DRAFT Behavioral Health Transformational Task Force Funding Allocation Recommendations

The following is a summary of recommendations discussed and agreed to for further discussion by the TF. The recommendations' primary outcome (see pg. 3) is indicated by a bolded number. All funding recommendations recognize that if funds are not used at the necessary rate that such funds should revert to other high-need recommendations.

Draft Task Force Funding Allocation Recommendations	Potential $ Range	
	Low End	High End
A. Southern Ute Behavioral Health Facility: One-time $ to support renovation of the existing Southern Ute 16-bed behavioral health facility for inpatient services as well as for establishing transitional housing. This facility would serve the Ute Mountain Ute tribal members as well as other regional tribal members and be fully sustainable after capital cost expenditures. **(1)**	$5m (1%)	$10m (2%)
B.1. Youth and Family Residential Care: Invest in intensive youth and family residential and outpatient care, ensuring that young people do not need to be sent out of state and families are able to receive respite across the state through the following strategies: 1) Youth Neuro-psychiatric capacity for up to 16 beds, 2) In-home and residential respite for 10 to 12 regions for children and families across the state, 3) Youth Psychiatric Residential Treatment Facility (PRTF) & Qualified Residential treatment Program (QRTP) ongoing support for 30 beds through Dec. 2026. Ensure that youth who need SUD treatment are able to get the care they need through these facilities. **(1)**	$54m (12%)	$66.5m (15%)
B.2. Children, Youth, and Families Community Services: Through the *Community BH Continuum of Care Gap Grant*, ensure there is a youth and family-oriented care access points within a two-hour drive of every community. Wherever possible such care should augment existing facilities and allow flexibility for communities to co-locate services in order to be efficient. Such access points need to be part of the care navigation / coordination system to ensure people are aware of services. Includes providing a broad range of community-based services, including expanding I-Matter youth telehealth services, evidence-based treatment for youth and their families, such as high fidelity wrap around, youth mobile response, and expanded caregiver interventions. **(2)**	$45m (10%)	$55m (12%)
B.3 School and Pediatric Care BH Integrations: Expand behavioral health investments in school-oriented environments, such as through School Based Health Centers, school-based services, and school mental health resources. Funding should also support the *Colorado Pediatric Psychiatry Consultation and Access Program* and the School Health Professionals grant program. **(2)**	$11.5m (2%)	$25m (6%)
C. Adult Residential Care[1]: Invest in adult residential care in high-need areas across the state that meets gaps for the adult population in each region. The purpose is to provide integrated step-up and step-down care to serve people with intellectual and developmental disabilities, serious mental illness, those with co-occurring conditions, those involved in the criminal justice and competency, people experiencing or at risk of homelessness, and other populations experiencing disparities exacerbated by COVID 19. Investments will support a) adding 16 beds of capacity at Fort Logan, b) residential step-down beds (aim for a minimum of 125 beds), c) recovery services (e.g., sober living homes, peer-run respite homes, club houses, and drop-in centers). Facilities should, wherever appropriate, 1) address both SUD and mental health and 2) flexibly service competency and then civil populations. **(1)**	$65m (13%)	$71m (14%)
D. Primary Care BH Integrations (formerly SIM): Invest in further integration of physical and behavioral health care and early behavioral health intervention through primary care practices. This investment increases access to screening, SUD and MH treatment, and referral services. Investments include the psychiatric consultation model (including for over-prescribers), universal contract, practice transformation grants, and technology investments. Note that pediatric consultation is in B3. **(2, 6)**	$35m (8%)	$37.6m (8%)
E.1. Community BH Continuum of Care Gap Grants: Provide funding for recommendations E2, and B2 that can be funded through the grant (totaling about $149.2m) as well as this additional amount to fund local governments and community-based organizations to address identified behavioral health needs. The *Community BH Continuum of Care Gap Grant* would provide funding to services along the continuum of behavioral health care that meet regional needs. Specifically, there should be investments in evidence-based programs along the continuum, including prevention, treatment, recovery, Treatment on Demand, care navigation and coordination, transitional housing, supportive housing[1], and recovery homes. To effectively implement these investments without further bifurcating the system, there should first be a county or regional level assessment that identifies gaps in the service continuum for that community and areas that need investment should be identified. See pg. 5 for more detail. **(4)**	$45m (10%) *All = $150m*	$100m (22%) *All = $220m*
E.2. Criminal Justice Grants: Diversion, CJ Early Intervention Program, intervention, and Competency: Through the *Community BH Continuum of Care Gap Grant*, fund communities to a) develop or expand early intervention programs (e.g., STAR, mobile response, co-responder)[2], b) post arrest diversion through the judicial branch, c) intensive community-based services, d) Medicated-Assisted Treatment, e) BH info sharing in CJ system, and f) one-stop-shop resource centers. In addition, allow for judicial districts to apply to add additional competency courts for	$60m (13%)	$65m (14%)

[1] Funding is expected to be paired with the Economic Recovery and Development Task Force to address homelessness and up to $50m to address permanent supportive housing and transitional housing at the high end of the *Community BH Continuum of Care Gap Grants* (E1)

[2] Note that HCPF is planning to ensure mobile response services will be covered by Medicaid.

