Joint Budget Committee

Staff Budget Briefing
FY 2025-26

Department of Health Care Policy and Financing

(Behavioral Health Community Programs)

JBC Working Document - Subject to Change

Staff Recommendation Does Not Represent Committee Decision

Prepared by:

Emily Pope, JBC Staff

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Joint Budget Committee Staff
200 E. 14th Avenue, 3rd Floor · Denver · Colorado · 80203
Telephone: (303) 866-2061 · TDD: (303) 866-3472
https://leg.colorado.gov/agencies/joint-budget-committee

Contents

ADDITIONAL RESOURCES

Brief summaries of all bills that passed during the 2024 legislative session that had a fiscal impact on this department are available in Appendix A of the annual Appropriations Report: https://leg.colorado.gov/sites/default/files/fy24-25apprept.pdf

The online version of the briefing document may be found by searching the budget documents on the General Assembly's website by visiting leg.colorado.gov/content/budget/budget-documents. Once on the budget documents page, select the name of this department's *Department/Topic*, "Briefing" under *Type*, and ensure that *Start date* and *End date* encompass the date a document was presented to the JBC.

Overview of HCPF Behavioral Health

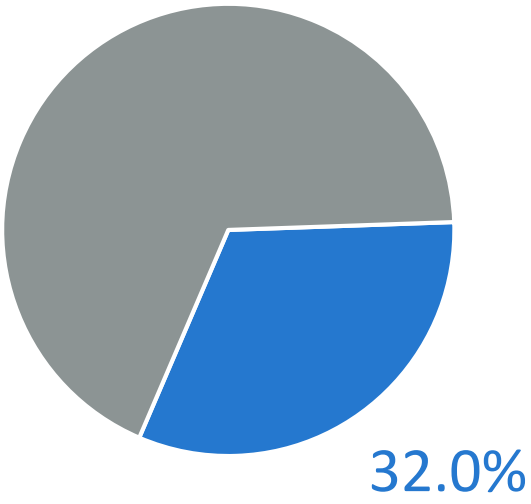
Recent Appropriations

HCPF Behavioral Health Community Programs: Recent Appropriations				
Funding Source	FY 2022-23	FY 2023-24	FY 2024-25	FY 2025-26*
General Fund	$236,698,363	$283,497,693	$275,847,686	$330,791,940
Cash Funds	93,026,955	86,656,628	79,656,824	99,791,612
Reappropriated Funds	0	0	0	0
Federal Funds	808,882,888	768,244,816	684,765,193	878,535,967
Total Funds	$1,138,608,206	$1,138,399,137	$1,040,269,703	$1,309,119,519
Full Time Equivalent Staff	0.0	0.0	0.0	0.0

*Requested appropriation

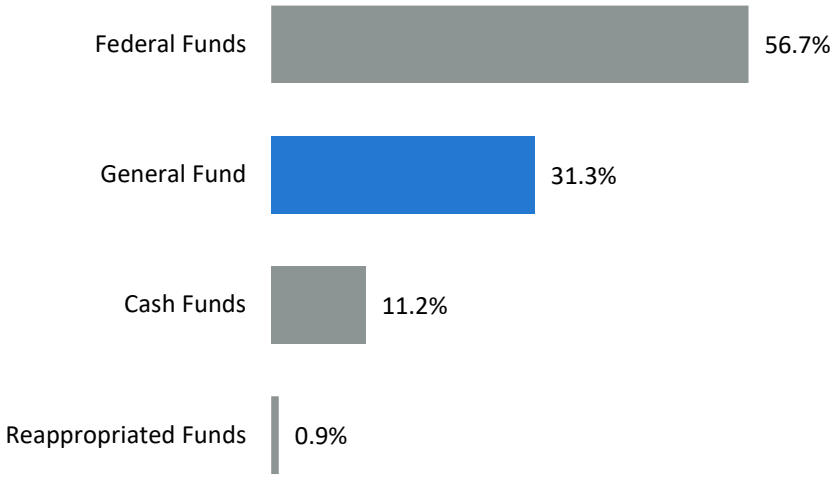
Graphic Overview

Department's Share of Statewide General Fund



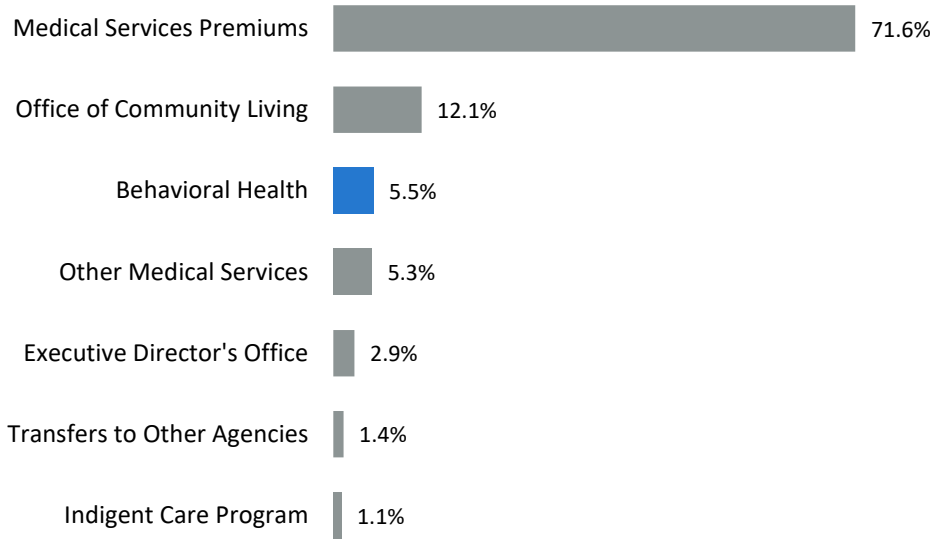
Based on the FY 2024-25 appropriation.

Department Funding Sources



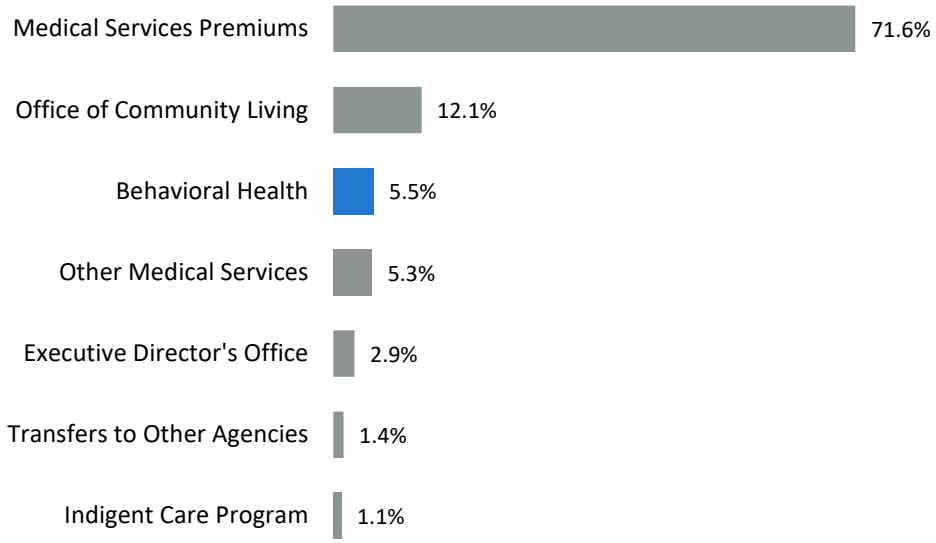
Based on the FY 2024-25 appropriation.

