COLORADO GENERAL ASSEMBLY
JOINT BUDGET COMMITTEE

FY 2016-17 STAFF BUDGET BRIEFING

DEPARTMENT OF HUMAN SERVICES

(Behavioral Health Services Only)

JBC Working Document - Subject to Change
Staff Recommendation Does Not Represent Committee Decision

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DEPARTMENT OF HUMAN SERVICES

Department Overview

The Department of Human Services is responsible for the administration and supervision of most non-medical public assistance and welfare activities of the State, including financial and nutritional assistance programs, child protection services, rehabilitation programs, and programs for older Coloradans. The Department is also responsible for inspecting and licensing child care facilities. The Department operates two mental health institutes, three regional centers for persons with intellectual and developmental disabilities, and ten institutions for delinquent juveniles. The Department also contracts with community-based organizations for: behavioral health services that are not otherwise available, services for persons with intellectual and developmental disabilities, and the supervision and treatment of delinquent juveniles.

This staff budget briefing document concerns the Department's Office of Behavioral Health, which is responsible for policy development, service provision and coordination, program monitoring and evaluation, and administrative oversight of the State's public behavioral health system. Funding in this section supports community-based mental health and substance use disorder services that are otherwise not available. This includes services for people with low income who are not eligible for Medicaid, as well as services for Medicaid-eligible clients that are not covered by the Medicaid program[1]. Funding in this section also supports administration and operation of the State's two mental health institutes, which provide inpatient hospitalization for individuals with serious mental illness. The institutes serve three populations: (a) individuals with pending criminal charges who require evaluations of competency to stand trial and services to restore competency; (b) individuals who have been found to be not guilty by reason of insanity; and (c) adults and adolescents who are referred for admission by the community mental health centers, county departments of social services, or the Division of Youth Corrections.

Department Budget: Recent Appropriations

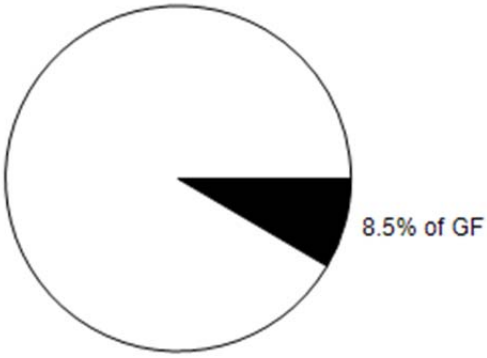
Funding Source	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17 *
General Fund	$719,139,332	$790,048,884	$811,905,208	$836,373,426
Cash Funds	360,140,503	346,553,374	348,624,954	360,224,239
Reappropriated Funds	497,414,430	128,165,697	131,723,226	127,019,684
Federal Funds	612,167,352	619,824,287	622,405,770	583,077,871
Total Funds	**$2,188,861,617**	**$1,884,592,242**	**$1,914,659,158**	**$1,906,695,220**
Full Time Equiv. Staff	4,879.0	4,961.2	4,970.9	4,837.7

*Requested appropriation.

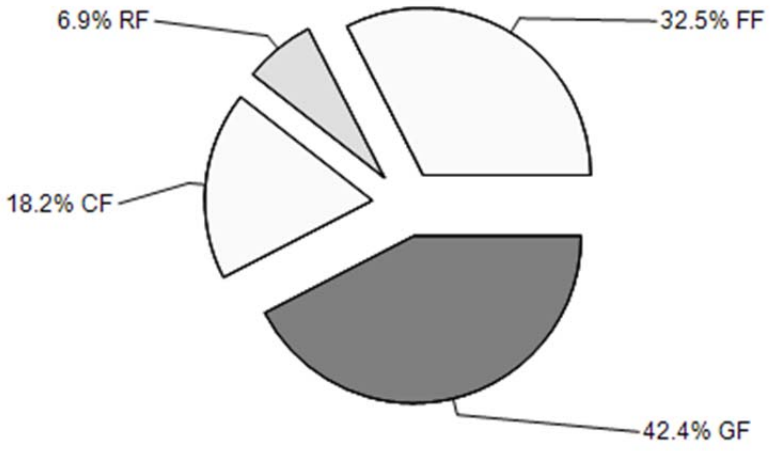
[1] Mental health and substance use disorder services for Medicaid-eligible clients are primarily funded through the Department of Health Care Policy and Financing.

Department Budget: Graphic Overview

Department's Share of Statewide General Fund

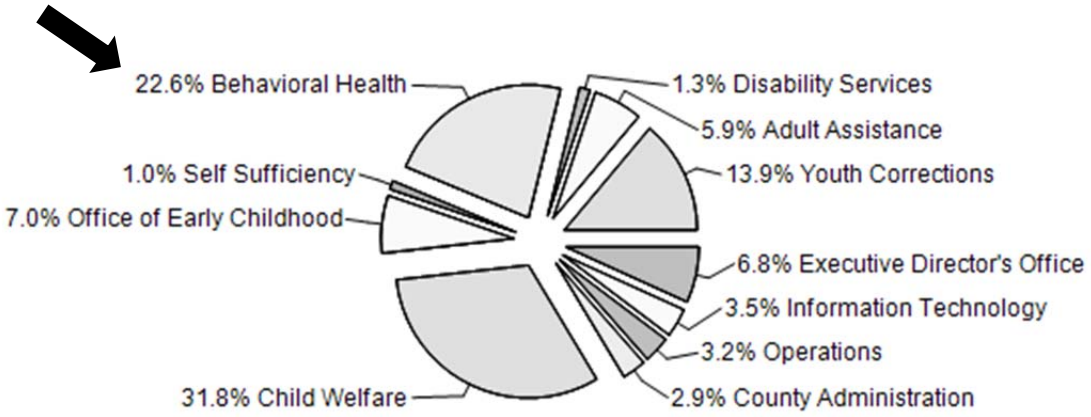


Department Funding Sources

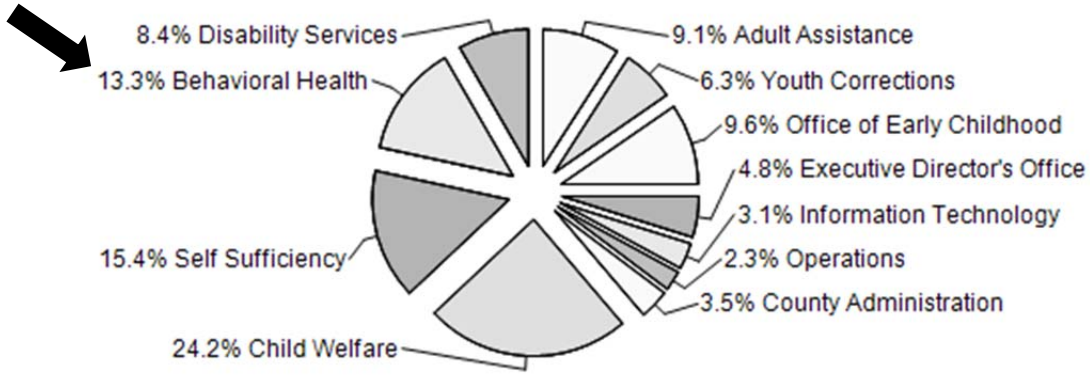


All charts are based on the FY 2015-16 appropriation.

Distribution of General Fund by Division



Distribution of Total Funds by Division



All charts are based on the FY 2015-16 appropriation

General Factors Driving the Budget

The FY 2016-17 request for the Behavioral Health Services section of the Department of Human Services budget consists of 70.9 percent General Fund, 8.6 percent cash funds, 7.1 percent reappropriated funds, and 13.4 percent federal funds. Cash funds primarily include patient revenues earned by the mental health institutes (including Medicaid and Medicare funds), marijuana tax revenues, and tobacco litigation settlement moneys that are credited to the Offender Mental Health Services Fund. Reappropriated funds primarily reflect transfers from the Department of Health Care Policy and Financing (which originate as General Fund and federal Medicaid funds) and the Judicial Branch (which originate as General Fund and drug offender surcharge revenues). Federal funds primarily include the Substance Abuse Prevention and Treatment Block Grant and the Mental Health Services Block Grant.

Community-based Programs and Services

The Office of Behavioral Health contracts with 17 community mental health centers (Centers) across the state to provide mental health services that are not otherwise available. Each Center is responsible for providing a set of core services, ranging from public education to inpatient services. Each Center has access to a certain number of inpatient beds at one of the mental health institutes, and is responsible for managing admissions to the allotted beds for adults within their service area.[2] The Office also contracts with four managed service organizations (MSOs) for the provision of substance use disorder treatment and detoxification services that are not otherwise available. MSOs subcontract with local treatment providers across the state to deliver these services. In addition, the Department administers funding for programs that integrate mental health and substance use-related services. While the majority of community-based behavioral health funding is allocated to Centers and MSOs, the Department also contracts with other organizations to provide specific types of services or services targeting specific populations.

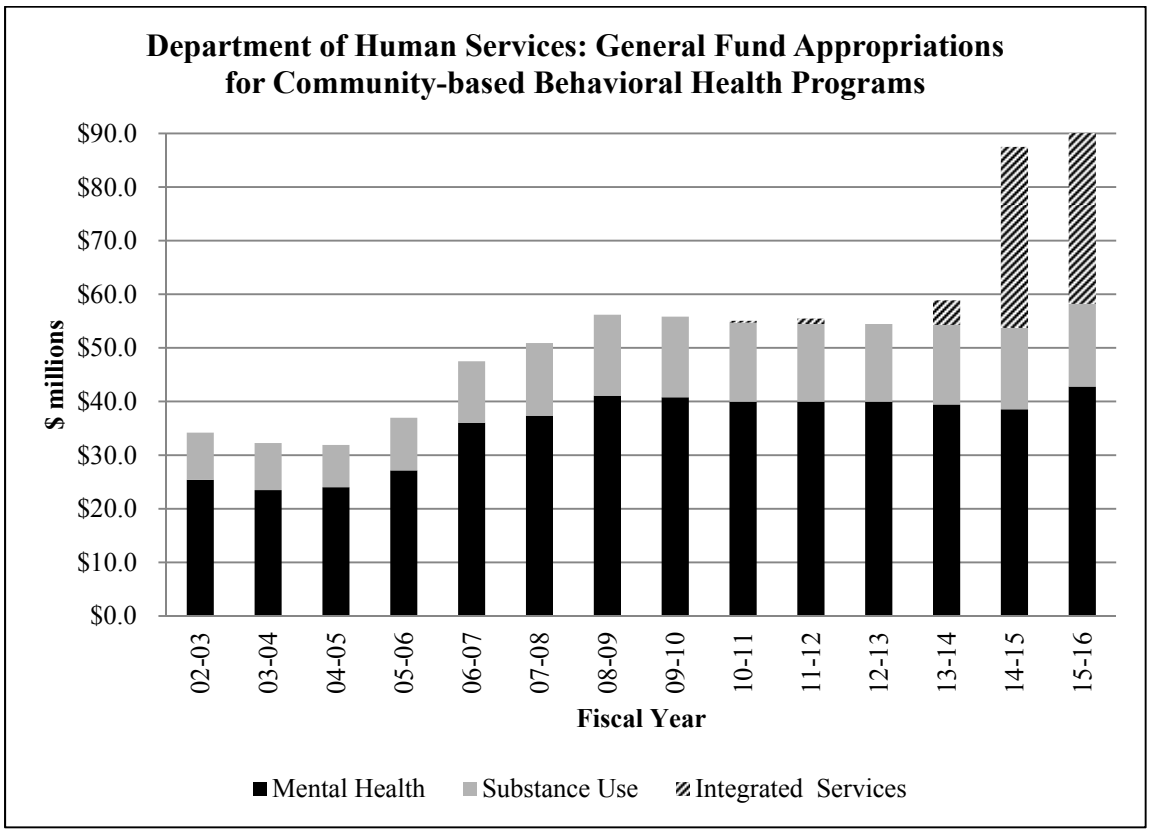
Mental health and substance use disorder services for Medicaid-eligible clients are primarily funded through the Department of Health Care Policy and Financing. Unlike the Medicaid program, the behavioral health services funded through this Department are not an entitlement. Thus, the number of individuals receiving services and the level of service provided is largely driven by the level state and federal funds available each year. The General Assembly periodically adjusts funding for Centers, MSOs, and other community providers to account for inflationary changes, to ensure that programs are viable over the long-term, and based on available revenues. The rate changes are generally consistent with the common policy adopted by the Joint Budget Committee for a variety of community providers. The following table lists rate changes for behavioral health providers from FY 2006-07 through FY 2015-16.

Changes in Community Provider Rates									
FY 06-07	**FY 07-08**	**FY 08-09**	**FY 09-10**	**FY 10-11**	**FY 11-12**	**FY 12-13**	**FY 13-14**	**FY 14-15**	**FY 15-16**
3.25%	1.50%	1.50%	0.00%	-2.00%	0.00%	0.00%	2.00%	2.50%	1.70%

[22] Please note that due to increased demand for forensic beds at the mental health institutes, the number of civil beds available to community mental health centers has declined.

The General Assembly also appropriates additional funds for the provision of specific services or services targeting specific populations (*e.g.*, alternative placements for people who would otherwise require hospitalization at a mental health institute, school-based behavioral health services for children, and services for juvenile and adult offenders).

The following chart depicts General Fund appropriations for community-based behavioral health services from FY 2002-03 through FY 2015-16. The significant increases provided for FY 2014-15 and FY 2015-16 primarily relate to the creation of a statewide behavioral health crisis response system and an effort to expand Centers' capacity to deliver behavioral health stabilization services to individuals who would otherwise require treatment at the mental health institutes.



In addition to General Fund appropriations depicted above ($90.4 million for FY 2015-16), the Office administers funds from the federal Mental Health Services Block Grant, the federal Substance Abuse Prevention and Treatment Block Grant, moneys transferred from the Department of Health Care Policy and Financing, moneys transferred from the Judicial Department, marijuana tax revenues, and tobacco settlement moneys that are credited to the Offender Mental Health Services Fund. These other fund sources are anticipated to provide an additional $46.2 million to support community-based behavioral health services in FY 2015-16.

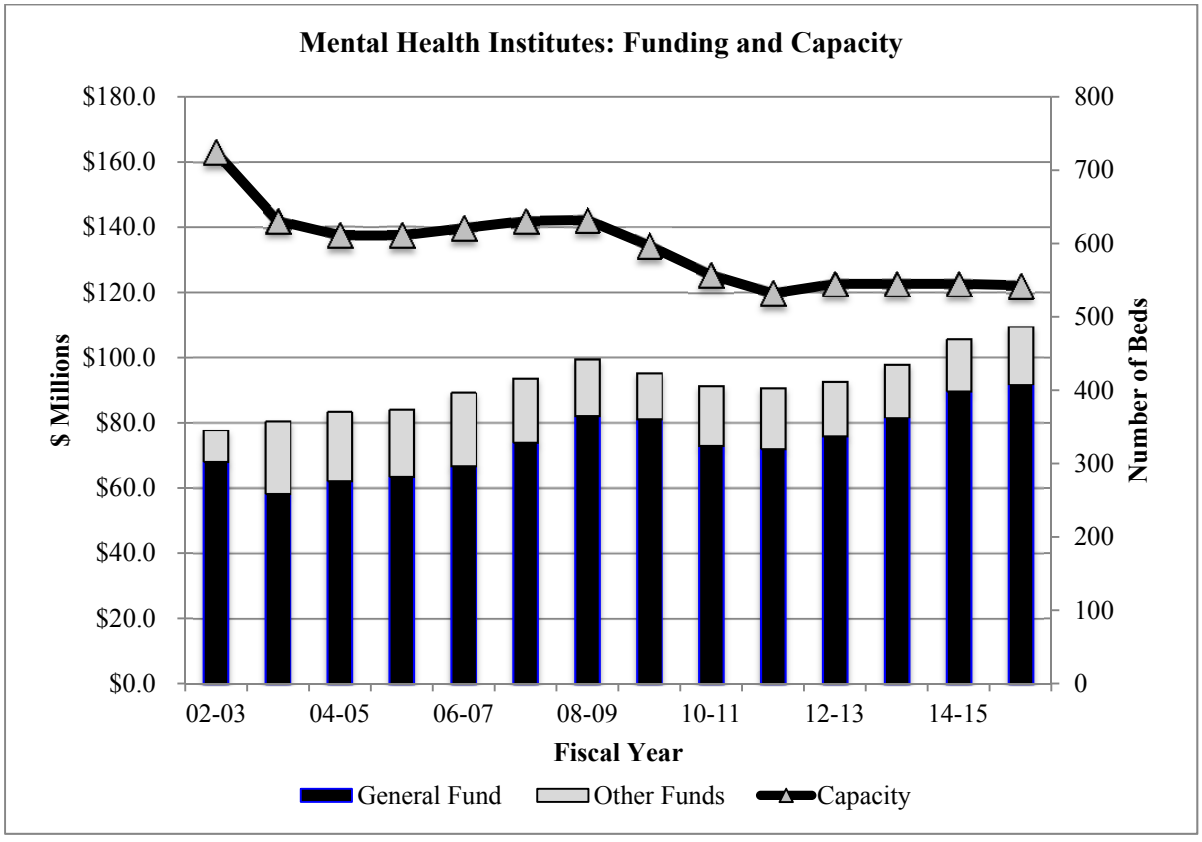
Mental Health Institutes

The Department administers and operates two mental health institutes that provide inpatient hospitalization for up to 543 individuals with serious mental illness. One institute is located in Pueblo and the other is located on the Fort Logan campus in southwest Denver. The institutes serve three populations:

- individuals with pending criminal charges who require evaluations of competency to stand trial and services to restore competency;
- individuals who have been found not guilty by reason of insanity; and
- adults and adolescents who are referred for admission by community mental health centers, county departments of social services, or the Department's Division of Youth Corrections.

The resources for first two populations are referred to as "forensic" beds, and the resources for the third population are referred to as "civil" beds.

The institutes are primarily supported by General Fund appropriations. Other sources of revenue include: patient revenues (including federal Medicare funds and federal Medicaid funds transferred from the Department of Health Care Policy and Financing), funds transferred from the Department of Corrections (DOC) for food services provided to DOC facilities on the Pueblo campus, and marijuana tax revenues that support the Circle Program in Pueblo. Funding for the institutes is affected by capacity, personnel costs, and operational costs (including medication expenses and the cost of purchasing medical services from local hospitals and medical providers). The chart below depicts recent changes in the institutes' bed capacity and funding.



As depicted in the above chart, the total capacity of the institutes has declined by 181 beds (25.0 percent) since FY 2002-03. The most recent closures approved by the General Assembly include closure of the children's, adolescent, and geriatric treatment divisions at Fort Logan (in FY 2009-10) and the closure of the therapeutic residential childcare facility treatment division at Fort Logan (in FY 2011-12). In addition, in late FY 2014-15, the Department modified an existing unit to treat patients who had previously been transferred to the DOC. This decreased the number of civil beds in Pueblo by two.

In FY 2013-14, the General Assembly provided funding for the Department to contract with a vendor to operate a 22-bed jail-based competency restoration program. This program is currently operated by GEO Care, LLC, within the Arapahoe County Detention Facility in Centennial. Thus, some of the addition funding reflected in the chart on the previous page increases the Department's capacity to provide services, but it does not reflect increased bed capacity within the mental health institutes.

Summary: FY 2015-16 Appropriation & FY 2016-17 Request

Department of Human Services	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
FY 2015-16 Appropriation						
SB 15-234 (Long Bill)	$254,178,268	$183,638,257	$18,265,045	$17,010,075	$35,264,891	1,281.1
Other Legislation	0	0	(1,550,000)	1,550,000	0	0.0
TOTAL	**$254,178,268**	**$183,638,257**	**$16,715,045**	**$18,560,075**	**$35,264,891**	**1,281.1**
FY 2016-17 Requested Appropriation						
FY 2015-16 Appropriation	$254,178,268	$183,638,257	$16,715,045	$18,560,075	$35,264,891	1,281.1
R3 Court ordered evaluation and jail-based bed space	3,994,550	3,994,550	0	0	0	7.5
R11 Intensive residential treatment for SUD	4,705,437	0	4,705,437	0	0	0.9
R12 Sober living homes	300,000	0	300,000	0	0	0.0
R13 Supported employment for people with severe SUD	500,000	0	500,000	0	0	0.0
R14 Behavioral health crisis services staffing	(38,107)	(38,107)	0	0	0	2.7
R19 Community provider rate adjustment	(1,072,130)	(1,045,853)	(9,041)	(17,236)	0	0.0
NP2 FMAP decrease	0	0	0	0	0	0.0
NP3 DOC food service inflation	45,977	0	0	45,977	0	0.0
Correctional Treatment Board Recommendation	0	0	0	0	0	0.0
Annualize prior year legislation	500,000	0	500,000	0	0	0.0
Annualize prior year budget action	(434,273)	(463,701)	(15,000)	22,073	22,355	0.3
Centrally appropriated line items	(58,788)	0	(58,788)	0	0	0.0
TOTAL	**$262,620,934**	**$186,085,146**	**$22,637,653**	**$18,610,889**	**$35,287,246**	**1,292.5**
Increase/(Decrease)	$8,442,666	$2,446,889	$5,922,608	$50,814	$22,355	11.4
Percentage Change	3.3%	1.3%	35.4%	0.3%	0.1%	0.9%

Description of Requested Changes

R3 Court ordered evaluation and jail-based bed space: The request includes $3,994,550 General Fund[3] and 7.5 FTE to address continued increases in the number of court-ordered competency evaluations and restorations to competency. In September, the Committee approved

[3] Please note that the Department's overall request includes an additional $117,135 General Fund in the Executive Director's Office to cover associated employee benefit expenses.

an interim supplemental request for $2.7 million General Fund and 4.5 FTE for FY 2015-16; this request represents continuation funding for FY 2016-17. *[For more information, see the issue brief titled, "Competency Evaluation and Restoration Services".]*

R11 Intensive residential treatment for substance use disorder (SUD): The request includes $4,705,437 cash funds from the Marijuana Tax Cash Fund[4] and 0.9 FTE to contract for programs to provide intensive residential treatment for individuals with the most severe SUDs. These programs would target pregnant women (32 beds), adult men (32 beds), and young adults ages 18 to 25 (16 beds).

R12 Sober living homes: The request includes $300,000 cash funds from the Marijuana Tax Cash Fund for the Department to contract with an organization to establish up to 15 sober living homes for individuals leaving SUD treatment. These homes would provide stable, drug-free housing for up to 60 people per year in various regions of the state.

R13 Supported employment for people with severe SUD: The request includes $500,000 cash funds from the Marijuana Tax Cash Fund for the Department to contract with substance abuse treatment providers to provide "Individual Placement and Support (IPS)" services to clients with severe SUDs. The requested funding would support ten contract staff at five sites, providing services to approximately 300 clients per year.

R14 Behavioral health crisis services staffing: The request includes an increase of $181,102 General Fund[5] and 2.7 FTE to expand from one to four the number of employees overseeing the statewide behavioral health crisis system contracts. The requested staff would expand the Office of Behavioral Health's capacity for: fiscal monitoring and oversight; data integrity and evaluation; and quality assurance and monitoring. This request is offset by a requested $219,209 reduction in the General Fund appropriation for behavioral health crisis response system services provided through consortiums of Community Mental Health Centers.

R19 Community provider rate adjustment: The Department's overall request includes a reduction of $7.9 million (including $4.7 million General Fund) for a 1.0 percent community provider rate decrease. With respect to the Behavioral Health Services section, the request includes a reduction of $1,072,130 total funds, including: $434,131 for mental health community programs; $170,369 for substance use treatment and prevention; $315,174 for integrated behavioral health services; and $152,456 for contract personnel at the mental health institutes.

Non-prioritized requested changes: The request includes an increase of $45,977 reappropriated funds to reflect the impact of three changes requested by other departments or entities:

- *HCPF R11 (Decreased FMAP):* The request reflects an adjustment in the proportions of General Fund and federal funds that are appropriated to the Department of Health Care

[4] Please note that the Department's overall request includes an additional $20,835 General Fund in the Executive Director's Office to cover associated employee benefit expenses.

[5] Please note that the Department's overall request includes an additional $38,107 General Fund in the Executive Director's Office to cover associated employee benefit expenses. Thus, the overall request for this initiative is $0 General Fund.

Policy and Financing (HCPF) and transferred to this department to support programs and services administered by this department. This shift is based on an anticipated decrease in Colorado's federal medical assistance percentage (FMAP) for the Medicaid program.

