COLORADO
Department of Health Care Policy & Financing

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Colorado System of Care (CO-SOC): A Behavioral Health Model for Children and Youth in Medicaid

Implementation Plan Version 1.0

May 30, 2025

ASSUMPTIONS AND DISCLAIMERS

This document is a confidential working version of an Implementation Plan intended to satisfy the requirements of the Settlement Agreement. Per the requirements of the Agreement, the Department of Health Care Policy and Financing (HCPF) will review and as needed, update the Implementation Plan at least annually for the duration of the Agreement. HCPF shall provide Plaintiff's Counsel with an opportunity to review and comment on any proposed updates or amendments at least 30 days prior to their effective date.

The Colorado System of Care (CO-SOC) is the designated framework developed collaboratively by HCPF and the Behavioral Health Administration (BHA) to serve children and youth with complex or high acuity behavioral health needs. While the long-term goal is to extend this structure and services to all children served by both HCPF and BHA, this plan specifically outlines the action items necessary to establish the system for Medicaid members under the age of 21. The length of all services under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), required for the Member, will depend on medical necessity.

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1. Executive Summary

In February 2024, Health Care Policy and Financing (HCPF) entered into a Settlement Agreement (Agreement) with the Center for Legal Advocacy, d/b/a Disability Law Colorado, and three children and youth with complex behavioral health needs (Plaintiffs) who filed a class action lawsuit on behalf of similarly situated Medicaid-eligible children and youth. A key requirement of the Agreement is for HCPF to create an Implementation Plan (Plan) that demonstrates how it will build a systematic approach to providing Medicaid members, who are under the age of 21, with intensive behavioral health services in their homes and communities.

The Plan, as required by the Agreement, focuses on reforming the delivery of services to members, under the age of 21, with complex behavioral health needs. The Plan is designed to improve service access and quality for children and youth, consistent with Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements, the Americans with Disabilities Act (ADA), and Section 504 of the Rehabilitation Act. The Plan sets out to address any gaps in services and supports currently faced by members with complex behavioral health needs and establish a coordinated and structured approach through a system of care that promotes collaboration, fosters an individualized approach and is responsive to the needs of the individual receiving care. The Agreement requires HCPF to address the gaps in services, thereby striving to reduce the likelihood of members needing residential or institutional treatment, and ensure an availability of services, supports and resources for these individuals to receive care and treatment in the least restrictive setting.

Utilizing an evidence-based systemic approach, the Plan proposes a Colorado System of Care (CO-SOC) for members under the age of 21. The Plan outlines the programmatic, policy, and financial considerations that are needed to effectively deliver intensive services within a system of care model, including:

1. **Identification Tool** - Identifying those members that are in need of the CO-SOC services.
2. **Enhanced Standardized Assessment** - A comprehensive assessment that highlights all of a member's strengths and needs.
3. **Intensive Care Coordination** - Care coordination provided by a designated professional who works hand-in-hand with the family in coordinating care across providers and child agencies.
4. **Stabilization Services (Mobile Crisis)** - Services designed to ameliorate a member's needs in the home during a crisis and thereby mitigate the need for care in an emergency department, residential treatment facility, or inpatient hospital setting.
5. **Intensive Home-Based Treatment** - Behavioral health clinical interventions provided to the member and their family in the home.
6. **Support Services** - Services that supplement the clinical intervention in order for the member and family to successfully engage in treatment.
7. **Behavioral Consultation Services** - Consultation provided by a behavioral expert who advises the clinical treatment team on best practice behavior strategies to include in the treatment plan.

As for these programmatic elements, Identification Tool (#1) and behavioral consultation services (#7) are minimal administrative costs to the Medicaid system. In addition, the Enhanced Standardized Assessment (ESA) (#2), intensive care coordination (#3), stabilization services (#4), and intensive home-based treatment (#5) include new policies to ensure the successful utilization and delivery of these existing service types in the current Medicaid capitation. Support services (#6) will be a new service type to eligible Medicaid members.

The Plan also highlights considerations for auxiliary efforts required to successfully create and implement a system of care; specifically, it focuses on how families access care, interagency collaboration, and the development of a robust workforce training approach to achieve compliance with the Agreement. Through a system of care with intensive in-home services, HCPF aims to significantly reduce dependency on out-of-home placements, support family stability, and ensure that behavioral health needs are adequately addressed in the least restrictive environment.

To create a robust CO-SOC, there is a critical need for a well-trained workforce to provide the required evidence-based services. HCPF, in collaboration with the Behavioral Health Administration (BHA), will contract with a vendor(s) to create a Workforce Capacity Center (WCC). The WCC will oversee training, credentialing, and fidelity monitoring of providers to ensure adherence to the standards of models such as High Fidelity Wraparound, intensive home-based treatment models, including Multisystemic Therapy, and other services. In addition to the WCC, BHA's learning management system, OwnPath Learning Hub, will provide online training to providers on the Enhanced Standardized Assessment and other care standards. Increasing and training the workforce is a critical step toward enabling better care delivery to members and their families, and preparing providers to meet the needs of members under the age of 21 with complex behavioral health needs.

The Plan also outlines the strategic planning and development of operational components required to ensure the successful rollout and sustainability of the CO-SOC. Specifically, the Plan outlines the steps needed to:

- Establish a continuous quality improvement (CQI) process for evaluating and enhancing the CO-SOC;
- Detail the phased approach to roll out the entirety of the CO-SOC;
- Create and manage a consumer feedback tool to capture the experiences of the CO-SOC care recipients;
- Create a process for public reporting, which also serves to inform stakeholders invested in the success of the CO-SOC; and
- Create a budget that forecasts the cost of services and implementation years to achieve the CO-SOC.
- HCPF, in conjunction with the BHA, plans to create a series of oversight protocols to monitor and assess the effectiveness of the CO-SOC, including contractual management and outcomes/metrics tracking.

HCPF will continuously refine and improve the Plan over the next several years to improve the CO-SOC efficiency and efficacy in ensuring timely and individualized care. It will reflect the feedback from families and stakeholders.

To ensure an effective implementation of the CO-SOC, HCPF has created a strategic rollout plan spread over 7 years, starting with an initial planning year. The rollout is structured to meet the timeline outlined in the Agreement. The first year will begin on July 1, 2025, and will serve members who are discharging from residential treatment settings or have an Extended Stay status per C.R.S. § 27-50-101(13.5). It will include:

- The development of a Workforce Capacity Center,
- The third phase of HCPF's Accountable Care Collaborative (ACC 3.0) is scheduled to start July 1, 2025, and will have enhanced oversight responsibilities to ensure families have access to services.
- Services available in the early rollout years of the CO-SOC are specifically outlined in the ACC 3.0 contract language, which includes:
    - Use of an Enhanced Standardized Assessment,
    - Provision of intensive care coordination through High Fidelity Wraparound, and
    - Intensive Home-Based Treatment through Multisystemic Therapy or Functional Family Therapy models.

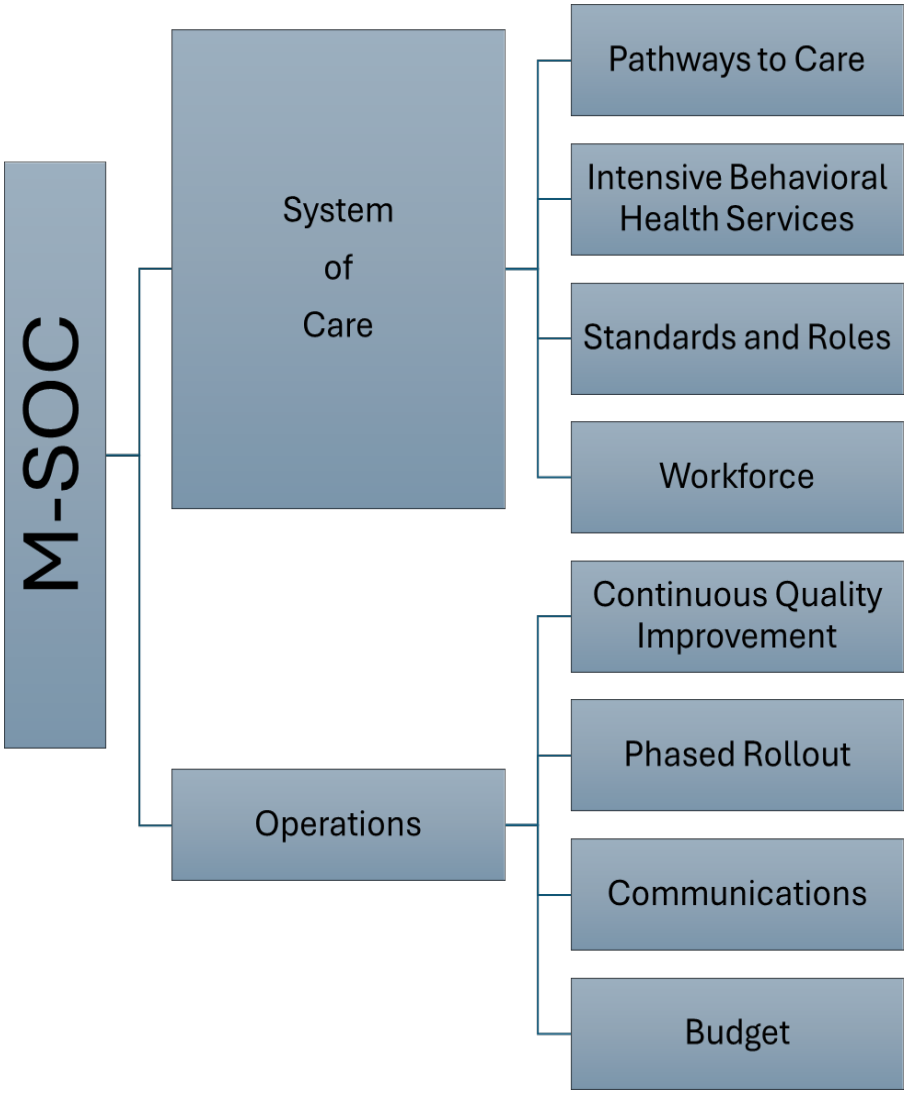
Subsequent years will focus on rolling out:

- An additional intensive care coordination (ICC) model,
- The creation of a process to identify families in need of the CO-SOC services,
- The development and implementation of additional Intensive Home-Based Treatments, Support Services, and Behavioral Consultation Services, and
- Improving and expanding crisis services specific to the CO-SOC.

The systemic shift proposed in this Plan is significant, requiring broad collaboration for successful execution. Further, consideration needs to be made for challenges in developing a sustainable workforce and budgetary constraints because of the state's Taxpayer Bill of Rights (TABOR) constitutional provision, which limits the amount of revenue the state government can retain and spend without voter approval.

Figure 1 illustrates how the components of the Colorado System of Care (CO-SOC) are laid out in this document. This diagram reflects the table of contents for this Plan.