Distribution of General Fund by Division



Based on the FY 2024-25 Appropriation

Distribution of Total Funds by Division

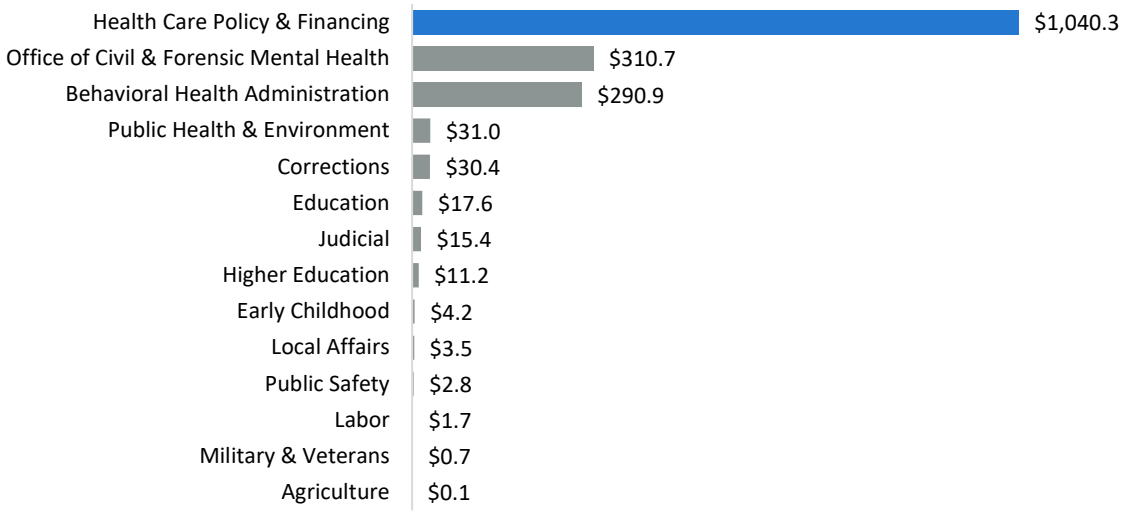


Based on the FY 2024-25 Appropriation

Statewide Behavioral Health Funding

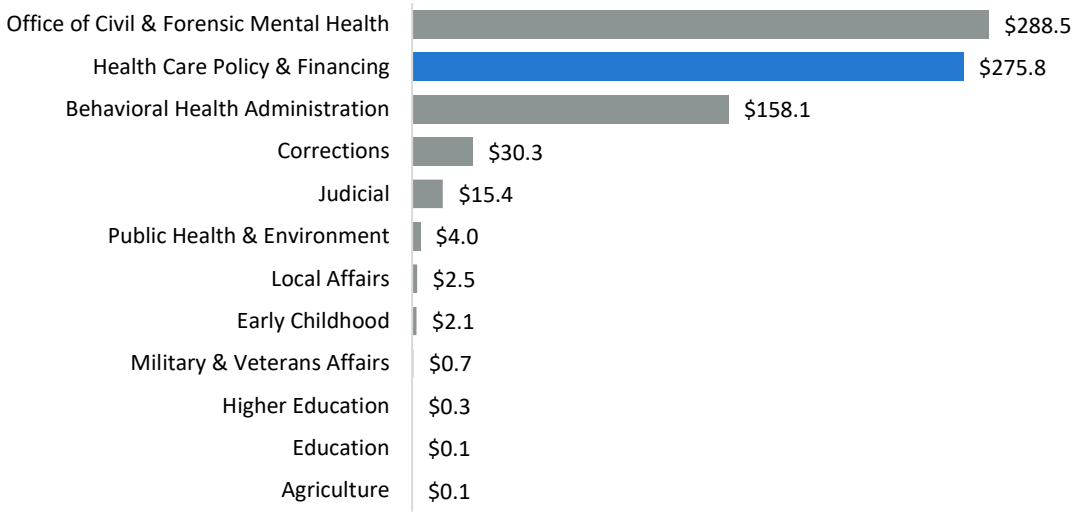
The following charts provide an estimation of statewide behavioral health funding by department based on FY 2024-25 appropriations. The estimation is based on a narrow definition of behavioral health programs, and does not include programs that may overlap with behavioral health in the Departments of Human Services of Health Care Policy and Financing outside of the core behavioral health divisions for those Departments.

Distribution of Total Funds for Behavioral Health Programs by Department



General Fund appropriations for the Office of Civil and Forensic Mental Health exceeded Health Care Policy and Financing in FY 2024-25. This was unique to that fiscal year after the HCPF forecast was reduced at the same time large increases were approved for OCFMH. The FY 2025-26 request for HCPF Behavioral Health is $42.6 million higher than the OCFMH request.

Distribution of General Fund for Behavioral Health Programs by Department



Cash Funds Detail

Behavioral Health Community Programs Cash Funds Detail				
Fund Name	FY 2024-25 Approp.	Note	Primary Revenue Sources	Primary Uses in Dept.
Healthcare Affordability and Sustainability (HAS) Fee Cash Fund	$79,622,905	[1]	Hospital fees	Behavioral health capitation payments ($78.9 million); Fee-for-service payments ($691,801)
Breast and Cervical Cancer Prevention and Treatment Fund	33,919		Tobacco settlement and special license plate revenues	Behavioral health services for breast and cervical cancer patients.
Total	$79,656,824			

[1] TABOR exempt.

Additional Detail for Select Funds

Healthcare Affordability and Sustainability (HAS) Fee Cash Fund: The HAS Fee is the largest source of cash funds for the Department. Hospitals pay fees into the fund that are then matched with federal funds returned to hospitals in the form of supplemental payments. A portion of revenue is used to pay for Affordable Care Act expansion populations, primarily adults without dependent children and higher income parents. The General Assembly designated the HAS Fee as part of an enterprise that is exempt from TABOR. Fees are set annually by the enterprise board.

Cash fund revenues and reserves

The following table provides the actual revenue and expenditures from the cash funds listed above for as reported by the Department in the November request. Appropriation totals are for the entire Department rather than behavioral health alone. Reports provide a point in time estimate and may include hard assets. The beginning fund balance does not independently indicate cash funds available for additional appropriations or transfers.

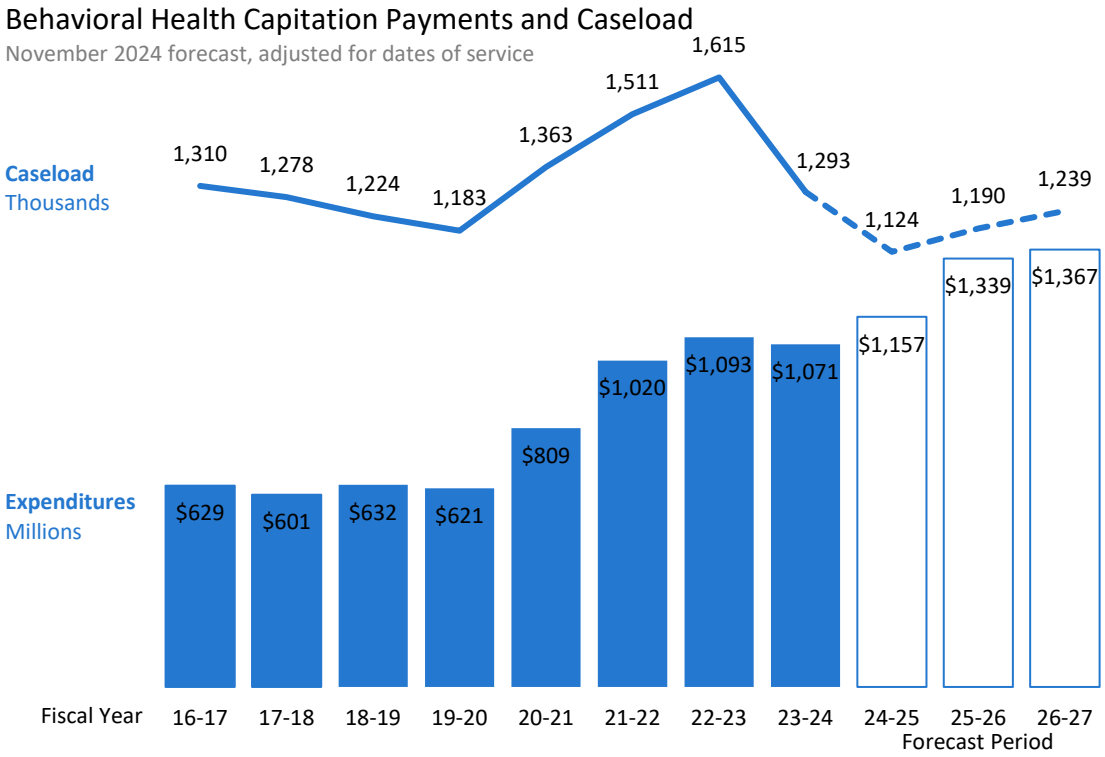
FY 2023-24 Cash Fund Reports				
Fund Name	Revenue	Appropriation	Expenditure	FY 25 Beg. Balance
Healthcare Affordability and Sustainability Fee Cash Fund	$5,013,368,661	$1,245,160,411	$1,254,635,676	$210,242,5445
Breast and Cervical Cancer Prevention and Treatment Cash Fund	1,133,869	621,155	623,847	3,797,465

General Factors Driving the Budget

Behavioral Health Community Programs

Behavioral health services include mental health and substance use-related services, and are provided to Medicaid clients through a statewide managed care or "capitated" program. The Department contracts with Regional Accountable Entities (RAEs) to provide behavioral health services for clients enrolled with each RAE. Each RAE receives a pre-determined monthly amount for each behavioral health Medicaid client. Rates paid to each RAE are unique for each service and geographic region. These rates are periodically adjusted based on actual utilization and expenses.