- *DOC R1 (Food service inflation):* The request includes $45,977 for the costs incurred by the Colorado Mental Health Institute at Pueblo (CMHIP) to provide meal services to Department of Corrections (DOC) facilities on the CMHIP campus (La Vista Correctional Facility, San Carlos Correctional Facility, and the Youthful Offender System), including: $34,939 an estimated 2.0 percent increase in the raw food; and $11,038 for an increase in the population housed at the La Vista Correctional Facility.
- *Correctional Treatment Board recommendation*: The Correctional Treatment Board recommends a shift of $95,000 reappropriated funds (transferred from the Judicial Department) from the Jail-based Behavioral Health Services program to the Short-term Intensive Residential Remediation and Treatment (STIRRT) program. This shift is intended to cover the costs of modifying the STIRRT program based on current research and best practices.

Annualize prior year legislation: The request includes $500,000 cash funds from the Marijuana Tax Cash Fund for treatment and detoxification contracts, maintaining the funding appropriated through H.B. 15-1367 and referred Proposition BB (recently approved by voters).

Annualize prior year budget actions: The request includes adjustments related to several prior year budget actions. With respect to the Behavioral Health Services section, the request includes a reduction of $434,273 total funds and an increase of 0.3 FTE, comprised of the following:

- *FY 2015-16 salary increases*: Add $1,409,062 (including $1,369,940 General Fund) to reflect the allocation of FY 2015-16 salary increases to each respective line item that supports employee salaries (primarily for staff at the mental health institutes).
- *FY 2014-15 DHS R11:* Add $50,762 General Fund and 0.3 FTE to fund a full 12 months of personal services and operating expenses associated with 8.0 FTE added over the last two fiscal years for both mental health institutes to provide customer support, management, analysis, and system modification support for the newly implemented automated electronic health record system.
- *FY 2015-16 DHCPF R12:* Add $5,306 reappropriated funds to provide a full 12 months of funding for targeted rate increases for the High Risk Pregnant Women program. *[For more information about this rate increase, see Appendix C, Long Bill footnote #17 in the JBC Staff Budget Briefing concerning the Department of Health Care Policy and Financing, Behavioral Health Services, dated December 9, 2015.]*
- *FY 2015-16 DHS R14:* Eliminate one-time appropriation of $1,659,403 General Fund for a variety of equipment replacements, repairs, and minor renovations at both mental health institutes.
- *FY 2015-16 DHS R13:* Eliminate one-time appropriation of $225,000 General Fund to allow the Department to contract with a vendor to analyze the potential for the Circle Program to operate as an autonomous program, separate from CMHIP.
- *Temporary increase in spending authority:* Reduce cash fund spending authority from the Cigarette, Tobacco Product, and Nicotine Product Use by Minors Prevention Fund by

$15,000. For FY 2014-15 and FY 2015-16, the spending authority from this fund was increased by $20,000 to reduce the excess fund balance.

Centrally appropriated line items: The request reflects a $58,788 reduction in cash fund appropriations from the Marijuana Tax Cash Fund based on the impact of common policies concerning employee benefits (*e.g.*, health, life, and dental insurance).

Issue: WICHE Study Concerning State's Behavioral Health Needs

The Department recently contracted with the Western Interstate Commission for Higher Education (WICHE) to conduct a comprehensive study to assess the state's current and future behavioral health needs. This issue brief summarizes the report findings and recommendations, and the Department's response to many of these recommendations.

SUMMARY:

- The WICHE study includes over 80 distinct recommendations concerning a variety of behavioral health delivery system issues. The implementation of many recommendations would require action or cooperation from other state agencies.

- The report evaluates the distribution of behavioral health services in various geographic regions and among various populations, and it identifies four promising practices that can help address some of the identified service gaps and disparities: (1) Telehealth; (2) Integrating primary and behavioral health care; (3) Prevention and early intervention; and (4) Peer support services.

- The report includes data that clearly demonstrates a reduction in the State's ability to provide inpatient psychiatric care for civil patients. The report includes four scenarios for addressing the availability of inpatient psychiatric care at the mental health institutes.

- The report also identifies systemic barriers that inhibit the effective delivery of behavioral health services. Several of these barriers involve the allocation of responsibilities between the Department of Human Services and the Department of Health Care Policy and Financing (HCPF).

RECOMMENDATION:

Staff recommends that the Committee ask the Department of Human Services to discuss (in conjunction with HCPF where appropriate) the findings of the WICHE study and its plans to address the study recommendations, including the following specific recommendations:

- Move the responsibility and authority for all behavioral health funding, planning, programs, and regulations into a single department.
- Explore the development of a common management information system for behavioral health data, or the modification of each agency system to share physical and behavioral health data using industry standard health information exchange standards.
- Determine how behavioral health crisis system services for Medicaid clients will be billed and reimbursed.
- Implement suspension, rather than termination, of Medicaid benefits for institutionalized individuals.

DISCUSSION:

Background Information

The Department's Office of Behavioral Health recently contracted with the Western Interstate Commission for Higher Education (WICHE) to conduct a comprehensive study to assess the state's current and future behavioral health needs. This study was expected to achieve a number of objectives, including the following:

- Assess the need for both civil and forensic beds at both mental health institutes, considering existing and projected wait lists, the number of behavioral health clients in hospital emergency departments, community need (*e.g.,* underserved, unserved, and homeless individuals), and other relevant factors.
- Analyze the projected impact of increasingly court-ordered evaluation and competency restorations on civil bed availability at the mental health institutes.
- Provide an inventory of existing state and community behavioral health resources, including the identification of the existing continuum of care bridging state and community resources.
- Identify existing service gaps in the continuum of care for all age ranges, including service gaps related to other payer sources, such as Medicaid, Medicare, and other third-party payers such as private insurance carriers.
- Assess the degree to which current system resources effectively serve specific populations in need (*e.g.,* adult, geriatric, individuals with dementia or traumatic brain injuries, indigent individuals, severely and persistently mentally ill individuals). Address child and adolescent behavioral health services including its connection with child welfare, juvenile justice, and education.
- Evaluate the degree to which Colorado sentencing reforms related to drug possession have and will expand the need for mental health, substance, and co-occurring disorders services.
- Provide recommendations as how to best align existing resources with future planning, so as to strategically maximize state resources.

The Department utilized federal Substance Abuse Prevention and Treatment Block Grant moneys to fund the study; the contracted amount was $339,924.

Study Findings and Recommendations

The study was conducted in FY 2014-15 by WICHE, in partnership with the National Association of State Mental Health Program Directors Research Institute and Advocates for Human Potential. WICHE completed a report titled, "Colorado Office of Behavioral Health Needs Analysis: Current Status, Strategic Positioning, and Future Planning" in April 2015.[6] The report includes over 80 distinct recommendations, which concern a variety of behavioral health service delivery system issues. Many recommendations could only be implemented with action or cooperation from other state agencies, including Judicial Branch agencies and the following departments:

[6] The full report can be accessed at the following web address:
https://drive.google.com/file/d/0B6eUVZvBBTHjSGhSYUJjVE95ck0/view

- Corrections
- Health Care Policy and Financing
- Higher Education
- Labor and Employment
- Local Affairs
- Public Health and Environment
- Public Safety
- Regulatory Agencies

Staff has compiled and summarized the recommendations that are included in the report in Appendix E. Staff attempted to eliminate duplicate recommendations, while maintaining the topical categories and recommendation numbers from the report to the extent possible. Staff has also included information provided by the Department of Human Services concerning budget requests and other initiatives that are under way to address some of the recommendations; these initiatives are described later in this issue brief.

General Topics and Themes

The report evaluates the distribution of behavioral health services in various geographic regions and among various populations. The report identifies four promising practices that can help address some of the identified service gaps and disparities.

- *Telehealth:* Telehealth uses technology to connect health care providers and patients in different locations. Telehealth can assist in improving access: (1) in rural, frontier, or other areas with geographic barriers; (2) for underserved communities and for those who have typically been less likely to seek care for behavioral health-related issues because of stigma, cultural, or financial reasons; (3) for individuals with mobility issues that limit their ability to travel to services; and (4) to specialty care that is not widely available. The report discusses existing telehealth initiatives in Colorado and makes recommendations for improving and expanding telehealth services.

- *Integrating primary and behavioral health care:* The report provides a national perspective on approaches to integrating the delivery of primary and behavioral health care, and barriers to integration. The report also describes three Colorado initiatives concerning integrated care, and it includes recommendations to support the implementation of integrated health care.

- *Prevention and Early Intervention:* Throughout the report, there is an emphasis on providing a full continuum of care, including preventative services and non-clinical support services such as housing, transportation, and employment services.

- *Peer Support Services:* The report discusses the utilization of peer specialists in the delivery of behavioral health services. Peer specialists are individuals with lived experience of a mental health condition or substance use disorder. Peer specialists model recovery, teach skills, and offer support for behavioral health clients. The report describes the ways that peer specialists are currently working in Colorado's behavioral health system, and includes recommendations for strengthening and expanding the involvement of peer specialists.

Need for Inpatient Psychiatric Care

The report includes a substantial discussion of the mental health institutes and the need for inpatient psychiatric care. The report indicates that "accurate quantitative data on the demand for inpatient beds is unavailable". However, the report includes data that clearly demonstrates a reduction in the availability of beds for civil patients. The report projects the number of inpatient beds needed based on the existing supply of psychiatric beds, the community-based services that existed at the time of the study, and a comparable data from other states. The report includes four scenarios for addressing the availability of inpatient psychiatric care at the mental health institutes:

- Scenario 1 takes current bed capacity and projects future bed need based on state population increases and the rise in forensic admissions. Based on an existing rate of 1.75 beds per 100,000 population, and the projected population growth and continued increases in the number of forensic beds, the report projects a need to add 157 civil beds by 2020 and another 331 civil beds by 2025.

- Scenario 2 uses the same projections as Scenario 1, but also reallocates 24 civil beds from the Colorado Mental Health Institute at Pueblo (CMHIP) to the Colorado Mental Health Institute at Fort Logan (CMHIFL) to reduce the travel time required for patients referred from four mental health centers that are geographically closer to CMHIFL.

- Scenario 3 uses the same projections and bed reallocation as Scenario 2, but it also increases the overall bed capacity for adolescent and geriatric patients based on the average number of beds per 100,000 persons in seven western states. These beds are added to CMHIFL. Specifically, this scenario adds 75 beds (29 adolescent and 46 geriatric) initially, and projects the need for an additional 15 beds for these populations by 2025 (over and above the need projected for adult civil beds in scenario 1).

- Scenario 4 builds on the above three scenarios, and it reallocates 98 forensic beds from CMHIP to CMHIFL to serve individuals who reside closer to Denver and who require less intensive forensic services. The remaining 209 forensic beds at CMHIP would be used for higher security risk patients and all patients with a status of "not guilty by reason of insanity".

While the report recognizes a need to increase the number of inpatient psychiatric beds, it also notes several factors that may mitigate the need for civil beds:

- The State recently implemented behavioral health crisis services (mobile crisis teams, stabilization units, and respite care).
- The State has implemented (and is in the process of expanding) jail-based competency restoration programs.
- Some private facilities have expressed interest in contracting to serve individuals with co-occurring behavioral health and medical/physical conditions (St. Mary's in Grand Junction, Lutheran–West Pines in Wheat Ridge, and Peak View in Colorado Springs).

- A new 92-bed inpatient facility is scheduled to open in Johnstown (Weld County) in fall 2015. The facility will include 36 adult/geriatric beds and 20 adolescent beds.

The report also includes several recommendations to mitigate or reduce the demand for inpatient forensic beds, and to increase the capacity of general hospitals, skilled nursing facilities, and nursing homes to provide psychiatric care for individuals requiring medical or other specialized care.

Systemic Barriers to Effective Behavioral Health Service Delivery

Finally, the report identifies systemic barriers that inhibit efficient and effective behavioral health service delivery. Several of these barriers involve the allocation of responsibilities between the Department of Human Services and the Department of Health Care Policy and Financing, and corresponding issues that relate to the funding of behavioral health care (*e.g.*, Medicaid eligibility requirements and processes, covered benefits). *[In Appendix F, staff has included information that was prepared by the Department of Human Services briefly describing the role of each state agency that is involved in licensing individuals and facilities that provide behavioral health services and related statutory provisions.]*

Department Actions and Requests in Response to Study Findings

In response to a staff request, the Department prepared a series of tables listing Department actions and initiatives that are responsive to WICHE study findings. *[Appendix E reflects these Department actions and initiatives as well.]* The first table lists five budget requests for FY 2016-17 that align with study recommendations.

DHS FY 2016-17 Decision Item	WICHE Needs Analysis Recommendation
R3 Court ordered evaluation and jail-based bed space (and associated supplemental request)	Colorado Mental Health Institutes, #1: Develop outpatient alternatives in order to slow the trend of increased forensic admissions: Colorado is higher than other states average for forensic patients. Colorado Mental Health Institutes, #2: Increase the percentage of evaluations conducted in outpatient settings to decrease the number of inpatient beds being used for this purpose: train and retain more evaluators.
R11 Intensive residential treatment for SUD	Aligning and Maximizing OBH Resources and Payer Sources, #2: Develop service delivery systems for individuals with significant co-occurring needs. Providers voiced continued frustration about the institutes' admissions/denials of referrals for co-occurring needs.
R12 Sober living homes	Regional Behavioral Health Service Distribution, #4: Peer support services: used to assist with community-based recovery and re-integrations supports for mental health and substance abuse. Community Integration and Olmstead, #1: Fully implement the Colorado Community Living Plan: offer a variety of services in integrated settings. Community Integration and Olmstead, #2: Improve access to housing and supports: adult consumers with Serious Mental Illness have access to affordable, integrated and supported housing.
R13 Supported employment for people with severe SUD	Housing and Employment, #6: Continue the implementation and expansion of the individual placement and support model of supported employment (IPS/SE) as an evidence-based practice. Housing and Employment, #8: Provide training for provider agencies on IPS/SE. Housing and Employment, #9: Set targets for the number of individuals to be served using the IPS/SE. Housing and Employment, #10: Develop strategic state-level partnerships with the Division of Vocational Rehabilitation. Community Living and Olmstead, #3: Continue to support the expansion of supported employment.
R14 Behavioral health crisis services staffing	Governor's Plan to Strengthen Colorado's Behavioral Health System, #1: Evaluate effectiveness, efficiency, and outcomes of the new crisis response services. Ongoing evaluation for longitudinal analysis. Regional Behavioral Health Service Distribution, #4: Peer support services: used to assist with community-based recovery and re-integrations supports for mental health and substance abuse. Aligning and Maximizing OBH Resources and Payer Sources, #4: Encourage discussion, among Office of Behavioral Health and Department of Health Care Policy and Financing staff and crisis services providers, of how crisis's services for Medicaid clients will be billed and reimbursed: either capitation rates need to be adjusted or providers need to be able to submit fee for services claims. Aligning and Maximizing OBH Resources and Payer Sources, #5: Encourage discussions, between OBH and crisis services providers, of processes for determining each client's ability to pay, including available payer sources, and review how providers are administering these processes. Aligning and Maximizing OBH Resources and Payer Sources, #6: Attempt to measure the impact of crisis services: develop a clearer picture of the impact of crisis services on the need for inpatient psychiatric hospital beds.

The second table identifies six interagency initiatives that align with study recommendations.

DHS Interagency Initiative	WICHE Needs Analysis Recommendation
Initiate a request to Judicial to adjust the reimbursement rates paid by the courts to CMHIP.	Colorado Mental Health Institutes, #3: Raise the daily reimbursement rates paid by the courts to the Colorado Mental Health Institute at Pueblo (CMHIP).
Continue to investigate amending C.R.S. 16-8.5-103 to require that a judge may only order an inpatient evaluation of competency to stand trial for defendants whom the criminal court believes would meet the state's certification criteria under C.R.S. 27-65-105 or with the written approval of the Executive Director of CDHS.	Colorado Mental Health Institutes Recommendations/considerations related to the four bed project scenarios: Amend Colorado law to require competency referrals to meet 27-65 criteria with alternative approval by OBH/DHS in special cases.
Establish a pilot in conjunction with Colorado's Dependency and Neglect System Reform (DANSR) Program based on the Sequential Intercept Model.	Colorado Mental Health Institutes #6: Develop pre- and post-adjudication services to decrease the number of justice-involved individuals being referred for competency evaluations.
Work collaboratively with the Department of Health Care Policy and Financing (HCPF) to support enhancement of crisis services for individuals with intellectual/developmental disabilities, including via HCPF's Intellectual and/or Developmental Disabilities (I/DD) Crisis Center Pilot.	Aligning and Maximizing OBH Resources and Payer Sources, #2: Develop service delivery systems for individuals with significant co-occurring needs.
Continue to collaborate with HCPF on the Colorado State Innovation Model and Colorado's System of Care Initiative.	Aligning and Maximizing OBH Resources and Payer Sources, #8: Explore the development of a common management information system.
Continue to collaborate with HCPF to identify gaps in Medicaid coverage for behavioral health care.	Drug Possession Sentencing Reform/ Medicaid Expansion, #3: There are too few resources to adequately treat and serve all of those in need.

The final table lists three contract-related changes that are in process and which address some of the Study recommendations.

CDHS Contracting Refinements in Progress	WICHE Needs Analysis Recommendation
As funds become available, increase contracts for behavioral health services in regions 1 and 2 (the southwestern and northeastern parts of the state).	Penetration Rates and Relative Need for Services: Align service availability with need (based on historical penetration and projected population change).
Redirect resources from behavioral health treatment contracts to intervene earlier and provide essential services that are not covered by Medicaid to include early intervention, housing supports, and employment assistance.	Community Integration and Olmstead, #2: Improve access to housing and supports. Community Integration and Olmstead, #3: Continue to support the expansion of supported employment and ACT. Housing and Employment, #6: Continue the implementation and expansion of the individual placement and support model of supported employment (IPS/SE) as an evidence-based practice. Housing and Employment, #9: Set targets for the number of individuals to be served using the IPS/SE. Housing and Employment, #14: Redirect spending of state funds on services that can be covered by Medicaid to improve housing options, provide transportation, promote employment, and other non-clinical services.
Use prevention contracts to enhance focus on both universal and targeted prevention efforts in the areas of marijuana and prescription drug safety and risk.	Legal Marijuana and Prescription Drug Abuse, #1: Redouble prevention efforts.

In addition, as part of the Governor's "contingent" budget request, the Department submitted a request for $1.2 million General Fund and 8.8 FTE in FY 2016-17, and $1.2 million and 14.1 FTE in FY 2017-18 and subsequent fiscal years, to relocate two existing units at the Colorado Mental Health Institute at Pueblo (CMHIP):

- the Adolescent Behavioral Treatment Unit (a 20-bed unit that serves civil and forensic adolescent populations); and
- the Circle Program (a 20-bed intensive inpatient treatment program that serves adults with co-occurring mental health and substance use disorders)

These relocations are designed to provide a safer, more therapeutic environment for adolescents, and to allow CMHIP to add 20 beds to an existing 12-bed transitional unit for patients who are preparing for community reintegration.

Staff Recommendation
In addition to inviting the Department of Human Services to discuss the findings of the WICHE study and its plans to address the study recommendations, staff recommends that the Committee ask the two departments to discuss actions taken to date or plans to address the following specific study recommendations:

- Move the responsibility and authority for all behavioral health funding, planning, programs, and regulations into a single department.
- Explore the development of a common management information system for behavioral health data, or the modification of each agency system to share physical and behavioral health data using industry standard health information exchange standards.
- Determine how behavioral health crisis system services for Medicaid clients will be billed and reimbursed.
- Implement suspension, rather than termination, of Medicaid benefits for institutionalized individuals.

Issue: Competency Evaluation and Restoration Services

The Department of Human Services (DHS) has requested additional resources in the current fiscal year for the mental health institutes to address continued increases in the number of competency-related court orders. This issue brief discusses this request, along with other actions taken by DHS to address the problem. This issue brief also summarizes information recently provided by the Judicial Department concerning the court's perspective on potential system improvements.

SUMMARY:

- In 2012, the Department of Human Services (DHS) entered into a Settlement Agreement related to a legal challenge concerning the length of time pretrial detainees wait to receive competency evaluations and competency restoration treatment.

- In September 2015, DHS submitted an interim supplemental request for $2.7 million General Fund in FY 2015-16 to address continued increases in the number of competency-related court orders, and DHS has submitted an associated request for $4.1 million General Fund in FY 2016-17. The requested funds are a critical component of the Department's plan to address the increasing number of court orders and to avoid further legal action.

- The Judicial Department recently indicated that it would support a statutory change to allow DHS to determine the most suitable location for competency evaluation (rather than the court). The Judicial Department also offered some additional options and expressed some concerns about the current system and potential changes to the system.

RECOMMENDATION:

Staff recommends that the Committee ask DHS to provide an update on its progress in implementing the changes for which additional funds were requested in September. In addition, staff recommends that the Committee ask the Department about the next steps that are necessary to improve the efficiency and effectiveness of the system (suggested questions are listed later in this issue brief).

DISCUSSION:

Department's September 2015 Interim Supplemental Request
In September the Department requested a total of $2.7 million General Fund and 4.5 FTE in FY 2015-16 to address continued increases in the number of court-ordered competency evaluations and restorations to competency. In 2012 the Department entered into a Settlement Agreement related to a legal challenge concerning the length of time pretrial detainees wait to receive competency evaluations and restoration treatment. *[Background information about the Settlement Agreement is provided at the end of this issue brief.]* The Agreement requires the Department to admit pretrial detainees to the Colorado Mental Health Institute at Pueblo

(CMHIP) for competency evaluations or for restorative treatment no later than 28 days after the individual is ready for admission, and to maintain a monthly average of 24 days or less for admission.

On August 3, 2015, the Department invoked the "Departmental Special Circumstances" provision of the Agreement. The Department is currently in negotiations with the Plaintiff to review the circumstances identified by the Department which impact CMHIP's ability to comply with the Agreement timeframes. If the parties agree that these circumstances exist and identify issues for resolution, the Department will be required to submit a proposal to address the issues. The resources requested through this supplemental are a critical component of the Department's plan. The Department does not have sufficient psychologist staff or bed space capacity to meet the demand for inpatient competency services. If the problem is not addressed, the Department is at risk of violating the terms of the Agreement and could be at risk for further legal action, including a possible contempt of court judgment.

The Department's FY 2015-16 request included two components:

- An increase of $333,917 General Fund for CMHIP to hire additional psychologists to perform court-ordered competency evaluations. These evaluations are performed at CMHIP, in county jails, in juvenile detention facilities, or at other locations in the community if the defendant is released on bond.

- An increase of $2,393,180 General Fund to increase CMHIP's capacity to house individuals requiring inpatient competency evaluations, and to house and provide treatment for individuals requiring inpatient competency restoration. The Department currently contracts for a 22-bed jail-based restoration program; this proposal would add another 30 beds. *[Background information about the existing jail-based restoration program is provided at the end of this issue brief.]* The contracted daily rate for the existing jail-based restoration program is $307.50 per day; this compares to the FY 2015-16 inpatient daily rate at CMHIP for forensic psychiatry of $676.00 per day.

The Committee approved the Department's interim supplemental request. The Department submitted a corresponding funding request for FY 2016-17 as part of its November 1 submittal. The table on the following page details the funding requested for FY 2015-16 and FY 2016-17.

Absent additional resources to conduct competency evaluations, to provide restoration treatment, and house defendants requiring such services, the length of time defendants wait to receive such services will continue to increase and jeopardize the Department's ability to comply with the terms of the Settlement Agreement.

Summary of Request for R3: Court Ordered Evaluation and Jail-based Bed Space			
Description	FY 2015-16 Appropriation	FY 2016-17 Request	Annual Change
Executive Director's Office			
General Administration			
Health, Life, and Dental	$47,563	$63,417	$15,854
Short-term Disability	709	1,048	339
S.B. 04-257 AED	14,198	26,473	12,275
S.B. 06-235 SAED	13,715	26,197	12,482
Subtotal	76,185	117,135	40,950
Office of Behavioral Health			
Mental Health Institutes, Mental Health Institute - Pueblo			
Personal Services	257,407	468,753	211,346
FTE	3.1	5.5	2.4
Operating Expenses	24,344	10,023	(14,321)
Jail-based Competency Restoration Program	2,369,161	3,515,774	1,146,613
FTE	1.4	2.0	0.6
Subtotal	2,650,912	3,994,550	1,357,959
FTE	4.5	7.5	3.0
Total General Fund	**$2,727,097**	**$4,111,685**	**$1,384,588**
FTE	4.5	7.5	3.0

Please note that in addition to its statutory obligations related to competency evaluations and restoration treatment, the Department is statutorily required to provide sanity and mental condition evaluations and exams for criminal defendants. The mental health institutes are further designated to provide treatment for civil patients, particularly those in psychotic crisis. In order to adhere to the terms of the Settlement Agreement concerning competency-related services, the management team at the CMHIP meets daily to review the referral and admission lists in order to manage the competing demands for inpatient civil and forensic beds. Failure to expand the capacity to meet the increasing demand for court-ordered competency evaluations and restoration services could place the Department at risk for further legal action due to longer waits for other types of hospital admissions.