Draft Task Force Funding Allocation Recommendations	Potential $ Range Low End	Potential $ Range High End
high-need areas for up to 3 years of funding. Focus MAT investments in communities with high need, including for the criminal justice system. Invest in community MAT providers to service jails to better ensure smooth transitions. Investments should be coordinated w/ 988 as appropriate. **(2)**		
F. Workforce: Direct relevant state agencies to develop a plan and invest in workforce expansion, recruitment, training, and retention. Such an evaluation should include how to best meet the workforce requirements indicated in the above recommendations. The plan shall include the following aspects: 1) Expand the workforce by creating more levels of providers. 2) Invest in rural opportunities that encourage rural community members to become and continue to serve as the behavioral health providers in their communities. 3) Expand telehealth options and reciprocity to immediately expand the eligible workforce and tap providers who represent under-resourced communities. 4) Ensure our safety net providers increase capacity and are trained to treat complex needs, substance use disorder (including harm reduction), sexual and domestic violence, serious mental illness, as well as use ASAM criteria and Medicaid benefit, and finally be culturally and linguistically competent through training and potentially certification. 5) Support peer support professionals through training and a ladder of opportunities. 6) Agencies running and implementing programs and policies outreach to providers to ensure they are aware of all benefits and opportunities. 7) Recruitment efforts should reflect the community being served and include ladders of opportunity to grow in the field. The strategy as a whole should ensure an adequate workforce in each region to meet the above investments, including workforce for children youth and family investments, adult residential care, including at Fort Logan, care navigation and coordination, community behavioral health paramedicine, and criminal justice competency and diversion. **(4, 5)**	$85.3m (19%)	$87.7m (19%)
G. BH System Investments in Care Navigation & Coordination and Immediate Pandemic Relief: 1.a) Train existing navigators in the safety net system to be able to use the navigation hub funded through SB21-137. Existing navigators include the RAE care managers/coordinators, 988 workers, and those in other safety net provider settings. 1.b) Use such navigators to help support the technology system, especially for identifying community-based and SDOH services and capacity and on the ground local support to encourage participation. 1.c) Such navigators will have a duty of care to support the safety net system, including those not covered by the RAE/ Medicaid (OR could add additional workforce). 1.d) Ensure that the technology platform can indicate where people can go if they need in-person navigation support. 2) Separately, enforce current statutes and strengthen language so that anyone who is eligible for Medicaid in the justice system is getting enrolled. 3) Support continued maintenance and stabilization after discharge from hospitalization or other BH facility. 4) Ensure the system and providers are accountable for connecting people to services and serving those with the highest needs. Results should be reported. 5) EHR lite that interfaces with the health information exchanges. 6) Direct investments to Naloxone bulk purchase fund for an additional 5 years, 7) harm reduction funding through CDPHE 's HIV/STI program. 7) Also includes grants for domestic and sexual violence. **(1,3)**	$44.2m (10%)	$50.7m (11%)
TOTALS:	**$450m** (100%)	**$568.5** (125%)

Draft Outcomes

1. Those with the highest needs get the care they need when they need it.
2. People can access services when they need it and as early in the continuum as possible.
3. People with behavioral health needs are connected to services across the continuum
4. Equitable, culturally responsive, inclusive, effective, and high-quality services are available in all regions across Colorado (or connected to highest acuity needs in state
5. Trained, qualified, and diverse workforce is sufficient to meet needs.
6. There is integration and parity between physical and behavioral health