Behavioral health services are primarily supported by the General Fund and federal funds. Capitated behavioral health program expenditures are driven by changes to caseload, rates, economic conditions, and services eligible for coverage. The state receives a 90 percent federal match for adults who are “newly eligible” pursuant to the federal Affordable Care Act. Services for these adults represents a significant portion of caseload, but expenditures tend to be driven by higher cost populations such as children and people with disabilities.



To better show the relationship between enrollment and expenditures, the chart above moves reconciliation payments to the fiscal year when the cost accrued, rather than the year it was paid. For this reason, the chart above will not exactly match actual and projected expenditures.

Summary of Request

Department of Health Care Policy and Financing						
Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 2024-25 Appropriation						
H.B. 24-1430 (Long Bill)	$1,037,769,703	$274,597,686	$79,656,824	$0	$683,515,193	0.0
Other legislation	2,500,000	1,250,000	$0	0	1,250,000	0.0
Total	$1,040,269,703	$275,847,686	$79,656,824	$0	$684,765,193	0.0
FY 2025-26 Requested Appropriation						
FY 2024-25 Appropriation	$1,040,269,703	$275,847,686	$79,656,824	$0	$684,765,193	0.0
R2 Behavioral Health	255,996,379	51,266,218	19,371,605	0	185,358,556	0.0
R12 BH and primary care integration	9,293,193	2,171,858	694,272	0	6,427,063	0.0
Annualize prior year budget actions	3,560,244	1,506,178	68,911	0	1,985,155	0.0
Total	$1,309,119,519	$330,791,940	$99,791,612	$0	$878,535,967	0.0
Increase/-Decrease	$268,849,816	$54,944,254	$20,134,788	$0	$193,770,774	0.0
Percentage Change	25.8%	19.9%	25.3%	0.0%	28.3%	0.0

This table only reflects the November request for HCPF Behavioral Health Community Programs. For the complete Department overview, refer to the staff briefing by Eric Kurtz dated December 11, 2024.

R2 Behavioral health forecast: The Department requests an increase of $256.0 million total funds for the Behavioral Health forecast in FY 2025-26. Amounts include $51.3 million General Fund and $185.4 million federal funds. The request increases to $392.2 million total funds, including $85.1 million General Fund, in FY 2026-27. The Committee will receive an updated forecast in February to inform the figure setting process.

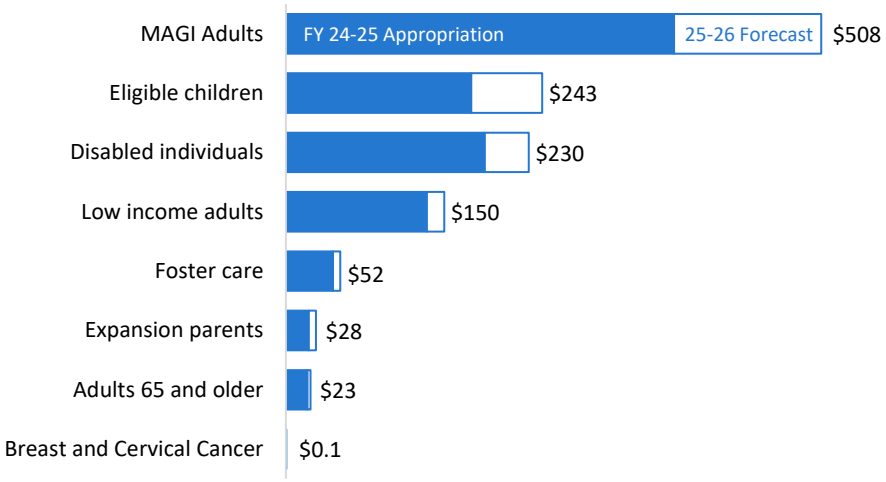
The Department indicates that actual caseload was lower than the forecast for FY 2023-24, but capitation rates were higher than anticipated and more than offset the caseload decrease. Per-member rates increased as high acuity patients remained enrolled and lower acuity patients were disenrolled. Enrollments are expected to increase in FY 2025-26 after a period of large disenrollments following the end of the Public Health Emergency declaration. In addition to forecast changes related to acuity, the Department indicates that general behavioral health need and utilization has increased since the COVID-19 pandemic.

Behavioral Health Capitation Forecast Changes		
Item	Total Funds	General Fund
FY 2024-25 Appropriation	$1,040,269,703	$275,847,686
Enrollment	38,732,612	14,263,628
Per capita cost	217,263,767	37,002,590
Forecast adjustment	$255,996,379	$51,266,218
FY 2025-26 Request	$1,296,266,082	$327,113,904

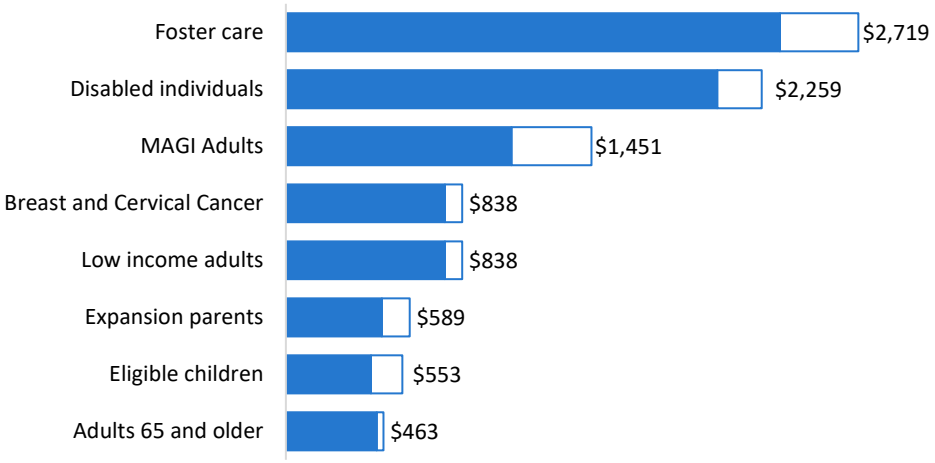
The forecast anticipates that enrollment and per capita rates will increase in all eligibility categories in FY 2025-26. The charts below provide the forecasted changes for total

expenditures and per capita rates by eligibility category in FY 2025-26 from the FY 2024-25 appropriation.

Forecasted expenditures by eligibility category (amounts in millions)



Forecasted per capita rates by eligibilty category



R12 Behavioral health and primary care integration: The Department requests a net increase of $1.6 million total funds to transition integrated care from medical services premiums to behavioral health capitation. This is reflected as an increase of $9.3 million total funds in behavioral health, partially offset by a $7.7 million decrease in other sections of the Department's budget. The Department indicates that integrated behavioral health care is a proven practice supported by a meta-analysis of 37 randomized control trials.

Integrated care refers to behavioral health services provided to patients in a primary care setting. The request includes three components resulting from stakeholder feedback.

