Colorado Department of Health Care Policy and Financing
R-023: Behavioral Health Claims and Eligibility Processing

Joint Technology Committee Staff Questions

A. Please provide written responses to the following questions to *jtc.ga@state.co.us* by 3:00 pm on Wednesday, March 17, 2021.

1. The request document explains that the project consists of three components:

- ***Eligibility processing*. Integrate with the Colorado Benefits Management System (CBMS) and the Colorado Program and Eligibility Application Kit (PEAK)**
- ***Claims and encounter processing*. Integrate claims processing with the Medicaid Management Information System (MMIS)**
- ***Data reporting*. The Business Intelligence and Data Management (BIDM) data warehouse will be updated to provide reports to program administrators and providers.**

a. What specific system modifications are needed?

RESPONSE:
High level systems modifications for CBMS and PEAK include the following:

- Modify PEAK/PEAK Mobile/Health First Colorado App, MyCOBenefits App to ask Behavioral Health Services (BHS) eligibility questions for members that are applying for Medical Assistance (MA) and/or denied or terminated for Medicaid. Information would be shared with CBMS and eligibility determination for BHS would be performed.

- Modify PEAKPro to either create a new user type or utilize existing user type (new or existing security profile) to allow providers to enter information for members to be determined for BHS. PEAKPro will collect information by either using an existing queue or creating a new queue. PEAKPro will transfer information to CBMS by using existing interfaces or creating a new interface.

- Modify CBMS to accept and store responses to these questions received from PEAK, PEAKPro, PEAK/PEAK Mobile/Health First Colorado App, MyCOBenefits App, or manually entered by a CBMS user (create new or modify existing CBMS pages and create a new queue).

- Modify CBMS to determine eligibility for BHS by adding new eligibility rules.

- Modify CBMS to create a medical span for eligible BHS members and transmit it to the Interchange.

- Modify CBMS to generate correspondence (English/Spanish, Med ID cards) to eligible BHS members.

High level systems modifications for MMIS and Data Warehouse include the following:

- Modify MMIS to accept and process CBMS medical spans for BHS members.
- Modify MMIS to determine the BHS benefit plan for the BHS members.
- Modify MMIS to determine new benefit plan rules for the various BHS eligibility types.
- Modify the MMIS to allow prior authorizations for specific BHS services.
- Modify the MMIS to allow providers to identify BHS members and benefit plan during eligibility verification of the member.
- Modify MMIS to create new provider type enrollments that are not currently available.
- Modify the MMIS BHS benefit plans to identify covered and non-covered services.
- Modify the MMIS BHS benefit plans to reimburse providers based on the various payment methodologies.
- Modify the MMIS BHS benefit plans to be able to report the services to the appropriate financial accounting codes. Services paid will need to separate the funds between the different programs.
- Modify the MMIS and the data warehouse to accept and process new data elements needed for the BHS program. New database tables will be developed.
- Modify the MMIS and data warehouse to create new reports needed to manage and maintain the BHS program.

b. Technically, are these components mutually exclusive? If not, please describe any dependencies.

RESPONSE: The CBMS, MMIS, and BIDM are separate systems. CBMS does not have a dependency on the MMIS or BIDM, however, the MMIS does have a dependency on the CBMS to complete their eligibility changes to produce files for the MMIS. The BIDM has a dependency on the MMIS for the claims data.

c. Will these project components be occurring simultaneously or in phases? What is the timeline for the updates?

RESPONSE: The projects will be occurring simultaneously in all systems, however, there is a dependency on the CBMS to complete their work prior to the MMIS being able to complete all of its change requests. This will result in the projects being worked in phases.

Once the detailed requirements are developed, specific timelines for updates can be provided.