Figure 1. Layout of CO-SOC Implementation Plan



2. Background

Over the past few years, Colorado has been working to reform its behavioral health system to address rising behavioral health needs. In Colorado, youth mental health issues have more than doubled since 2018, with the percentage of youth aged 11 to 18 reporting poor mental health rising from 8.8% to 18.5%[1]. In 2023, 5.5% of youth under 18 reported attempting suicide, and 28.4% reported poor mental health on most days in the past month[2]. Youth who identify as people of color or LGBTQ+ are particularly at risk, facing not only greater mental health challenges but also difficulty accessing culturally affirming care. Workforce shortages, coupled with a lack of diversity among providers—only 1 in 5 are non-white—further exacerbates these disparities. This is especially problematic in rural areas, where youth often have limited access to quality care that addresses their specific needs. Even those who access care through Colorado's crisis system struggle to find providers who are equipped to navigate the complexities of youth mental health. A recent study found that fewer than one-third of youth discharged from the emergency department receive outpatient care within seven days, and only 55% have a follow-up within 30 days. Without timely follow-up, 25% of youth are readmitted to mental health care within six months, worsening the cycle of unmet needs.[2] These are just some of the reasons why youth with highly acute behavioral health conditions need access to more proven and effective behavioral health services as well as advances in care coordination that connect them to these evolving services across a growing number of providers in Colorado.

Colorado's current behavioral health system for children was built over time and includes components and investments that are critical but not optimally coordinated for those with the most complex needs. Without a structured and coordinated system, these component parts will not have the intended sustainable impact. While Colorado has a myriad of services for the highest acuity children and youth, there is still an unmet need for community and home-based behavioral health services concurrent with a dependency on residential services. There is considerable literature[3] on the positive effects and long-term systemic benefits of having a robust system of care with intensive services.[4] A recent query of fiscal year 2024 utilization data of the most restrictive services demonstrated the following for children and youth:

- Approximately 7,755 children or youth visited an emergency room for a behavioral health condition
    - 1,390 children or youth had more than two visits within the year
- 389 children or youth stayed in a residential treatment facility
    - 50 children or youth had more than one residential stay within the year
- 3,331 inpatient behavioral health encounters

[1] https://www.coloradohealthinstitute.org/sites/default/files/2023-04/Solutions%20to%20Strenghten%20Youth%20MH.pdf

[2] https://cdphe.colorado.gov/healthy-kids-colorado-survey-dashboard

[3] https://gucchd.georgetown.edu/products/Toolkit_SOC_Resource2.pdf

[4] https://gucchd.georgetown.edu/products/Return_onInvestment_inSOCsReport6-15-14.pdf

The Plan identifies how HCPF will create a system of care to address the coordination of intensive treatment and support services, which will lead to strong quality outcomes and better lives for Medicaid members and their families.

2.1. Definitions:

- "Behavioral health" refers to an individual's mental and emotional well-being and actions that affect an individual's overall wellness. Behavioral health conditions, concerns and disorders include substance use disorders, serious psychological distress, suicide, and other mental health disorders. Further, problems ranging from unhealthy stress or subclinical conditions to diagnosable and treatable diseases are included in the term "behavioral health." The term "behavioral health" is also used to describe service systems that encompass prevention and promotion of emotional health, prevention and treatment services for mental health and substance use disorders, and recovery support.
- “Child and Adolescent Needs and Strengths” or “CANS” is a multi-purpose tool developed to support decision making, including level of care/need and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. The CANS was developed from a communication perspective so as to facilitate the linkage between the assessment process and the design of individualized service plans including the application of evidence-based practices. The CANS is a multipurpose information integration tool that is designed to be the output of an assessment process.
- “Child and Adolescent Needs and Strengths Decision Support Matrix” or “CANS Decision Support Matrix” refers to the CANS decision support applications, which include the development of specific algorithms for levels of care including residential treatment (QRTP and PRTF), intensive community services, and Intensive Care Coordination. Algorithms can be localized for sensitivity to varying service delivery systems and cultures.
- “Early and Periodic Screening, Diagnostic, and Treatment Benefit” or “EPSDT” means the benefit authorized under 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), and 1396d(r) that provides comprehensive and preventive health care services for Medicaid Members under the age of 21. For purposes of this plan, subsections one and five of 1396d(r) are addressed.
- “Eligible Medicaid Members” or “Members” means children under the age of 21 who are enrolled in Colorado’s Medicaid program and who have been diagnosed with a mental health or behavioral disorder and for whom intensive home-based services have been determined to be Medically Necessary.
- "Family” is inclusive of the child’s biological family, adoptive family, guardian and/or authorized caregiver, as appropriate to each child’s needs and situation.

- "Medical Necessity" as defined in 10 CCR 2505-10 section 8.076.1.8 means a good or service that, consistent with 42 U.S.C. § 1396d(r)(5):

    1. Will, or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all. For members under 21, per section 8.280.4E, this includes a reasonable expectation that the service will assist the member to achieve or maintain maximum functional capacity in performing one or more Activities of Daily Living.

    2. Is provided in accordance with generally accepted professional standards for health care in the United States.

    3. Is clinically appropriate in terms of type, frequency, extent, site, and duration;

    4. Is not primarily for the economic benefit of the provider or primarily for the convenience of the member, caretaker, or provider.

    5. Is delivered in the most appropriate setting(s) required by the member's condition;

    6. Is not experimental or investigational; and

    7. Is not more costly than other equally effective treatment options.

- "Support Services" means essential resources and services provided to members, under the age of 21, and families to help them cope with challenges, achieve well-being and maximize community involvement.

- "System of Care" means[5]: a spectrum of effective, community-based services and supports for Eligible Medicaid Members with significant or complex mental health concerns or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.

- "System of Care (SOC) Certified Intensive Care Coordination Provider (Certified ICC Provider)" are providers for ICC who coordinate the intensive behavioral health service providers and support service providers. Certified ICC Providers will serve as the care coordination point agency in cases where a youth is dual/multi-system involved. The Certified ICC Providers are responsible for 9 functions: Member engagement, ICC which includes High Fidelity Wraparound (HFW) and the Families experiencing meaningful connections, Outcomes, Coordination, Unconditional positive regard, Short-term process (FOCUS), material goods, determine Children's Habilitation

[5] https://gucchd.georgetown.edu/products/Toolkit_SOC_Resource1.pdf

Residential Program (CHRP) referral, creation of the care plan, matching of services and supports defined in the plan, identification of social determinants of health needs and referral as appropriate, assist residential treatment providers in appropriate and expeditious discharge planning, and serves as point of contact across all agencies on care plan. Further information regarding the functions of a Certified ICC Provider is located in the Agency Roles section.

- "Utilization Management" means the process by which an organization reviews the use of medical services to ensure the services and resources are medically necessary, performed in the most appropriate care setting and are at or above quality standards.

See Appendix H For a complete list of definitions and acronyms.

2.2. Overview of the Agreement

In February 2024, Health Care Policy and Financing (HCPF) entered into a voluntary Settlement Agreement (Agreement) with Plaintiffs to resolve a federal lawsuit, G.A. et al v. Bimestefer, initially filed in September 2021. The goal of the Agreement is to:

- Enable the state of Colorado to develop and improve upon its delivery of Intensive Behavioral Health Services (IBHS) to enrolled Medicaid Members eligible for these services, consistent with EPSDT, the Americans with Disabilities Act (ADA), and Section 504 of the Rehabilitation Act.

The Implementation Plan (Plan) is intended to comply with the terms of the Agreement. The state's Plan is founded on the evidence that demonstrates that, when able, children are best served in their homes and communities rather than in out-of-home care settings or institutional placements. To achieve this purpose, there must be a sustainable and effective system of care that serves members in their homes and the communities. The Plan sets forth a roadmap for creating a system of care structure that provides quality intensive services and the related accountability structures necessary to deliver intensive behavioral health services to enrolled Medicaid Members under the age of 21, statewide.

2.2.1. Services Outlined in the Agreement

Intensive Behavioral Health Services (IBHS) are a continuum of medically necessary mental health and support services or interventions – as required and authorized by the Social Security Act – provided in the most integrated setting appropriate to the needs of Medicaid Members.[1] IBHS will include, but are not limited to, the following:

- **Intensive Care Coordination Services** provided to Medicaid Members to facilitate assessment, care planning, coordination of services, authorization of services, and monitoring of services and supports. Such services are guided by the needs of the children and families and ensure a single point of accountability for ensuring necessary services are accessed, coordinated, and delivered to children and families.

- **Intensive In-Home and Community Services** provided to Medicaid Members in their homes or community settings to correct or ameliorate their behavioral health condition(s). Such services include educational opportunities, behavior management, therapeutic services, and clinical services.
- **Mobile Crisis Intervention and Stabilization Services** are provided to Medicaid Members in their homes or community settings, and which will be available 24 hours a day, 7 days a week. Such services include crisis planning, stabilization, referral and coordination, and prevention and post-crisis follow-up services.

HCPF agreed to develop a model accompanied by the Plan for delivering IBHS to children and families in Colorado. The Plan reflects the following components, as outlined in the Agreement:

4.6.1 A systematic approach through which Medicaid Members will be provided the Medicaid-authorized, medically necessary IBHS Services needed to correct or ameliorate their mental health or behavioral disorders.

4.6.2 A provider outreach plan to educate Medicaid providers regarding the availability of periodic and inter-periodic mental health screenings of Medicaid Members and the availability of IBHS.

4.6.3 A standardized assessment process for identifying which Medicaid Members qualify for particular IBHS services, and the intensity (scope and frequency) of service delivery. A standardized assessment process may include a standardized assessment tool that can be used to establish eligibility for IBHS.

4.6.4 Tiers of care coordination, including intensive care coordination, and a method for assigning and delivering care coordination levels to Medicaid Members within the standardized assessment process.

4.6.5 Strategies that support individual plans of care for each Medicaid Member. The individual plans of care will address and describe the necessary IBHS to be provided to each Medicaid Member in the least restrictive setting appropriate to meet the Medicaid member's treatment goals and needs.

4.6.6 Procedures to avoid unnecessary emergency room services, hospitalizations and out-of-home placements for Medicaid Members through the provision of IBHS.

4.6.7 A data collection, tracking, monitoring, and quality assurance system to analyze mental and behavioral health services, including IBHS, and network capacity to Medicaid Members.

The Plan reflects the following logistical components, as outlined in the Agreement:

4.7.1 Specific tasks, timetables, goals, programs, plans, strategies and protocols.

4.7.2 Descriptions of set standards for the timely provision of IBHS to Medicaid Members.

4.7.3 Descriptions for hiring, training, and supervising personnel.

4.7.4 Descriptions of the activities required to support the development and availability of IBHS. This includes, but is not limited to:

4.7.4.1 Collecting and analyzing Medicaid claims data to determine provider capacity needed and funding necessary to provide IBHS as required by this Agreement.

4.7.4.2 Developing cross-system protocols to identify and serve Medicaid Members across different child-serving agencies, including child welfare and juvenile justice/probation.

4.7.4.3 Identifying and using quality management tools to measure and assess the effectiveness of IBHS.

4.7.5 Descriptions for monitoring, reviewing, and revising, as necessary, managed care entity contracts to include obligations to provide timely access to necessary IBHS to Medicaid Members (e.g., timely access and time/distance and travel time standards for delivery of IBHS services).

4.7.6 Descriptions of how information will be disseminated to Medicaid Members and Medicaid providers, the process by which Medicaid Members may request services, and the manner in which the HCPF will maintain records of Medicaid Members' service requests.

To ensure alignment with the Settlement Agreement, HCPF has created a crosswalk between the Agreement requirements and this Plan (see Appendix G).