1 **Increase $4.5 million total funds** to expand coverage to include Health and Behavioral Assessment and Intervention (HBAI) Services. HBAI is a 15-minute assessment that is better adapted to primary care visits than an existing 60-minute assessment.
2 **Decrease $5.8 million total funds** for anticipated reduced utilization of Short Term Behavioral Health (STBH) Services resulting from the shift to HBAI services.
3 **Increase $2.9 million total funds** to expand coverage for Collaborative Care Management (CoCM) Services. CoCM is a team-based model that allows primary care providers to collaborate with psychiatrists on a treatment plan. The increase is partially offset by anticipated decreases to hospitalization and inpatient care.

The 2019 Behavioral Health Task Force recommended that the General Assembly integrate primary care and behavioral health using federal stimulus funds from the American Rescue Plan Act of 2021 (ARPA). House Bill 22-1302 (Health-care Practice Transformation) created the Primary Care and Behavioral Health Statewide Integration Grant Program. Grants were expected to support infrastructure and workforce developments related to implementing integrated care.

The request indicates that the Department received feedback from providers that integrated care was not sustainable without an updated billing model. Under the current structure, the first six STBH sessions are billed fee-for-service, and additional sessions are billed through the RAEs for behavioral health capitation. Supporting HBAI under capitation is intended to decrease the time spent on assessments while also simplifying billing administration for providers.

Annualize prior year actions: The request includes a net increase of $3.6 million total funds for the out-year cost of prior year legislation and budget actions, provided in the table below.

Annualize prior year budget actions

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
HB 23-1038 High acuity youth	$2,500,000	$1,250,000	$0	$0	$1,250,000	0.0
HB 24-1045 SUD treatment	1,025,500	243,900	67,807	0	713,793	0.0
FY 24-25 R6 Provider rates	18,308	4,060	1,104	0	13,144	0.0
FY 24-25 New DD waiver enroll	16,436	8,218	0	0	8,218	0.0
Total	$3,560,244	$1,506,178	$68,911	$0	$1,985,155	0.0

Budget Reduction Options

The Executive Budget Request does not include General Fund reductions for Behavioral Health Community Programs. This issue brief reviews additional reduction options identified by staff. A comprehensive review for the entire Department will be presented on December 11, 2024.

Summary

- Behavioral Health Community Programs in the Department of Health Care Policy and Financing represents 1.8 percent of total state General Fund appropriations in FY 2024-25.
- The Executive budget request does not include reductions for this section of the budget. The request reflects an overall increase of $54.9 million General Fund, which is a 19.9 percent increase over FY 2024-25.

Discussion

Funding History FY 2018-19 to FY 2024-25

Behavioral Health Community Programs in the Department of Health Care Policy and Financing represents 1.8 percent of total state General Fund appropriations in FY 2024-25. As reflected in the table below, General Fund in this section of the budget has increased by 18.1 percent since FY 2018-19 after adjustments for inflation[1]. This is more than the statewide increase in General Fund appropriations of 11.3 percent over the same period after adjustments. Over the same period total funding in this section of the budget, after adjustments, has increased by 23.7 percent. The table below reflects behavioral health alone, and not the entire Department.

FY 2018-19 to FY 2024-25 Appropriations Comparison - Adjusted for Inflation					
	FY 2018-19			Increase/ -Decrease after inflation adjustment	
Fund	Nominal	FY 24-25 Dollars	FY 2024-25	Amount	Percent
General Fund	$184,437,583	$233,596,992	$275,847,686	$42,250,694	18.1%
Total Funds	$663,729,374	$840,637,697	$1,040,269,703	$199,632,006	23.7%

Additional Options for JBC Consideration

The table below summarizes options identified by the JBC staff that the Committee could consider in addition to or instead of the options presented in the budget request. A General

[1] Fiscal year 2018-19 appropriations are adjusted for inflation, calculated based on the Legislative Council Staff September forecast, which reflects an increase in the Denver-Aurora-Lakewood consumer price index of 26.7 percent between FY 2018-19 and FY 2024-25.

Fund reduction of 5.0 percent to the sections of the budget covered in this briefing would require a reduction of $13.8 million.

Additional Options for General Fund Relief				
Option	General Fund	Other Funds	Bill? Y/N	Description
Revenue Enhancements				
None.	$0	$0	N	NA
Subtotal - Revenue	$0	$0		
Expenditure Reductions				
High acuity youth	-$5,774,639	-$5,774,639	Y	HB 23-1038 requires HCPF to expand CHRP eligibility and develop a system of care for high acuity youth. Repealing the bill would reduce General Fund in DHS by an additional $11.3 million.
Subtotal - Expenditures	-$5,774,639	-$5,774,639		
Net General Fund Relief	$5,774,639			

House Bill 24-1038 High Acuity Youth

House Bill 24-1038 (High Acuity Youth) is the highest cost recent legislation impacting Behavioral Health Community Programs. Overall, the bill is intended to increase resources for high acuity youth by increasing and aligning provider rates regardless of system involvement.

The bill requires HCPF to expand CHRP eligibility, evaluate the reimbursement rate for youth psychiatric residential treatment facilities (PRTF), and develop a system of care in coordination with the Behavioral Health Administration and Department of Human Services. The bill included a total General Fund appropriation of $15.3 million across the three agencies. The fiscal note assumes that costs will increase to $27.1 million General Fund by FY 2026-27.

CHRP Expansion

The Children's Habilitation Residential Program (CHRP) supports youth who are at risk for out-of-home placement and is currently limited to youth with development disabilities. The bill requires HCPF to apply for federal approval to expand the program to include youth with serious emotional disturbances.

The fiscal note assumes that expansion will increase enrollment by 20.0 percent for the first full year of implementation in FY 2025-26. Associated costs were $555,052 General Fund in FY 2024-25 and $1.5 million in FY 2025-26.

PRTF Reimbursement rate

The bill requires HCPF to contract with a third party to conduct an actuarial analysis of the PRTF reimbursement rate. PRTF is the highest acuity youth residential placement under the Federal Family First Act of 2018. A total of $101,250 General Fund was appropriated on a one-time basis in FY 2024-25. The FY 2024-25 rate for PRTF is $803.71 per youth per day.

System of Care

The bill requires HCPF, the BHA, and DHS to create a system of care for the youth populations they deem appropriate, including youth covered by Medicaid. The system is meant to be overseen by representatives from each agency. Costs associated with this portion of the bill totaled $1.9 million General Fund in FY 2024-25, and increase to $6.4 million in FY 2025-26. At a minimum, the system must:

- Implement a tool to assess treatment needs;
- Provide intensive care coordination;
- Expand access to treatment foster care, including access under Medicaid; and,
- Expand access to supportive services under CHRP.

System of care is discussed in further detail in the last issue brief. Any decrease to system of care funding could expose the State to litigation following the G.A. v. Bimestefer settlement agreement.

Department of Human Services

Costs in the Department of Human Services are primarily associated with an emergency residential treatment program, provider incentive payments, and covering the cost of room and board for Medicaid eligible youth. The fiscal note assumed a total General Fund cost of $27.2 million by FY 2026-27 for DHS and the BHA.

The Emergency Residential Treatment Program was a term-limited program supported by ARPA funds and General Fund reversions from the Child Welfare block. Funding allowed the Department to contract with providers for additional PRTF beds. The program supported 27 youth in FY 2023-24.

An additional provider incentive program allocates $223 per youth per day to facilities to treat high-need children. The fiscal note assumes the program supports 32 beds. Finally, the bill requires the BHA to reimburse the cost of room and board for Medicaid clients, which is currently only reimbursed if the youth is in county custody. Families may therefore be faced with absolving custody of their child to afford necessary medical care prior to implementation of the bill. The fiscal note assumes this portion of the bill applies to 42 youth annually.

Reduction Options

The General Assembly could repeal H.B. 24-1038, or reduce the scope of the DHS Emergency Residential Treatment Program. Any adjustment is expected to reduce or eliminate services for high acuity youth and require legislation. In absence of PRTF placements, youth may be placed in hospitals, out of state, or forego necessary medical treatment. Alternatives to reducing the scope of H.B. 24-1038 would likely include reducing eligible services for residential substance use treatment or IMD stays.

H.B. 18-1136 (Substance Use Disorder Treatment) authorized the Department to add residential and inpatient substance use treatment as behavioral health programs. The original fiscal note estimated an annual cost of $34.2 million General Fund. However, the benefit has been under-

utilized and the Department has submitted budget reduction requests and downward forecast revisions related to implementation.

