

Second Regular Session  
Seventy-fourth General Assembly  
STATE OF COLORADO

INTRODUCED

LLS NO. 24-0343.01 Jane Ritter x4342

SENATE BILL 24-059

---

SENATE SPONSORSHIP

**Kirkmeyer and Michaelson Jenet**, Fields, Pelton B., Zenzinger

HOUSE SPONSORSHIP

**Duran and Pugliese**, Bradley, Evans, Froelich, Joseph, Young

---

**Senate Committees**  
Health & Human Services

**House Committees**

---

A BILL FOR AN ACT

101 CONCERNING ESTABLISHING A CHILDREN'S BEHAVIORAL HEALTH  
102 STATEWIDE SYSTEM OF CARE.

---

**Bill Summary**

*(Note: This summary applies to this bill as introduced and does not reflect any amendments that may be subsequently adopted. If this bill passes third reading in the house of introduction, a bill summary that applies to the reengrossed version of this bill will be available at <http://leg.colorado.gov/>.)*

**Colorado's Child Welfare System Interim Study Committee.**  
The bill requires the behavioral health administration (BHA), in partnership with the office of children, youth, and families in the department of human services; the department of health care policy and financing; the division of insurance in the department of regulatory agencies; and the department of public health and environment, to

Shading denotes HOUSE amendment. Double underlining denotes SENATE amendment.  
Capital letters or bold & italic numbers indicate new material to be added to existing law.  
Dashes through the words or numbers indicate deletions from existing law.

develop, establish, and maintain a comprehensive children's behavioral health statewide system of care (system of care). The system of care will serve as the single point of access to address the behavioral health needs of children and youth in Colorado, regardless of payer, insurance, and income.

The system of care shall serve children and youth up to twenty-one years of age who have mental health disorders, substance use disorders, co-occurring behavioral health disorders, or intellectual and developmental disabilities.

The system of care must include, at a minimum, a statewide behavioral health standardized screening and assessment, trauma-informed mobile crisis response and stabilization services for children and youth, tiered care coordination for moderate and intensive levels of need, parent and youth peer support, intensive in-home and community-based services, and respite services.

The bill establishes the office of the children's behavioral health statewide system of care (office) in the BHA. The office is the primary governance entity and is responsible for convening all relevant state agencies involved in the system of care, including, but not limited to, the department of human services office of children, youth, and families, the division of child welfare, and the division of youth services; the department of health care policy and financing; the division of insurance in the department of regulatory agencies; and the department of public health and environment. The office will be directed by the deputy commissioner of the office.

The bill requires the office to create and convene, on or before November 1, 2024, a leadership team responsible for decision-making and oversight. The leadership team is required to provide a report to the house of representatives public and behavioral health and human services committee and the senate health and human services committee, or their successor committees, on or before July 1, 2027.

The office is required to create and convene, on or before January 15, 2025, an implementation team that shall create an implementation plan for the system of care. The implementation plan must receive an annual minimum appropriation of \$10 million and include the creation of a capacity-building center, which shall develop, implement, and fund, within available appropriations, the following:

- A student loan forgiveness program for students in behavioral health disciplines who make a 3- to 5-year commitment to work in shortage areas in the system of care;
- Paid internships and clinical rotations in the system of care and a description of multiple options for payment;
- Revisions to graduate medical education programs at Colorado institutions of higher education to support

internships, residencies, fellowships, and student programs in child and youth behavioral health;

- A financial aid program for youth transitioning out of foster care who wish to pursue a career in children and youth behavioral health, developed in partnership with Colorado institutions of higher education and community colleges; and
- An expansion of current BHA efforts related to behavioral health apprenticeships, internships, stipends, and pre-licensure workforce support specific to service children, youth, and families.

On or before January 15, 2025, the office is required to create an advisory council, composed of, at a minimum, family and youth providers, local partners, county departments of human and social services, county commissioners, juvenile justice agencies, families or individuals with lived experience using children's or youths' behavioral health services, consumer advocacy organizations, and university partners.

The BHA shall develop a state-level process to monitor, report on, and promptly resolve complaints, grievances, and appeals, including recipient rights issues. The process must be available to providers, clients, case management entities, and anyone else working with the children and youth in the system of care.

The bill requires the leadership team to begin, or contract for, on or before January 1, 2025, a cost and utilization analysis of the populations of children and youth who are included in the system of care.

On or before July 1, 2025, the department of health care policy and financing, in consultation with the office, is required to establish standard and uniform medical necessity criteria for all system of care services. The department of health care policy and financing is required to set standard rate and utilization floors for all system of care services across all managed care entities.

On or before July 1, 2025, the bill requires the department of health care policy and financing to establish a standard statewide medicaid fee schedule or rate frame for behavioral health services for children and youth and incorporate the fee schedule and rate frame into the contracts with managed care entities and behavioral health administrative services organizations. The fee schedule or rate frame must increase rates and incorporate enhanced rates or quality bonuses for evidence-based practices and extended weekday and weekend clinic hours and allow maximum flexibility for use of telehealth to expand access.

The bill requires that each managed care entity or behavioral health administrative services organization contract with or have single-use agreements with every qualified residential treatment facility

or psychiatric residential treatment facility that is licensed in Colorado.

The office, advised by state and county partners, providers, and racially, ethnically, culturally, and geographically diverse family and youth representatives, is required to develop and establish a data and quality team. The data team shall track and report annually on key child welfare factors.

The bill requires the BHA, advised by the office, to establish or procure a capacity-building center. The capacity-building center shall, at a minimum:

- Train, coach, and certify providers of the array of services offered through the system of care;
- Provide training, coaching, and certification related to the use of behavioral health screening and assessment tools to support a uniform assessment process and training in trauma-informed care to staff at relevant state agencies;
- Work with rural health clinics and federally qualified health centers to expand their capacity to provide behavioral health services to children and youth;
- Offer training and other strategies to expand the number of behavioral health providers in rural and other underserved communities; and
- Utilize data and reports to target its investment to build capacity in regions identified as lacking capacity.

The bill requires the BHA to develop a website to provide regularly updated information to families, youth, providers, staff, system partners, and others regarding the goals, principles, activities, progress, and timelines for the system of care. The website must include key performance dashboard indicators; changes in access by the child welfare population; changes in access disparities between racial, ethnic, and regional groups; and changes in access to intensive- and moderate-care coordination with high-fidelity wraparound.

---

1 *Be it enacted by the General Assembly of the State of Colorado:*

2 **SECTION 1.** In Colorado Revised Statutes, **add** part 10 to article  
3 50 of title 27 as follows:

4 **PART 10**  
5 **CHILDREN'S BEHAVIORAL HEALTH**  
6 **STATEWIDE SYSTEM OF CARE**

7 **27-50-1001. Short title.** THE SHORT TITLE OF THIS PART 10 IS THE

1 "CHILDREN'S BEHAVIORAL HEALTH STATEWIDE SYSTEM OF CARE".

2 **27-50-1002. Definitions.** AS USED IN THIS PART 10, UNLESS THE  
3 CONTEXT OTHERWISE REQUIRES:

4 (1) "ADVISORY COUNCIL" MEANS THE ADVISORY COUNCIL  
5 CREATED BY THE OFFICE PURSUANT TO SECTION 27-50-1004 (4).

6 (2) "BEHAVIORAL HEALTH ADMINISTRATIVE SERVICES  
7 ORGANIZATIONS" ARE THOSE ORGANIZATIONS THE BHA SELECTS AND  
8 CONTRACTS WITH PURSUANT TO PART 4 OF THIS ARTICLE 50.

9 (3) "CAPACITY-BUILDING CENTER" MEANS THE  
10 CAPACITY-BUILDING CENTER CREATED OR PROCURED BY THE BHA  
11 PURSUANT TO SECTION 27-50-1010.

12 (4) "DATA TEAM" MEANS THE DATA AND QUALITY TEAM CREATED  
13 BY THE OFFICE PURSUANT TO SECTION 27-50-1009.

14 (5) "DEPUTY COMMISSIONER" MEANS THE DEPUTY COMMISSIONER  
15 OF THE OFFICE, APPOINTED PURSUANT TO SECTION 27-50-1004.

16 (6) "EARLY AND PERIODIC SCREENING, DIAGNOSTICS, AND  
17 TREATMENT" MEANS THE FEDERAL MANDATORY MEDICAID BENEFIT FOR  
18 CHILDREN AND YOUTH, AS PROVIDED FOR IN SECTION 25.5-5-102 (1)(g).

19 (7) "FUNCTIONAL FAMILY THERAPY" MEANS A SHORT-TERM  
20 PROGRAM DESIGNED TO ADDRESS RISK AND PROTECTIVE FACTORS TO  
21 PROMOTE HEALTHY DEVELOPMENT FOR YOUTH EXPERIENCING  
22 BEHAVIORAL OR EMOTIONAL PROBLEMS. FUNCTIONAL FAMILY THERAPY  
23 IS TYPICALLY DELIVERED BY THERAPISTS IN HOME AND CLINICAL SETTINGS  
24 AND LASTS FROM THREE TO SIX MONTHS.

25 (8) "IMPLEMENTATION PLAN" MEANS THE SYSTEM OF CARE  
26 IMPLEMENTATION PLAN CREATED PURSUANT TO SECTION 27-50-1005.