2. **The request document explains that the project work will be managed with contract amendment(s) with existing vendors.**

   a. **Please summarize the contract type, such as fixed-price or time & materials.**

   RESPONSE: The contracts are fixed price operational contracts with a fixed hourly rate for system changes. The system change request estimates are time and material based upon the number of hours necessary to complete the changes. The contractors have provided the time and cost estimates based on the high-level requirements provided by HCPF and OBH.

   b. **Will different vendors be engaged for all three components? Please explain, including any risks the department might need to mitigate in managing different vendors.**

   RESPONSE: Different vendors will be used to implement all three components, Deloitte and OIT for the CBMS, Gainwell for the MMIS, and IBM for the BIDM. The risks the Department needs to mitigate are going to be managed by the HCPF's Project Manager and Project Coordinators, as risks are identified when developing and managing the project plan. Initially the known risks that will need to be identified are risks associated with the project timeline once detailed requirements are developed and coordinating the hiring and training of the new staff.

3. **During the JBC hearing on January 7, 2021, the department explained that the implementation of the eligibility and billing is integrated since the data must be exchanged between the systems (see #44 on page 75 of the JBC hearing document). The department further explained that the high-level phases include:**

   - **conducting an analysis of all of the eligibility requirements across programs for the eligibility system (CBMS) changes (implementing the program eligibility within CBMS would be the first system implementation);**
   - **streamlining the access for provider enrollment into the department's claims processing system (MMIS); and**
   - **developing and implementing the requirements in the MMIS for benefits, providers, and services.**

   a. **Please provide a list of high-level milestones for years one and two, along with estimated costs.**

   RESPONSE:
   CBMS/MMIS for OBH and HCPF in Year 1:
   - Hire new Business Analysts, User Acceptance Testers, Program/Policy Analysts, Project manager and Project coordinators.

- Develop and communicate project key performance indicators, schedule, tasks, roles and responsibilities
- Identify program benefits within the Behavioral Health programs with program/policy analysts for new system benefit
- Design and Develop detailed system change requests
- Estimated FTE and operating year one expenses: $2,090,225
    - Estimated system design and development (MMIS and BIDM): $3,153,555
    - Estimated system design and development (CBMS/PEAK): $2,223,000

CBMS/MMIS for OBH and HCPF in Year 2:

- Developing and implementing detailed system change requests
- System Testing
- Pilot new benefit in system with stakeholders/providers
- Implement necessary system changes based on stakeholder feedback
- User Acceptance Testing completion
- Stakeholder approvals
- Train call center staff
- Post Implementation stabilization
- Estimated FTE and operating Year two expenses: $2,052,479

4. **Regarding the "claims and encounter processing" component, the request document explains that providers will be paid the same after the system change; however, the change will provide program managers the ability to validate services.**

    a. **Please summarize how program managers validate services now, and how the MMIS change will improve this validation.**

    RESPONSE: Currently, providers billing OBH for services that are not covered by Medicaid or for non-Medicaid covered individuals will submit a claim to OBH. These claims are not processed in the same way that the HCPF MMIS processes a claim but are used to validate the number of services provided to a client. Providers then submit invoices manually via email for payments on a monthly basis and the number of services rendered are used to validate the payments that are made via an invoice. Providers are also required to submit copies of the claims submitted to Medicaid to OBH to manually help identify if there are duplicate payments from OBH. Providers complete this process for multiple funding types across the multiple behavioral health line items, and must go through another validation process for each agency, and sometimes within the same agency. For example, a community mental health center serving a single person who needs treatment for alcohol use, opioid addiction and anxiety would repeat the billing and validation process three times. This process is cumbersome to both provider and state administration in both the payment and budget tracking process.

Creating a single infrastructure to pay a claim will eliminate the need for providers to submit copies of claims paid by Medicaid, claims to validate payments from OBH, and submission of invoices for payment from OBH. Additionally, this will streamline reimbursement for providers and ensure payments are made more quickly, accurately and efficiently.

b. Please give a specific example of current challenges, the approximate rate of occurrence, and the impact.

RESPONSE: In 2016 OPSB conducted an analysis of this issue from a sample of records and found that 3,674 Medicaid eligible individuals received OBH funded services during FY 2014-15 while enrolled with a Medicaid managed care organization. Of these individuals, 664 (18%) were enrolled with a managed care organization on the date services were provided by the CMHC. Thus, it is assumed OBH made case rate payments of $3,186 per client (the FY 2014-15 case rate amount) to CMHC's for clients who were also funded by Medicaid capitation. The total estimated amount of these payments is approximately $2.1 million. This same report states "The state's current behavioral health service delivery and reimbursement system is outdated and its structure prevents any significant increases in efficiency and effectiveness." This same report goes on to state that "providers use multiple methods for obtaining reimbursement for contracted services which creates 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 clients."