The Department's FY 2024-25 behavioral health request included increased resources to cover IMD stays, partial hospitalization, and permanent supportive housing. The associated General Fund cost in FY 2025-26 is $2.1 million General Fund. Of that amount, approximately 82.4 percent is attributed to IMD stays.

IMD is a federal designation for facilities with 16 or more beds that are primarily engaged in providing treatment for individuals with mental health or substance use diagnoses, referred to as "Institutes of Mental Disease." Previously, the Department covered IMD stays up to 15 days. The budget request provided funding associated with a waiver to increase the allowed average length of stay of 30 days, with a maximum allowable stay of 60 days.

Issue: Prospective Payment System

This issue brief provides an overview of the newly implemented prospective payment system for comprehensive behavioral health providers designated by the Behavioral Health Administration.

Summary

- A Prospective Payment System (PPS) for comprehensive behavioral health providers designated by the BHA came into effect July 1, 2024.
- PPS is intended to provide a flexible funding methodology and serve as an incentive for providers to apply for comprehensive status with the BHA.
- Providers have expressed concern with the early stages of implementation, including lower reimbursement rates.

Recommendation

Staff recommends that the Committee discuss implementation of the Prospective Payment System for comprehensive behavioral health providers at the Department hearing.

Discussion

Senate Bill 19-222 (Individuals at Risk of Institutionalization) required the Department to create a behavioral health safety net system and establish incentives for providers to accept Medicaid clients with severe mental health disorders. The bill included a one-time appropriation of $150,000 for the Department to hire a contractor to evaluate alternative payment plans.

House Bill 22-1278 (Behavioral Health Administration) charged the Behavioral Health Administration (BHA) with creating a comprehensive behavioral health safety net rather than HCPF. The bill further required HCPF to work with the BHA to establish sustainable payment methodologies for the safety net, including but not limited to consideration of value-based payment models.

HCPF worked with the contractor from S.B. 19-222 to model rate methodologies for value-based payment models for safety net providers designated by the BHA. Value-based payments are intended to incentivize quality of care rather than quantity of service.

Prospective Payment System

Modeling resulted in the selection of a Prospective Payment System (PSS) for comprehensive providers designated by the BHA. Comprehensive providers are required to provide safety net services and may not refuse service based on insurance. Providers are able to apply with the BHA for comprehensive designation on a rolling basis, and began receiving PPS on July 1, 2024.

The Department describes PPS as a flexible reimbursement model that ties payment to daily encounters instead of individual services. A provider receives encounter payments for each patient, and payment is the same regardless of service. PPS is intended to encourage providers to deliver services effectively, and reduce overutilization of unnecessary services.

The rate paid is based on actual historic costs, so rates may be different for each individual provider. Costs may be inclusive of expenses for uninsured or underinsured clients that were traditionally uncompensated. PPS is therefore expected to be the main incentive for providers to seek the comprehensive safety net designation with the BHA.

Early Implementation Concerns

Providers have raised concerns with early implementation. Primarily, PPS is based on recent actual utilization and expenditures. Implementation began at the end of the public health emergency when disenrollments interrupted caseload and expenditure trends. Additionally, providers have expressed concern that PPS will incentivize utilization of lower cost treatment options because reimbursement is dependent on the number of patients seen rather than the type of service provided.

Stakeholders have indicated that experiences with early implementation vary by provider. Some providers have seen better rates under PPS, while some are indicating much lower rates under the new system. Because rates are based on actual expenditures, current rates driven down due to low enrollment would be expected to improve over time. However, providers express concern about their ability to maintain services under current rates. HCPF further indicates that providers should not be incentivized to utilize low-cost services because this would drive down their reimbursement rate in the long-term, and the provider would not be meeting standards of care.

Issue: Youth System of Care

This issue brief provides an overview of recent efforts to establish a system of care for youth behavioral health, including a recent settlement agreement in Colorado and the system of care developed by the state of New Jersey.

Summary

- Recent legislation has charged HCPF, the BHA, and DHS with establishing systems of care.
- HCPF entered into a settlement agreement in 2024 that requires the Department to establish a system of care for intensive youth behavioral health treatment by 2029.
- The first phase of the Department's plan to address the settlement agreement was funded through H.B. 24-1038 (High Acuity Youth). Funding has not been requested to address the next four implementation phases.
- New Jersey established a system of care after a settlement agreement resulted in almost twenty years of court monitored implementation.

Discussion

The following sections describe recent efforts to establish a system of care for youth behavioral health in Colorado. Implementation of a system of care has been estimated to cost the state $1.0 billion. Establishing a system of care has cost similar amounts in other states, and required long-term implementation and accountability.

Recent Legislation

At least three bills have recently charged the Department of Health Care Policy and Financing and the Behavioral Health Administration with creating comprehensive systems of care. A comprehensive system of care ensures necessary and timely treatment options are available to anyone in need, regardless of payer and system involvement.

S.B. 19-195 (Child and Youth Behavioral Health System) required HCPF and DHS to develop and implement a system of care for children and youth at risk of out-of-home placement no later than July 1, 2020. The bill required that HCPF seek federal authorization to provide wraparound services for Medicaid youth. The original fiscal note assumed that wraparound services would cost $9.6 million split between General and federal funds by FY 2021-22.

H.B. 22-1278 (Behavioral Health Administration) created the BHA, and charged the organization with creating a coordinated, cohesive, and effective behavioral health system in Colorado. The bill further charged the BHA to coordinate with HCPF and the Department of Public Health and Environment to establish a comprehensive safety net behavioral health system, required to include services for children, youth, and adults along a continuum of care.

H.B. 24-1038 (High Acuity Youth) required HCPF to coordinate with the BHA and DHS to establish a system of care for high acuity youth. The bill included an appropriation of $3.9

million total funds, half General Fund and half federal funds, for this purpose in FY 2024-25. The fiscal note assumes that associated costs will increase to $12.8 million total funds by FY 2026-27.

G.A. v. Bimestefer

A federal class action lawsuit was filed against HCPF on behalf of three youth plaintiffs in September 2021. The three plaintiffs were Colorado teenagers diagnosed with a mental illness who alleged harm from not receiving services. All three cycled through hospitalization due to a lack of availability of Home and Community Based Services.

A settlement agreement was reached in February 2024. The agreement requires HCPF to develop and implement a system of care that delivers intensive behavioral health services to all Medicaid members ages 0-21. The plan must be developed and submitted to the court for approval within 12 months, and implementation must be complete within five years.

Organizers of the lawsuit indicate that similar class action cases filed against other states have been successful in establishing a comprehensive system of care in Massachusetts, California, and Illinois. The organizers indicate that the goal of the lawsuit is to provide federally required treatment to youth in the community so that children are not placed in more restrictive residential placements than are medically necessary.

HCPF System of Care Plan

The Department has proposed a system of care plan in response to the settlement agreement. The plan includes 7 parts intended to be implemented in 5 phases over 5 years. The first phase was funded through H.B. 24-1038.

Part 1: Identification tool

An identification tool would be utilized by RAEs to identify families that would benefit from standardized assessment. Youth could be referred to the RAE for identification by any number of sources, including but not limited to schools, crisis telephone hotlines, emergency departments, juvenile justice, county departments, or other health care providers.

Part 2: Standardized assessment

A single standardized assessment would be utilized to inform treatment and care plans, and provide important information to all agencies involved in providing services. Assessments could be conducted by BHA assessors, community service agencies, or certified providers.

Part 3: Intensive care coordination

Intensive care coordination (ICC) requires a more rigorous approach to care coordination than provided to the general public. ICC is delivered through a high fidelity wraparound model or intensive treatment facilitation. The plan indicates that Community Service Agencies (CSAs) will serve as the care coordination point agency for multi-involved youth. CSAs are intended to serve as an access point to all agencies.

Part 4: Mobile response stabilization services

Crisis response would include in-home, mobile crisis response, and crisis stabilization units. In-home services are intended to be intensive and short-term to prevent out-of-home placement. Mobile teams are intended to provide 24/7 dispatch resources for families. Crisis stabilization units provide intensive, short-term residential beds to assist in stabilization before returning home.