2.2.2. Timelines for Meeting the Agreement

The Settlement Agreement states that HCPF must meet all components of the Agreement by June 30, 2031. The Agreement was signed in February 2024. To meet the requirement and the significant scale of the services and population to be served will require a phased approach to reaching compliance.

HCPF is designing a strategic multi-year roll-out of who is served and what services are available in each year of the roll-out. There is a planning year (which is the year in which the state is developing the Plan and other tasks outlined in this document) as well as 6 subsequent rollout years (see Section 4.1 for more details). The next stage of the roll-out is year 1 or state fiscal year (SFY) 25/26, which begins July 1, 2025.

3. System of Care

The vision for Colorado's System of Care for children and youth (CO-SOC) is to create an array of services that meet the needs of Medicaid Members and families so that, as appropriate, Members can remain in their homes or communities instead of requiring services to be obtained in residential or inpatient settings. In addition, the CO-SOC is structured to incorporate the voices of families in the design of services and development of program policies. In cases where families interact with multiple systems, CO-SOC helps Members and families navigate between systems, such as juvenile justice, child protection, developmental disabilities, mental health and addiction, education, and others. The CO-SOC will provide an evidence-based approach to delivering services in a well-designed manner to address the needs of the Medicaid Members receiving services.

Core Values:

- Family and youth driven;
- Community-based; and
- Culturally and linguistically competent.

Core Principles:

- Comprehensive array of services and supports;
- Individualized and strength-based services and supports;
- Evidence-based and evidence-informed practices;
- Trauma-informed;
- Least restrictive and natural environment for the Member and family;
- Partnerships with the Member and family;
- Interagency collaboration;
- Care coordination;
- Developmentally appropriate services and supports;
- Data driven and accountability; and
- Protection of Member and family rights and advocacy.

With the creation of the CO-SOC, the goal is to improve the overall well-being of Members by serving them in their homes and the communities to reduce:

- Unnecessary emergency department visits;
- Out-of-home and out-of-state placements;
- Length of time spent out of the home;
- Re-entry into higher levels of care; and
- Involvement in the juvenile justice system.

3.1. CO-SOC Eligibility

Children, youth or young adults under the age of 21 who may be eligible for intensive services are based on recommendations from an Enhanced Standardized Assessment that highlights the

medically necessary services a member and their family need. Eligibility for Medicaid reimbursable intensive in-home services are outlined below.

Members who are under the age of 21, who are enrolled in Medicaid and are at risk of disruption in the home (including involvement in the juvenile justice and child welfare systems), community, or school due to their complex behavioral health needs are eligible for these services. Eligible Members must meet medical necessity criteria and will not be excluded based on their disability or any other diagnosis. Members can be referred for determination by a variety of sources. More information on referral sources is in Section 3.3, Pathways to Care.

The population receiving CO-SOC services will be determined by the ESA or medical necessity determines that CO-SOC is needed to ameliorate clinical concern. Eligibility includes the following:

- Child or youth has a primary mental health or substance use disorder diagnosis, and may have a co- occurring diagnosis of intellectual and developmental disability;

OR

- Child or youth may have a primary intellectual or development disability diagnosis and a co-occurring diagnosis of mental health or substance use disorder;

AND

- There is a medically necessary need for services in the Colorado System of Care (CO-SOC) level of care;
  OR
- Member's symptoms and behaviors are unmanageable at home, school, or in other community settings without specialized support due to their mental health or substance use disorder condition AND, per medical necessity, are at risk of needing a psychiatric residential treatment facility (PRTF) or qualified residential treatment programs (QRTP) placement.
- and may have a co- occurring diagnosis of intellectual and developmental disability (IDD);

- Results of the Enhanced Standardized Assessment indicate the need for services in a CO-SOC level of care for behavioral health concerns;

  AND

- Symptoms and behaviors are unmanageable at home, school, or in other community settings without specialized support due to their mental health or substance use disorder AND the

The intensive services and the CO-SOC are for all eligible Medicaid Members under the age of 21. While the model can serve any member (as defined in Section 2.1), specific considerations are needed for certain populations. Specifically, in addition to the intensive in-home interventions used by most Members, HCPF identified three specific populations in which their age or condition requires a unique in-home treatment model. best suited to ameliorate the

condition of the Member. In addition, the same services all Members receive in the CO-SOC, the following Members require additional interventions tailored to their specific needs:

- Under eight years of age, how symptoms present, and the role of the caretaker-child dyad becomes an important factor when providing services to families with Members in this age group. Colorado has developed a strong infant and early childhood mental health strategy that has afforded the state with interventions and workforce for this specific age group. HCPF will work with stakeholders and professionals in the infant and early childhood mental health field to select the age-appropriate intervention.
- Members under 21 years of age but older than 18 years of age are included in the Members eligible for the interventions in this Plan. However, specific considerations need to be given to Members between 18 and 21 when identifying the age appropriate intervention and pathways to care. Special consideration should be given to the legal status of the Member and who has legal decision-making authority or if guardianship has been granted to a custodian. In addition, the focus for Members ages 18 to 21 should target transition to independence or install supports in the absence of other familial or personal support networks.
- All Members with behavioral health needs under 21 years of age are eligible for the services outlined in the Plan, including Members with IDD. A diagnosis of IDD will not exclude a Member from the CO-SOC when the medical necessity for behavioral health services is present. Therefore, the CO-SOC model should ensure that the interventions and pathways to care selected are effective in meeting the behavioral health needs of Members with IDD. In addition, since long-term support services and home and community-based services are afforded to the IDD population through Medicaid waivers, HCPF will have clear policies and protocols on how IDD providers and case management entities interact with behavioral health providers and care coordinators. The system must mitigate undue burden on the Members and their families as well as avoid potential miscommunication between agencies serving the Member.

These population specific approaches will be developed and phased into the CO-SOC benefit array during the timeframes described in Table 1 below.

Table 1. Population specific decision making

Task	Fiscal Year Due Date
Create policies and procedures for how the CO-SOC will interact with current systems for Members under 8, Members 18-20 and Members with IDD (i.e. interactions with CDEC, CMAs, familial supports)	Q2 FY26/27*
Identify appropriate pathways to care and interventions for Members 18 to 20 years and 364 days of age and develop relevant policies and protocols.	Q2 FY26/27
Identify appropriate pathways to care and interventions for families with Members who have an IDD and develop relevant policies and protocols.	Q2 FY26/27
Identify appropriate pathways to care and interventions for families with Members under the age of 8 and develop relevant policies and protocols.	27/28

* Given the comprehensive nature of this Implementation Plan, only the first two fiscal years will be outlined on a quarterly basis, with the details for subsequent fiscal years to be determined later.

3.2. Components of the CO-SOC

This document presents the CO-SOC in four components: (1) Pathways to Care; (2) Intensive Behavioral Health Services; (3) Roles and Standards; and (4) Workforce. The CO-SOC will create the structure to deliver In-Home Behavioral Health Services to Members and families consistent with EPSDT, the ADA, and Section 504 of the Rehabilitation Act.

Successful implementation of a system of care must include intensive care coordination (ICC). ICC focuses on deliberate organization between all individuals involved in the care plan for the Member and their families to facilitate appropriate delivery and referral of services and care. ICC focuses on ensuring Members and their families have:

- Robust assessment and family-centered care planning;
- Access to a wide array of services;
- Coordination amongst a variety of services and resources;
- Access to crisis resources;
- Progress monitoring; and
- Ensuring Members and their families have basic needs met.

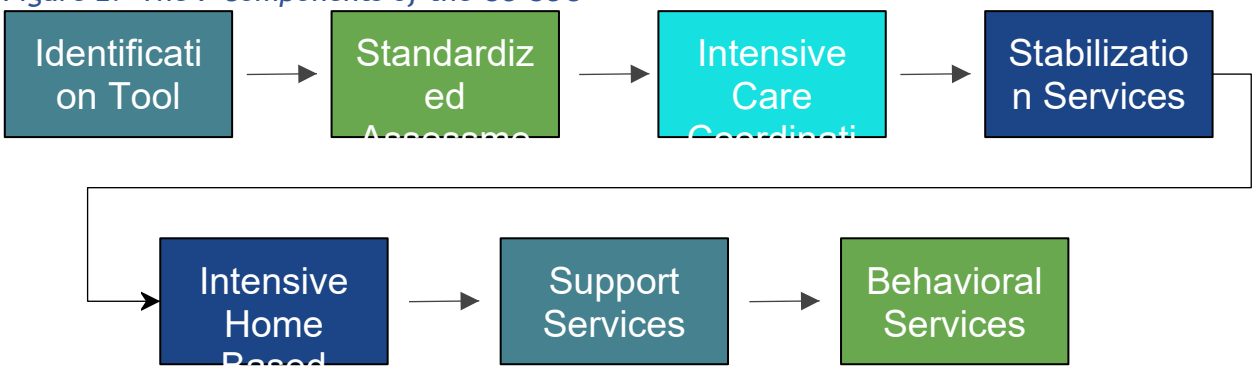
Generally, care coordination is often fragmented and siloed between agencies or services, leaving Members and their families feeling overwhelmed and frustrated when trying to access the support needed. ICC within the CO-SOC will help Members and their families be successful in their homes and communities. There have been many notable investments and quality providers in Colorado's behavioral health system. However, for Members with high acuity or complex needs, those services must be well coordinated and delivered in a structured manner, such as in a system of care.

The seven specific components of the CO-SOC as outlined in the Plan include:

1. **Identification Tool** - Identifying those Members that are in need of the CO-SOC services.
2. **Enhanced Standardized Assessment** - A comprehensive assessment that highlights all the Members strengths and needs, which includes the CANS tool.
3. **Intensive Care Coordination** - Care coordination provided by a designated professional who works hand-in-hand with the family in coordinating care across providers and child agencies.
4. **Stabilization Services (Mobile Crisis)** - Services designed to ameliorate a Member's needs in the home during a crisis and prevent the need to have them admitted to an emergency department, residential treatment facility, or inpatient hospital.
5. **Intensive Home Based Treatment** - Behavioral health clinical interventions provided to the Member and their family in the home.
6. **Support Services** - Services that supplement the clinical intervention in order for the family and child to successfully engage in treatment.

7. **Behavioral Consultation Services** - Consultation provided by a behavioral expert who advises the clinical treatment team on best practice behavior strategies to include in the treatment plan.

Figure 2. The 7 Components of the CO-SOC



3.3. Pathways to Care

To reduce fragmentation in accessing the CO-SOC, there will be a single point of entry for Medicaid-eligible children and youth and their families. This ensures that an agency is tracking the request for services and is accountable for making sure the necessary services are accessed by the Member and their family.

Colorado utilizes a managed care structure known as the Accountable Care Collaborative (ACC), in which managed care entities called Regional Accountable Entities (RAEs) streamline the process and improve overall access to quality care. The RAEs are not only accountable for Member access to the services in their Medicaid benefit plan but are also responsible for the payment of those covered services. Since RAEs ensure timely access to the right type of care and pay for covered services, RAEs serve as the point of entry for Members to access the CO-SOC services. A single point of entry reduces barriers to access for individuals navigating complex systems and allows for a centralized system to determine the most appropriate treatment.

