Department of Human Services

FY 2025-26 Joint Budget Committee Hearing

Part 2: Economic Security, Civil and Forensic Mental Health, Behavioral Health Administration

Thursday, December 19, 2024

1:30-1:35 Introduction

Main Presenters:

- Michelle Barnes, Executive Director, Department of Human Services

1:35-2:45 Office of Economic Security

Main Presenters:

- Shelley Banker, Director of the Office of Economic Security

Topics:

- Colorado Works (TANF): Pages 1-10, Questions 1-13 in the packet, Slides 6-10
- SNAP Corrective Action Plan: Page 11, Question 14 in the packet, Slide 12
- County Administration (R1): Page 11, Question 15 in the packet, Slides 13, 15
- Community Food Assistance Provider Grant Program (H.B. 24-1407): Page 12, Question 16 in the packet, Slide 16
- Budget Reductions (CO Diaper Distribution Program): Pages 12-15, Questions 17-21 in the packet, Slide 16

2:45-3:30 Office of Civil and Forensic Mental Health

Main Presenters:

- Leora Joseph, Director of the Office of Civil and Forensic Mental Health

Topics:

- ARPA Program Expenditures and Common Questions: Pages 15-16, Question 22, Slide 23; Pages 18-21, Questions 26-28, in the packet, Slides 25-26, 32; Pages 22-25, Question 32, Slides 31-32
- Competency Capacity: Pages 16-18, Questions 23-25, Slides 23-24, 29; Pages 21-22, Questions 29-31 in the packet, Slides 28-29, 34

3:30-5:00 Behavioral Health Administration

Main Presenters:

- Dannette R. Smith, BHA Commissioner

Topics:

- Administration: Page 1-2, Questions 1-2 in the packet, Slide 6
- BHASO Implementation and Coordination with HCPF: Page 2-12, Questions 3-9 in the packet, Slides 7-11
- Prioritized Requests: Page 12-26, Questions 10-18 in the packet, Slides 12-20
- ARPA Program Expenditures and Common Questions: Page 26-34, Questions 19-25 in the packet, Slides 21-22
- Recently Created Programs: Page 34-36, Question 26 in the packet, Slide 22

Department of Human Services

FY 2025-26 Joint Budget Committee Hearing

Part 2: Thursday, December 19, 2024; 1:30-5:00 PM

OFFICE OF ECONOMIC SECURITY

1. ***Colorado Works (TANF) -*** *Rep. Sirota:* How will Colorado be impacted by the new federal TANF rules (i.e., RIN 0970-AC97 and RIN 0970-AD04) that will likely be finalized at some point in the near future? **(slide 6)**

   The two proposed rules would affect TANF programming in Colorado, as follows:

   RIN 0970-AC97: The Notice of Proposed Rulemaking (NPRM) "Strengthening Temporary Assistance for Needy Families as a Safety Net and Work Program" would make several substantive changes to how states operate TANF programs. Overall, this rule could limit state flexibility to fund programs and initiatives focused on poverty prevention. However, states are still awaiting implementation guidance from the Administration for Children and Families (ACF), as this rule has not been finalized.

   - A key change anticipated from this NPRM will reduce the number of low-income families served with TANF funding by reducing income eligibility to 200 percent Federal Poverty Level (FPL). In Colorado, eligibility for BCA entails income below 30 percent FPL. However, households with children and annual income below $75,000 are eligible for TANF funded services in Colorado.
   - The rule would also require increased accountability and transparency in spending. Implementing this rule may require changes to how the Colorado counties report spending.
   - The proposed rule may also limit a state's ability to transfer TANF funds to cover expenditures for non-TANF programming.

   RIN 0970-AD04: The Fiscal Responsibility Act (FRA) passed in 2023; it includes four new provisions regarding the TANF program. These four provisions will become effective on different timelines; they will all be finalized by 2026. Only one of the four provisions makes a significant change in program implementation and reporting, which will likely have a low to moderate impact on Colorado's TANF program. As such, Outcomes Based Reporting (Provision 3) will require states to report Work Participation Rate (WPR) along with new measures that align with the Workforce Innovation and Opportunity Act

(WIOA): a) Employment Rate after 2nd Quarter After Exit (aligned exactly with WIOA); and b) Employment Rate after 2nd and 4th Quarter After Exit. Implementing this new measure will require Colorado to begin collecting data and reporting on these measures for TANF clients. Data sharing agreements have been initiated with the Colorado Department of Labor and Employment (CDLE) in order to report this information.

2. ***Colorado Works (TANF) -*** *Sen. Kirkmeyer:* What is the long-term (5-7 years) financial status of the Colorado Long-term Works Reserve? What are the current expenditure obligation affecting the Colorado Long-term Works Reserve? **(slide 6)**

   Table 1 presents the Department's projection of available federal TANF funds in the Long-term Works Reserve (LTR), over the statutorily required $33.9 million floor, over the next seven years. The decrease in the LTR balance could be accelerated if statewide county reserves reach their floor before the State reserve hits its floor, requiring additional State TANF funds to implement H.B. 22-1259 or if the General Assembly approves additional TANF appropriations or transfers.

   Table 1: Colorado Works LTR Balance

State Fiscal Year	LTR Balance (above $33.9 million floor)
FY 2024-25	$48,995,627
FY 2025-26	$38,583,485
FY 2026-27	$32,210,242
FY 2027-28	$25,724,752
FY 2028-29	$19,124,134
FY 2029-30	$14,405,434
FY 2030-31	$9,556,621

   Per Section 26-2-721, C.R.S., the TANF Long-term Works Reserve (LTR) consists of unappropriated Temporary Assistance for Needy Families (TANF) block grant funds, State General Fund appropriated to it, and money transferred from several other identified sections of TANF statute (that all consist of unexpended federal TANF appropriations managed by the Department). The federal funds available in the LTR are a line of credit with the federal government that are available to the State to appropriate for

TANF-eligible services. Because the available TANF funds are simply spending authority per current and past TANF block grants and Contingency Fund awards, all expenses are paid from all the available funds, using the oldest funds first.

In 2022, a parallel LTR cash fund was created as a place to transfer the ARPA funds that were appropriated per H.B. 22-1259. The available ARPA funds were depleted by November 2024. Additionally, the $2 million General Fund appropriation that was not spent given the availability of ARPA funds to cover all H.B. 22-1259 costs was transferred to that cash fund at the end of FY 2023-24. That fund can only be used to pay for increased BCA costs per H.B. 22-1259 and is not anticipated to be used this year.

3. ***Colorado Works (TANF) -*** *Sen. Kirkmeyer:* Please detail TANF expenditures that are driven by state-only policies and state policies that exceed federal requirements. **(slide 7)**

   The overall federal purpose of TANF is to increase flexibility for states to meet four federal statutory goals: 1) provide assistance to needy families so that children may remain in their homes; 2) end the dependence of needy parents on government benefits through work, job preparation, and marriage; 3) reduce out-of-wedlock pregnancies; and 4) promote the formation and maintenance of two-parent families. Within these broad guiding principles, states have considerable flexibility to use TANF funds for programs and services that best meet their distinct needs. Virtually all policies and programs using TANF in Colorado are driven by state policy; all comply with federal requirements.

   In FY 2024-25, 80.4 percent of Colorado's TANF appropriations are allocations to counties per the County Block Grant; 9.4 percent of the appropriations are for State administration/operation [including State staff, CBMS, Common Policies, evaluation, Electronic Benefits Transfer (EBT), and training]. The remaining 10.2 percent of the appropriations are for additional legislative action for initiatives to prevent poverty that are appropriated from the TANF block grant in FY 2024-25 and managed at the State level. All of this spending meets federal guidelines to serve TANF-eligible households within the four purposes of TANF (noted above) or allowable transfers to the Social Services Block Grant (Title XX) per legislative action. The following list presents those TANF appropriations which comprise this 10.2 percent in FY 2024-25:

   - TANF transfers to Child Welfare = $8.3 million
     - Foster Transportation (H.B. 18-1306) = $2.8 million
     - Kinship Foster Care Homes (S.B. 24-008) = $5.5 million
   - Domestic Abuse Program = $0.63 million
   - Stable Housing for Survivors of Abuse = $2 million

- Subsidized Employment and Training Program (CW STEP) = $2 million
- Child Support Services Employment Program = $1.1 million
- Refugee Assistance = $2.8 million

4. ***Colorado Works (TANF) -*** *Sen. Kirkmeyer:* With regard to H.B. 24-1431 (Stable Housing for Survivors of Abuse Program), does this program qualify for Proposition KK funding? **(slide 7)**

   The Department's Stable Housing for Survivors of Abuse Program would not qualify for Proposition KK funds. A coalition led by Colorado Coalition Against Sexual Assault (CCASA), Violence Free Colorado (VFC), Colorado Organization for Victim Assistance (COVA), and the Colorado Children's Alliance coordinated legislative and campaign efforts regarding Proposition KK on behalf of the domestic and sexual violence services community. The coalition communicated to the CDHS' domestic violence programs that these funds were primarily intended to offset federal Victims of Crimes Act (VOCA) reductions. Thus, the Office of Victim's programs at the Division of Criminal Justice, Department of Public Safety will administer a $30 million portion of the resulting funds from the new taxes.

5. ***Colorado Works (TANF) -*** *Rep. Sirota:* What is driving increases in TANF spending for some counties? **(slide 8)**

   Several factors are contributing to the recent increases in TANF expenditures in some counties:

   - Administrative costs: County administrative costs are the largest driver of increased spending, increasing 29.5 percent from FY 2019-20 to FY 2023-24. Based on anecdotal data reported from counties [received through the Work Allocation Committee (WAC) and the WAC Finance Workgroup], this increase is primarily due to higher staff salaries to retain employees, rising insurance premiums, and other operating expenses.
     - Additionally, counties have reported a significant spike in TANF applications, especially among applicants from individuals without children, who are ineligible. Processing this increased volume of applications carries an administrative cost for counties, as all applications need to be processed. Between FY 2021-22 to FY 2023-24, total ineligible applications increased by 19.3 percent. In FY 2023-24, 20.6 percent of TANF application denials were due to the applicant not having a child. To reduce the number of inappropriate applications for the TANF program from individuals without children, the Department implemented three CBMS projects in October 2024 to help mitigate applications from

ineligible households, specifically applications with no dependents. Preliminary data shows an overall reduced volume of applications as well as an 8 percent decrease in the number of applications denied due to no child in the home, suggesting the improvements made to the application are providing better clarity on the eligibility requirements for TANF, specifically the need to have a child in the home. State staff will continue to monitor trends and evaluate options for enhancements to reduce administrative burden for counties and clients.

- Increased Basic Cash Assistance (BCA) caseload: The BCA caseload has gradually increased from its historic low in September 2021, nearing pre-pandemic levels in FY 2023-24. As BCA caseload rises, BCA expenditures follow suit. In FY 2022-23 and FY 2023-24 ARPA funds have covered all the increased BCA expenditures per H.B. 22-1259 (Modifications To Colorado Works Program).

6. ***Colorado Works (TANF) -*** *Rep. Sirota:* Does the state have data that enables it to understand, at a state level, how Colorado is spending its TANF funds and how many and which families are being served, and how? **(slide 8)**

   The Department has access to data, through the Colorado Benefits Management System (CBMS), regarding BCA/State Diversion caseloads and details about the families served through these programs. Additionally, monthly settlement accounting reports outline total county expenditures for BCA/State Diversion, supportive services, contracts, and administration.

   As Table 2 details, FY 2023-24 county expenditures were as follows:

   - BCA/State Diversion = $87,010,588
   - Supportive Services = $21,235,064
     - e.g. transportation support; work tools; school clothing for children; domestic violence services; short-term housing; and much more
   - Administration = $45,718,682
   - Contracts = $6,219,234

   Total = $160,183,568*

   **None of these dollars were for counties to implement H.B. 22-1259; all H.B. 22-1259 costs were fully covered by ARPA through November 2024.*

   - H.B. 22-1259 Costs = $10,218,021**

   ***ARPA Funds*

Beginning in November 2024, counties' costs for implementing H.B. 22-1259 will be included in the BCA/State Diversion figures. This spending will be available to the State through the monthly Settlement reports. As such, BCA spending is anticipated to increase to cover counties' one-sixth of the expenditures for the increased BCA costs, including annual cost-of-living adjustment (COLA) increases and policy changes that a) enable households to remain on the caseload longer by allowing them to earn more income, b) avoid losing benefits for first instances of non-compliance, and c) extending benefits beyond the 60 month lifetime limit, will increase the current fiscal pressures.

However, outside of BCA costs, the State has limited data about who is being served and how. While the State has a broad understanding of spending and service delivery data, counties have full discretion on their administration, contracts, and supportive service payments, as long as they align with at least one of the four federally-defined purposes of TANF [1) provide assistance to needy families so that children may remain in their homes; 2) end the dependence of needy parents on government benefits through work, job preparation, and marriage; 3) reduce out-of-wedlock pregnancies; and 4) promote the formation and maintenance of two-parent families]. Thus, the Department does not have access to details about county spending or outcomes outside of BCA, unless State staff specifically request that counties provide that information directly and counties voluntarily comply with the request.

Table 2: County Colorado Works Spending

Colorado Works: Statewide Expenditures					
	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
BCA/State Diversion	$83,893,556	$73,836,876	$67,742,282	$77,129,556	$87,010,588
Supportive Services	$23,062,045	$23,498,917	$28,032,104	$30,768,590	$21,235,064
Administration	$35,292,725	$36,928,730	$39,248,525	$43,177,254	$45,718,682
Contracts	$6,040,158	$5,300,009	$6,329,734	$7,008,374	$6,219,234
Total Expenditures (Excluding 1259)	$148,288,484	$139,564,532	$141,352,645	$158,083,774	$160,183,567
H.B. 22-1259 Expenditures (Covered by ARPA)				$7,306,894	$10,218,021

7. ***Colorado Works (TANF) -*** *Rep. Sirota:* Does the state have transparency into the other parts of the TANF program? **(slide 8)**

   The State does not have transparency into the other parts of the TANF program because the State does not have the authority to regulate county spending. Currently, counties are only required to report financial data to the State through the County Financial Management System (CFMS) through the monthly settlement process. There are numerous object codes that roll-up into umbrella spending categories; the Department provides coding guidelines to counties to use when booking expenditures. However, these guidelines may be interpreted differently from county to county in booking expenditures in CFMS. For example, one county may book a community contract for transportation assistance to Supportive Services, while another may book a community contract for transportation to Contracts. Thus, it is difficult for the State to fully assess the efficacy of county TANF spending on supportive services, contracts, and administration.

8. ***Colorado Works (TANF) -*** *Rep. Sirota:* Can the state see how counties are spending administrative and contract dollars? **(slide 8)**

   Aggregated data on county-level spending is available in CFMS. State staff can pull reports for a county's charges to their TANF allocation; however, State staff cannot see what kinds of services are being provided through county contract expenditures or with whom they are contracting. Furthermore, the variation in accounting codes counties use to book expenditures, based on the nuanced spending, would require access to county and vendor administrative data. Once State staff received this data from counties, they would need to manually review, track, and analyze trends in these data sets for all 64 counties to build a comprehensive statewide picture. The Colorado Works' research and evaluation team is currently working on a project to explore how counties spend their funds for contracts and administration.

   a. ***Colorado Works (TANF) -*** *Rep. Sirota:* What would be needed to get that info accurately? **(slide 8)**

   Obtaining detailed, accurate information on county-level administrative and contract-spending would require the State to implement standardized reporting requirements for counties through rule change at a minimum. For instance, this could include creating uniform data submission projects in CBMS, increasing the frequency of reporting, and integrating expenditure data into a centralized data system. Another critical component to obtaining accurate information from counties would entail a

requirement for counties to evaluate and report client outcomes from contract spending. Additional staffing resources and technology enhancements would likely be needed to streamline this process and ensure consistent tracking and analysis over time. While this data would be useful for State staff to better understand expenditures and program performance, it would increase the administrative burden on county workers.

9. ***Colorado Works (TANF) -*** *Sen. Kirkmeyer:* How have the policy changes enacted by H.B. 22-1259 affected the TANF Work Participation Rates and contract support services? **(slide 9)**

   On December 4, 2024, the Department was notified by the U.S. Department of Health and Human Services, Office of Family Assistance (OFA) that Colorado had successfully met the Work Participation Rate (WPR) for federal fiscal year 2023. The policies enacted through H.B. 22-1259 will not directly affect WPR or contracted supportive services. However, as county reserves decline, counties could reduce contracts and supportive services. This could affect the WPR if counties reduce supportive services that help to remove client barriers to participating in work-related activities. Typically, clients enter the Colorado Works program in crisis and need help stabilizing their situation; these activities count towards the WPR, and are typically provided via supportive services. However, counties provide case management to all Colorado Works clients. Solid case management practices (e.g. guiding clients to the most appropriate activities, good data entry, listening to clients, and offering referrals and other resources) are also important to meeting the WPR. Even if available supportive services for clients decrease, case management practices can support both the client and the WPR.

10. ***Colorado Works (TANF) -*** *Rep. Bird:* Please describe the statutory requirements for annual increases to the TANF basic cash assistance payments. What has been the annual rate of increase in basic cash assistance payments since the enactment of H.B. 22-1259? **(slide 9)**

    House Bill 22-1259 implemented a one-time 10 percent increase to TANF Basic Cash Assistance (BCA) benefits to households, beginning in July 2022. Benefit levels did not change again until July 2024 when the first annual COLA, per H.B. 22-1259, was applied. Statute prescribes that the annual COLA shall be the average of the last three calendar years Social Security Administration (SSA) COLA or 2.0 percent, whichever is higher. In July 2024, a 5.93 percent COLA was applied. In July 2025, a 4.80 percent COLA will be applied.

    Table 3 presents the change in the TANF BCA payments, based on the average BCA award for a family of three (one parent and two children), correlating with the fiscal

analysis for H.B. 22-1259, and the rate of increase from FY 2021-22 through FY 2025-26 for this average household's monthly benefit.

Table 3: BCA Rate of Increase

State Fiscal Year	Average Monthly BCA	One-time 10 Percent BCA Increase	COLA	Total Percent Increase (over FY 2021-22)
FY 2021-22	$508	n/a	n/a	n/a
FY 2022-23	$559	$51	n/a	10%
FY 2023-24	$559	n/a	n/a	10%
FY 2024-25	$592	n/a	5.93% (+$33)	16.5%
FY 2025-26	$620	n/a	4.80% (+$28)	22%

11. ***Colorado Works (TANF)*** **-** *Sen. Kirkmeyer:* Please describe the TANF closeout process. **(slide 10)**

During the TANF closeout process, the Department's Settlement Accounting team determines final, year-end county expenditures and reserve balances. This process entails several distinct steps:

a. The closeout process begins with distributing Small County Mitigation Fund, whereby $430,000 of the available funds are allocated to small counties (i.e. receive less than $250,000 in their County Block Grant) based on their spending as well as their reserve limits.
b. Next, the Excess Reserve Distribution process is completed. Statute allows counties to maintain a reserve balance of 40 percent of the county's allocation or $100,000, whichever is greater. If a county's unused TANF funds would exceed the cap, those funds are redistributed to counties with reserve balances below the cap. These adjustments are made in the subsequent year's allocation.
c. Once the mitigation fund and excess reserve distributions are completed, Settlement Accounting completes their closeout process, including finalizing transfers, cap reversions, final spending, and reserve balances.

Since passage of H.B. 22-1259, program staff calculate the H.B. 22-1259 policy costs (sanctions, earned income disregard, and extensions) and sends this data to Settlement

Accounting to ensure that these costs, along with the 10 percent increase to BCA and the COLA, beginning in FY 2024-25, are charged to the appropriate fund sources prescribed by the bill. Thus, H.B. 22-1259 spending is closed out in a parallel process since there are multiple funding sources, only one-sixth of which is contributed by counties. Up until November 2024, all H.B. 22-1259 costs have been charged to the ARPA appropriation per H.B. 22-1259. Moving forward, two-thirds of these costs will be charged to the General Fund appropriation, one-sixth to State TANF funds, and one-sixth to County TANF funds.

12. ***Colorado Works (TANF) -*** *Sen. Kirkmeyer:* What are the county TANF reserves of each county? **(slide 10)**

    County reserve balances are included in tab C in the TANF RFI. The updated County TANF Reserve balances are included in Attachment 1[1]. Each county's reserve balances are presented in column M 'SFY 2023-24 Final Ending Balance'.

13. ***Colorado Works (TANF) -*** *Sen. Kirkmeyer:* How much of the TANF block grant was transferred for the purpose of funding child welfare (Social Security block grant) and child care (Child Care Development block grant)? **(slide 10)**

    As presented in Attachment 1, counties transferred a total of $259,118 to the Social Services Development Fund (Title XX) for Child Welfare close-out (column I) in FY 2023-24. Counties transferred $0 to the Child Care Development Fund (CCDF) (column H) and $973,114 for child care quality initiatives (column G). Additionally, the State spent nearly $2.8 million of the TANF funds transferred to Title XX for Foster Care Transportation per H.B. 18-1306 (Improving Educational Stability For Foster Youth) in FY 2023-24. These transfers meet an allowable federal provision for states to transfer up to 30 percent of their annual TANF Block Grant to CCDF and up to 10 percent of the allowable 30 percent transfer authority to Title XX. When dollars are transferred in this way, they lose their 'color of money' for TANF and become a Title XX or CCDF dollar when spent.

[1] https://drive.google.com/file/d/1IMJJ8gvIlhMRvlUkWF52Bj7GiMMJyT01/view

14. ***SNAP Corrective Action Plan -*** *Sen. Kirkmeyer:* Counties have reported part of the difficulty with addressing SNAP application processing timeliness is that the applications for SNAP and Medicaid are combined, requiring additional time processing both set of applications. What actions is the Department taking to address this situation and streamline the SNAP application process? **(slide 12)**

    The Department values ensuring that Coloradans can receive all the benefits they are eligible for in the most efficient manner. A key impact of the Affordable Care Act and the Medicaid Expansion was generally aligning eligibility for SNAP and Medicaid. Because many households are eligible for both SNAP and Medicaid, having separate applications would likely have the opposite effect on timeliness: county workers would need to process two distinct applications instead of one, increasing demands on workers' time to process multiple applications that contain similar information. Additionally, this approach would likely increase administrative costs to process the same information twice.

    Colorado's integrated application helps to ensure that Coloradans who are applying for Medicaid can also apply for SNAP and vice-versa. Additionally, the existing integrated application streamlines the collection of common eligibility criteria across programs, saving both clients and county workers time and creating a more holistic experience for clients.