5. The request document explains that funds are needed for contractor and temporary staff. Please provide a list of each role, with the corresponding role quantity, biweekly salary, and total weeks.

RESPONSE: For Design, Development, and Implementation of the new benefit in the MMIS, CBMS and Data Warehouse for HCPF and OBH resources include: 11 Business Analysts, 3 User Acceptance Testers, 1 Project Manager, 2 Project Coordinators and 6 Program/Policy Benefit Analysts. As identified in the R-23 budget request, these positions will be Administrator IV level staff with a bi-weekly salary of $2,456. The estimate is 72 to 96 weeks.

6. System integration can be accomplished using several different approaches, such as using an enterprise service bus architecture. If known, please describe the approach the project will use and the reason. Please also explain if the department plans to use any of the existing integration middleware licenses via OIT.

RESPONSE: System integration for the OBH system into the MMIS will occur in phases as specific requirements are designed, utilizing the current system change process and architecture, which the Department currently utilizes for large system changes to the CBMS, MMIS, and BIDM. These systems already utilize enterprise architectural solutions that will be reused, therefore, will not impact existing system file transfers. Utilizing the existing solutions will eliminate the file transfer issues that generally occur with new implementations.

7. **What is the average time providers currently spend on eligibility determination and billing? How much cost savings are expected for providers with this project?**

RESPONSE: OBH recently completed a comprehensive behavioral health needs assessment that included both qualitative and quantitative analysis. A major finding from this analysis is the fragmentation and the lack of integration at the administrative system level. (Colorado Behavioral Health Needs Assessment, 2020. State of the State. Pg.15) A quote from a community member states "There are too few resources to address the behavioral health needs in our state and significant fragmentation is what is there. At this point most know fragmentation is the issue, and decision makers are not willing to commit to significantly upgrading the system to meet the already present and consistently growing system needs."

OBH does not have a comprehensive and quantifiable analysis of the time spent on billing but a reasonable estimate of a single provider that accepts both Medicaid and Commercial insurance, and then has contracts with other non-profits or government organizations is that for a clinician seeing 25 clients per week you would spend about 8 -12 hours per week on administrative billing processes and then another 8-10 hours on case management or care coordination services meaning half of your time in a given week is spent on administrative burden rather than seeing clients. Streamlining billing processes, in addition to reduction of administrative burden through regulatory changes and other steps, are intended to decrease the time spent getting paid and increase time with patients.

Regarding the amount of time spent on eligibility, we do not have insight into the amount of time providers, care coordinators, counties, patients and their families spend. Since the system is complex and information about how to access state behavioral funding is disparate, even the most familiar providers have to track down eligibility requirements across multiple different websites and program pages. Many providers don't qualify for reimbursement for time spent on system navigation, and the BHTF testimony was full of examples of how exhausting it is to try and find funding if they are uninsured or if a service is covered under a health plan. During secret shopper calls done by the state, even some publicly funded providers inaccurately told callers there were no funding options at their location. Automating this process creates a more equitable and accessible system.

8. **How were costs for this project estimated, specifically the system change costs in Table 2.1 in Appendix A**?

   RESPONSE: The system costs follow the HCPF's standard estimation process and are provided by the system vendors, using high level business requirements estimates.

B. Please address the following questions during the presentation to the JTC.

1. **During past JTC and JBC presentations, it has been mentioned that there are 75 behavioral health programs across 10 different agencies. Does the department anticipate that this project would involve bringing the eligibility and billing systems used at all 75 programs into the new consolidated system?**

   RESPONSE: The Colorado Health Institute identified 75 programs, which could be better described as 75 different line items that fund behavioral health programs. Not all 75 programs will be consolidated for this project. Of the 75 programs, a majority of the line items go to purchase behavioral health treatment through contracts or subcontracts, often from the same vendors. Of the 75 programs, only the programs that reimburse for clients services (prevention, screening, treatment, recovery) would be included in this expansion. For example, a small portion of federal Block Grant funding from the Office of Behavioral Health is used to pay for state staff, which would not be incorporated. It is also used to pay community mental health centers and managed service organizations for serving clients who are uninsured, which would be incorporated. Another example is the funding for the Department of Public Health and Environment, who has funding for drug and alcohol surveillance, which would not likely be included.