Part 5: Intensive home based treatment

The plan indicates that the state plans to develop an in-home intensive treatment model through certified providers. Providers would be trained and credentialed to provide hands-on services for youth and families. Current training programs available in other states are owned by private companies. HCPF would be required to contract for these services, or develop a new system unique to Colorado.

Part 6: Support services

Support services are intended to supplement care to address the needs of the child and family in order to successfully engage in treatment. Services include respite care and therapeutic mentoring. Respite care provides temporary assistance for families with intensive needs to increase capacity for non-care related household needs. Therapeutic mentoring includes paraprofessionals partnering with youth to apply therapy techniques in real life settings.

Part 7: Behavioral services

Includes in-home treatment teams that utilize expertise of behavior specialists through e-consultation. The specialist will assist providers in applying strategies for the child's treatment plan.

Implementation timeline

Initial implementation has begun through existing legislation. Each year of the settlement is assigned a phase. Three service types have been implemented in year one, and the plan anticipates that the Department will increase to 5 services in year two, 6 services in year three, and partially implement all 7 services by year four for full implementation as required by year five. Unless the Department utilizes existing resources, only phase 1 is currently funded.

Phase 1 includes services that have been funded through legislative changes, including ARPA programs, S.B. 19-125, and H.B. 24-1038. As of the summer of 2024, the Department indicated that phase 1 includes training 100 providers for standardized assessment, training 70 providers for intensive care coordination, and contracting with venders to train 54 providers in in-home intensive treatment.

ARPA investments included $5.1 million for workforce capacity and $17.0 million for high intensity outpatient treatment capacity grants. Senate Bill 19-125 included $9.3 million for high fidelity wraparound services. House Bill 24-1038 included resources for standardized assessment, intensive care coordination, CHRP support services, and treatment foster care.

Outstanding concerns

At this time, it is unclear how and whether outstanding portions of the system of care plan will be funded and how much full implementation will cost. Additional costs to schools, counties, and other effected agencies is also unknown. Stakeholders have expressed additional concern about potential lack of oversight and information sharing with the General Assembly. HCPF also appears to be using a narrow definition of the affected population, while the intention was to

address system of care for all Medicaid youth. Even if fully implemented, the plan is not intended to address establishing a system of care for non-Medicaid youth.

New Jersey System of Care

The state of New Jersey is frequently cited as a national model for youth system of care. Representatives from New Jersey presented to Colorado's Child Welfare System Interim Study Committee in 2023. The presentation indicated that the number of youth in out-of-home placements decreased from 3,668 to 1,958 from 2015 to 2022.[2]

A federal class action lawsuit, Charlie and Nadine H. v. Murphy, was filed against New Jersey's child welfare system in 1999. As a result of the lawsuit, the court appointed an independent monitor to report on the state's implementation of a system of care. Monitoring ended in 2023 when the child welfare system was determined by the court to be transformed. Access to the child system of care requires families to complete a Medicaid application.[3]

The following sections describe lessons learned from the system of care established be New Jersey, frequently cited as a nationwide model for youth system of care. Budget and Legislative Policy Research Assistant Michelle Curry conducted extensive research on the system, provided in Appendix B.

Single contracted entity for statewide care navigation

New Jersey contracts with a third party to provide a single entry point for care navigation statewide. The contract includes on online platform that includes statewide provider and patient information to support care coordination. All providers contracted with the state have access to the system.

Screening and emergency assessment

Youth and families may call the care navigation entity 24/7/365. Services are not limited by insurance type or system involvement. Care navigators conduct a single intake assessment at the first point of contact to determine treatment need. The assessment may include collecting insurance information, or supporting the family in applying for Medicaid. Response can include immediate dispatch of mobile crisis resources, connection to a care management organization, or connection to a family service organization.

Regional Care Management Organizations

Care management organizations (CMOs) are county based nonprofits that provide regionally specific care management for youth and families with complex needs. There are 16 CMOs to

[2] https://leg.colorado.gov/sites/default/files/images/presentation_from_the_new_jersey_department_of_children_and_families.pdf

[3] https://www.performcarenj.org/families/eligibility.aspx

align with New Jersey's 16 counties. The New Jersey Medicaid and Human Services departments are under the same entity. CMOs are therefore similar to RAEs and BHASOs, but serve all youth regardless of insurer.

CMOs are funded through contracts with the state, and sub-contract for services with providers. Providers must be certified with the state, and are required to be Medicaid providers.

Family Support Organizations

Family Support Organizations are also county specific non-profits who provide peer support to families. In addition to providing care management and mentorship support to families, FSOs may work with government agencies and providers on behalf of families to organize for care or advocate for the family's needs.

Conclusion

Some components of New Jersey's system of care overlap with recent efforts to improve care coordination and access to services in Colorado. However, funding for the Department's settlement plan remains unknown, and access to care remains fragmented based on Medicaid access.

Footnotes and Requests for Information

This section of the Long Bill did not have any footnotes in FY 2024-25.

Update on Requests for Information

The Joint Budget Committee annually submits requests for information (RFIs) to executive departments and the judicial branch via letters to the Governor, other elected officials, and the Chief Justice. Each request is associated with one or more specific Long Bill line item(s), and the requests have been prioritized by the Joint Budget Committee as required by Section 2-3-203 (3), C.R.S. Copies of these letters are included as an Appendix in the annual Appropriations Report (Appendix H in the FY 2024-25 Report):
https://leg.colorado.gov/sites/default/files/fy24-25apprept.pdf

The RFIs relevant to this document are listed below.

Department of Health Care Policy and Financing

2 Department of Health Care Policy and Financing, Behavioral Health Community Programs -- The Department is requested to submit a report by November 1, 2024, discussing member utilization of capitated behavioral health services in FY 2022-23 and the Regional Accountable Entity's (RAE's) performance on network provider expansion, timeliness of processing provider claims within contract requirements, and timeliness of credentialing and contracting network providers. The report should include aggregated data on the number of members accessing inpatient and residential mental health treatment, inpatient and residential substance use disorder treatment, outpatient mental health and substance use disorder services, and alternative services allowed under the Department's waiver with the Centers for Medicare and Medicaid Services. For Calendar Year 2023, the Department shall report aggregated provider data by quarter showing changes in the number of providers contracted, monthly claims processing timeframes by each RAE, and timeliness of provider credentialing and contracting by each RAE. Also, please discuss differences in the performance of the RAEs, how the Department monitors these performance measures, and any actions the Department has taken to improve RAE performance and client behavioral health outcomes.

Comment: The report indicates that 303,546 members, or 19.4 percent of total Medicaid clients, utilized capitated behavioral health services in FY 2022-23. Of those who accessed services, 66.1 percent were for a primary mental health diagnosis, and 15.8 percent were for a primary substance use diagnosis. Mental health utilizers were 99.8 percent outpatient, while SUD was 88.0 percent outpatient.

Out of overall capitated utilization, 30.2 percent was at community mental health centers. A total of 38.5 percent of mental health services and 18.1 percent of substance use services were at CMHCs.

HCPF requires that RAEs pay 90.0 percent of all clean claims within 30 of receipt in compliance with federal regulations, and 99.0 percent of clean claims within 90 days. The report indicates that all RAEs met this standard in calendar year 2023.

5 Department of Health Care Policy and Financing, Behavioral Health Community Programs – The Department is requested to submit a report by January 2, 2025 regarding the implementation of the FY 2023-24 mid-year capitated payment increase in response to the end of the public health emergency. The report should include how the increase was spent by managed care entities and how funds were utilized to support providers and clinical services in a manner that is compliant with federal regulations.

Comment: The Department response is due to the Committee in January.

Department Annual Performance Report

Pursuant to Section 2-7-205 (1)(b), C.R.S., the Department of Health Care Policy and Financing is required to publish an **Annual Performance Report** for the *previous state fiscal year* 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 the designated fiscal year. In addition, pursuant to Section 2-7-204 (3)(a)(I), C.R.S., the Department is required to develop a **Performance Plan** and submit the plan for the *current fiscal year* 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 Department's FY 2025-26 budget request, the FY 2023-24 Annual Performance Report and the FY 2024-25 Performance Plan can be found at the following link:

https://www.colorado.gov/pacific/performancemanagement/department-performance-plans

Appendix A: Numbers Pages

Appendix A details actual expenditures for the last two state fiscal years, the appropriation for the current fiscal year, and the requested appropriation for next fiscal year. This information is listed by line item and fund source.