15. **County Administration (R1) -** *Sen. Kirkmeyer:* For FY 2023-24, what was the total overexpenditure borne by counties for county administration of public assistance programs? What is the projected overexpenditure for FY 2024-25 and FY 2025-26? **(slide 15)**

    Following the close-out of FY 2023-24, counties collectively overspent the County Administration appropriation by nearly $19 million. Fifty percent of this spending was matched by the federal government. Within the County Administration appropriation, 20 percent is county funds, 30 percent is General Fund, and 50 percent is federal funds. Overspending, in this case, means the General Fund was depleted. Thus, counties cover 30 percent more of the total spending than their 20 percent share when the appropriation is overspent. Based on county spending in the first four months of FY 2024-25, the County Administration appropriation is on-track to be overspent by approximately $29 million of which 50 percent should receive a federal fund match. It is too soon to predict spending patterns for FY 2025-26.

16. **Community Food Assistance Provider Grant Program (H.B. 24-1407) -** *Sen. Kirkmeyer and Rep. Sirota:* Is it possible to reduce or eliminate the administrative cost of managing this program, in order to increase the amount of funding for the purchase of food supplies? Would addressing administrative costs require legislation, or are there regulatory/administrative steps the Department could implement? **(slide 16)**

    Section 26-2-145, C.R.S., allows the Department to use up to five percent of the appropriation for the direct and indirect costs of administering and monitoring the program. Accordingly, in FY 2024-25, the Department retained $150,000 of the $3 million appropriation and contracted $2.85 million to its program administrator to issue grants. The Department's administrative cost cannot be fully eliminated, but it can be reduced. These costs are anticipated to be less than $50,000 (primarily time to execute the contract, monitor the contract, accounting, and indirect costs). The Department can work closely with our accounting team to estimate these exact administrative costs and amend the vendor's contract in spring 2025 to push out more resources for food purchases.

17. ***Budget Reductions (CO Diaper Distribution Program) -*** *Rep. Bird*: Please provide and discuss the program's outcomes and impacts. **(slide 16)**

    The Diaper Distribution Program provides diapers and diapering supplies statewide to ensure that vulnerable households have access to resources to ensure their babies/toddlers are properly diapered and avoid health complications. The Department does not have specific outcomes data from its vendors. However, recent national research[2] indicates that one in two families with young children in the United States cannot afford enough diapers to keep their children dry and healthy. Additionally, this research found that one in four parents miss work or school because they cannot afford to provide requisite diapers for their children to attend childcare.

    Evidence of the demand for diapering supplies in Colorado is evident in the additional use of a one-time $500,000 investment to expand the Diaper Distribution Program via funds transferred to the Department from the Department of Law (DOL) secured through a settlement agreement with Walmart.

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[2] https://nationaldiaperbanknetwork.org/wp-content/uploads/2023/06/NDBN-Diaper-Check-2023_Executive-Summary-FINAL.pdf

18. ***Budget Reductions (CO Diaper Distribution Program) -*** *Rep. Bird*: How many diaper distribution centers receive funding and how much funding have those centers received? **(slide 16)**

The Diaper Distribution Program is currently operated by 11 contracted vendors, serving nearly 90 percent of Colorado counties. Funds are allocated based on the vendors' estimates of the number of people they expect to serve. These vendors have distributed resources to more than 50 distribution centers. Many of these distribution centers provide diapering supplies to smaller organizations in their areas (e.g. foodbanks, church pantries, shelters) to distribute. Table 4 presents the funding provided to Diaper Distribution centers across Colorado since the program was created. As noted in the table, the Diaper Distribution Program was expanded through a one-time $500,000 investment in FY 2023-24 from funds transferred from the Department of Law (DOL) secured through a settlement agreement with Walmart.

Table 4: Colorado Diaper Distribution Program

Vendor	FY 2021-22	FY 2022-23	FY 2023-24*
A Precious Child	$204,735	$346,327	GF = $276,144 DOL = $74,552
Aspen Community Health Services	$12,876	$2,676	N/A
Bent County Public Health	$5,413	N/A	N/A
Catholic Charities Marisol Family	$461,808	$289,376	GF = $283,570 DOL = $76,557
Dolores County	$21,073	$23,652	GF = $21,127 DOL = $5,704
Early Childhood Council of the San Luis Valley	N/A	$140,129	GF = $137,318 DOL = $37,073
Food Bank for Larimer County	$171,800	$62,193	GF = $60,945 DOL = $16,454
Full Circle of Lake County	$21,043	$19,118	GF = $18,735 DOL = $5,058

Vendor	FY 2021-22	FY 2022-23	FY 2023-24*
Gunnison County	$7,395	$9,661	GF = $6,955 DOL = $1,881
Hilltop Community Resources	N/A	$41,196	GF = $40,370 DOL = $10,898
Moffat County	$48,566	$12,142	N/A
Montezuma County Public Health	$56,284	$56,015	GF = $54,114 DOL = $14,859
Prowers County	$10,948	N/A	N/A
United Way of Weld County	$131,527	$115,255	GF = $112,943 DOL = $30,492
WeeCycle	$676,079	$906,612	GF = $838,849 DOL = $226,470

**$500,000 in additional funding was provided by the Colorado Department of Law (DOL) through a settlement with Walmart. Dollars were added to vendor contracts. General Fund and settlement (DOL) funds are separated for transparency.*

19. ***Budget Reductions (CO Diaper Distribution Program) -*** *Rep. Bird*: How many Coloradans have been served by the diaper distribution centers since the inception of this program, by fiscal year? **(slide 16)**

    Table 5 presents the total number of clients served since the program was created via S.B. 21-027 (Emergency Supplies For Colorado Babies And Families). As Table 5 demonstrates, the program's reach has increased steadily since the program became operational.

Table 5: Coloradans Served by Diaper Distribution Program

State Fiscal Year	Unduplicated Households Served*
FY 2021-22	18,000
FY 2022-23	70,000
FY 2023-24	80,000

**Approximations as program vendors have reported client data in different formats.*

20. ***Budget Reductions (CO Diaper Distribution Program) -*** *Sen. Amabile*: How many diaper distribution centers are stand-alone operations and how many are organizations that provide other services? Is there efficiencies to be gained by encouraging funding to be directed to multi-service organizations? **(slide 16)**

    None of the Department's vendors for the Diaper Distribution Program are stand-alone organizations. All vendors are either county agencies or non-profit entities that provide additional services. This approach enables the Department to capitalize on efficiencies by contracting with organizations with a broad footprint in serving vulnerable families who may need diapering products.

21. ***Budget Reductions (CO Diaper Distribution Program) -*** *Sen. Bridges*: What would be the impact on the programs of the JBC Staff proposed reduction? How many fewer Coloradans would the program be able to serve? **(slide 16)**

    Reducing the program budget by $1 million (50 percent of the total) will equate to about a 50 percent reduction in the number of households served. Based on the approximate unduplicated households served in the last two years, reducing the program budget by $1 million would reduce the number of households served by up to 40,000.

OFFICE OF CIVIL AND FORENSIC MENTAL HEALTH

22. ***ARPA Program Expenditures -*** *Sen. Amabile:* What new units have opened at the state hospitals in recent years, and how do these relate or not relate to H.B. 22-1303 construction projects? **(slide 23)**

Table 6: Beds Opened Since October 2022
(unit names in parentheses)

Year	Pueblo	Ft. Logan	RISE	Private Hospital Forensic Beds	MHTL	Total
2022	n/a	+22 new (F1)	n/a	+23	n/a	+45
2023	+39 reopened (RNRU)	+22 new (F2)	n/a	+10	+36*	+107

Year	Pueblo	Ft. Logan	RISE	Private Hospital Forensic Beds	MHTL	Total
2024	+41 reopened 31 adult (E2) 10 adolescent (ABTU)	n/a	+0 -18 Boulder +18 Arapahoe	+31	+32*	+104
2025	n/a	+16* new (G-Wing)	n/a	n/a	+86*	+102
Total	+80	+60	0	+64	+154**	+358

**indicates funding through H.B. 22-1303 (16 hospital + 154 MHTL = 170 total)*

***contracts are pending for 10 additional MHTL beds*

23. ***Competency Capacity*** **-** *Sen. Amabile:* Please describe current funding and need for the Restoring Individuals Safely and Effectively (RISE) program. What locations receive RISE funding and how is it used? How does the Department evaluate success and determine ongoing need for the program? Can patients served through RISE be supported through community-based programs? **(slide 23)**

    OCFMH's Jail-Based Restoration (JBR) program enables individuals to be restored to competency in a jail setting for those who have higher level charges. Inpatient restoration in a hospital is most appropriate for individuals who require an acute level of psychiatric care and the needs of these individuals often do not reach that level. For those who do not require an acute level of care and are not released on bond, the jail-based setting has proven successful for restoration.

    The RISE program and the Denver Restoration Treatment Unit (DRTU) are part of OCFMH's Jail-Based Restoration (JBR) programs. Funding for the JBR programs consists of $17,050,457 General Fund and 5.3 FTE. Arapahoe County RISE has provided competency evaluation or restoration to 1,531 Coloradans through this partnership of Wellpath Recovery Solutions, the Arapahoe County Sheriff's Office and the JBR team over the past ten years. DRTU provides 18 beds to male defendants from Denver County with any charge level and of mild to moderate psychiatric acuity. In both programs, FSDV-trained clinicians within the JBR based program review records, identify treatment needs, determine program placement, audit programs, and coordinate all admissions.

    OCFMH had an 18-bed RISE location in the Boulder County jail from 2019 until June 30, 2024. This was a collaboration between OCFMH, the Boulder County Sheriff's Office

(BCSO), and Recovery Solutions. Although this partnership served more than 232 patients over four years, the Boulder County Jail has faced a growing census and made the difficult decision to use these beds for its general inmate population rather than jail-based restoration. CDHS and Recovery Solutions arranged to increase the bed count at Arapahoe RISE by 18 to avoid net loss of beds. Remaining patients served by Boulder RISE were transferred to Arapahoe RISE at the end of May 2024.

The successes of these JBR programs include:

- 55 dismissals of cases allowing these individuals to either return to the community or be placed into civil commitment;
- 24 orders that were converted into outpatient restoration;
- Increased placement of higher acuity clients at CMHHIP;
- Average lengths of stay of 102 days at Arapahoe RISE and 72 days at DRTU; and
- Development and implementation of involuntary medication administration at Arapahoe RISE for individuals with standing court orders prior to admission. Since this initiative began, Arapahoe RISE has served nine individuals who were admitted with involuntary medication orders.

Individuals served by JBR programs are typically individuals with higher level charges and low to medium acuity. Due to the criminal charges level served by this program, most of the individuals cannot be served in the community. Additionally, evaluators determine the appropriate level of inpatient treatment placement, including placement in the JBR program, during the initial evaluation based on the client's current medication noncompliance or need for further psychiatric assessment. If the client is actively experiencing symptoms of a mental health disorder that may be interfering with their functional ability and capacity to participate meaningfully in outpatient restoration treatment, and does not pose a current safety concern that would require state hospitalization, the evaluators will recommend inpatient treatment at JBR or a private hospital bed. For these particular clients, JBR is usually the best of these options because of the client's level of charges. Additionally, evaluators will assess if the clients have been previously placed in outpatient restoration and how well the client did at managing their mental health and psychiatric symptoms in an outpatient restoration treatment setting.

However, in recent years, the JBR program has seen an increase in the number of individuals whose cases were dismissed or they were released on personal recognizance bonds and referred to outpatient restoration. Because treating individuals in the least restrictive environment necessary is the ultimate goal, providing outpatient restoration in the community is often preferable to restoration in jail or in a hospital where they may have to wait for admission. As the Department moves toward compliance with the Consent Decree, these are ongoing decisions that will need to be made regarding which inpatient programs will best serve the needs of pre-trial defendants.

24. ***Competency Capacity -*** *Sen. Bridges:* When does the Department anticipate that there will not be an inpatient competency restoration waitlist? Does the Department anticipate that the waitlist can be eliminated with existing services? **(slides 24, 29)**

    The Department anticipates compliance with Consent Decree wait times near the end of calendar year 2025 contingent upon approval of the Department's FY 2025-26 requests. While the number of people on the waitlist is a key metric for measuring progress, the Consent Decree measures the amount of time each individual is on the waitlist, not the total number of people on the waitlist. Specifically, the Colorado Revised Statutes requires Tier 1 (higher acuity) patients be admitted for inpatient restoration within seven days of a court order and Tier 2 (lower acuity) patients be admitted for inpatient restoration within 28 days of a court order. Although the Department strives to have individuals wait for as little time as possible, some wait times may be necessary to ensure the individual is admitted to a unit in the least restrictive setting possible. The Department anticipates compliance with these statutory and Consent Decree requirements within existing resources.

25. ***Competency Capacity -*** *Sen. Amabile:* What is the anticipated impact to the waitlist if funding is reduced for diversion programs currently supported with fines committee funding? **(slide 24)**

    Although the Department believes that upstream diversion is critical to reducing the burden on the competency system, it does not have data models estimating the impact of reduced funding to these diversion programs on the waitlist. It has always been the goal that these diversion programs develop sustained funding mechanisms outside of the temporary fines committee funding. These expectations are set during the application and approval process for fines funding.

26. ***ARPA Program Expenditures -*** *Sen. Amabile:* How do youth PRTF beds relate to the juvenile justice system? Are there youth awaiting competency restoration in detention that would be more appropriately served in PRTF beds? Would increasing PRTF beds be expected to have an impact on detention capacity? **(slides 25, 26)**

    Youth must meet a medical necessity standard in order to be placed in a PRTF bed. . Most youth in detention who are awaiting mitigation services do not need the level of treatment offered by a PRTF.

    Very few youth are receiving competency restoration in detention. Currently, only 5 youth are receiving restoration services in a detention facility as compared to 185 receiving outpatient competency restoration services in the community. If a youth who has been found incompetent to proceed meets the medical necessity standard for hospital psychiatric care, the youth will be admitted to CMHHIP for inpatient competency restoration services. If they do not meet medical necessity, those services can be provided directly in the youth detention facility. Outpatient competency

restoration services can be provided if the youth does not pose a safety risk or a flight risk. Youth receiving competency restoration in detention are receiving it because they have been screened into detention, and the court has not determined them to be eligible to be discharged to a community placement. They are not being held solely for the restoration service. They are being held for the alleged crime(s) and other contributing factors.

It is unlikely that increasing PRTF beds will have an impact on detention capacity because eligibility for a PRTF is based on a medical standard and so few youth meet the medical standard. Per the **Alternative to Detention Report dated July 1, 2024,** of all the youth released (FY 2022-23) from detention, 0.9 percent (26 youth) were initially placed in a PRTF.

27. ***ARPA Program Expenditures -*** *Sen. Bridges:* Please provide an update of the construction status for the youth neuro-psych facility from H.B. 22-1283, and the Fort Logan G-wing unit from H.B. 22-1303. What construction delays has the Department experienced? When does the Department anticipate that the units will be operational? What assurances does the Department have that the units will open when anticipated? **(slides 26, 32)**

    Youth Neuro-Psych Facility (H.B. 22-1283, Youth And Family Behavioral Health Care), now known as the Psychiatric Residential Treatment Facility (PRTF) at the Ft Logan campus: The first phase of design of the facility, which consists of schematic design, is complete. Abatement and demolition of the existing site are ongoing and construction is projected to start in the Fall of 2025. The Department expects that construction will be completed and the facility will begin operations in late 2026. Originally, according to the fiscal note for H.B. 22-1283, the Department received funding in FY 2022-23 for construction of the facility with staffing in place in FY 2024-25. Construction was delayed because the original design for the facility was projected to come in over budget and the design needed to be re-evaluated this summer to ensure that construction will come in within the budget. The project team has been meeting on a weekly basis to assess the budget and schedule for construction and ensure we are meeting key milestones and trending on target for a successful completion. The Department also anticipates identifying and contracting with the operator of the facility in early 2025 which will allow adequate time for the operator to occupy the building and prepare to open the facility quickly after construction is completed.

    G-Wing: The 16-bed Fort Logan G-Wing project is currently under construction and the existing space within the H-Building, identified for this program, is being demolished in order to construct the new facility. Originally, the G-Wing was scheduled to be renovated in FY 2022-23 per the fiscal note for H.B. 22-1303 with the facility fully staffed in FY 2023-24. However, the construction timeline for G-Wing was delayed because the estimate for design and construction of the facility exceeded available funding from HB 22-1303. The Department requested a supplemental in FY 2023-24 to ensure sufficient

funding for design and construction. Currently the Department is projecting that the facility can be turned over to the program for training and operations in August 2025. Like many other pending construction projects, the G-Wing project could still be affected by market slowdowns or subcontractor issues that are beyond CDHS' control. At this time, we are not anticipating any of those issues and are working diligently to support the contractor with direction and timely responses to ensure they can keep their commitments. Once construction is completed (estimated August 2025), CMHHIFL will be able to staff and operate the facility. Initially, G-Wing will admit forensic patients on the competency waitlist for restoration treatment. House Bill 22-1303 requires the Department to notify the JBC and develop and implement a plan to convert G-Wing to a civil unit when the waitlist is trending toward elimination, which will open additional beds for individuals in the community needing acute psychiatric hospitalization.

28. ***ARPA Program Expenditures -*** *Sen. Amabile:* Please describe the anticipated impact of not constructing the youth neuro-psych unit, or reducing capacity at Fort Logan or the Mental Health Transitional Living Homes. Would the state experience higher costs for serving youth out of state or in other facilities compared to the Fort Logan youth neuro-psych unit? **(slide 26)**

    Funding for the neuro-psych unit, now called Psychiatric Residential Treatment Facility (PRTF) at the Fort Logan campus, addresses a need for additional beds for youth with high acuity mental health needs within the state. Colorado continues to lack the right number and types of therapeutic options for children with highly complex medical and behavioral health needs who require psychiatric treatment services in a residential setting designed specifically for youth. The PRTF will help fill a gap in the care continuum in the state by serving very high acuity youth who cannot be supported by the currently operating PRTF's. If the unit is not constructed, the state would continue to use currently contracted PRTF beds, and these providers already have waiting lists. Across the state, there were 55 children/youth on waitlists at the end of November for all four PRTFs in Colorado. For PRTF contracted beds, that waitlist is 8. Additionally, without these new PRTF placements, youth may continue to wait in emergency rooms and hospitals unable to discharge while they await a placement in a PRTF, in state or out of state.

    If funding for the MHTL Homes were reduced by eliminating the state-run homes, the Department projects that Consent Decree compliance would be delayed from December 2025 to March 2027 at the earliest and increase the expected cost of Consent Decree fines in FY 2025-26. Availability of beds in MHTL Homes is relevant to the Consent Decree because the state hospitals can discharge adult patients restored to competency to the MHTL Homes, which frees up beds for individuals on the competency restoration waitlist. As beds in the MHTL Homes become available, the hospitals can continue discharging competency patients to these beds where appropriate.

    If funding for Fort Logan were reduced by eliminating the G-Wing, between 48 and 64 fewer adult patients would be admitted from the competency waitlist each year. This

would delay Consent Decree compliance from December 2025 until April 2026 at the earliest and also likely increase projected Consent Decree fines for FY 2025-26.

If funding for both the state-run MHTL Homes and G-Wing at Fort Logan were impacted as described, the Department would likely not be able to comply with the Consent Decree timeframes by the court-mandated deadline of December 2027. Furthermore, the Department would not be able to reduce Consent Decree fines below the $12 million cap for any of the fiscal years leading up to the deadline.

29. ***Competency Capacity -*** *Rep. Bird:* Why would the state reduce private hospital contract beds when there are still 241 individuals on the inpatient competency restoration waitlist? **(slide 28)**

    In the R-04 request, the Department is requesting a $2 million reduction to funding for competency beds at private hospitals. If this request is approved, the Department would reduce the number of competency beds at private hospitals by five. As OCFMH's beds serve an average of three to four patients per year, 15 to 20 fewer patients would be served by beds at private hospitals each year. However, the Department would still be funded to operate 64 beds in private hospitals. Overall, the Department has a total of more than 350 inpatient beds in use for competency patients across all settings and can place these patients with little to no increase in their wait times.

    As the waitlist has reduced, the Department's ability to respond to the needs of patients has increased and it has become easier to manage with beds at the state hospitals and in the Jail-Based Restoration program. As such, a small reduction in private beds is appropriate to consider particularly with the state facing difficult budgetary challenges. If approval of this request slows the Department's progress in reducing the waitlist at all, such a delay is anticipated to be minor.

30. ***Competency Capacity -*** *Sen. Amabile:* What is the impact of the proposed $2.0 million reduction for private hospital contracts? What would be the impact of utilizing these funds for civil beds upstream of the competency system? **(slide 28)**

    In the R-04 request, the Department is requesting a $2 million reduction to funding for competency beds at private hospitals. If this request is approved, the Department would reduce the number of competency beds at private hospitals by five. As OCFMH's beds serve an average of three to four patients per year, 15 to 20 fewer patients would be served by beds at private hospitals each year. However, the Department would still be funded to operate 64 beds in private hospitals. Overall, the Department has a total of more than 350 inpatient beds in use for competency patients across all settings and can place these patients with little to no increase in their wait times.

    Although OCFMH believes that increased investment in civil beds will help divert individuals upstream from the competency system, we do not have data to drive an

estimate of the impact of preventing these individuals from entering the competency system or comparing it with the impact of inpatient competency restoration in a hospital. We are seeing that other states have programs and services where individuals likely to need competency restoration are served in the civil system and are diverted before the issue of competency is raised. We are reviewing these programs to better understand how they have upstream impacts on the competency systems in those states.

31. ***Competency Capacity -*** *Rep. Sirota:* How does utilization of contract nurses compare to one year ago? Does the Department estimate that hiring and retention bonuses have decreased contract staffing? Does the Department anticipate that current state FTE can be retained without maintaining hiring and retention bonuses in FY 2025-26? **(slide 34)**

    From October 2023 to October 2024, the CMHHIP vacancy rate for nursing staff dropped from 52 percent to 45 percent. At CMHHFL during the same period, it dropped from 26 percent to 23 percent. Although the total number of contract nurses increased from 130 to 177 in that same time span, this is a slightly misleading comparison because the hospitals used contract staff to open, or reopen, beds in four units resulting in a need for more staff overall. The hospitals have also increased the average number of filled state FTE nursing positions between FY 2023-24 and FY 2024-25 year to date. In FY 2023-24, the hospitals averaged 212 FTE nurses. In FY 2024-25 year to date, the hospitals have averaged 225 FTE nurses.

