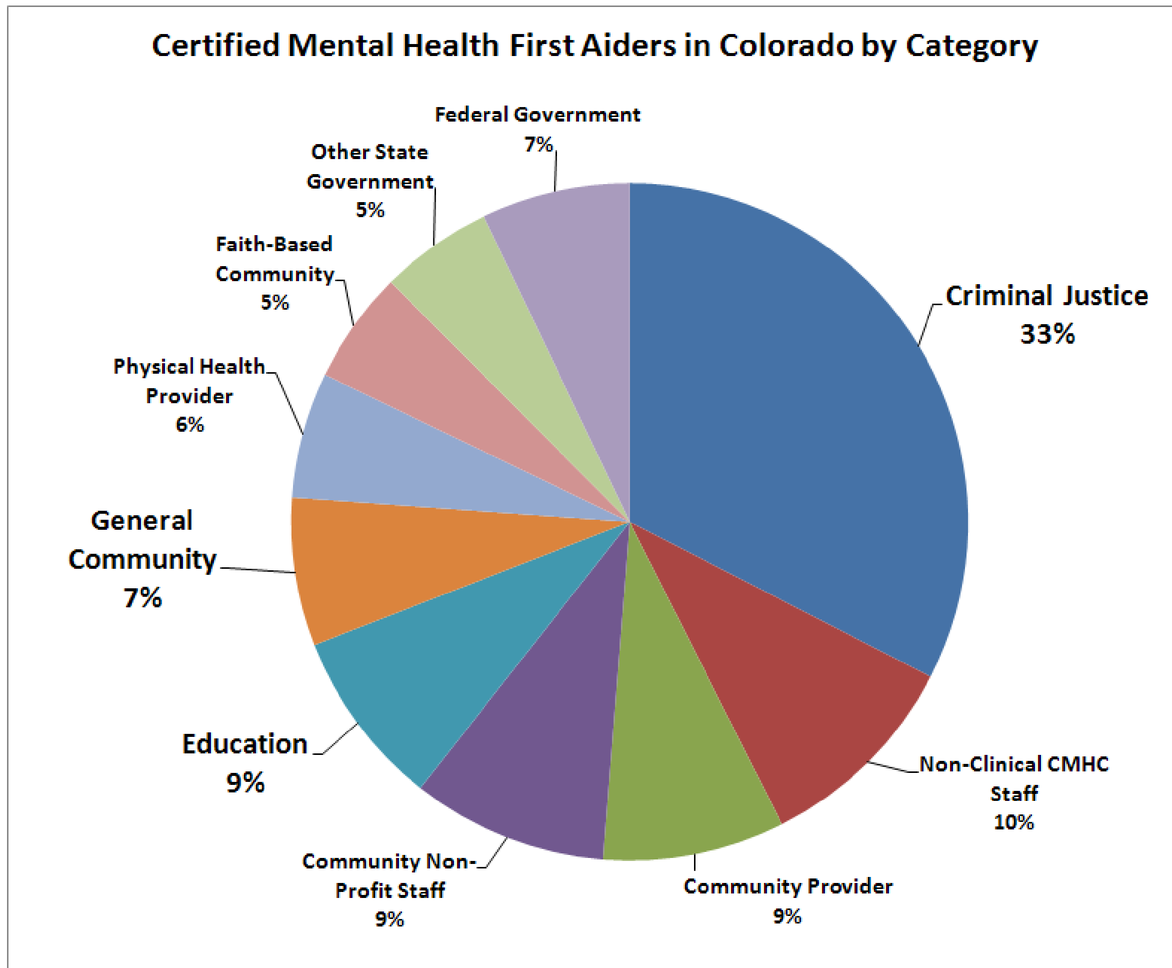
9. Please describe the types of individuals who have participated in mental health first aid (MHFA) certification courses to date. If state funding is provided for certification courses in FY 2014-15, what types of individuals would the Department seek to certify?

Behavioral health first aid is intended for all community members.

According to staff from the Colorado Behavioral Health Council, the types of individuals who have participated in MHFA include: family members, educators, first responders, social workers, military, doctors and nurses, faith based organizations, criminal justice governmental, non-profits, and others in the community. Additionally, this initiative will focus on targeting youth serving organizations as means for early intervention.

This initiative is complementary to the Governor's "Strengthening Colorado's Mental Health System: A Plan to Safeguard all Coloradans." The goal of this request is to promote public awareness about mental health and provide education on how to properly engage, identify, and respond to individuals who may help with their mental health issues, throughout the state.

The following pie chart represents the current demographic profile of individuals trained by Mental Health First Aid of Colorado.



10. To date, have any individuals paid a fee to attend an MHFA certification course or to attend an MHFA instructor course?

    Yes, individuals have paid a fee to attend mental health first aid certification courses and to attend MHFA instructor courses. The estimated cost to train individuals on mental health first aid and to train trainers is $80 and $1,166, respectively. These rates are based on information collected in the development of the budget request (R15). The calculations are as follows:

    - **$540,000 ($2,000/course X 270 courses) annually to train 6,750 people (twenty-five people per course) or $80/individual**
    - **$210,000 (6 courses X $35,000/course) to train 180 train-the-trainer instructors (thirty people per course) or $1,166/trainer.**

11. Why is the Department requesting state funding for both MHFA instructor courses and for individual certification courses in FY 2014-15? Do the fees for either of these courses create an attendance barrier?

    The Department is requesting funding for Mental Health First Aid instructors in order to "seed" local communities with technical expertise to pass on to others in that field.

For example educational trainers, once certified, will have the capacity to train teachers and other school staff within local school districts.

The Department is requesting funding for individual Mental Health First Aid certification for communities and agencies that do not have local area budgets or expertise to support this type of training. The dollars requested are intended to jump start Mental Health First Aid throughout the state and maximize exposure for all citizens to benefit from this important curriculum. Additionally, the vision is to gain parity with traditional first aid training as a community norm.

Mental Health First Aid is a curriculum that seeks to reduce stigma of mental illness and increase mental health public awareness. The Department's experience with this project is that some communities charge fees for MHFA. The Department believes that many public serving agencies prioritize free training opportunities for their staff and as a result of tight local area budgets, it is also believed that funding is a consideration when agencies prioritize training for their staff.

12. Is MHFA certification required for any position or vocation?

The Department does not require, nor is it aware of other entities that require, Mental Health First Aid certification as a prerequisite course for any position or vocation.

Additionally, the Department inquired with the Attorney General's Office Peace Officer Standards and Training (P.O.S.T.) Board regarding baseline behavioral health training that is required by P.O.S.T. Mental Health First Aid is not a P.O.S.T. training requirement. According to the P.O.S.T. Board staff, behavioral health is covered under "victim rights" and "risk assessment response" classes that are offered at training academies.

13. Is MHFA training appropriate for law enforcement officers, or is a more specialized training more appropriate?

The Department does not have expertise to identify what is most appropriate for law enforcement specialized training. However, the Department believes that Mental Health First Aid (MHFA) training is appropriate for all audiences, including law enforcement officers.

There are other behavioral health specific trainings available, which depend on the behavioral health literacy level of the individuals and/or agencies. MHFA is foundational training that is appropriate for all audiences including law enforcement that do not have behavioral health educational resources.

Some law enforcement agencies in the State utilize Crisis Intervention Team (CIT) training for their officers when the local community invests in developing local behavioral health crisis response teams.

14. What interactions have the Office of Behavioral Health and/or Mental Health First Aid Colorado had with the Department of Public Safety related to MHFA training?

    The Mental Health First Aid Colorado project has been a positive collaborative project that involved various community and public agency members. The Office of Behavioral Health and the Department of Public Safety have worked together as participants of Mental Health First Aid Colorado advisory team meetings.