27 (9) "IMPLEMENTATION TEAM" MEANS THE TEAM CREATED BY THE

1 OFFICE PURSUANT TO SECTION 27-50-1004 (3) TO DEVELOP THE  
2 IMPLEMENTATION PLAN AND OPERATIONALLY OVERSEE AND GUIDE  
3 IMPLEMENTATION.

4 (10) "LEADERSHIP TEAM" MEANS THE LEADERSHIP TEAM CREATED  
5 PURSUANT TO SECTION 27-50-1004 (2) AND RESPONSIBLE FOR  
6 DECISION-MAKING AND OVERSIGHT OF THE OFFICE.

7 (11) "MANAGED CARE ENTITY" OR "MCE" MEANS A MANAGED  
8 CARE ENTITY RESPONSIBLE FOR THE STATEWIDE SYSTEM OF COMMUNITY  
9 BEHAVIORAL HEALTH CARE, AS DESCRIBED IN SECTION 25.5-5-402 (3), AND  
10 THAT IS NOT OWNED, OPERATED BY, OR AFFILIATED WITH AN  
11 INSTRUMENTALITY, MUNICIPALITY, OR POLITICAL SUBDIVISION OF THE  
12 STATE.

13 (12) "MULTISYSTEMIC THERAPY" OR "MST" MEANS AN INTENSIVE  
14 COMMUNITY-BASED, FAMILY-DRIVEN TREATMENT FOR ADDRESSING  
15 ANTISOCIAL OR DELINQUENT BEHAVIOR IN YOUTH. MST FOCUSES ON THE  
16 ECOLOGY OF THE YOUTH DURING SERVICE DELIVERY TO ADDRESS THE  
17 CORE CAUSES OF ANTISOCIAL OR DELINQUENT BEHAVIORS, WITH A FOCUS  
18 ON SUBSTANCE USE, GANG AFFILIATION, TRUANCY, EXCESSIVE TARDINESS,  
19 VERBAL AND PHYSICAL AGGRESSION, AND LEGAL ISSUES.

20 (13) "OFFICE" MEANS THE OFFICE OF THE CHILDREN'S BEHAVIORAL  
21 HEALTH STATEWIDE SYSTEM OF CARE CREATED PURSUANT TO SECTION  
22 27-50-1004.

23 (14) "PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY" HAS THE  
24 SAME MEANING AS SET FORTH IN SECTION 25.5-4-103.

25 (15) "SYSTEM OF CARE" MEANS THE CHILDREN'S BEHAVIORAL  
26 HEALTH STATEWIDE SYSTEM OF CARE, ESTABLISHED PURSUANT TO THIS  
27 PART 10.

1 (16) "THERAPEUTIC FOSTER CARE" HAS THE SAME MEANING AS SET  
2 FORTH IN SECTION 26-6-903.

3 (17) "TREATMENT FOSTER CARE" HAS THE SAME MEANING AS SET  
4 FORTH IN SECTION 26-6-903.

5 (18) "WRAPAROUND" MEANS A HIGH-FIDELITY, INDIVIDUALIZED,  
6 FAMILY-CENTERED, STRENGTHS-BASED, AND INTENSIVE CARE PLANNING  
7 AND MANAGEMENT PROCESS USED IN THE DELIVERY OF BEHAVIORAL  
8 HEALTH SERVICES FOR A CHILD OR YOUTH WITH A BEHAVIORAL HEALTH  
9 DISORDER.

10 **27-50-1003. Children's behavioral health statewide system of**  
11 **care - established - eligibility - purpose - components - rules.** (1) THE  
12 BEHAVIORAL HEALTH ADMINISTRATION, IN PARTNERSHIP WITH THE OFFICE  
13 OF CHILDREN, YOUTH, AND FAMILIES IN THE DEPARTMENT OF HUMAN  
14 SERVICES; THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING;  
15 THE DIVISION OF INSURANCE IN THE DEPARTMENT OF REGULATORY  
16 AGENCIES; AND THE DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT,  
17 SHALL DEVELOP, ESTABLISH, AND MAINTAIN A COMPREHENSIVE  
18 CHILDREN'S BEHAVIORAL HEALTH STATEWIDE SYSTEM OF CARE. THE  
19 SYSTEM OF CARE SERVES AS THE SINGLE POINT OF ACCESS TO ADDRESS THE  
20 BEHAVIORAL HEALTH NEEDS OF CHILDREN AND YOUTH IN COLORADO,  
21 REGARDLESS OF PAYER, INSURANCE, AND INCOME.

22 (2) THE SYSTEM OF CARE SHALL SERVE CHILDREN AND YOUTH UP  
23 TO TWENTY-ONE YEARS OF AGE WHO HAVE MENTAL HEALTH DISORDERS,  
24 SUBSTANCE USE DISORDERS, CO-OCCURRING BEHAVIORAL HEALTH  
25 DISORDERS, OR INTELLECTUAL AND DEVELOPMENTAL DISABILITIES.

26 (3) SERVICES COVERED THROUGH THE SYSTEM OF CARE MUST BE  
27 PAID FIRST THROUGH MEDICAID AND PRIVATE INSURANCE. THE BHA

1 SHALL PROMULGATE RULES DEFINING THIS PAYMENT STRUCTURE, AS WELL  
2 AS WHEN GENERAL FUND DOLLARS MUST PAY FOR SERVICES.

3 (4) AFTER THE IMPLEMENTATION PLAN IS DEVELOPED AND FULLY  
4 IMPLEMENTED, THE SYSTEM OF CARE MUST INCLUDE, AT A MINIMUM:

5 (a) A STATEWIDE BEHAVIORAL HEALTH STANDARDIZED SCREENING  
6 AND ASSESSMENT. THE OFFICE OF THE CHILDREN'S BEHAVIORAL HEALTH  
7 STATEWIDE SYSTEM OF CARE SHALL EXPAND THE NETWORK OF  
8 INDIVIDUALS ACROSS THE STATE WHO ARE TRAINED IN BEHAVIORAL  
9 HEALTH SCREENING AND ASSESSMENT TOOLS. THE BEHAVIORAL HEALTH  
10 STANDARDIZED SCREENING AND ASSESSMENT MUST REQUIRE:

11 (I) THAT BEHAVIORAL HEALTH SCREENINGS ARE AVAILABLE IN  
12 PEDIATRIC PRIMARY CARE PROVIDER SETTINGS FOR MEDICAID-ENROLLED  
13 CHILDREN AND YOUTH THROUGH THE FEDERAL EARLY AND PERIODIC  
14 SCREENING, DIAGNOSIS, AND TREATMENT BENEFIT;

15 (II) THAT BEHAVIORAL HEALTH SCREENINGS ARE AVAILABLE IN  
16 SCHOOL SETTINGS FOR MEDICAID-ENROLLED CHILDREN AND YOUTH  
17 THROUGH THE FEDERAL EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND  
18 TREATMENT BENEFIT; AND

19 (III) THE USE OF THE ASSESSMENT TOOL, AS DESCRIBED IN SECTION  
20 27-62-103, TO SUPPORT INITIAL ELIGIBILITY DECISIONS, CRISIS SUPPORT  
21 INTERVENTION, LEVEL OF CARE AND INTERVENTION NEED, AND  
22 TREATMENT PLANNING. WHEN A CARE MANAGEMENT ENTITY USES THE  
23 ASSESSMENT TOOL TO PROVIDE INTENSIVE-CARE COORDINATION WITH  
24 HIGH-FIDELITY, WRAPAROUND, AND MODERATE-INTENSIVE-CARE  
25 COORDINATION TO CREATE A TREATMENT PLAN, THE MANAGED CARE  
26 ENTITY MUST USE THE PLAN TO DETERMINE THE SERVICES OFFERED BY  
27 BEHAVIORAL HEALTH ADMINISTRATIVE SERVICES ORGANIZATIONS OR



1 MCEs THAT WILL BE PROVIDED TO THE CLIENT.

2 (b) TRAUMA-INFORMED MOBILE CRISIS RESPONSE AND  
3 STABILIZATION SERVICES FOR CHILDREN AND YOUTH. THE DEPARTMENT  
4 OF HEALTH CARE POLICY AND FINANCING, IN COORDINATION WITH THE  
5 IMPLEMENTATION TEAM AND UNDER THE GUIDANCE OF THE ADVISORY  
6 COUNCIL, SHALL, AS PART OF ITS EXISTING MOBILE CRISIS RESPONSE UNIT,  
7 REVISE STATEMENT CERTIFICATION CRITERIA AND ESTABLISH A CHILDREN-  
8 AND YOUTH-SPECIFIC MOBILE CRISIS RESPONSE AND STABILIZATION  
9 SERVICE THAT IS AVAILABLE FOR ALL CHILDREN AND YOUTH, REGARDLESS  
10 OF PAYER. THE MOBILE CRISIS RESPONSE AND STABILIZATION SERVICE  
11 MUST:

12 (I) REFLECT NATIONAL BEST PRACTICES FOCUSED SOLELY ON  
13 CHILDREN AND YOUTH;

14 (II) ALLOW THE CALLER TO DEFINE WHAT CONSTITUTES A CRISIS  
15 FOR THAT CALLER;

16 (III) PROVIDE SERVICES, WHEN APPROPRIATE, FOR UP TO  
17 FORTY-FIVE DAYS, ALONG WITH A ONE-TO-ONE CRISIS STABILIZER WHEN  
18 NECESSARY;

19 (IV) MAKE INITIAL SERVICES AVAILABLE FOR UP TO SEVENTY-TWO  
20 HOURS; AND

21 (V) ON OR BEFORE JULY 1, 2025, EXPAND CRISIS RESOLUTION  
22 TEAMS STATEWIDE FOR CHILDREN AND YOUTH UP TO TWENTY-ONE YEARS  
23 OF AGE, BASED ON THE IMPLEMENTATION PLAN. THE MOBILE CRISIS  
24 RESPONSE AND STABILIZATION SERVICES PROVIDER SHALL ALSO PROVIDE  
25 CRISIS RESOLUTION TEAMS OR ESTABLISH CONTINUITY BETWEEN A CRISIS  
26 RESOLUTION TEAM PROVIDER AND A MOBILE CRISIS RESPONSE AND  
27 STABILIZATION SERVICES PROVIDER.