    Because this year's enhanced hiring incentives have only been in place for five months, the Department does not have enough data to reach conclusions about the precise impact of the hiring and retention bonuses, especially because there are so many other factors influencing vacancy rates. Nevertheless, the Department believes they are critical to maintaining and increasing hiring and retention levels. Without these hiring incentives, the Department would be at a disadvantage when competing with the private sector.

COMMON QUESTIONS FOR DISCUSSION

32. Please describe any budget requests that replace one-time General Fund or ARPA funded programs with ongoing appropriations, including the following information:
    a. Original fund source (General Fund, ARPA, other), amount, and FTE;
    b. Original program time frame;
    c. Original authorization (budget decision, legislation, other);
    d. Requested ongoing fund source, amount, and FTE; and
    e. Requested time frame (one-time extension or ongoing). **(slides 31, 32)**

    CDHS has no budget requests that replace one-time programs. However, the Department's R-06 and R-07 budget requests for the Office of Civil and Forensic Mental Health (OCFMH) include ongoing appropriations and FTE assumed in H.B. 22-1303

(Increase Residential Behavioral Health Beds), including 16 inpatient beds in the G-Wing at the Colorado Mental Health Hospital in Fort Logan (CMHHIFL) and at least 125 residential beds in mental health residential facilities that are now called Mental Health Transitional Living (MHTL) Homes, respectively. H.B. 22-1303's fiscal note indicates that CDHS expenditures are initially paid from the Behavioral and Mental Health Cash Fund (CF), which consists of State and Local Fiscal Recovery Funds (SLFRF) from the federal American Rescue Plan Act (ARPA), and that these expenditures would be supported ongoing with General Fund in FY 2024-25.

R-06 Staffing and Funding the Fort Logan G-Wing for Patient Acuity

Table 7: CMHHIFL G-Wing Operational Appropriations

	H.B. 22-1303	FY 2024-25 appropriation	H.B. 24-1465 & 1466 SLFRF Recapture	R-06 FY 2025-26	Total
General Fund	$0	$2,778,742	$0	$6,856,155	$9,634,897
Cash Funds	$6,578,266	$0	($6,578,266)	$0	$0
FTE	59.2	15.6	(59.2)	56.9	72.5

House Bill 22-1303 appropriated $6,578,266 and 59.2 FTE from the Behavioral and Mental Health Cash Fund for FY 2022-23 with the requirement to spend or obligate these funds by December 30, 2024. Section 27-94-107(2), C.R.S., indicates that these beds could be used for persons needing competency services until the waitlist for these services is eliminated or trending toward elimination within one year. CDHS would be required to transition these beds to serve civil patients thereafter on an ongoing basis and immediately notify the JBC of this transition.

After some construction delays, the G-Wing is expected to open in the first quarter of FY 2025-26. Because of these delays, CDHS reverted the $6,578,266 in FY 2024-25 for G-Wing's operations. In order to hire and train staff in anticipation of the completion of construction and the opening of the unit, the JBC approved $2,778,742 and 15.6 FTE as a quarter-year of funding in FY 2024-25 and ongoing, with the intent to increase to a full-year level of funding in FY 2025-26. The hospital has also found that additional staff beyond what was initially planned are necessary to operate units with the additional security needs and patient acuity that come from forensic treatment.

R-06 requests $6,856,155 General Fund and 56.9 FTE in FY 2025-26 in order to staff and operate the G-Wing for a full year in FY 2025-26. For FY 2026-27 and ongoing, the amount requested in R-06 is $6,661,286 General Fund and 57.1 FTE.

R-07 Mental Health Transitional Living Home Funding Adjustment

Table 8: Mental Health Transitional Living Homes Operational Appropriations

	H.B. 22-1303	FY 2024-25 Appropria-tion	H.B. 24-1465 & 1466 SLFRF Recapture	H.B. 24-1465 & 1466 SLFRF Refinance	R-07 FY 2025-26	Total
General Fund	$0	$12,599,486	$0	$5,700,000	($12,195)	$18,287,291
Cash Fund	$39,854,179	$0	($22,299,160)	$5,485,761	$0	$5,485,761
Reappro-priated Funds	$0	$0	$0	$0	$5,207,824	$5,207,824
FTE	21.8	0.0	0.0	0.0	32.9	54.7

House Bill 22-1303 appropriated $39,854,179 and 21.8 FTE from the Behavioral and Mental Health Cash Fund for FY 2024-25 with the requirement to spend or obligate these funds by December 30, 2024. If funds are obligated by December 30, 2024, then the deadline is December 30, 2026 for spending them. House Bill 22-1303 authorizes OCFMH to use these funds for oversight costs and FTE related to MHTL Homes, costs and FTE associated with MHTL homes located in Department-owned properties, and contract beds in and renovation of MHTL Homes. $16,586,000 of this funding was appropriated in FY 2022-23 for use and renovation of contract beds while CDHS and the Department of Health Care Policy and Financing (HCPF) applied for a federal waiver to reimburse CDHS for serving Medicaid patients in these homes starting in FY 2023-24.

In FY 2024-25, CDHS recaptured and repurposed $22,299,160 of ARPA funding for programs approved by the General Assembly under H.B. 24-1465 due to construction and licensing delays and because the properties with contract beds required only minimal renovations. The General Assembly appropriated a total of $12,599,486 in FY 2024-25 for ongoing contracting, operational, and staffing costs associated with the MHTL Homes. House Bill 24-1465 & 1466 also rolled forward $11,185,761 of the original SLFRF appropriation that must be spent by December 31, 2025, consisting of $5,485,761 cash funds and $5,700,000 of SLFRF refinanced as General Fund. All of these appropriations support contract beds in MHTL Homes that are currently admitting

residents and staffing and operations of Department-owned homes expected to open in the first quarter of 2025.

R-07 requests an increase of $5,207,824 reappropriated funds, a reversion of $12,195 General Fund, and 32.9 FTE for the MHTL Homes in FY 2025-26. Although the federal government approved the waiver, H.B. 22-1303 did not provide spending authority for Medicaid funds reappropriated to CDHS by HCPF. CDHS estimates that the MHTL Homes will receive $5,207,824 in reappropriated funds from HCPF per year and R-07 provides spending authority for these funds. House Bill 22-1303 also did not provide an adequate number of FTE to staff the program, especially the Department-owned homes that require 24/7 staffing levels. OCFMH has sufficient ongoing funding in FY 2024-25 to staff the homes for about half of the fiscal year but not for a full year. R-07 enables OCFMH to staff the MHTL Homes for a full year starting in FY 2025-26. For FY 2026-27 and ongoing, R-07 requests $5,207,824 RF, a reversion of $33,098 General Fund, and 33.1 FTE for the MHTL Homes.

COLORADO
Department of Human Services

“We are the people who help people”

Fiscal Year 2025-26

Joint Budget Committee Hearing
December 19, 2024

Agenda

1:30PM - 3:30PM

- Introduction
- Office of Economic Security
- Office of Civil and Forensic Mental Health

Office of Economic Security

COLORADO
Department of Human Services

Office of Economic Security: Serving Coloradans

OES mission is to provide income, nutritional and support services to Coloradans in need. OES services include:

Income Support
$187M in FY 2023-24

Employment Support
$47M in FY 2023-24

Food & Safety
$1.43B in FY 2023-24

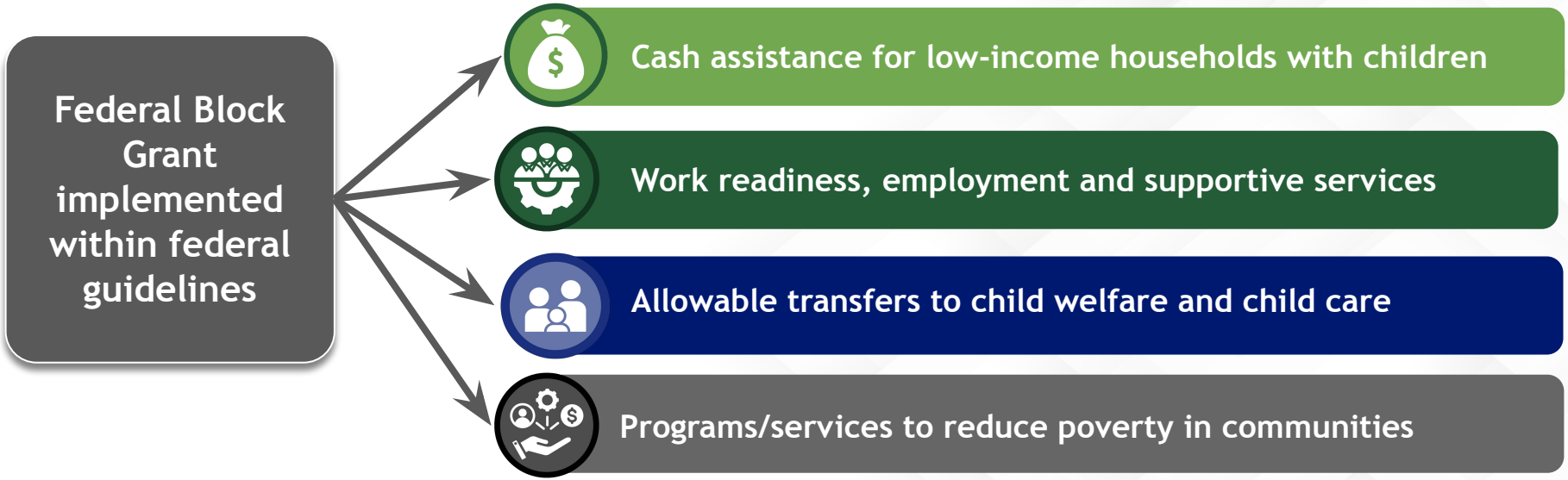
Targeted support
$52M in FY 2023-24

Office of Economic Security

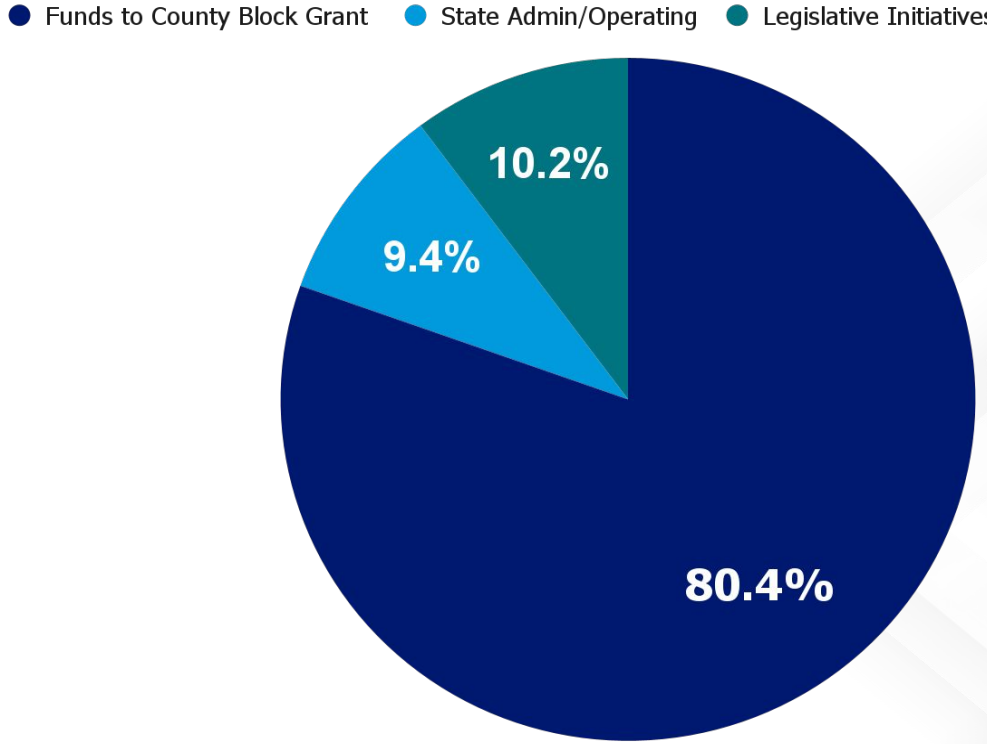
Supporting Coloradans through Income Assistance and Employment

COLORADO
Department of Human Services

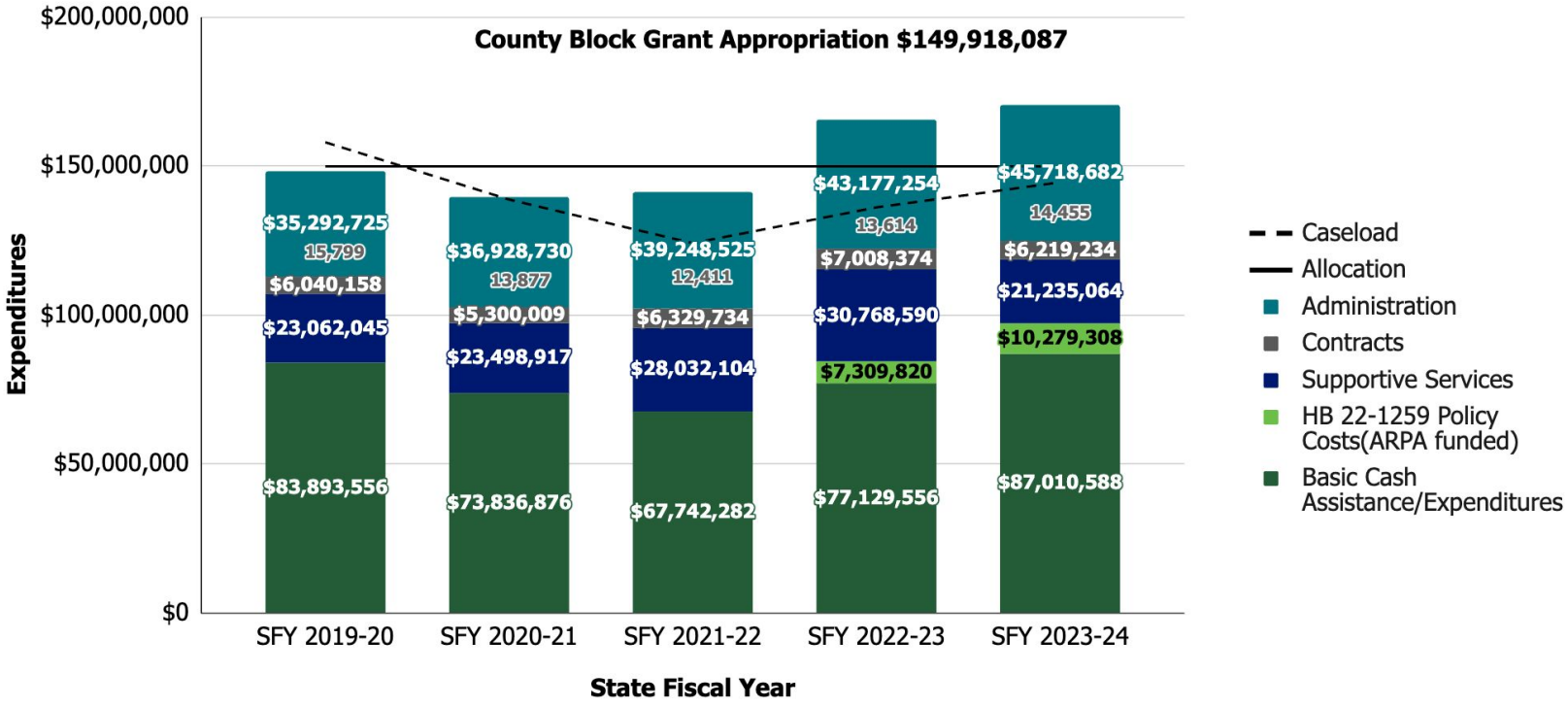
Temporary Assistance for Needy Families (TANF) (Q1, pg.1 | Q2, pg.2)



Colorado TANF Priorities (Q3, pg.3 | Q4, pg.4)



County TANF Block Grant Spending by Category FYs 2019-20 through 2023-24 (Q5-8a, pg.4-7)



HB 22-1259: Modifications to Colorado Works Program (Q9, pg.8 Q10, pg.8)

Cash Assistance

Increased BCA payments by 10% in July 2022. Annual COLA beginning July 2024.

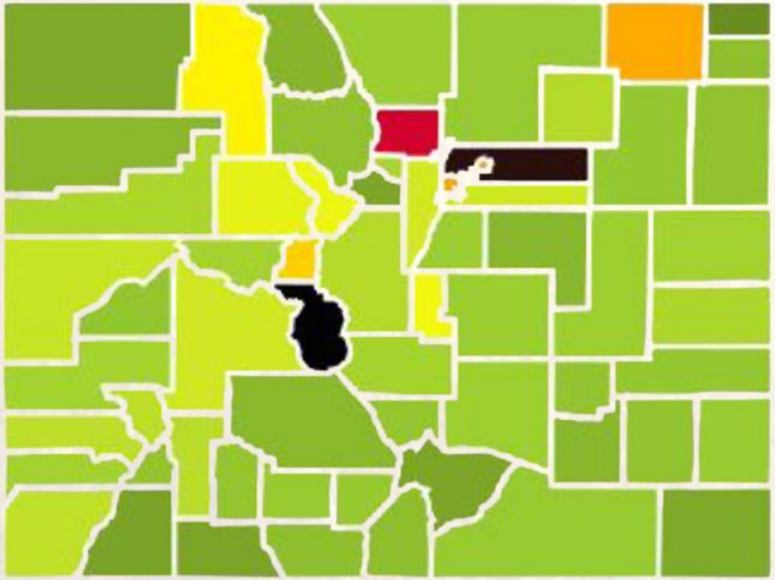
Eligibility

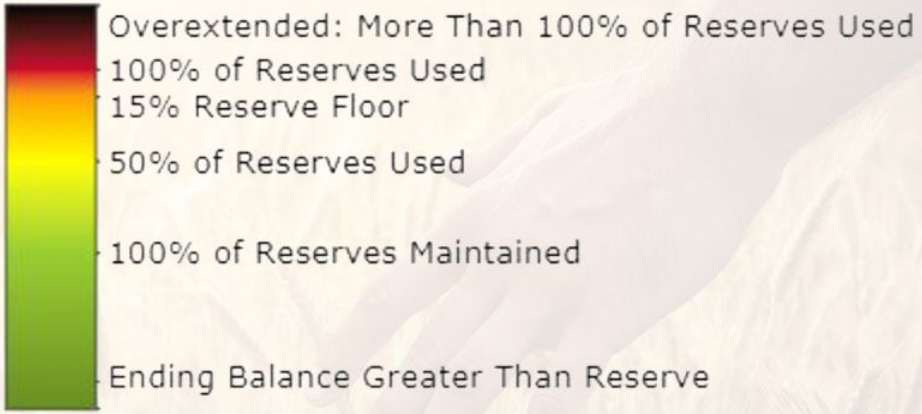
Expanded eligibility per sanctions, income disregards, extensions

Funding

Created a new GF appropriation to cover ⅔ of increased costs; County TANF cover ⅙ of costs; State TANF cover ⅙

TANF Reserves Used by County (Q11-13, pg.9-10)



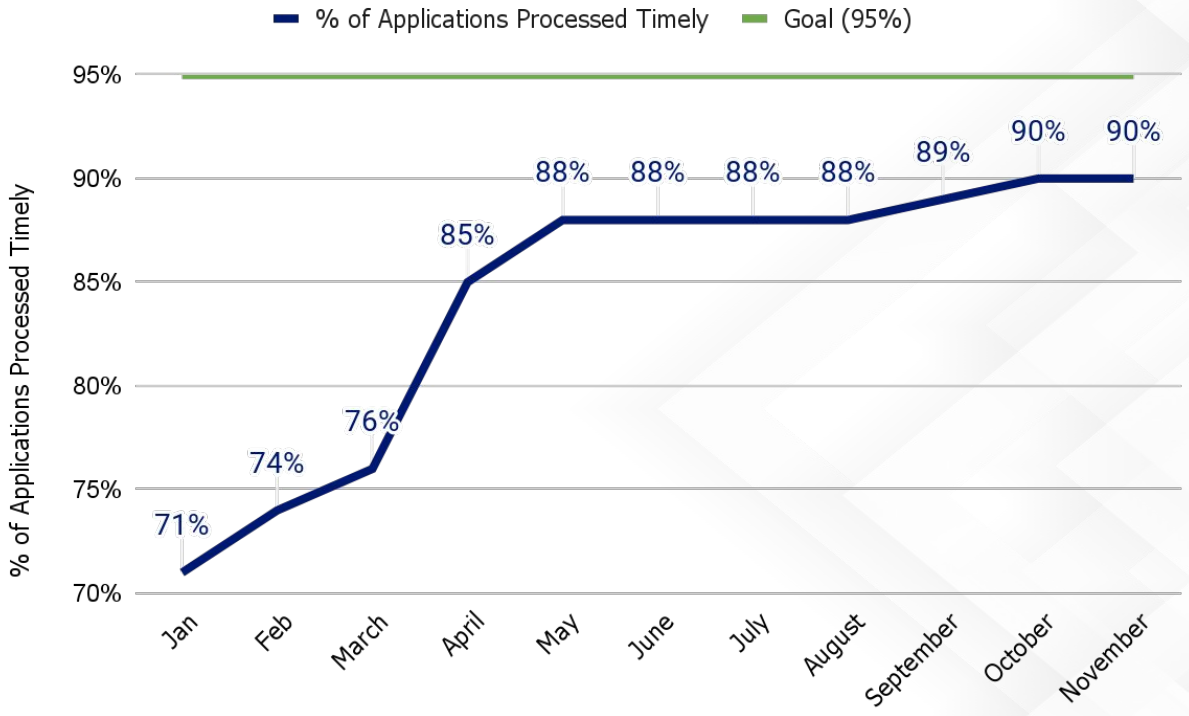


Office of Economic Security

Supporting Coloradans through Food Assistance

COLORADO
Department of Human Services

Improving Timely Processing of SNAP Applications (Q14, pg.11)

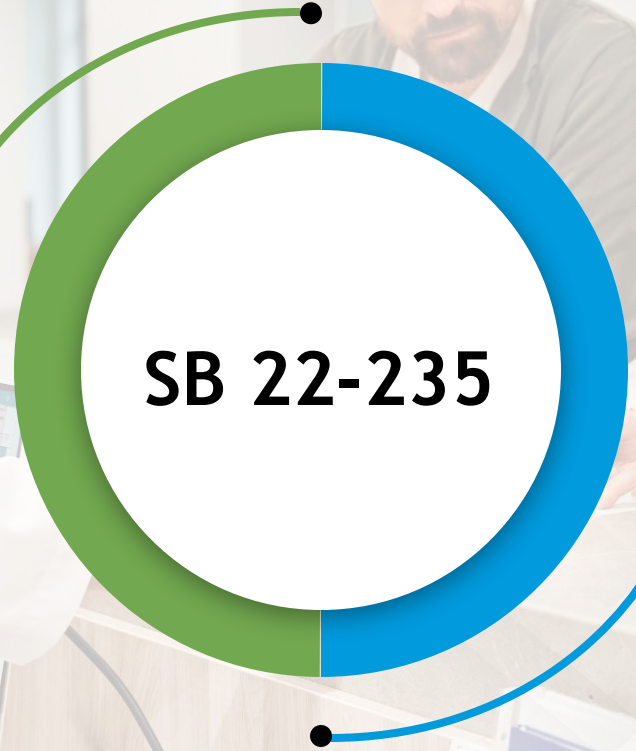


This incredible work of the counties has resulted in

4,428

additional Coloradans with timely approvals, estimate per month.