The Department's request is designed to provide more flexibility by creating bed space outside CMHIP for defendants who need either a competency evaluation or restoration treatment, and by allowing this new capacity to be used by defendants from outside the metro Denver area when appropriate.

Additional Actions Taken by Department to Address Situation

In response to a question from the Committee during the JBC staff budget briefing for the Judicial Branch, the Department provided the following description of other steps it has taken to address the backlog.

- The Department has had conversations with the Judicial Department, judges, and prosecutors and is in the process of scheduling a meeting with the public defenders. Due to an improvement in stabilizing factors within the hospital (related to staffing and acuity), there has also been an increase in the number of individuals admitted for inpatient evaluations, which is reducing admission timeframes.

- The Department has assigned a psychologist to screen collateral information for defendants, in order to identify those that are likely to be opined competent or require minimal intervention, and another dedicated psychologist to do the evaluations. The Department continues to monitor the number of patients being discharged daily, and continually makes adjustments to the admissions schedule. All admissions administrative staff working weekends were moved to weekdays to assist with the increase in admissions. This freed up six staff and one nurse per shift for each weekend day.

- In September 2015, the Department posted an Invitation for Bid for independent competency evaluation contractors.

- In early October, the Department began asking the courts to consider outpatient competency evaluations versus inpatient evaluations, when appropriate.

- The Department modified the current contract with the jail-based restoration vendor, to permit the Department to refer defendants to the program for whom an inpatient competency evaluation had been ordered. The contract amendment was executed on October 8, 2015.

- Discussions with the University of Colorado, Forensic Psychiatry Training Program took place to explore to what extent the forensic psychiatry fellows can perform a greater number of competency evaluations.

- Discussions took place with the Director of the Wisconsin Forensic Unit to learn about how other states are managing these issues.

- The Department also spoke with a private hospital to explore the idea of utilizing a private hospital's unoccupied space.

- The Department considered whether space within the Department of Corrections could be used for inpatient competency evaluation and restoration services. Use of the Colorado Mental Health Institute at Fort Logan was also explored as an option, and is currently helping to reduce the bed capacity burden for the CMHIP.

Judicial Department Responses to Potential Changes

In response to a proposal by the Department of Human Services, the Committee recently asked the Judicial Department whether it would consider either: (1) applying the legal standard for involuntary civil commitment to determine the location of a competency evaluation; or (2) allowing the Department of Human Services (DHS) to determine the location of a competency evaluation. The Judicial Department indicated that it would not support the first option because the court would not have enough information at the initial hearing to determine if the criteria applied and would need expert input (*i.e.*, an evaluation) to make this determination. However, the Judicial Department did support the second option, and indicated that it would support a statutory change to allow DHS to determine the most suitable location for competency evaluation.

In addition, the Judicial Department offered some additional options and expressed some concerns:

- The Judicial Department is willing to participate in a study group if necessary to develop a comprehensive plan to address this matter.

- Since the judge's primary obligation is to ensure that the defendant is provided with due process, an increase in the fee charged to the courts by CMHIP for inpatient evaluations would not (and should not) affect court orders.

- Judges, and particularly judges in rural areas, have expressed concern about DHS' inability to consistently complete outpatient evaluations on a timely basis.

- The Judicial Department believes that the higher rate of competency findings arising when the defendant is in inpatient care is generally a result of better care at the facility. The CMHIP provides more appropriate medication than is available in jails and has more ability to maintain compliance with medication orders. The professionals at CMHIP are better trained in mental health, are more apt at detecting malingering, and have more opportunity to observe and monitor defendants undergoing competency evaluations than the staff at jails.

- Generally, the perception of judges is that competency evaluations that are conducted at CMHIP are more accurate and reliable.

- The Judicial Department's priority is to ensure that criminal cases proceed as quickly as possible, so it is concerned about creating any unnecessary steps or delays into competency-related processes.

Next Steps

Staff recommends that the Committee ask the Department to provide an update on its progress in implementing the changes for which additional funds were requested in September. In addition, staff recommends that the Committee ask the Department about the next steps that are necessary to improve the efficiency and effectiveness of the system. Specifically:

- What statutory change(s) does the Department recommend to allow DHS (rather than the courts) to determine the most suitable location for competency evaluation?

- If the Judicial Department no longer has the discretion to order an inpatient evaluation, does it make sense for CMHIP to continue charging the Judicial Department for such competency evaluations (*i.e.*, should this existing statutory provision that requires CMHIP to bill the courts for the cost of housing defendants for the purpose of conducting an inpatient competency evaluation be repealed, and the corresponding General Fund appropriations be shifted to CMHIP with an equal reduction in CMHIP cash funds spending authority)?

- What steps can DHS take to address rural judges' concern about DHS' inability to consistently complete outpatient evaluations on a timely basis?

- How does DHS respond to the Judicial Department's assertion that a defendant is more likely to be found competent at CMHIP compared to a jail setting as a result of better care and medication compliance?

- What steps can DHS take to increase the Judicial Department's confidence in the accuracy and reliability of outpatient competency evaluations?

- What steps can DHS take to improve services for defendants when they return to the community in order to reduce the number who continue to cycle through the criminal justice system due to low level "nuisance" charges and who require multiple competency evaluations?

Background Information

Court Ordered Services Concerning a Defendant's Competency

In 2008, the General Assembly passed legislation[7] to create a new procedure to address competency to proceed issues in adult criminal cases separate from not guilty by insanity issues. Current law regarding these practices is outlined below.

[7] See House Bill 08-1392.

Competency Evaluation

The court may order a psychiatric evaluation to determine whether an individual with pending criminal charges (the defendant) is competent to proceed at a particular stage of the criminal proceeding[8]. The issue of competency may be raised by the court, the defense, or the prosecution. A defendant is determined to be "incompetent to proceed" if he or she has a mental disability or developmental disability that: (1) prevents him or her from having sufficient present ability to consult with the defense attorney with a reasonable degree of rational understanding in order to assist in the defense; or (2) prevents him or her from having a rational and factual understanding of the criminal proceedings[9].

The Department of Human Services is statutorily obligated to conduct a court-ordered competency evaluation and provide a report to the court. The evaluation can be conducted by or under the direction of the Department by a licensed physician who is a psychiatrist or a licensed psychologist. A competency evaluator is required to have some training in forensic competency assessments, or be in forensic training and practicing under the supervision of a psychiatrist or licensed psychologist who has forensic expertise.

The court has the discretion to determine the location for a competency evaluation, but the court is required to give priority to the place where the defendant is in custody. An "inpatient" evaluation is required to be conducted at CMHIP[10]. An "outpatient" evaluation is also conducted by CMHIP staff or CMHIP contractors, but the evaluation is done at the county jail, prison, or juvenile detention facility where the defendant is in custody, or at another location in the community if the defendant is released on bond.

Not all competency evaluation orders result in the completion of a competency report to the court, as the competency examination order may be subsequently withdrawn by the court for a variety of reasons[11]. The Department indicates that 12 to 15 percent of competency evaluations ordered each year are not completed, either due to the charges being dropped or to new orders issued to change the evaluation location between inpatient and outpatient settings.

Following the preparation of an inpatient competency evaluation, CMHIP is required to "present to the court an accounting of the cost, evidenced by a statement thereof based upon the established per diem rate of the place of confinement". These payments totaled $370,836 in FY 2013-14. It is staff's understanding that CMHIP currently charges the court $36/day for any juvenile or adult mental health evaluations (including those unrelated to competency). This rate dates back to at least the mid-1970s. This rate covers only 5.3 percent of the FY 2015-16 inpatient daily rate at CMHIP for Forensic Psychiatry of $676 per day.

[8] Section 16-8.5-101, *et seq.*, C.R.S.

[9] It is staff's understanding that there is a long-standing legal recognition that a criminal trial of an incompetent defendant violates the defendant's right to due process of law and the right to have assistance of counsel for his defense.

[10] Please note that there are a few individuals who are routed for admission and treatment at the Colorado Mental Health Institute at Fort Logan.

[11] For example, Section 16-8.5-116 (1), C.R.S., states that an individual may not be confined for a period in excess of the maximum term of confinement that could be imposed for the offenses with which the defendant is charged, less any earned time.

Restoration Treatment

If a defendant is determined to be incompetent to proceed, the court has two options[12]:

- If the defendant is released on bond, the court may require as a condition of that bond that the defendant obtain any treatment or habilitation services that are available to the defendant in the community. Statute requires, however, that there to be a presumption that the incompetency of the defendant will inhibit the ability of the defendant to ensure his or her presence for trial.
- If the court finds the defendant is not eligible for release from custody, the court may commit the defendant to the custody of the Department so that the defendant can receive restoration to competency services on an inpatient basis.

It is staff's understanding that services that are provided to restore an individual's competency may differ from those provided to a patient with a different legal standing (*e.g.*, an involuntary civil commitment), and may not necessarily address all of a patient's symptoms or mental health needs[13].

Current law is silent concerning the qualifications of individuals who provide competency restoration treatment. The Department utilizes a multidisciplinary team consisting a psychiatrist, psychologist, social worker, nursing staff, mental health clinicians, and other clinical disciplines. Once the defendant's multidisciplinary treatment team determines that competency has been restored, the Department conducts a competency evaluation. If the Department evaluator agrees, the Department prepares a report to the court; the court determines whether the defendant is restored to competency. At such time as the Department recommends to the court that the defendant is restored to competency, the defendant may be returned to custody of the county jail or to previous bond status.

2012 Settlement Agreement with the Center for Legal Advocacy

The Center for Legal Advocacy (the Center) brought a legal action[14] against the Department of Human Services to challenge the length of time it was taking for pretrial detainees in Colorado jails to receive competency evaluations or restorative treatment. *[Background information about competency evaluations and restoration services is provided at the end of this issue brief.]* The parties resolved the claim through a settlement agreement in April 2012. The Agreement was initially effective beginning July 1, 2012, for a ten year period. However, the term of the Agreement could be periodically reduced when Department has fully complied with the terms of the Agreement in the preceding year. Based on compliance from July 2012 through June 2014, the Agreement term has been reduced by two years. The U.S. District Court for Colorado retains

[12] Section 16-8.5-111, C.R.S.

[13] In a 2003 decision [*Sell v. United States*, 539 U.S. 166 (2003)], the U.S. Supreme Court imposed limits on the right of a lower court to order the forcible administration of antipsychotic medication to a criminal defendant who had been determined to be incompetent to stand trial for the sole purpose of making them competent and able to be tried.

[14] *Center for Legal Advocacy d/b/a The Legal Center for People with Disabilities and Older People v. Reggie Bicha, in his official capacity as Executive Director of the Colorado Department of Human Services, and Teresa A. Bernal, in her official capacity as Interim Superintendent of the Colorado Mental Health Institute at Pueblo*, Case No. 11-cv-02285-BNB (D. Colo.).

jurisdiction for the purpose of enforcing the terms of the Agreement for the entire duration of the Agreement and for 60 days after CMHIP provides the final monthly report.

The Agreement requires the Department to:

- admit pretrial detainees[15] to CMHIP for inpatient competency evaluations or restorative treatment no later than 28 days after he or she is ready for admission[16];
- maintain a monthly average[17] of 24 days or less for admission to CMHIP for inpatient evaluations or restorative treatment; and
- complete all outpatient competency evaluations of pretrial detainees no later than 30 days after CMHIP's receipt of a court order directing the evaluation and receipt of collateral materials.

The Department is required to provide monthly reports concerning all pretrial detainees referred to CMHIP for inpatient competency evaluations, outpatient competency evaluations, or restorative treatment.

The Agreement recognizes that to some extent the Department's ability to perform its obligations under the Agreement is based on factors beyond its control. The Agreement allows the time frame requirements to be temporarily suspended or delayed due to two types of special circumstances:

- "*Individual Special Circumstances*" means a situation that delays the offering of admission to an individual pretrial detainee, where the circumstances are not within the control of the Department (*e.g.*, the court, jail, or defense counsel requests that admission be delayed because they are seeking a more appropriate placement; or the inmate is not medically cleared for admission due to illness or other non-psychiatric medical need). Under such a circumstance, the Department may notify the Legal Center.
- "*Departmental Special Circumstances*" means circumstances beyond the control of the Department which impact CMHIP's ability to comply with the Agreement timeframes (*e.g.*, an unanticipated spike in referrals or a substantial and material decrease in CMHIP's budget). The parties are required to confer to review the reasons for invocation and to determine issues for resolution. The Department is then required to submit in writing a proposal to address the issues.

[15] "Pretrial detainee" means a person who is being held in the custody of a county jail, and whom a court has ordered to undergo an outpatient evaluation in the county jail, an inpatient evaluation at CMHIP, or restorative treatment at CMHIP. Persons serving a sentence in the Department of Corrections, juveniles, and persons on bond are excluded from the Agreement.

[16] "Ready for admission date" means the date on which CMHIP has received the court order for admission to CMHIP, and, in the case of a court-ordered competency evaluation, CMHIP has received the collateral materials required for the evaluation. "Collateral materials" are the police incident reports for the offense and the charging documents.

[17] "Monthly average" means the average timeframe for admission for all pretrial detainees within that calendar month who (1) were admitted to CMHIP for inpatient competency evaluations or restorative treatment; or (2) have an outpatient competency evaluation performed at the county jail.

The parties agreed to "work together in good faith to ensure the cooperation of other interested groups such as the State Judiciary, District Attorneys, Public Defenders, and County Sheriffs in the successful implementation of this Agreement".

The annual reports prepared by the Center for Legal Advocacy for FY 2012-13 and FY 2013-14 indicate that the Department fully complied with the required time frames. In comparison to the required monthly average for all inpatient admissions (24 days), the monthly average during these two fiscal years ranged from six to 14 days.

Jail-based Competency Restoration Program (RISE)

The Department's budget currently includes funding ($2,546,965 and 1.0 FTE) for a 22-bed jail-based restoration program for defendants who have been determined by the court to be incompetent to proceed in their criminal cases. This program was first funded in FY 2013-14 to reduce admissions to CMHIP, thus increasing the availability of beds for civil patients. The Department has contracted with GEO Care, LLC, to provide these services at the Arapahoe County Detention Facility in Centennial. The new program, also known as RISE (Restoring Individuals Safely and Effectively), treats male defendants from county jails in Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, El Paso, Jefferson, Larimer, and Weld counties. This program generally serves men who:

- do not have significant medical needs identified;
- do not have significant medication compliance issues; and
- are likely to be restored in a relatively short period of time.

The contracted daily rate for RISE FY 2015-16 is $307.50 per day. This compares to the FY 2015-16 inpatient daily rate at CMHIP for Forensic Psychiatry of $676.00 per day.

Informational Issue: Impact of Medicaid Expansion on Community Mental Health Centers

In September 2015 the Department of Human Services submitted a request to the Joint Budget Committee to reduce General Fund support for community mental health centers by $2.5 million for FY 2015-16 based on the impact of Medicaid eligibility expansion. This issue brief discusses the Committee's response to the request, and the Department's subsequent actions to finalize its FY 2015-16 contracts with community mental health centers.

SUMMARY:

- In September 2015 the Department of Human Services requested an appropriation reduction to reflect a portion of a $4.5 million anticipated reversion in FY 2015-16 based on existing contracts with community mental health centers. This anticipated reversion was directly related to the impact of expanding eligibility for the Medicaid program.

- The Joint Budget Committee denied the request to reduce the appropriation, and instead sent a letter to provide feedback to the Department and request consideration of several issues as the Department finalized its FY 2015-16 contracts with community mental health centers.

- Following the Committee's action, the Department worked with the Centers to finalize FY 2015-16 contracts. The Department now anticipates reverting less than $100,000 General Fund in FY 2015-16. The Department's request for FY 2016-17 does not reflect any further contract-related changes.

DISCUSSION:

Department's September 2015 Interim Supplemental Request
In September 2015 the Department requested two adjustments to FY 2015-16 appropriations:

- Reduce the General Fund appropriation to the Department of Human Services for "Services for Indigent Mentally Ill Clients" by $2.5 million to partially reflect an anticipated reversion of the appropriation at the end of FY 2015-16. The Department essentially sought legislative approval of some proposed changes to its contracts with community mental health centers (Centers). These changes included: (1) utilizing lower contracted client numbers and reduced case rates; and (2) reinvesting $2.0 million of the projected savings back into Centers to cover one-time systemic and capacity needs of Centers as they transition to full implementation of Medicaid eligibility expansion.

- Increase the General Fund appropriation to the Office of State Planning and Budgeting (OSPB) for "Personal Services" by $200,000 so that it can contract with an outside vendor to examine how funding should be distributed and aligned between the Department of Human Services and the Department of Health Care Policy and Financing and among service providers to best support mental health and substance use disorder services statewide.

The following table details the three components of the Department's interim supplemental request for FY 2015-16.

Summary of Interim Supplemental #2 Community Behavioral Health System Realignment			
Description	**Total Funds**	**General Fund**	**Federal Funds**
Community mental health savings	($4,507,259)	($3,857,315)	($649,944)
Flexible funds for community system	2,000,000	1,350,056	649,944
Subtotal: Proposed funding reduction	(2,507,259)	(2,507,259)	0
OSPB Behavioral health system study	200,000	200,000	0
Total	($2,307,259)	($2,307,259)	$0

The Committee approved the request for the OSPB study, but denied the request concerning Center contracts. Instead, the Committee sent a letter to Director Bicha stating the following:

> "The Joint Budget Committee has considered the Department's interim supplemental request concerning Community Behavioral Health System Realignment (ES-02). We appreciate the Department's recent efforts to work cooperatively with the affected service providers to develop contract terms that are informed by available data, are practical, and ensure that Centers can continue to provide essential services during this transition period. This letter is intended to provide feedback to the Department in response to the proposed contract modifications. We ask that you consider the following issues as you finalize the contracts for the remainder of FY 2015-16.
>
> - If the purpose of the proposal is to allow Centers more time to assess and react to recent changes in the Medicaid program, the limitation on which Centers may access these funds seems unwarranted. If this is a short-term solution, a simpler approach may be to establish a minimum and maximum level of funding for each Center for FY 2015-16, thereby reducing uncertainty and allowing Centers to focus on making appropriate operational and capacity changes.
>
> - While Centers should continue to prioritize those individuals with the most serious mental health needs, the Committee supports the proposal by the Colorado Behavioral Healthcare Council to change the Department's contract definition of "medically indigent" (at least for FY 2015-16) to include

indigent uninsured individuals who have a mental disorder consistent with the current Medicaid covered diagnosis. This would allow some Centers to receive reimbursement for services provided to individuals who have not yet been categorized with the most serious mental health needs, and it may allow the Department to gather data about this population from all Centers to determine the number of uninsured individuals and their service needs. Such data could facilitate the Administration's goal of quantifying the impact of Medicaid eligibility expansion on the behavioral health system, and inform future policy decisions about what behavioral health services the State intends to fund for the non-Medicaid eligible population.

- Given the delay in finalizing the revised contract and the proposed purpose of reinvesting the savings, it seems prudent to minimize the administrative burden placed on Centers that need access to these flexible funds. Perhaps rather than a cost-reimbursement process the Department could require each Center to report and describe actual expenditures of such funds."

Final FY 2015-16 Contact Terms

Following the Committee's action on the interim supplemental request, the Department worked with the Centers to finalize the FY 2015-16 contracts. The Department indicates that it anticipates only $98,469 General Fund and $38,040 of federal block grant funds remaining unspent from the FY 2015-16 appropriation based on the contracts. The federal block grant dollars will be reallocated to data system improvements and/or other block grant related goals.

Specifically, for FY 2015-16, the Department made the following changes to the contract terms:

1. Changes to the definition of "medically indigent clients" include adding a category of "lower severity" clients. This "lower severity" definition includes the client types described in the following table:

Client Type	Definition Change
Adults and Older Adults (ages 18+)	Clients that score a 6 or below on the "Self-Care/Basic Needs scale" of the Colorado Client Assessment Record.
Adolescents (ages 12-17)	Clients that score a 6 or below on the "problem severity scale" of the Colorado Client Assessment Record.
Children (ages 0-11)	Clients that score a 4 or below on the "problem severity scale" of the Colorado Client Assessment Record.

2. Changes to the per-client rate paid to each Center for each severe medically indigent client served. Average per-client rates range from $1,189 to $3,240 depending on level of severity and the rate by Center.

3. The basis for determining the amount available to each Center was determined through negotiations with the Centers.

The Department stated that the funding may be spent on the following: "The program is intended to be used to cover needed behavioral health system capacity that is not funded or insufficiently funded by Medicaid or other payer sources. The following areas that could be covered include:

- Staff training costs associated with evidence based practices
- Unreimbursed client transportation costs
- Unreimbursed psychiatric services
- Other gaps in services that are not fully funded through other sources and will assist clients or Centers to successfully transition to the new service delivery system provided under the Affordable Care Act."

There are two options for reimbursement of these services. The first option is a modified cost reimbursement basis. If the Centers have other revenues they must offset the costs with those revenues and invoice the Department the difference. The second option is a cost reimbursement basis to cover costs such as trainings and workforce development. This entails the submission of invoices with supporting documentation such as receipts. Contractors were required to submit a plan for consideration for approval for the use of the funds by November 1, 2015.

Request for FY 2016-17

The only adjustment the Department has requested for the "Services for Indigent Mentally Ill Clients" line item for FY 2016-17 is based on implementing the common policy concerning community provider rates. The request thus reflects a one percent ($310,395) General Fund reduction.

Informational Issue: Substance Use Disorder Services for Adolescents and Pregnant Women

This issue brief summarizes a report recently submitted by the Department of Human Services concerning existing state programs that provide substance use disorder (SUD) treatment and prevention services for adolescents and pregnant women, and the whether there is a need for additional state funding to meet the SUD prevention and treatment needs of these populations.

SUMMARY:

- Senate Bill 14-215 included an appropriation of $1,500,000 cash funds from the Marijuana Tax Cash Fund for the provision of substance use disorder treatment services for adolescents and pregnant women. The General Assembly subsequently clarified that this appropriation could be used for prevention services and intensive wrap around services (in addition to treatment services), and authorized the Department to spend any funds that remain available in FY 2015-16. No additional funding was provided for these services in FY 2015-16.

- The Joint Budget Committee requested that the Department of Human Services work with the Department of Health Care Policy and Financing to prepare and submit a report to inform the General Assembly's decision about whether to reinstate the appropriation for these services for FY 2016-17.

DISCUSSION:

Use of Funding Provided in FY 2014-15
Senate Bill 14-215 included an appropriation of $1,500,000 cash funds from the Marijuana Tax Cash Fund for provision of substance use disorder treatment services for adolescents and pregnant women. Senate Bill 15-167 subsequently clarified that this appropriation could be used for prevention services and intensive wrap around services (in addition to treatment services), and authorized the Department to spend any funds that remain available in FY 2015-16.

The Department only spent $278,108 of the $1.5 million appropriation in FY 2014-15. It is staff's understanding that of the amount remaining available for FY 2015-16 will be spent as follows: 10 percent will be spent on outreach to priority populations; and the remaining 90 percent will be available for the treatment services.

Client eligibility criteria include the following:
- All clients must have a substance use disorder
- If client has Medicaid or other private insurance, these funds may be used to treat these clients for non-covered services
- Clients must not be funded by community corrections
- Clients from any referral source may be eligible
- Providers must be licensed by the Office of Behavioral Health (OBH)
- Providers must be licensed to treat minors and/or to provide gender-responsive treatment

- Funds may be used with clients with a minor in possession citation if the provider is licensed by OBH to provide such services.

For pregnant women, funds may be used for up to 12 months postpartum if the client stays enrolled at the same agency. The woman may be eligible for Medicaid if she does not have access to a Special Connections provider. Treatment can include detoxification, residential, or outpatient modalities. For adolescents, a client must be under the age of 18[18], and must have marijuana as a Primary, Secondary, or Tertiary substance on the admission assessment (DACODS). Treatment may include detoxification, residential, or outpatient modalities, and treatment shall use evidence based curricula.