   The Department of Human Services currently has a contract with Health Management Associates to review the eligibility and payment process for each of these programs. The vendor will provide a full set of recommendations as to which programs and funding lines should be incorporated into the MMIS. The Department anticipates at least 50 of the 75 identified programs will be incorporated into the MMIS, a majority of which are currently administered by the Department of Human Services. The first programs that would be prioritized would be the largest programs within the Department of Human Services-Office of Behavioral Health, including:

   - Residential SUD Room and Board Payments that cover a portion of the Medicaid Residential Benefit
   - Adult Mental Health and Substance Use Block Grant (Indigent/Uninsured Population)
   - Adult Criminal Justice Services (outpatient, offender treatment)

- Crisis Services (Crisis Services- Mobile, Walk-in, Stabilization, & Respite Services)
- Children and Adolescent Mental Health and Substance Use Block Grant (Uninsured and Underinsured)

2. **Please provide information about any stakeholding work the department did with behavioral health care providers in developing this project plan in order to understand their needs. Additionally, what change management efforts does the department plan to undertake as part of this project, especially as it relates to addressing providers' skepticism about the proposed benefits of the project?**

   RESPONSE: Recommendations around consolidating infrastructure, reporting and data analysis, billing, and financial administration was a regular topic of discussion during the Behavioral Health Task Force over the past two years and included in the unanimously adopted Blueprint for Behavioral Health Reform. HCPF, along CDHS, DOI, and CDPHE participated in multi-stakeholder discussions, including providers, on the main Task Force and three different subcommittees. During this time, the concerns from providers were consistent and aligned that trying to understand who and how to bill for services was one of their top issues. Another consistent complaint from providers was the different data and quality reporting processes across different programs. HCPF and CDHS relied on this stakeholder process to build this budget request. The Departments did not directly engage with providers to the level of setting the project plan timeline or milestones, as the budget process is not public. The CDHS behavioral health statewide needs assessment included multiple interviews and surveys with providers. All OBH contracted providers were sent the survey and the Regional Accountable Entities (RAEs) were asked to share with their contracted providers. The report identified complex funding and administrative burden as an issue of workforce retention and contributing to provider burnout.

   Health Management Associates, the vendor hired to do the behavioral health system analysis will be creating an implementation plan due June 30, 2021 for the state which includes a change management plan. This will focus on how the state will implement the recommendations of the Blueprint for Behavioral Health Reform and will include timelines through July 2022.

3. **Please provide the committee with greater detail about the project scope to specifically address the JBC's concerns that the project scope, as outlined in the original request document, lacks clear definition, including the project cost, timing, and programs to be included.**

   RESPONSE: HCPF has been working with vendors and CDHS on this concept for many years. Additionally, the scope determination is developed through an existing system change

estimation process, as HCPF is reusing the existing MMIS infrastructure. The cost estimate is based on the HCPF's standard process for developing high level scope costs with system vendors that do not contain detailed system change request information initially. The next step in that process is for program analysts and business analysts to develop specific system change requirements with specific system details in partnership with the OBH and HCPF program and policy analysts to determine the specific system change scope. The timing for this request supports a coordinated timeline with the build out and implementation of the Behavioral Health Administration, so that the MMIS will be a tool to support some of the core functions of this agency. With the recognition that the project design and development is included in the request and takes at least 18 months, this expansion should be functional just as the state is implementing the longer change management plan related to behavioral health reform as outlined in the Blueprint for Behavioral Health Reform.

The programs to be included in the MMIS expansion will be determined through a formal analysis currently being conducted by Health Management Associates which, who will also be making recommendations around how to streamline program eligibility for clients and families by June 2020.

4. **Does the department plan to use an agile methodology for the implementation of the project?**

   RESPONSE: HCPF uses Agile, Waterfall, and a combination of the two system development life cycles as required by the system change.