While RAEs will serve as the point of entry to accessing the CO-SOC services for families, referrals for those services can come from a variety of partners working with the family as stated in Section 3.3.1, and there will be a “no wrong door” approach to getting families connected to the RAEs so they can begin accessing services. For information on how families and providers will be aware of the ability to ask for services and make referrals, see the Education and Outreach Section, which includes details on how HCPF will take steps to raise awareness of the CO-SOC program to Members, families, providers, advocates, and the public.

3.3.1. Referral Sources

Point of Entry into Colorado System of Care

Referrals for access to the CO-SOC can come from many sources. Since the CO-SOC is a Medicaid-funded set of behavioral health services covered within the behavioral health Medicaid capitation, Members can access these services through their managed care entities, RAEs, which determine eligibility. RAEs are entities responsible for coordinating both physical and behavioral health for Medicaid Members. Once the RAE has received a request for the CO-SOC services, via referral, it is responsible for ensuring that the necessary behavioral health services are provided to meet the needs of the Member. The function is overseen through the process of utilization management, including screening, access to services, and payment of the necessary treatment. As part of that larger utilization management function, RAEs will need to identify Members that need a more robust behavioral health assessment, additional services, and/or services provided in the CO-SOC. The RAEs complete the function by administering a state-designed and approved Identification Tool. The RAEs will all use the same Enhanced Standardized Assessment template, CANS Tool and Colorado CANS Decision Support Matrix to help ensure Members experience consistency across the state. See section 3.5.4 Agency Roles for more information regarding RAE roles.

Referrals for behavioral health services can come from a family member, provider or agency working with the family, or other systems in which the Member or family is engaged. Families will use the existing process of contacting the RAE using the information provided to them upon becoming enrolled with that RAE. Further information on outreach and education to members and providers is located in section 4.3.1. Examples of referral sources include, but are not limited to:

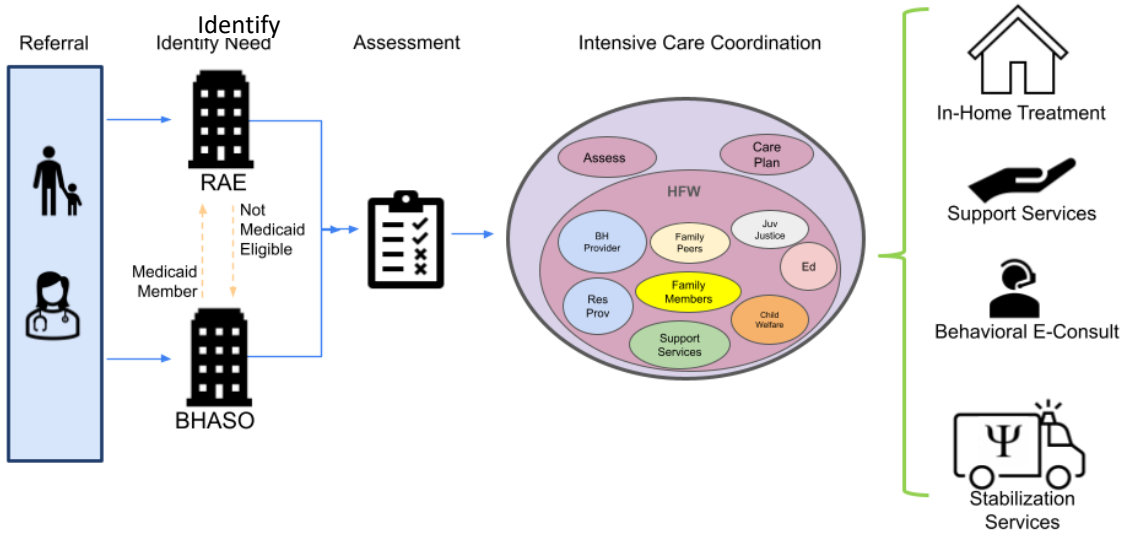
- Family and/or Self
- County Child Welfare
- Integrated Behavioral Health Primary Care Providers
- Non-Behavioral Health Primary Care
- Case Management Agencies
- Crisis System Hotline
- Residential Treatment Providers
- Schools
- Juvenile Justice System
- Emergency Departments
- Urgent Care
- Behavioral Health providers
- Youth Detention
- Youth Commitment

3.3.2. Access to Care

The CO-SOC for children and youth flow chart addresses the array of services outlined in the below sections and how to access the various services. A system of care is not a single program but a coordinated network of services that work together to improve Member and

family outcomes. If a Member is identified as needing a more thorough assessment (via the Enhanced Standardized Assessment (ESA) described in more detail in 3.4.1)) the RAE will connect the Member with a provider. In addition, if a RAE determines higher intensity services are needed or the assessment determines that, the RAE will assign an intensive care coordinator to coordinate the necessary in-home treatment, mobile crisis response, support services, and/or e-consultation. Section 4 of this document outlines the specific details for each of the services in the CO-SOC model.

Figure 3. Overview of the Colorado System of Care



Children and youth who are not Medicaid-eligible will be referred for a determination of services through other entities. For example, when an individual is not Medicaid-eligible and has behavioral health needs, the child or youth will be referred to a Behavioral Health Administrative Service Organization (BHASO).[6] Starting July 1, 2025, BHASOs will establish, administer, and maintain regional networks of behavioral health care providers that serve people without Medicaid across Colorado. Since BHASOs will have a public-facing component, BHASOs will work with RAEs to assist Medicaid members in getting connected to their assigned RAE, where such assistance is necessary. For those not currently enrolled in Medicaid and under the age of 21, who may or may not have a disability and meet criteria for a Medicaid waiver, such as Children's Habilitation Residential Program (CHRP), the individual can be referred to a Case Management Agencies (CMA)[7] for further assessment. Both BHASOs and CMAs will work with RAE coordinators to ensure successful transition for families who are determined Medicaid eligible, as needed.

[6] https://bha.colorado.gov/press-release/behavioral-health-administration-announces-regions-for-new-behavioral-health-services

[7] https://hcpf.colorado.gov/case-management-agency-directory

Table 2. Referral Implementation Plan Steps

Task	Fiscal Year Due Date
Work with BHA to develop policies and procedures for referral process to BHASOs for individuals who are not Medicaid-eligible and ensure a robust provider network of providers who bill Medicaid and providers who accept alternative payment options (i.e.. grants, the Children and Youth Mental Health Treatment Act (CYMHTA), etc.)	Q2 FY25/26
Plan for educating Members on the existence of services	Q3 FY26/27
Plan for educating Members on how and where to make a referral	Q3 FY26/27
Develop the process to educate providers and public agencies on how and where to make a referral	Q3 FY26/27

3.3.3. Identification Tool (CO-SOC Part One)

Programmatic Outline

The Identification Tool, which will be a CANS Screen developed with the University of Kentucky, is a brief series of questions aimed at identifying any presence or risk of acute or complex behavioral health needs in a Medicaid Member. The Identification Tool does not replace the requirements for EPSDT screening, which primary care providers (PCPs) are required to complete, and which is a comprehensive screening for all members under the age of 21. PCPs can utilize EPSDT screening to determine if a referral to the RAE for administration of the Identification Tool should occur as part of the utilization management process. The tool is designed to identify all the members who would benefit from a more thorough assessment of the Member's and their family's needs. The Identification Tool is a standardized approach that all RAEs will use when determining whether the ESA (see Section 3.4.1) is necessary and the first step in getting families on the right pathway to intensive services. The RAEs will:

- Use the Identification Tool to identify all Members who will benefit from receiving the ESA; and
- Track referrals of members, under the age of 21, eligible for the CO-SOC.

Service Definition of the Identification Tool: TO BE DEVELOPED. HCPF will work with the Lived Experience, Leadership and Implementation committees and stakeholders to develop a formal service definition, medical necessity criteria and process for referral and screening. The Identification Tool will be a CANS Screen.

Policy/Process Outline

When the Identification Tool does not indicate complex behavioral health needs:

> If the tool does not indicate the need for the ESA, the member will receive standard ongoing care coordination for appropriate behavioral health services provided via the RAEs.

When the Identification Tool identifies complex behavioral health needs:

> The RAE will connect the Member with a certified assessment provider, and the Member will receive an ESA.

Information other than the Identification Tool can be used to determine necessity of the CO-SOC services, including:

- The RAE has already determined that intensive care coordination and intensive in-home services are medically necessary.
- The Member is discharging from an inpatient hospital stay for substance use disorder (SUD) and/or Mental Health (MH).
- The Member steps down from a residential level of care (QRTP or PRTF).

Finance Outline

The Identification Tool will be a quick list of questions meant to bolster decision-making in the utilization management function of the RAEs managed care arrangement. No additional new costs are anticipated as the brief tool will be completed as part of the RAE's administrative responsibilities.

Table 3. Identification Tool Implementation Plan Steps

Task	**Fiscal Year Due Date**
Create Service Definition for Identification Tool	Q3 FY25/26
Create Identification Tool	Q1 FY26/27
Train RAEs on use of Identification Tool	Q3 FY26/27
Ensure RAE outreach measures inform providers of comprehensive EPSDT screening requirements vs. Identification Tool	Q3 FY26/27
Update utilization management protocols to include use of tool and include tracking metrics	Q4 FY26/27

3.4. Intensive Behavioral Health Services

While the behavioral health continuum includes an array of interventions for members, the CO-SOC includes intensive services that support the unique behavioral health needs of the Member while increasing stability in the home. Intensive Behavioral Health Services (IBHS) are

the components of the CO-SOC that focus on the types of services delivered to the Member and family. Services include both behavioral health interventions and family supports that are provided in the home or community. Specifically, IBHS services include:

- Enhanced Standardized Assessment;
- Intensive Care Coordination (High Fidelity Wraparound or FOCUS);
- Intensive Home-Based Treatment (Multisystemic Therapy, Functional Family Therapy and a Colorado-specific model);
- Crisis Mobile and Resolution Services (Mobile Crisis Response and Crisis Resolution Teams);
- Support Services, including family support partners and respite; and
- Behavioral Consult Services.

Service providers will be contracted by the RAE to deliver services as part of the RAE's network. RAEs will be responsible for ensuring network adequacy that meets the provider access ratios established by the evidence-based models or the state (see service ratios in Section 3.5.3 for more details). Providers selected by the RAEs to deliver services in the CO-SOC will be required to be trained and certified by either the CO-SOC workforce capacity center (WCC) or the BHA's learning management system (LMS).

3.4.1. Enhanced Standardized Assessment (CO-SOC Part Two)

Programmatic Outline

The Enhanced Standardized Assessment (ESA) is a term to reflect a robust assessment that includes biopsychosocial and background information and the Child and Adolescent Needs and Strengths (CANS) tool. The ESA will be consistent across the state and can be completed by any licensed mental health professional who is certified in the CANS and has completed the Enhanced Standardized Assessment training available through the BHA's Learning Management System. The ESA will:

- Inform treatment decisions;
- Assist in the development of care plans;
- Identify the specific needs of the family; and
- Identify the Members who would benefit from CO-SOC.

See Appendix E for more details on the service definition of the ESA.

Service Definition of the Enhanced Standardized Assessment (ESA): Enhanced standardized Assessment (ESA) is behavioral health encounter conducted by a non-physician, licensed or licensure candidate behavioral health professional. The ESA is a comprehensive, clinical assessment completed by a behavioral health provider to assist in determining appropriate treatment/service recommendations for children, youth, and families. The ESA includes a collection of biopsychosocial information, the use of the CANS and CANS Decision Support Matrix.