Request for Information
The Joint Budget Committee requested that the Department prepare and submit a report to inform the General Assembly's decision about whether to reinstate the appropriation for these services for FY 2016-17. This "request for information" is provided below:

3. **Department of Health Care Policy and Financing, Behavioral Health Community Programs; and Department of Human Services, Behavioral Health Services** -- The Department of Human Services is requested to work with the Department of Health Care Policy and Financing and any other relevant state agencies to provide a report to the Joint Budget Committee by November 1, 2015, concerning substance use disorder (SUD) treatment and prevention services for adolescents and pregnant women. The report is requested to include the following information: (a) a brief description of each state program that provides SUD prevention or treatment services for adolescents or pregnant women; (b) actual expenditures for SUD prevention or treatment services for adolescents and pregnant women in FY 2014-15, by program and fund source; and (c) information indicating whether there is a need for additional state funding to meet the SUD prevention and treatment needs of adolescents or pregnant women.

The remainder of this issue brief summarizes the Department's response to this request.

Programs Administered by the Department of Human Services (DHS)
The departments provided information about each existing program that provides substance use disorder treatment or prevention services to adolescents or pregnant women. Staff has included the description for each program below, along with total FY 2014-15 expenditures.

Programs for Adolescents
Adolescent Residential Treatment [$703,150 General Fund]. Both the University of Colorado's Addiction Research and Treatment Services (ARTS) and Arapahoe House receive state funding for adolescent residential programs. The ARTS Synergy (15 beds) and Arapahoe House

[18] Individuals who are 18, 19, or 20 years of age may be treated with these funds if the clinical assessment indicates that the client's maturity level warrants treatment focused on adolescent needs and issues. This may be particularly likely if treatment is ordered as a result of a minor in possession citation.

Stepwise (20 beds) programs serve adolescents with substance use disorders in a residential setting. The average length of stay is 90 - 120 days at ARTS Synergy and 45 days at Arapahoe House Stepwise. This level of intensive residential treatment with integrated behavioral health services is required to adequately address the complex and severe problems of this population, many of whom have failed in lower levels of care. The aim is to reduce the suffering and mortality and increase the functioning of adolescents and their families and to successfully return adolescents to their families and communities. The need for this funding arose when Medicaid discontinued coverage residential substance use disorder (SUD) services for adolescents beginning in 2006.

Synergy Multisystemic Therapy (MST) [$275,526 General Fund]. The ARTS Synergy program also provides multisystemic therapy (MST) therapeutic services to adolescents in both residential and outpatient settings. MST therapeutic services include community/home-based family, systems, and individual therapies twice weekly using the MST framework, with seven days per week on-call therapeutic coverage. The frequency of in-home, direct services tapers towards the end of treatment to promote sustainable long term success. The case management portion of the program includes incentives for negative urinalysis results. The average length of treatment is three to five months depending on the level of severity of the adolescent client's substance abuse disorder and treatment needs, the needs of family, and progress of the adolescent. A legislative initiative passed by the Joint Budget Committee (Long Bill FY 2007-08) provided support directly to ARTS for MST services to enhance the intensity of services for adolescents at very high risk of being placed out of the home.

Adolescent Treatment [$109,138 cash funds from the Adolescent Substance Abuse Prevention and Treatment Fund]. The services required to respond to a "minor in possession" charge were established in S.B. 06-122 "Creation of the Adolescent Substance Abuse Prevention and Treatment Fund", and the Department defined the hours of services based on the first, second, or subsequent offense. The purpose of this program is to establish consistency across the State for providers that choose to deliver this level of care. Agencies chosen to receive these funds need to demonstrate an unmet need in their communities for this level of care, as well as the economic hardship it poses on the families.

These funds are directed and utilized to provide adolescent substance abuse prevention and treatment services, as well as to support training for clinicians on two curricula: Underage Drinking and Driving and Pathways to Self-Discovery and Change. The programs focus on education and treatment service needs for youth that have received a "minor in possession" charge. These classes are designed to reduce the chances of subsequent offenses. When youth or young adults do receive a second or subsequent offense, these funds provide treatment services for adolescent outpatient (up to five hours per week of therapeutic contact in an outpatient setting) or intensive outpatient level of care (six or more therapeutic contact hours in an outpatient setting). These funds fill a need in communities that are experiencing high numbers of youth receiving "minor in possession" citations, and support families struggling with the ability to pay for these services.

Colorado Youth and Family Bridges Project [$840,106 federal funds]. A $950,000 annual federal discretionary grant supports treatment to adolescents with substance use and co-occurring mental health disorders using the Adolescent Community Reinforcement Approach and the Global Appraisal of lndividual Needs (GAIN) instruments at two licensed provider sites: Arapahoe Mental Health Center and Crossroads Turning Points. The services provided include treatment services, interventions, assessments, care management, as well as wrap around/recovery support services designed to improve access and retention. The time-limited federal grant currently supporting this program is expected to end in 2017 (this grant does not appear in the Long Bill).

Substance Use Primary Prevention for Adolescents [$1,279,858 federal Substance Abuse Prevention and Treatment block grant funds]. This program is designed to: reduce alcohol, tobacco and other drug use rates for adolescents; prevent early initiation of substance use; promote healthy behaviors that mitigate substance use; and provide education and programs that support positive choices in local schools and communities. In FY 2014-15, the Department executed 14 prevention contracts to utilize about $1.4 million of the block grant funds. In FY 2015-16, the Department plans to use approximately $2.1 million from the federal block grant for 21 new adolescent substance use prevention contracts.

Programs for Adolescents and Women Who Are Pregnant

Adolescent and Pregnant Woman Treatment [$278,108 cash funds from the Marijuana Tax Cash Fund]. Senate Bill 14-215 (Disposition of Legal Marijuana Related Revenue) included an appropriation for substance use disorder treatment services for adolescents and pregnant women. The Department contracted with managed service organizations (MSO) to use their respective provider networks to deliver treatment services. The funds were disbursed on a fee-for-service basis consistent with established procedures, based on a negotiated fee schedule. The services included residential and outpatient treatment for adolescents and pregnant women whose treatment was not covered by Medicaid.

Programs for Women Who Are Pregnant

Special Connections [$969,806 Medicaid funds transferred from HCPF]. The Special Connections program provides substance use disorder treatment for pregnant women who are eligible for Medicaid. These funds are utilized for fee-for-service treatment at five provider agencies: Arapahoe House, Inc., Mental Health Partners, Centennial Mental Health Center, Inc., Crossroads' Turning Points, Inc., and the University of Colorado's ARTS. The covered services include: assessment; outpatient group and individual counseling; health education sessions; case management; and residential treatment. The purpose of the program is to help pregnant women attain and maintain abstinence from substances, thereby increasing the likelihood that their infants will be born healthy and at an adequate birth rate. Other benefits of the program include maintenance of the family unit, parenting skills, and healthy parent-child interactions within the family unit. Women who are pregnant are a difficult population to engage in treatment, so this specialty program is needed to engage this population.

Specialized Women's Services [$1,500,044 federal Substance Abuse Prevention and Treatment block grant funds]. The Department utilizes some block grant funds to increase capacity for specialized substance use disorder treatment for women who are pregnant and/or have dependent children. These funds are distributed through the managed service organization (MSO) system to providers who are able to maintain and increase capacity to serve women in gender responsive residential and outpatient treatment programming. The funding covers counselor salaries, client care expenses such as transportation, and child care.

Programs Administered by the Department of Health Care Policy and Financing (HCPF)
Special Connections Waiver. This Medicaid-funded program is administered by the Department of Human Services (see program description in the DHS section, above).

SUD Behavioral Health Organizations [Medicaid funding (General Fund and federal funds): Adolescents = $2,997,655; Pregnant Women = $392,131]. All Medicaid clients with a diagnosed substance used disorder are eligible for the following benefits:
i. drug/alcohol assessment;
ii. individual, family, and group counseling;
iii. targeted case management;
iv. social/ambulatory detoxification;
v. medication assisted treatment; and
vi. regular drug screening/monitoring.
The above expenditures were made by behavioral health organizations (BHOs) for adolescents and pregnant women who are enrolled in the behavioral health capitation program.

Behavioral Health Fee-for-Service Payments [Medicaid funding: Adolescents = $16,554; Pregnant Women = $6,813]. This program covers the same benefits listed above for Medicaid clients with a substance use disorder but who are not enrolled in the behavioral health capitation program.

Pharmacy Benefits for Pregnant Women and Adolescents [$339,022 Medicaid funding]. The Medicaid prescription drug benefit covers some medications used for substance use disorders. Prescription drugs are covered for Colorado Medicaid members as a fee for service benefit, rather than included as part of the substance use disorder benefit. The following drugs are used to treat substance use disorders: Suboxone, buprenorphine, buprenorphine/naloxone, naltrexone, Bunavail, Zubsolv, Campral, Antabuse, disulfiram, naloxone, and Vivitrol.

Additional State Funding to Meet the SUD Prevention and Treatment Needs of Adolescents or Pregnant Women

<u>Department of Human Services</u>
The Department of Human Services has identified a need for additional state funding for substance use disorder services for adolescents and pregnant women. The Department submitted a request for funding from the Marijuana Tax Cash Fund to support intensive residential treatment for SUD (R11). The additional capacity, if approved, would utilize existing state funding to pay for services at these new programs. In addition, the Department would like the flexibility to extend the scope of current treatment and services to include training and technical

assistance, potential startup for new programs and additional beds, increasing access to services in rural regions, and addressing service gaps not currently covered by Medicaid.

Needs for Adolescents

Residential treatment services. Although Medicaid currently provides insurance coverage for many adolescents with substance use disorders who were previously uncovered; gaps in service coverage and availability remain. Specifically, Medicaid does not fund substance use disorder treatment for adolescents in the custody of county departments of human/social services (*i.e.* child welfare) or adolescents in the custody of the Division of Youth Corrections. In July 2006, HCPF, in conjunction with the Division of Child Welfare, determined that substance use disorder treatment was not a covered service under the fee-for-service model for residential child care facilities. This has resulted in fragmented or non-existent residential substance use disorder treatment services.

Capacity for Treatment Services in Rural Areas. Specialized treatment services for adolescents are not uniformly available across the state. Rural areas of the state have a difficult time maintaining capacity for treatment because the demand is not consistently adequate to maintain specialized programs, especially when programs must rely on fee-for-service reimbursement from Medicaid to sustain their basic operating costs. For specialized treatment, this is even more challenging due to the level of staff expertise needed in areas where qualified staff are scarce. Adequate staffing, treatment space, and physical access to treatment can severely limit the amount and type of treatment available. Treatment providers are often located many miles away from adolescents needing services. This challenge exists in many rural parts of the state, including the Western Slope, Eastern Plains and many mountain areas.

Treatment Services for Adolescents Transitioning to Adulthood. Treatment services appropriate for adults can often prove inappropriate and ineffective for youth transitioning into adult programs because this population spans the adolescent and adult services systems. There is a need for services that bridge the two systems so that treatment is not fragmented or discontinued when a young person ages to legal adulthood. Age-based funding restrictions, and being forced to transition to new types of care as youth age into adulthood contributes to incomplete delivery of effective treatment services.

Prevention Services. Additional state funding is needed to expand primary substance use prevention services in order to reduce drug induced deaths and prevent the onset and development of illicit and prescription drug abuse and alcohol use among Colorado teens. The Office of National Drug Control Policy (August 2013) identifies that in Colorado the number of drug-induced deaths exceeds that of deaths from motor vehicle accidents and firearms. Further, Colorado has been identified by the U.S. Drug Enforcement Agency as part of a regional interstate High Intensity Drug Trafficking Area (HIDTA) since 1996 (Office of National Drug Control Policy, 2014). The National Survey on Drug Use and Health (NSDUH) has consistently ranked Colorado among the top 10 states for alcohol and illicit drug use for all age groups and, more recently, with regards to prescription drug abuse, among 12-17 and 18-25 year olds.

SAMHSA's 2014 Behavioral Health Barometer on Colorado, as well as the 2013 Healthy KidsColorado Survey report the following statistics related to 12-17 year olds:

- Colorado youth are more likely than their peers in other states to use illicit drugs (including marijuana).
- Colorado youth are more likely to perceive no or little risk from having five or more drinks once or twice a week.
- Approximately 8 in 10 (80.4%) adolescents perceive no great risk from smoking marijuana once a month.
- 60.1% of Colorado high school students had at least one drink of alcohol on one or more days during their life.
- 58.6% students feel it would be "sort of easy" or "very easy" to get alcohol if they wanted.
- In 2013, underage drinking cost the citizens of Colorado $1.3 billion (PIRE, 2015).
- Colorado high school students (36.9%) have used marijuana one or more times during their life.
- 54.9% of high school students feel it would be "easy" or "very easy" to get marijuana if they wanted.
- 13.6% of students have taken a prescription drug without a doctor's prescription one or more times during their life.

These surveys point to a need for more aggressive youth prevention efforts to both prevent drug and alcohol use and to intervene early in use in order to reduce the risk that Colorado youth will develop significant problems with alcohol or prescription or illicit drugs as they enter young adulthood.

Needs for Pregnant Women

Residential Treatment Capacity. There is limited capacity for residential treatment for pregnant women, regardless of funding source. Even if additional funds were available on a fee-for-service basis, the treatment beds necessary to utilize those funds are not available. Currently 58 beds are available statewide at four residential programs (The Haven: 16 beds; Aspen Center: 10 beds; Crossroads: 16 beds; Mind Springs Women's Recovery Center: 20 beds). These programs currently have waiting lists up to 30 days or more for admission of pregnant women. Although 58 beds are available for pregnant women, only a total of 38 women can participate in residential treatment statewide at any given time through Special Connections. This is a result of the Institution for Mental Disease (IMD) exclusion that prohibits programs with more than 16 beds from collecting Medicaid reimbursement. As a result of this federal policy, the Mind Springs program is unable to accept Medicaid clients.

Because start-up and fixed costs associated with operating a residential treatment program for women and children are very high, programs must be able to maintain a base level of referrals to cover their costs. Because reimbursement under Medicaid is on a fee-for-service basis, it is often difficult or impossible for programs to cover their start-up and fixed costs for a very expensive set of services. Additional state funding could add capacity for more residential treatment services, which could then be paid for by Special Connections on a fee-for-service basis. The Governor's November 1 budget request is proposing to add capacity for residential treatment by funding two residential treatment programs for women who are pregnant and parenting. The two sites will add a total of 30 beds (15 beds per site) for women who are pregnant and parenting. The requested funding to meet the substance use disorder treatment needs of women who are

pregnant will support start-up funding for residential treatment programs where women could be treated along with their infants and small children. Startup costs could include expenditures for treatment space (*i.e.*, building rent or purchase and remodeling), staff training to include women's gender responsive treatment issues and appropriate treatment approaches, as well as trauma informed and trauma specific services.

Training in Gender-responsive Treatment Services. Appropriate services for women who are pregnant require a focus on women's needs. As training in women's gender responsive treatment is not a required component of any mental health or substance use disorder license in Colorado, licensed or certified staff cannot be assumed to have had needed training to work with this population. Indeed, the only available training on women's treatment is available as an on-line training from the Addiction Technology Transfer Centers funded by SAMHSA. Additional training is also needed for current providers of outpatient and residential treatment services to ensure current use of best practices with this population. The most popular evidence-based program for use in Colorado with women in treatment has been Seeking Safety. Other evidence-based practices reviewed for women by the Substance Abuse and Mental Health Services Administration consist only of A Woman's Path to Recovery and the Boston Consortium Model. Although a great deal of literature exists on medical issues of drug use and pregnancy, as well as the value of women's gender responsive treatment, current training for mental health and addiction treatment professionals does not include required training in women specific issues, including the interaction between substance use and pregnancy as a behavioral health clinical (as opposed to medical) issue.

In addition to residential treatment needs, there is a grave need for assertive outreach and engagement of pregnant women in substance use disorder treatment services. State statistics show that the number of pregnant women in need of treatment far outweighs the numbers who receive treatment. PRAMS (Pregnancy Risk Assessment Monitoring System, CDPHE) data from 2011 provides an estimated rate of alcohol use at approximately ten percent. Based upon the number of births during that time, ten percent of pregnancies would demonstrate a need for treatment for 6,760 women. Department data shows a maximum of 781 treatment admissions into the publicly funded system. This shows that approximately 12 percent of women who may need treatment for substance use disorders are actually receiving it, leaving the remainder to cope with their substance use in some other way.

Children of women who are receiving treatment need services to address their physical and emotional development. While some services are covered by Medicaid, other services, such as diagnostic evaluations for fetal alcohol spectrum disorders, are not universally available and are needed in order to reduce the risk of adverse events due to prenatal alcohol and other substance exposure. Lastly, access to services must address the need for safe transportation and child care to render treatment accessible and provide linkages to primary and prenatal care, as well as other behavioral health care for women who are pregnant. Women who are pregnant and have substance use disorders also need specialized counseling to address shame and grief associated with substance use during pregnancy. Where and when these services are not covered by Medicaid, they are needed in order to assure that treatment is accessible.

Department of Health Care Policy and Financing (HCPF)

Covered services provided under the Medicaid program are an entitlement, which means that they are provided based on need rather than an appropriated budget amount. Consequently, program funding is provided as needed for existing covered services and additional state funding is not required. Since substance use disorder services have become part of the behavioral health capitation program, a larger number of clients have accessed these services. The Department will continue to work with it behavioral health organizations (BHOs) to ensure and increase access to these services for pregnant women and adolescents. It is important to note that Medicaid is designed to provide covered, medical services, as a result, only a limited number of preventive services are covered by the program. Thus, there may be a need to fund additional preventive services outside of the Medicaid program.

Informational Issue: Gambling Addiction Program Audit

An August 2015 audit conducted by the Office of the State Auditor concerning the Department of Human Service's Gambling Addiction Program found that the Department has not awarded grants in compliance with statute or maximized the use of its resources to address problem gambling.

SUMMARY:

- The Gambling Addiction Program supports the provision of gambling addiction counseling services to Colorado residents. The Program is administered by the Department of Human Services, and is currently supported by an annual appropriation of $100,000 cash funds from limited gaming revenues.

- A recent audit by the Office of the State Auditor found that over the last five fiscal years, the Department has used only 36 percent of Program funds for grants; the remaining funds were used for administrative and marketing costs or not used at all. The audit found that the Program has not operated effectively to address problem gambling.

DISCUSSION:

Gambling Addiction Program
In 2008 the General Assembly established a program to support the provision of gambling addiction counseling services to Colorado residents. The Gambling Addiction Program is supported by 2.0 percent of the gaming revenues (including gaming tax revenues, licensing fees, and fines paid by Colorado casinos) that are annually transferred to the Local Government Limited Gaming Impact Fund[19]. The annual transfer to the Local Government Limited Gaming Impact Fund is $5,000,000, so $100,000 is annually transferred to the Gambling Addiction Account.

Moneys in the Account may be used to provide grants to state or local public or private entities and programs that provide gambling addiction counseling services and that have or are seeking nationally accredited gambling addiction counselors. Ten percent of the moneys in the Gambling Addiction Account must be awarded to addiction counselors who are actively pursuing national accreditation as gambling addition counselors. Up to 5.0 percent of moneys in the Gambling Addiction Account may be used annually for the Department's associated administrative expenses[20].

The Department has assigned three staff with part-time responsibilities to monitor the Program's contractor and to write the statutorily required report that is submitted to the House and Senate Health and Human Services Committees.

[19] See Sections 12-47.1-1601 (1) (a) and 12-47.1-701 (2) (a) (III), C.R.S.
[20] See Section 12-47.1-1601 (4) (a.5) (I), C.R.S.

Audit Findings

The audit found that the Department has not maximized the use of moneys in the Account for Program grants. As detailed in the following table (from the audit report), the Department has not spent the amount appropriated each fiscal year, causing the Account fund balance to reach $227,300 at the end of FY 2014-15. Since July 2010, DHS has used only 36 percent of Gambling Addiction Program funds for grants; the remaining funds were used for administrative and marketing costs or not used at all.

EXHIBIT 3.3
GAMBLING ADDICTION PROGRAM APPROPRIATIONS, EXPENDITURES, AND GAMBLING ADDICTION ACCOUNT BALANCES
FISCAL YEARS 2011 THROUGH 2015

	2011	2012	2013	2014	2015	Percent Change
Beginning Account Balance	$102,700	$112,900	$113,700	$118,600	$169,300	65%
Plus: Allocations Received[1]	$85,200	$72,000	$67,600	$100,000	$100,000	17%
Total Funds Available	**$187,900**	**$184,900**	**$181,300**	**$218,600**	**$269,300**	**43%**
Less: Expenditures						
DHS Administrative Costs[2]	$3,900	$3,000	$5,800	$4,200	$4,300	10%
Contractor Administrative Costs[3]	$10,800	$10,400	$7,400	$11,200	$25,500	136%
Contractor Marketing Costs[3]	$11,400	$1,000	$0	$7,200	$4,900	-57%
Contractor Administrative and Marketing Costs as a Percent of "Total Funds Available"	12%	6%	4%	8%	11%	-8%
Program Grants and Services[4]	$48,900	$56,800	$49,500	$26,700	$7,300	-85%
Program Grants as a Percent of "Total Funds Available"	26%	31%	27%	12%	3%	-88%
Total Expenditures	**$75,000**	**$71,200**	**$62,700**	**$49,300**	**$42,000**	**-44%**
Ending Account Balance	$112,900	$113,700	$118,600	$169,300	$227,300	101%
Appropriations[5]	$151,100	$151,000	$64,200	$70,000	$100,000	-34%

SOURCE: Office of the State Auditor's analysis of data and invoices provided by DHS and the Center, and financial data from the Colorado Financial Reporting System (COFRS) and Colorado Operations Resource Engine (CORE).
[1] "Allocations Received" shows the funds that the Program's Gambling Addiction Account received from the Local Government Limited Gaming Impact Fund. The Account's allocations declined in Fiscal Years 2011 through 2013 due to diversion of some appropriated Account funds to help balance the State's budget and an overall decline in casino tax revenue.
[2] These funds were used to pay for part of the salaries and benefits for DHS staff who monitored the Gambling Addiction Program contractor.
[3] From July 2010 to August 2013, these expenditures were for DU's costs. From September 2013 to June 2015, these expenditures were for the Center's costs.
[4] From July 2010 to August 2013, these funds were used for a grant to DU to provide training and supervision to counseling students who provided counseling to Colorado residents, and to pay personnel costs for a professor who supervised the students. From September 2013 to June 2015, these funds were primarily used for grants to counselors to obtain gambling addiction counseling training and seek national accreditation.
[5] "Appropriations" shows the Gambling Addiction Program's spending authority that was approved in the Long Bill. According to Joint Budget Committee staff, in 2013 and 2014 the Program's appropriation was based on gaming tax revenue forecasts.

The audit also found that the Program has been poorly administered, including: a lack of clear, accurate program rules; vendor contracts that do not align with statutory requirements; and

inadequate contract monitoring. The audit included the following table to summarize the Program outcomes for the past five fiscal years:

EXHIBIT 3.1
GAMBLING ADDICTION PROGRAM
SUMMARY OF OUTCOMES
FISCAL YEARS 2011 THROUGH 2015

	2011 [1]	2012 [1]	2013 [1]	2014 [2]	2015 [2]
INDIVIDUALS COUNSELED THROUGH THE PROGRAM	48 [3]	29 [3]	39 [3]	0	1
COUNSELORS WHO RECEIVED NATIONAL ACCREDITATION THROUGH THE PROGRAM	0	0	0	1 [4]	4 [4]

SOURCE: Office of the State Auditor's analysis of data provided by DHS and the Center.
[1] From Fiscal Year 2011 through Fiscal Year 2013, DHS contracted with DU to provide Program services.
[2] In Fiscal Years 2014 and 2015, DHS contracted with the Center to administer the Program.
[3] These were individuals counseled through DHS' contract with DU. DU students who were "counselors-in-training" provided these counseling services.
[4] DHS, through its contract with the Center, awarded grants for 23 counselors to attend training and/or take exams needed for national accreditation as gambling addiction counselors. Five of the 23 grant recipients obtained accreditation as of June 2015.

From July 2010 to August 2013, the Department contracted with the University of Denver (DU) to provide counseling services. Specifically, the Department awarded DU about $65,500 annually to pay for a professor (who was a gambling addiction counselor) to supervise DU psychology students who provided to problem gamblers and their families. The audit indicates that the students who provided counseling were "counselors-in-training" who did not have and were not specifically seeking national accreditation. Through its contract with DU, the Department did not use any Program funds to help counselors obtain national accreditation as gambling addiction counselors.