For Discussion Only: BHTTF Policy Considerations

1. **Reciprocity**: Expand reciprocity to domestic and international licensures and encourage providers to move to Colorado. This will help expand the ability to provide cultural competency. At the same time, continue to invest in Colorado's telehealth infrastructure to reach clinicians / providers nationwide with specialty care. (Related to F.)
2. **1115 Mental Health Waiver**: Explore Medicaid 1115 waiver for mental health in addition to the one Colorado has on SUD. (Related to C and Ridge View proposal)
3. **Audit/ sunset review of BH line item**: Identify programs and line items that should be audited or undergo a sunset review. Items include: 1. Strategic Individualized Remediation Treatment (STIRT), 2. Jail Based Behavioral Health Services, 3. Offender Behavioral Health Services, 4. Correctional Treatment Cash Fund (CTCF), 5. Offender Services, 6. Approved Treatment Provider program, 7. Problem Solving Courts (with a focus accreditation).
4. **Decrease Admin Burden**: Reduce admin burden that gets in the way of treating patients in a timely manner and overwhelming the workforce while also ensuring quality & transparency. (Related to F)
5. **Judicial diversion**: Explore creating expanded authority for judicial diversion. Allow judicial officers to sentence people to treatment rather than incarceration. (Related to E3)
6. **988 BH line**: Institute legislative policy for using the 988 Suicide Prevention line as a Colorado Behavioral Health Crisis Line, which should include connections to: 1) the forthcoming Colorado behavioral health resource navigation system with information that more quickly links individuals in crisis with available services, 2) the forthcoming care coordination system, 3) peer support services, 4) information about payer sources and payer funding for services. (Related to E4)
7. **Certified Addiction Technicians and Specialists**: Adjust requirements of CAT/S hours to be more in line with registered nurses or Licensed Practice Nurses. Currently CAT requires 1,000 hours more than these professions and CAS 2,000 more. (Related to F)
8. **Discharge Strategy**: Minimal funding to examine how to ensure people are not discharged into homelessness, such as through an evaluation, strategy development, and/or stakeholder consultation. (Related to E4)

9. **Buprenorphine**: Eliminate any requirements for prior authorization to fill buprenorphine products for the treatment of opioid use disorders. (Related to E2)
10. **Special competency population**: Consider making the competency population a special population within HCPF & provide resources to manage the population with the RAEs. Covering these services could be a requirement of the contracted network adequacy plan. (Related to E3)
11. **Medicaid in the jails, community corrections, DYS, & DOC**: Enforce current statutes and strengthen language so that anyone who is eligible for Medicaid in the justice system is getting enrolled. In addition, maximize Medicaid funding to allow greater flexibility for criminal justice funds and reducing the amount of treatment dollars the criminal justice system needs to access via the state General Fund. Would also include children and youth going into detention under Division of Youth Services. (Related to E3)
12. **Transparency and accountability**: For rates, HCPF give us an annual report outlining rates to the CMHCs and IPN vs. what they pay FFS? Consider reimbursement requirements for care coordination and higher reimbursements. Consider CCBHC or elements of that proposal for accountability. (Related to E4)
13. **Transform Payer System & Care Coordination**: Consider policy to consolidate MSOs and ASOs, and ensure RAEs are expanded to serve everyone. Have money follow people and services, not organizations and make sure those with highest needs are served with high level of reimbursement rates, and per above, incentives of reimbursement for RAEs doing sufficient care coordination including receipt of next set of services. Explore instituting a value-based payment model that incentivizes high success rates and positive outcomes. (Related to E4)
14. **Community Competency Restoration**: Allow for competency restoration in community when appropriate.
15. **MAT**: Require MAT in jails and DOC and provide technical support and outreach.
16. **Insurer Therapy Coverage**: Ensure insurance allows people to see a therapist without requiring a diagnosis. This is part of parity for mental health access. Conduct proactive evaluations of coverage to determine whether the intent of Colorado's parity laws are being achieved is needed.
17. **Social Emotional Learning**: Enact a policy to support the K-5 Social Emotional ACT using existing $2.5m. SEL includes supporting the ability to set goals, self-regulation, sharing, etc.
18. **Behavioral Health Administration**: Streamline and make more effective disparate programs with overlapping responsibilities.

Community Behavioral Health Care Continuum Gap Grant Framework

Invest ARPA funding to support local communities in achieving transformational behavioral health outcomes, with the goal of doubling these state allocated dollars. *The Community Behavioral Health Care Continuum Gap Grant* provides an opportunity for local governments (counties, municipalities, school districts, law enforcement, and judicial districts) as well as Community Based Organizations and nonprofits to meet regional gaps and transform behavioral health. The grant seeks to balance solutions that are both locally driven while connected to statewide priorities and systems. Key components of the grant include:

a. Ensure transparency and accountability mechanisms.
b. Require a county or regional level assessment that identifies gaps in the service continuum for that community and areas that need investment should be identified. This will help prevent further bifurcating the system.
c. Allow for non-financial match to be used as an addition or alternative to a financial match; waivers in certain instances may be necessary.
d. Incentivize alignment with regional opioid settlement plans and local public health needs assessments.
e. Include a cap on indirect costs.
f. Require projects are connected with larger state systems (for example, if mobile crisis response is being funded in a community, it would need to respond to 988 calls).
g. Require applicants to demonstrate sustainability for receipt of funds.
h. Encourage applicants to work regionally, such as through the opioid regional boards, or other regional efforts.
i. Demonstrated need for one-time funding, and outreach to these communities with an offer to provide grant writing support.