Creation of the Assessment Tool

HCPF contracted with the University of Kentucky to expand the work on the CANS tool, which is a component of the ESA. The work includes the expansion of current modules, the

development of the Identification Tool, and the Colorado-specific CANS Decision Support Matrix. The three components of the ESA plus the Identification Tool are defined as:

- The **Identification Tool** will leverage a small number of questions from the CANS tool which will allow RAEs to identify those families that will benefit from receiving the ESA. Referrals for the Identification Tool can come from many sources.
- The **ESA** is a comprehensive, clinical assessment completed by a behavioral health provider to assist in determining appropriate treatment/service recommendations for children, youth, and families. The ESA also includes biopsychosocial information, the CANS Tool, and the CANS Decision Support Matrix.
    - **Biopsychosocial information** is a comprehensive collection of a client's biological, psychological, and social factors that affect a person's health and mental health.
    - **CANS Tool** is a multi-purpose tool developed to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. The CANS was developed from a communication perspective so as to facilitate the linkage between the assessment process and the design of individualized service plans including the application of evidence-based practices. The CANS is a multipurpose information integration tool that is designed to be the output of an assessment process.
    - **CANS Decision Support Matrix** is the output from specific algorithms for levels of care including residential treatment (QRTP and PRTF), intensive community services, and Intensive Care Coordination. Algorithms can be localized for sensitivity to varying service delivery systems and cultures.

HCPF will incorporate modules within the CANS specific to different demographics of children and youth receiving services. HCPF, in partnership with BHA, will develop the criteria for when and how the CANS guides decision-making, including intensity of services required and service planning, quality improvement initiatives, and the monitoring of the outcomes of services. To avoid duplication, processes involving child welfare and Division of Youth Services' Families First Prevention Services Act (FFPSA) will receive an ESA that is required to be completed by an independent person for QRTP placements. However, child welfare and Division of Youth Services QRTP placements under FFPSA will have additional requirements for courts and under federal legislation that is not part of the ESA.

The customized CANS will utilize a decision-support matrix specific to child and adolescent needs and strengths. A decision-support matrix is a structured tool that helps clinicians assess the child or youth's presenting needs. It helps select the most appropriate intensity of services based on symptom severity, functional impairment, risk factors and available resources to the child or youth and their family. The matrix will include different ratings of criteria (including but not limited to behavioral needs, emotional needs, risk behaviors, functioning needs, and caregiver needs) to determine if a youth is eligible for CO-SOC. The decision support matrix will ensure that there is consistency across the different entities using the ESA. The CANS Decision Support Matrix will be developed and completed by July 2025. However, roll out of the CANS Decision Support Matrix is dependent on the plan to acquire the necessary financial and technology resources to make such rollout successful.

Training and Certification Process for the Enhanced Standardized Assessment (ESA)

Training and certification for the CANS will occur through a universal training platform for easy accessibility. Providers will need to re-certify every two years to maintain their active status. Further information regarding the ESA is in Appendix E.

Policy/Process Outline

When the ESA rules OUT intensive services:

> If the ESA does not indicate the need for intensive care coordination, the member will receive ongoing care coordination accessible to all members via the RAEs, which includes medically necessary behavioral health services.

When the ESA rules IN intensive services:

> When the ESA determines a Member's eligibility for the CO-SOC, RAEs will ensure a referral to the Certified ICC Provider occurs within three days for intensive care coordination (ICC). The Certified ICC Provider must initiate contact with the family within 3 business days and begin the engagement process. The Member and their family have up to 30 days to engage with the Certified ICC Provider and complete the initial treatment team meeting. The Certified ICC Provider must work to actively engage the family and resolve any concerns prior to the initial treatment team meeting. While the initial ESA must be completed by a licensed clinician contracted with the RAE, updates to the ESA every 90 days or as needed can be completed by the Certified ICC Provider.

When the ESA is NOT needed for intensive care coordination:

> When the RAE has already determined a Member is in need of intensive services the ESA still needs to be completed within 14 calendar days of referral, however completion of the ESA is not required to initiate the intensive services. The ESA will support ongoing treatment planning and the Member's care plan.

Finance Outline

The initial ESA will be paid per assessment. Ongoing assessment utilizing the CANS tool and Colorado Decision Support Model will be completed by the Certified ICC Provider (see Section 3.4.2.)

While the RAEs utilized an assessment for QRTP in a small scope under ACC 2.0, these had previously been paid through the administrative costs. In ACC 3.0, ESAs will be paid as a service out of the behavioral health capitation. Any additional components of the assessment that go beyond the ESA and are needed to meet FFSPA or courts will not be paid from the capitation.

Table 4. ESA Implementation Plan Steps

Task	**Fiscal Year Due Date**
HCPF and BHA will create ESA and related policies and protocols	Q4 FY24/25

Create provider training on completing the standardized assessment and referral process to receive appropriate treatment	Q4 FY24/25
Ensure RAE contracts outline process for identifying providers and referring to WCC or LMS for training to ensure network adequacy	Q2 FY25/26
Create provider certification process to track those trained and approved to provide ESA	Q2 FY25/26

3.4.2. Intensive Care Coordination (CO-SOC Part Three)

Intensive care coordination services (ICC) is a more comprehensive approach to care planning, coordination of services, authorization of services, and monitoring of services and supports than that provided in traditional clinical or medical settings. ICC is an intensive service provided by coordinators, with enhanced clinically oriented training, who help meet the needs of Members and their families by coordinating care and services, developing care plans, and updating the information in the assessment via the CANS every 90 days. ICC is developed in collaboration with the Members and their family to ensure it is family-guided, child- or youth-driven, and services are provided in an accessible manner.

ICC is an intervention provided through evidenced-based wraparound models covered under the Medicaid capitation benefit and provided by state-trained and certified providers. To avoid duplication of care coordination, RAEs will continue to follow and complement the goals of the care plan developed by the ICC team.

CO-SOC has two National Wraparound Implementation Center (NWIC) models of ICC: High Fidelity Wraparound (HFW) and the Families experiencing meaningful connections, Outcomes, Coordination, Unconditional Positive Regard, Short-Term Process (FOCUS). HFW and FOCUS are models provided by a Certified ICC Provider, who deliver intensive care coordination in alignment with the Systems of Care philosophy of interagency collaboration, individualized strengths-based care, cultural competence, child and family involvement, community-based services, and accountability. The determination for which ICC intervention the Member and family receive is dependent on the needs of the Member.

- **High-Fidelity Wraparound (HFW): HFW** is an evidence-based model that includes the provision of an intensive coordination process for youth and families experiencing crisis and/or at imminent risk of out-of-home placement. The level of intensity of HFW includes services and supports to stabilize and support a youth and their family in their community. Care coordination is delivered consistent with the HFW model and focus is on the reduction of crisis and out-of-home placement. The work with a family and youth is done through a wraparound team to ensure access and quality of facility and community-based services and supports.

  HFW is unique in its approach to partnering with families with youth with complex behavioral needs. A foundational premise includes that traditional services alone are not enough to match a family's needs and families need support that exceeds the bounds of traditional outpatient services. Moving from the traditional approach of a worker and a family to a team-based planning process requires unique skills that may differ from historically successful, traditional mental health workers.

Colorado plans to deliver the HFW model consistent with The National Wraparound Implementation Center's (NWIC) four key elements. The four elements include:

1. An approach that is grounded in a strength's perspective;
2. Driven by underlying needs;
3. Supported by an effective team process; and
4. Family centered.

The HFW approach includes a full-time facilitator who will work with eight to ten Members under the age of 21 and their families. HFW facilitators will work with the families to create a wraparound team that will work collaboratively and cohesively to support the family.

Family peer support services will be included as part of the model in subsequent years of the CO-SOC roll out. Family peer support partners are trained parents and caregivers who have previously participated in and completed the CO-SOC services. The family peer support partner will use their experience to help other families navigate the CO-SOC and provide guidance, advocacy and support. Family peer support partners work one-on-one with families and provide frequent contact with Members and their families. Family peer support partners educate and empower Members and families on how to navigate the various systems Members and families are involved in and provide resources to available community supports. More information about HFW can be found in Appendix E.

The goal of HFW is to help the youth and family reach success while remaining in their home and communities. The process involves a facilitator, regular team meetings that include the Member, family, friends, community resources, and professionals. (see Appendix E for more details).

Service Definition of High Fidelity Wraparound (HFW): High Fidelity Wraparound (HFW) is a team-based, evidence-informed, structured approach to care coordination that adheres to required procedures for child and family engagement, individualized care planning, identifying and leveraging strengths and natural supports while monitoring progress and fidelity to the required process.

- **Families Experiencing Meaningful Connections, Outcomes, Coordination, Unconditional Positive Regard, Short-Term Process (FOCUS).** FOCUS is an Evidence Informed Practice (EIP) that is a time-limited care coordination model designed to support decreased system involvement while working to build connections and supports for families through community-based resources. Like the HFW model, FOCUS was developed by NWIC. FOCUS operationalizes the guiding principles within a system of care framework for youth:
    - Who may not have multi-system involvement;
    - Who would not benefit from HFW;
    - Whose ESA states exclusionary criteria present for HFW;

- And/or whose family declines HFW but who still could be system involved, at risk of deeper system involvement, and whose challenges exceed the resources of a single organization or a family's capacity to gain access to needed supports and services.

Using evidence-informed model approaches, the overall goal of FOCUS is to provide individualized and strength-based support for Members and families in reaching their goals or "family visions" with a decrease in need for higher levels of care, including out-of-home placements. (See Appendix E for more details.)

Service Definition of Families Experiencing Meaningful Connections, Outcomes, Coordination, Unconditional Positive Regard, Short-Term Process (FOCUS): FOCUS is a community-based program that offers a care coordination approach to families needing assistance gaining access to care for children and youth who have behavioral health needs including crisis concerns.

Policy/Process Outline

Intensive care coordination models (both HFW and FOCUS) will be provided by a Certified ICC Provider that will coordinate intensive behavioral health services (IBHS) and will also support providers rendering services for these Members. Certified ICC Providers are a point of contact for care coordination for eligible Members. Further information on Certified ICC Providers is located in Section 3.5 (Standards and Roles) and Section 3.5.4 (Agency Roles). Certified ICC Provider is a new certification that can be given to an existing or new provider organization approved by the state.

Certified ICC Providers will be responsible for:

- Member Engagement;
- High Fidelity Wraparound with Family Peer Supports or FOCUS;
- Administration of Material Goods (Flex Dollars);
- Determining CHRP Referrals;
- Creating Care Plans;
- Matching with all Services and Supports Defined in Care Plan;
- Identifying Social Determinants of Health (SDoH) Needs and Referring to Human Services as Appropriate;
- Serving as a Liaison to Residential Treatment Facilities; and
- Serving as a Point of Contact Across all Agencies on Care Plan Delivery.

Once the RAE confirms eligibility for the CO-SOC, the RAE will identify and assign a Certified ICC Provider to the Member and their family. The Certified ICC Provider must initiate contact with the Member and their family within three business days and begin the engagement process. The Member and their family have 30 days to engage with the Certified ICC Provider and complete the initial treatment team meeting. During the interim, the Certified ICC Provider must work to actively engage the family and resolve any concerns prior to the initial treatment team meeting. The treatment team meetings shall include, at minimum, the RAE

care coordinator, the Member, family/caregiver, natural supports, treatment providers, and relevant social service, juvenile justice, and/or education entities.