5. **If the department does not receive funding for this request, would that impact the work of the Behavioral Health Administration?**

   RESPONSE: The Behavioral Health Administration is charged with: leading and promoting the state's behavioral health priorities; providing the infrastructure needed to deliver on the reform recommendations; and being responsible for responding to the changing needs of Colorado communities. Without a comprehensive system to track funding, utilization, quality metrics, providers, and clients accessing services, all of these tasks will be difficult and administratively inefficient and costly.

6. **Please elaborate on the estimates the department used to come to the conclusion 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." The BHA projects and work with our vendor partners to determine the ongoing operational costs. Does the department have an estimate of the ongoing operations and maintenance expenses or the corresponding administrative efficiency savings for the project? Please address the**

observation that the administrative savings will be realized by the providers, and not the department, while the ongoing system expenses will be the department's responsibility.

RESPONSE:
HCPF and OBH do not have an estimate of the ongoing operations and maintenance expenses or the corresponding administrative efficiency savings for the project at this time. There are two anticipated sources of administrative savings to be realized by OBH or the State.

- **Savings through federal match**: Using a single system removes the risk of duplicative payments and ensures the HCPF leverages enhanced federal financing whenever possible. This system will not only be more efficient, it will help to prevent fraud, waste, and abuse. Many of these programs serve vulnerable populations that may be eligible for Medicaid and have a potential overlap with Medicaid. When someone is Medicaid eligible but not enrolled, services are billed to CDHS for indigent/uninsured benefit, but then the client is enrolled in Medicaid and then HCPF can be billed retroactively for those same services. In 2016, OSPB completed a Behavioral Health Billing Analysis that recommended "OBH/HCPF should take immediate action to significantly reduce or eliminate the payment of indigent client funding to CMHCs for individuals who are Medicaid eligible" This allows state program dollars to go further from other non-Medicaid programs.

- **Savings through state resource efficiencies and reallocation, in coordination with the BHA**. As the state seeks to defragment our behavioral health system into a single cohesive structure, the agencies that fund behavioral health services are currently participating in a change management analysis led by Health Management Associates. One of the key aspects is to take a wide angle view of how the state spends money across agencies. The current funding allocated across multiple agencies for the purposes of eligibility determination, claim processing and data collection and analysis will need to be reconsidered, as it relates to the programs being integrated into the MMIS.

This is one of a few initiatives that are upcoming related to behavioral health reform in which the cost savings may be realized beyond a single agency, which will always be a challenge in true reform initiatives. But siloed state administration should not limit our ability as a state to see the bigger picture and improve our infrastructure for the betterment of a system that is more effective for patients and providers.

7. **If the department does not receive funding for this request, what impact would that have on the "consolidated behavioral health data collection" component of the Department of Human Services' Behavioral Health Infrastructure Investments IT capital project that the JTC recommended funding, or any other components of that IT capital project?**

RESPONSE: Without funding to modify the HCPF systems behavioral data will still be fragmented and reporting will still be required to separate state agencies. Clients and providers will still be required to manually determine what programs a client may be eligible for. Providers will have separate portals to view outcomes and performance data that will be difficult to understand and compare effectiveness of the system. The CDHS-OBH request to consolidate administrative and clinical data collection between Medicaid, commercial insurance and other relevant funding organizations is an opportunity to ensure that clients eligible for coverage through Medicaid are enrolled and to improve financial transparency between our two agencies so that state funds are used to cover non-medicaid covered services and individuals, and to decrease provider burden by having one system for eligibility, claims payments and reporting. There are longstanding challenges to understanding services and safety net providers, as well missed opportunities to ensure individuals that are eligible for Medicaid are enrolled in coverage. Integrating OBH client information with HCPF systems including claims payment system (MMIS), the eligibility determination system (CBMS), and the business data warehouse (e.g., HCPF's BIDM).

Consolidating data collection and billing requirements into a single infrastructure reduces the administrative burden for providers, improves reporting back to providers, improves the State's ability to support quality improvement efforts, build capacity in prioritized areas and ensure clients needing coverage for healthcare services are connected to appropriate funding sources for treatment services. In addition, this increases the opportunity to identify Medicaid reimbursable services that may be currently paid out of state funds.