From September 2013 to June 2015, Department contracted with the Center for Governmental Training (Center) to administer the Program, including marketing, soliciting grant applications, and awarding grants. During this time period, the Department awarded a combined total of about $28,000 in grants for counselors to pursue the gambling addiction counselor accreditation. However, 17 of the 23 counselors (74 percent) who received a total of $20,956 in grants did not meet at least one of the grant eligibility requirements in DHS' contract with the Center. During this time period, the Department awarded only $650 for counseling services.

Audit Recommendations

The audit provided 2014 survey data indicating that an estimated 95,000 Coloradans (about 2.4 percent of Colorado's adult population) have a gambling disorder that included "persistent and recurrent problematic gambling behavior leading to clinically significant mental impairments or distress". Further, the National Problem Gambling Helpline (a nationwide call center for people seeking help for gambling addiction) reported that it received about 9,300 calls from Coloradans seeking help in 2014. In order to improve the Program's effectiveness in making gambling addiction counseling services available to Colorado residents, the audit included the two recommendations listed below (along with the Department's planned implementation dates):

1. Ensure the Gambling Addiction Program operates effectively and in accordance with statute to help address problem gambling by:
   a. ensuring that grants are offered primarily for providing counseling to Colorado residents as well as for pursuing national counselor accreditation, in accordance with statute *[November 2015]*;
   b. revising Program rules to clarify the requirements for counselor grant applicants *[December 2015]*;
   c. ensuring written agreements are executed with grantees, Program contracts align with statute, and contracts and agreements include reasonable expectations for the use of grant funds *[November 2015]*;
   d. ensuring any future Program contractors provide written reports that contain specific information to allow for adequate monitoring of contracts *[November 2015]*; and
   e. training staff on the statutory requirements for the Program, the requirements of the Program contract, and how to hold future contractors accountable for contract terms *[November 2015]*.

2. Maximize the use of funds in the Gambling Addiction Account to fulfill the purpose of the Gambling Addiction Program by:
   a. evaluating the demand for counseling and accreditation grants, offering grants for both purposes as statute requires, and seeking the authority to spend Account resources to conduct the evaluation, if authority is needed *[July 2016]*;
   b. ensuring that criteria for awarding grants align with the results of the evaluation in Part A *[July 2016]*;
   c. seeking authority to use more of the unspent funds in the Account, either through statutory change to obtain continuous spending authority or through the annual budget request process *[May 2016]*; and
   d. establishing a clear rationale for determining the amount of administrative and marketing funds to allow the Program contractor(s) to spend to fulfill contractual duties and administer an effective Program *[November 2015]*.

Appendix A: Number Pages

	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	Request vs. Appropriation
DEPARTMENT OF HUMAN SERVICES **Reggie Bicha, Executive Director**					
(8) BEHAVIORAL HEALTH SERVICES					
The Office of Behavioral Health is responsible for policy development, service provision and coordination, program monitoring and evaluation, and administrative oversight of the State's public behavioral health system. Funding in this section supports community-based mental health and substance use disorder services that are not otherwise available. [Most mental health and substance use disorder services for Medicaid-eligible individuals are funded through the Department of Health Care Policy and Financing (HCPF).] Funding in this section also supports administration and operation of the State's two Mental Health Institutes. This section is primarily supported by General Fund, the federal Substance Abuse Prevention and Treatment Block Grant, transfers from HCPF (originating as General Fund and federal Medicaid funds), Mental Health Institute patient revenues, the federal Mental Health Services Block Grant, transfers from the Judicial Branch (originating as General Fund and drug offender surcharge revenues), tobacco litigation settlement moneys that are credited to the Offender Mental Health Services Fund, and marijuana tax revenues.					
(A) Community Behavioral Health Administration					
Funding in this section supports staff who administer community-based mental health and substance use disorder services. This section is primarily supported by the federal Substance Abuse Prevention and Treatment Block Grant, the federal Mental Health Services Block Grant, General Fund, and transfers from HCPF (originating as General Fund and federal Medicaid funds).					
Personal Services	4,110,516	4,331,440	4,931,808	5,247,078 *	
FTE	49.5	49.3	58.6	62.2	
General Fund	1,264,817	1,323,612	1,425,472	1,644,547	
Cash Funds	209,395	240,399	318,090	375,163	
Reappropriated Funds	663,540	764,781	862,087	878,854	
Federal Funds	1,972,764	2,002,648	2,326,159	2,348,514	

	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	Request vs. Appropriation
Operating Expenses	270,638	254,436	290,180	318,150 *	
General Fund	24,381	19,679	19,679	36,638	
Cash Funds	13,736	22,096	36,524	47,535	
Reappropriated Funds	12,715	2,563	16,266	16,266	
Federal Funds	219,806	210,098	217,711	217,711	
Federal Programs and Grants	133,850	8,271	2,567,997	2,567,997	
FTE	0.5	0.0	1.5	1.5	
Federal Funds	133,850	8,271	2,567,997	2,567,997	
Indirect Cost Assessment	278,719	2,088	270,861	270,861	
Cash Funds	1,410	2,088	3,280	3,280	
Federal Funds	277,309	0	267,581	267,581	
Other Federal Grants	284,128	0	0	0	
FTE	2.3	0.0	0.0	0.0	
Federal Funds	284,128	0	0	0	
SUBTOTAL - (A) Community Behavioral Health Administration	5,077,851	4,596,235	8,060,846	8,404,086	4.3%
FTE	52.3	49.3	60.1	63.7	6.0%
General Fund	1,289,198	1,343,291	1,445,151	1,681,185	16.3%
Cash Funds	224,541	264,583	357,894	425,978	19.0%
Reappropriated Funds	676,255	767,344	878,353	895,120	1.9%
Federal Funds	2,887,857	2,221,017	5,379,448	5,401,803	0.4%

	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	Request vs. Appropriation
(B) Mental Health Community Programs					
This section provides funding to support mental health services delivered through Colorado's community mental health centers. This section is primarily supported by General Fund, the federal Mental Health Services Block Grant, and tobacco litigation settlement moneys that are credited to the Offender Mental Health Services Fund.					
Services for Indigent Mentally Ill Clients	39,129,072	36,629,154	37,434,930	37,124,535	*
General Fund	33,029,170	30,413,968	31,039,452	30,729,057	
Reappropriated Funds	0	0	161,909	161,909	
Federal Funds	6,099,902	6,215,186	6,233,569	6,233,569	
Medications for Indigent Mentally Ill Clients	1,705,423	1,521,855	1,554,437	1,538,893	*
General Fund	1,705,423	1,521,855	1,554,437	1,538,893	
School-based Mental Health Services	0	1,188,380	1,213,254	1,201,121	*
General Fund	0	1,188,380	1,213,254	1,201,121	
Assertive Community Treatment Programs	658,104	674,557	5,489,587	5,434,691	*
General Fund	658,104	674,557	4,803,563	4,755,527	
Cash Funds	0	0	686,024	679,164	
Alternatives to Inpatient Hospitalization at a Mental Health Institute	3,201,657	3,261,625	3,337,487	3,304,112	*
General Fund	3,201,657	3,261,625	3,337,487	3,304,112	
Mental Health Services for Juvenile and Adult Offenders	3,297,287	3,088,993	3,061,390	3,061,390	
Cash Funds	3,297,287	3,088,993	3,061,390	3,061,390	

	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	Request vs. Appropriation
Mental Health Treatment Services for Youth (H.B. 99-1116)	922,172	725,331	1,078,847	1,071,059 *	
General Fund	622,172	417,309	655,223	648,671	
Cash Funds	300,000	299,345	300,000	300,000	
Reappropriated Funds	0	8,677	123,624	122,388	
Mental Health First Aid	266,730	750,000	210,000	210,000	
General Fund	266,730	750,000	210,000	210,000	
SUBTOTAL - (B) Mental Health Community Programs	49,180,445	47,839,895	53,379,932	52,945,801	(0.8%)
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	39,483,256	38,227,694	42,813,416	42,387,381	(1.0%)
Cash Funds	3,597,287	3,388,338	4,047,414	4,040,554	(0.2%)
Reappropriated Funds	0	8,677	285,533	284,297	(0.4%)
Federal Funds	6,099,902	6,215,186	6,233,569	6,233,569	0.0%

	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	Request vs. Appropriation
(C) Substance Use Treatment and Prevention					
This section provides funding to support community-based substance use disorder services not otherwise available. This section also includes funding for pregnant women in need of substance use disorder treatment (including women who are eligible for Medicaid), as well as funding for a variety of substance abuse prevention programs. This section is primarily supported by the federal Substance Abuse Prevention and Treatment Block Grant, General Fund, transfers from HCPF (which originate as General Fund and federal Medicaid funds), transfers from the Judicial Branch (which originate as General Fund and drug offender surcharge revenues), and marijuana tax revenues.					
(I) Treatment Services					
Treatment and Detoxification Contracts	30,414,104	30,743,690	23,827,561	28,844,364	*
General Fund	11,550,713	11,793,199	12,055,021	11,934,471	
Cash Funds	331,216	1,602,901	359,905	5,497,258	
Reappropriated Funds	760,150	939,299	1,064,688	1,064,688	
Federal Funds	17,772,025	16,408,291	10,347,947	10,347,947	
Case Management for Chronic Detoxification Clients	369,359	411,673	369,464	369,438	*
General Fund	2,476	2,538	2,581	2,555	
Federal Funds	366,883	409,135	366,883	366,883	
Short-term Intensive Residential Remediation and Treatment (STIRRT)	3,407,498	3,447,833	3,574,435	3,637,970	*
General Fund	3,018,432	3,039,845	3,146,489	3,115,024	
Reappropriated Funds	389,066	407,988	427,946	522,946	
High Risk Pregnant Women Program	1,138,015	969,806	1,600,000	1,589,306	*
Reappropriated Funds	1,138,015	969,806	1,600,000	1,589,306	

	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	Request vs. Appropriation
SUBTOTAL -	35,328,976	35,573,002	29,371,460	34,441,078	17.3%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	14,571,621	14,835,582	15,204,091	15,052,050	(1.0%)
Cash Funds	331,216	1,602,901	359,905	5,497,258	1427.4%
Reappropriated Funds	2,287,231	2,317,093	3,092,634	3,176,940	2.7%
Federal Funds	18,138,908	16,817,426	10,714,830	10,714,830	0.0%
(II) Prevention and Intervention					
Prevention Contracts	5,390,967	5,398,574	3,982,941	3,967,590 *	
General Fund	33,649	34,490	35,076	34,725	
Cash Funds	21,378	85,312	121,635	106,635	
Federal Funds	5,335,940	5,278,772	3,826,230	3,826,230	
Persistent Drunk Driver Programs	1,662,028	1,890,919	2,035,823	2,035,823	
Cash Funds	1,662,028	1,890,919	2,035,823	2,035,823	
Law Enforcement Assistance Fund Contracts	100,000	255,000	255,000	255,000	
Cash Funds	100,000	255,000	255,000	255,000	
SUBTOTAL -	7,152,995	7,544,493	6,273,764	6,258,413	(0.2%)
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	33,649	34,490	35,076	34,725	(1.0%)
Cash Funds	1,783,406	2,231,231	2,412,458	2,397,458	(0.6%)
Federal Funds	5,335,940	5,278,772	3,826,230	3,826,230	0.0%
(III) Other Programs					
Federal Grants	5,380,355	3,220,975	2,625,422	2,625,422	
FTE	0.0	0.0	0.0	0.0	
Federal Funds	5,380,355	3,220,975	2,625,422	2,625,422	

	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	Request vs. Appropriation
Balance of Substance Abuse Block Grant Programs	343,319	216,467	6,683,127	6,681,150 *	
General Fund	189,688	175,543	197,735	195,758	
Federal Funds	153,631	40,924	6,485,392	6,485,392	
Community Prevention and Treatment	782,400	692,659	765,348	765,348	
Cash Funds	782,400	692,659	765,348	765,348	
Rural Substance Abuse Prevention and Treatment	88,443	124,829	151,243	151,243	
Cash Funds	88,443	124,829	151,243	151,243	
Gambling Addiction Counseling Services	65,949	82,343	100,000	100,000	
Reappropriated Funds	65,949	82,343	100,000	100,000	
SUBTOTAL -	6,660,466	4,337,273	10,325,140	10,323,163	(0.0%)
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	189,688	175,543	197,735	195,758	(1.0%)
Cash Funds	870,843	817,488	916,591	916,591	0.0%
Reappropriated Funds	65,949	82,343	100,000	100,000	0.0%
Federal Funds	5,533,986	3,261,899	9,110,814	9,110,814	0.0%
SUBTOTAL - (C) Substance Use Treatment and Prevention	49,142,437	47,454,768	45,970,364	51,022,654	11.0%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	14,794,958	15,045,615	15,436,902	15,282,533	(1.0%)
Cash Funds	2,985,465	4,651,620	3,688,954	8,811,307	138.9%
Reappropriated Funds	2,353,180	2,399,436	3,192,634	3,276,940	2.6%
Federal Funds	29,008,834	25,358,097	23,651,874	23,651,874	0.0%

	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	Request vs. Appropriation
(D) Integrated Behavioral Health Services					
This section provides funding for: a statewide behavioral health crisis response system; behavioral health services and supports for individuals transitioning from the Mental Health Institutes to the community; and community-based mental health and substance use disorder services for offenders and other specialized populations. This section is supported by General Fund, transfers from the Judicial Branch (originating as General Fund and drug offender surcharge revenues), and marijuana tax revenues.					
Crisis Response System - Walk-in, Stabilization, Mobile, Residential, and Respite Services	0	22,007,161	22,952,410	22,503,677	*
General Fund	0	22,007,161	22,952,410	22,503,677	
Crisis Response System - Telephone Hotline	659,699	2,355,865	2,395,915	2,371,956	*
General Fund	659,699	2,355,865	2,395,915	2,371,956	
Crisis Response System - Marketing	600,000	615,000	600,000	600,000	
General Fund	600,000	615,000	600,000	600,000	
Community Transition Services	2,437,827	4,801,597	5,147,901	5,896,422	*
General Fund	2,437,827	4,801,597	5,147,901	5,096,422	
Cash Funds	0	0	0	800,000	
Jail-based Behavioral Health Services	2,999,779	1,207,129	5,128,522	5,033,522	*
Cash Funds	0	0	0	0	
Reappropriated Funds	2,999,779	1,207,129	5,128,522	5,033,522	
Rural Co-occuring Disorder Services	324,200	512,500	1,021,213	1,011,001	*
General Fund	324,200	512,500	1,021,213	1,011,001	

	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	Request vs. Appropriation
SUBTOTAL - (D) Integrated Behavioral Health Services	7,021,505	31,499,252	37,245,961	37,416,578	0.5%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	4,021,726	30,292,123	32,117,439	31,583,056	(1.7%)
Cash Funds	0	0	0	800,000	0.0%
Reappropriated Funds	2,999,779	1,207,129	5,128,522	5,033,522	(1.9%)

(E) Mental Health Institutes

The Department administers and operates two Mental Health Institutes providing inpatient hospitalization for individuals with serious mental illness. The Institutes provide comprehensive psychiatric, psychological, rehabilitation, and therapeutic care. This section is primarily supported by General Fund, patient revenues (including federal Medicare funds and transfers from HCPF that originate as General Fund and federal Medicaid funds), funds transferred from the Department of Corrections (DOC) for food services provided by CMHIP to DOC facilities located on the Pueblo campus, and marijuana tax revenues.

(1) Mental Health Institute - Ft. Logan

Personal Services	18,367,445	17,951,731	18,653,854	18,904,058	*
FTE	229.1	229.1	218.5	218.6	
General Fund	16,385,815	16,214,105	16,866,275	17,116,479	
Cash Funds	1,949,875	1,618,778	1,619,709	1,619,709	
Reappropriated Funds	31,755	118,848	167,870	167,870	
Contract Medical Services	0	814,208	1,269,465	1,269,465	
General Fund	0	814,208	1,269,465	1,269,465	
Operating Expenses	1,146,270	1,196,938	1,074,076	1,078,092	
General Fund	986,987	1,073,211	914,667	918,683	
Cash Funds	123,601	123,727	123,727	123,727	
Reappropriated Funds	35,682	0	35,682	35,682	

	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	Request vs. Appropriation
Capital Outlay	0	0	920,448	9,000	
General Fund	0	0	920,448	9,000	
Pharmaceuticals	1,131,750	1,128,323	1,353,110	1,353,110	
General Fund	993,851	1,067,956	1,215,211	1,215,211	
Cash Funds	107,007	60,367	107,007	107,007	
Reappropriated Funds	30,892	0	30,892	30,892	
SUBTOTAL -	20,645,465	21,091,200	23,270,953	22,613,725	(2.8%)
FTE	229.1	229.1	218.5	218.6	0.0%
General Fund	18,366,653	19,169,480	21,186,066	20,528,838	(3.1%)
Cash Funds	2,180,483	1,802,872	1,850,443	1,850,443	0.0%
Reappropriated Funds	98,329	118,848	234,444	234,444	0.0%
(2) Mental Health Institute - Pueblo					
Personal Services	65,082,366	70,838,650	68,148,302	69,569,151 *	
FTE	993.1	1,023.7	977.5	983.2	
General Fund	56,493,778	57,736,095	58,172,152	59,593,001	
Cash Funds	5,640,594	5,484,689	3,954,220	3,954,220	
Reappropriated Funds	2,947,994	7,617,866	6,021,930	6,021,930	
Contract Medical Services	0	3,569,146	3,589,425	3,589,425	
General Fund	0	3,569,146	3,589,425	3,589,425	
Operating Expenses	5,262,458	5,853,469	5,479,546	5,568,214 *	
General Fund	4,425,217	3,200,568	2,778,434	2,821,125	
Cash Funds	345,086	709,620	399,247	399,247	
Reappropriated Funds	492,155	1,943,281	2,301,865	2,347,842	

	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	Request vs. Appropriation
Capital Outlay	0	0	790,955	43,000	
General Fund	0	0	790,955	43,000	
Pharmaceuticals	3,304,236	3,447,299	3,127,321	3,127,321	
General Fund	2,660,547	3,149,894	2,483,632	2,483,632	
Cash Funds	297,405	297,405	297,405	297,405	
Reappropriated Funds	346,284	0	346,284	346,284	
Educational Programs	361,632	168,121	205,909	205,909	
FTE	2.2	2.4	2.7	2.7	
General Fund	34,555	0	52,720	52,720	
Reappropriated Funds	104,085	132,026	153,189	153,189	
Federal Funds	222,992	36,095	0	0	
Jail-based Competency Restoration Program	1,424,610	2,197,506	2,546,965	6,039,250	*
FTE	1.0	1.0	1.0	3.0	
General Fund	1,424,610	2,197,506	2,546,965	6,039,250	
Circle Program	0	0	2,136,789	2,075,820	*
FTE	0.0	0.0	21.3	21.3	
General Fund	0	0	0	0	
Cash Funds	0	0	2,119,468	2,058,499	
Reappropriated Funds	0	0	17,321	17,321	
Circle Program Business Plan Analysis	0	0	225,000	0	
FTE	0.0	0.0	0.0	0.0	
General Fund	0	0	225,000	0	

	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	Request vs. Appropriation
SUBTOTAL -	75,435,302	86,074,191	86,250,212	90,218,090	4.6%
FTE	996.3	1027.1	1002.5	1010.2	0.8%
General Fund	65,038,707	69,853,209	70,639,283	74,622,153	5.6%
Cash Funds	6,283,085	6,491,714	6,770,340	6,709,371	(0.9%)
Reappropriated Funds	3,890,518	9,693,173	8,840,589	8,886,566	0.5%
Federal Funds	222,992	36,095	0	0	0.0%
SUBTOTAL - (E) Mental Health Institutes	96,080,767	107,165,391	109,521,165	112,831,815	3.0%
FTE	1,225.4	1,256.2	1,221.0	1,228.8	0.6%
General Fund	83,405,360	89,022,689	91,825,349	95,150,991	3.6%
Cash Funds	8,463,568	8,294,586	8,620,783	8,559,814	(0.7%)
Reappropriated Funds	3,988,847	9,812,021	9,075,033	9,121,010	0.5%
Federal Funds	222,992	36,095	0	0	0.0%
TOTAL - (8) Behavioral Health Services	206,503,005	238,555,541	254,178,268	262,620,934	3.3%
FTE	1,277.7	1,305.5	1,281.1	1,292.5	0.9%
General Fund	142,994,498	173,931,412	183,638,257	186,085,146	1.3%
Cash Funds	15,270,861	16,599,127	16,715,045	22,637,653	35.4%
Reappropriated Funds	10,018,061	14,194,607	18,560,075	18,610,889	0.3%
Federal Funds	38,219,585	33,830,395	35,264,891	35,287,246	0.1%

NOTE: An asterisk (*) indicates that the FY 2016-17 request for the line item is affected by one or more decision items.

Appendix B:
Recent Legislation Affecting Department Budget

2015 Session Bills

S.B. 15-167 (Modify FY 2014-15 Appropriations from Marijuana Revenue): Aligns FY 2014-15 appropriations from the Marijuana Tax Cash Fund (MTCF) with actual marijuana tax revenue collected in FY 2013-14. With respect to the Department of Human Services, the act reduces the cash funds appropriation for Jail-based Behavioral Health Services by $452,787 (from $2,000,000 to $1,547,213). In addition, the act clarifies that a FY 2014-15 appropriation of $1,500,000 cash funds from the MTCF for the provision of substance use disorder treatment services for adolescents and pregnant women may be used for substance use disorder prevention services and intensive wrap around services, and authorizes the Department to spend any funds that remain available in FY 2015-16.

H.B. 15-1269 (Transfer Persons To and From Correctional Facility): Repeals the authority of the Department of Human Services (DHS) to transfer a dangerous person receiving care at one of the mental health institutes to the Department of Corrections (DOC), unless that person is serving a sentence to the DOC. Clarifies that mentally ill inmates may only be transferred from the DOC to the DHS when the transfer is done in accordance with a policy that provides for due process and in situations where the inmate cannot be safely confined in a DOC facility. Authorizes the DHS to return an inmate to the DOC if that person cannot be safely confined in the DHS facility. The act does not include any appropriations. In June 2014, the DHS returned all five patients that had previously been transferred to the DOC back to the Colorado Mental Health Institute at Pueblo. The costs of implementing this change were covered by General Fund appropriations that were included in S.B. 15-149 ($2,413,428 for FY 2014-15) and S.B. 15-234 ($2,611,755 for FY 2015-16). These appropriations were based on the assumption that the DHS would require an additional 30.6 FTE for FY 2014-15 and 36.7 FTE for FY 2015-16.

H.B. 15-1367 (Retail Marijuana Taxes): Refers a ballot issue to voters in November 2015, asking whether the State may retain and spend revenue collected from the Proposition AA excise and special sales taxes on retail marijuana in FY 2014-15. Creates a $58.0 million Proposition AA Refund Account in the General Fund. Contingent on voter approval of the ballot issue, the act makes several appropriations to the Department of Human Services for FY 2015-16, as detailed in the following table.

Appropriations to Department of Human Services That Are Contingent on Voter Approval		
Division and Line Item	**Fund Source**	**Dollar Amount**
Division of Child Welfare		
Appropriation to Youth Mentoring Services Cash Fund	CF - Proposition AA Refund Account	$1,000,000
Colorado Youth Mentoring Program	RF - Youth Mentoring Services Cash Fund	1,000,000
Colorado Youth Mentoring Program - grants to statewide membership organizations	CF - Proposition AA Refund Account	1,000,000
Behavioral Health Services		
Treatment and Detoxification Contracts	CF - Proposition AA Refund Account	500,000
Total Appropriations		**$3,500,000**

Independent of whether the voters approve the ballot issue, the act broadens purposes for which funds in the Marijuana Tax Cash Fund (MTCF) may be expended and requires that appropriations from the MTCF for jail-based behavioral health services be made through the Correctional Treatment Cash Fund. The act includes a corresponding change to FY 2015-16 appropriations, replacing a $1,550,000 cash funds appropriation from the MTCF for jail-based behavioral health services with an appropriation of $1,550,000 reappropriated funds transferred from the Judicial Department.