County Administration Of Public Assistance Programs



Phase 1
Assess the delivery of public and medical assistance programs

Phase 2
Develop a comprehensive, statewide funding model

OES FY 2025-26 Budget Requests

R-01: Resourcing Counties to Administer Public Assistance Programs
$4,185,074 in FY 2025-26

R-14: Teen Drivers License Program
($100,000) in FY 2025-26

R-16: Further Right-sizing Home Care Allowance
($1,050,000) in FY 2025-26

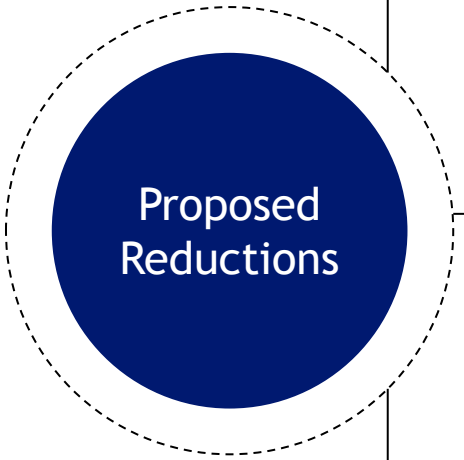
R-17: ReHire Colorado Adjustment
($250,000) in FY 2025-26

R-01 Resourcing Counties to Administer Public Assistance Programs (Q15, pg.11)

The Department's County Administration request will:

- Make progress to ensure sufficient resources to process public assistance cases
- Promote equitable access to benefits

Proposed Budget Reductions (Q16, pg.12 | Q17-21, pg.12-15)



R-14: Teen Drivers License Program
($100,000) in FY 2025-26

R-16: Further Rightsizing Home Care Allowance
($1,050,000) in FY 2025-26

R-17: ReHire Colorado Adjustment
($250,000) in FY 2025-26

Thank you!
Questions?

COLORADO
Department of Human Services

Office of Civil & Forensic Mental Health

COLORADO
Department of Human Services

Office of Civil and Forensic Mental Health

01	Mental Health Hospitals	Provide inpatient behavioral health services for civil and forensic patients.
02	Forensic Services	Provide evaluation, treatment, and case management to the forensic population statewide.
03	Mental Health Transitional Living Homes	Provide a less restrictive residential setting for individuals with serious mental illness. (Created in HB 22-1303)

What is Competency?

Competency is a legal construct referring to an individual's current capacity to function meaningfully and knowingly in a legal proceeding.

When someone is found incompetent to proceed, the entire legal process pauses until competency is restored.

Competency can be raised at any point in criminal proceedings.

The Consent Decree

CDHS was sued in 2011 for failure to provide timely competency evaluations and restoration treatment which created a significant waitlist of adult pretrial detainees.

CDHS has been subject to requirements resulting from the lawsuit since then and is currently under a 2019 consent decree.

As part of the consent decree, CDHS pays up to $12 million annually in fines because we are not in compliance.

Previous Funding has Supported…

Beds Opened Since Oct. 2022 (Q22, pg.15 | Q23, pg.16)

Year	Pueblo	Fort Logan	Jail Based	Private Hospitals	MHTL	Total
2022	N/A	+22	N/A	+23	N/A	**+45**
2023	+39	+22	N/A	+10	+36*	**+107**
2024	+41 31 adult 10 youth	N/A	+0 -18 Boulder +18 Arapahoe	+31	+32*	**+104**
2025	N/A	+16* (new)	N/A	N/A	+86*	**+102**
Total	**+80**	**+60**	**0**	**+64**	**+154**	**+358**

*Indicated funding through HB 22-1303 (16 Fort Logan hospital + 154 = 170)

Waitlist Progress (Q24, pg.18 | Q25, pg. 18)

Between Fall 2023 and Fall 2024 OCFMH achieved a:

- **47% decrease** in the waitlist
- **37% decrease** in wait time
- **83% decrease** in Tier 1 wait time

Year	People on Waitlist	Average Days Waited	
2022	412	Tier 1	74
		All	103
2023	432	Tier 1	101
		All	96
2024	**223**	**Tier 1**	**17**
		All	**67**

Juvenile Competency (Q26, pg.18)

	Inpatient (ABTU at CMHHIP)	Facility-Based (DYS detention facility)	Outpatient (Community)
Criteria for placement/ admission	Medical necessity for inpatient hospital	Detention criteria but not medical necessity	Anyone not meeting detention or inpatient criteria
Current number of youth	3	5	185
Average length of stay	261 days	Not yet enough data to determine	208 days

There is currently no waitlist for juvenile restoration treatment

Psychiatric Residential Treatment Facility (Neuro-Psych) Update (Q27, pg.19 | Q28, pg.20 | Q26, pg.18)

PRTF will provide treatment for youth with high acuity mental health needs who are waiting in inappropriate settings in Colorado

- Initially funded through HB 22-1283
- There is a critical need for beds at this acuity level for children and youth currently awaiting treatment
- Initial design phase is complete
- Construction scheduled to begin Fall 2025

FY 2025-26 Requests

27

R-04 Savings from Competency Beds at Private Hospitals (Q29, pg.21 | Q30, pg.21)

$2 million ongoing reduction of private hospital bed funding from General Fund

OCFMH received funding for private hospital beds in FY 2024-25 through our R-01 request.

Due to the decrease in the waitlist, OCFMH can scale back five beds without impact to Consent Decree compliance.

R-05 Reduce Consent Decree Fines (Q24, pg.18)

$5 million ongoing reduction of Consent Decree fine payments from General Fund

In recent years, CDHS has spent $12 million annually in fines, the maximum amount in accordance with the Consent Decree.

CDHS anticipates spending $7.2 million on fines in FY 2025-26 due to reductions in the competency waitlist.

Impact of Mental Health Transitional Living Homes

R-07 Mental Health Transitional Living (MHTL) Home Funding Adjustment (Q32, pg.22)

Adjustment of $5.2 million for the MHTL Homes in FY 2025-26 and ongoing

Spending authority for $5.2 million of federal funds reappropriated from HCPF

OCFMH received $21.4 million in ongoing operational funding through HB 22-1303 for beds in residential mental health homes; the initial funding was through ARPA including construction of 24 beds in state-owned buildings.

The homes will be fully operational, with 164 total beds, in FY 2025-26, and will cost a total of $17.8 million to run. This cost is $5.2 million more than in FY 2024-25, when not all homes were online for the full year.

If spending authority is granted, the $5.2 million will come from federal funds for Medicaid patients, and no additional General Fund will be necessary.

R-06 Funding Fort Logan G-Wing (Q27, pg.19 | Q32, pg.22)

Adjustment of $6.9 million in FY 2025-26 & $6.7 million in FY 2026-27 and ongoing

OCFMH received funding through HB 22-1303 to renovate and operate a new forensic wing of the Fort Logan hospital. The initial funding was provided through ARPA with ongoing operations from General Fund.

OCFMH received partial funds of $2.7 million for a quarter of FY 2024-25 with the understanding of an ongoing need to fund operations at this level.

This request aligns the amount of funding with what is necessary for a full year of operations beginning in FY 2025-26.

R-09 Maintain Electronic Health Records Amid Changing Technical & Regulatory Requirements

Increases funding by $800,000 for FY 2025-26 & $900,000 for FY 2026-27 and ongoing

Hospitals face significant fines or negative care outcomes if electronic health records are not kept up to date.

The EHR system was initially funded in FY 2016-17. That funding has remained unchanged despite technological updates and growing regulatory requirements and costs.

Since our EHR vendor was acquired by a third party in 2022, the billing model has changed to a subscription based model resulting in unanticipated cost increases.

OCFMH maintains more than **10,000 electronic health records** for individuals through a contract with our vendor, Cerner.

Nurse Staffing Updates (Q31, pg.22)

	2023	2024
CMHHIP Nursing Vacancy Rate	52%	45%
CMHHIFL Nursing Vacancy Rate	26%	23%
Number of Contract Nurses	130	177
Nurses (FTE) Hired	90	148

But for over one year, Colorado competence-related services have been improving. At the end of this quarter (October 31, 2024), the waitlist is less than half the length it was exactly one year prior. Indeed, the total number of people admitted to inpatient restoration this quarter (n=308) continues a year-long trend of admitting more than 300 people to inpatient restoration every quarter-the most since the start of the Consent Decree. Newly opened Mental Health Transitional Living homes (MHTLs) now provide a crucial level of care that has long been lacking in Colorado….

The Department's trajectory is one of improvement.

-Special Master Report
November 2024

Thank you!
Questions?

COLORADO
Department of Human Services

Behavioral Health Administration

FY 2025-26 Joint Budget Committee Hearing

Thursday, December 19, 2024

ADMINISTRATION

1. *Sen. Kirkmeyer:* Does the BHA fund administrative programs like HR and IT services internally? Please describe which administrative functions are managed internally at the BHA, and which are managed by the Department of Human Services and the associated FTE at the BHA.

CDHS provides administrative support to BHA. A small portion of funds appropriated to BHA's line items are utilized by CDHS HR, IT, Audit, and Financial Services teams via indirect costs to provide support for these functions. This structure allows BHA to leverage the infrastructure and expertise that exists on these CDHS teams, and avoid replication of back end staff and processes.

Separate from the administrative support that CDHS provides, BHA has the following FTE:

- HR - BHA 1.0 FTE
- Timekeeping - BHA 1.0 FTE
- Contracting and Procurement - BHA -12.0 FTE
- Program accounting - BHA -10.0 FTE

Contracting and Procurement:

There are 2.0 FTE dedicated to Procurement. The BHA Procurement team handles about 15 major solicitations annually, performing the tasks of identifying the proper solicitation types to be used, guiding program staff through concepting and development of their scopes of work and solicitations, drafting and refining solicitation documents, responding to questions from applicants, organizing procurement scoring meetings, and coordinating with the Contracts Team once awardees are identified. The CDHS Procurement staff (separate FTE from those listed above) act as the Procurement Officials on each solicitation, post and manage the solicitation during the open period, and lead scoring meetings, among other roles defined in the Procurement Code of the Procurement Official delegee and subdelegees

There are 10.0 FTE dedicated to contracting functions. BHA Contracts staff are responsible for primary development of contracts, amendments, and purchase orders. Their work results in finished documents that CDHS then reviews and approves. BHA Contracts staff guide program staff through the development and refinement of scopes of work, assemble documents, perform quality control, and coordinate execution of all documents. They also provide regular maintenance such as amending contracts to reallocate budgets or refining scopes of work. As Contracts staff remain dedicated to the same contract groups year to year, they also provide advice and guidance to program staff in matters of performance improvement and long term provider relationships. The CDHS Contracts team (separate FTE from those listed above) sets

templates, policies and procedures for contracting in compliance with the Fiscal Rules and OSC policies, review BHA submitted contracting items for Fiscal Rules and OSC policy compliance before release for signature, set up our contracts in CORE, and obtain signatures from the Controller's Office.

Program Accounting:

BHA's 10.0 accountants manage spending and pay invoices for an assigned set of contracts each fiscal year. The accounting team is primarily responsible for the workflow surrounding receipt and payment of invoices from providers, ensuring timely payment, and compliance with State and other applicable fiscal rules. CDHS Accounting team manages data entry into CORE; approves invoices; reconciles all general and grant ledger accounts; manages federal reporting; oversees the proper classification, processing, and timing for recording financial accounting transactions, and booking spending authority; and produces required financial exhibits using the information available in CORE.

2. *Sen. Marchman:* Please provide the vacancy and turnover rate by program.

BHA has a vacancy rate of 20% (38 out of 190) and a turnover rate of 13% annually. Turnover rates are not currently available by functional areas, but vacancy rates are shown below.

Table 2 - Vacancy and Turnover Rates

Functional Areas	**Vacancy Rate**
Adult BH Continuum	13% (6 out of 45)
Children, Youth, & Families	09% (2 out of 22)
Finance	15% (6 out of 38)
Strategy	32% (10 out of 31)
Commissioner's Office (includes Quality & Standards Division)	26% (14 out of 54)

BHASO IMPLEMENTATION AND COORDINATION WITH HCPF

3. *Sen. Amabile: It doesn't seem appropriate to fund ongoing health care needs through grant structures. Does the BHA plan to shift away from grant structures for ongoing services?*

BHA's state funding is currently discretionary, and will in that way, continue to align in some ways with grant structures. However, BHA's role in the behavioral health system is to ensure that statewide, in partnership with other agencies, Colorado is maximizing federal drawdowns, strategically utilizing federal funding such as Substance Abuse and Mental Health Services Administration (SAMHSA) block grants, and maximizing the impact of state funding to expand access to a high quality services across Colorado. This statewide approach uses BHA's limited

grant funding to fill gaps, build capacity across the system, and address the needs of the uninsured population, while also ensuring that these efforts are coordinated with a broader approach to funding the behavioral health care system.

While still aligned with a grant structure, the BHASOs will also catalyze a shift in how BHA distributes funding by moving away from siloed funding streams and programs, to a model under where BHA is able to best leverage state discretionary funds, in complement to other funding, to bolster the system. In the short term, this will look like consolidating Crisis, SUD, and Mental Health funding under the BHASOs. In coming years, BHASOs will be central partners for BHA in creating and implementing additional reforms. The fundamental goal is to advance BHA payment models and accountability of public funds while sustaining Safety Net Providers and other Network providers and avoiding disruptions in services for the people of Colorado. BHA will make payment model changes gradually while other significant and intersecting policy changes are implemented.

4. *Sen. Kirkmeyer:* What is the anticipated cost of administration for the BHASOs? How does this cost compare to historic administrative costs for MSOs and ASOs? What costs are associated with the BHASO contract that did not exist under the MSO and ASO contracts? How did the BHA assess that existing funding was sufficient for the new structure?

In the BHASO RFP released in the summer of 2024, BHA requested BHASO bidders to propose an administrative rate to fund their operations, not to exceed 10%. The organizations selected to operate the BHASOs, Rocky Mountain Health Plans and Signal Behavioral Health Network, proposed a 7.5% rate and 6.7% rate respectively. Applying these rates, BHA will pay about $11.8 million TF (~$7million GF) in administrative costs as a share of the $171 million TF, not including pooled funds that are shared amongst all Regions or federal discretionary grant contracts (which often set their own administrative rate caps).

These rates are in line with the administrative rates the organizations currently charge as Crisis Administrative Service Organizations; both Signal and Rocky charge 7%. These rates are lower than the Managed Service Organization rates currently, as the MSO contract sets a universal administrative rate for all MSOs at 10%.

New programming / costs in the BHASO system that did not exist in the previous systems include:

- Care coordination: Care coordination, inclusive of navigation, happened at the provider level in the previous system, but this is the first time that the activity of care coordination has been expressly included in contracts with our intermediaries. BHA R-01 for FY2025-26 would support this new programming and cost. The paired care coordination roles of providers and BHASOs is reflective of feedback received from providers and advocates during the BHASO RFI process.
- Network requirements: BHASOs are now required to identify and contract with providers in order to create a network that meets access and availability minimum requirements in BHA system rules. If there are gaps, BHASOs must report to BHA a work

plan to get to adequacy. If that workplan requires additional funding, BHASO must articulate the cost to BHA.

- S.B. 22-177, an originally ARPA funded project, is actively supporting technology enhancements that are being built or already in place for potential BHASO utilization, including:
    - Central Registry for Medication Assisted Treatment (MAT)
    - Bed Capacity Tracker for Bed Availability in Inpatient and Residential facilities
    - Client Care Search Referral System
    - LADDERS Licensing Modernization
    - Modernized Data Collection Tooling
    - Data Lakehouse for BHASO Interoperability
    - OwnPath Care Directory for Public Navigation

As BHA has implemented safety net reforms driven by H.B. 22-1278, including the new safety net provider requirements and the BHASO system, we have assessed the sufficiency of current funding and have gathered feedback from providers. Two consistent themes have emerged in this process:

1. The system does not have any new funding in place to account for the new service requirements, including care coordination that providers must provide to both individuals receiving care, and those who may need support in accessing alternative care or services outside the scope or capacity of the provider.

2. Coming into compliance with new requirements has come with administrative costs that providers are not reimbursed for. This includes updates to EHRs, developing new policies and procedures, developing and implementing new trainings for staff, etc.

In response to these needs, BHA carefully developed R-01, with a 3 pronged approach to addressing these concerns. BHA believes the R-01 request will appropriately address provider concerns regarding FY 2025-26 funding needs as BHASOs launch in 2025.

5. *Sen. Amabile:* Can a company that is a RAE also serve as a BHASO? Does it create excess administrative burden and cost at the state level to have one agency serving separate populations as a BHASO and RAE? Would it be more cost effective and improve service access for individuals if BHASOs and RAEs were combined?

Yes, a single organization can operate as both a BHASO and RAE if the organization is able to demonstrate the ability to perform the duties associated with both contracts. Based on the RAE and BHASO awards, Rocky Mountain Health Plans has been awarded both a RAE award for ACC 3.0 and a BHASO award beginning July 1, 2025. All HCPF RAEs were given an opportunity to bid to provide BHASO services in their same RAE region, and all but one chose not to bid on the BHASO work. Looking at how the BHASO and RAE contracts were awarded, there is only an opportunity to move from 5 contracted organizations to 4 organizations between both HCPF/RAE and BHA/BHASOs, given that the BHA awarded 3 regions to 1 organization. To force

organizations to perform work that they choose not to bid on is not an efficiency opportunity; it would likely create far more challenges than efficiencies.

Regional Accountable Entities (RAEs) manage Medicaid funds for Colorado. Commercial carriers manage behavioral health in the private insurance space through offerings such as employer-sponsored benefits, individual and family plans on and off of the Connect for Health marketplace exchange, and within Medicare Advantage. The BHASO will manage state and federal behavioral health funds directed to BHA. BHASO's will cover care for those without coverage will also leverage funding and lead collaborative efforts across state agencies, partners and stakeholders, to build and maintain critical service capacity that will support all people in Colorado regardless of payer.

To maximize alignment and deliver improved quality of service to individuals, HCPF and BHA have had intentional decisions as we have collaborated on the launch of ACC 3.0 and BHASOs. We have aligned the four BHASO and RAE regions to promote greater whole system alignment, and the BHASOs will enter into formal agreements with RAEs to establish coordination and cooperation between BHASOs and RAEs. These agreements will include:

- Policies and procedures to ensure continuity of care for all Individuals transitioning into or out of Medicaid enrollment, preventing disruption or delay to an Individual's services.
- Data sharing and privacy policies for individuals transitioning onto or off of Medicaid, as well as those who are receiving coverage from both BHASOs and RAEs simultaneously.
- Definition of roles in Care Coordination to reduce duplication.
- Methods to leverage resources within Medicaid and BHA to optimize funding for needed services.
- Procedures to monitor equity and outcomes within the Region and share data with one another.
- Procedures to report and share quality information relevant to monitoring the provider network.
- Methods to support provider quality improvement through shared or coordinated training, grievances, and technical assistance.

Details on RAEs: RAEs, managed by the Department of Health Care Policy and Financing (HCPF), are responsible for managing a network of primary care providers and behavioral health providers to ensure access to appropriate physical health and behavioral health care for Medicaid members, in line with CMS requirements. This includes paying behavioral health claims to providers, submitting those claims through the Medicaid Enterprise System, negotiating standard and specialty rates for all providers, maintaining and reporting on network adequacy standards, providing care navigation, maintaining member and provider call centers, paying physical and behavioral health providers for whole person care coordination services, submitting all federally required Medicaid data for outcomes and encounters, determining and documenting medical necessity for all services (also known as utilization management), providing practice transformation and technical assistance for providers, contracting with out-of-state providers for clients that cannot be served in Colorado, analyzing and aggregating provider performance and quality data, managing level one grievances and appeals in accordance with state and federal Medicaid laws, and meeting all federal Managed Care Entity

regulations as a health plan. The RAE budgets are determined based on actuarially sound rates, and all provider payment from the RAE to providers are governed by federal Medicaid laws and regulations.

Details on BHASOs: BHASOs will coordinate behavioral health services, not physical health services. Though often providing services to different groups of individuals, BHASOs and RAEs must collaborate to ensure alignment in behavioral health system strategies and in requirements for providers and individuals seeking care. Additionally, BHASOs must maintain close connections to RAEs, as BHASOs are expected to support individuals to enroll in Medicaid, coordinate warm handoffs for Medicaid-enrolled individuals seeking physical health or covered behavioral health services, and support other connections to the RAE's care coordination team for ongoing support.

6. *Sen. Kirkmeyer:* Are RAEs required to contract with comprehensive providers? How can a safety net system be established if RAEs are not required to contract with providers designated by the BHA?

RAEs are, and will continue to be, required to offer contracts to all willing and qualified Comprehensive providers. HCPF identified that inconsistent guidance was given at an informal provider presentation. HCPF wants to assure that the following language is retained in the in RAE contract for ACC Phase III:

> Contractor shall offer contracts to all willing and qualified FQHCs, Comprehensive Providers, RHCs, and Indian Health Care Providers located in the Contractor's assigned region(s).

BHA supports this decision as it achieves goals shared by HCPF and the BHA, including creating aligned BHASO and RAE provider networks where possible, and aligning incentives for safety net providers to serve medicaid and uninsured populations.

7. *Sen. Amabile:* Why do comprehensive and essential providers designated by the BHA receive enhanced payment models and rates under HCPF when the BHA and HCPF are addressing different populations?