15. How would the requested funding be distributed? Does the Department plan to build off of the existing relationship between the Office of Behavioral Health and Mental Health First Aid Colorado to administer the requested funds?

    Pursuant to State law, the Department intends to distribute funding via a competitive bid.

    C.R.S 24-103-201 states "Unless otherwise authorized by law, all state contracts shall be awarded by competitive sealed bidding..." Other methods that are authorized by law include statutorily authorized procurement, governmental, and sole source procurements, etc. C.R.S. 24-103-205 states the criteria for a sole source procurements. Mental Health First Aid is available from more than one entity, therefore a sole source procurement is not feasible.

16. Has the Office of Behavioral Health considered whether the Red Cross could provide the infrastructure to support statewide MHFA training?

    The Department has not pursued an analysis to determine if the Red Cross could provide the infrastructure to support statewide MHFA training.

<u>(NPI1) Meal Services to Department of Corrections (DOC)</u>

17. Please provide specific examples of the types of hospital operational expense reductions that have been required due to the shortfall in DOC payments for meal services.

    The Colorado Mental Health Institute at Pueblo (CMHIP) Operating Expenses line item includes funds to pay for waste services, repairs and maintenance, computer leases and software, rental of medical equipment/oxygen, telephones, medical and laboratory supplies, laundry service, office supplies, and food, among other miscellaneous categories.

    The estimated FY 2012-13 shortfall between the Department of Corrections meal reimbursement rate and the actual CMHIP cost is ($323,492).

    Due to increasing food costs and the static meal reimbursement rates with the Department of Corrections, the Department has postponed and/or eliminated necessary repairs and replacements within the hospital in order to stay within the allocated spending authority.

The cost of postponed repairs and replacements in the list below is approximately $200,000. Postponed repairs/replacements include:

- **Remodel bathrooms in the geriatric patient units for improved patient access and programmatic need;**
- **Replacement of commercial kitchen mixer;**
- **Replacement of on–grounds patient transportation carts;**
- **Efficiency modifications within the Admissions Unit for improved confidentiality and security; and**
- **New hospital beds with improved alarm and duress systems, especially within the geriatric units.**

10:30-10:45 BREAK

10:45-11:00 IMPLEMENTATION OF FY 2013-14 INITIATIVES

18. Please provide an update on the Department's implementation of S.B. 13-266.

SB13-266 is part of Colorado's Executive and Legislative leaderships plan to strengthen Colorado's mental health system to safeguard all Coloradans. The goal of this system changing legislation is to establish a comprehensive, coordinated, easily accessible, culturally competent, and integrated system for people who are experiencing behavioral health crisis.

The Department revised the request for proposal (RFP) for Crisis Services (stabilization/ mobile/respite) and posted it to the Colorado Bids Information and Distribution System (BIDS) on November 22, 2013. Proposals are to be received by January 3, 2014. The Department will identify awardee apparent(s) the week of January 20th, 2014 and the contract is proposed to be finalized the week of February 24th, 2014, with program operations to begin March 1, 2014.

The Department revised the RFPs for the Public Information and Educational Marketing Campaign and the Crisis Hotline and Warmline. The RFPs were posted to BIDS on December 6, 2013. Proposals are to be received by January 7th and January 8th, respectively with awardee apparent(s) to be identified the week of January 27th. The contracts will be finalized the week of February 24th for operations beginning March 1, 2014.

19. Please provide an estimate of the amount the Department is likely to spend in FY 2013-14 for the implementation of S.B. 13-266, as well as for Community Transition Services and the Jail-based Competency Restoration Program.

The Department will present a supplemental by January 1, 2014 reflecting the amount estimated to be spent on SB 13-266 in FY 2013-14.

The following table details the implementation status for Community Transition Services.

Implementation Status for Community Transition Services Program

Component	Provider(s)	Implementation Status	Proposed Expenditure in FY 2013-14
Assertive Community Treatment (ACT)	Community Mental Health Centers	Contract Amendments to be Fully Executed – December 2013	Full Appropriated amount of $1,974,981
Enhanced Alternative Living Residence (ALR)	Pending Decision by Department for Program Direction	Expect March 1, 2014 Implementation	Full Appropriated amount of $2,031,350
Housing Subsidy (Vouchers)	Dept. of Local Affairs	Implemented October 2013	Full Appropriated amount of $734,524
Housing Subsidy with Wrap-around Services	Dept. of Local Affairs (Housing) – Various Providers (Services)	Dept. of Local Affairs (October 2013) / Services pending award for Transition Specialist.	Full Appropriated amount of $245,000
Behavioral Health Transition Specialist (7)	Provider selected through competitive bid solicitation	Solicitation to be released December 2013. Service delivery to begin February 2014.	Full Appropriated amount of $192,845

Jail-based restoration was implemented effective November 1, 2013. As this project is operational, the Department projects to utilize the full appropriation.

20. What actions has the Department taken or does the Department plan to take to address the Department of Personnel and Administration's recommendations for improving the Department's solicitation processes? Please include information specific to the following issues:

The Department is evaluating all of its processes and procedures within the Procurement Division. The goal is to create a comprehensive and standardized process from the initial development of a solicitation through the award to a vendor. Additionally, the expected skill sets and expertise of the individuals involved, whether program, legislative, financial, or procurement individuals will be refined to align with these new requirements. Finally, the Department is in the process of making organizational changes within the Procurement Division to enhance the teams' performance in the future.

a. The skill sets of staff who play a key role in the solicitation process;

The Department selects individuals, both internal and external, who are subject matter experts in key areas that are important to the specific solicitation (program knowledge, quality assurance, fiscal/contracting, data/evaluation, population experience/representation, system knowledge/experience, etc.).

b. Department workload and procurement team involvement in program plans;

The Department has created a centralized procurement tracking and monitoring list that, among other things, includes the name of the procurement agent responsible for the solicitation. This document is distributed to the Division of Procurement Director, the Community Behavioral Health Division Director, and the Office Director on a weekly basis, so workload will be easily assessed. The Procurement Division is in communication with the program and involved in the solicitation process from the beginning of every solicitation. No request for proposals, or similar documents, are published without the procurement division discussing the solicitation with the program and the procurement agent reviewing and editing (if necessary) the document.

c. The process the Department uses to proactively perform due diligence in order to vet and approve all bid evaluation committee members; and

Department program staff provides the Procurement Division with a list of potential committee members. Procurement Division staff reviews all committee member qualifications and expertise and then approves them to be included on the evaluation team prior to the formation of the committee. Procurement Division follows protocol to provide individuals with the Evaluator's Handbook, review the key points within the handbook with all potential committee members, requires a Conflict of Interest attestation, and reviews all information again with the entire committee prior to delivering proposals for review.

d. The potential of using financial analysts or experts to offer proactive guidance to bid evaluators and the procurement team.

The extent to which the budget is weighted as a component of the overall score is a consideration for additional financial analysis and guidance or expert guidance.

The Department will often include a financial expert on evaluation committees or has a financial expert review the bids and provide analysis and opinions to the committees for consideration. The Department will consider all value-added resources to improve its processes, effectiveness, and efficiency of procurement.

11:00-11:20 MENTAL HEALTH INSTITUTES

21. Please discuss the need for psychiatric inpatient care in Colorado and the availability of such services. Specifically:

    a. Provide a table detailing the changes in capacity at each Mental Health Institute since FY 2000-01.

    Please see Attachment A.