Appendix A: Numbers Pages

	FY 2022-23 Actual	FY 2023-24 Actual	FY 2024-25 Appropriation	FY 2025-26 Request	Request vs. Appropriation
Department of Health Care Policy and Financing **Kim Bimestefer, Executive Director**					
(3) Behavioral Health Community Programs Healthcare Affordability and Sustainability Cash Fund.					
Behavioral Health Capitation Payments	1,073,070,076	1,028,527,782	1,028,600,571	1,297,927,993	
General Fund	215,820,743	257,694,490	273,047,567	328,102,845	
Cash Funds	92,271,268	75,710,138	78,964,399	99,127,714	
Reappropriated Funds	0	0	0	0	
Federal Funds	764,978,065	695,123,154	676,588,605	870,697,434	
Behavioral Health Fee-for-service Payments	8,929,133	10,956,804	11,669,132	11,191,526	
General Fund	1,692,019	2,563,728	2,800,119	2,689,095	
Cash Funds	558,233	665,268	692,425	663,898	
Reappropriated Funds	0	0	0	0	
Federal Funds	6,678,881	7,727,808	8,176,588	7,838,533	
TOTAL - (3) Behavioral Health Community Programs	1,081,999,209	1,039,484,586	1,040,269,703	1,309,119,519	25.8%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	217,512,762	260,258,218	275,847,686	330,791,940	19.9%
Cash Funds	92,829,501	76,375,406	79,656,824	99,791,612	25.3%
Reappropriated Funds	0	0	0	0	0.0%
Federal Funds	771,656,946	702,850,962	684,765,193	878,535,967	28.3%

Appendix A: Numbers Pages

	FY 2022-23 Actual	FY 2023-24 Actual	FY 2024-25 Appropriation	FY 2025-26 Request	Request vs. Appropriation
TOTAL - Department of Health Care Policy and Financing	1,081,999,209	1,039,484,586	1,040,269,703	1,309,119,519	25.8%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	217,512,762	260,258,218	275,847,686	330,791,940	19.9%
Cash Funds	92,829,501	76,375,406	79,656,824	99,791,612	25.3%
Reappropriated Funds	0	0	0	0	0.0%
Federal Funds	771,656,946	702,850,962	684,765,193	878,535,967	28.3%

Appendix B: Youth System of Care

The attached memo was prepared by Legislative Budget and Policy Research Assistant Michelle Curry to describe the elements of the Children's System of Care in New Jersey.

MEMORANDUM

JOINT BUDGET COMMITTEE

To	Emily Pope
From	Michelle Curry, JBC Staff Assistant
Date	December 4, 2024
Subject	New Jersey Children's System of Care Overview

New Jersey's Children's System of Care was created in 2006 as part of a two-decades long court settlement. The system supports youth under the age of 21 with emotional and mental health care needs, substance use challenges, and/or intellectual/developmental disabilities and their families. A division of New Jersey's Department of Children and Families, which is housed within the Department of Human Services, CSOC prioritizes keeping children in their homes and providing culturally competent support to families. The Division could act as a model system for Colorado's Behavioral Health Agency.

Summary of Impactful Components

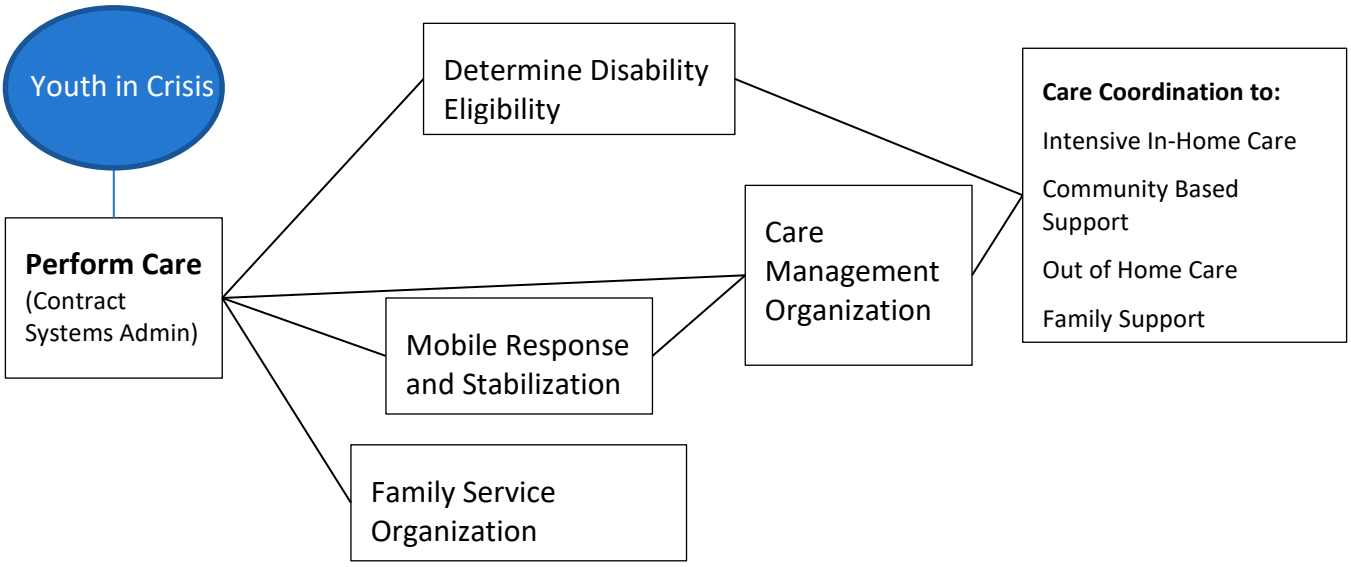
- The Children's System of Care was developed over nearly two decades under strict observation by a court appointed independent agency per the Modified Settlement Agreement. This included semi-annual reports detailing goals and progress made by the State. The extensive reporting process ended in 2023 when the child welfare system had been deemed "transformed"[1].
- New Jersey's single State Medicaid Authority – the Division of Medical Assistance and Health Service (DMAHS)- is housed within the Department of Human Services alongside the Department of Children and Families, which houses the NJ Children's System of Care. DMAHS manages funding for all youth behavioral health services including distributing funds to Care Management Organizations which administer contracts with providers by pooling behaviors health funds from Medicaid, Waivers, and state appropriations.
- Care Management Organizations (equivalent to BHASOs) are aligned with counties and judicial districts to streamline services for children involved across systems.
- New Jersey contracts out initial care navigation services to Perform Care, which provides the "single door" point of contact and maintains patient records across service providers.
- The primary goals of CSOC are family satisfaction and home stability for youth. These outcomes have proven outstanding via supporting the DHS workforce, supporting family

[1] Court appointed monitoring was conducted by the Center for the study of Social Policy. All reports can be found online at https://cssp.org/our-work/projects/our-projects/class-action-litigation-new-jerseys-department-of-children-and-families/ and https://cssp.org/resource/charlie-and-nadine-h-report-on-progress-april-25-october-25-2023/

connections, reduced interactions with child protective services, and reducing the need for foster care[2].

Notable Components of Children's System of Care

The standard operating procedure used by CSOC is streamlined according to the following flowchart. The role of each component is detailed below.



Contracted Systems Administrator

New Jersey has streamlined services for children and families by creating a "single-door" entry system. Since the inception of the Division, the state has contracted with PerformCare to provide this service. The initial point of contact for PerformCare is a website housing resources for families, youth, and providers. The web platform includes a comprehensive directory for providers and services; educational resources; and a data portal that allows for care coordination by housing patient information across care providers. All providers contracted with CSOC have access to their patient's information, which also incorporates information for schools and the juvenile justice system.

In addition to the online platform, Perform Care allows any family member, school personnel, or police officer to request support via phone call 24 hr, 365 days a year. When called, trained

[2] The full exit report delineates all measured and accomplished indicators.

customer service agents (care navigators) determine the level of need and either answer specific questions, connect the family with the appropriate Care Management Organization, or dispatch the Children's Mobile Response and Stability Services (CMRSS). Depending on the need, initial calls can take up to 40 minutes. During this time, Perform Care collects information about the child's insurance provider or supports the family to begin the process of applying for Medicaid.