The behavioral health safety net requires, by design, coordination between BHA and HCPF as providers approved by the BHA serve a population that encompasses Medicaid-eligible individuals. The behavioral health safety net exists to ensure that "priority populations" defined in 27-50-101, C.R.S. as people who are uninsured, underinsured, medicaid-eligible, publicly insured, or whose income is below thresholds established by the BHA; and presenting with acute or chronic behavioral health needs, including but not limited to individuals who have been determined incompetent to stand trial, adults with serious mental illness, and children and youth with serious emotional disturbance, are able to access the behavioral health care that they need. A comprehensive funding model that leverages all available funding sources is necessary to ensure the viability of the safety net system. This funding model is expected to use state funds to complement and not supplant other funding sources including Medicaid, federal Substance Abuse Prevention and Treatment Block Grants (SABG), and federal Mental Health

Services Block Grants (MHBG). Ultimately, BHA and HCPF together want to prioritize opportunities to support the safety net with federal match funds that can be drawn down.

Beyond paying for specific services for certain populations, BHA is responsible for ensuring access to quality behavioral health safety net services. BHA approves agencies as comprehensive and essential safety net providers. As an approved safety net provider, comprehensive and essential safety net providers commit to meet the safety net regulations, including the no refusal requirements, and serve priority populations, inclusive of Medicaid members.The safety net approval from BHA allows a provider to enroll in HCPF as the corresponding provider type, and to be prioritized for contracts by the BHASOs.

Medicaid reimburses comprehensive providers using a cost-based prospective payment system (PPS). HCPF cost-based rates are an incentive to participate in the safety net system. Medicaid reimbursements are key to safety net provider's revenue and stability, and HCPF and BHA together have a shared interest in ensuring that safety net providers achieve financial stability, keeping their doors open to provide critical services to uninsured, underinsured, and Medicaid covered individuals. Cost based rates are the best way to do that.

In addition to the cost based rates paid to comprehensive providers for services provided to Medicaid members, BHASOs are statutorily required to prioritize comprehensive providers when contracting for safety net services.

Essential safety net providers are eligible to receive enhanced rates that are designed to provide reimbursement for the additional requirements they meet. Beyond the opportunity to receive enhanced rates from HCPF for services provided to Medicaid members, Essential Safety Net providers may contract with the BHASOs to be reimbursed for safety net services provided to uninsured and underinsured individuals.

Ultimately, braided funding from HCPF and BHA seeks to ensure that safety net providers can provide care to both HCPF and BHA "populations".

8. *Sen. Kirkmeyer:* How is the BHA coordinating with HCPF on an ongoing basis? How do the two agencies coordinate to ensure there is not duplication of services, or gaps in services, between the two agencies?

The BHA is charged with leading and developing the state's vision and strategy for behavioral health in Colorado. Every state agency that administers a behavioral health program is required to collaborate with BHA to achieve the goals and objectives established by the BHA. In addition to formal written agreements, HCPF participates in the interagency council, chaired by BHA's Commissioner, made up of 12 executive directors of state agencies that administer behavioral health programs where BHA coordinates multiple initiatives across state agencies. To promote efficient and unduplicated services, BHA and HCPF also engage in daily communication,

collaboration, and coordination from individual contributors to senior leadership. BHA and HCPF are aligned in such a way that even the foundation pillars align.

Table 1 - BHA and HCPF Foundational Pillars

Pillars of BHA	Pillars of HCPF
Access	Care Access
Affordability	Affordability Leadership
Workforce and Support	Employee Satisfaction
Accountability	Operational Excellence and Customer Service
Whole Person Care	Member Health
Lived Expertise and Local Guidance	Health First Colorado Value

As the largest payer of behavioral health services in the state, HCPF is partnering closely with BHA, along with local communities, safety net providers, advocates, members and families, to inform the design and implementation of policies to a coordinated, cohesive, and effective behavioral health system in Colorado. HCPF and BHA coordinate through integrated planning, data sharing, joint stakeholder engagement, and aligned policies to ensure efficient service delivery, address gaps, and prevent duplication in behavioral health care. The shared BHA and HCPF pillar of Access To Care is highlighted through the development of the safety net system.
HCPF and BHA don't just share the intention of collaboration, but have multiple policies and programs that demonstrate that alignment.

Safety Net Reform: HCPF and the BHA have worked closely to ensure that reforms and the implementation of Colorado's Safety Net system are cohesive. The BHA defines and regulates safety net services and providers, then HCPF relies on those definitions and licenses to enroll BH providers in Medicaid. BHA and HCPF worked closely through the regulatory review process to ensure Medicaid regulations and infrastructure were considered throughout the new rule structure and the BH service definitions did not include any services that could not be covered by Medicaid. This close collaboration then informed HCPFs reform efforts related to creating pathways to enroll, identify, and reimburse safety net providers, and has led to a significant increase in licensed safety net providers enrolled in Medicaid. Through co-facilitated stakeholder engagement, coordinated responses to providers, and jointly developed FAQs, the new Safety Net system went live in July 2024.

As of December 12, 2024, BHA has issued 19 Comprehensive Provider approvals, 18 are enrolled with HCPF across multiple locations, and one is in process. BHA has issued 160 Essential Provider approvals and HPCF has processed 141 enrollments. Open communication

and collaboration continues with weekly updates regarding BHA licenses and approvals and new HCPF enrollments shared with the Regional Accountable Entities (RAEs).

SUD Benefit: In response to expanded and discrete regulatory definitions in BHA rules, HCPF expanded Medicaid provider enrollment options to allow for the full continuum of SUD services based on the levels of care outlined in American Society of Addiction Medicine (ASAM) criteria, which also aligned with HCPF's SUD residential waiver. This SUD continuum now includes multiple levels of outpatient, high intensity outpatient, residential and inpatient enrollment categories. BHA sends HCPF a monthly report of all licensed SUD providers at every level which allows HCPF to monitor member access to SUD providers statewide. 100% of BHA-licensed Opioid Treatment Programs (OTPs) are enrolled as Medicaid providers, 53% of licensed Residential SUD providers are enrolled as Medicaid providers, and 50% of Essential Safety Net providers are enrolled as SUD providers. In preparation for the transition from ASAM 3rd Edition to ASAM 4th Edition taking effect July 1, 2026, HCPF and BHA are co-facilitating a withdrawal management-focused workgroup to gather insight from providers and collaboratively prepare for this transition.

Provider Supports: HCPF supported the BHA in developing and delivering Training and Technical Assistance (TTA) modules aimed at Safety Net and independent providers as part of the BH transformations. HCPF prioritized funding through ARPA to contract with a vendor ensuring that the trainings were developed in alignment with adult learning styles and help providers BHA training requirements. These training modules remain available across a provider-focused Learning Management System and a Safety Net Provider website managed by BHA and HCPF, respectively. Topics include administrative functions like contracting and enrollment, licensing standards for BHA and CDPHE, evidence-based practices in program design, and financing skills like how to bill Medicaid and BHA or how to complete a cost report.

Aligning Regional Accountable Entities and Behavioral Health Administrative Service Organizations: HCPF and BHA have worked closely to thoughtfully align program design for the RAEs and BHASOs. This includes:

- **Create an aligned regional map for RAEs and BHASOs.** HCPF heard from stakeholders about the importance of aligning the RAE and BHASO regions to create simplicity and reduce confusion for those that may interact with both entities, such as members and providers. HCPF and BHA jointly hosted stakeholder meetings and reviewed statewide population data to determine the optimal region map and other considerations as both ACC Phase III and the BHASOs go live on July 1, 2025.
- **Development of joint care coordination expectations**. Stakeholders have emphasized the importance of aligning care coordination standards between the RAEs and BHASOs. Since early 2023, HCPF and BHA have worked closely to develop a tiered approach to care coordination for Medicaid members served by RAEs and Coloradans served by BHASOs. Aligning these service definitions is intended to ensure Coloradans moving from Medicaid coverage continue to receive the navigation and coordination support they need.

- **Alignment of the contracts between RAEs and BHASOs.** While RAEs serve Medicaid members, there are many members that may churn off of Medicaid and would therefore be served by BHASOs. Additionally, there are many requirements around the services that Medicaid can or cannot provide. There may be instances where BHASOs cover additional services for members. HCPF has worked closely with BHA to crosswalk key contract requirements and ongoing operations between the RAEs and BHASOs. Both agencies have looked at the general role of RAEs versus BHASOs, the administrative burden for other agencies that may need to work with both entities, care coordination expectations, requirements for community engagement, and quality and data sharing. Additionally, HCPF and BHA plan to work with both RAEs and BHASOs to ensure that network providers are trained on the role of each entity.

Children and Youth: HCPF has been actively collaborating with BHA in the development of the Medicaid System of Care around the Settlement Agreement Implementation Plan which consists of the Identification Tool, the Standardized Assessment including the Child & Adolescent Needs and Strengths (CANS) tool, and Intensive Care Coordination with High Fidelity Wraparound (HFW). The Medicaid System of Care will leverage the existing Colorado Crisis Services Mobile Response managed by BHA. In addition, the internal state group creating a proposed System of Care framework consists of leaders from both HCPF and BHA. This group meets no less than weekly to ensure alignment in vision and execution for system of care across state agencies.

Peer and Recovery Services: HCPF continues to actively collaborate with BHA on the implementation of HB 21-1021 which directed BHA to establish rule and licensing for Recovery Support Services Organizations (RSSOs) and authorized HCPF to reimburse RSSOs for permissible claims for peer support services. HCPF and BHA staff meet at least once per month to collaborate on this work, discuss stakeholder and provider questions and concerns, and strategize on responses. As a result of this ongoing collaboration, BHA and HCPF staff have supported a smooth transition for new RSSOs to go through BHA licensing, Medicaid enrollment, and RAE contracting and billing. There are currently 8 RSSOs licensed through BHA and an additional 10 open applications. HCPF has published web-based policy guidance and FAQs for providers.

Colorado Crisis System: HCPF and BHA continue to partner on improving the Statewide Crisis Continuum. BHA and HCPF worked together to standardize Mobile Crisis Response (MCR) services in alignment with federal standards to assure appropriate reimbursement for Medicaid members and access 85% federal medical assistance percentage (FMAP) for those members. Stakeholder engagement for MCR was conducted in tandem, both in person and virtually. HCPF and the BHA co-published clarifying policy memos and co-authored the MCR Service Definition[1], demonstrating a closed loop for providers by indicating that all MCR providers must contract with the BHA ASO and the HCPF RAE, which is key to maximizing federal funding where possible. HCPF also contributed to the development of BHA's Crisis Professional Curriculum which aims to narrow the scope of training of crisis professionals to those who have completed

[1] https://hcpf.colorado.gov/sites/hcpf/files/7.5.23%20MCR%20Final%20Service%20Definition%20%281%29.pdf

the curriculum, thus expanding the workforce to include individuals with lived experience and various disciplines. BHA, HCPF, and CDPHE co-host monthly Crisis office hours for providers and RAEs, and regularly hold collaboration meetings, to assure alignment between regulations, reimbursement strategies, and broader crisis system goals. The 988 implementation plan[2] is an example of this alignment effort, where HCPF was tasked "with the goal of having Medicaid revenue support the crisis center (both crisis lines 988 and 844)" and has done so while supporting BHA and the 988 Enterprise through vendor transition.

CCBHC Grant: H.B. 24-1384 legislated that HCPF and BHA coordinate to complete a competitive application for the SAMHSA-sponsored CCBHC Planning Grant. HCPF and BHA preparation and planning meetings began monthly but ramped up heavily once the short application window was released, nearly reaching a daily rate, through collaborative strategy meetings, cross-agency executive leadership check-ins, monthly stakeholder forums, and ad hoc informal meetings. All application materials, support materials, and a HCPF CCBHC website were approved by both HCPF and BHA leadership. This joint effort led to the successful completion and submission of the planning grant.

Operational Partnerships: In addition to the larger system alignment efforts, HCPF and BHA jointly participate in several ongoing public meetings, including:

- BHA and BHASOs have been incorporated into the membership and leadership of the collaborative forum to support youth involved in the child welfare system called the HRC2B2 (HCPF, RAEs, CHDS, counties, BHA, BHASOs). In this forum, BHA helps select the agenda, presents topics, solicits feedback and provides input on any issues that impact the child welfare system. The HRC2B2 forum also has associated workgroups such as the Assessment Workgroup where BHA and current Administrative Service Organization (ASO) staff are actively working to increase alignment between systems (Medicaid, child welfare, and Children and Youth Mental Health Treatment Act).
- HCPF also participates in BHA facilitated workgroups. An example is the BHA workgroup to improve the independent assessment process for youth in foster care. BHA and HPCF staff coordinate agendas and tasks to ensure efforts are aligned and to avoid duplication.
- Alignment between HCPF and BHA is also demonstrated in the ACC's Program Improvement Advisory Committee (PIAC). PIAC is the regular public stakeholder advisory structure for the ACC program. Currently, BHA has a seat on the behavioral health subcommittee, BHA joins PIAC to present topics of shared interest (such as explaining the similarities and differences between RAEs and BHASOs), and representatives of current ASO/future BHASO serve as committee members.
- HCPF and the BHA collaborate regularly on more narrow program management items such as implementing reimbursement for room and board in residential treatment per H.B. 24-1038. Collaboration on these items happens via multiple channels such as the forums listed above, BHA staff joining ACC operational meetings, and state technology solutions (email, Google Chat, shared document editing etc.).

[2] https://drive.google.com/file/d/14miYUWAh8NcPEUAKnNS7L8i2o_gzkWXv/view?usp=sharing

- HCPF and BHA also collaborate regularly for member specific items under the Child and Youth Consulting Staffing meetings. HPCF management meets with BHA and CHDS child welfare management to support members whose needs are extremely complex and / or difficult to address. These state staff work to ensure all available resources, regardless of the program, are used effectively.

9. *Sen. Bridges:* Do any recently created programs help address the G.A. v. Bimestefer settlement agreement in HCPF?

BHA has been actively collaborating with HCPF in the development of the Medicaid System of Care and the Settlement Agreement Implementation Plan. In doing so, BHA and HCPF are leveraging existing cross-agency work streams, including updates to the Child & Adolescent Needs and Strengths (CANS) tool, and Intensive Care Coordination with High Fidelity Wraparound (HFW). The Medicaid System of Care will also leverage the existing Colorado Crisis Services Mobile Response managed by BHA. In addition, the BHA is working with HCPF on developing workforce capacity solutions for the proposed system of care outlined for the settlement agreement in HCPF.

BHA's role as the state agency establishing standards for quality of care in the behavioral health system, including system of care, is key in HCPF successfully meeting their obligations in the settlement agreement. BHA, in collaboration with HCPF, has created a system of care rules and standards of care for services that are proposed in the settlement agreement.

The team developing the Settlement Agreement Implementation Plan consists of leaders from both HCPF and BHA. This group meets no less than weekly to ensure alignment in vision and execution for system of care across state agencies. Implementation Plan development is based on the settlement agreement, community feedback from providers, counties, and families, evidence based programs, and national and state data.

The Settlement Agreement Implementation Plan has not been finalized at this time. BHA understands that JBC has requested a briefing on the settlement from HCPF and would defer to HCPF to provide a detailed update on the settlement agreement.

PRIORITIZED REQUESTS

R2 Advancing the Children and Youth Behavioral Health Implementation Plan

10. *Sen. Kirkmeyer:* Please describe the steps of the child and youth implementation plan that have been completed in the first year, and the steps the BHA expects to complete in year two.

The Children and Youth Behavioral Health Implementation Plan, launched in January 2024, is a five year plan that lays out existing efforts and planned implementation activities across state agencies to achieve a continuum of care that spans from prevention to recovery and allows for youth and families to access the care they need, when and where they need it. Additionally, it lays the foundation to join together existing work and investments across the state that too often today exist in silos by putting into place foundational structures for communication and

coordination across agencies, in line with BHA's role as the single entity responsible for driving coordination and collaboration across state agencies.

The CYBHI Plan is foundational to, but not the entirety of, the behavioral health reforms BHA must accomplish. The collaboration fostered by the plan ensures building upon existing CYF behavioral health efforts in Colorado, connecting the dots and beginning to create a true continuum where families move seamlessly between levels of care. Work began with the creation of the Steering Committee, which is attended by all state departments who have action items identified in the plan. This is a leadership group of twelve state agencies and a division within the Lieutenant Governor's Office, who meet monthly to support the direction of the plan, ensure the alignment of the plan goals and the goals of each State agency, and identify potential corrections which need to be made to the plan to have the greatest impact. This group successfully aligned the action items to the continuum of care. BHA staff also meet monthly, with the specific staff within each State agency who are working on each year one action item to support the continuation of progress and reduce barriers to completion.

In year one, BHA's efforts to implement the CYBHI plan have focused on these foundation setting elements of putting into place the structures to ensure collaboration, alignment and transparent tracking of cross agency efforts to achieve the continuum of care, and setting the foundation of the system of care for youth with complex needs. This work is driven by H.B. 24-1038, and the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) settlement agreement. BHA, CDHS, and HCPF were responsible for the nineteen unique action[3] items identified in the Children and Youth Implementation Plan for year one. Eighteen of the nineteen items have been completed with a single remaining item expected to be complete by the end of the calendar year. These action items were prioritized to address the immediate needs of youth with high acuity behavioral health needs. Some completed tasks are iterative or ongoing. For these, completion indicates that processes and structures are in place to continue the related work. These year one tasks are shown in the table beginning on the next page.

Since the plan's release, BHA has acknowledged that efforts across agencies and partners will continue to evolve the children and youth behavioral health system. Some tasks will also be iterative. BHA will lead the collaboration across state agencies and periodically review priorities on at least a year-by-year basis. Moving forward, while the plan will continue to guide our work, and leverage the foundational collaboration and tracking that is now in place, with this foundation laid, discussions and descriptions will be less about the plan and more about the continuum. What matters to families isn't that a task has been marked complete, but whether they can access the care that they need. To address this BHA is:

- Actively working with a cross agency data group to identify shared metrics that will be used to monitor the CYF continuum of care. These metrics are informed also by community partners through efforts including the H.B. 23-1269 extended stay data group, and Tackling Barriers. These new metrics, and not a percentage of tasks in the

[3] Children and Youth Implementation Plan - *Year 1 CYBHI Plan Action Items*, https://docs.google.com/spreadsheets/d/1j0JUkqs8XiaAmDazkdSwczOPFavU2UdPG4oJJ8N_F_4/edit?usp=sharing

plan completed, will ultimately be the way to measure success and to hold BHA accountable; and

- Putting forward budget request R-02. This request helps us close some of the current knowledge gaps identified in the plan so that we can move full steam ahead from assessment to implementation of solutions that work for Colorado families, including identifying means to expand access to the system of care for youth with complex needs beyond Medicaid members.

With this, agencies are set to begin work on 41 tasks in year two[4]. These tasks are shown below, including some that have begun already and one that has been completed early as shown.

Table 3 - CYBHI Plan Year 1 Tasks

Action Item	Lead Agency	Year Started	Status
Increase engagement with hospitals, Colorado Crisis Services Continuum, County Partners, Judicial Partners, etc., on the Standardized Assessment process to support identifying high-acuity children and youth with complex behavioral health needs.	BHA	Year 1	Complete
BHA, CDHS/OCYF, and HCPF to work with Colorado Hospital Association to determine how to remove barriers to children receiving assessments timely when they are awaiting a placement upon discharge.	BHA	Year 1	Complete
Meet regularly with state agencies to ensure ongoing alignment in the delivery of care for children, youth and families.	BHA	Year 1	Complete
Continue to carry out the requirements outlined in S.B. 22-181 that address workforce strategies prior to the end date tied to the appropriations.	BHA	Year 1	Complete
Use information from RFI for BHASO and publish the BHASO RFP in the spring of 2024, select vendors in the fall of 2024: And Establish a framework for a behavioral health continuum of care and network, a BHASO will establish and maintain.	BHA	Year 1	Complete

[4] Children and Youth Implementation Plan - *Year 1 CYBHI Plan Action Items*, https://docs.google.com/spreadsheets/d/1j0JUkqs8XiaAmDazkdSwczOPFavU2UdPG4oJJ8N_F_4/edit?usp=sharing

Action Item	Lead Agency	Year Started	Status
Determine which current BHA services and programs will be integrated into BHASO contracts during the RFP process.			
Develop the capacity for crisis stabilization beds to serve individuals with co-occurring disabilities	BHA	Year 1	Complete
All state agencies on the Operational Committee shall have their teams review the 2020 memo by the Colorado Health Institute on the menu of screening tools and collectively determine an avenue to streamline screening across agencies.	BHA	Year 1	Complete
BHA to increase awareness of CRT to emergency rooms and crisis stabilization units across the state.	BHA	Year 1	Complete
Develop a plan to operate all 20 adolescent beds at CMHHIP	CDHS	Year 1	Complete
OCYF / CDHS should lead a joint effort with BHA and HCPF to identify a multi-agency approach to financially sustaining a robust treatment foster care system.	CDHS	Year 1	Complete
Publish an updated version of the 2023 psychotropic medication guidelines for children and adolescents in Colorado's child welfare system	CDHS	Year 1	Complete
CDHS, HCPF, and Counties identify and analyze to what extent Core Services dollars are utilized for Medicaid eligible children and families.	CDHS	Year 1	Complete
OCYF/CDHS to identify the capacity needed and find opportunities to sustain the PRTF incentive approach that is currently being implemented via RFP.	CDHS	Year 1	Complete
Have standardized room and board rates	CDHS	Year 1	Complete

Action Item	Lead Agency	Year Started	Status
across all state agencies, CYMHTA, Medicaid children via BHA, and CDHS / OCYF.			
CDHS / OCYF to identify the opportunities to create an incentive approach to QRTPs, similar to the program with PRTFs, in order to address the cost associated with youth who have high acute needs and require a QRTP setting.	CDHS	Year 1	Complete
BHA and HCPF identify a robust centralized list of intensive in-home and community-based behavioral health interventions that should be available to the children and families of Colorado.	HCPF	Year 1	Complete
Collaborate with DYS to determine a plan for reimbursing Medicaid Reentry Services provided to eligible youth, as defined in Section 5121 of the Consolidated Appropriations Act of 2023 and H.B. 24-1045. This would include addressing federal compliance with CAA 5121 and incorporating the expanded scope of services authorized through the pending 1115 Waiver amendment.	HCPF	Year 1	In Progress
Starting with the Medicaid population, create the foundation for a system of care structure that utilizes key services for children with high acuity needs in a well-designed manner that orchestrates a care system. This means purposeful, cross-systems interaction, high fidelity wraparound, appropriate clinical interventions and support services.	HCPF	Year 1	Complete
Track the progress of adding Mobile Crisis Response as a Medicaid benefit	HCPF	Year 1	Complete

The Children and Youth Implementation Plan contains 41[5] unique action items scheduled to begin in year two. Not all of these action items are scheduled to be completed in year 2 as some action items are longer term. BHA, CDHS, HCFP, CDPHE, and CDE are each responsible for various action items.