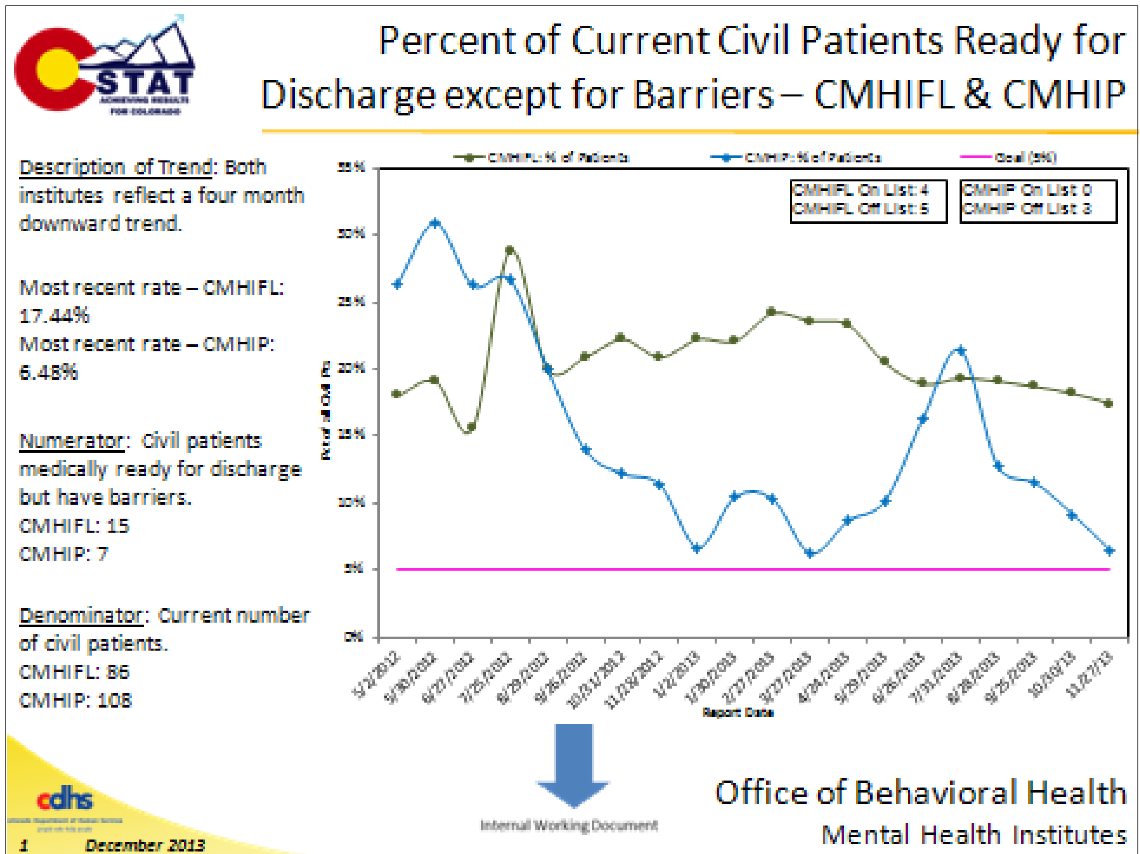
    b. What has been the impact of recent unit closures at the Colorado Mental Health Institute at Ft. Logan? Are the inpatient psychiatric needs of children, adolescents, and geriatric patients currently being met statewide?

    The unit closures in FY 2009-10 and FY 2010-11 at the Colorado Mental Health Institute at Fort Logan reduced the number of beds available to various populations; the remaining 94 beds consistently operate at capacity.

    The Department has been monitoring the status of any civil patient that has had to wait for admission to the Mental Health Institutes as part of its C-Stat performance measurement efforts. This monitoring helps the Department minimize the patient length-of-stay and improves patient outcomes.

    The data collected from March 1, 2013 through May 17, 2013 has shown:
    - **47% of patients referred to the Institutes were admitted,**
    - **38% of referrals were withdrawn by the referring facility,**
    - **9% were denied admission and at the time of the assessment, and**
    - **7% were awaiting determination.**

    Of those referrals which were withdrawn or denied:
    - **53% were admitted to another inpatient psychiatric facility,**
    - **30% were discharged to the community,**
    - **7% were admitted to a detox facility,**
    - **6% were admitted to an Acute Treatment Unit,**
    - **2% were admitted to jail, and**
    - **1% were admitted to a supervised residential facility.**



The inpatient psychiatric needs of children, adolescents, and geriatric patients are currently being met statewide in collaboration with the Mental Health Institutes, community mental health centers, private hospitals, and other care facilities.

The Department will conduct a study that will strategically guide CDHS in its future planning over the next decade. This study will accomplish a number of goals including but not limited to providing an inventory of existing state and community resources, including inpatient psychiatric beds.

c. How do the Mental Health Institutes ensure that they are in compliance with the court ruling in *Olmstead v. L.C.* [the U.S. Supreme Court case regarding discrimination against people with mental disabilities]?

Olmstead v. L.C. is a 1999 United States Supreme Court case that held that continued hospitalization of a person who could otherwise live safely in the community with appropriate services represents discrimination. In the years following the Supreme Court's ruling, the United States Department of Justice, Office of Civil Rights has expanded the class of persons protected under Olmstead and requires that facilities closely monitor and aggressively address the community reintegration of institutionalized persons.

The Department has complied with the requirements under Olmstead through a variety of interventions. Utilization Review Committees at the Mental Health Institutes conduct ongoing reviews and assessments of clients' ability to function independently in the community. This ongoing review process is a mechanism for ensuring frequent evaluations of patients' need to remain hospitalized (termed "Medical Necessity" by the Centers for Medicare and Medicaid Services (CMS)).

Additionally, Extended Stay Review Committee(s) evaluate all patients who have been at the Institute(s) for more than one calendar year. These in-depth reviews examine – among other variables – that patients remain 1) gravely disabled 2) a risk to self and/or others and 3) at substantial risk for decompensation if discharged.

Inpatient services such as Occupational Therapy, Work Therapy, and the Community Readiness Program are in place to provide patients with the skills necessary for successful community reintegration.

Collaborative efforts between the Institutes and the Community Mental Health Centers focus on providing patients supportive services in the least restrictive environment possible, relative to the client's abilities.

The Department actively monitors waitlists, readmissions, and barriers to discharge as a component of the Mental Health Institutes' C-Stat measures. The focused attention to resolve discharge barriers has resulted in successful community reintegration for a number of patients at both Institutes who would have otherwise remained in the hospital. The Department continues to identify common factors that impede community reintegration and works to remove those barriers to enable our patients to live productive and fulfilling lives in the community.

d. How many inpatient psychiatric beds are available in public and private hospitals or facilities other than the Institutes?

The table below details the C.R.S. 27-65 involuntary commitment designated public and private psychiatric facility bed capacity. This count does not include non-designated facility beds. A non-designated facility bed is typically within a physical health emergency department and temporarily used in the event that a person with mental health needs presents at the emergency department for mental health evaluative services.

Type of Beds	FY 2013-14
C.R.S. 27-65 Psychiatric Hospital	789
Acute Treatment Unit (ATU)	80
Psychiatric Residential Treatment Facility (PRTF)	224
Residential Child Care Facilities (RCCF)	4,350
Total	5,443

The Department reached out to the Colorado Hospital Association for the total number of private psychiatric beds that are not designated by the Department. This information was not readily available, however when/if it is, the Department will make it available to the Committee.

e. Has the Department conducted a formal study of the need for inpatient psychiatric care in Colorado, or is the Department aware of another entity that has done so?

No, the Department has not conducted a formal study of the need for inpatient psychiatric care in Colorado, nor is aware of another entity that has recently done so in the past 10 years. The Department will conduct a study that will strategically guide the CDHS in its future planning over the next decade. This study will accomplish a number of tasks including, but not limited to providing an inventory of existing state and community resources, including inpatient psychiatric beds.

f. Please describe any Department plans to study the need for inpatient psychiatric care, including the Department's capital funding request concerning Mental Health Institute facility program plans and site master plans.