1 (c) TIERED CARE COORDINATION FOR MODERATE AND INTENSIVE  
2 LEVELS OF NEED. THE BHA SHALL ESTABLISH MODERATE- AND  
3 INTENSIVE-CARE COORDINATION USING WRAPAROUND PRINCIPLES  
4 PROVIDED BY A CONFLICT-FREE CASE MANAGEMENT, AS DEFINED IN  
5 SECTION 25.5-6-1702, AND AVAILABLE TO ALL CHILDREN AND YOUTH UP  
6 TO TWENTY-ONE YEARS OF AGE WHO ARE AT HIGH RISK BUT DO NOT NEED  
7 THE INTENSITY OF INTENSIVE-CARE COORDINATION. THE BHA AND, WHEN  
8 APPROPRIATE, THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING,  
9 SHALL:

10 (I) DEVELOP CRITERIA THAT INCORPORATE WRAPAROUND  
11 PRINCIPLES AND ELEMENTS OF NATIONAL MODELS, INCLUDING CRITERIA  
12 AND CERTIFICATION OF INTENSIVE-CARE COORDINATION WITH  
13 HIGH-FIDELITY WRAPAROUND SERVICES PROVIDED BY A CONFLICT-FREE  
14 ENTITY FOR THOSE CHILDREN AND YOUTH WHO MEET ESTABLISHED  
15 CRITERIA FOR COMPLEX OR SEVERE BEHAVIORAL HEALTH NEEDS. THE  
16 CRITERIA MUST ALIGN WITH THE HIGH-FIDELITY STANDARDS OF A  
17 NATIONAL WRAPAROUND INITIATIVE. TO FACILITATE THE EXPANSION OF  
18 COLORADO'S FEDERALLY FUNDED SYSTEM OF CARE MODEL OF  
19 INTENSIVE-CARE COORDINATION USING HIGH-FIDELITY WRAPAROUND  
20 SERVICES STATEWIDE, THE BHA SHALL:

21 (A) APPROPRIATE FUNDING THAT CORRESPONDS TO THE AMOUNT  
22 OF THE CURRENT FEDERAL SUBSTANCE ABUSE AND MENTAL HEALTH  
23 SERVICES ADMINISTRATION GRANT; AND

24 (B) APPLY FOR ADDITIONAL FUNDING THROUGH THE FEDERAL  
25 SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION  
26 CHILDREN'S MENTAL HEALTH INITIATIVE GRANT; AND

27 (II) IN ITS CONTRACTS WITH CARE MANAGEMENT ENTITIES AND

1 BEHAVIORAL HEALTH ADMINISTRATIVE SERVICES ORGANIZATIONS,  
2 RESPECTIVELY, REQUIRE THAT EACH ESTABLISH CONTRACTS WITH A  
3 CONFLICT-FREE CASE MANAGEMENT ENTITY AND LOCALLY BASED CARE  
4 MANAGEMENT ENTITY RESPONSIBLE FOR PROVIDING INTENSIVE-CARE  
5 COORDINATION WITH HIGH-FIDELITY WRAPAROUND, AND A NEW LEVEL OF  
6 MODERATE-CARE COORDINATION FOR CHILDREN AT HIGH RISK WHO DO  
7 NOT NEED THE INTENSITY AND FREQUENCY OF HIGH-FIDELITY  
8 WRAPAROUND.

9 (d) PARENT AND YOUTH PEER SUPPORT. THE BHA SHALL REVISE  
10 AND EXPAND MEDICAID-FUNDED PARENT PEER SUPPORT TO INCLUDE  
11 PARENT PEER SUPPORT AND ESTABLISH A YOUTH PEER SUPPORT PROGRAM  
12 TO USE IN CONJUNCTION WITH INTENSIVE- AND MODERATE-CARE  
13 COORDINATION, MOBILE CRISIS RESPONSE AND STABILIZATION SERVICES,  
14 AND INTENSIVE IN-HOME AND COMMUNITY-BASED SERVICES.

15 (e) INTENSIVE IN-HOME AND COMMUNITY-BASED SERVICES, AS  
16 FOLLOWS:

17 (I) FAMILY THERAPY AND INTENSIVE HOME-BASED SERVICES FOR  
18 ALL MEDICAID-ELIGIBLE CHILDREN WHO ARE WITHOUT A MENTAL HEALTH  
19 DIAGNOSIS, BUT INCLUDING THOSE WHO ARE AT HIGH RISK FOR  
20 DEVELOPING SERIOUS BEHAVIORAL HEALTH CHALLENGES BECAUSE OF  
21 SPECIFIC RISK FACTORS, SUCH AS MALTREATMENT; EXPOSURE TO  
22 DOMESTIC OR INTIMATE PARTNER VIOLENCE; OR HAVING A PARENT OR  
23 CAREGIVER WITH SPECIFIC RISK FACTORS, SUCH AS A SUBSTANCE USE  
24 DISORDER, SERIOUS MENTAL HEALTH DISORDER, OR A HISTORY OF  
25 DOMESTIC OR INTIMATE PARTNER VIOLENCE. THE DEPARTMENT OF HEALTH  
26 CARE POLICY AND FINANCING SHALL REQUIRE THAT EACH MCE AND THE  
27 BHA SHALL REQUIRE EACH BEHAVIORAL HEALTH ADMINISTRATIVE

1 SERVICES ORGANIZATION TO PAY FOR THE FAMILY THERAPY AND  
2 INTENSIVE HOME-BASED SERVICES.

3 (II) ACCESS TO SUBSTANCE USE DISORDER SERVICES TO  
4 QUALIFYING PERSONS; AND

5 (III) ACCESS TO TRAUMA-SPECIFIC SERVICES.

6 (f) OUT-OF-HOME TREATMENT SERVICES, AS FOLLOWS:

7 (I) PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES. THESE  
8 FACILITIES SHALL REVIEW AND DEVELOP OR REVISE CRITERIA AS  
9 NECESSARY TO REFLECT NATIONAL BEST PRACTICES, INCLUDING MODELS  
10 OF SMALL, COMMUNITY-BASED PSYCHIATRIC RESIDENTIAL TREATMENT  
11 FACILITIES THAT ARE TRAUMA-INFORMED, CONNECTED TO COMMUNITY  
12 PROVIDERS, AND ENGAGE YOUTH AND FAMILIES IN ALL PROGRAM ASPECTS.

13 (II) ACCESS TO SUBSTANCE USE DISORDER SERVICES TO  
14 QUALIFYING PERSONS;

15 (III) AS DEVELOPED BY THE OFFICE AND ELIGIBLE TO ALL  
16 CHILDREN AND YOUTH REGARDLESS OF PAYER, MECHANISMS TO OVERSEE  
17 AND MANAGE INPATIENT PSYCHIATRIC HOSPITALIZATION ADMISSIONS,  
18 LENGTHS OF STAY, TRANSITIONS TO STEP-DOWN COMMUNITY SERVICES,  
19 AND APPROPRIATE DISCHARGE PLANNING, INCLUDING DISCHARGE TO:

20 (A) COMMUNITY PSYCHIATRIC INPATIENT CARE;

21 (B) COMMUNITY PSYCHIATRIC OUTPATIENT CARE;

22 (C) PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES;

23 (D) OTHER RESIDENTIAL TREATMENT CENTERS;

24 (E) TREATMENT FOSTER CARE AND THERAPEUTIC FOSTER CARE;

25 AND

26 (F) AN ARRAY OF HOME- AND COMMUNITY-BASED SERVICES; AND

27 (g) RESPITE SERVICES.