FOCUS is an available model for Members who may not need HWF, such as those who are not multisystem involved, those who decline HFW, or Members who are currently out of state. However, if a Member's needs are not met through FOCUS, the RAE can make the decision to move the Member into HFW.

Finance Outline

ICC services will be paid in a monthly encounter code to cover the cost of providers to deliver all nine services aforementioned. A funding source will need to be identified for material goods along with permission from CMS for this type of expenditure.

Table 5. ICC Implementation Plan Steps

Task	Fiscal Year Due Date
Create policy for RAE contracts on identifying and selecting Certified ICC Providers to ensure network adequacy	Q4 FY24/25
HCPF will determine and seek any needed federal authority to implement and pay for ICC services.	Q4 FY24/25
Generate regional estimated capacity per fiscal year for the RAEs and establish guidance on expected number of Members served in each region and associated provider amount needed	Ongoing
Create WCC to develop ICC training	Q1 FY25/26
Create provider training and practice manual on HFW and FOCUS	Q2 FY25/26
Create provider certification process to track those trained and approved to provide ICC	Q2 FY25/26
Define Certified ICC Provider as a certification type	Q2 FY25/26
Identify funding source for material goods and process for administrating	27/28

3.4.3. Crisis Mobile and Resolution Services (CO-SOC Part Four)

Crisis Mobile and Resolution Services (CMRS) provide immediate behavioral health services, at home or at another safe location, for young people under 21, experiencing significant behavioral or emotional distress. Within Colorado, there are opportunities to provide stabilization services by building upon the existing Colorado Crisis System. Colorado has had a crisis services system since 2013 that includes a Colorado Crisis line, walk-in centers, crisis stabilization units, mobile crisis response (MCR) and respite. In 2022, the BHA launched Crisis Resolution Teams (CRTs) as part of its crisis services array. CRTs support families with youth and young adults who are experiencing behavioral health challenges and would benefit from short-term, intensive services in the home while permanent services are being established. CRTs are not available 24/7 and are only in 21 counties throughout the state. Due to

limitations in availability of CRTs, HCPF will work with BHA to expand access to crisis services specific to children and youth as part of the CO-SOC.

As part of the existing state crisis system, Colorado has crisis stabilization units (CSU), which are short-term, bed-based crisis stabilization services in a 24-hour environment for individuals who cannot be served in a less restrictive environment. CSUs provide urgent diagnostic and functional assessments; crisis intervention, treatment, and support; and medical assessment, including for youth with co-occurring disorders. To keep a child or youth out of emergency departments, a CRT or MCR can refer the child or youth to a CSU. As of the date of this report, there is only one CSU for youth between the ages of 10 and 18 in the state of Colorado. Although CSUs are not specifically a part of the CO-SOC model, CSUs play a vital complementary role in keeping children from spending longer durations in out-of-home placements and are designed to only be very short-term with the goal of returning the member to their home. As the CO-SOC is built out, the goal is to also expand CSUs so there is equitable accessibility for children and youth across Colorado.

Programmatic Outline

CMRS includes two components: (1) Mobile Crisis Response services are intended to offer de-escalation and stabilization to individuals in a self-defined behavioral health crisis; and (2) Crisis Resolution Teams as a direct service that assists with deescalating the severity of a person's level of distress and/or need for urgent care associated with a mental health or substance use disorder.

- MCR is part of the current crisis services system and is available statewide. The service is delivered by a two-person multidisciplinary team with qualified training and expertise. The team is available 24/7 and responds to Members within the community. While MCR teams complete six hours of training on working with children and youth in crisis, MCR teams are not required to have a child specific responder or clinician. The training is provided via BHA. For the CO-SOC model to be successful and ensure access to expertise in child and youth crisis de-escalation, all mobile crisis teams will have 24/7 consultation access to a clinical specialist in working with children and youth presenting with a crisis. (See Appendix E for more details.)

  Service Definition for Mobile Crisis Response: Mobile Crisis Response services are community-based crisis interventions to members in self-defined Behavioral Health Crises, including screening and assessment, de-escalation and stabilization, safety planning, and coordination with resources. MCR services include initial face-to-face crisis response, initial follow up consultation (24 hours after initial crisis and for up to five days), and secondary follow up to ensure warm hand off.

- CRT is a group of providers, trained to work specifically with children and youth, that offer ongoing stabilization needs until members can be connected to treatment and/or other support services. Services include crisis planning, stabilization, referral and coordination, and prevention and post-crisis follow-up services. The services are intensive, short-term (four to six weeks), in-home services and link to ongoing

supports. Services are offered at a minimum of three days per week, up to a variety of services multiple times daily depending on clinical need. Because CRT is not available 24/7 or statewide, MCR will be utilized to offer support in lieu of CRT. Under the CO-SOC reform, these services will be statewide for all children with the goal of stabilizing children in the home until a permanent in-home treatment team is set up. Further details about CRT can be found on BHA's website.[8] (see Appendix E for more details.)

Service Definition for Crisis Resolution Teams: Crisis Resolution Teams provide intensive in-home services to children, youth and their families following a crisis episode. CRT employs a multidisciplinary team-based approach, with corresponding supervision based on the level of experience and expertise of the team. Services included are: Consultation, assessments, service planning, case management and care coordination, family supports, therapy interventions, psychiatry services, discharge planning, and post-program discharge follow-up.

Policy/Process Outline

- Referral sources for MCR: If mobile crisis services are initiated by the statewide Crisis Line, the MCR team will update the statewide Crisis Line (also known as 988) with the outcome of their visit within 24 hours in the Mobile Dispatch Portal.
- If the MCR team is unable to make contact with the individual requesting the service from the statewide Crisis Line, the MCR team will inform the statewide Crisis Line at the time such determination is made.
- The statewide Crisis Line will make such data accessible to the BHASO for the purposes of data collection, payment determinations, and case management.
- HCPF will collaborate with the BHA to develop policies and protocols for both the CO-SOC providers and crisis providers on how these two services will interact.

Prior to assigning an Intensive Home-Based Treatment team, referral sources for CRT include:

- Hospital emergency departments, critical care units, and the Colorado Crisis Services (CCS) continuum are existing referral sources for CRT. Eligibility criteria include children, youth, and families who present to the crisis system and/or emergency department with high acuity needs, who have received a crisis evaluation and are determined to be safe to remain in the home or community to receive intensive, short-term stabilization interventions. The local CRT team may serve children or youth who present with high-acuity behavioral health needs referred to by other agencies (i.e. schools, pediatricians, etc.). The program is not intended to serve as a step-down from high levels of care.
- Walk-in Centers and Mobile Crisis - A child or youth, who has sought services and has been determined to not need a higher level of care based on the assessment of the program provider.

[8] https://bha.colorado.gov/behavioral-health/crisis

- Other referrals may be accepted based upon CRT availability at the discretion of the BHASO.

Referral from outside of the statewide Crisis Line adhere to the following guidelines:

- Consistent CCS Dispatch Protocol, developed in collaboration with Contractor, must be used to deploy team;
- Dispatch Protocol shall be determined by the statewide crisis line, the BHASOs and BHA.

For Members who have already been assigned a Certified ICC Provider and an Intensive Home-Based Treatment (IHBT) provider, the CO-SOC CMRS protocols may vary from those used by other members. Specifically, the Certified ICC Provider can dispatch mobile crisis teams via the crisis hotline to assist with stabilization interventions for a Member when CRT is no longer needed as the IHBT provider is working with the family in the home. Since IHBT integrates core mental health services, including crisis into one seamless service delivery for Members and families, the ICC team will collaborate with Members and their family to develop a plan when crisis stabilization services are required. For Members who no longer have an IHBT provider, Certified ICC Providers will ensure the safety plan outlines steps for accessing CMRS services, when necessary, to stabilize the Member.

- The ICC team will develop and establish a crisis safety plan with the Member and their family that will outline the available resources for crisis services and how to access both the Certified ICC Provider and the IHBT providers during a crisis.
- The treatment team will be responsible for transitioning the family from CRT to intensive in-home treatment.
- The treatment team will also request mobile response services when concerned about a Member's ability to stabilize in the home at any point during treatment.
- Prior to a crisis, the Certified ICC Provider will have already established a relationship with the local mobile crisis and other crisis providers to ensure linkage to appropriate services for the Member that focus on the Member and their family's safety.
- Mobile crisis services will be focused on defusing and managing current crises and stabilizing the Member in the least restrictive setting so their IHBT services will not be disrupted.

Finance Outline

HCPF will explore increasing the total allocation of funds available for MCR services to include the increased frequency for mobile responses due to mobile teams being dispatched at the IHBT provider's request. In addition, to be consistent with standards that MCR will provide child- and youth-specialized interventions, a contract will need to be established for 24/7/365 e-consultation with a youth clinician and be accessible to any MCR across the state by telephone or virtual medium.

Total funds available must account for the costs associated with expanding CRT statewide and adjust the overall costs of these services to cover any increase in the frequency of utilization. Funding should also contemplate expanding capacity for crisis stabilization units (CSUs) across

the state to meet the needs of children and youth in crisis and requiring removal from the home.

CMRS services are already covered in the Medicaid benefit; therefore, no changes to existing Medicaid authorities is needed.

Table 6. CMRS Implementation Plan Steps

Task	Fiscal Year Due Date
HCPF will collaborate with the BHA to develop policies and protocols for both the CO-SOC providers and crisis providers on how these two services will interact.	Q4 FY25/26
Develop service and policy enhancements to crisis services to better meet the needs of children and youth in the CO-SOC	Q1 FY26/27
Create training for Certified ICC providers on how they will connect with connection with CMRS services	27/28
Create process and identify funding for ensuring a youth clinician is available and accessible with any MCR via telephone or virtual platform	27/28
HCPF and BHA will work to enhance provider workforce to increase CRT availability	28/29
HCPF and BHA will work to expand available CSUs for youth	29/30

3.4.4. Intensive Home-Based Treatment (CO-SOC Part Five)

Intensive Home-Based Treatment (IHBT) is an intensive, mental health service for youth with serious emotional disabilities and their families. IHBT is provided in the home, school and community where the youth live, with the goal of stabilizing mental health concerns, identifying educational needs and supports, and safely maintaining the youth in the least restrictive, most normative environment. The length of time for IHBT will be determined on medical necessity criteria for the Member.

Programmatic Outline

IHBT includes a comprehensive set of therapeutic and rehabilitative services, integrated by a team of providers into a seamless set of services delivered to the family. The role of IHBT is to:

- Correct or ameliorate the child's mental health conditions;
- Reduce the need for more intensive or restrictive treatment as well as out-of-home treatment (including psychiatric hospitalization, PRTF, and residential treatment);
- Successfully reunify families from more restrictive mental health services;
- Identify opportunities for educational support and coordinate with schools accordingly;
- Work with schools to identify behavioral health strategies that will support the

Member in educational settings;
- Work with other providers to help the Member ameliorate any mental health crisis events; and
- Enhance the family's capacity to improve the youth's function in the home and community.