Table 4 - CYBHI Plan Year 2 Tasks

Action Item	Lead Agency	Year Started	Status
BHA will formally document Colorado's children, youth and family advisory council structure to inform the creation of a systemwide governance structure. In addition, all advisory councils will require the inclusion of different perspectives, including individuals with varying abilities, race, ethnicity, life-experience and / or advocacy.	BHA	Year 2	In Progress
Using existing committees, councils, and workgroups across the state, the governance structure includes BHA consolidating all Children Youth and Family (CYF) Behavioral Health (BH) efforts across the state into a single state children and youth behavioral health system governance plan.	BHA	Year 2	In Progress
BHASOs operational by July 2025.	BHA	Year 2	In Progress
Develop standards of care to be utilized in ACC Phase III.	BHA	Year 2	In Progress
Establish and expand the standardized assessment for CYF across state agencies that provide or purchase behavioral health services for children and youth who need intensive services in the home, community, residential, or inpatient setting.	BHA	Year 2	In Progress
Determine a schedule for applying standardized assessment and a re-assessment schedule.	BHA	Year 2	In Progress
MCR providers are trained to work with children and youth and include IDD training.	BHA	Year 2	Complete

[5] Children and Youth Implementation Plan - *Year 2 CYBHI Plan Action Items*, https://docs.google.com/spreadsheets/d/1WLtURzMaSHsJTKKp4x84F9ddVtLRcgY0iUSmRrdrkQQ/edit?usp=sharing

Action Item	**Lead Agency**	**Year Started**	**Status**
Work with partners to develop a level of care framework that builds off of SSUM and aligns with ASAM. This would be a MH equivalent of the ASAM level of care approach.	BHA	Year 2	In Progress
In recognition of shortages of Colorado child and adolescent psychiatrists, BHA should review the funding sufficiencies of CPPCAP.	BHA	Year 2	Not Started
BHA efforts on addressing workforce capacity for child and adolescent psychiatry should include meeting with leaders at the University of Colorado Department of Psychiatry.	BHA	Year 2	In Progress
Develop metrics to measure system quality: Identify and adopt metrics (KPI's) from federal agencies and limit variations of similar KPIs across agencies	BHA	Year 2	In Progress
An advisory council will meet at least once a year to review the school-based approach and support coordinated by CDE and other related school-based behavioral health efforts.	BHA	Year 2	Not Started
BHA will collaborate with The Colorado Department of Education (CDE) to lead the efforts in executing H. B. 23-1003 and establish the protocols and infrastructure for school based mental health screenings.	BHA	Year 2	In Progress
Identify methods to address the bifurcation between behavioral health and cognitive disability, neurodiversity, and brain injury.	BHA	Year 2	Not Started
BHA, HCPF, and CDHS will develop a point-of-entry system (with “no wrong door”) that is culturally, linguistically, and developmentally responsive to help individuals with co-occurring diagnoses navigate the full continuum of behavioral health services.	BHA	Year 2	In Progress
BHA in partnership will develop and implement culturally and linguistically competent models	BHA	Year 2	In Progress

Action Item	**Lead Agency**	**Year Started**	**Status**
of care along the continuum.			
Assess the success and potential expansion of the Center for START Services pilot program for people with intellectual and developmental disabilities	BHA	Year 2	Not Started
Develop standards of care to be established in rule	BHA	Year 2	In Progress
Establish standards of care that are inclusive of various disabilities and unique needs of those populations	BHA	Year 2	In Progress
BHA to assess and determine the necessary capacity for CRT to be available to any child who needs it in Colorado.	BHA	Year 2	In Progress
BHA to determine the true need and current capacity of the Momentum program for children and youth specifically.	BHA	Year 2	In Progress
BHA and HCPF to assess what Momentum services should be covered under Medicaid funds instead of general funds or BHA block grants.	BHA	Year 2	In Progress
Continue exploration of reciprocity processes for licensed behavioral health positions where workforce shortage has been identified.	BHA	Year 2	In Progress
As part of the council, CDE will work with BHA to lead a multi-agency effort in creating a unified approach (a framework) for state resources to support local school districts in addressing the behavioral health needs of students.	CDE	Year 2	Not Started
Examine feasibility of specific reimbursement rates or incentives for providers to serve individuals with co-occurring disabilities	CDHS	Year 2	In Progress
CDHS, HCPF, and BHA meet to propose	CDHS	Year 2	In Progress

Action Item	**Lead Agency**	**Year Started**	**Status**
solutions to addressing the systemic issues causing rural counties to use Core Services dollars for Medicaid-eligible services.			
BHA, CDHS, and HCPF integrate FFSPA into the children and youth behavioral health continuum.	CDHS	Year 2	In Progress
Create an advisory council for children and youth behavioral health prevention to coordinate state-level primary prevention efforts.	CDPHE	Year 2	Not Started
CPDHE, with the advisory council, shall create a children and youth behavioral health state-level prevention framework	CDPHE	Year 2	Not Started
Incorporate accountability policy changes proposed for ACC Phase III	HCPF	Year 2	In Progress
HCPF to include the standardized assessment tool as part of ACC phase III and OCYF / CDHS and BHA to use the same standardized assessment in determining the level of care and need.	HCFP	Year 2	In Progress
Under ACC Phase III establish a Children's Behavioral Health Benefit	HCPF	Year 2	In Progress
For ACC Phase III make primary care behavioral health integration a distinct Integrated Care Benefit.	HCPF	Year 2	In Progress
Add the foundations for the System of Care to the Medicaid services delivery system, including ACC Phase III.	HCPF	Year 2	In Progress
Identify early dyadic services as a distinct group of services in ACC Phase III.	HCPF	Year 2	In Progress
Add High Fidelity Wrap-around as a benefit in ACC Phase III	HCPF	Year 2	In Progress
Incorporate intensive care coordination as part	HCPF	Year 2	In Progress

Action Item	Lead Agency	Year Started	Status
of ACC Phase III of the managed care system in order to provide comprehensive care coordination for children and youth with complex behavioral health needs.			
HCPF to review the current rates for PRTF providers to ensure it is capturing the cost to provide this level of care.	HCPF	Year 2	In Progress
Expand the support services afforded to children, youth, and families with IDD to those with complex behavioral health needs.	HCPF	Year 2	In Progress
Expand the habilitative residential services afforded to children, youth and families with IDD to those with complex behavioral health needs.	HCPF	Year 2	In Progress
Secure Federal approval on 1115 Waiver amendment to support Medicaid Reentry Services	HCPF	Year 2	In Progress

11. *Sen. Kirkmeyer:* Has the BHA coordinated with HCPF regarding the potential for Medicaid to cover room and board costs rather than the BHA as contemplated in H.B. 24-1038 (High Acuity Youth)?

Room and board costs are excluded from Medicaid coverage. In developing H.B. 24-1038, HCPF, BHA and CDHS worked closely together to identify opportunities to maximize federal draw downs and achieve policy goals.

12. Sen. Kirkmeyer: What is the source of federal funds for HB 24-1038 (High Acuity Youth)? If it is ARPA funds, were the funds originally allocated in a different bill? Please provide the bill and program that the funds were originally expected to support.

BHA receives Mental Health Block Grants from Substance Abuse and Mental Health Services Administration (SAMHSA). In FY 2024-25, BHA identified funding from this source to apply towards room and board payments. In FY 2025-26 a small portion of Block Grants were able to be budgeted for this purpose, however beyond FY 2025-26 funds for this purpose are not available from this federal source.

R3 Crisis Consolidation

13. *Rep. Bird:* Has the BHA received feedback from providers about consolidating the crisis lines? What impacts does the BHA anticipate consolidation could have on providers?

Colorado has long been a national leader in providing our communities with crisis services through the Colorado Crisis Line (CCL). When the 988 line was established nationally, Colorado followed suit by creating the 988 Mental Health Line. When BHA and the 988 Enterprise launched a marketing campaign for 988, there was extensive outreach and communication with the providers and other community leaders who have utilized and promoted CCL for the last 14 years. One of the most critical pieces of feedback that BHA heard from providers was that CCL is a familiar and trusted resource and that any transition away from CCL must be a phased approach. R-03 will not impact providers or the community as R-03 is a consolidation of funding sources without impacting current service delivery. While the long term goal remains a single 988 crisis hotline, BHA assumes the phasing to only 988 will be driven by the rise of 988 utilization and the decrease of Colorado Crisis Line (CCL) utilization.

14. *Sen. Bridges:* Is there a reason the Colorado Crisis Line was not included in the 988 Enterprise in the original legislation that created the Enterprise?

Senate Bill 21-154 required the 988 Enterprise Board of Directors to consider recommendations from the 988 Implementation Planning Committee (IPC) to determine how the 988 crisis hotline will interact with the 24-hour telephone crisis line created as part of the Behavioral Health Crisis Response System, Section 27-64-103 (7), C.R.S. IPC provided vital input to the BHA and eventual 988 Crisis Hotline Enterprise to develop clear roadmaps for how to address key coordination, capacity, funding, and communication issues in preparation for the launch of 988. The first of nine high level recommendations from the IPC was for Colorado to maintain two lines for the near future with ongoing assessment of feasibility to merge the lines at a future date. Consideration for consolidation would be contingent on the 988 Enterprise's review of overall demand and center performance with consideration of:

- geo-routing status (988 call and text routing);
- call volume (Colorado Crisis Line and 988);
- scope of both call lines; and
- text and chat capacity.

With geo-routing advancement and appropriate text and chat capacity in place, BHA is shifting to promoting only 988, making it an appropriate time to consolidate funding sources. As noted in question 12, R-03 will not impact current service delivery.

R-04 Alternative Funding for Services

15. *Sen. Amabile:* Please provide information on current operations for the Circle Program. Where are Circle Programs located? How many people are served? What is the average and maximum allowed length of stay? What is the overlap with Medicaid and RAEs?

Three providers operate Circle programs in the state: Summitstone Garcia House (Fort Collins); Crossroads (Pueblo), and MindSprings Health (Grand Junction). All locations provide 24 / 7 comprehensive residential treatment to individuals with co-occurring substance use and mental health disorders with the capability to provide residential levels of care including ASAM 3.7 level of care facility, and optionally, lower levels of care. All three programs are enrolled with RAEs and accept Medicaid.

- There are a total of 59-60 beds between all agencies on average: Crossroads - 11 beds; MindSprings - 32.3; Garcia House - 16. (The partial number reflects a change in the number of beds operating as part of the program during the reporting period.)
- The average total length of stay residential services for each site is shown below; the maximum length of stay is determined by utilizing the American Society of Addiction Medicine Criteria to determine medical necessity. For Medicaid members, length of stay is governed by medical necessity and does not have a maximum limit, but rather members transition between residential levels of care across the continuum.
- In FY 2023-24, 449 individuals were served by the three circle programs. The majority of these individuals were Medicaid members, and reflect services billed to Medicaid.

Table 5 - FY 2023-24 Circle Program Data

Agency	Number of Unique Clients Admitted	Average Length of Service (days)	% of Unique Clients where Medicaid was billed
SummitStone	72	36	92%
Crossroads	138	25	96%
Mindsprings	239	26	85%

16. *Sen. Bridges:* Please provide an update for the implementation of H.B. 23-1003 (School Mental Health Assessment). What schools are served under the program? How many youth have been served?

The purpose of the Sixth through Twelfth Grade Mental Health Screening Program is to identify potential risks related to unmet behavioral health needs of students in grades six through twelve and to provide resources and referrals to address those concerns. The Program aims to positively impact student readiness to learn and future academic success by identifying and addressing unmet behavioral health needs.

The contract with the school mental health screening vendor, Possibilities for Change (P4C), was executed on July 1st, 2024. Upon execution of the contract, BHA, with input from CDE and

CDPHE, worked with the vendor to determine the screening tools to be used, and develop informative program documents such as Frequently Asked Questions and implementation timelines and guidelines to provide to schools. It was determined that the program would screen for student risk of depression, anxiety, suicidal ideation, substance use, and social determinants of health that may impact behavioral health.

As advised by CDE, all 201 public school districts in Colorado were invited to participate in the program. Invitations were sent out in March of 2024, and a live Question and Answer session was held in April of 2024. A total of 169 responded indicating interest in learning more about participating in the screening program. An information session was hosted in August for interested schools.

Following the information session, 17 schools made program participation commitments. Many schools that opted not to participate cited concerns about the timeline of the legislative requirement to inform parents of participation within the first two weeks of the start of the school year. Ultimately, only eleven schools met the legislative timeline to inform parents (as required by H.B. 23-1003). In December Sheridan School District, which had three schools confirmed to participate, dropped out of the program citing a lack of staff and resources due to unforeseen district changes mid-year. The current program participation is eight schools. These eight schools are in the Garfield 16, Colorado River BOCES, Canon City, and Revere School Districts (Garfield, Fremont, and Sedgwick counties respectively).

In January the staff at each of these schools will be trained to administer the mental health screening through the screening technology platform from Possibilities for Change. In February the screenings will take place on dates determined by the schools. The screening technology will be supported on screening day by Possibilities for Change and the screening response needs (crisis intervention, suicide risk assessments, and general mental health support as needed) will be supported by BHA and the Office of School Safety's Crisis Response Unit. The estimated number of students to be screened for the 2024-25 school year is 2,615.

Given the low participation, BHA has solicited feedback from schools who declined to participate after showing initial interest in the program. Schools have generally indicated a lack of resources / capacity as the reason for not participating, including: not enough staff / workforce to implement the screening program, not enough time due to other screenings or district / school initiatives, and concerns that the screening will prompt more students to seek school mental health resources that will exceed the school's capacity.

BHA is closely monitoring implementation and identifying, along with CDE and P4C, opportunities to address school concerns and increase participation in future years. This includes creating a marketing and outreach plan to increase program familiarity and the scope of participation. In addition, BHA is collaborating with Project AWARE on their School Mental Health Screening Toolkit with the goal of cross-promotion and increased school support through this combined effort.

R6 Right-sizing I Matter

17. *Rep. Bird:* Is the requested funding sufficient to meet current need for the program? How does the BHA assess need?

In recent years, BHA has reverted from the $6.0 million in annual appropriations to this program. On average, spending for the program has been approximately $5.0 million annually, resulting in approximately $1.0 million in reversions annually.

In FY 2024-25 the General Assembly made the decision to appropriate $5.0 million to the program. To account for the reduced budget, BHA did the following:

- decreased the program's marketing budget to $800,000;
- maintained the current rate for provider payments; and
- maintained contractor expenses at the same rate.

It is also important to note that the statute states "The BHA shall reimburse providers up to a maximum of three sessions per youth client; except that subject to available money, the BHA may reimburse a provider for additional sessions" Section 27-60-109 (2)(b), C.R.S. With current funding, up to six sessions are consistently made available to youth. Not all youth require or choose to access all six sessions, and on average youth access 4 sessions.

BHA believes that with an ongoing budget of $5.0 million annually, I Matter will continue to provide low-barrier access to short-term intervention services, as well as an entry point to services for youth and families who might not know where to start getting care, and will need ongoing support.

BHA is actively working to increase quality of and access to mental health services for youth in a variety of settings and through programs that offer youth mental health services separately from I Matter, as is outlined in the Children and Youth Behavioral Health Implementation Plan. This expands the resources and services to which youth and families can be referred beyond I Matter. As a result, BHA anticipates that an ongoing $5.0 million per year budget for the I Matter program will be sufficient to continue the program in an effective manner as one program within the larger youth behavioral health continuum.

18. *Sen. Bridges:* Does I Matter provide services otherwise available through Medicaid or private insurance?

While many insurance plans do cover counseling services like those offered by I Matter, there are often barriers associated with accessing these services. This includes costs including copays, prior authorization requirements, assessment and diagnosis requirements, all of which can delay care or prevent individuals from accessing the services. I Matter in an innovative solution that facilitates prompt, low barrier access to high quality behavioral health services for youth, regardless of their insurance status.

While BHA is committed to ensuring that I Matter remains an option for youth who need it, opportunities are actively being explored to better leverage alternative payors and to continue

expanding access to services for youth through I Matter and services and programs across the continuum.

BHA has explored opportunities for Medicaid and commercial insurance to reimburse for services. In doing so, BHA has identified several challenges and opportunities. These include:

- Credentialling and billing: Currently, I Matter's licensed providers are not required to be enrolled with Medicaid or credentialed with other insurance companies. This eliminates the administrative burden the program and providers would face if credentialing was required. Additionally, the program, and in some cases individual providers are not set up to bill these payors, and a shift to do so would increase burden on youth and providers as well as drive administrative costs needed to make data, billing and other financial and regulatory requirements possible.
- Prior authorization and diagnosis: In order to provide rapid access to services the program does not require a diagnosis or prior authorization which are known factors to delaying treatment. Youth and families are able to fill out a quick online screening and schedule an appointment within minutes.

In 2023, the Colorado Legislature passed Senate Bill 23-174 that required the Department of Health Care Policy and Financing (HCPF) to provide access to a limited set of behavioral health services to members under the age of 21 without a covered diagnosis. The legislation detailed service categories that must be included under this coverage, and HCPF engaged stakeholders to identify the specific service codes that are included. This coverage policy went into effect July 1, 2024[6]. This policy change allows BHA and HCPF to work together to identify mechanisms to reimburse providers for I Matter services delivered to Medicaid members.

ARPA PROGRAM EXPENDITURES & COMMON QUESTIONS FOR DISCUSSION

19. Please describe any budget requests that replace one-time General Fund or ARPA funded programs with ongoing appropriations, including the following information:

    a. Original fund source (General Fund, ARPA, other), amount, and FTE;
    b. Original program time frame;
    c. Original authorization (budget decision, legislation, other);
    d. Requested ongoing fund source, amount, and FTE; and
    e. Requested time frame (one-time extension or ongoing).

BHA's requests for budget increases for FY 2025-26 do not replace one-time General Fund or ARPA funded programs with ongoing appropriations.

[6] https://hcpf.colorado.gov/sb23-174-coverage-policy

20. *Sen. Kirkmeyer:* How many FTE are administering ARPA programs? How many positions are state FTE or contracted? How many positions are ongoing or term-limited?

While BHA staff are broadly involved in administering ARPA programs through significant involvement across all levels and teams of the organizational chart, the following are fully dedicated to, and funded through, ARPA programs. All of these positions are term-limited.

- State FTE: 11.0 (through December 2026)
- Contracted: 28.0 (end dates align with program completion dates)

21. *Sen. Bridges:* Is there any funding associated with ARPA programs that has not been awarded? What would be the impact of forcing programs to end early to retain one-time General Fund? Please describe any anticipated reversions based on current expenditures for all ARPA programs.

As of the date of this submission (December 17, 2025) all State and Local Fiscal Recovery Funds (SLFRF - sometimes referred to as ARPA) are encumbered in contracts or grants, and most refinanced general funds are entered into contracts or grants. This information reflects encumbrances that have been made since September 30, 2024 and will be reflected on the Colorado Forward website when updated during the next quarterly update.

Funds that remain unencumbered at this time are committed to projects where the full award cannot be encumbered at the outset of a project because the work plan requires a series of smaller consecutive contracts across the project timeline. This includes projects where work is contracted in smaller, incremental steps like BHA's Learning Management System (LMS) builds, and technology development, due to the need for a phased approach across multiple vendors and / or workstreams. This also includes administrative funds that will be used to ensure compliance as remaining funds are spent and projects are finalized through 2027. At this time, BHA anticipates no future reversions. All funds are on track to be spent by statutory deadlines.

Ending ARPA programs early would result in the following:

- active contracts would need to be terminated; and
- projects that are in process would be left unfinished. Examples include leaving LMS courses that are in development incomplete, and leaving tech projects such as the expansion of a referral system and interoperability with the BHASOs, unfinished.

Colorado Forward data from S.B. 21-137 reflects $1.42 million in unencumbered dollars that BHA no longer has spending authority for. This number does not account for final closeout transactions and processes, so the true final remaining amount is less than $350k and will be directed to other purposes approved by the general assembly per H.B. 24-1466.

22. *Sen. Bridges:* Please provide an update on the expected expenditure timelines for S.B. 22-181 and S.B. 22-177. When does the BHA anticipate that funds will be fully expended? Are the full amounts allocated by the legislation committed in contracts or grants? Please describe any implementation delays or anticipated reversions.

S.B. 22-181

S.B. 22-181 funding is utilized through a variety of distinct projects implemented concurrently to support and expand the behavioral health workforce through comprehensive and strategic approaches. All S.B. 22-181 funds will be fully expended by December 31, 2026 per the legislative spending authority granted in H.B. 24-1465. Since funds are utilized for distinct projects, funds will fully expend at varied rates based on the different workplans.

Contracts with most grantees have been extended through December 2026 to ensure partners are able to fully expend funds through sustainable implementation, however BHA program managers are working closely with each grantee based on appropriate timelines to ensure spending is not unnecessarily delayed and programs are benefiting people in Colorado as intended. Most grant agreements with community partners are anticipated to complete spending and close contracts in mid - FY 2025-26, other programs (primarily including interagency agreements) are anticipated to complete spending and close contracts at the end of FY 2025-26, and funds focused on the Learning Management System (LMS) will complete spending into FY 2026-27 prior to December 31, 2026. LMS spending extends farthest into the legislative spending authority as timing is dependent on curriculum development completion to be released on a rolling basis through FY 2025-26. When all curriculum is completed and delivered by the end of FY 2025-26, funds will then be utilized for LMS expenses related to platform licenses, expansion, and development to accommodate the final curriculum. At this point all funds allocated by the legislation are fully committed to workforce development projects.

As of this date, since the most recent available fiscal data as posted on Colorado Forward website, all State and Local Fiscal Recovery (SLFRF - sometimes referred to as ARPA) are encumbered in contracts or grants and most refinanced general funds are entered into contracts or grants. This will be reflected on the Colorado Forward website when updated during the next quarterly update. The refinanced general funds that will remain are reserved for operational expenses that are essential to manage and complete the programs including BHA temporary contractor staffing expenses and LMS technology platform development. These funds cannot be encumbered into a contract in advance because the state pricing agreement for the temporary contractor company renews in May 2025 (at which point a contract can be executed), and LMS technology platform development requires a series of smaller and incremental encumbrances to ensure compliant and responsible utilization of funds in the phased workplan.