Relevant Bills From Previous Sessions

S.B. 14-215 (Disposition of Legal Marijuana Related Revenue): Creates the Marijuana Tax Cash Fund (MTCF) and directs that all sales tax moneys collected by the state starting in FY 2014-15 from retail and medical marijuana be deposited in the MTCF instead of the Marijuana Cash Fund. Specifies permissible uses of moneys in the MTCF, including the following purposes relevant to the Department of Human Services (DHS):

- To provide inpatient treatment for adults who suffer from co-occurring disorders at the Colorado Mental Health Institute at Pueblo (*i.e.*, the "Circle Program");
- For community-based programs to provide marijuana prevention and intervention services to youth;
- For local judicial-district based programs to provide marijuana prevention and intervention services to pre-adjudicated and adjudicated youth;
- To expand the provision of jail-based behavioral health services in underserved counties and to enhance the provision of jail-based behavioral health services to offenders transitioning from jail to the community to ensure continuity of care;
- For the provision of substance use disorder treatment services for adolescents and pregnant women; and
- To provide child welfare training specific to issues arising from marijuana use and abuse.

Under existing law, the State Treasurer is required to annually transfer the first $2.0 million of sales tax revenues attributable to medical marijuana to the General Fund. These transfers were intended to offset General Fund expenditures for two programs: (1) The DHS' Circle Program; and (2) Screening, brief intervention, and referral for treatment for substance abuse ("SBIRT"),

an optional service covered under the State's Medicaid program and funded through the Department of Health Care Policy and Financing. This act continues these transfers for FY 2013-14 and FY 2014-15, and eliminates these transfers starting in FY 2015-16. Instead, the act authorizes the General Assembly to appropriate moneys from the MTCF for the Circle Program.

With respect to DHS, appropriates $7,600,000 from the MTCF for FY 2014-15, including:

- $2.0 million for the Tony Grampsas Youth Services Program for programs specifically related to the prevention and intervention of adolescent and youth marijuana use;
- $2.0 million for the expansion and enhancement of jail-based behavioral health services;
- $2.0 million for SB 91-94 programs related to the provision of marijuana prevention and intervention services to pre-adjudicated and adjudicated youth;
- $1.5 million for the provision of substance use disorder treatment services for adolescents and pregnant women; and
- $100,000 for child welfare training specific to issues arising from marijuana use and abuse.

S.B. 13-200 (Expand Medicaid Eligibility): Expands Medicaid eligibility for adults to 133 percent of the federal poverty level (FPL). The newly eligible populations affected by this change include adults without dependent children with incomes from 11 percent through 133 percent of the FPL and parents with incomes from 101 percent through 133 percent of the FPL. With respect to the Department of Human Services, reduces appropriations for community-based mental health services by $651,875 General Fund for FY 2013-14.

S.B. 13-266 (Coordinated Behavioral Health Crisis Response): Directs the Department to issue a request for proposals to entities with the capacity to create a statewide coordinated and seamless behavioral health crisis response system. Proposals will be accepted for each of five specific components of a crisis system: a 24-hour crisis telephone hotline, walk-in crisis services and crisis stabilization units, mobile crisis services, residential and respite crisis services, and a public information campaign. Appropriates $19,792,028 General Fund and 0.9 FTE to the Department for FY 2013-14 for implementation of the five components.

Appendix C:
Update on Long Bill Footnotes & Requests for Information

The following Long Bill Footnotes (LBF) and Requests for Information (RFI) relate to behavioral health services administered by the Department of Human Services and are included in this Appendix:

Mental Health Community Programs
LBF #35 and Human Services RFI #16 – Mental Health First Aid
Statewide RFI #4 – Programs funded with Tobacco Master Settlement moneys

Substance Use Treatment and Prevention
LBF #36 – Treatment and Detoxification Contracts – Incentive-based payments
Statewide RFI #1 – Cash funds that are utilized by multiple state agencies
Statewide RFI #3 – Substance use disorder (SUD) treatment and prevention services for adolescents and pregnant women
Statewide RFI #4 – Programs funded with Tobacco Master Settlement moneys

Integrated Behavioral Health Services
LBF #37 – Rural Co-occurring Disorder Services

Mental Health Institutes
LBF #38 – Authority to transfer funds between line item appropriations
LBF #42a – Authority to "roll forward" FY 2014-15 spending authority for sanity examination-related expenses
Statewide RFI #6 – Inventory of state-owned buildings or structures

Long Bill Footnotes

35 **Department of Human Services, Behavioral Health Services, Mental Health Community Programs, Mental Health First Aid** -- It is the intent of the General Assembly that this appropriation be used for the purpose of augmenting existing contracts with the approved agencies as specified in Section 27-66-104, C.R.S., in order to train additional Mental Health First Aid instructors.

Comment: This footnote was first included in H.B. 14-1238, the supplemental bill for the Department for FY 2013-14, and was continued in the FY 2014-15 Long Bill. The purpose of the footnote is to express the General Assembly's intent that the Department simply augment existing contracts, rather than using a request for proposal process, to administer the funding provided for Mental Health First Aid training and certification.

In April 2014, the Department awarded a contract to the Colorado Behavioral Healthcare Council (CBHC) and the Mental Health First Aid Colorado initiative to manage the $266,730 that was appropriated mid-year for FY 2013-14.

For FY 2014-15, the Department chose to use an RFP process. The contract was awarded to CBHC and the Mental Health First Aid Colorado initiative. The $750,000 appropriation for FY 2014-15 was awarded in three parts:

- $107,756 was awarded through a two-month extension of the FY 2013-14 contract (for July and August of 2014).
- For a brief period in September 2014 there was a gap in funding that resulted from the finalization of the RFP and issuance of an interim purchase order.
- $154,479 was awarded through an interim purchase order for the period October 1 through December 31, 2014.
- The remaining $487,765 was contracted out for the period from January 1 through June 30, 2015.

The Department has indicated that it is not required to use an RFP process for awarding the $210,000 General Fund that has been appropriated for Mental Health First Aid in FY 2015-16, and the Department can renew the contract with CBHC for an additional four years (FY 2015-16 through FY 2018-19).

36 Department of Human Services, Behavioral Health Services, Substance Use Treatment and Prevention -- It is the intent of the General Assembly that the Department refrain from withholding any portion of the state funds appropriated in this section from contractors for the purpose of making subsequent incentive-based payments.

Comment: This footnote was first included in H.B. 14-1336 (the FY 2014-15 Long Bill) to express the General Assembly's intent that the Department not move forward with certain contract changes until certain actions are taken. The above version of this footnote states the General Assembly's intent that the Department refrain from withholding state funds from contractors for the purpose of making subsequent incentive-based payments. The Department provided the following information concerning this footnote as part of the November 2, 2015 budget submission:

> "The Department is increasingly using performance-based contracts to incentivize providers to improve their performance. In this instance, the Department continued to gradually implement performance-based contracts where possible and applied state funds and federal funds equally to any performance-incentive pool. Implementation of performance-based contracting has been gradual and designed in such a way that most providers are successful at meeting performance targets. In FY 2014-15, the Department used a total of $64,904 for performance-based contracts; $2,774 of this total was state funds."

In addition, in response to a JBC staff request, the Department provided information about the specific behavioral health line item appropriations for which FY 2015-16 contracts include a provision that makes a portion of the contractor's payment contingent on certain performance data. The Department prepared a table that is included on the next three pages, identifying the following information for each line item:

- The dollar amount and fund source for each performance award;
- The number of programs and contracts affected; and
- A description of the performance criteria.

The Department has made a portion of a contractor's payment contingent on certain performance data for a total of eight line items in FY 2015-16. For these line items, a total of $7,154,413 (9.2 percent) is at risk, including $4,695,747 state funds and $2,458,666 federal funds. The Department indicates that the difference in the performance percentages assigned to each contract reflects the variations in negotiations between the Department and program contractors. Performance criteria generally focus on a client's engagement in mental health treatment, access to substance use treatment, improvement in mental health symptom severity, and reduction in substance use.

Long Bill footnote #36 only pertains to line item appropriations in the "Substance Use Treatment and Prevention" subsection. As detailed in the above table, the Department has made the payment of $2,269,013 (primarily federal funds) to managed service organizations (MSOs) contingent on certain performance data. The MSOs subcontract with local substance use treatment providers to deliver services. These providers vary significantly in size, ranging from a small provider with one location that might serve fewer than 130 individuals in a year to a large provider with 13 locations serving more than 23,000 individuals in a year.

Generally, MSOs and providers are supportive of contracts that require accountability and improve service quality and patient outcomes. The MSOs are pleased that the Department decided not to withhold performance funding up front, but rather to "claw back" funds (if necessary) after performance metrics are analyzed each quarter. This change has reduced provider cash flow concerns. However, the MSOs continue to express concern about the performance measures and benchmarks selected by the Department, the data and reporting requirements associated with these (and other) measures, and the impact of these measures on small providers that serve a small number of clients.

Long Bill Line Item	Long Bill Appropriation	Performance Dollar Amount	Performance Percentage	Number of Programs Affected	Description of Performance Measures
(B) Mental Health Community Programs					
Services for Indigent Mentally Ill Clients (General Fund-GF)	$ 31,039,452	$ 2,776,214	9%	19 Community Mental Health Center (CMHC) contracts	Performance Goal #1: Engagement in treatment (provision of 4 services within 45 days of admission) Performance goal #2: Improvement in symptom severity (improvement of number of persons with lesser symptom severity at follow-up)
Services for Indigent Mentally Ill Clients (Federal Funds - FF)	$ 6,233,569	$ 343,781	6%	18 CMHC contracts	Performance Goal #1: Engagement in treatment (provision of 4 services within 45 days of admission) Performance goal #2: Improvement in symptom severity (improvement of number of persons with lesser symptom severity at follow-up)
Assertive Community Treatment (General Fund - GF)	$ 4,803,563	$ 886,898	18%	17 CMHC contracts	Performance Goal #1: Assertive Community Treatment (ACT) clients will meet or exceed a 20% reduction in hospital bed days 1 year after enrollment in the program. Performance goal #2: Meets or exceeds 70 percent of ACT clients living independently or in supported housing.
Alternatives to Inpatient Hospitalization at a MHI (General Fund - GF)	$ 3,337,487	$ 314,973	9%	12 CMHC contracts	Performance Goal #1: Engagement in treatment (provision of 4 services within 45 days of admission) Performance goal #2: Improvement in symptom severity (improvement of number of persons with lesser symptom severity at follow-up)
Mental Health Services for Juvenile and Adult Offenders (Cash Funds - CF)	$ 3,061,390	$ 306,139	10%	11 CMHC contracts	Performance Goal #1: Engagement in treatment (provision of 4 services within 45 days of admission) Performance goal #2: Improvement in symptom severity (improvement of number of persons with lesser symptom severity at follow-up)
TOTAL (B) Mental Health Community Programs	**$ 48,475,461**	**$ 4,628,005**	**10%**		

Long Bill Line Item	Long Bill Appropriation	Performance Dollar Amount	Performance Percentage	Number of Programs Affected	Description of Performance Measures
(C) Substance Use Treatment and Prevention					
Treatment and Detoxification Contracts (General Fund - GF)	$ 12,055,021	$ 66,198	1%	3 programs - 2 Managed Service Organization (MSO) contracts	Performance Goal #1: Access to Substance Use Disorder (SUD) Treatment (number of persons offered an appointment of SUD Treatment within 7 days from the date of 1st contact). Performance Goal #2: Reduction in Use - Outpatient (OP) Treatment. (Number of persons who reduced their use of substances at discharge) Performance Goal #3: Successful Discharge from Detox (Number of persons being discharged from a detox facility who either completed treatment at the facility or who were transferred to another substance use treatment program)
Treatment and Detoxification Contracts (Re-appropriated Funds - RF Correctional Treatment Cash Funds - CTCF)	$ 1,064,688	$ 87,930	8%	1 program - 6 MSO contracts	Performance Goal #1: Access to SUD Treatment (number of persons offered an appointment of SUD Treatment within 7 days from the date of 1st contact). Performance Goal #2: Reduction in Use - OP (Number of persons who reduced their use of substances at discharge)
Treatment and Detoxification Contracts (Federal Funds - FF)	$ 10,347,947	$ 2,077,251	20%	3 programs - 6 MSO contracts	Performance Goal #1: Access to SUD Treatment (number of persons offered an appointment of SUD Treatment within 7 days from the date of 1st contact). Performance Goal #2: Reduction in Use - OP (Number of persons who reduced their use of substances at discharge) Performance Goal #3: Successful Discharge from Detox (Number of persons being discharged from a detox facility who either completed treatment at the facility or who were transferred to another substance use treatment program)
Case Management for Chronic Detoxification Clients (Federal Funds - FF)	$ 369,464	$ 37,634	10%	1 program - 1 MSO contract	Performance Goal #1: Reduction in Use - OP (Number of persons who reduced their use of substances at discharge)
TOTAL Substance Use Treatment and Prevention	**$ 23,837,120**	**$ 2,269,013**	**10%**		

Long Bill Line Item	Long Bill Appropriation	Performance Dollar Amount	Performance Percentage	Number of Programs Affected	Description of Performance Measures
(D) Integrated Behavioral Health Services					
Community Transition Services (General Funds - GF)	$ 5,147,901	$ 257,395	5%	1 program - 1 contract	Performance Goal #1: Improvement in number of clients referred to Contractor, who have a transition plan, with client input, in place within 30 days of a transition specialist being assigned. Performance Goal #2: Improvement in number of clients referred to Contractor, who have 4 contacts with transition specialist staff within the first 45 days after discharge Performance Goal #3: Improvement in number of clients referred to Contractor with a transition specialist or peer attending their first CMHC visit
TOTAL Integrated Behavioral Health Services	**$ 5,147,901**	**$ 257,395**	**5%**		

37 **Department of Human Services, Behavioral Health Services, Integrated Behavioral Health Services, Rural Co-occurring Disorder Services** -- It is the intent of the General Assembly that this appropriation be used for the purpose of providing a full continuum of co-occurring behavioral health treatment services in southern Colorado and the Arkansas Valley.

Comment: This line item appropriation was first included in the FY 2013-14 Long Bill to provide funding ($500,000 General Fund) for a full continuum of co-occurring behavioral health services to adolescents and adults in southern Colorado and the Arkansas Valley. It is staff's understanding that this appropriation was provided based on data that demonstrated a gap in the service delivery system for southern Colorado related to the co-occurring, dually diagnosed population -- primary substance use and secondary mental health (Axis I) anxiety and depression. A corresponding footnote like the one above was included to specify the General Assembly's intent in making the appropriation.

The Department awarded these funds to Crossroads' Turning Point, Inc. (CTP), a partner in Signal Behavioral Health Network, Inc., as a result of the request for proposal process. The counties in sub-state planning area #4 benefit from this appropriation, including: Alamosa, Baca, Bent, Conejos, Costilla, Crowley, Huerfano, Kiowa, Las Animas, Mineral, Otero, Prowers, Pueblo, Rio Grande, and Saguache. The Department indicates that specific treatment clinics are located in Alamosa, Lamar, La Junta, Pueblo, and Walsenburg.

The services CTP provides include residential and outpatient based services with a combination of individual and group mental health therapies, individual and group substance use treatment, case management, medication assisted therapy, substance use testing, and other similar services.

For FY 2015-16, the General Assembly increased this appropriation by $500,000, over and above the $21,213 that has been added consistent with the statewide policy concerning community provider rates.

38 **Department of Human Services, Behavioral Health Services, Mental Health Institutes** - In addition to the transfer authority provided in Section 24-75-108, C.R.S., the Department is authorized to transfer up to 10.0 percent of the total appropriations in this subsection among line items in this subsection.

Comment: The Department is in compliance with this footnote. This footnote provides the Department with the authority to transfer up to 10.0 percent of total appropriations in the Mental Health Institutes subsection of the Long Bill among line items in that subsection. In FY 2014-15, the Department was authorized to transfer a total of $10,532,975 among line items ($105,329,750 X 10%). The Department transferred a total of $1,764,711 (1.7 percent of total appropriations) among line items in FY 2014-15, as detailed in the following table.

Transfers Among Line Item Appropriations for the Mental Health Institutes: FY 2014-15				
Long Bill Line Item	**Fund Source**	**Transfers In**	**Transfers Out**	**Net Transfer / 1**
(1) Mental Health Institute - Ft. Logan				
Personal Services	Total Funds	$372,631	$413,839	($41,208)
	General Fund	372,631	413,839	(41,208)
	Cash Funds			0
	Reappropriated Funds			0
Contract Medical Services	Total Funds	0	455,257	(455,257)
	General Fund		455,257	(455,257)
	Cash Funds			0
	Reappropriated Funds			0
Operating Expenses	Total Funds	167,000	1,435	165,565
	General Fund	167,000	1,435	165,565
	Cash Funds			0
	Reappropriated Funds			0
Pharmaceuticals	Total Funds	0	147,255	(147,255)
	General Fund		147,255	(147,255)
	Cash Funds			0
	Reappropriated Funds			0
(2) Mental Health Institute - Pueblo				
Personal Services	Total Funds	685,528	541	684,987
	General Fund	493,608	541	493,067
	Cash Funds			0
	Reappropriated Funds	191,920		191,920
Contract Medical Services	Total Funds	541	20,279	(19,738)
	General Fund	541	20,279	(19,738)
	Cash Funds			0
	Reappropriated Funds			0
Operating Expenses	Total Funds	539,000	226,403	312,597
	General Fund	539,000	44,253	494,747
	Cash Funds			0
	Reappropriated Funds		182,150	(182,150)
Pharmaceuticals	Total Funds	0	181,932	(181,932)
	General Fund		181,932	(181,932)
	Cash Funds			0
	Reappropriated Funds			0
Educational Programs	Total Funds	0	9,770	(9,770)
	General Fund			0
	Reappropriated Funds		9,770	(9,770)
Jail-based Competency Restoration Program	Total Funds	11	308,000	(307,989)
	General Fund	11	308,000	(307,989)
	Cash Funds			0
	Reappropriated Funds		0	0
Total	**Total Funds**	**$1,764,711**	**$1,764,711**	**$0**
	General Fund	1,572,791	1,572,791	0
	Cash Funds	0	0	0
	Reappropriated Funds	191,920	191,920	0

1 / The "Net Transfer" column is calculated as the follows: "Transfers In" LESS "Transfers Out"
A positive value represents a net transfer in and a negative value represents a net transfer out

Background Information: This footnote was first included in H.B. 14-1336, the FY 2014-15 Long Bill. The FY 2014-15 Long Bill included two format changes to maintain a transparent delineation of expenditures at the Mental Health Institutes while allowing the Department more flexibility to manage these appropriations and minimize the number mid-year appropriation adjustments. First, funding for outside medical expenses was removed from the Personal Services line items for each Institute and placed in a two new line item appropriations for "Contract Medical Services" – one for each Institute. Second, the above footnote was added to allow the Department to transfer up to 10 percent of the total appropriations in the Mental Health Institutes subsection of the Long Bill, starting in FY 2014-15.

FY 2014-15 Long Bill Footnote Added During the 2015 Legislative Session (S.B. 15-149)

42a **Department of Human Services, Behavioral Health Services, Mental Health Institutes, Mental Health Institute - Pueblo, Personal Services** -- Up to $499,079 of the General Fund moneys appropriated in this line item not expended prior to July 1, 2015, are further appropriated to the Department for the fiscal year beginning July 1, 2015, for sanity examination-related expenses.

Comment: In January 2015 the Department requested a one-time appropriation of $499,079 General Fund for FY 2014-15 to cover estimated expenses for sanity examinations and related trial expenditures associated with one case: *The People of the State of Colorado v. James Holmes* (12CF1522). The Department also requested "roll-forward" authority to allow it to spend a portion of the appropriation in FY 2015-16 if necessary. The General Assembly approved the request.

The Department spent a total of $327,703 on sanity evaluations in FY 2014-15 related to the Holmes case. Of the remaining amount, $50,000 was rolled forward (encumbered) to FY 2015-16, and the $121,376 was unspent and reverted in FY 2014-15.

Requests for Information

Requests Applicable to Multiple Departments

1. **Department of Corrections; Department of Human Services; Judicial Department; Department of Public Safety; and Department of Transportation** -- State agencies involved in multi-agency programs requiring separate appropriations to each agency are requested to designate one lead agency to be responsible for submitting a comprehensive annual budget request for such programs to the Joint Budget Committee, including prior year, request year, and three year forecasts for revenues into the fund and expenditures from the fund by agency. The requests should be sustainable for the length of the forecast based on anticipated revenues. Each agency is still requested to submit its portion of such request with its own budget document. This applies to requests for appropriation from: the Alcohol and Drug Driving Safety Program Fund, the Law Enforcement Assistance Fund, the Offender Identification Fund, the Persistent Drunk Driver Cash Fund, and the Sex Offender Surcharge Fund, among other programs.

   Comment: This request for information is intended to ensure that Departments coordinate requests that draw on the same cash fund. Each Department is required to include, as part of its budget request, a Cash Fund Report (a "schedule 9") for each cash fund it administers to comply with the statutory limit on cash fund reserves, and to allow both the Office of State Planning and Budgeting and the Joint Budget Committee to make informed decisions regarding the utilization of cash funds for budgeting purposes. For funds that are shared by multiple departments, the department that administers the fund is responsible for coordinating submission of expenditure and revenue information from all departments to construct a schedule 9 that incorporates all activity in the fund. Three of the funds that are referenced in this RFI and pertain to this department are listed below, with a brief explanation of fund revenues and authorized expenditures.

   Alcohol and Drug Driving Safety Program Fund [Section 42-4-1301.3 (4) (a), C.R.S.] - Section 42-4-1301.3, C.R.S., sets forth sentencing guidelines for persons convicted of driving under the influence (DUI), persons convicted of driving while ability impaired (DWAI), and persons who are habitual users of a controlled substance who are convicted of driving a vehicle. The Judicial Department is required to administer an Alcohol and Drug Driving Safety (ADDS) Program in each judicial district. This program is to provide: (1) pre-sentence and post-sentence alcohol and drug evaluations of all persons convicted of driving violations related to alcohol or drugs; and (2) supervision and monitoring of those persons whose sentences or terms of probation require completion of a program of alcohol and drug driving safety education or treatment.

   The ADDS Program Fund consists of assessments designed to ensure that the ADDS Program is self-supporting. Assessments include fees paid by individuals for alcohol and drug evaluations, as well as inspection fees paid by approved alcohol and drug treatment facilities. The evaluation fee was increased from $181 to $200 in FY 2007-08. Moneys in

the Fund are subject to annual appropriation to the Judicial Department and the Department of Human Services' Office of Behavioral Health for the administration of the ADDS Program. These two departments are required to propose changes to these assessments as required to ensure that the ADDS Program is financially self-supporting. Any adjustment in the assessments approved by the General Assembly is to be "noted in the appropriation...as a footnote or line item related to this program in the general appropriations bill".

The Judicial Department's FY 2016-17 budget request includes a schedule 9 for this fund. The Judicial Department receives a direct appropriation from the Fund to support probation programs ($6,504,320 for FY 2015-16), and a portion of this funding is transferred to the Department of Human Services for the administration of alcohol and drug abuse services ($458,257 for FY 2015-16). However, fund revenues are not currently sufficient to support these appropriations, so a program restriction of $3,000,000 has been put in place for the Judicial Department for FY 2015-16.

Law Enforcement Assistance Fund [Section 43-4-401, C.R.S.] – This fund consists of revenues from a $75 surcharge on drunk and drugged driving convictions to help pay for enforcement, laboratory charges, and prevention programs. Moneys in the fund are appropriated to the Department of Human Services (for a statewide program for the prevention of driving after drinking), the Department of Public Health and Environment (for evidential breath alcohol testing and implied consent specialists), and the Department of Public Safety's Colorado Bureau of Investigation (for toxicology laboratory services). Remaining funds are credited to a Drunken Driving Account and made available to the Department of Transportation's Office of Transportation Safety for allocation to local governments for drunken driving prevention and law enforcement programs. The Department of Human Services is appropriated $255,000 cash funds for FY 2015-16 for law enforcement assistance fund contracts. The Department of Transportation's FY 2016-17 budget request includes a schedule 9 for this fund.

Persistent Drunk Driver Cash Fund [Section 42-3-303 (1), C.R.S.] - This fund consists of penalty surcharge fees paid by persons convicted of DUI, DUI per se, or DWAI, as well as a person who is a habitual user of a controlled substance who is convicted of a misdemeanor for driving a vehicle. Moneys in the Fund are subject to annual appropriation to:

- pay the costs incurred by the Department of Revenue concerning persistent drunk drivers;
- pay for costs incurred by the Department of Revenue for computer programming changes related to treatment compliance for persistent drunk drivers;
- support programs that are intended to deter persistent drunk driving or intended to educate the public, with particular emphasis on the education of young drivers, regarding the dangers of persistent drunk driving;
- pay a portion of the costs of intervention and treatment services for persistent drunk drivers who are unable to pay for such services;

- assist in providing court-ordered alcohol treatment programs for indigent and incarcerated offenders;
- assist in providing approved ignition interlock devices for indigent offenders; and
- assist in providing continuous monitoring technology or devices for indigent offenders.