1           **27-50-1004. System of care - governance and infrastructure -**  
2           **office of the children's behavioral health statewide system of care -**  
3           **established - leadership team - implementation team - advisory**  
4           **council - reports.** (1) THE OFFICE OF THE CHILDREN'S BEHAVIORAL

5 HEALTH STATEWIDE SYSTEM OF CARE IS ESTABLISHED IN THE BHA. THE  
6 OFFICE IS THE PRIMARY GOVERNANCE ENTITY AND IS RESPONSIBLE FOR  
7 CONVENING ALL RELEVANT STATE AGENCIES INVOLVED IN THE SYSTEM OF  
8 CARE, INCLUDING, BUT NOT LIMITED TO, THE DEPARTMENT OF HUMAN  
9 SERVICES OFFICE OF CHILDREN, YOUTH, AND FAMILIES, DIVISION OF CHILD  
10 WELFARE, AND DIVISION OF YOUTH SERVICES; THE DEPARTMENT OF  
11 HEALTH CARE POLICY AND FINANCING; THE DIVISION OF INSURANCE IN THE  
12 DEPARTMENT OF REGULATORY AGENCIES; AND THE DEPARTMENT OF  
13 PUBLIC HEALTH AND ENVIRONMENT. THE OFFICE SHALL CREATE, AT A  
14 MINIMUM, TWO STAFF POSITIONS:

- 15           (a) A DEPUTY COMMISSIONER, WHO WILL GOVERN THE OFFICE; AND
- 16           (b) A PERSON TO WORK WITH COUNTY DEPARTMENTS OF HUMAN  
17 AND SOCIAL SERVICES; THE STATE DEPARTMENT OF HUMAN SERVICES; AND  
18 THE OFFICE OF CHILDREN, YOUTH, AND FAMILIES, ON ALL CHILD  
19 WELFARE-RELATED ISSUES AND CONCERNS.

20           (2) (a) ON OR BEFORE NOVEMBER 1, 2024, THE OFFICE SHALL  
21 CREATE AND CONVENE A LEADERSHIP TEAM RESPONSIBLE FOR  
22 DECISION-MAKING AND OVERSIGHT.

- 23           (b) THE LEADERSHIP TEAM INCLUDES, BUT IS NOT LIMITED TO:
  - 24           (I) THE DEPUTY COMMISSIONER;
  - 25           (II) THE EXECUTIVE DIRECTOR OF THE DEPARTMENT OF HUMAN  
26 SERVICES, OR THE EXECUTIVE DIRECTOR'S DESIGNEE;
  - 27           (III) THE EXECUTIVE DIRECTOR OF THE DEPARTMENT OF HEALTH

1 CARE POLICY AND FINANCING, OR THE EXECUTIVE DIRECTOR'S DESIGNEE;

2 (IV) THE EXECUTIVE DIRECTOR OF THE DEPARTMENT OF PUBLIC  
3 HEALTH AND ENVIRONMENT, OR THE EXECUTIVE DIRECTOR'S DESIGNEE;

4 (V) THE COMMISSIONER OF INSURANCE, OR THE COMMISSIONER'S  
5 DESIGNEE;

6 (VI) ONE OR MORE COUNTY COMMISSIONERS, AS DESIGNATED BY  
7 THE STATEWIDE ORGANIZATION THAT REPRESENTS COUNTY  
8 COMMISSIONERS;

9 (VII) ONE OR MORE DIRECTORS OF A COUNTY DEPARTMENT OF  
10 HUMAN OR SOCIAL SERVICES, AS DESIGNATED BY THE STATEWIDE  
11 ORGANIZATION THAT REPRESENTS COUNTY HUMAN AND SOCIAL SERVICES  
12 DIRECTORS;

13 (VIII) ONE OR MORE FAMILIES OR INDIVIDUALS WITH LIVED  
14 EXPERIENCE USING CHILDREN'S OR YOUTHS' BEHAVIORAL HEALTH  
15 SERVICES; AND

16 (IX) ONE OR MORE REPRESENTATIVES FROM A CONSUMER  
17 ADVOCACY ORGANIZATION.

18 (c) IN ADDITION TO ITS OVERSIGHT AND DECISION-MAKING DUTIES,  
19 THE LEADERSHIP TEAM HAS THE FOLLOWING REPORTING RESPONSIBILITIES:

20 (I) ON OR BEFORE JULY 1, 2027, THE LEADERSHIP TEAM SHALL  
21 REPORT TO THE HOUSE OF REPRESENTATIVES PUBLIC AND BEHAVIORAL  
22 HEALTH AND HUMAN SERVICES COMMITTEE AND THE SENATE HEALTH AND  
23 HUMAN SERVICES COMMITTEE, OR THEIR SUCCESSOR COMMITTEES,  
24 INCLUDING A RECOMMENDATION FOR WHETHER THE BHA CONTINUES TO  
25 BE THE APPROPRIATE STATE AGENCY TO HOUSE THE OFFICE. THE STATE  
26 MANAGEMENT ENTITY MUST HAVE DEEP PROGRAMMATIC CONTENT  
27 EXPERTISE IN CHILDREN'S BEHAVIORAL HEALTH; THE TECHNICAL

1 KNOWLEDGE, CAPACITY, AND AUTHORITY TO OVERSEE AND HOLD  
2 ACCOUNTABLE A MANAGED CARE SYSTEM; THE DATA CAPACITY OR READY  
3 ACCESS TO SUCH CAPACITY TO TRACK AND REPORT ON KEY INDICATORS  
4 AND ENGAGE IN QUALITY IMPROVEMENT ACTIVITIES; THE AUTHORITY AND  
5 CAPACITY TO ENGAGE KEY SYSTEM PARTNERS; AND SUFFICIENT STAFFING  
6 TO EFFECTIVELY OVERSEE AND MANAGE THE DELIVERY SYSTEM.

7 (II) ON OR BEFORE JULY 1, 2027, THE LEADERSHIP TEAM SHALL  
8 DETERMINE WHETHER TO RECOMMEND IF THE DEPARTMENT OF HEALTH  
9 CARE POLICY AND FINANCING OR THE BHA SHOULD PURSUE  
10 PROCUREMENT OF A SINGLE STATEWIDE MCE TO OVERSEE THE SYSTEM OF  
11 CARE AND REPORT THAT RECOMMENDATION TO THE HOUSE OF  
12 REPRESENTATIVES PUBLIC AND BEHAVIORAL HEALTH AND HUMAN  
13 SERVICES COMMITTEE AND THE SENATE HEALTH AND HUMAN SERVICES  
14 COMMITTEE, OR THEIR SUCCESSOR COMMITTEES.

15 (3) (a) ON OR BEFORE JANUARY 15, 2025, THE OFFICE SHALL  
16 CREATE AND CONVENE AN IMPLEMENTATION TEAM THAT SHALL CREATE  
17 THE PLAN OUTLINED IN SECTION 27-50-1005.

18 (b) THE IMPLEMENTATION TEAM INCLUDES, BUT IS NOT LIMITED  
19 TO:

20 (I) THE DEPUTY COMMISSIONER;

21 (II) THE EXECUTIVE DIRECTOR OF THE DEPARTMENT OF HUMAN  
22 SERVICES, OR THE EXECUTIVE DIRECTOR'S DESIGNEE;

23 (III) THE EXECUTIVE DIRECTOR OF THE DEPARTMENT OF HEALTH  
24 CARE POLICY AND FINANCING, OR THE EXECUTIVE DIRECTOR'S DESIGNEE;

25 (IV) THE EXECUTIVE DIRECTOR OF THE DEPARTMENT OF PUBLIC  
26 HEALTH AND ENVIRONMENT, OR THE EXECUTIVE DIRECTOR'S DESIGNEE;

27 (V) THE BHA COMMISSIONER, OR THE COMMISSIONER'S DESIGNEE;

1 (VI) THE COMMISSIONER OF INSURANCE, OR THE COMMISSIONER'S  
2 DESIGNEE;

3 (VII) ONE OR MORE COUNTY COMMISSIONERS, AS DESIGNATED BY  
4 THE STATEWIDE ORGANIZATION THAT REPRESENTS COUNTY  
5 COMMISSIONERS;

6 (VIII) ONE OR MORE DIRECTORS OF A COUNTY DEPARTMENT OF  
7 HUMAN OR SOCIAL SERVICES, AS DESIGNATED BY THE STATEWIDE  
8 ORGANIZATION THAT REPRESENTS COUNTY HUMAN OR SOCIAL SERVICES  
9 DIRECTORS; AND

10 (IX) ONE OR MORE FAMILIES OR INDIVIDUALS WITH LIVED  
11 EXPERIENCE USING CHILDREN'S OR YOUTHS' BEHAVIORAL HEALTH  
12 SERVICES.

13 (c) ON OR BEFORE JANUARY 15, 2026, THE IMPLEMENTATION TEAM  
14 SHALL PROVIDE THE FINAL IMPLEMENTATION PLAN TO THE HOUSE OF  
15 REPRESENTATIVES PUBLIC AND BEHAVIORAL HEALTH AND HUMAN  
16 SERVICES COMMITTEE AND THE SENATE HEALTH AND HUMAN SERVICES  
17 COMMITTEE, OR THEIR SUCCESSOR COMMITTEES.

18 (d) THE DEPUTY COMMISSIONER SHALL DESIGNATE MEMBERS FROM  
19 THE IMPLEMENTATION TEAM TO MANAGE THE IMPLEMENTATION PROCESS  
20 AND ENSURE SUFFICIENT STAFF CAPACITY TO FULFILL THIS DUTY.

21 (e) ON OR BEFORE JANUARY 15, 2030, THE DEPUTY  
22 COMMISSIONER, THE BHA COMMISSIONER, AND THE ADVISORY COUNCIL  
23 SHALL PERFORM A REVIEW OF THE IMPLEMENTATION TEAM'S DUTIES AND  
24 FUNCTIONS. IF A CONCLUSION IS REACHED THAT THE IMPLEMENTATION  
25 TEAM IS NO LONGER NEEDED, IT IS DISBANDED.