S.B. 22-177

The Behavioral Health Administration (BHA) anticipates a full expenditure of S.B. 22-177 funds by June 30th, 2026 for all technology related costs and systems. As of FY 2024-25, $4.3 million will be allocated to contracts that support the critical technology infrastructure, including:

- a platform to support behavioral health providers who do not have Electronic Health Records in engaging in digital care coordination activities with people and their colleagues around the state. This includes outreaching to and training navigators on the platform [Administrative Burden Interoperability efforts and data modernization];
- technology capabilities to support navigation to behavioral health services that are funded through Medicaid and private insurance [OwnPath Expansion and Client Care Search Referrals);
- Technology capabilities so that people and providers could engage directly with BHA navigators to find behavioral health services and BHA's Behavioral Health Administrative Services Organizations [BHASO technology ecosystem integration]; and
- Collection and reporting of outcomes of individuals who were assisted via care coordination infrastructure [Data Collection and Data Lakehouse]

Due to BHASO launch timelines shifting to July 1, 2024, several initiatives launched in the current fiscal year will extend into FY 2025-26 to accomplish the interoperability efforts with EHRs and the broader health landscape. These programs, which started as Minimally Viable Products (MVPs), require further enhancement and development to reach full functionality. As a result, the remaining $6.9 million will be encumbered for FY 2025-26 contracts and continued OIT services and support to ensure alignment with statewide enterprise technology best practices.

In FY 2025-26, the implementation costs will support the expansion of Care Coordination Infrastructure, including enhancements to the referral system and the public-facing access point for behavioral health care, OwnPath. Significant resources will also be invested in improving interoperability for data collection, reducing administrative burdens, and ensuring integration with existing systems, including the SHIE for SDOH resource placement.

These efforts will require ongoing collaboration with existing and new vendor partners, as well as resources from both OIT and BHA technology program staff. It is important to note that none of these funds will be allocated to grants, as they are earmarked for licensing, operational support, and vendor services.

Table 6 provides a breakdown of these technology requirements and status.

Table 6 - Technology Requirements and Status

Major requirement	BHA's Plan
A platform to support behavioral health providers without Electronic Health Records to	This work will be completed in three phases: Completed **LAUNCHED IN 06/24**

Major requirement	BHA's Plan
engage in digital care coordination activities with people and their colleagues around the state. This includes outreaching to and training navigators on the platform.	Phase 1 (FY24 Q4 - April to June 2024): Develop and launch platform where hospital and in-patient behavioral health providers can find an available provider and complete a referral for transition to in-patient care. This will cost approximately $2.5 million, including vendors supplying platform / software licensing and augmented engineering for platform configuration and custom build support. New Requirements **IMPLEMENTING NEW BHASO INFRASTRUCTURE REQUIREMENTS:** Phase 2 FY25 Q3: Outreach to and train select providers based on Phase 1 use case. Goal to have 75% saturation in in-patient providers participating in behavioral health safety net, mandated to use the tool and 30% saturation in emergency rooms. Make functionality adjustments based on provider feedback. Expand functionality to support referrals for stepping down from in-patient to select outpatient behavioral health services. This will cost approximately $2.5 million, including vendors supplying application workflow development, project management, and program coordination support and training. ● 84% saturation with bed tracking functionality ● Currently piloting referral features with provider groups but will hold on scaling until the BHASO requirements are better understood in February 2025. ● As a note, there is currently no mandate for leveraging this tool. In Progress **ON TRACK BUT DEPENDENT ON S-HIE RELEASE TIMELINE** Phase 3 (FY26 Q4 April to June 2026): Broad outreach and training to behavioral health providers. Goal to have 60% saturation in all behavioral health providers and 85% saturation in providers participating in behavioral health safety net. Fully incorporate referrals to social determinants of health supports leveraging the Office of eHealth Innovation's Social-Health Information Exchange Infrastructure. This will cost approximately $3.5 million, including vendors supplying data integration, application workflow development, project management, and program coordination support.
Technology capabilities to support navigation to behavioral health services that are funded through Medicaid and private insurance	In Progress **WORKING WITH HCPF TO AUTOMATE THIS QUARTERLY PROVIDER DATA EXCHANGE** FY25 Q4 - Intentional outreach to approved safety net providers (most, if not all, of which will be Medicaid providers) to onboard to the provider platform. This will cost approximately $1 million, including vendors supplying application development, marketing and communication services, project management, and program coordination support and training. New Requirements **ADDITIONAL REQUIREMENTS WILL NEED TO BE REFINED WITH THE BHASO STRUCTURE FOR PRIOR AUTHORIZATION** FY26 Q3 - January to March 2026: Develop integrations for HCPF to check for prior authorization for services as part of e-referrals. This streamlines and incentivizes use by Medicaid providers. This will cost approximately $400K, including vendors supplying data integration, application workflow development, project management and program coordination.

Major requirement	BHA's Plan
Technology capabilities for people and providers to engage directly with BHA navigators to find behavioral health services and BHA's BHASOs	New Requirements **ADDITIONAL REQUIREMENTS WILL NEED TO BE REFINED WITH BHASO STRUCTURE FOR CARE COORDINATION** FY26 Q2 - October to December 2025: Incorporate of workflows that support people engaging with BHA's navigators and state-managed service providers via OwnPath and the provider platform. Goal to have all BHA's Behavioral Health Administrative Services Organizations incorporated to all care coordination use cases in the provider platform. Make functionality adjustments based on provider and user feedback. This will cost approximately $1.2 million, including vendors supplying data integration, application workflow development, project management, and program coordination support and training.
Collection and reporting outcomes for individuals who were assisted via care coordination infrastructure	In Progress **ONGOING EFFORTS THAT CONTINUE TO PROGRESS TOWARD THIS END GOAL** FY26 Q2 - October to December 2025: Incorporation and integration of all data from provider platform efforts to the BHA Data Lakehouse and updated within master data management practices; analytics and data science engineering development to iteratively provide reporting on each specific type of care supported by the care coordination efforts and outcomes detailed above (hospital/in-patient; safety-net; social determinants of health; Medicaid; private insurance; BHASO). This will cost approximately $1.1 million, including vendors supplying data integration, application workflow development, project management, data analysis and program coordination support and training.

These funds are being expended through iterative contract processes with external vendors and flexible OIT engagements, with smaller, more flexible outcomes based scopes that allow for quick pivots and responsive technology development. These funds will be used for contract amendments with existing partners and to support vendor services, including licensing, implementation, and personnel. One vendor contract is currently awaiting renewal of their State Pricing Agreement, which is temporarily delaying further encumbrance of funds. This approach aligns with industry best practices for technology budgeting, as outlined by GSA 18F's Technology Budgeting Handbook[7], which emphasizes gradual encumbrance of funds to allow for adaptive and efficient project execution, rather than encumbering large sums upfront and creating a monolithic waterfall technology system. BHA is strategically and iteratively encumbering funds over time to ensure the final product is built based on end user needs. This method helps reduce the risk of investing funding into systems that do not scale and create large technical debt.

Given this strategic approach to contracting and iterative development, BHA does not anticipate any reversion of funds at the end of the next fiscal year.

23. *Sen. Amabile:* Please describe the programs funded by S.B. 22-196. Are all allocated funds fully committed in contracts or grants? Could unencumbered money be used to support Jail-based behavioral health for MAT programs?

[7] https://guides.18f.gov/derisking-government-tech/

Senate Bill 22-196 funded a number of efforts across various agencies , and under BHA established the early intervention, deflection, and redirection from the criminal justice system grant program. This program provides grants to local governments, federally recognized Indian tribes, health-care providers, community-based organizations, and nonprofit organizations to fund programs and strategies that prevent people with behavioral health needs from becoming involved with the criminal justice system or that redirect individuals in the criminal justice system with behavioral health needs to appropriate services. As of June 2024, 6,386 individuals have been served through expansion of early intervention, deflection and / or redirection across 29 initiatives.

Initiatives for early intervention include services for youth including multisystemic family therapy in rural Colorado, school-based programming for at-risk youth, bilingual youth services, and restorative justice programs. The grant program also funds capital infrastructure for two 24/7 crisis walk-in service centers which will provide medication-assisted treatment, withdrawal management, and case management. These centers provide early intervention for those seeking behavioral health resources and meet vital needs for the continuum of care in other deflection, diversion, and reentry programs.

Deflection and diversion programs created or expanded include co-responder, law enforcement-assisted diversion, and community responder programs to meet the behavioral health needs of individuals in communities. Other supports include harm reduction programs, intensive case management, substance use disorder and inpatient behavioral health treatment referrals, drop-in and day programs for individuals with substance use disorders, pre-trial services, DUI classes, and culturally responsive therapy.

For those individuals with criminal justice involvement, the S.B. 22-196 grant develops and supports programs that provide necessary behavioral health support and off-ramps for successful reintegration back into the community. These programs include pre-release planning and support, wrap-around case management, peer support groups, housing support, job skills training, and sex offender-specific support.

All S.B. 22-196 early intervention, deflection, and redirection from the criminal justice system grant program funds are fully committed in contracts, and BHA has plans to fully expend all funds by the 2026 statutory deadline. Due to the nature of these projects, BHA anticipates that some of the currently encumbered funds will not be fully spent by awardees. This is the result of adjusted workplans (eg: grantees removing or adjusting capital expenditures, requesting modification to scope based on feasibility, etc), and awardee initiated renegotiated budgets. All of the projects are being closely monitored and BHA is offering support to grantees to achieve project aims. Based on the projection that some encumbered funds will not be spent by current awardees, BHA has plans in place to fully spend these funds for their statutorily intended purposes.

The grant program’s statutory requirements do not currently include jail-based MAT services as an allowable use of these funds.

24. *Rep. Bird:* In response to recent reporting related to substance use recovery grants, how does the BHA track and audit the use of grant funds? How does the BHA evaluate awardees and ensure that people are connected with appropriate services?

Grantees have diverse funding streams for various uses. During the procurement and award process, BHA requests and reviews information to identify duplication of funding and sustainability. While BHA cannot speak to the transparency and oversight between vendors and other funding entities - BHA follows the following processes when evaluating and awarding grants.

- Pre-award Evaluation: Grant applications undergo a structured and transparent process to ensure fairness, alignment with program and legislative goals, and the selection of the qualified applicants. Here is an outline of how grant evaluations are conducted.
    - **Scoring Rubric:** Solicitations include detailed evaluation criteria, outlining how the grant application will be scored according to alignment with program goals, feasibility, sustainability, equity, best use of state dollars.
    - **Evaluation Committees:** Diverse group of subject matter experts, community representatives, and stakeholders are assembled by the BHA program to review and score applications.
    - **Screening for Eligibility:** Applications are checked for compliance with basic eligibility requirements.
    - **Scoring & Evaluation:** Evaluators score applications independently based on the rubric. Key factors typically include:
        - Grant Project Design: clarity and goal alignment
        - Impact: expected outcomes and target populations
        - Capacity: staffing and resources
        - Equity: strategies to serve diverse and underserved populations
        - Budget: reasonableness and justification
    - **Review Meeting & Consensus:** Evaluation committee meets to finalize scores, recommend awardees and notify recipients.
- Post-award Evaluation and Tracking:
    - All grant awards are monitored by BHA staff, including fiscal and programmatic teams, per BHA and federal code of regulations to provide grantee technical assistance, ensure compliance, and monitor implementation success or barriers.
    - Monitoring occurs through regularly scheduled group office hours and individual meetings, desk reviews and / or site visits as appropriate, review and approval of quarterly and annual performance reports as required in contracts, and detailed review of supporting documentation with each invoice prior to approval.
    - Grantee spending and performance details are reviewed and included in standard BHA reporting processes dependent upon the source of funds which may include internal reviews, monthly spending and performance submissions to the Governor's Office, quarterly and / or annual reporting to the federal government, reporting and transparency with Colorado legislature, etc.

25. *Sen. Kirkmeyer:* Please provide any ongoing programs that originated as ARPA programs.

The following ongoing programs were originally funded with ARPA-SLFRF:

- **Crisis Resolution Teams -** S.B. 21-137 provided funding for a Crisis Resolution Teams (CRT) pilot that was extended by H.B. 22-1283. This funding has allowed BHA to operate a crisis resolution team pilot in 21 counties and the city of Colorado Springs since 2022.

  A Crisis Resolution Team supports youth who are experiencing behavioral health challenges and their families. The teams provide intensive, short-term (4-6 weeks), in-home services up to 3 times per week and linkage to ongoing supports. While the team's focus is the youth, they also provide services to family members directly involved with the youth to increase sustainable interventions and support. CRT aims to avoid out-of-home placement like hospital admission or residential / psychiatric placement by wrapping services around the family in an effective manner. Referrals to CRT typically come through emergency departments and Colorado Crisis Services.

  Program outcomes are monitored and reported. The program has consistently had over a 90% success rate at keeping kids safely in their homes and avoiding the need to transition to costly residential or inpatient treatment since its launch. Over 600 families have accessed these services for youth and young adults with high acuity behavioral health needs since the program's launch.

  The CRT program is expected to receive $1.25 million GF in FY 2025-26.

  Proposition KK directs $3.0 million annually to continue and expand access to these behavioral health crisis response system services for children and youth.

- The **I Matter program** originated from H.B. 21-1258 and was continued by H.B. 22-1243. The program currently receives $5.0 million GF and was made ongoing by S.B. 24-001.

RECENTLY CREATED PROGRAMS

26. *Sen. Bridges:* Please describe the ongoing programs implemented by S.B. 21-137 (Rural vouchers, recovery residence certification, recovery services, workforce learning, care coordination, and SUD housing). How does the BHA evaluate the impact and ongoing need for these programs?

Recovery Residence Certification - Recovery residences are residential settings for individuals recovering from substance use disorder that provide an alcohol and drug-free living environment, peer support, assistance with obtaining behavioral health services and other substance use disorder recovery assistance. S.B. 21-137 established an ongoing requirement that BHA must hire a contractor for certification and training on industry best practices for recovery residences. $200,000 GF is appropriated for this purpose annually. The Colorado

Agency for Recovery Residences is contracted by BHA as the certifying body for recovery residences. Three hundred thirty-one (331) recovery residences have been certified to date. The certification process includes application review, site inspections, policy documentation review, Technical Assistance (TA), and follow up and monitoring. This certification is meant to ensure that recovery residences adhere to established national standards for safety, quality, and accountability, ensuring the residents in the homes receive enhanced recovery outcomes.

Housing Assistance Program - This program provides temporary assistance for individuals with a Substance Use Disorder who have no supportive housing options when the individual is transitioning out of a residential treatment setting and into recovery, or receiving treatment for the individual's substance use disorder.

The Housing Assistance Program allows Managed Service Organizations (MSOs), contracted by the Behavioral Health Administration (BHA), to provide stipends to Recovery Residences and Oxford houses to cover costs for eligible individuals residing in the setting. These stipends can only be paid to CARR certified recovery residences or chartered Oxford Houses. Recovery residences are residential settings for individuals recovering from substance use disorder that provide an alcohol and drug-free living environment, peer support, assistance with obtaining behavioral health services and other substance use disorder recovery assistance.

The Program stipends are designed to provide short term support for recovery residence service costs until the individual can pay their own way or no longer needs recovery oriented housing services. It is important to note that these stipends are targeted towards ensuring access to these critical recovery services along the behavioral health continuum, and can only be used to support individuals experiencing or recovering from a Substance Use Disorder and residing in these settings. The stipends are not transferable or able to be used for generic rental subsidies.

The Program receives an annual appropriation of $4.0 million GF that supported 1,461 unique individuals with access to a recovery residence in Q1 of FY 2024-25. Currently, these funds are distributed through MSOs. Beginning in July 2025, the Behavioral Health Administrative Service Organization's (BHASO) will distribute these funds.

Measurement: MSOs develop and report on workplans related to the program, including the number of individuals who receive services.

Recovery Support Services (RSS) Grant Program - The RSS Grant Program provides grants to recovery community organizations for the purpose of providing recovery-oriented services to individuals with a substance use disorder or co-occurring substance use and mental health disorder. The recovery services that have been implemented and carried out successfully are comprehensive support for individuals' recovery from substance use and mental health.

Under the recovery umbrella are recovery residences, Recovery Community Organizations, and Peer Support. These organizations provide support including Art, Education, Groups (education & support), Hobby Inspiration, Meditation / yoga, Prayer / Spirituality, Coaching & Mentorship, Social Support. These programs empower individuals across Colorado to experience whole-person health through accessible and trusted systems.

These recovery programs are grounded in lived experience and evidence-based practices in communities. Research consistently demonstrates peer support enhances recovery outcomes, reduces relapse rates, and increases engagement in treatment. The MSO reports to BHA the number of unique clients served, number of clients served in a month, individual peers services, 1:1, individual peers services, group.

Rural Behavioral Health Vouchers - BHA contracts with the Colorado Farm Bureau to administer this program. They support training to build capacity to serve rural agricultural workers as well as issue vouchers for services to providers with the cultural competence to provide direct services to farmers, ranchers, and other agricultural workers and their families.

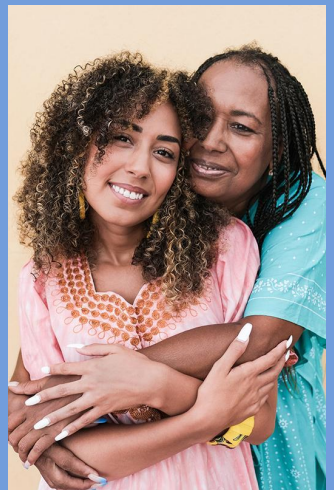
Individual programs often have their own metrics for measuring outcomes. These may differ based on funding source, statutory requirements, provider and community input, and other factors. BHA evaluates programs for impact and identifies opportunities to make improvements, including, when necessary proposing statutory changes. Additionally, as BHA strengthens and streamlines the behavioral health safety net system through new statutorily driven standards and the implementation of BHASOs, we are working to standardize how and what we collect in order to draw more holistic conclusions, identify gaps, and measure improvements across the system as a whole.

On July 1, 2025 BHA launched the Performance Hub[8]. The first version of the Performance Hub sets a baseline for metrics related to service usage, capacity, and complaints. Over time, more data will launch to support improvements and address inequalities to healthcare in Colorado.

Today, BHA is reporting on the following outcomes through performance hub:

- Number of people who received publicly-funded community mental health services per 1,000 people
- Number of people with health insurance and at least one claim who received mental health services at a rate per 1,000 people
- Number of people with health insurance and at least one claim and a mental health diagnosis who received mental health services at a rate per 1,000 people
- Number of people who received substance use disorder care under a BHA-funded or overseen program per 1,000 people
- Number of residential beds for substance use disorder treatment in Colorado by county
- Number of complaints made to BHA about behavioral health services
- Number of children and youth that spent time in inappropriate care settings past when they are releasable

[8] https://bha.colorado.gov/data-and-reports/performance-hub



Behavioral Health Administration

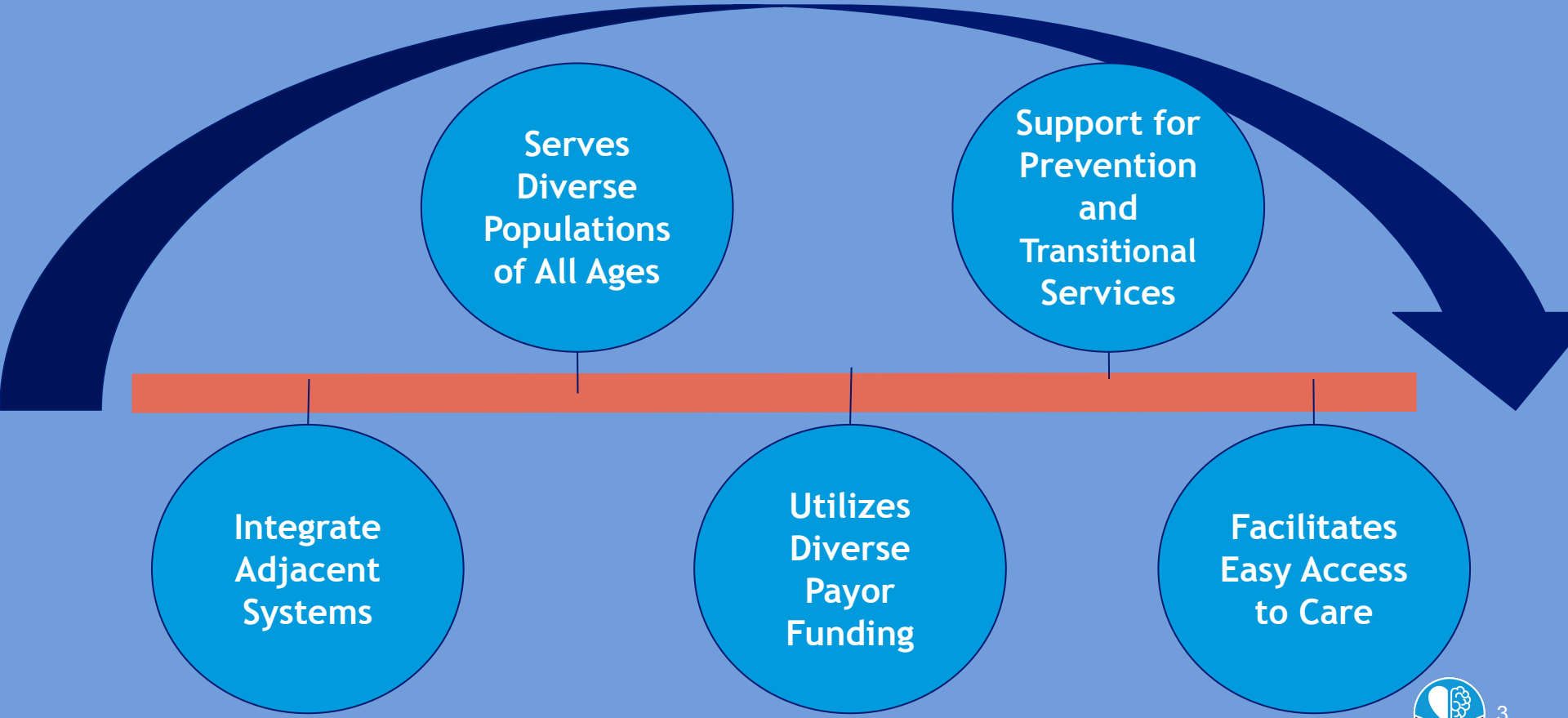
Joint Budget Committee Presentation
December 2024
Commissioner Dannette R. Smith

COLORADO
Behavioral Health Administration

What You'll Hear Today

1. Vision.
2. Internal Alignment to the Vision.
    a. Administration
    b. BHASO Implementation
3. BHA's 2026 Budget Request.
4. ARPA Impact Update.