Care Management Organizations

Care Management Organizations are community-based organizations charged with "advocacy, service planning and delivery, and care coordination into a single, integrated, cross-system process that assesses, designs, implements, and manages child-centered and family-focused individual service plans for children, youth, and young adults whose needs are complex."[3] Although encompassing a broader scope, these organizations are comparable to the intentions of Colorado's BHASOs. Unlike Colorado, New Jersey's CSOC houses all children with complex needs, both Medicaid eligible and not, whose needs are not already being met by a different waiver program (i.e. medically needy program; traumatic brain injury waiver program, etc.), so all providers are required to be both approved by the Department and enrolled as a Medicaid provider. Additionally, CMOs are county based in order to align with judicial districts to streamline comprehensive support across institutional needs.

At a base level, CMOs are charged with creating an individualized, interim plan for stabilization followed by a more comprehensive service plan based on an initial comprehensive assessment. CMO contracts provide the organization with flexible funding to support the administration of services when other funding (i.e. Medicaid) is unavailable. In practice, CMOs act as community based care coordinators charged with assessment and family advocacy with a focus on equity. One requirement of accessing CMO services is that the family completes an application for NJ Family Care to determine Medicaid/CHIP eligibility.

In addition to providing care coordination, CMOs are responsible for financial management and monitoring for providers. Statute mandates that payment to providers is based on individualized service plans that can vary widely based on need and includes funding from both Medicaid and a flexible funding pool, which is administered with continuous authority for the Department[4].

[3] §N.J.A.C. 10:73-3.2

[4] § N.J.A.C. 10:73-3.19

Mobile Response and Stabilization

The Children's Mobile Response and Stabilization Service (MRSS) can be dispatched by PerformCare based on acuity and severity of a caller's immediate need. Behavioral health workers can be dispatched to any convenient location within 1 hour or at a scheduled time within 24 hours of a call. Units include care coordinators who (1) collect insurance/Medicaid information or support with application process; (2) conduct initial crisis assessment; (3) provide intensive support for 72 hours or up to 8-weeks with the goal of de-escalation and stabilization; (4) initiate connection to CMO for further services. MRSS is available to all families and children in crisis regardless of involvement with any other state agency.

Family Support Organizations

Family Support Organizations (FSOs) are a family-run, community-based non-profits who assist families in navigating access to CSOC. They work collaboratively with various agencies related to youth services in order to provide peer support for parents and guardians struggling to help their children. In addition to providing help to families, FSOs interact at a policy and systems level with government agencies in order to provide feedback from the perspective of the family. These organizations are intentionally led and staffed by caregivers in order to operate from a lens of lived experience. FSOs are certified for contract funding based on a series of trainings provided by Rutgers University and the NJ alliance of Family Support Organizations. Additionally, the certification requires FSO staff to meet specific criteria including trauma informed practices[5] and certification by Nurtured Hearts Approach[6]. Although the approach is not evidence based, CSOC's Collaborative Quality Improvement assessment identified that 95.2 percent of families connected to an FSO are satisfied with their services and 94.3 percent report being better able to manage their youth's services and support. Supports provided by FSO's vary but may include family support groups, assignment of a trained family support partner, and/or Youth Partnership activities to support leadership development.

[5] Trauma Informed Care is theory informed but lacks sufficient evidence to be considered evidence based according to the What Works for Health Clearinghouse. https://www.countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/trauma-informed-health-care

[6] Nurtured Hearts Approach is a theory informed practice aimed at supporting parents to support their children with behavioral health diagnoses. It is in the process of deeper evaluation: Ahmann, Elizabeth. "Encouraging Positive Behavior in 'Challenging' Children: The Nurtured Heart Approach." *Pediatric Nursing* 40, no. 1 (2014): 38-42.

Collaborative Quality Improvement (CoQI)

As part of their exit plan, the New Jersey Department of Children and Families was required to establish a comprehensive review system to monitor the quality of care practices. This comprehensive report compiles data from various sources to produce a holistic, annual review of goals and outcomes to inform "Rapid and Annual Improvement Planning Cycles," each of which is focused on continuous, data-informed improvement. This holistic review encompasses data from case record reviews; interviews with youth and families served by the Department; supervisor observations; and key indicators from NJ SPIRIT – the New Jersey Statewide Protective Investigation and Information Tool, which integrates data for caseworkers across the state. Additional data on care quality is collected via collaboration with Rutgers University School of Social Work, which conducts surveys with families involved in CSOC. Additionally, statute requires CMOs to develop Quality Assessment and Performance (QAPI) Plans[7].

Revenue Streams for CSOC and Providers

State Appropriations to Children's Systems of Care

Within New Jersey's Annual Appropriations for FY 2023-24, the CSOC was appropriated $1,919,000 for direct state services, which has remained consistent since FY 2012 when the division was established. CSOC was also appropriated an additional $454,634,000 for Grants-in-Aid. This grant funding is distributed as follows:

02	Care Management Organizations	(101,194,000)
02	Out-of-Home Treatment Services	(160,017,000)
02	Family Support Services	(33,417,000)
02	Mobile Response	(37,398,000)
02	Intensive In-Home Behavioral Assistance .	(85,985,000)
02	Youth Incentive Program	(1,384,000)
02	Outpatient	(10,689,000)
02	Contracted Systems Administrator	(11,519,000)
02	State Children's Health Insurance Program - Care Management Organizations	(2,691,000)
02	State Children's Health Insurance Program	(5,229,000)

[7] § N.J.A.C. 10:73-3.21

	- Out-of-Home Treatment Services	
02	State Children's Health Insurance Program - Mobile Response	(1,245,000)
02	State Children's Health Insurance Program - In-Home Behavioral Assistance	(3,455,000)
02	Mental Health Association of Essex and Morris, Inc. - Riskin Children's Center .	(161,000)
02	Society for Prevention of Teen Suicide - Mental Health Toolkits	(250,000)

Of particular note is the $11,519,000 appropriated to paying for the contracted systems administrator (PerformCare New Jersey) and $101,194,000 for Care Management Organizations (equivalent to Colorado's BHASOs). These amounts do not include federal funding for the program, which consists of Medicaid and 1115 Waiver funding.

New Jersey's annual appropriations bill includes multiple footnote provisions stating:

> In order to permit flexibility in the handling of appropriations and ensure the timely payment of claims to providers of medical services, amounts may be transferred among accounts in the Children's System of Care program classification. Amounts may also be transferred to and from various items of appropriation within the General Medical Services program classification of the Division of Medical Assistance and Health Services in the Department of Human Services and the Children's System of Care Services program classification in the Department of Children and Families. All such transfers are subject to the approval of the Director of the Division of Budget and Accounting. Notice thereof shall be provided to the Legislative Budget and Finance Officer on the effective date of the approved transfer[8].

This is true for all state level appropriations associated with CSOC, allowing for Department directed appropriation changes that streamline compensation for providers across services.

Federal Revenue Streams

The majority of funding for CSOC services comes from Medicaid and comprehensive waivers. As such, a major step in the care navigation process is requiring uninsured and underinsured families to apply for New Jersey Family Care (NJFC), the branded title of New Jersey's Medicaid/CHIP program. In addition to Medicaid, CSOC has two components under their 1115 comprehensive waiver: The Children's Support Services Program for youth with severe

[8] §P.L. 2023, Chapter 74

emotional disturbance (SED) and the Children's Support Services Program for Youth with Intellectual and Developmental Disabilities (I/DD).

Compensating Providers

Compensation to providers is based on contracts administered by CMOs and informed by services rendered based on individualized plans. Youth who receive services outside of Medicaid eligibility and waiver programs are funded via a state fund. Once they are connected to CMO or MRSS services, their eligibility coordinator will submit an application in CSOC's electronic record system (CYBER) to allow for authorizations and provider claiming. The application creates a 3560, which is a Medicaid "look-alike" number that allows for record keeping that is aligned with Medicaid eligible youth, but does *not* receive any federal funding. Provider compensation for these youth come from the flexible state funding pool administered by the Department and CMOs.