26 (4) ON OR BEFORE JANUARY 15, 2025, THE OFFICE SHALL CREATE  
27 AN ADVISORY COUNCIL, COMPOSED OF, AT A MINIMUM, FAMILY AND



1 YOUTH PROVIDERS, LOCAL PARTNERS, COUNTY DEPARTMENTS OF HUMAN  
2 OR SOCIAL SERVICES, COUNTY COMMISSIONERS, JUVENILE JUSTICE  
3 AGENCIES, UNIVERSITY PARTNERS, FAMILIES OR INDIVIDUALS WITH LIVED  
4 EXPERIENCE USING CHILDREN'S OR YOUTHS' BEHAVIORAL HEALTH  
5 SERVICES, CONSUMER ADVOCACY ORGANIZATIONS, AND OTHERS. THE  
6 ADVISORY COUNCIL MUST REPRESENT THE RACIAL, ETHNIC, CULTURAL,  
7 AND GEOGRAPHIC DIVERSITY OF THE STATE AND INCLUDE ONE OR MORE  
8 PERSONS WITH A DISABILITY. THE ADVISORY COUNCIL SHALL RECEIVE  
9 ROUTINE BRIEFINGS FROM THE DEPUTY COMMISSIONER, THE OFFICE, AND  
10 ANY ENTITIES PURSUING BEHAVIORAL HEALTH REFORM EFFORTS. THE  
11 ADVISORY COUNCIL MAY PROVIDE FEEDBACK AND ACTIONABLE ITEMS AS  
12 A METHOD TO ENSURE ACCOUNTABILITY AND TRANSPARENCY AND  
13 PROVIDE DIVERSE COMMUNITY INPUT ON CHALLENGES, GAPS, AND  
14 POTENTIAL SOLUTIONS TO INFORM THE BHA'S VISION, STRATEGIC PLAN,  
15 AND IMPLEMENTATION OF THE SYSTEM OF CARE.

16 **27-50-1005. Implementation plan - components - rules.**

17 (1) THE IMPLEMENTATION PLAN DEVELOPED BY THE IMPLEMENTATION  
18 TEAM MUST INCLUDE, BUT IS NOT LIMITED TO:

- 19 (a) A PLAN FOR:
  - 20 (I) STRATEGIC COMMUNICATIONS;
  - 21 (II) OUTREACH, INFORMATION, AND REFERRAL;
  - 22 (III) TRAINING, TECHNICAL ASSISTANCE, COACHING, AND  
23 WORKFORCE DEVELOPMENT;
  - 24 (IV) IMPLEMENTING AND MONITORING EVIDENCE-INFORMED AND  
25 PROMISING INTERVENTIONS;
  - 26 (V) ACHIEVING MENTAL HEALTH EQUITY AND ELIMINATING  
27 DISPARITIES IN ACCESS, QUALITY OF SERVICES, AND OUTCOMES FOR

1 DIVERSE POPULATIONS; AND

2 (VI) CREATING A TIMELINE FOR IMPLEMENTING THE FULL  
3 CONTINUUM OF BEHAVIORAL HEALTH SERVICES, TAKING INTO ACCOUNT  
4 THE TIMING OF THE EXPANSION OF MEDICAID WAIVERS AND SERVICES;

5 (b) WAYS TO EXPAND SCREENING, INCLUDING THE USE OF  
6 APPROPRIATE SCREENING TOOLS, IN PRIMARY CARE AND SCHOOL  
7 SETTINGS;

8 (c) MEANS OF IDENTIFYING WHICH ASSESSMENT TOOLS TO UTILIZE  
9 IN VARIOUS CIRCUMSTANCES, INCLUDING COMPREHENSIVE ASSESSMENTS  
10 FOLLOWING POSITIVE SCREENING IN PRIMARY CARE AND SCHOOL SETTINGS  
11 USING STANDARDIZED SCREENING TOOLS, DURING A MOBILE CRISIS  
12 RESPONSE, AND CARE PLANNING FOR POPULATIONS ACCESSING BOTH  
13 INTENSIVE- AND MODERATE-CARE COORDINATION WITH HIGH-FIDELITY  
14 WRAPAROUND;

15 (d) PLANS FOR IDENTIFYING AND CREDENTIALING INDIVIDUALS  
16 WHO ADMINISTER THE ASSESSMENT TOOLS, INCLUDING TRAINING,  
17 COACHING, AND CERTIFICATION FOR ASSESSORS WHO CONDUCT THE  
18 STANDARDIZED ASSESSMENT;

19 (e) WAYS TO EXPAND CRISIS RESOLUTION TEAMS STATEWIDE,  
20 INCLUDING A PLAN TO BUILD CAPACITY AND TRAIN PROVIDERS;

21 (f) WAYS TO EXPAND INTENSIVE- AND MODERATE-CARE  
22 COORDINATION USING HIGH-FIDELITY WRAPAROUND STATEWIDE,  
23 INCLUDING IDENTIFYING THE COSTS, MAXIMIZING MEDICAID, AND  
24 SECURING ADDITIONAL FEDERAL GRANT MONEY AND STATE FUNDING  
25 SOURCES TO COVER THE EXPANSION;

26 (g) WAYS TO REVISE THE DEFINITION AND QUALIFICATIONS OF  
27 PARENT AND YOUTH PEER SUPPORT TO BE USED IN CONJUNCTION WITH

1 INTENSIVE- AND MODERATE-CARE COORDINATION, MOBILE CRISIS  
2 RESPONSE AND STABILIZATION SERVICES, AND INTENSIVE IN-HOME AND  
3 COMMUNITY-BASED SERVICES;

4 (h) MEANS OF IDENTIFYING WHAT INTENSIVE IN-HOME AND  
5 COMMUNITY-BASED SERVICES, IN ADDITION TO MULTISYSTEMIC THERAPY  
6 AND FUNCTIONAL FAMILY THERAPY, SHOULD BE INCLUDED IN THE ARRAY  
7 OF SERVICES OFFERED THROUGH THE SYSTEM OF CARE AND HOW THE  
8 OFFICE PERIODICALLY REVIEWS ADDITIONAL AND EMERGING SERVICES  
9 THAT MAY BE INCLUDED IN THE FUTURE;

10 (i) MEANS OF IDENTIFYING WHAT OUT-OF-HOME SERVICES, IN  
11 ADDITION TO PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES, SHOULD  
12 BE INCLUDED IN THE ARRAY OF SERVICES OFFERED THROUGH THE SYSTEM  
13 OF CARE AND HOW THE OFFICE PERIODICALLY REVIEWS ADDITIONAL AND  
14 EMERGING SERVICES THAT MAY BE INCLUDED IN THE FUTURE;

15 (j) WAYS TO ADDRESS EXPANDING ACCESS TO TRAUMA-SPECIFIC  
16 SERVICES AND SUBSTANCE USE DISORDER SERVICES, INCLUDING BUT NOT  
17 LIMITED TO DETOX, INPATIENT TREATMENT, RESIDENTIAL TREATMENT,  
18 INTENSIVE OUTPATIENT TREATMENT, OUTPATIENT TREATMENT, AND  
19 EARLY INTERVENTION;

20 (k) WAYS TO EXPAND RESPITE SERVICES STATEWIDE;

21 (l) WAYS TO REMOVE CUMBERSOME PRIOR AUTHORIZATION  
22 REQUIREMENTS, SERVICE LOCATION REQUIREMENTS, AND SERVICE  
23 LIMITATIONS THAT HAMPER ACCESS TO CHILD BEHAVIORAL HEALTH  
24 SERVICES;

25 (m) WAYS TO WORK WITH THE DIVISION OF INSURANCE IN THE  
26 DEPARTMENT OF REGULATORY AGENCIES TO IMPLEMENT A POLICY THAT  
27 REQUIRES COMMERCIAL INSURANCE PLANS TO OFFER THE SAME CHILD

1 BEHAVIORAL HEALTH SERVICES AS IN THE "COLORADO MEDICAL  
2 ASSISTANCE ACT" PURSUANT TO PART 8 OF ARTICLE 5 OF TITLE 25.5;

3 (n) WAYS TO EXPAND FUNDING FOR SCHOOL-BASED BEHAVIORAL  
4 HEALTH SERVICES, INCLUDING CHILD AND ADOLESCENT HEALTH CENTERS,  
5 AND ENSURE THEY MAXIMIZE THE USE OF MEDICAID;

6 (o) WAYS TO REIMBURSE OR PROVIDE FUNDING OPTIONS TO  
7 CONTINUE PAYMENT FOR SERVICES PROVIDED TO FAMILIES WHEN A CHILD  
8 BECOMES INELIGIBLE FOR MEDICAID BECAUSE OF HOSPITALIZATION OR  
9 DETENTION;

10 (p) THE CURRENT STATUS OF AND RECOMMENDATION ON WAYS TO  
11 IMPROVE ACCESS TO MEDICAID WAIVERS;

12 (q) MAKING RECOMMENDATIONS ON FULL-TIME EMPLOYEES  
13 NEEDED FOR THE OFFICE; AND

14 (r) RECOMMENDATIONS CONCERNING THE EXPANSION OF FUNDING  
15 FOR THE CAPACITY-BUILDING CENTER CREATED IN SUBSECTION (3) OF THIS  
16 SECTION.