The Department of Human Services' FY 2016-17 budget request includes a schedule 9 for this fund.

For FY 2015-16, a total of $2,327,044 is appropriated from this fund to the Department of Human Services, including the following:

- $2,035,823 for Persistent Drunk Driver Programs (of this amount, $888,341 is transferred to the Judicial Department)
- $265,000 for Treatment and Detoxification Contracts
- $26,221 for Office of Behavioral Health administrative expenses.

In addition, the Department of Revenue spends $2,000 annually from this fund.

The schedule submitted by the Department of Human Services indicates that the Fund balance was $1,541,101 at the end of FY 2014-15 – well in excess of the statutory reserve balance of 16.5 percent of expenditures. However, the Committee approved a staff recommendation to increase the annual appropriation from this fund by $365,000 for three years, starting in FY 2014-15, to reduce the fund balance by $1,095,000 (thus leaving a balance of about 16.5 percent of base annual expenditures).

3. Department of Health Care Policy and Financing, Behavioral Health Community Programs; and Department of Human Services, Behavioral Health Services -- The Department of Human Services is requested to work with the Department of Health Care Policy and Financing and any other relevant state agencies to provide a report to the Joint Budget Committee by November 1, 2015, concerning substance use disorder (SUD) treatment and prevention services for adolescents and pregnant women. The report is requested to include the following information: (a) a brief description of each state program that provides SUD prevention or treatment services for adolescents or pregnant women; (b) actual expenditures for SUD prevention or treatment services for adolescents and pregnant women in FY 2014-15, by program and fund source; and (c) information indicating whether there is a need for additional state funding to meet the SUD prevention and treatment needs of adolescents or pregnant women.

Comment: See the issue brief in this document titled "Substance Use Disorder Services for Adolescents and Pregnant Women" for more information about the Department's response to this request for information.

4. Department of Education, Assistance to Public Schools, Grant Programs, Distributions, and Other Assistance, Reading and Literacy, Early Literacy Competitive Grant Program; Department of Health Care Policy and Financing,

Medical Services Premiums; Indigent Care Program, Children's Basic Health Plan Medical and Dental Costs; Department of Higher Education, Colorado Commission on Higher Education, Special Purpose, University of Colorado, Lease Purchase of Academic Facilities at Fitzsimons; Governing Boards, Regents of the University of Colorado; Department of Human Services, Division of Child Welfare, Tony Grampsas Youth Services Program; Office of Early Childhood, Division of Community and Family Support, Nurse Home Visitor Program; Behavioral Health Services, Mental Health Community Programs, Mental Health Services for Juvenile and Adult Offenders, and Mental Health Treatment Services for Youth (H.B. 99-1116); and Substance Use Treatment and Prevention, Other Programs, Community Prevention and Treatment; Department of Military and Veterans Affairs, Division of Veterans Affairs, Colorado State Veterans Trust Fund Expenditures; Department of Personnel, Division of Human Resources, Employee Benefits Services, H.B. 07-1335 Supplemental State Contribution Fund; Department of Public Health and Environment, Administration and Support, Local Public Health Planning and Support; Disease Control and Environmental Epidemiology Division, Administration, General Disease Control, and Surveillance, Immunization Operating Expenses; Special Purpose Disease Control Programs, Sexually Transmitted Infections, HIV and AIDS Operating Expenses, and Ryan White Act Operating Expenses; Prevention Services Division, Chronic Disease Prevention Programs, Oral Health Programs; Primary Care Office -- Each Department is requested to provide the following information to the Joint Budget Committee by November 1, 2015, for each program funded with Tobacco Master Settlement moneys: the name of the program; the amount of Tobacco Settlement moneys received for the program for the preceding fiscal year; a description of the program including the actual number of persons served and the services provided through the program; information evaluating the operation of the program, including the effectiveness of the program in achieving its stated goals; and a recommendation regarding the amount of Tobacco Master Settlement funds the program requires for FY 2016-17 and why.

Comment: This request for information is discussed in Megan Davisson's staff budget briefing presentation concerning the Tobacco Master Settlement Agreement, dated November 19, 2015.

6. **All Departments** -- All Departments that own or have administrative custody of or administrative responsibility for State-owned buildings or structures are requested to provide by October 1, 2015, to the Joint Budget Committee an inventory list of all such department buildings or other department structures that are 50 years or older; each building's or structure's general condition and use status; and the estimated cost to address controlled maintenance needs or to provide for demolition.

Comment: This request for information is discussed in Alfredo Kemm's staff budget briefing presentation concerning Capital Construction Issues, dated November 12, 2015.

Requests Applicable to the Department of Human Services

16. Department of Human Services, Behavioral Health Services, Mental Health Community Programs, Mental Health First Aid -- The Department is requested to provide, by November 1, 2015, a report concerning the expenditure and impact of state funds to support mental health first aid training. The Department is requested to include information concerning the number of instructors who were trained and the number of educators, first responders, and military service personnel who were certified as a result of FY 2014-15 expenditures. The Department is also requested to provide information about planned expenditures for FY 2015-16.

Comment: The Department provided the report as requested.

Background Information. The General Assembly first provided state funding for Mental Health First Aid (MHFA)[21] in FY 2013-14. MHFA is a public education program committed to training adults to identify mental health and substance abuse problems, connect individuals to care, and safely de-escalate crisis situations if needed. The MHFA program meets requirements established by the federal Substance Abuse and Mental Health Services Administration's registry of evidence based programs and practices. By reaching out to people who regularly interact with adults and youth, the program educates individuals regarding the early signs and symptoms associated with mental health and substance abuse issues so they can identify adults and youth who are at risk. The program is intended to teach lay people methods of assisting young people and adults who may be developing a behavioral health problem and encourage them to seek appropriate support and services as early as possible.

Department Response. The Department contracted with the Colorado Behavioral Health Council for FY 2014-15, and expended the full appropriation for FY 2014-15 ($750,000 General Fund). The contract supported the operation of a centralized online registration and evaluation system for instructor training and certification courses, marketing and advertising, a website for public education, and program management. Marketing efforts were aimed at promoting courses as well as reducing stigma, increasing mental health literacy, and offering resources for connecting individuals with care.

A component of the contract was to facilitate a competitive selection process to identify and select qualified individuals to participate in adult and youth MHFA Instructor train-the-trainer events. Train-the-trainer events ensure a broad range of perspectives and target audiences, leverages existing local initiatives, and addresses geographic, cultural and linguistic diversity. Additionally, the contract provided for ongoing web trainings and educational materials for MHFA Instructors and other stakeholders on the MHFA Colorado website.

[21] For more information, see: http://www.mentalhealthfirstaid.org/cs/.

In FY 2014-15, a total of 105 MHFA Instructors were trained, and 6,274 individuals were certified in MHFA. The following table provides more detail concerning the types of individuals certified.

Description	Number
Instructors Trained	105
Priority Audiences Certified	
Educators	2,044 (33%)
First Responders	946 (15%)
Military Service Personnel	147 (2%)
Other Audiences Certified	3,137 (50%)
Total Certified	**6,274**

MHFA Colorado subcontracted with the Western Interstate Commission for Higher Education (WICHE) to evaluate the impact of MHFA trainings and the impact of having a coordinated statewide MHFA initiative. Participant pre- and post-tests were administered before taking the course and at regular intervals after completing the course. This research indicates that MHFA training is best at increasing trainee confidence in helping someone experiencing a mental health crisis or challenge, expanding their use of effective helping behaviors, and advancing trainee knowledge about available mental health resources.

Quantitative outcomes of the evaluation effort included the following measures:

- Confidence to help others in emotional or mental health distress
- Use of effective helping behaviors to help individuals experiencing a mental health challenge or crisis
- Knowledge about available mental health resources
- Identification as serving in a helping role for individuals in their community
- Opinions and attitudes toward individuals with emotional or mental health challenges

An Organization Leadership Impact Survey assessed the quantitative outcomes related to the impact of MHFA trainings on organization practices, policies, and environment toward mental health. This survey found that organizations that had a significant portion of their employees trained in MHFA demonstrated increased knowledge, increased dialogue, and advanced culture where mental health challenges are more openly discussed and addressed. This led to organizational policy changes in over half of respondent organizations.

In summary, the evaluation indicates that MHFA training in Colorado had substantial positive benefits at both the organization and individual level. The training is best at increasing trainee confidence to help others in distress; expanding their use of effective helping behaviors; and advancing trainee knowledge about available mental health resources.

For FY 2015-16, the General Assembly appropriated $210,000 General Fund to continue to support MHFA instructor training to ensure that any first responders, educators, social workers, medical personnel, family members, or members of the public who have the need or desire for MHFA certification can have access to a course. It is anticipated that alternative funding sources (federal funds, local funds, payments from course participants) would be used to support certification courses in FY 2015-16 and subsequent fiscal years.

The Department indicates that the FY 2015-16 appropriation will be used for statewide coordination, and outreach and promotion efforts. The Department anticipates that 180 MHFA Instructors will be trained (as intended), and 735 individuals will be certified in MHFA.

Appendix D: FY 2014-15 SMART Act Annual Performance Report and FY 2015-16 Performance Plan

Pursuant to Section 2-7-205 (1) (b), C.R.S., the Department of Human Services is required to publish an Annual Performance Report by November 1 of each year. This report is to include a summary of the Department's performance plan and most recent performance evaluation. For consideration by the Joint Budget Committee in prioritizing the budget request submitted by the Department, the FY 2014-15 report can be found at the following link:

https://drive.google.com/file/d/0B8ztIiGduUWbMmNOS19ZQUg0czA/view

Pursuant to Section 2-7-204 (3) (a) (I), C.R.S., the Department of Human Services is required to develop a performance plan and submit that plan to the Joint Budget Committee and appropriate Joint Committee of Reference by July 1 of each year. For consideration by the Joint Budget Committee in prioritizing the budget request submitted by the Department, the FY 2015-16 plan can be found at the following link:

https://drive.google.com/file/d/0B8ztIiGduUWbaG4xUTN3X1pWeEk/view

Appendix E: WICHE Study Recommendations

Section/ Topic	WICHE Study Recommendations Recommendation	DHS Initiative
Penetration Rates and Relative Need for Services		
	1. Among all regions, **region 2 (Northeastern Counties**: Cheyenne, Kit Carson, Lincoln, Logan, Morgan, Phillips, Sedgwick, Washington, Weld, Yuma) **is projected to have the greatest population increase among both children and adults, and thus may warrant special consideration and observation over the coming years to ensure that service capacity grows proportionately**.	As funds become available, increase contracts for behavioral health services for region 2
	2. **Region 1** (Western Counties: Archuleta, Delta, Delores, Eagle, Garfield, Grand, Gunnison, Hinsdale, Jackson, La Plata, Larimer, Mesa, Moffat, Montezuma, Montrose, Ouray, Pitkin, Rio Blanco, Routt, San Juan, San Miguel, Summit) **has the lowest penetration rate, and region 4** (Southeastern Counties: Alamosa, Baca, Bent, Chaffee, Conejos, Costilla, Crowley, Custer, Fremont, Huerfano, Kiowa, Lake, Las Animas, Mineral, Otero, Prowers, Pueblo, Rio Grande, Saguache) **has the highest penetration rate.**	As funds become available, increase contracts for behavioral health services for region 1
Aligning and Maximizing Resources and Payer Sources		
Payer Sources	1. **Implement suspension, rather than termination, of Medicaid eligibility for individuals in institutions for more than 30 days, including state hospitals, prisons, and juvenile facilities (for individuals who emancipate)**. Sometimes placement options are denied because the individual has not obtained Medicaid eligibility status when they are ready to leave prison or a juvenile facility or no longer need to be in a psychiatric hospital.	
	2. **Develop service delivery systems for individuals with significant co-occurring needs** (*e.g.*, individuals with developmental/intellectual disabilities, traumatic brain injury, primary dementia with decreasing mental illness, or substance use disorder). The mental health institutes are neither appropriate settings to provide the best care for these individuals, nor are they permitted to admit individuals without a primary psychiatric diagnosis that requires inpatient psychiatric care. The Department of Health Care Policy and Financing (HCPF) and the state should adopt a Medicaid State Plan amendment to facilitate the implementation of health homes as a means to integrate primary care and behavioral health service delivery.	R11 Intensive residential treatment for SUD; Work with HCPF to support enhanced crisis services through I/DD Crisis Center Pilot
	3. **Monitor affordability of care and the federal Affordable Care Act (ACA)**. A study conducted by the Urban Institute found that adults with physical and/or mental health issues, especially those with low family income, had more difficulties obtaining and affording health care than adults who reported no health problems.	

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Crisis Services	4. **Determine how crisis services for Medicaid clients will be billed and reimbursed**. Given that Medicaid behavioral health benefits are provided under a capitated, per member/per month reimbursement rather than fee-for-service reimbursement, either capitation rates need to be adjusted or providers need to be able to submit fee-for-service claims for crisis services.	R14 Behavioral health crisis services staffing
	5. **Establish processes for determining each client's ability to pay, including available payer sources, and review how providers are administering these processes.** While crisis-services contracts require all individuals who present to receive appropriate services irrespective of ability to pay, it is important that providers are diligent in identifying and billing all available payers.	R14 Behavioral health crisis services staffing
	6. **Evaluate the effectiveness, efficiency, and outcomes of the new crisis response services, including the impact of such services on the need for inpatient psychiatric hospital beds.** Multiple systems are impacted by the new services—hospitals, law enforcement and jails, community mental health centers—in addition to individuals in crisis and their families. Ongoing evaluation will not only inform longitudinal analysis, but also quality-improvement and gap-identification efforts.	R14 Behavioral health crisis services staffing
System Alignment	7. **Identify a single state behavioral health authority, and move the responsibility and authority for all behavioral health funding, planning, programs, and regulations into a single department**. While many state agencies would still retain management of behavioral health services provided to their clients (*e.g.* , Department of Corrections, the Judicial Department's Probation Services), combining the Department of Human Services' Office of Behavioral Health (OBH) and HCPF's behavioral health roles would move the state forward in reducing provider confusion and burdens, and better position the state for integrating physical and behavioral healthcare.	
	8. **Explore the development of a common management information system for behavioral health data**, or the modification of each agency system to share physical and behavioral health data using industry standard health information exchange standards.	Collaborate with HCPF on the Colorado State Innovation Model (SIM) and Colorado's System of Care Initiative

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Colorado Mental Health Institutes		
Forensic/ Criminal Justice Population	1. **Develop outpatient alternatives in order to slow the trend of increased forensic admissions**. To keep pace with increasing forensic admissions and to maintain the current civil bed rate, the number of inpatient psychiatric beds at Colorado's two mental health institutes will have to increase by 90 percent (from 545 to 1,033 beds) by 2025.	R3 Court ordered evaluation and jail-based bed space
	2. **Increase the percentage of competency *evaluations* conducted in outpatient settings by training and retaining more evaluators, providing certification and oversight, and raising the reimbursement rate.**	R3 Court ordered evaluation and jail-based bed space
	3. **Raise the daily reimbursement rates paid by the courts to the Colorado Mental Health Institute at Pueblo (CMHIP)**. The current rate of $35 per day is insufficient to offset the cost of an inpatient stay.	Initiate a request to Judicial to adjust rates.
	4. **Create additional community-based competency *restoration* programs for treatment-engaged persons out on bond who do not require the intensity of inpatient psychiatric services. Expand jail-based competency restoration services, including strong behavioral health and medication management components, to reduce the potential for individuals to be transferred back to CMHIP for behavioral reasons**. With nearly one-quarter of these individuals staying more than one year, CMHIP is forced to use a larger and larger portion of its civil beds to serve this population. The combination of increased admissions and longer length of stays is the driving force behind a projected shortage of beds over the next decade.	R3 Court ordered evaluation and jail-based bed space
	5. **Develop services at the Colorado Mental Health Institute at Ft. Logan (CMHIFL) to serve lower security risk forensic patients**. Offering such services in the metro Denver area would reduce travel time and allow individuals to receive treatment closer to where they reside.	
	6. **Develop pre- and post-adjudication services for lower security risk individuals based on mental health clinics in courts, and the existing Wellness Court, to decrease the number of justice-involved individuals being referred for competency evaluations**.	Establish a pilot in conjunction with Colorado's Dependency and Neglect System Reform (DANSR) Program based on the Sequential Intercept Model

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	7. **Strengthen the continuity of care between inpatient behavioral healthcare services and jail to reduce the likelihood that individuals will return to the hospital**. Support services for persons leaving jail and returning to community-based care should be increased, including assistance with obtaining health insurance or Medicaid to eliminate gaps in coverage.	
	Amend Section 16-8.5-103, C.R.S., to require that a judge may only order an inpatient competency evaluation for defendants who meet the State's civil commitment criteria under Section 27-65-105, C.R.S., or with written approval of the Department of Human Services.	Continue to investigate statutory change
General Recommendations	8. **Increase inpatient services for adolescents in either hospital or residential settings**. Adding adolescent beds to CMHIFL would provide better access to inpatient services for youth residing in the metro Denver area. Developing adolescent outpatient competency restoration services would allow a larger percentage of adolescents with civil commitments to access existing inpatient beds.	
	9. **Increase total geriatric bed capacity by adding beds to CMHIFL to increase access to and availability of services.**	
Individuals with Mental Illness Who Are Physically Compromised		
	1. **Consider operation by the state of one or more skilled nursing facilities for the treatment of individuals with behavioral health disorders requiring medical and/ or skilled nursing care**. Such facilities could be part of the mental health institutes or State Veterans Community Living Centers. Other options include: (a) contracting with private providers to either operate, or construct and operate, a facility for use by the state; (b) expanding the number of state nursing homes, with enhanced behavioral health supports; and (c) bring intensive medical and/or behavioral health treatment to the individual and allowing this population to age in place with less disruption in their care and treatment.	

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	2. **Increase the Medicaid reimbursement rates for inpatient psychiatric services to provide an incentive for additional civil beds to be built in general hospitals throughout the state**. It is more cost-effective for persons with significant co-occurring medical conditions to be treated in general hospitals and provided behavioral supports than to equip the state institutes to treat significant medical conditions. [Recommendation #10 for Institutes] **Identify hospitals and nursing facilities across the state that already have some medical and psychiatric capacity, and develop mechanisms to enhance their capacity to treat psychiatrically challenged individuals with co-morbid physical health conditions**. Augmenting existing services offers opportunities for individuals to be treated closer to their home communities, avoiding unnecessary transportation and separation from family and support systems. Additionally, developing the capacity to treat serious mental and physical health conditions concurrently in facilities that are not "Institutions for mental disease" (IMD) allows federal Medicaid dollars to cover some of the cost of services for individuals who are Medicaid-eligible and under the age of 65. Some private facilities have expressed interest in contracting to serve individuals with co-occurring behavioral health and medical/physical conditions (St. Mary's in Grand Junction, Lutheran–West Pines in Wheat Ridge, and Peak View in Colorado Springs). 3. **Develop additional state nursing home capacity to meet current and future demand attributable to population growth, individuals living longer, and the projected increase in persons with Alzheimer's disease and dementia**. The geographic location of new capacity should take into consideration regions that have significant service gaps for this population. Additionally, it may be beneficial to consider telehealth, specifically behavioral health services, to support individuals with challenging behaviors as they progress through the stages of their disease and would benefit from behavioral management interventions and supports and could reduce the need to transfer some individuals to another facility.	

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	4. **Develop Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT) team approaches that include using the medical home model of care**. These evidence-based programs were originally developed to engage adults with serious and persistent mental illnesses in outpatient psychiatric treatment through the use of outreach and comprehensive services available 24 hours a day, seven days a week. FACT adds legal support and leverage for individuals such as those discharged from forensic services or on conditional release from inpatient forensic programs. Such integrated services could be added to existing ACT programs that have been implemented statewide. The FACT team would be available to actively support individuals residing in a variety of living arrangements from supported housing to assisted-living facilities to nursing homes. ACT and FACT teams could also provide additional medical services and supports to these individuals, as needed, to reduce their risk of re-hospitalization for medical or psychiatric reasons. Given the seriousness of the offenses for which forensic individuals were charged and the reluctance of existing private facilities to serve these individuals, developing intensive community-based programs may allow many of these individuals to successfully step down from costly inpatient services and experience an enhanced quality of life.	
Considerations for other special populations	**Allow flexibility in unit structure to accommodate a few swing beds for younger patients on the adolescent unit if the need arises.** **Ensure that programming, capacity, and workforce are responsive to the special requirements of the small number of patients who may present with Intellectual/ Developmental Disabilities (ID/DD) or Traumatic Brain Injuries (TBI).** The low number of such cases does not warrant a designated unit. **Occasional requests by the Division of Youth Corrections (DYC) and the Department of Corrections that a detainee be transferred to one of the state mental health institutes should be accommodated, and a streamlined protocol for such admissions should be established.** **Re-establish the DYC Sol Vista program for youth with serious emotional disorders and complex behavioral needs** who can be more appropriately served in a smaller specialized therapeutic treatment environment. There is a growing demand for these services, including in the metro Denver area, and the average daily bed cost the Sol Vista program was less than the cost of CMHIP inpatient beds. **Individuals with substance use disorders should be served outside of Institutions for Mental Disease (IMD) to the greatest extent possible, to make the services reimbursable through Medicaid.**	

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Community Integration and Olmstead		
	1. **Fully implement the Colorado Community Living Plan**. It is important that OBH continue to offer a variety of services in integrated settings, and follow the strategies outlined in Colorado's Community Living Plan.	R12 Sober living homes
	2. **Improve access to housing and supports for adults with serious mental illness (SMI)**. Direct efforts toward ensuring that adult consumers with SMI have access to affordable, integrated, and supported housing.	R12 Sober living homes; Redirect treatment contract resources to provide essential services that are not covered by Medicaid (early intervention, housing supports, and employment assistance)
	3. **Continue to support the expansion of supported employment and Assertive Community Treatment**. While the practices are currently in place across the state, there is variability in the breath of these programs across the regions and fidelity to the models and outcomes should be regularly monitored.	R13 Supported employment for people with severe SUD; Redirection of resources described above
Telehealth		
	1. **Develop a statewide telehealth strategy** that includes the operational aspects of telehealth, best practices, implementation protocols, technology guidelines, and staff training standards to guide community behavioral health providers in their telehealth efforts. The strategy should address opportunities in rural communities to increase overall broadband capabilities, especially given the affordability and scalability of telehealth.	
	2. **Support infrastructure, implementation, and growth of telehealth in emergency departments and crisis-response stabilization units and respite care facilities**.	
	3. **Support efforts that eliminate restrictions such as the "in-person" requirement related to prescribing via telehealth, as well as any geographic or population-based limitations to telehealth imposed on providers**.	
	4. **Create incentives and funding mechanisms that support the broad adoption and implementation of telehealth and other technology that supports the care provided by a broad range of healthcare providers in community mental health, substance use, and integrated-care service delivery settings.**	

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	5. **Create Current Procedural Terminology (CPT) codes and adopt reimbursement policies that allow for telehealth services to be provided to consumers in their homes or other locations**. 6. **Expand the utilization of telehealth between the two state mental health institutes and between the institutes and the community** (*e.g.* , for civil patients and the courts). This is especially important for specific sectors, such as nursing home settings and youth corrections facilities, where staff to address behavioral health issues is limited. **Telehealth could also be used to provide consultative support to rural hospital emergency rooms that do not have psychiatric staff.** 7. **Explore using telehealth between the state mental health institutes and the community behavioral health center and other community providers to conduct competency evaluations** in order to address the increase in these evaluations and increase the geographic reach of this service. CMHIP has providers with significant forensic expertise who could support the training and consultation of community providers conducting competency evaluations. **Periodic and consistent training via telehealth for judges, defense attorneys, public defenders, and forensic evaluators on the conditions when the request for competency evaluations is most applicable may alleviate inappropriate requests for competency in the first place**. 8. **Identify providers with specialty expertise across Colorado in high-need areas** such as gerontology, child and adolescent, and intellectual/developmental disabilities, to increase access to appropriate care that aligns with patient needs. **Identify existing advanced-degree programs with a training emphasis on these specialty areas in Colorado, and explore opportunities to use interns or recent graduates to fill the gaps in high-need areas**. 9. **Explore telehealth options aimed at improving coordination between primary-care providers and behavioral health specialists**. 10. **Expand the provision of home health services to reimburse for behavioral health-related issues via telehealth.** 11. **Expand the use of telehealth for individuals receiving rehabilitation and intellectual disability services who have a specific need for behavioral health assessment, consultation, and treatment to complement their current care plan.**	

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	12. **Identify hubs for culturally and linguistically competent services statewide** (*e.g.* , translation, interpretation services for refugee populations, and the deaf and hard-of-hearing etc.). 13. **Consider piloting a state licensure compact between Colorado and bordering states to expand the provider pool and access to care, especially in rural communities.** 14. **Expand the use of telehealth for workforce development-related training and supervision through existing educational networks** (*e.g.* , AHECs, academic institutions).	
Housing and Employment		
Housing	1. **Implement permanent supportive housing (PSH) as an evidence-based practice** to improve access to affordable housing and supportive services for people with behavioral health disorders. This evidence-based practice aligns well with the 159 targeted housing vouchers that became available in FY 2013-14 targeted for individuals leaving the mental health institutes and other psychiatric inpatient facilities. 2. **Recruit and train a cadre of regional housing coordinators to work with local housing providers (including public housing authorities, landlords, and property managers)** to expand access to existing affordable housing and support implementation of PSH. 3. **Provide training for provider agencies on PSH**, including a focus on implementation with fidelity. Lead regional housing coordinators could learn the process and train peers if the system supports a train-the-trainer structure. 4. **Set targets for the number of individuals to be served using PSH**. 5. **Develop state-level strategic partnerships with the state housing agency and other crucial partners to create new integrated housing options for people with behavioral health disorders** . Explore opportunities to create a bridge subsidy program through the use of state General Fund in combination with available federal HUD funds.	