Clear Vision: BHA is Colorado's Behavioral Health Authority



Moving From “Old” to Transformed

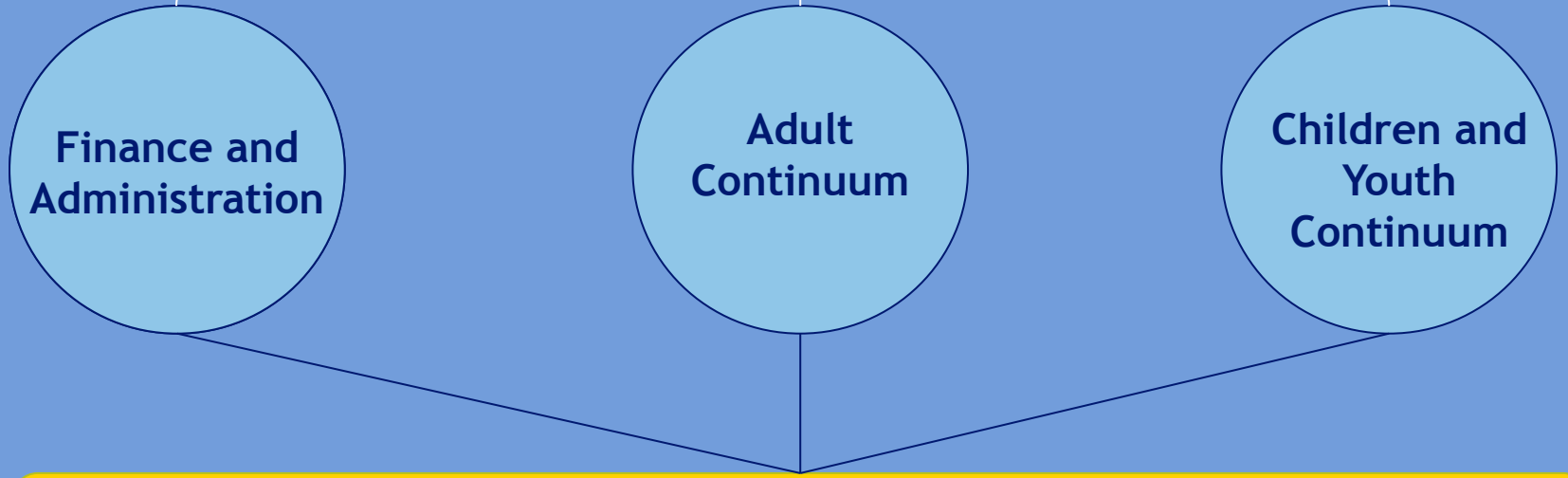
Patchwork System of Programs and Payors

BHA

4 Areas of Action

1. Realigning Organizational Structure
2. Updating Internal Structures and Processes
3. Developing an Entrepreneurial and Collaborative Finance Model
4. Implementing the BHASO Networks

BHA's Realigned Workstreams

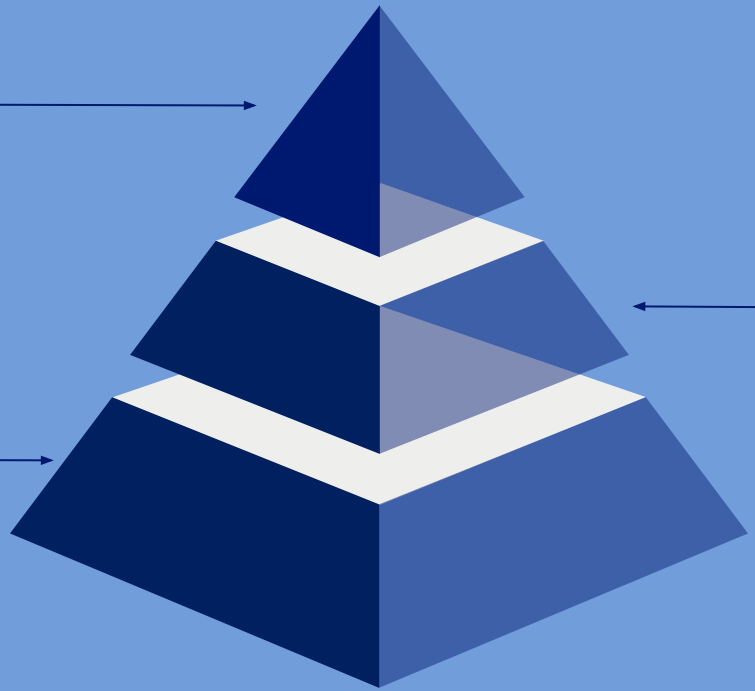


BHA is methodically solidifying its foundation of passionate staff with subject matter expertise.

Q1, pg.1; Q2, pg. 2

Civic Initiatives and Finance Model

Entrepreneurial approach to financing agency and system!

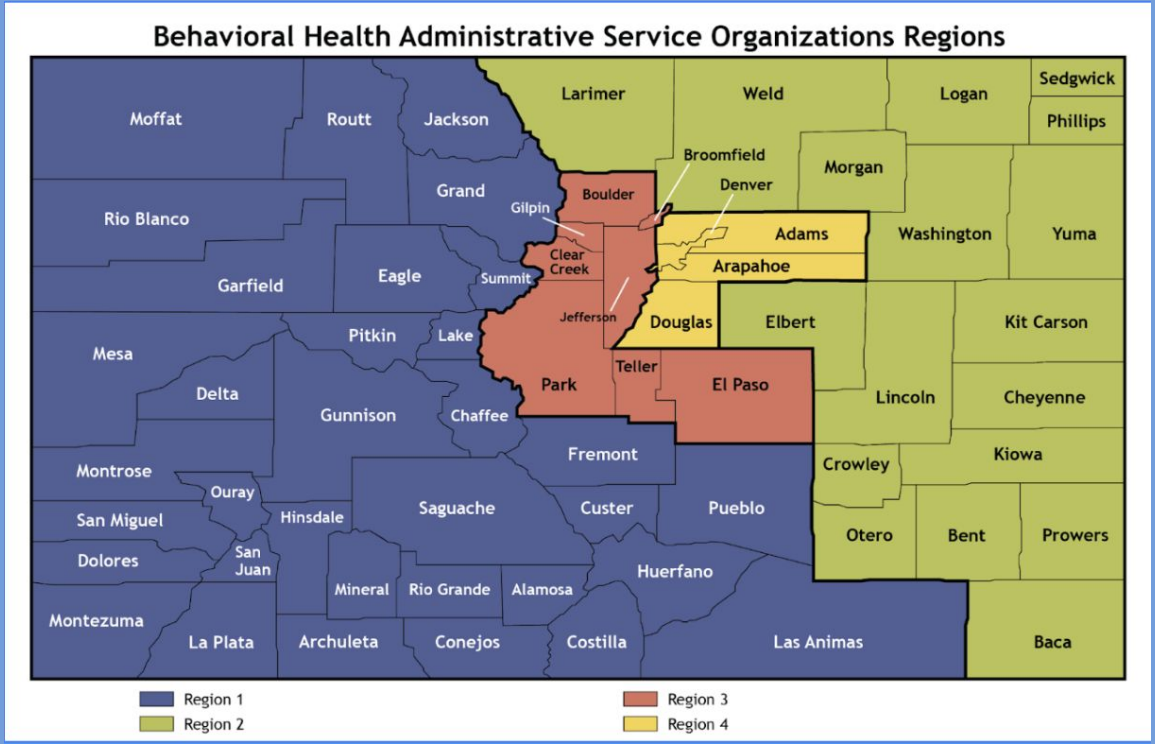


Leveraging discretionary funds to bolster the behavioral health system and expand access.

Solid internal structures to support the portfolio of a behavioral health authority.

Q3, pg. 2

Behavioral Health Administrative Service Organizations



- Care Coordination
- Administrative Services
- Direct contracting with providers and other community-based behavioral health organizations

BHASO Funding

BHASO Administrative Rate

7.5% & 6.7%

BHASO RFP required that bidders propose an administrative rate to fund their operations, not to exceed 10%.

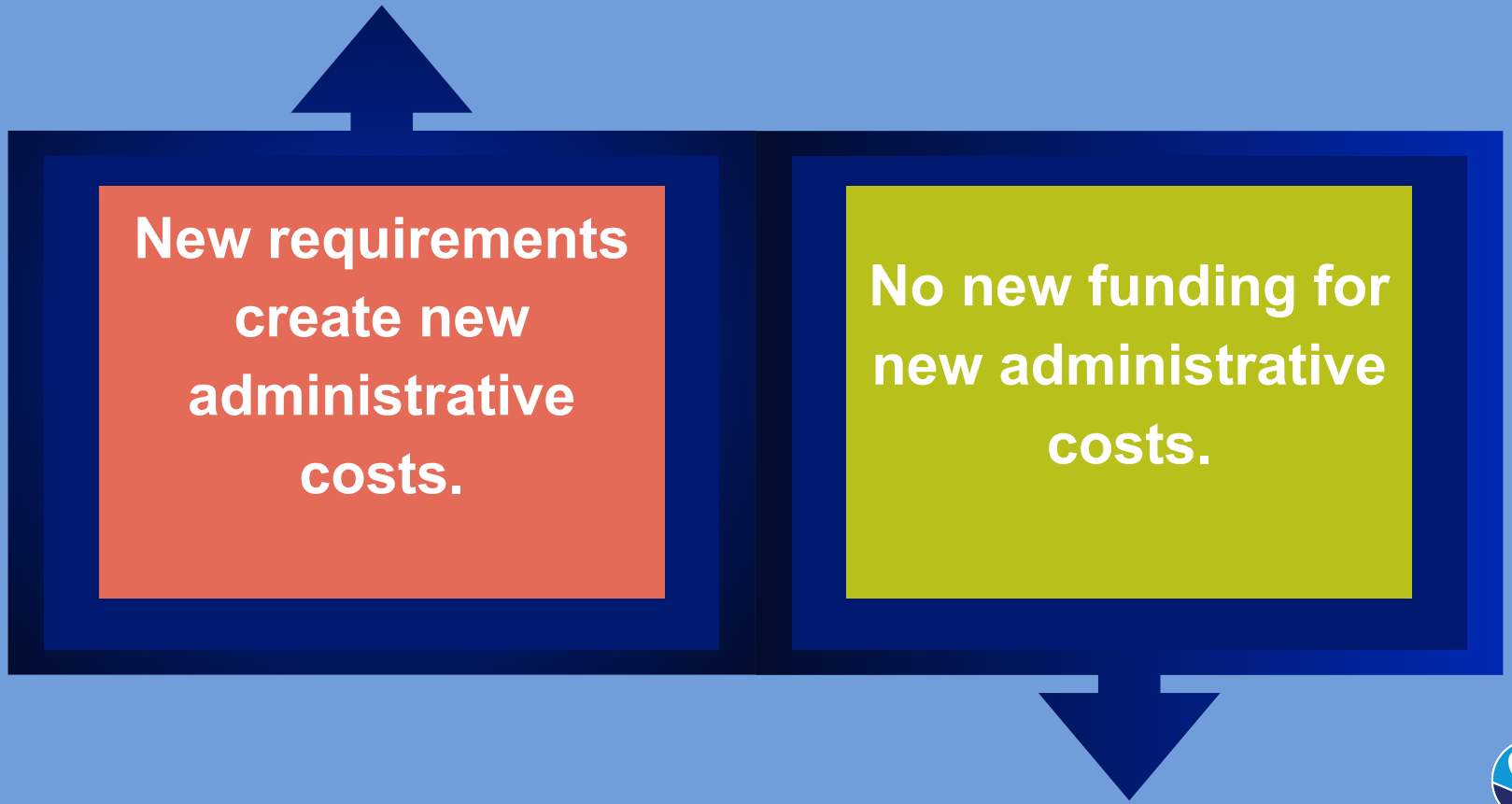
MSO Administrative Rate

10%

Managed Service Organization contract sets a universal administrative rate for all MSOs at 10%.

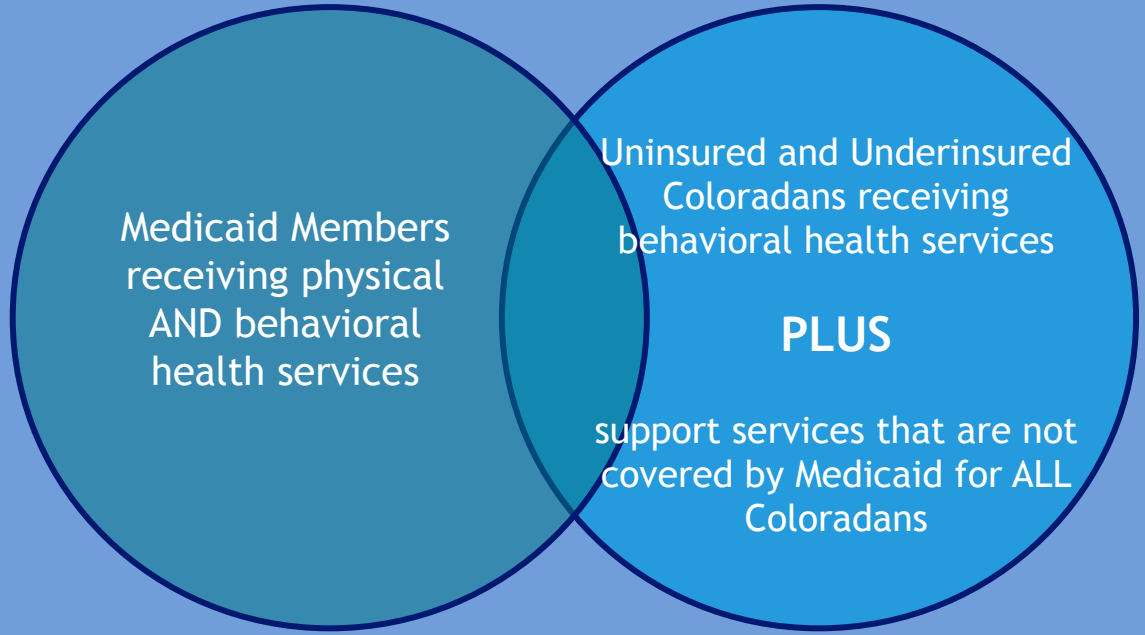
Q4, pg.3

Provider Feedback on BHASOs



RAEs vs BHASOs

Safety Net Providers receive enhanced rates for providing additional services.



Contracted Safety Net Providers *reimbursed* for services to uninsured and underinsured.

Q5, pg. 4; Q6, pg. 6, Q7, pg. 6

BHA FY 2026 Budget Request At a Glance

R1	*Increasing Access to Behavioral Health Care*	$3.15M
R2	*Advancing the Children and Youth Behavioral Health Implementation Plan*	$0.35M
R3	*Streamlining Crisis Care*	Net $0.20M
R4	*Alternative Funding for Behavioral Health Services*	-$1.6M
R5	*School Mental Health Screening Savings*	-$0.78M
R6	*Rightsizing I Matter*	-$6.0M
R7	*BHE Licensing Cash Fund Spending Authority*	Net $0.42M
R8	*High-Acuity Crisis for Youth and Children*	$3.35M

R-01 Increasing Access to Care $3.15M

Coordination

Service funding for care coordination services provided by safety net providers.

Navigation

Expanded care navigation by BHASOs to get people connected to care.

Compliance

Administrative support for providers taking on new responsibilities to support communities.

R-02 Advancing the Children and Youth Behavioral Health Implementation Plan (CYBHIP) $350K

Assessment

Capacity assessment will determine gaps and strategies to connect and expand services across the continuum.

Analysis

Analysis will consider opportunities to offset costs informed by capacity expansion recommendations.

Access

Inform strategies to streamline public funds to maximize access to, and quality of, behavioral health care for children and youth in Colorado.

Q9, pg. 12 ; Q10, pg. 20; Q11, pg. 21; Q12, pg. 21

Advancing the Children and Youth Behavioral Health Implementation Plan

Regular meetings among state agencies establish a habit of collaboration.

Participation across 12 state agencies and the Lt. Governor's Office.

6 Priorities and 19 Year 1 Action Items.

R-03 Streamlining Crisis Care

$200K

Align

Placing the Colorado Crisis Line under the 988 Enterprise - 988 is much easier to remember than the CCL number.

Expand

988's services would expand to include a peer warm line, as is currently available through CCL.

Transition

Begin a clear transition to 100% use of the 988 Mental Health Line.

Q13, pg.21; Q14, pg. 22

R-04 Alternative Funding for Behavioral Health Services

$1.5M

Rightsize

The Circle Program has seen decreased demand for BHA funding due to changes in Medicaid coverage.

Quality

R4's reductions will not sacrifice quality or access.

Progress

This request is another example of BHA's desire to move forward from the "old" framework of funding a patchwork of programs to a continuum of care approach.

Q15, pg. 22

R-05 School Mental Health Screening Savings $775K

Consolidate

The current vendor responsible for providing services through the School Mental Health Screening program is able to fulfill both the screening and data aspects of the project.

Continue

Per statute, schools must notify parents during the first two weeks of the school year, which has significantly affected participation.

Q16, pg. 23

R-06 Rightsizing I Matter

$6M

Maintain

I Matter is able to continue to operate on the 5 million dollar budget that this committee approved for the current fiscal year.

Discover

BHA continues to work to address challenges and opportunities related to leveraging other payors to expand the I Matter program.

Q17, pg. 24; Q18, pg. 25

R-07 and R-08 - Technical Corrections

Spending Authority

Technical Error

Colorado's ARPA Behavioral Health Investments

Behavioral & Mental Health (BMH) Fund

$550M

SLFRF from the BMH Fund appropriated across 9 departments and the judicial branch.

BHA Appropriations

$294M

One time SLFRF appropriated to BHA for behavioral health, workforce and public health investments from the BMH Fund.

Q19, pg. 26; Q20, pg. 26, Q21, pg. 26; Q22, pg.27; Q23, pg. 31

ARPA Examples

1. Children's Hospital Colorado Mental Health Emergency Unit - 8 New Beds
2. BHA'S Learning Management System - 81 New Courses
3. Crisis Resolution Teams in 21 Counties - 600 Families Served
4. Recovery Support - 3 Ongoing Programs

Q24, pg.31;Q25, pg. 34; Q26, pg.34

What You've Heard Today

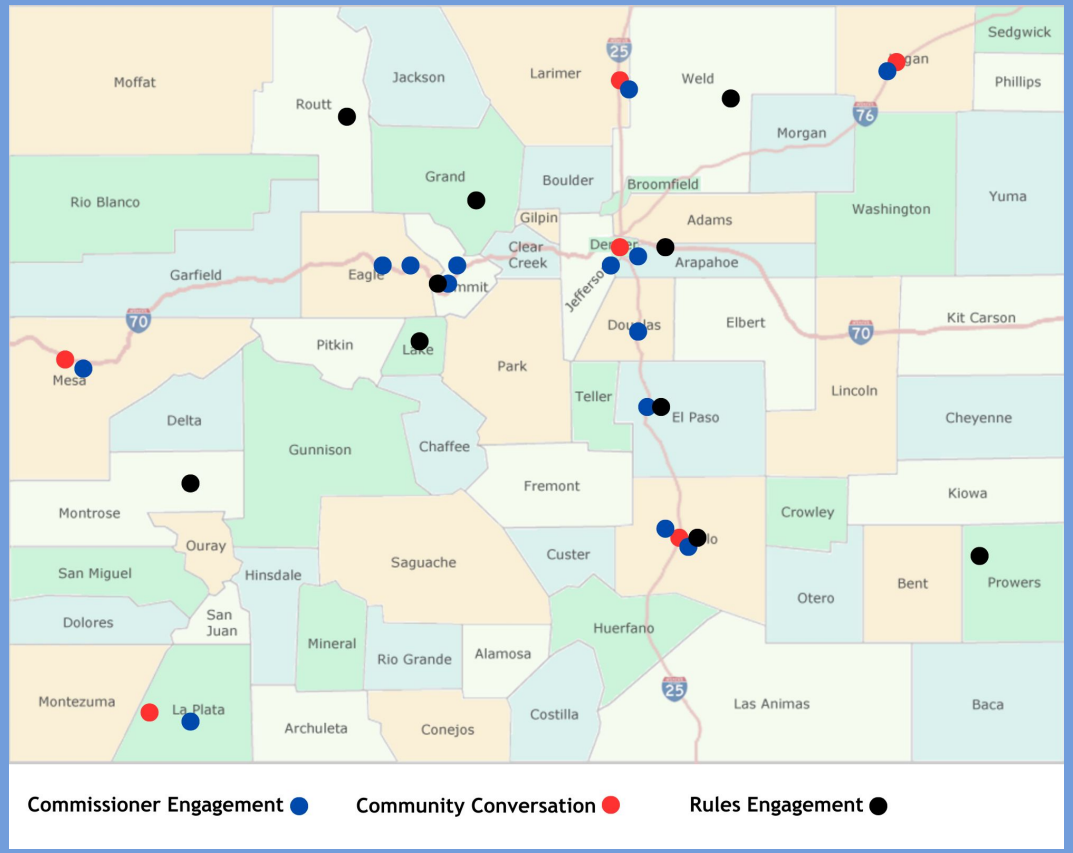
1. BHA's vision for the future.
2. BHA's internal alignment to that vision.
3. BHA's 2026 budget request.
4. BHA's APRA progress.

Commissioner's Leadership

Service

Commitment

Results



Community Conversations and BHA Engagement

Commissioner Smith's Engagement Around the State

Number of Sessions

120+

Commissioner Smith and BHA Staff hosted over 120 community meetings and listening sessions.

Total Hours

200+

Commissioner Smith and BHA Staff have spent over 200 hours meeting with community members and partners in behavioral health reform.

Emerging Themes

10

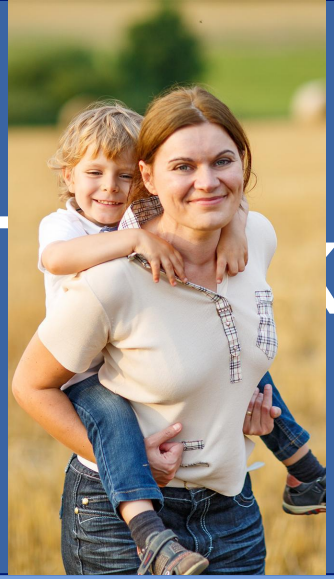
All across the state, 10 consistent themes emerged, which will inform BHA's future work.

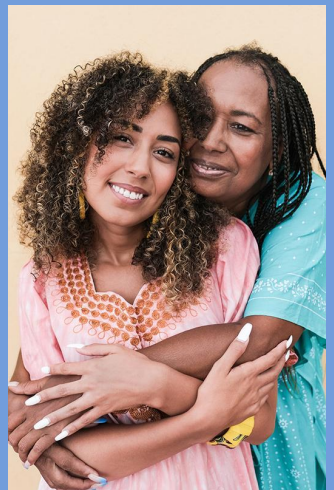
BHA's Commitment

Execution

Leadership

Measurement





Thank You!

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