17 (2) THE BHA, IN CONSULTATION WITH THE DEPARTMENT OF  
18 HEALTH CARE POLICY AND FINANCING AND THE OFFICE, SHALL  
19 PROMULGATE RULES PURSUANT TO SECTION 27-50-104 ON INTENSIVE  
20 IN-HOME AND COMMUNITY-BASED SERVICES TO ALLOW PROVIDERS WHO  
21 USE A LICENSED CLINICIAN REGISTERED WITH THE SOCIAL WORK,  
22 COUNSELING, MARRIAGE AND FAMILY THERAPY, OR PSYCHOLOGY BOARD  
23 TO WORK WITH PARAPROFESSIONALS, TRAINEES, OR INTERNS. THE OFFICE  
24 SHALL DEVELOP GUIDELINES FOR THE PROVIDERS TO USE IN IMPLEMENTING  
25 THE RULES.

26 (3) THE IMPLEMENTATION PLAN MUST INCLUDE THE CREATION OF  
27 A CAPACITY-BUILDING CENTER, WHICH MUST RECEIVE AN ANNUAL

1 MINIMUM APPROPRIATION OF TEN MILLION DOLLARS. THE  
2 IMPLEMENTATION PLAN MUST DEVELOP, IMPLEMENT, AND FUND, WITHIN  
3 AVAILABLE APPROPRIATIONS, THE FOLLOWING:

4 (a) A STUDENT LOAN FORGIVENESS PROGRAM FOR STUDENTS IN  
5 BEHAVIORAL HEALTH DISCIPLINES WHO MAKE A THREE- TO FIVE-YEAR  
6 COMMITMENT TO WORK IN SHORTAGE AREAS IN THE SYSTEM OF CARE. THE  
7 BHA SHALL PROMULGATE RULES ON OR BEFORE JULY 1, 2026, FOR THE  
8 ADMINISTRATION AND IMPLEMENTATION OF THE STUDENT LOAN  
9 FORGIVENESS PROGRAM.

10 (b) PAID INTERNSHIPS AND CLINICAL ROTATIONS IN THE SYSTEM OF  
11 CARE AND A DESCRIPTION OF MULTIPLE OPTIONS FOR PAYMENT;

12 (c) REVISIONS TO GRADUATE MEDICAL EDUCATION PROGRAMS AT  
13 COLORADO INSTITUTIONS OF HIGHER EDUCATION TO SUPPORT  
14 INTERNSHIPS, RESIDENCIES, FELLOWSHIPS, AND STUDENT PROGRAMS IN  
15 CHILD AND YOUTH BEHAVIORAL HEALTH;

16 (d) A FINANCIAL AID PROGRAM FOR YOUTH TRANSITIONING OUT OF  
17 FOSTER CARE WHO WISH TO PURSUE A CAREER IN CHILDREN AND YOUTH  
18 BEHAVIORAL HEALTH, DEVELOPED IN PARTNERSHIP WITH COLORADO  
19 INSTITUTIONS OF HIGHER EDUCATION AND COMMUNITY COLLEGES; AND

20 (e) AN EXPANSION OF CURRENT BHA EFFORTS RELATED TO  
21 BEHAVIORAL HEALTH APPRENTICESHIPS, INTERNSHIPS, STIPENDS, AND  
22 PRE-LICENSURE WORKFORCE SUPPORT SPECIFIC TO SERVICE CHILDREN,  
23 YOUTH, AND FAMILIES.

24 **27-50-1006. Grievance policy.** THE BHA SHALL DEVELOP A  
25 STATE-LEVEL PROCESS TO MONITOR, REPORT ON, AND PROMPTLY RESOLVE  
26 COMPLAINTS, GRIEVANCES, AND APPEALS, INCLUDING RECIPIENT RIGHTS  
27 ISSUES. THE PROCESS MUST BE AVAILABLE TO PROVIDERS, CLIENTS, CASE

1 MANAGEMENT ENTITIES, AND ANYONE ELSE WORKING WITH THE CHILDREN  
2 AND YOUTH IN THE SYSTEM OF CARE. THE BHA SHALL PROVIDE AN  
3 ANNUAL REPORT TO THE HOUSE OF REPRESENTATIVES PUBLIC AND  
4 BEHAVIORAL HEALTH AND HUMAN SERVICES COMMITTEE AND THE SENATE  
5 HEALTH AND HUMAN SERVICES COMMITTEE, OR THEIR SUCCESSOR  
6 COMMITTEES, THAT MAKES RECOMMENDATIONS ON CHANGES TO THE  
7 OFFICE BASED ON AN ANALYSIS OF GRIEVANCES.

8 **27-50-1007. Cost and utilization analysis - report.** ON OR  
9 BEFORE JANUARY 1, 2025, THE LEADERSHIP TEAM SHALL BEGIN, OR  
10 CONTRACT FOR, A COST AND UTILIZATION ANALYSIS OF THE POPULATIONS  
11 OF CHILDREN AND YOUTH WHO WILL BE INCLUDED IN THE SYSTEM OF  
12 CARE. THE COST AND UTILIZATION ANALYSIS MUST, AT A MINIMUM,  
13 ANALYZE CHILDREN AND YOUTH MEDICAID MEMBERS WHO WERE OR ARE  
14 HIGH UTILIZERS OF BEHAVIORAL HEALTH SERVICES. THE LEADERSHIP  
15 TEAM SHALL REPORT ITS FINDINGS TO THE HOUSE OF REPRESENTATIVES  
16 PUBLIC AND BEHAVIORAL HEALTH AND HUMAN SERVICES COMMITTEE AND  
17 THE SENATE HEALTH AND HUMAN SERVICES COMMITTEE, OR THEIR  
18 SUCCESSOR COMMITTEES, ON OR BEFORE JULY 1, 2025.

19 **27-50-1008. Contracts with managed care entities and**  
20 **behavioral health administrative services organizations - reporting**  
21 **- rules.** (1) (a) ON OR BEFORE JULY 1, 2025, THE DEPARTMENT OF HEALTH  
22 CARE POLICY AND FINANCING, IN CONSULTATION WITH THE OFFICE, SHALL  
23 ESTABLISH STANDARD AND UNIFORM MEDICAL NECESSITY CRITERIA FOR  
24 ALL SYSTEM OF CARE SERVICES, INCLUDING, BUT NOT LIMITED TO, MOBILE  
25 CRISIS RESPONSE AND STABILIZATION; CRISIS RESPONSE TEAMS;  
26 INTENSIVE- AND MODERATE-CARE COORDINATION USING HIGH-FIDELITY  
27 WRAPAROUND; INTERMEDIATE-CARE COORDINATION; PARENT PEER

1 SUPPORT; YOUTH PEER SUPPORT; RESPITE, INTENSIVE-HOME, AND  
2 COMMUNITY-BASED SERVICES, INCLUDING MULTISYSTEMIC THERAPY AND  
3 FUNCTIONAL FAMILY THERAPY; SUBSTANCE USE DISORDER SERVICES FOR  
4 CHILDREN AND YOUTH; AND OUT-OF-HOME SERVICES, INCLUDING  
5 PSYCHIATRIC RESIDENTIAL TREATMENT. THE MEDICAL NECESSITY  
6 CRITERIA AND STANDARDS FOR THE SYSTEM OF CARE SERVICES MUST BE  
7 THE SAME FOR MCEs AND BEHAVIORAL HEALTH ADMINISTRATIVE  
8 SERVICES ORGANIZATIONS. THE MEDICAL NECESSITY CRITERIA AND  
9 STANDARDS FOR SYSTEM OF CARE SERVICES APPLY TO SERVICES PAID FOR  
10 BY MEDICAID, THE BHA, AND BEHAVIORAL HEALTH ADMINISTRATIVE  
11 SERVICES ORGANIZATIONS.

12 (b) ON OR BEFORE AUGUST 30, 2028, THE BHA AND THE DIVISION  
13 OF INSURANCE IN THE DEPARTMENT OF REGULATORY AGENCIES SHALL  
14 DETERMINE WHETHER THEY RECOMMEND THAT PRIVATE INSURERS BE  
15 REQUIRED TO ADOPT THE SAME MEDICAL NECESSITY CRITERIA DEVELOPED  
16 PURSUANT TO SUBSECTION (1)(a) OF THIS SECTION AND SHALL PROVIDE A  
17 REPORT WITH THAT RECOMMENDATION TO THE HOUSE OF  
18 REPRESENTATIVES PUBLIC AND BEHAVIORAL HEALTH AND HUMAN  
19 SERVICES COMMITTEE AND THE SENATE HEALTH AND HUMAN SERVICES  
20 COMMITTEE, OR THEIR SUCCESSOR COMMITTEES.