As identified in response to Question 21e, the Department will conduct a study that will strategically guide CDHS in its future planning over the next decade. This study will accomplish a number of tasks including but not limited to providing an inventory of existing state and community resources, including the statewide needs for inpatient psychiatric care.

11:20-11:40 TREATMENT FOR OFFENDERS

Correctional Treatment Cash Fund

22. Discuss the Department's use of moneys from the Correctional Treatment Cash Fund (CTCF), including the following:

Detail the allocation of CTCF moneys by line item appropriation for FY 2013-14.

	S.B. 13-230 Long Bill	Restriction	FY 2013-14 Total Appropriation
(8)(D)(1) Treatment and Detoxification Contracts	$887,300	($126,702)	$760,598
(8)(D)(1) Short-term Intensive Residential Remediation and Treatment (STIRRT)	$389,066	$0	$389,066
(8)(D)(E) Substance Use Disorder Offender Services (H.B. 10-1352)	$3,013,790	$0	$3,013,790
Total	$4,290,156	($126,702)	$4,163,454

Describe the nature of the expenditures supported by the CTCF within each line item appropriation, including the types of services or treatment that are provided.

The Correctional Treatment Board approves of the Department using the Treatment and Detoxification Contracts line item for STIRRT Program and H.B. 10-1352 Program expenditures.

Treatment and Detoxification Contracts

Here are the three programs funded under the Treatment and Detoxification Contracts portion of the funds:

i. **Strategies for Self-improvement and Change (SSC) program.**

SSC is provided in steps or phases that are developed around three stages in the cycle of change. Phase I builds knowledge and skills in several areas. It is the challenge phase of change. This phase consists of 20 sessions. Phase II is commitment to change. It focuses on strengthening one's knowledge and skills in bringing about changes that lead to a more responsible and fulfilling life. This phase also focuses on one's personal strengths and the problems identified in Phase I. Phase II consists of 22 sessions. Phase III moves into greater ownership of one's change. This is where one develops critical reasoning skills, learns how to resolve conflict, learns about lifestyles and activities to maintain change, examines work and job issues, and learns how to become a mentor for others. The main targets of change in this participant workbook are criminal conduct and substance abuse. Other targets include improving relationships with others, managing emotions, and being more responsible to the community. Each client receives the Participant's Workbook, which they use throughout treatment.

The total budget for the SSC program for FY 2013-14 is $633,221.

ii. SSC Training

Administer five training opportunities of 20 participants per training in the SSC curriculum. The training opportunities will take place with two in the Denver Metro area; one in the Southern Region; one on the Western Slope; and one in the Northern Region for the following purposes:

- **To disseminate knowledge of and use of the SSC curriculum among Colorado's Office of Behavioral Health (OBH) licensed treatment agencies for offender services.**

- **To increase the number of SSC sessions/groups for the offender population with properly trained clinicians.**

The FY 2013-14 budget for the SSC Training is $8,622.

iii. The Haven

The Haven is a 65-bed Modified Therapeutic Community (MTC) located in Denver for women, mothers and their infants. Licensed by the Office of Behavioral Health, the program offers long-term, intensive treatment for clients with addictions. Clients are referred from the Department, County Human Services Departments through Temporary Assistance for Needy Families (TANF), the criminal justice system, homeless shelters, friends and family members, or through self-referral.

Haven clients typically stay nine to 12 months in residential treatment, followed by an additional 12 months of outpatient MTC treatment services. Of mothers who enter The Haven, 90.1 percent remain free from drugs, alcohol, and crime two years after completion.

These funds pay for a small portion of services offered at the Haven. In FY 2013-14, this program will receive $46,143 from these funds.

<u>Short Term Intensive Residential Remediation Treatment (STIRRT)</u>

The STIRRT program is a nine month program which begins with two weeks of residential treatment with a minimum of 112 therapeutic hours, and eight to nine months of continuing care services. These funds pay for a portion of the residential and continuing care services for the STIRRT program.

Additionally the programs provide:

- **Agency point of contact for criminal justice agency referrals,**
- **Psychological testing and 30-day supply of psychotropic medication,**
- **Job training and preparation,**
- **Life skills training,**
- **Case management services,**
- **Participation in quarterly advisory meetings,**

- **Program evaluation and reporting.**

The budget for FY 2013-14 for STIRRT Residential care is $391,234 and $36,712 for STIRRT continuing care.

Substance Use Disorder Offender Services (H.B. 10-1352)
This line item funds Jail Based Behavioral Health Services (JBBS). JBBS funds are used to create programs in the jails to screen for and provide care to adult inmates with a substance use disorder or a co-occurring mental health disorder. In addition, programs are expected to provide continuity of care to these inmates when released from incarceration. Continuity of care should be provided without any interruption in services and with care from the same provider agency.

The goal of JBBS is to provide appropriate behavioral health services to inmates while supporting continuity of care within the community after release from incarceration. This approach should result in shortened jail sentences and decreased recidivism through better identification and treatment of behavioral health needs. There are 15 contracts for JBBS with county Sheriff's Departments and 32 county jails have a JBBS program.

Services Offered:
- **Screening for substance use disorders. Mental health disorders, trauma and brain injury.**
- **Community transition planning,**
- **Group therapy treatment,**
- **Individual therapy treatment,**
- **Driving Under the Influence Level II Education,**
- **Case Management services**

$3,047,522 is allocated to the JBBS program in FY 2013-14.

Describe the types and numbers of offenders who benefit from such expenditures, including: (1) whether they are juveniles or adults; and (2) whether they are serving a diversion sentence, serving a probation sentence, on parole, sentenced or transitioned to a community corrections program, or serving a sentence in a county jail or are receiving after-care treatment following release from jail.

The funds pay for only a portion of care the individual needs in various parts of the correctional system, therefore it is not feasible to determine the actual number of unique individuals who receive services from these particular funds.

Treatment and Detoxification Contracts

i. **Strategies for Self-improvement and Change (SSC) program.**

This curriculum serves adult male and female offenders who could be serving a diversion sentence, serving a probation sentence, on parole, sentenced or transitioned

to a community corrections program, or serving a sentence in a county jail, or are receiving after-care treatment following release from jail.

ii. The Haven

The Haven serves adult women who could be serving a diversion sentence, on parole, sentenced or transitioned to a community corrections program.

<u>Short Term Intensive Residential Remediation Treatment (STIRRT)</u>

The STIRRT program is designed specifically for the adult substance-abusing offender either male or female who is at least 18 years of age or older and has had at least one prior felony conviction; and have had a positive urinalysis prior to admission. Data from all STIRRT contracts show 8,153 individuals received continued care services from STIRRT programs. Data for STIRRT residential services is not available.

<u>Substance Use Disorder Offender Services (H.B. 10-1352)</u>

JBBS funds are for male and female adult offenders who are serving a sentence in a county jail. A total of approximately 2,000 offenders across the state receive services through the JBBS programs each year.

23. Discuss how the Department would utilize the funding increases proposed by the Correctional Treatment Board for FY 2014-15.

<u>Treatment and Detoxification Contracts</u>

The $250,000 requested amount will fund portions of the SSC program that was previously funded through the Substance Abuse Prevention and Treatment (SAPT) Block Grant. The Block Grant funds are no longer available.

<u>Substance Use Disorder Offender Services (H.B. 10-1352)</u>

$310,000 will be used for recovery support services for offenders released from facilities. The Correctional Treatment Board has requested these funds to assist offenders with immediate needs upon release such as emergency housing vouchers, transportation costs, fees for obtaining identifications. These dollars shall be divided among the programs based on the number of offenders served by their contract and regional needs.