IHBT includes:

- Enhanced Multisystemic Therapy (MST) is an intensive, home-based treatment model for youth ages 12-17, who have serious delinquency or substance use problems. MST addresses gang involvement, runaway behaviors, heavy substance use, or those who are at-risk for juvenile justice system involvement. Features of MST include:
    - Integration of treatment approaches to address a range of risk factors across a youth's family, peer, school, and community;
    - Promotion of behavior changes in the youth's natural environment and empowering caregivers; and
    - Quality assurance that focuses on the outcomes related to behavior change.

  MST has proven effectiveness in working with populations in need of SUD treatment. (See Appendix E for more details).

> **Service Definition for Enhanced Multisystemic Therapy:** Enhanced Multisystemic Therapy (MST) is an intensive, in-home treatment focusing on factors in an adolescent's (ages 12-17) environment that contribute to his/her anti-social behavior, including adolescent characteristics, family relations, peer relations, and school performance.

- Enhanced Functional Family Therapy (FFT) is an intensive, short-term therapeutic model that offers in-home family therapy to address the concerning behaviors from a relational, family-based perspective. FFT is provided using a home-based model of service delivery. Providers of FFT must meet the specific training and supervision requirements. FFT is designed for youth between the ages of 11 and 18 who are at-risk or have been referred for behavioral or emotional problems. FFT is a program with five steps that build on each other: 1. Engagement; 2. Motivation; 3. Relational; 4. Assessment; 5. Behavior Change; and 6. Generalization. (See Appendix E for more details).

> **Service Definition for Enhanced Functional Family Therapy (FFT):** Enhanced Functional Family Therapy (FFT) is a systematic, evidence-based, manual-driven, family-based treatment program used for a wide range of problems (including drug use and abuse, conduct disorder, mental health concerns, truancy, and related family problems) affecting youth ages 11-18 and their families.

MST and FFT may not meet the needs of every Member receiving IHBT, making it important for Colorado to create its own model. The CO-IHBT Model is a plan for Colorado to build its own intensive in-home treatment model that uses the same evidence-based tenets from other models. The reasons for creating a Colorado-based model includes:

- Proprietary models require reliance on those companies to train and re-train providers. While those training courses can maintain a small or moderate size workforce, having a full-scale workforce to serve Members across the state will require a nimble approach to training, retraining, and re-certifying providers.
- MST and FFT are suitable models for specific populations but are not necessarily the best model for all Members that require in-home services. Colorado needs to have a model that is tailored to the differing populations within the eligible Members for these services.

HCPF will work with committees and stakeholders to develop a formal service definition, eligibility criteria and steps for training and credentialing providers by 2029. The formal service definition for CO-IHBT model will also be looking into the potential inclusion of a clinical aide to serve as the second person on the IHBT team. This aide will assist the primary clinician as needed by the family and functions may include serving as a therapeutic mentor for the youth. Therapeutic mentoring is when a paraprofessional works with a Member in their community environment and assists the Member in the application of the techniques learned in therapy to real-life settings. Therapeutic mentoring is designed to help members, under the age of 21, build skills through experiences that occur in everyday life. Therapeutic mentors work to model, educate, motivate, and coach members on how to use and practice overcoming obstacles related to these skills. Therapeutic mentors will receive training via the workforce capacity center.

> **Service Definition for Therapeutic Mentoring:** TO BE DEVELOPED. HCPF will work with the Lived Experience, Leadership and Implementation committees and stakeholders to develop a formal service definition, eligibility criteria and steps for implementing therapeutic mentoring to be a service covered under a waiver available to members receiving IBHS.

In addition to the IHBT services that will be available statewide, HCPF has identified three subpopulations of youth that would benefit from population-specific intensive in-home intervention models. To provide services appropriate for the unique needs of all eligible members, under the age of 21, in Colorado, Colorado will need to expand its search to include evidence-based or evidence-informed practices that are specific to:

- *Members under the age of eight (8).* HCPF hosted a stakeholder meeting with those working or advocating for the treatment of young children. One of the common themes across several recommendations include Child Parent Psychotherapy (CPP). The model is an intervention for those who have experienced a traumatic event and/or are experiencing mental health, attachment or behavioral problems. The model is based on the attachment

theory; however, it incorporates psychodynamic, developmental, trauma, cognitive behavioral theories and social learning. The sessions include both the child and the primary caregiver(s) with the goal to strengthen the relationship. Additional decision making must occur to solidify the treatment approach for young children.

- *Members with intellectual or developmental disabilities*. For members with an IDD, Colorado will review evidence-based practices that are appropriate for the population. It may include Systemic, Therapeutic, Assessment, Resources and Treatment (START), which is an evidence-based, community crisis prevention and intervention service model. It is also looking at models suggested by stakeholders, such as Collaborative & Proactive Solutions (CPS).
- *Young adults ages 18 to 21*. For members who are being served by both the youth and adult systems, an age-appropriate intervention approach is needed to best serve the population. Key decisions need to be made in defining a set of services, including intensive in-home services, for the age group.

As described in Table 1, these enhancements will be planned and implemented across state fiscal years 2026-2028.

Policy/Process Outline

The ESA and other factors will help inform which model is most appropriate for the Member. Colorado plans to have the CO-IHBT model, once developed, to meet the needs for a majority of Members. However, due to a Member's age, disposition, or behavioral health need, MST or FFT may be a better fit for the member. MST has strong validity with the juvenile justice system-involved population whereas FFT is a trauma-informed model that may be better suited for Members with trauma exposure. In sum, the Member's needs will dictate which intervention is best suited to treat the Member and their family.

All providers are to be trained and certified in their respective models. In addition to delivering the service in the Member's home, the treatment team will be responsible for coordination with any CMRS services and requesting mobile response services when concerned about a Member's ability to stabilize in the home. As these services are developed, related policies and guidance will be developed to ensure that each child is referred to the most appropriate IHBT model available to meet their needs.

Colorado's CO-SOC for IHBT will consist of one licensed clinician and the possibility of a second team member depending on the needs of the Member. To maximize the use of the non-licensed workforce, the CO-SOC model would like to incorporate Qualified Behavioral Health Assistant (QBHA) to be a member of the IHBT team. A QBHA is a non-licensed individual who is trained and certified, who can deliver certain clinical functions under the supervision of a licensed clinician.[9]

[9] https://cccs.edu/colleges-programs/programs/workforce-programs/behavioral-health/#:~:text=Qualified%20Behavioral%20Health%20Assistant,of%20Colorado%20Behavioral%20Health%20Administration.

Finance Outline

IHBT models are most effective when paid by a monthly encounter claim for the services. HCPF still needs to finalize what the necessary rates are to cover the cost to providers and have a sustainable network of certified IHBT providers.

Table 7. IHBT Implementation Plan Steps

Task	Fiscal Year Due Date
Identify appropriate in-home intervention model with children under the age of 8.	Q4 FY26/27
Identify appropriate in-home intervention model for Members 18 to 21 years.	Q4 FY26/27
Identify appropriate in-home intervention model for Members who have an Intellectual or Developmental Disability.	Q4 FY26/27
Implement in-home intervention models for children under 8, Members 18 to 21 and Members who have an Intellectual or Developmental Disability	27/28
Create Service Definition for CO Model	27/28
Build and train providers on CO Model	27/28
Identify and create a policy for determining whether the IHBT model will consist of 1 or 2 providers including collaborating with BHA to identify whether usage of QBHAs is appropriate and available	27/28
Create provider tracking process on those trained and approved to provide IHBT services	27/28
Create a service definition for therapeutic mentoring	27/28
Develop policies and guidance to ensure that each child receives the most appropriate IHBT model to meet their needs.	27/28
HCPF will explore a monthly encounter rate for IHBT models, including the intervention for those under the age of 8, 18 to 21, I/DD and the CO-IHBT model	27/28

3.4.5. Support Services (CO-SOC Part Six)

Members with complex behavioral health needs require appropriate clinical interventions. However, these are not sufficient to meet the complexity of their needs, requiring complementary support services. Support services are services that are needed for the Member and their family to successfully engage in treatment and increase the effectiveness of the clinical intervention. While some support services are available in Colorado, there are

a limited number of providers and limited access. As a result, these services will be expanded as the CO-SOC is developed.

Programmatic Outline

Support services include:

- Respite services provide safe and supportive environments on a short-term basis for Members with mental health conditions when their families need relief and can help encourage and promote the family unit with the ability to stay together in the home. Respite Services allow family members an opportunity to have time independent of a young person with intensive needs. It also allows caretakers short-term relief to take a break for themselves. Respite care should be flexible to ensure that the Member's daily routine is maintained. (See Appendix E for more details.)

> **Service Definition for Respite Services:** Respite services are services rendered in the Member's home, community, or other place of service as a temporary relief from stressful situation/environment or to provide additional support in home environment to maintain the Member in an outpatient setting. Services include observation, support, direct assistance with, or monitoring of the physical, emotional, social and Behavioral Health needs of the Member by someone other than the primary caregivers.

- Additional support services include family peer support partners via the NWIC model, therapeutic mentoring through the CO-IHBT model, and material goods (flex funds) which is a function provided by the Certified ICC Provider. Since these support services are components of other IBHS services, they were not repeated in this section.
    - Family Peer Support Partners, further discussed in section 3.5.4, are typically individuals with lived experience as the parent or primary caregiver of a child or youth who has received mental health, substance use, or behavioral services. These partners have received training and will continue to receive ongoing supervision throughout the process.
    - Therapeutic mentors, who serve as optional clinical aides, are discussed in more detail within the CO-IHBT model outlined in section 3.4.4. These paraprofessionals work with a member in their community environment, helping them apply the techniques learned in therapy to real-life situations.
    - Material goods or flex funds refer to tangible resources or flexible funding that support the well-being of the member and their family, helping them remain at home and continue engaging in treatment. This support service is integrated into the functions of a Certified ICC Provider, as outlined in section 3.5.4. These funds can be used to:
        - Purchase goods and services that would otherwise be inaccessible, such as sensory tools or calming devices
        - Support families in keeping children safely at home
        - Purchase tangible items that increase the Member's ability to remain at home, including:

- Shatterproof dishes
- Shatterproof windows
- Window alarms
- Repairs for damage

Policy/Process Outline

These services will not negate services that the member is eligible for through their health plan or an HCBS waiver. The necessary clinical services the child needs are coverable as section 1396d(r) services under EPSDT before covering them under an HCBS waiver program or one of the state plan options e.g.. 1915(i), (j), (k). Further information on waivers is in Appendix D. There are different types of respite care distinctly defined in their respective waivers or benefits.

Finance Outline

Respite services are currently covered under Colorado Medicaid through Home and Community-Based Services (HCBS) waivers. HCPF would need to consider a 1915(i) State Plan option to cover certain material goods not currently available under existing waivers.

Table 8. Support Services Implementation Plan Steps

Task	Fiscal Year Due Date
Apply for Medicaid waiver to pay for any support services not covered under capitation	28/29
Build support service workforce capacity	28/29
Determine best funding mechanism to have a sustainable workforce	28/29

3.4.6. Behavioral Management Consultation Services (CO-SOC Part Seven)

Programmatic Outline

In the model, behavioral management consultation is for the In-Home Behavioral Health Treatment team to utilize the resources and expertise of a behavior specialist via an e-consultation. While all licensed clinicians will be expected to have a baseline understanding of behavioral interventions, the behavior specialist can assist treatment providers with more acute and specialized treatment usually through applied behavioral analysis (ABA). The behavioral management consultation is as an adjunct to IHBT given the intensity and complexity of behavioral and emotional needs the IHBT will be expected to address. It's also important to add that you will create policies and guidance on when IHBT behavioral consultation is sought, when referrals to ABA are expected, and when both resources would be pursued. Behavioral management focuses on actively changing specific behaviors through techniques while behavioral health encompasses the whole person's mental and emotional well-being.