21 (2) ON OR BEFORE JULY 1, 2025, THE DEPARTMENT OF HEALTH  
22 CARE POLICY AND FINANCING SHALL SET STANDARD RATE AND  
23 UTILIZATION FLOORS FOR ALL SYSTEM OF CARE SERVICES ACROSS ALL  
24 MCEs, INCLUDING, BUT NOT LIMITED TO, MOBILE CRISIS RESPONSE AND  
25 STABILIZATION; CRISIS RESPONSE TEAMS; INTENSIVE- AND  
26 MODERATE-CARE COORDINATION USING HIGH-FIDELITY WRAPAROUND;  
27 INTERMEDIATE-CARE COORDINATION; PARENT PEER SUPPORT; YOUTH PEER

1 SUPPORT; RESPITE, INTENSIVE-HOME, AND COMMUNITY-BASED SERVICES,  
2 INCLUDING MULTISYSTEMIC THERAPY AND FUNCTIONAL FAMILY THERAPY;  
3 SUBSTANCE USE DISORDER SERVICES FOR CHILDREN AND YOUTH; AND  
4 OUT-OF-HOME SERVICES, INCLUDING PSYCHIATRIC RESIDENTIAL  
5 TREATMENT. THE BHA SHALL ALIGN ITS RATE AND UTILIZATION FLOORS  
6 FOR BEHAVIORAL HEALTH ADMINISTRATIVE SERVICES ORGANIZATIONS  
7 BASED ON THE RATES AND UTILIZATION FLOORS ESTABLISHED BY THE  
8 DEPARTMENT OF HEALTH CARE POLICY AND FINANCING PURSUANT TO THIS  
9 SUBSECTION (2).

10 (3) ON OR BEFORE JULY 1, 2025, THE DEPARTMENT OF HEALTH  
11 CARE POLICY AND FINANCING AND THE BHA SHALL ESTABLISH A  
12 STATEWIDE FEE SCHEDULE OR RATE FRAME FOR MEDICAID AND  
13 NON-MEDICAID BEHAVIORAL HEALTH SERVICES FOR CHILDREN AND  
14 YOUTH, AND INCORPORATE THE FEE SCHEDULE AND RATE FRAME INTO THE  
15 MCEs' AND BEHAVIORAL HEALTH ADMINISTRATIVE SERVICES  
16 ORGANIZATIONS' CONTRACTS. THE FEE SCHEDULE OR RATE FRAME MUST  
17 INCREASE RATES AND INCORPORATE ENHANCED RATES OR QUALITY  
18 BONUSES FOR EVIDENCE-BASED PRACTICES AND EXTENDED WEEKDAY AND  
19 WEEKEND CLINIC HOURS, AND ALLOW MAXIMUM FLEXIBILITY FOR USE OF  
20 TELEHEALTH TO EXPAND ACCESS.

21 (4) (a) EACH MCE AND BEHAVIORAL HEALTH ADMINISTRATIVE  
22 SERVICES ORGANIZATION SHALL CONTRACT WITH AN ADEQUATE NUMBER  
23 OF PROVIDERS WITHIN ACCESSIBLE GEOGRAPHICAL DISTANCES TO FULLY  
24 SERVE ITS POPULATION OF CHILDREN AND YOUTH WHO ARE ELIGIBLE FOR  
25 THE SYSTEM OF CARE SERVICES, INCLUDING, BUT NOT LIMITED TO, MOBILE  
26 CRISIS RESPONSE AND STABILIZATION; CRISIS RESPONSE TEAMS;  
27 INTENSIVE- AND MODERATE-CARE COORDINATION USING HIGH-FIDELITY



1 WRAPAROUND; INTERMEDIATE-CARE COORDINATION; PARENT PEER  
2 SUPPORT; YOUTH PEER SUPPORT; RESPITE, INTENSIVE-HOME, AND  
3 COMMUNITY-BASED SERVICES, INCLUDING MULTISYSTEMIC THERAPY AND  
4 FUNCTIONAL FAMILY THERAPY; SUBSTANCE USE DISORDER SERVICES FOR  
5 CHILDREN AND YOUTH; AND OUT-OF-HOME SERVICES, INCLUDING  
6 PSYCHIATRIC RESIDENTIAL TREATMENT.

7 (b) THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING  
8 AND THE BHA, INFORMED BY THE IMPLEMENTATION TEAM, SHALL  
9 ANNUALLY REVIEW WHETHER ADDITIONAL PROVIDER SPECIALIZATIONS  
10 SHOULD BE INCLUDED IN THE MCEs' AND BEHAVIORAL HEALTH  
11 ADMINISTRATIVE SERVICES ORGANIZATIONS' CONTRACTS. EACH MCE AND  
12 BEHAVIORAL HEALTH ADMINISTRATIVE SERVICES ORGANIZATION SHALL  
13 REPORT THE NUMBER OF PROVIDERS IN EACH CATEGORY, THE UTILIZATION  
14 OF EACH PROVIDER, AND THE AVAILABILITY OF IN-PERSON SERVICES  
15 COMPARED TO TELEHEALTH SERVICES.

16 (c) WHILE AN MCE OR BEHAVIORAL HEALTH ADMINISTRATIVE  
17 SERVICES ORGANIZATION MAY CONTRACT FOR TELEHEALTH SERVICES, IT  
18 SHALL ENSURE THAT IN-PERSON SERVICES ARE AVAILABLE AND  
19 ACCESSIBLE WITHIN AND OUTSIDE OF THE GEOGRAPHIC CATCHMENT AREA  
20 WHEN APPROPRIATE, BASED ON AN INDIVIDUAL'S TREATMENT PLAN.

21 (d) THE BHA, IN CONSULTATION WITH THE DEPARTMENT OF  
22 HEALTH CARE POLICY AND FINANCING, SHALL PROMULGATE RULES TO  
23 ESTABLISH A DEFINITION OF ADEQUATE PROVIDERS WITHIN ACCESSIBLE  
24 GEOGRAPHICAL DISTANCES. THE DEFINITION MUST TAKE INTO ACCOUNT  
25 GEOGRAPHICAL AREAS WITHIN AN MCE'S OR BEHAVIORAL HEALTH  
26 ADMINISTRATIVE SERVICES ORGANIZATION'S REGION AND CONSIDER HOW  
27 FAR FAMILIES AND CLINICIANS MUST TRAVEL TO ACCESS OR DELIVER

1 SERVICES.

2 (5) EACH MCE OR BEHAVIORAL HEALTH ADMINISTRATIVE  
3 SERVICES ORGANIZATION SHALL CONTRACT WITH OR HAVE SINGLE-USE  
4 AGREEMENTS WITH EVERY QUALIFIED RESIDENTIAL TREATMENT FACILITY  
5 OR PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY THAT IS LICENSED IN  
6 COLORADO.

7 (6) THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING  
8 AND THE BHA SHALL CLARIFY, IN CONTRACTS WITH MCEs OR  
9 BEHAVIORAL HEALTH ADMINISTRATIVE SERVICES ORGANIZATIONS,  
10 RESPECTIVELY, THAT THE SERVICES AVAILABLE IN THE SYSTEM OF CARE  
11 APPLY TO ALL CHILDREN OR YOUTH WHO MEET ELIGIBILITY CRITERIA,  
12 REGARDLESS OF OTHER SYSTEM INVOLVEMENT, SUCH AS CHILD WELFARE  
13 OR JUVENILE JUSTICE.

14 **27-50-1009. Data collection and quality monitoring - data and**  
15 **quality team.** (1) THE OFFICE, ADVISED BY STATE AND COUNTY  
16 PARTNERS, PROVIDERS, AND RACIALLY, ETHNICALLY, CULTURALLY, AND  
17 GEOGRAPHICALLY DIVERSE FAMILY AND YOUTH REPRESENTATIVES, SHALL  
18 DEVELOP AND ESTABLISH A DATA AND QUALITY TEAM. THE DATA TEAM  
19 SHALL, AT A MINIMUM:

20 (a) IDENTIFY KEY INDICATORS OF QUALITY AND PROGRESS;

21 (b) IDENTIFY DATA REQUIREMENTS THAT CREATE DUPLICATION OR  
22 INEFFECTUAL REPORTS;

23 (c) IDENTIFY BARRIERS TO DATA SHARING AND STRATEGIES TO  
24 RESOLVE THOSE BARRIERS; AND

25 (d) DETERMINE HOW THE BUSINESS INTELLIGENCE DATA  
26 MANAGEMENT AND DATA SYSTEM WILL SUPPORT MEANINGFUL DATA  
27 COLLECTION AND SHARING TO FACILITATE THE IMPLEMENTATION OF THE

1 SYSTEM OF CARE.

2 (2) THE DATA TEAM SHALL, AT A MINIMUM, TRACK AND REPORT  
3 ANNUALLY ON:

4 (a) CHILD AND YOUTH BEHAVIORAL HEALTH SERVICE UTILIZATION  
5 AND EXPENDITURES ACROSS THE DEPARTMENT OF HEALTH CARE POLICY  
6 AND FINANCING; MCEs; THE BHA AND BEHAVIORAL HEALTH  
7 ADMINISTRATIVE SERVICES ORGANIZATIONS; SCHOOL-BASED HEALTH  
8 CENTERS; AND CHILD WELFARE, JUVENILE JUSTICE, AND INTELLECTUAL  
9 AND DEVELOPMENTAL DISABILITIES;

10 (b) THE TYPE OF SERVICES PROVIDED, DISAGGREGATED BY  
11 GENDER, AGE, RACE AND ETHNICITY, AID CATEGORY, DIAGNOSIS  
12 CATEGORY, AND REGION; AND

13 (c) ACCESS BY VARIABLES AND PROGRESS OVER TIME, WITH  
14 PARTICULAR ATTENTION TO RACIAL, ETHNIC, AND GEOGRAPHIC  
15 DISPARITIES, AND DISPARITIES IN ACCESS FOR CHILDREN AND YOUTH IN  
16 FOSTER CARE.