24. Does the statutory provision governing the use of CTCF moneys preclude services or treatment expenditures that would be appropriate and justifiable? Does it preclude the provision of services to certain juvenile or adult offenders that would be appropriate and cost-effective? If so, please explain.

The Correctional Treatment Board has reviewed the statutory language in HB12-1310 to ensure that it corresponds with the current funding structure that exists. Resources from the cash fund support the Summit View program in Mesa County, which is a pre-trial program for high risk/high need offenders. There is currently no language in the

bill that corresponds to this specific type of program. The Board is working with Mesa County to develop appropriate language and seek legislative change this next session. As the Board continues to work with local boards and identify gaps in programming and services, it will continue to assess the statutory language and seek adjustments where necessary. Right now, the only change in language that is being pursued is the addition of pre-trial programming such as that provided by the Summit View program. No final language recommendations have been made; possible language revisions are still being discussed.

25. Describe how the Department evaluates (or plans to evaluate) the effectiveness of treatment and services that are supported by the CTCF.

The Correctional Treatment Board and its related state agencies do not currently measure effectiveness of treatment. Rather they measure program outcomes for their respective programs/services, which is different than measuring treatment effectiveness. The topic of effective treatment is something the Correctional Treatment Board is starting to discuss. While there is no clear path yet to measuring effective treatment, it is largely agreed that any efforts must be done in strong partnership with the treatment community. Currently, the Correctional Treatment Board is looking at existing agency program outcome measures and will then determine what measures should be collected and the feasibility of getting those programmed into four different data systems. Information from treatment providers will also need to be assessed and work needs to be done on creating partnerships with the treatment community to allow for sharing of that information. This is not an easy or quick task, but it is something the Board is looking to address over the long-term.

Treatment and Detoxification Contracts

The Department reimburses SSC providers on a cost reimbursement basis. In the next year, encounter level data will be available to review actual number of services paid for by these dollars. Client Engagement and Reduction in Use will be outcomes evaluated for these services.

Short Term Intensive Residential Remediation Treatment (STIRRT)

The STIRRT Program includes state level program coordination, oversight/accountability, and program evaluation services to assess the impact of offender specific enhanced treatment on offender recidivism and system improvement. Additionally, the STIRRT Program aims to return the offender to the community as a contributing member of the community and society. The Department is seeking to add outcome measures for the STIRRT Program in the contract for FY 2014-15.

Substance Use Disorder Offender Services (H.B. 10-1352)

JBBS clients are tracked upon release from facilities to ensure continuity of care in the community in treatment services. Number of clients served and actual number of services provided are tracked via a web based database. Programs currently track clients recidivating into the same county, but do not have access to recidivism data for crimes and arrests that occur in other counties. This is an area the Department would like to study in the future to measure the impact on statewide recidivism and jail sentences for those receiving JBBS. In the future, the Department would also like to measure the impact on recidivism for clients receiving JBBS.

26. Describe whether and how the Department monitors or evaluates the reasonableness of rates charged by treatment and service providers.

The Correctional Treatment Board has put the issue of treatment rates on its annual work plan for the next year given a concern over rising rates. The Board is collecting information about each agency's existing policies/practices around payment of treatment rates and will then discuss the concept of standard rates, assess the impact on the availability of treatment providers - particularly in rural communities, and then develop a policy around the issue of whether or not the state should be setting rates for treatment. As with treatment effectiveness, this is not a quick or easy task, but it is one the Correctional Treatment Board is working to address.

Treatment and Detoxification Contracts

The Department negotiates for SSC services and ensures treatment service contracts with providers are at or below fair market rates as established by similar contracts and market studies.

Short Term Intensive Residential Remediation Treatment (STIRRT)

All rates for STIRRT continuing care and residential services are negotiated and compared against local and national rates to ensure rates are at or below fair market value. While the three providers of residential services have different rates, all of the many providers of continuing care services are paid the same rate.

Substance Use Disorder Offender Services (H.B. 10-1352)

Contracts for JBBS were based on competitive bids and newly funded programs in FY 2013-14 were funded using the FY 2011-12 contract benchmarks. These programs are funded on a cost reimbursement basis. If services are not provided, the contractor is not reimbursed.

27. Does the Department make any effort to require offenders to pay a portion of the cost of services provided, if they are able to do so?

<u>**Treatment and Detox Contracts**</u>

SSC contractors require offenders to pay a nominal copayment for groups using a sliding fee scale.

<u>**Short Term Intensive Residential Remediation Treatment (STIRRT)**</u>

The STIRRT residential services do not require a copayment from participants. Some contractors require offenders to pay a $5 copayment for groups for the continued care services. The contracts also allow for one urine analysis per week per offender. The offender is required to pay if additional urine analyses are required.

<u>**Substance Use Disorder Offender Services (H.B. 10-1352)**</u>

Offenders are not required to pay for JBBS while they are in the jail facility. They may be required to pay for care in the community based on the services to which they are referred.

11:40-12:00 OTHER TOPICS

28. Please provide an overview of General Fund support for Community Mental Health Centers since FY 2000-01, including increases and decreases related to community provider rates and other General Fund adjustments.

This response is provided in a separate file (Attachment B) which details changes in the General Fund Budget for the (8) Behavioral Services (B) Mental Health Community Programs section of the Long Bill, which supports Community Mental Health Centers and clinics.

The attachment only illustrates General Fund appropriations to support Community Health Centers; however, the community system is also supported by federal grants including the Mental Health Services Block Grant and the Projects for Assistance in Transition from Homelessness (PATH) Grant.

29. Please define the term "medically indigent", and reference any statutory provision or rule where this term is defined.

The Long Bill references the term “medically indigent” but does not define it or specify requirements.

The term “medically indigent” is defined by the Department in contract as an individual at or below 300% of the federal poverty level, without behavioral health insurance. Additionally, to qualify as “medically indigent” clients must have a Serious Mental

Illness or a child or adolescent must have a severe emotional disturbance as defined by the Colorado Client Assessment Record.

The Department defined the term "medically indigent" based upon C.R.S 27-66-104(2)(b)(2) which requires the Department to serve "most in need." Based upon this legislative guidance, the Department established a "medically indigent" definition in contract beginning in FY 2007-08.

In FY 2011-12 the Department expanded the definition medically indigent to include children, adolescents, or their primary caregivers who do not have a Severe Emotional Disturbance as a means to provide early mental health intervention.

30. Do Community Mental Health Centers have the ability to provide services to clients who are eligible for Medicaid or private insurance benefits and bill the relevant entity for the provision of such services?

Yes, Community Mental Health Centers have the ability to provide services to clients who are eligible for Medicaid or private insurance benefits and bill the relevant entity for the provision of such services. By contract, Community Mental Health Centers are required to bill other payer sources before they bill the Department.

31. What data does the Department collect to determine who is receiving services through Community Mental Health Centers based on the funding allocations made available through the Office of Behavioral Health? Does the Department have any plans to use this data to track the impact of S.B. 13-200 and the federal Affordable Care Act on the number of medically indigent clients?

The Department has a billing protocol that all providers follow, which addresses this issue. The Department requires that providers determine eligibility for Department funded program populations. In the event that clients are retro-eligible for other payment sources, the contractors are required to submit corrected refund billing adjustment data to the Department. The Department asserts through contract that its funds must be billed as the payee of last resort, after other payors (including Medicaid).