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Employment	6. **Continue the implementation and expansion of the individual placement and support model of supported employment (IPS/SE) as an evidence-based practice** to improve access to jobs paying a living wage.	R13 Supported employment for people with severe SUD; Redirect treatment contract resources to provide essential services that are not covered by Medicaid (early intervention, housing supports, and employment assistance)
	7. **Recruit and train a cadre of regional employment coordinators to work with local workforce centers, employers, city/county employment efforts, and private nonprofit organizations focused on employment of low-income individuals**. These coordinators would also support implementation of supported employment.	
	8. **Provide training for provider agencies on IPS/SE**. This training can be coordinated with housing training described above. Training must focus on implementation with fidelity.	R13 Supported employment for people with severe SUD
	9. **Set targets for the number of individuals to be served using the IPS/SE**.	R13 Supported employment for people with severe SUD; Redirection of resources described above
	10. **Develop strategic state-level partnerships with the Division of Vocational Rehabilitation** . Address Order of Selection difficulties and mitigate the negative effects of this practice.	R13 Supported employment for people with severe SUD
General	11. **Improve data collection and sharing by all state agencies to identify people in need of affordable housing**. Include housing status in all client databases.	
	12. **Ensure that data collection is culturally sensitive to people experiencing homelessness**, and minimize paperwork and pre-authorization to rapidly link people to needed supports.	
	13. **Train state and regional workers in trauma-informed care principles**.	

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	14. **Redirect spending of state funds and federal mental health block grant funds on services that can be covered by Medicaid to improve housing options, provide transportation, promote employment, and other nonclinical services**. 15. **Create a workforce development plan to fund, recruit, and keep providers, especially mental health and specialty care workers**.	Redirection of resources described above
Peer Mentors, Recovery Coaches, and Family Advocates		
	Peer support services can be used to assist with community-based recovery and re-integration supports for both mental health and substance abuse. Such supports were cited as a gap across all regions. [Regional behavioral health service distribution recommendation #4] 1. **Continue efforts to develop and implement a state certification program for peer support specialists**. As part of the certification initiative, develop training, supervision, and continuing education standards for both individual peers and employing organizations. Ensure that any credentialing program has provisions for transportability to other states and recognizing certification from other states. 2. **Establish standardized ethical guidelines as part of the certification and develop a mechanism for oversight and self-monitoring ethical violations**. 3. **Enhance funding to ensure access to quality training for peer specialists and supervisors of peers across the state**. 4. **Enhance and expand current training programs, and link training to the certification and continuing education requirements**. Provide funding support for curriculum development, "specialist" and "setting-specific" training opportunities, and broader access to all training. Develop a structure for an internship program that helps bridge training with employment and certification. 5. **Promote peer attendance at in-state and out-of-state conferences** for professional development, networking, and learning how other states and programs address issues faced by peers in the Colorado services system. 6. **Address workforce issues, including compensation, access, and upward mobility**. Work with both peer and provider associations and organizations to establish consistent pay scales; salary enhancement for training, education, and experience; and model job descriptions.	R12 Sober living homes

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	7. **Expand opportunities within the state for peer mentors**. This would entail working with both the public and private behavioral health service systems to promote employment of certified peer specialists. 8. **Establish a standardized program for training supervisors of peers**. 9. **Increase public awareness of peer services offered in the state**.	
Whole Health Integration		
	1. **Reach out to and monitor the progress of existing initiatives**. The Advancing Care Together demonstration project, SIM grant, and SHAPE financing study offer promising avenues for identifying and addressing key barriers to successful whole health integration. 2. **Build relationships and communication with other Colorado state agencies**. Stakeholders within the HCPF were especially eager to build relationships to create efficient execution, improvement, and evaluation of programs with shared interests.	
Legal Marijuana and Prescription Drug Abuse		
	1. **Redouble drug prevention efforts**. Prevention efforts–for youth and adults–were repeatedly recommended by stakeholders consulted for this report. Education efforts, including information for families on safe storage of marijuana and prescription drugs, are essential. Interventions targeting the perception of risk in marijuana and prescription drug abuse are needed. Both universal and selective prevention efforts targeting highest-risk regions and populations should be considered. 2. **Review treatment and recovery practices in regions 2** (NE counties) **and 4** (SE counties) **to assess treatment capacity and service need**. These regions appear to have the greatest number of substance abuse treatment admissions for both marijuana and prescription opioid abuse as the primary drugs of choice. 3. **Build stronger partnerships and communication avenues with state agencies, including those serving education, public health, Medicaid, and criminal justice interests**. Collaboration with these agencies is one key to understanding and reacting to the most current marijuana use data (public health), creating and implementing drug prevention practices (education), tracking and preventing systemic prescription drug misuse (Medicaid), and meeting the treatment needs resulting from shifts in drug laws and drug court referrals (criminal justice).	Use prevention contracts to enhance focus on universal and targeted prevention efforts in the areas of marijuana and prescription drug safety and risk

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	4. **Support CDPHE efforts to standardize data quality and collection**. This was a major barrier to compiling current data on the impact of marijuana on service needs. 5. **Create policies and partnerships that encourage the use of core evidence-based practices**. The practices used to prevent, treat, and support recovery from substance abuse issues are not well defined or accessible in Colorado. This variation limits peer support, sustainability, and quality improvement through collaboration and efficient use of funds. Building partnerships with other state agencies, along with identifying and supporting training and coaching for specific core evidence-based practices, may help to standardize and regulate the use of research-tested practices across the state. 6. **Regularly maintain and update content on the OBH website**. This site can be a key resource for individuals seeking information about drug services, state initiatives, or other details relevant to marijuana and prescription drug abuse.	
Drug Possession Sentencing Reform/Medicaid Expansion		
	1. The criminal justice population is unlike most other clients seeking treatment. They are usually court-ordered and require additional resources and/or multiple treatment episodes in order to truly recover and maintain a healthy lifestyle. Their criminogenic needs must be addressed as well as clinical needs. **Behavioral health treatment providers and criminal justice stakeholders must collaborate**. If expanded treatment capacity is required, new providers will have to be included and educated on the intricacies of this population. The systems must also collaborate on funding. While not all criminogenic needs are covered by Medicaid, some such as anger management are. 2. **To facilitate positive outcomes for individuals, the criminal justice and health care systems must be involved in planning, implementing, and sustaining treatment programs**. For example, behavioral health systems can educate courts and prosecutors about the benefits of community-based treatment, as opposed to residential treatment, which may be overused.	
	3. Resources for treatment and healthcare providers remain low. **In order to provide the specialized supervision necessary for the increased caseload created by drug sentencing reforms, the state, drug, and specialty courts will require increased judicial resources.**	Continue to collaborate with HCPF to identify gaps in Medicaid coverage for behavioral health care.

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Section/ Topic	WICHE Study Recommendations Recommendation	DHS Initiative
	4. There are too few resources to adequately treat and serve all of those in need of treatment and detox services. In many cases, Medicaid does not provide treatment allowances in-network for services that are court-ordered. For behavioral health services, clients must have a covered diagnosis and go to specific providers, and the treatment must be deemed medically necessary. **These processes need to be simplified and streamlined to create better service.** 5. There is a disincentive for treatment providers to become Medicaid treatment providers when the Medicaid rate is lower than the rates paid by various criminal justice entities. As more probationers and parolees obtain Medicaid coverage, the courts need to consider treatment capacity when assigning conditions of release. **Courts might wish to consider appointing an expert, or a liaison with the behavioral health system, who can determine whether court recommendations for intensive treatment are appropriate and capable of being fulfilled**. 6. **The judiciary may have to explore a broad-based strategy to handle offenders with drug treatment needs**. Prosecutors' offices should reassess their culture to ensure that prosecutors are recommending diversion in appropriate cases. Judges should be prepared to recommend diversion when appropriate, even when it conflicts with prosecutors' wishes. 7. **It is necessary for criminal justice employees and treatment providers to cooperate with one another to close service gaps and improve continuity of care when clients are released from correctional supervision.** This effort can include processes on the front end through discharge planning, proactive involvement, and follow-up case management. The use of medication-assisted treatment, including injected naltrexone, will not only address the heightened risk of drug overdose deaths for re-entering inmates within the first 30 days, but also will enhance treatment outcomes thereafter.	

Appendix F: Behavioral Health System Oversight

The following information was prepared by the Department of Human Services in response to a JBC staff request for a document briefly describing the role of each state agency that is involved in licensing individuals and facilities that provide behavioral health services and related statutory provisions.

Behavioral Health System Oversight
Colorado's public behavioral health care system (substance use and mental health) is administered primarily by three separate executive branch departments, the Department of Human Services - Office of Behavioral Health (the Single State Authority for Substance Use Prevention and Treatment, and the State Mental Health Authority), the Department of Health Care Policy and Financing (the State Medicaid Authority), and the Department of Public Health and Environment (the State Public Health Authority). The licensing of all professions and occupations is the responsibility of the Department of Regulatory Agencies (DORA). This includes the licensing of individual mental health professionals.

The criminal justice departments provide behavioral health services to people involved in the criminal justice system, but descriptions of licensing or regulations in these areas is not included here.

The information below is intended to point the reader in the correct direction as to the scope, statutory authority and structure of the licensing responsibilities of other departments that perform these functions. To gain the full scope of authority and operations of other departments, please contact them directly.

Behavioral health system licensing (oversight) is provided in the following ways:

- The Colorado Department of Human Services (CDHS), Office of Behavioral Health (OBH) licenses substance use disorder facility programs in the State.
- The CDHS works with the Colorado Department of Public Health and Environment (CDPHE) to license mental health facility programs. CDHS, OBH provides the programmatic (not facility) review and approval for CDPHE (which reviews the facility) to issue a license for mental health facility programs.
- The CDPHE is the licensing agency for all health facilities, including mental health facilities, in the State.
- The Department of Health Care Policy and Financing (HCPF) has an agreement with CDPHE to provide certification for receipt of Medicaid funds as required by the federal Centers for Medicare and Medicaid (CMS). Any facility that receives Medicaid funding must have this certification.
- DORA provides individual practitioner licenses (e.g., licensed clinical social worker, certified addiction counselor (CAC), nurse, physician, psychologist).
- The HCPF has no licensing responsibility, other than the federal requirement to certify agencies that receive Medicaid funds. HCPF provides funding to agencies under the State's fee for service and "behavioral health capitation" programs.

The following section contains information on the statutory authority, regarding licensing, on each Department.

Department of Human Services

- Title 27, Articles 65 through 69, Colorado Revised Statutes (C.R.S.) governs the operation of mental health programs.
- Title 27, Articles 80, 81, and 82, C.R.S. governs the operation of the substance use disorder programs.
- 27-65-105 C.R.S. and 27-66-105 C.R.S. authorizes CDHS, OBH to approve or reject mental health facility programs for involuntary mental health commitments and for the purchasing of mental health services. Department of Public Health and Environment (CDPHE) reviews and issues the license for mental health facility programs.
- 27-81-106(3) C.R.S. (references alcohol only) and 27-82-103(3) C.R.S. (references drug only) requires CDHS to maintain a list of approved facilities. The "approval" is the licensure and these statutes allow CDHS to suspend, revoke, limit, restrict, or refuse to grant approval for failure to meet standards.

In total, CDHS, OBH, in accordance with statute, oversees community behavioral health providers of services, including:

- Seventeen community mental health centers.
- Fourteen community mental health clinics or psychiatric specialty clinics. (Clinics serve special populations such as members of racial, ethnic or linguistic minority groups.)
- Forty-eight designated facilities (involuntary mental health treatment, 1,445 psychiatric beds, including the two state psychiatric institutes).
- Four designated managed service organizations across seven sub-state purchasing areas that contract with 41 funded substance use disorder treatment providers.
- Six acute treatment facilities.
- Forty residential facilities providing residential mental health services for children (psychiatric residential treatment facilities and therapeutic residential child care facilities).
- Six hundred and ninety-eight licensed substance use disorder treatment provider agencies.
- Forty-four prevention providers (94 statewide programs/strategies).

This includes specialized designations and licenses such as community mental health centers (CMHCs); CMHC psychiatric specialty clinics; psychiatric hospitals; 72-hour treatment and evaluation facilities; acute treatment units; short-term treatment facilities; long-term treatment facilities; therapeutic residential child care facilities; and psychiatric residential treatment facilities. Categories of specialized substance use treatment licenses, based on the American Society of Addiction Medicine levels of care, include gender-responsive women's treatment; medication-assisted treatment for opiate dependence; treatment for minors; offender education, treatment and adjunct services; driving under the influence (DUI) court-ordered classes, driving while ability impaired (DWAI) classes, and driving under the influence offender education and treatment; and treatment of persons involuntarily committed to substance use treatment.

Department of Public Health and Environment

- Title 25, Article 1.5, Part 103 C.R.S. authorizes CDPHE to conduct regulatory oversight of and licensing authority over health facilities and the provision of agency licenses for

hospitals, community mental health centers and community mental health clinics, nursing homes, and school-based health clinics.

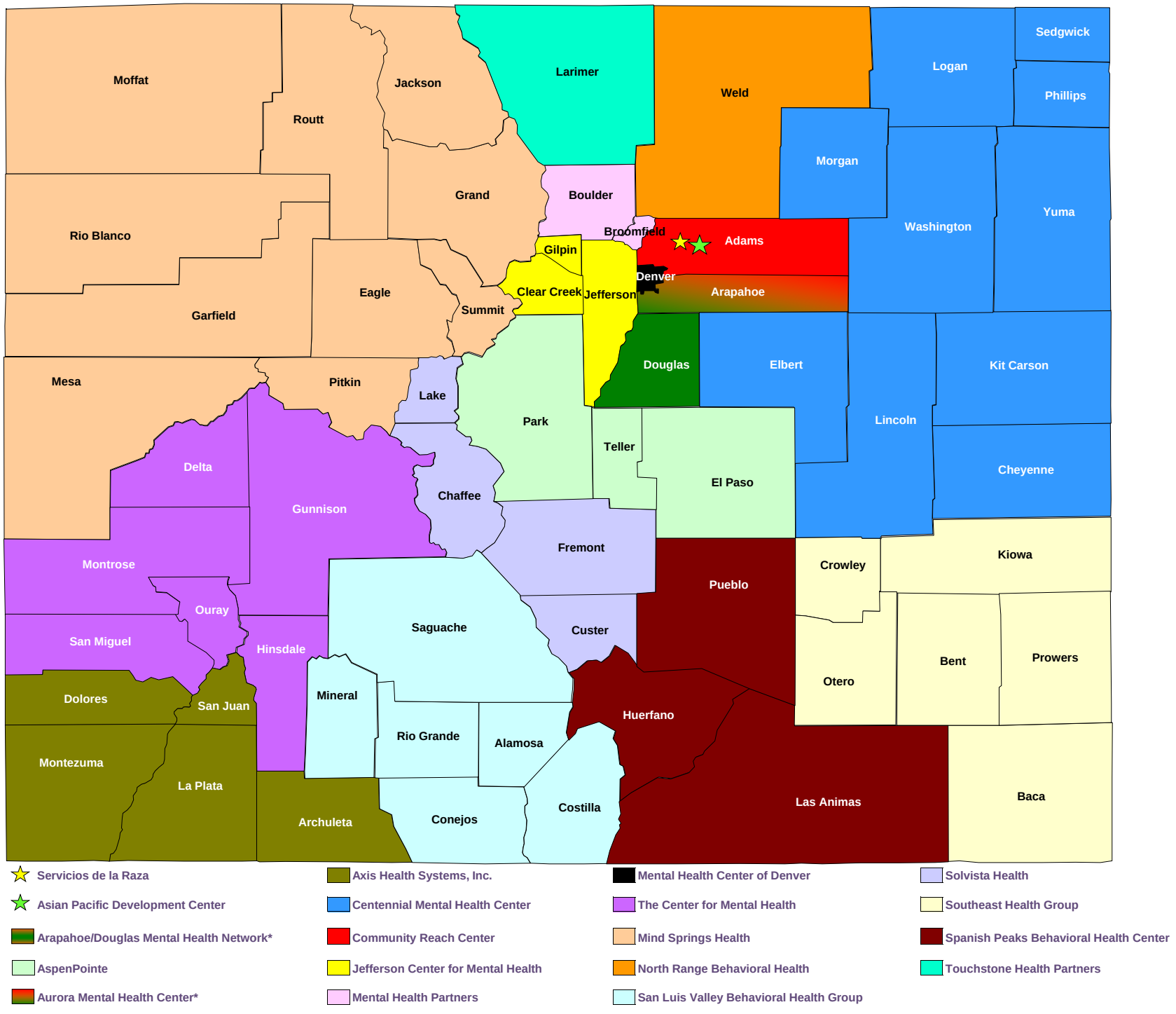
- As stated above, CDPHE surveys and certifies all Medicare and Medicaid providers through a sub-agreement with HCPF. Medicare and Medicaid providers must comply with the National Fire Protection Association 101 Life Safety Code requirements and applicable laws, regulations, and compliance information. CDPHE both licenses facilities and certifies, for HCPF, compliance with the life safety code. A provider must be both licensed and certified.

Department of Regulatory Agencies

- DORA is the consumer protection and oversight agency for individual professions and practitioners. The Division of Professions and Occupations grants licenses to all health professionals including behavioral health providers. Each licensed professional category has a board overseeing each provider group.
- Mental health professions are regulated through Title 12, Article 43 C.R.S. and include the general provisions (Part 2), psychologists (Part 3), social workers (Part 4), marriage and family therapists (Part 5), licensed professional counselors (Part 6), state board of registered psychotherapists (Part 7), and addiction counselors (Part 8).

Department of Health Care Policy and Financing

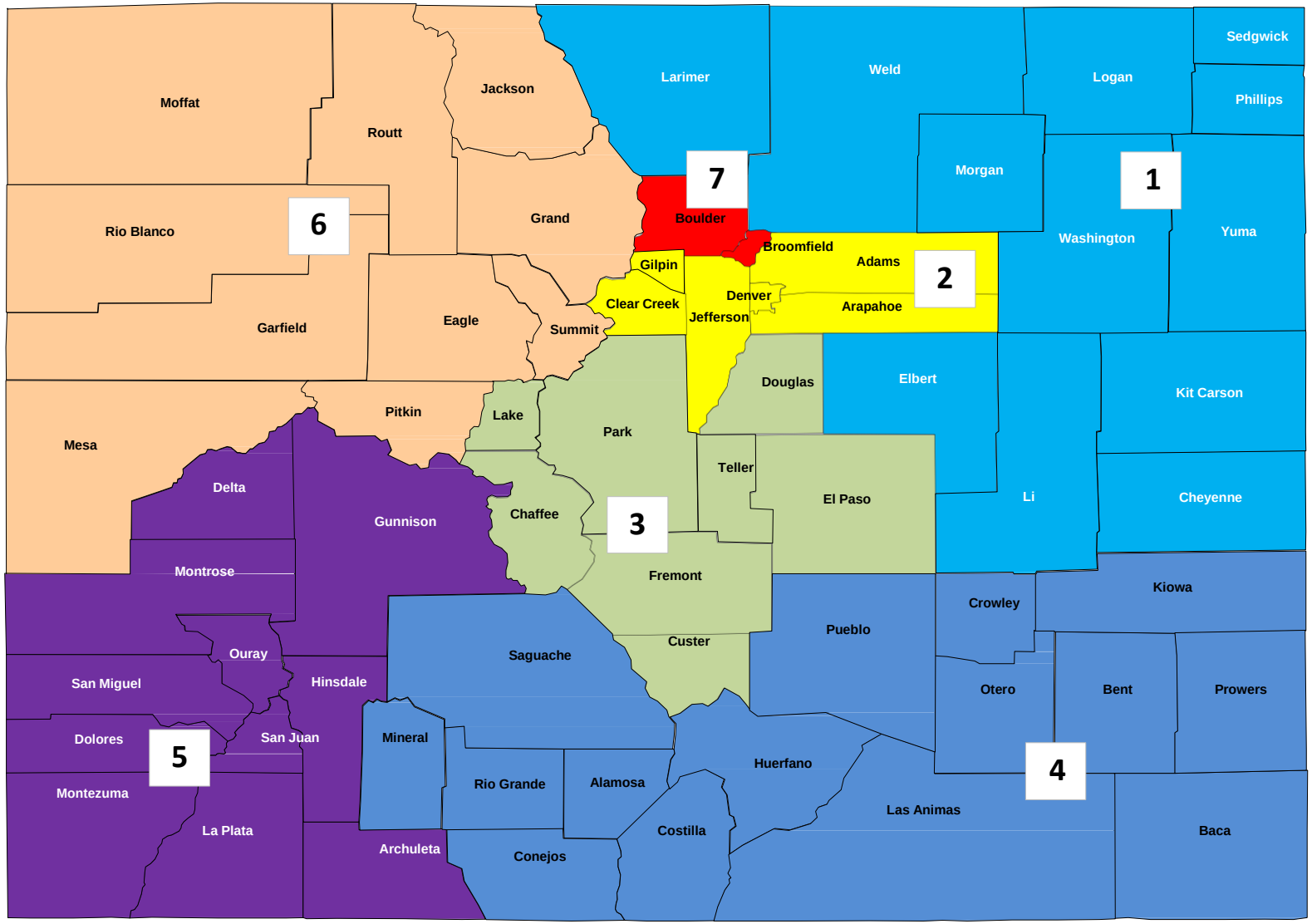
- Title 25.5 Article 4 C.R.S. establishes the authority for Medicaid-funded services and health care purchasing within the HCPF. Medicaid-funded behavioral health services include both mental health and substance use disorder services.
- Most behavioral health services are provided to Medicaid-eligible clients through statewide managed care via a 1915(b) waiver (waived services from the Medicaid state plan) or behavioral health "capitated" program. HCPF contracts with five regional entities, known as behavioral health organizations (BHOs), to provide or arrange for “medically-necessary” behavioral health services to Medicaid-eligible clients. Each BHO receives a pre-determined monthly amount for each client who is eligible for Medicaid behavioral health services. In addition to funding for capitation payments to behavioral health organizations, a separate appropriation covers fee-for-service payments for behavioral health services provided to clients who are not enrolled in a BHO and for the provision of behavioral health services that are not covered by the BHO’s contract.



** Arapahoe County is served by Arapahoe/Douglas MHN excluding the city of Aurora, which is served by Aurora MHC.*

Colorado Community Mental Health Centers by County Served

Prepared by Colorado Behavioral Healthcare Council



Colorado Managed Service Organizations
Catchment Areas by Sub-State Planning Areas (SSPA)

MSO	SSPA
Mental Health Partners	7
AspenPointe	3
Signal Behavioral Health Network, Inc.	1 2 4
West Slope Casa, LLC	5 6

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