17 (3) THE DATA TEAM SHALL MEASURE AND MONITOR KEY DATA  
18 POINTS THAT DEMONSTRATE THE EFFICACY OF THE SYSTEM OF CARE,  
19 INCLUDING, BUT NOT LIMITED TO, SERVICE UTILIZATION, MEDICAL  
20 NECESSITY DENIALS, QUALITY, OUTCOMES, EQUITY, AND COST. THE  
21 MEASUREMENT AND MONITORING MUST ANALYZE THE ENTIRE SYSTEM OF  
22 CARE WHILE ALSO CAPTURING SPECIFIC DATA BY REGION, OVERSIGHT  
23 ENTITY, POPULATION TYPE, SERVICE TYPE, PAYER, AND DEMOGRAPHIC  
24 CATEGORIES.

25 (4) THE BHA SHALL DEVELOP MEASURABLE TARGETS TO USE FOR  
26 EXPANDING THE AVAILABILITY AND UTILIZATION OF THE FOLLOWING  
27 SERVICES:

- 1 (a) MOBILE CRISIS RESPONSE AND INTENSIVE STABILIZATION
- 2 SERVICES;
- 3 (b) INTENSIVE IN-HOME AND COMMUNITY-BASED SERVICES;
- 4 (c) INTEGRATED CO-OCCURRING TREATMENT FOR ADOLESCENT
- 5 SUBSTANCE USE DISORDERS;
- 6 (d) OUT-OF-HOME SERVICES;
- 7 (e) PARENT PEER SUPPORT;
- 8 (f) YOUTH PEER SUPPORT;
- 9 (g) RESPITE CARE; AND
- 10 (h) INTENSIVE- AND MODERATE-CARE COORDINATION WITH
- 11 HIGH-FIDELITY WRAPAROUND.

12 (5) THE BHA SHALL CREATE A MAP, SEARCHABLE BY SERVICE  
13 TYPE AND COUNTY, THAT DEPICTS WHERE EACH SERVICE REQUIRED BY THE  
14 SYSTEM OF CARE EXISTS BY PROVIDER, WHETHER EACH PROVIDER ACCEPTS  
15 NEW PATIENTS, AND WHAT FORMS OF PAYMENT THE PROVIDER ACCEPTS.

16 (6) THE BHA, IN CONSULTATION WITH THE DEPARTMENT OF  
17 HEALTH CARE POLICY AND FINANCING, SHALL ESTABLISH, REQUIRE, AND  
18 MONITOR TIMELINES AND REPORTING REQUIREMENTS FOR COMPLETION OF  
19 CURRENT MCE AND BEHAVIORAL HEALTH ADMINISTRATIVE SERVICES  
20 ORGANIZATIONS SERVICE ELIGIBILITY AND AUTHORIZATION REQUESTS.

21 **27-50-1010. Workforce development - capacity-building**  
22 **center - training.** (1) THE BHA, ADVISED BY THE OFFICE, SHALL  
23 ESTABLISH OR PROCURE A CAPACITY-BUILDING CENTER. THE  
24 CAPACITY-BUILDING CENTER SHALL TRAIN, COACH, AND CERTIFY  
25 PROVIDERS OF THE ARRAY OF SERVICES OFFERED THROUGH THE SYSTEM  
26 OF CARE.

27 (2) THE CAPACITY-BUILDING CENTER SHALL, AT A MINIMUM,

1 PROVIDE TRAINING, COACHING, AND CERTIFICATION RELATED TO THE USE  
2 OF BEHAVIORAL HEALTH SCREENING AND ASSESSMENT TOOLS TO SUPPORT  
3 A UNIFORM ASSESSMENT PROCESS AND TRAINING IN TRAUMA-INFORMED  
4 CARE TO STAFF AT RELEVANT STATE AGENCIES.

5 (3) THE CAPACITY-BUILDING CENTER, IN PARTNERSHIP WITH  
6 COLORADO'S NUMEROUS FAMILY- AND YOUTH-RUN ORGANIZATIONS,  
7 SHALL DEVELOP, IMPLEMENT, MONITOR, AND EVALUATE THE EXTENT TO  
8 WHICH PROVIDERS THROUGHOUT THE STATE ARE INCORPORATING  
9 PRINCIPLES OF FAMILY-DRIVEN AND YOUTH-GUIDED CARE BY USING THE  
10 ASSESSMENT TOOLS.

11 (4) THE BHA, THROUGH ITS CAPACITY-BUILDING CENTER, SHALL:

12 (a) DEVELOP A TRAIN-THE-TRAINER APPROACH TO EXPAND  
13 WORKFORCE UNDERSTANDING OF EVIDENCE-BASED AND BEST PRACTICES  
14 AND ESTABLISH A CHILDREN'S BEHAVIORAL HEALTH PROVIDER LEARNING  
15 COMMUNITY TO FOSTER PEER-TO-PEER CAPACITY BUILDING ACROSS  
16 PRACTITIONERS AND PROVIDERS;

17 (b) OFFER TRAINING AND OTHER STRATEGIES TO EXPAND THE  
18 NUMBER OF BEHAVIORAL HEALTH PROVIDERS IN RURAL AND OTHER  
19 UNDERSERVED COMMUNITIES; AND

20 (c) UTILIZE THE REPORTS CREATED PURSUANT TO SECTION  
21 27-50-1009 (2), (3), AND (4) TO TARGET ITS INVESTMENT TO BUILD  
22 CAPACITY IN THE REGIONS IDENTIFIED AS LACKING CAPACITY.

23 (5) THE CAPACITY-BUILDING CENTER SHALL WORK WITH RURAL  
24 HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS TO EXPAND  
25 THEIR CAPACITY TO PROVIDE BEHAVIORAL HEALTH SERVICES TO CHILDREN  
26 AND YOUTH.

27 **27-50-1011. System of care website - public education and**

1     **outreach.** (1) THE BHA SHALL DEVELOP A WEBSITE TO PROVIDE  
2     REGULARLY UPDATED INFORMATION TO FAMILIES, YOUTH, PROVIDERS,  
3     STAFF, SYSTEM PARTNERS, AND OTHERS REGARDING THE GOALS,  
4     PRINCIPLES, ACTIVITIES, PROGRESS, AND TIMELINES FOR THE SYSTEM OF  
5     CARE. THE WEBSITE MUST INCLUDE KEY PERFORMANCE DASHBOARD  
6     INDICATORS; CHANGES IN ACCESS BY THE CHILD WELFARE POPULATION;  
7     CHANGES IN ACCESS DISPARITIES BETWEEN RACIAL, ETHNIC, AND  
8     REGIONAL GROUPS; AND CHANGES IN ACCESS TO INTENSIVE- AND  
9     MODERATE-CARE COORDINATION WITH HIGH-FIDELITY WRAPAROUND.

10           (2) THE BHA AND THE OFFICE SHALL USE THE CAPACITY-BUILDING  
11     CENTER TO FURTHER ORIENT AND EDUCATE PROVIDERS, SYSTEM  
12     PARTNERS, FAMILIES, YOUTH, AND OTHERS ABOUT THE SYSTEM OF CARE  
13     IMPLEMENTATION GOALS AND ACTIVITIES, INCLUDING CONDUCTING A  
14     EDUCATION CAMPAIGN.

15           (3) THE BHA AND OFFICE SHALL PROVIDE FUNDING TO STATE AND  
16     LOCAL FAMILY- AND YOUTH-RUN ORGANIZATIONS TO SUPPORT  
17     AWARENESS CAMPAIGNS AND TO ENGAGE FAMILIES AND YOUTH IN  
18     PLANNING AND PARTICIPATION IN ALL ASPECTS OF THE SYSTEM OF CARE.

19           (4) THE BHA AND OFFICE SHALL SUPPORT A STATEWIDE EFFORT  
20     TO ORIENT AND EDUCATE KEY STAKEHOLDERS, INCLUDING PROVIDERS,  
21     FAMILIES, YOUTH, MCEs, COURTS, AND PARTNER AGENCIES, REGARDING  
22     THE GOALS AND ACTIVITIES OF THE SYSTEM OF CARE.

23           (5) THE BHA AND OFFICE SHALL PROVIDE REGULAR OUTREACH TO,  
24     AND EDUCATION OF, YOUTH AND FAMILIES REGARDING AVAILABLE  
25     SERVICES AND HOW TO ACCESS THEM.

26           **SECTION 2. Act subject to petition - effective date.** This act  
27     takes effect at 12:01 a.m. on the day following the expiration of the

1 ninety-day period after final adjournment of the general assembly; except  
2 that, if a referendum petition is filed pursuant to section 1 (3) of article V  
3 of the state constitution against this act or an item, section, or part of this  
4 act within such period, then the act, item, section, or part will not take  
5 effect unless approved by the people at the general election to be held in  
6 November 2024 and, in such case, will take effect on the date of the  
7 official declaration of the vote thereon by the governor.