In partnership with the Department of Health Care Policy and Financing and the Robert Wood Johnson Foundation, the Department is examining each population in the Department to determine:

1) **What services does Medicaid cover that are provided by other state programs;**
2) **The magnitude (number) of people who are eligible for Medicaid, but not enrolled;**
3) **Assess administrative systems to maximize Medicaid and third-party payer reimbursement; and**
4) **Develop recommendations to repurpose state dollars and reduce duplication.**

By early January 2014, the Department will be able to outline its next steps for pursuing additional Medicaid enrollment and Medicaid and third-party claiming.

Between Medicaid expansion and the inclusion of behavioral health services in the essential health benefit package of the Affordable Care Act, many individuals who did not have benefits will be able to access insurance for behavioral health care. This analysis will examine clients in the state's behavioral health system and ensure that the Department is maximizing Medicaid billing for all behavioral health services.

32. Will federal sequestration have an impact on funding for substance abuse and mental health treatment services? If so, please describe.

For FY 2013-14, the Mental Health Institutes are realizing a 2% reduction in Medicare revenue reimbursements due to the sequestration, estimated at $160,000.

It is anticipated that sequestration will result in reductions to both the Mental Health Services (MHS) Block Grant and Substance Abuse Prevention and Treatment (SAPT) Block Grant. In the FY 2014-15 Block Grant applications, the Department estimated, that there would be an 8% or $461,549 MHS and up to a $1,407,561 (1%) reduction in SAPT funding. It is estimated that in FY 2013-14 contracts may need to be adjusted by 4% or $230,775 in MHS and 0.5% or $703,781 in SAPT Block grant funding.

These estimates may be adjusted accordingly, contingent upon receipt of actual grant awards that is expected to be received sometime in January 2014.

In the event that sequestration continues, the Department will need to evaluate options that could include drastic decisions impacting services and operations. Ongoing funding reductions as a result of sequestration jeopardize the sustainability of program and service delivery within the Department.

Attachment C, "Sequestration Estimates as of December 12, 2013" table demonstrates the projected impact assuming a 2% reduction of Medicare revenue at the Mental Health Institutes beginning in FFY 2011-12 and 7.8% for the Substance Abuse Prevention and Treatment and Mental Health Services Block Grants beginning in FFY 2014-15.

33. The Colorado Commission on Criminal and Juvenile Justice (CCJJ) recently approved a recommendation to allocate moneys from the Marijuana Cash Fund to the Adolescent Substance Abuse Prevention and Treatment Fund for purposes of adolescent education and prevention related to marijuana use.

Please describe the amount and types of revenues that are currently credited to this fund.

Please see table below, in the next response, for revenue information for the last two fiscal years. The source of revenue is a cash fund that is derived from a court imposed surcharge of twenty-five dollars from "a person convicted of a violation of illegal

possession or consumption of ethyl alcohol by an underage person…", pursuant to C.R.S. 18-13-122.

Please describe the types of programming and activities that are currently supported by this fund, and detail actual fund expenditures for the last two fiscal years.

These cash funds support four (4) small agencies serving Grand, Garfield, Pueblo, and Denver counties to provide services to families that cannot afford to pay for treatment when a youth receives a Minor In Possession (MIP) offense. These services include education/prevention and intervention efforts, and make it possible for these providers to offer services that meet the court requirements of an MIP offense in rural areas where it would not otherwise be available. These funds also support statewide community training on Driving With Care, Education and Treatment of the Underage Impaired Driving Offender. The table below represents revenues and expenses for the last two years.

State Fiscal Year	(8)(D)(1)Treatment Services	(8)(D)(2) Prevention & Intervention	Total
2011-12 Revenue	$66,218	$22,072	$89,290
2011-12 Expense	$62,520	$15,000	$77,520
2012-13 Revenue	$66,218	$22,072	$88,290
2012-13 Expense	$66,144	$15,000	$81,144

Is an appropriation from the Adolescent Substance Abuse Prevention and Treatment Fund to the Office of Behavioral Health the best way to fund these education and prevention efforts, or would it be more appropriate to direct moneys from the Marijuana Cash Fund to the Tony Grampsas Youth Services Program for these efforts?

The Governor's Office is currently weighing options for use of moneys from the Marijuana Cash Fund and plans to present legislation or budget requests when decisions have been made.

What is the relationship between the Office of Behavioral Health and the Tony Grampsas Youth Services Program?

The Tony Grampsas Youth Services Program (TGYS), originally called the Youth Crime Prevention and Intervention Program (YCPI), was created in Fiscal Year 1994-95 after the Summer of Violence and provides funding to local organizations that work with youth and their families through programs designed to prevent youth crime and violence, and child abuse and neglect. These programs operate in six funding areas: General Violence Prevention, School Dropout Prevention, Before & After School Programs, Mentoring Programs, Restorative Justice and Early Childhood Programs.

TGYS was moved to CDHS effective July 1, 2013 in an effort to align child development programs pursuant to HB 13-1117. TGYS is increasing linkages with OBH and youth development services statewide through being housed at CDHS, and through the TGYS Board's role in the Statewide Youth Development Plan (HB13-1239); which is also housed in CDHS' OCYF and works closely with OBH. As a result of the legislation passed last year, TGYS is involved in the initiative to identify key issues affecting youth and align strategic efforts and partnerships statewide to achieve positive outcomes for all youth.

The Department's Office of Behavioral Health primary prevention focus is on substance use prevention services. The Office of Behavioral Health does not fund any prevention programs specifically addressing youth violence prevention that is funded by the Tony Grampsas Youth Services Program.

Attachment A

Colorado Department of Human Services
Mental Health Institute Bed Capacity Summary
By Institute / By Unit / by Fiscal Year (Year-End Total)
For Period FY 1999-00 through FY 2013-14 (Est.)

CMHI-PUEBLO	FY 1999-00	FY 2000-01	FY 2001-02	FY 2002-03	FY 2003-04	FY 2004-05	FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11	FY 2011-12	FY 2012-13	Y 2013-14 (Est.)
Adolescent	30	30	30	16	16	16	16	16	16	16	20	20	20	20	20
Adult	96	96	96	64	64	64	64	64	64	64	64	64	64	64	64
Addiction Dual Dx	30	30	30	20	20	20	20	20	20	20	20	20	20	20	20
Medical / Surgical	20	20	20	20	20	20	20	20	20	20					
Geriatric	60	60	60	60	40	40	40	40	40	40	40	40	40	40	40
Total Forensic	278	278	278	278	278	278	278	298	298	310	310	294	307	307	307
TOTAL BEDS CMHI-PUEBLO	**514**	**514**	**514**	**458**	**438**	**438**	**438**	**458**	**458**	**470**	**454**	**438**	**451**	**451**	**451**
CMHI-FT LOGAN	**FY 1999-00**	**FY 2000-01**	**FY 2001-02**	**FY 2002-03**	**FY 2003-04**	**FY 2004-05**	**FY 2005-06**	**FY 2006-07**	**FY 2007-08**	**FY 2008-09**	**FY 2009-10**	**FY 2010-11**	**FY 2011-12**	**FY 2012-13**	**FY 2013-14**
Childrens	16	16	16	16	16	16	16	16	16	16					
Adolescent	22	22	22	18	18	18	18	18	18	18					
Adult	110	110	110	94	94	94	94	94	94	94	94	94	94	94	94
Addiction Dual Dx	27	27	27	27											
Geriatric	25	25	25	25	25	25	25	25	25	25					
RCCF	20	20	20	20	20	20	20	20	20	20	20				
TOTAL BEDS CMHI-FT LOGAN	**220**	**220**	**220**	**200**	**173**	**173**	**173**	**173**	**173**	**173**	**114**	**94**	**94**	**94**	**94**
Both MHIs Combined	**FY 1999-00**	**FY 2000-01**	**FY 2001-02**	**FY 2002-03**	**FY 2003-04**	**FY 2004-05**	**FY 2005-06**	**FY 2006-07**	**FY 2007-08**	**FY 2008-09**	**FY 2009-10**	**FY 2010-11**	**FY 2011-12**	**FY 2012-13**	**FY 2013-14**
Childrens	16	16	16	16	16	16	16	16	16	16					
Adolescent	52	52	52	34	34	34	34	34	34	34	20	20	20	20	20
Adult	206	206	206	158	158	158	158	158	158	158	158	158	158	158	158
Total Addiction Dual Dx	57	57	57	47	20	20	20	20	20	20	20	20	20	20	20
Medical / Surgical	20	20	20	20	20	20	20	20	20	20					
Geriatric	85	85	85	85	65	65	65	65	65	65	40	40	40	40	40
Forensic	278	278	278	278	278	278	278	298	298	310	310	294	307	307	307
RCCF	20	20	20	20	20	20	20	20	20	20	20				
TOTAL BEDS CDHS - CMHI	**734**	**734**	**734**	**658**	**611**	**611**	**611**	**631**	**631**	**643**	**568**	**532**	**545**	**545**	**545**
Percent change each year	*Base Year*	*0%*	*0%*	*-10%*	*-7%*	*0%*	*0%*	*3%*	*0%*	*2%*	*-12%*	*-6%*	*2%*	*0%*	*0%*
Percent change from FY 1999-00	*Base Year*	*0%*	*0%*	*-10%*	*-17%*	*-17%*	*-17%*	*-14%*	*-14%*	*-12%*	*-23%*	*-28%*	*-26%*	*-26%*	*-26%*

SIGNIFICANT EVENTS BY FISCAL YEAR

FISCAL YEAR	EVENT DESCRIPTION
FY 2002-03	CMHI-Pueblo closed the Open Adolescent unit and reduced the Locked Adolescent Unit (14 beds total), closed the Adult 72 unit (32 beds) and reduced Circle (Dual Dx) by 10 beds) due to budget.
FY 2002-03	CMHI-Ft Logan closed the 16-bed Adult Residential Unit and reduced 4 beds from the Adolescent Unit due to budget.
FY 2003-04	CMHI-Pueblo closed the Geriatric GW02 and GW08 units (20 beds) due to budget constraints.
FY 2003-04	CMHI-Ft Logan closed the 27-bed Team 6 Dual Dx Unit due to budget constraints.
FY 2006-07	CMHI-Pueblo added a 20-bed ITP Restoraton unit due to Zuniga lawsuit.
FY 2008-09	CMHI-Pueblo closed old Forensic units and opened the High Security Forensic Institute (Hawkins Building) for a net gain of 12 forensic beds due to the Neiberger lawsuit.
FY 2009-10	CMHI-Pueblo closed the 20-bed Medical\Surgical unit for operating efficiency and added 4 beds to the Locked Adolescent Unit.
FY 2009-10	CMHI-Ft Logan closed the 25-bed Geriatric Unit, the 16- bed Childrens Unit, and the 18-bed Adolescent Unit due to budget constraints.
FY 2010-11	CMHI-Pueblo closed Forensic unit F2 (16 beds) to shift staff and increase patient and staff safety.
FY 2010-11	CMHI-Ft Logan closed the 20-bed Residential Child Care Facility due to budget constraints.
FY 2011-12	CMHI-Pueblo added 13 beds back to existing community reintegration forensic units - outside of the Hawkins Building.

Colorado Department of Human Services
8 Behavioral Health Services (B) Mental Health Community Programs General Fund
For the Period FY 2000-01 to FY 2013-14

	FY 2000-01	FY 2001-02	FY 2002-03	FY 2003-04	FY 2004-05	FY 2005-06	FY 2006-07
Total 8(B) General Fund for Community Mental Health Center/Clinic Clients	$ 27,939,837	$ 26,721,301	$ 24,324,662	$ 23,509,229	$ 24,061,794	$ 26,980,271	$ 35,451,208
Fiscal Year to Fiscal Year General Fund Change Rate		-4.4%	-9.0%	-3.4%	2.4%	12.1%	31.4%
General Fund Change		$ (1,218,536)	$ (2,396,639)	$ (815,433)	$ 552,565	$ 2,918,477	$ 8,470,937
Cumulative General Fund Change		$ (1,218,536)	$ (3,615,175)	$ (4,430,608)	$ (3,878,043)	$ (959,566)	$ 7,511,371

	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14
Total 8(B) General Fund for Community Mental Health Center/Clinic Clients	$ 36,668,785	$ 40,526,571	$ 40,225,721	$ 39,419,334	$ 39,419,334	$ 39,419,334	$ 40,725,725
Fiscal Year to Fiscal Year General Fund Change Rate	3.4%	10.5%	-0.7%	-2.0%	0.0%	0.0%	3.3%
General Fund Change	$ 1,217,577	$ 3,857,786	$ (300,850)	$ (806,387)	$ -	$ -	$ 1,306,391
Cumulative General Fund Change	$ 8,728,948	$ 12,586,734	$ 12,285,884	$ 11,479,497	$ 11,479,497	$ 11,479,497	$ 12,785,888

Attachment C

Department of Human Services
Budget Control Act "Sequestration" Estimates As of Dec. 12, 2013
Office of Behavioral Health

Grant	FFY 12 Grant Award	FFY 13 Est. Award	FFY 14 Est. Award	FFY 15 Est. Award	FFY 16 Est. Award
	Actual	Actual	Estimated	Estimated	Estimated
Block Grants for Community Mental Health Services	$ 7,176,225	$ 6,021,813	$ 6,021,813	$ 5,552,112	$ 5,119,047
Substance Abuse Prevention & Treatment Block Grant	$ 26,103,262	$ 24,718,036	$ 24,718,036	$ 22,790,029	$ 21,012,407
Colorado Mental Health Institute Medicare (-2%)	$ 160,000	$ 160,000	$ 156,800	$ 153,664	$ 150,591
Total	**$ 33,439,487**	**$ 30,899,849**	**$ 30,896,649**	**$ 28,495,805**	**$ 26,282,045**
Annual Reduction		**$ 2,539,638**	**$ 3,200**	**$ 2,400,844**	**$ 2,213,760**
Cumulative Loss		**$ 2,539,638**	**$ 2,542,838**	**$ 4,943,682**	**$ 7,157,442**

Grant	FFY 17 Est. Award	FFY 19 Est. Award	FFY 20 Est. Award	FFY 21 Est. Award
	Estimated	Estimated	Estimated	Estimated
Block Grants for Community Mental Health Services	$ 4,719,761	$ 4,012,194	$ 3,699,242	$ 3,410,702
Substance Abuse Prevention & Treatment Block Grant	$ 19,373,439	$ 16,469,051	$ 15,184,465	$ 14,000,076
Colorado Mental Health Institute Medicare (-2%)	$ 147,579	$ 141,735	$ 138,900	$ 136,122
Total	**$ 24,240,779**	**$ 20,622,979**	**$ 19,022,607**	**$ 17,546,900**
Annual Reduction	**$ 2,041,265**	**$ 1,735,579**	**$ 1,600,372**	**$ 1,475,707**
Cumulative Loss	**$ 9,198,708**	**$ 12,816,508**	**$ 14,416,880**	**$ 15,892,587**

DEPARTMENT OF HUMAN SERVICES
(Office of Behavioral Health[1])

FY 2014-15 JOINT BUDGET COMMITTEE HEARING AGENDA

Tuesday, December 17, 2013
9:30 am – Noon

9:30-9:40 INTRODUCTIONS AND OPENING COMMENTS

9:40-10:30 QUESTIONS RELATED TO FY 2014-15 BUDGET PRIORITIES

(R10) Outside Medical Expenses

1. What is driving recent increases in outside medical costs? How much of the increase is attributable to an aging population?

2. How are other states handling the costs of providing inpatient psychiatric care, including medical care, for an aging population?

3. How are the rates paid by the Department to outside medical providers determined?

4. Please discuss the current Long Bill appropriation structure for the Mental Health Institutes, and any impacts this structure has on your ability to manage the two Institutes. Would approval of R10 provide the Institutes with sufficient management flexibility while providing the General Assembly with transparent and readily available information concerning expenditures at each Institute?

(R11) Mental Health Institutes Electronic Health Record System

5. Please provide an overview of this initiative, including the capital and operating requests for FY 2014-15, as well as projected capital and operating expenditures for the subsequent two fiscal years.

6. Describe the existing information systems that the proposed Electronic Health Record (EHR) System would replace. Further, please explain how this request relates to a request that the Department submitted in FY 2012-13 for an electronic health record and pharmacy system feasibility study (R2).

[1] This section of the budget includes: Community behavioral health administration; Mental health community programs; Substance use treatment and prevention; Co-occurring behavioral health services; and the Mental health institutes.

7. Explain how the proposed EHR system would communicate with other state agencies, vendors, and care providers. Further, how would the Department ensure that the proposed system would comply with privacy and legal requirements related to medical records?

(R14) Psychiatrist Base Salary Adjustment

8. Please clarify the status of psychiatrists who are employed by the Mental Health Institutes. Are they state employees or independent contractors?

(R15) Mental Health First Aid

9. Please describe the types of individuals who have participated in mental health first aid (MHFA) certification courses to date. If state funding is provided for certification courses in FY 2014-15, what types of individuals would the Department seek to certify?

10. To date, have any individuals paid a fee to attend an MHFA certification course or to attend an MHFA instructor course?

11. Why is the Department requesting state funding for both MHFA instructor courses and for individual certification courses in FY 2014-15? Do the fees for either of these courses create an attendance barrier?

12. Is MHFA certification required for any position or vocation?

13. Is MHFA training appropriate for law enforcement officers, or is a more specialized training more appropriate?

14. What interactions have the Office of Behavioral Health and/or Mental Health First Aid Colorado had with the Department of Public Safety related to MHFA training?

15. How would the requested funding be distributed? Does the Department plan to build off of the existing relationship between the Office of Behavioral Health and Mental Health First Aid Colorado to administer the requested funds?

16. Has the Office of Behavioral Health considered whether the Red Cross could provide the infrastructure to support statewide MHFA training?

(NPI1) Meal Services to Department of Corrections (DOC)

17. Please provide specific examples of the types of hospital operational expense reductions that have been required due to the shortfall in DOC payments for meal services.

10:30-10:45 BREAK

10:45-11:00 IMPLEMENTATION OF FY 2013-14 INITIATIVES

18. Please provide an update on the Department's implementation of S.B. 13-266.

19. Please provide an estimate of the amount the Department is likely to spend in FY 2013-14 for the implementation of S.B. 13-266, as well as for Community Transition Services and the Jail-based Competency Restoration Program.

20. What actions has the Department taken or does the Department plan to take to address the Department of Personnel and Administration's recommendations for improving the Department's solicitation processes? Please include information specific to the following issues:
    a. the skill sets of staff who play a key role in the solicitation process;
    b. Department workload and procurement team involvement in program plans;
    c. the process the Department uses to proactively perform due diligence in order to vet and approve all bid evaluation committee members; and
    d. the potential of using financial analysts or experts to offer proactive guidance to bid evaluators and the procurement team.

11:00-11:20 MENTAL HEALTH INSTITUTES

21. Please discuss the need for psychiatric inpatient care in Colorado and the availability of such services. Specifically:
    a. Provide a table detailing the changes in capacity at each Mental Health Institute since FY 2000-01.
    b. What has been the impact of recent unit closures at the Colorado Mental Health Institute at Ft. Logan? Are the inpatient psychiatric needs of children, adolescents, and geriatric patients currently being met statewide?
    c. How do the Mental Health Institutes ensure that they are in compliance with the court ruling in *Olmstead v. L.C.* [the U.S. Supreme Court case regarding discrimination against people with mental disabilities]?
    d. How many inpatient psychiatric beds are available in public and private hospitals or facilities other than the Institutes?
    e. Has the Department conducted a formal study of the need for inpatient psychiatric care in Colorado, or is the Department aware of another entity that has done so?
    f. Please describe any Department plans to study the need for inpatient psychiatric care, including the Department's capital funding request concerning Mental Health Institute facility program plans and site master plans.

11:20-11:40 TREATMENT FOR OFFENDERS

Correctional Treatment Cash Fund

22. Discuss the Department's use of moneys from the Correctional Treatment Cash Fund (CTCF), including the following:

    a. Detail the allocation of CTCF moneys by line item appropriation for FY 2013-14.

    b. Describe the nature of the expenditures supported by the CTCF within each line item appropriation, including the types of services or treatment that are provided.

    c. Describe the types and numbers of offenders who benefit from such expenditures, including: (1) whether they are juveniles or adults; and (2) whether they are serving a diversion sentence, serving a probation sentence, on parole, sentenced or transitioned to a community corrections program, or serving a sentence in a county jail or are receiving after-care treatment following release from jail.

23. Discuss how the Department would utilize the funding increases proposed by the Correctional Treatment Board for FY 2014-15.

24. Does the statutory provision governing the use of CTCF moneys preclude services or treatment expenditures that would be appropriate and justifiable? Does it preclude the provision of services to certain juvenile or adult offenders that would be appropriate and cost-effective? If so, please explain.

25. Describe how the Department evaluates (or plans to evaluate) the effectiveness of treatment and services that are supported by the CTCF.

26. Describe whether and how the Department monitors or evaluates the reasonableness of rates charged by treatment and service providers.

27. Does the Department make any effort to require offenders to pay a portion of the cost of services provided, if they are able to do so?

11:40-12:00 OTHER TOPICS

28. Please provide an overview of General Fund support for Community Mental Health Centers since FY 2000-01, including increases and decreases related to community provider rates and other General Fund adjustments.

29. Please define the term "medically indigent", and reference any statutory provision or rule where this term is defined.

30. Do Community Mental Health Centers have the ability to provide services to clients who are eligible for Medicaid or private insurance benefits and bill the relevant entity for the provision of such services?

31. What data does the Department collect to determine who is receiving services through Community Mental Health Centers based on the funding allocations made available through the Office of Behavioral Health? Does the Department have any plans to use this data to track the impact of S.B. 13-200 and the federal Affordable Care Act on the number of medically indigent clients?

32. Will federal sequestration have an impact on funding for substance abuse and mental health treatment services? If so, please describe.

33. The Colorado Commission on Criminal and Juvenile Justice (CCJJ) recently approved a recommendation to allocate moneys from the Marijuana Cash Fund to the Adolescent Substance Abuse Prevention and Treatment Fund for purposes of adolescent education and prevention related to marijuana use.
    a. Please describe the amount and types of revenues that are currently credited to this fund.
    b. Please describe the types of programming and activities that are currently supported by this fund, and detail actual fund expenditures for the last two fiscal years.
    c. Is an appropriation from the Adolescent Substance Abuse Prevention and Treatment Fund to the Office of Behavioral Health the best way to fund these education and prevention efforts, or would it be more appropriate to direct moneys from the Marijuana Cash Fund to the Tony Grampsas Youth Services Program for these efforts?
    d. What is the relationship between the Office of Behavioral Health and the Tony Grampsas Youth Services Program?