Service Definition for Behavioral Management Consultation: TO BE DEVELOPED. HCPF will work with committees and stakeholders to develop a formal service definition, eligibility criteria and steps for training and credentialing of behavioral service consultants by 2029.

Policy/Process Outline

The e-consult service will be available during regular business hours. Any IHBT team will have access to the consultant. The consultant must have expertise in evidence based applied behavioral models.

Finance Outline

Contract and payment for services will be managed by the WCC (see workforce Section 3.6.1.1 for more details).

Table 9. Behavioral Supports Implementation Plan Steps

Task	Fiscal Year Due Date
Create a service definition for Behavioral Management Consultation	28/29
Establish contracts for behavioral support via the CO-SOC Workforce Capacity Center	28/29

3.5. Standards and Roles

3.5.1. Transition Points and Re-Referral

Continued Engagement in Services

Successful engagement by the Member and family throughout IBHS is vital; however, keeping families engaged throughout the process can be difficult. To ensure continued engagement by the family and Members, the process of IBHS must be collaborative and youth-driven. Some key points to keeping families and Members engaged are:

- Trust: A trusting, supportive relationship with the team can help increase family engagement;
- Teamwork and communication: Members, under the age of 21, and families must feel a part of the process and feel that their concerns are heard as well as ensure that the services are provided in an effective and timely manner;
- Psychological safety: Members, under the age of 21, and families should feel safe enough to feel their concerns will be heard and addressed by the team; and
- Transparency: the treatment team should be transparent with the Member and family about progress, goals, concerns, etc. And in return the family and Members should be transparent about what is going well, concerns and other external factors that may cause a disruption in services.

Transition from Intensive Services

There are several reasons why a Member might transition out of IBHS:

- The Member has successfully completed HFW or FOCUS. At that time, the Member transitions to Tier 3 care coordination through the RAE for at least the next six months. The Member continues to work with the same care coordinator;
- The Member decides that they have completed the program and/or stops participating. The Certified ICC Provider will continue to try and engage the Member for 30 days after their participation ends; or
- The Member needs a higher level of care than IBHS or is committed to a juvenile detention center. The Certified ICC Provider will continue to try to engage with the family; however, depending on the length of stay, care coordination will move back to the RAEs.
- At times, members may experience inpatient or QRTP stays to address their behavioral health needs. HCPF will be defining policies that address the continuity of IBHS services during those brief periods, and policies for when a pause or transition from IBHS should be considered. These policies will be documented in forthcoming service definitions, practice guidance, and billing guidance.

Policy for Re-Referral

If a Member needs to be re-referred to CO-SOC within a six-month period of leaving it, the Member will return to the Certified ICC Provider, which will develop a care plan. If it has been more than six months since the member has engaged in CO-SOC, the RAE will utilize the

Identification tool as the first step in the pathway to care. The RAE will refer to an ESA, which includes the CANS based on the outcome of the Identification tool. If the ESA decision is made that the member is eligible for re-referral, a new care plan must be created with clearly defined goals that identify and address the challenges faced by the family and the reason for previous disengagement, along with objectives to mitigate these issues moving forward. Targeted interventions should be included to address the identified issues and there will need to be consistent monitoring and review to evaluate the progress of the member and their family and adjustment in the treatment plan as appropriate.

Table 10. Transition Policies Implementation Plan Steps

Task	Fiscal Year Due Date
Create transition policies and educate providers on how to implement policies	Ongoing
Develop re-referral policies for Members and educate providers on process	27/28

3.5.2. Timeliness

Timeliness standards for Members to access services and provider responsiveness are supported by behavioral health care best practices. All timeframes need to be further verified for accuracy and consistency across contracts and regulations. Timeliness standards for each service will be defined for urgent referrals and routine referrals in managed care contracts and provider manuals.

The Identification Tool should be completed immediately upon referral to the RAE to determine if the ESA is required. Referral for the ESA must occur within three business days and the ESA must be completed within 14 calendar days of referral. If the ESA determines eligibility for ICC, the Member and family must be referred to a Certified ICC Provider within three business days and an initial treatment plan meeting should occur within 30 calendar days. A reassessment of the CANS should occur every at least 90 days for every Member in HFW or FOCUS by the coordinator or facilitator.

Table 11. Timeline Standards

CO-SOC Function	Referral	Timeliness Standard (if applicable)	Frequency Standard (if applicable)
Identification Tool	N/A	Immediately upon referral	N/A
Initial ESA	Three business days	14 calendar days	If required for re-entry back into CO-SOC
Follow-up/ Updating CANS	N/A	Within 90 calendar days of ESA	Every 90 calendar days, or more often as needed by the Certified ICC Provider

Intensive Care Coordination	Three business days	The ICC facilitator or coordinator must initiate contact with the family within three business days and begin the engagement process. The Member and their family have 30 days to engage with the Certified ICC Provider and complete the initial treatment team meeting.	HFW and FOCUS will align with NWIC model standards. Will update once the contract with NWIC is final.
Stabilization Services	Refer to crisis service standards	Refer to crisis service standards	N/A (as needed)
Intensive Home-Based Treatment	Three business days of identified need	TBD	MST Initially multiple times per week but varies on clinical needs of Member and lasts over the course of three to four months FFT Typically, one time per week but based on needs of Members and their families, consists typically of 12-14 sessions over three to four months
Support Services	TBD	TBD	As medically necessary TBD
Behavioral Consult Services	TBD	TBD	As needed by an IHBT clinician.

Table 12. Timeliness Policy Implementation Plan Steps

Task	**Fiscal Year Due Date**
Develop policy for Intensive Home-Based Treatment in which timelines will be determined, including for emergent, urgent and routine timeliness for each service.	Q3 FY24/25
Develop policy for support services in which the timelines will be determined	28/29
Develop policy for Behavioral Consult Services in which timelines will be determined	28/29

3.5.3. Clinician Ratios and Provider Networks

The availability of providers to meet the needs of Members is critical to the ability to serve families adequately and in a timely manner. The CO-SOC needs to have a workforce available to ensure there are no significant wait times for Members with substantial needs. HCPF will develop policies around the appropriate workforce capacity as well as ratios of Members to clinicians, clinicians to supervisors for in-home treatment models, and providers per region. Ratios for HFW, MST, and FFT are based on national best practices. For CO-IHBT, HCPF plans to use the same ratios established by MST and FFT models. The length of all services under EPSDT, required for the Member will depend on medical necessity. However, the length of services is only for calculation of the initial workforce needed per region and is not intended to imply a ceiling on length of stay for an individual child in a service. The average duration of each service is outlined below.

Table 13. Provider Ratios

Service	Members per Clinician	Provider per Supervisor	Avg Expected Length of Service (months)
ESA	n/a	n/a	0.5
HFW	10	6	12
FOCUS	15	6	9
MST	6	6	5
FFT	6	6	5
CO-IHBT	6	6	5
Respite	TBD	TBD	TBD
Therapeutic Mentoring	TBD	TBD	TBD
Family Peer Support	TBD	TBD	12

HCPF will use these ratios as the basis for defining what is an adequate number of providers per RAE region. In addition to ratios, HCPF will need to consider distance for providers to Members. Taking distance and ratios into consideration, HCPF will create a policy that establishes clear expectations for the number of trained and certified providers in each region. The final numbers will be determined after HCPF has a stronger grasp on the number of Members in need of the CO-SOC per region or community.

Which providers are selected per region will be determined by several factors:

- The total number of providers needed for each region will be calculated based on provider to clinician ratio for each service type and distance to Members;

- The RAE will identify which providers in their region to select to get trained and certified by the state selected vendor (see Section 3.5.4); and
- If the RAE does not have enough providers who become certified, it must make efforts to recruit providers for certification and the state will provide assistance as appropriate.

Table 14. Provider Ratio Policy Implementation Plan Steps

Task	Fiscal Year Due Date
HCPF develop a workforce capacity strategy plan	Q4 FY25/26
Establish client to provider and provider to supervisor ratios for Family Peer Support	Q4 FY26/27
Establish client to provider and provider to supervisor ratios for respite	28/29
HCPF will develop policies to identify appropriate workforce capacity and work with the RAEs to establish expectations for the number of trained and certified providers in each region to meet the needs of Members receiving CO-SOC services.	Ongoing

3.5.4. Agency Roles

Regional Accountable Entities

The RAEs were established in July 2018 as the single regional entities to manage the Capitated Behavioral Health Benefit and coordinate physical health and behavioral health services for Medicaid Members. The RAEs, authorized under a 1915(b) waiver, are responsible for promoting an integrated, whole-person approach to members' physical and behavioral health. The RAEs must administer the Capitated Behavioral Health Benefit by maintaining a network of providers and providing or arranging for the delivery of medically necessary mental health and SUD services utilizing a community-based continuum of care that adapts to a member's changing needs and provides appropriate access to care.

HCPF utilizes contracts as the primary mechanism for formal accountability for their Managed Care Entities, which includes the RAEs. These contracts are updated no less than annually. HCPF will use subsequent amendments to increase the RAEs' accountability as the implementation and expansion of this work moves forward.

Upon ACC 3.0 contract execution, the RAEs will begin participating in a collaborative process with HCPF on the development of a CO-SOC Manual. HCPF will also bring in other stakeholders/contributors in the development process as needed. The CO-SOC Manual will lay out statewide requirements for the following:

- Timely access to care requirements
- RAE contracting requirements

- Clarify additional roles and responsibilities between RAEs, Certified ICC Providers, CO-SOC Services and Treatment Providers, and the Workforce Capacity Center.
- CO-SOC Policies and Procedures
- RAE and CO-SOC Operational Plans
- Subsequent monitoring and reporting requirements
- Subsequent quality assurance efforts

To help ensure statewide consistency and implementation of CO-SOC and the CO-SOC Manual, the RAEs are engaged in the following activities:

- At least one CO-SOC workgroup meeting per month with the RAEs and HCPF, with reporting to the IBHS Implementation Advisory Committee.
- Involvement in the development of the Identification Tool, CANS Tool and CANS Decision Support Matrix, in collaboration with the University of Kentucky.

Care Coordination Requirements

RAEs must ensure whole-person care coordination is available to and provided for its members by implementing a comprehensive care coordination program that addresses the full range of members' physical health, behavioral health, oral health, and health-related social needs. RAEs must deliver care coordination within the current three-tiered model, which categorizes the types of care coordination services that should be made available to members (see Appendix B for more details on ACC 3.0 and RAE responsibilities). RAEs are responsible for creating a delivery model for culturally relevant services and supports in the most integrated and least restrictive setting and are responsible for delivering care coordination in a culturally responsive manner. This includes ensuring there is a strategy to retain and recruit qualified, diverse and culturally responsive providers to serve Members.

RAE Responsibilities within the CO-SOC

Beginning July 1, 2025, there will be four RAEs to help with care coordination of Member's needs and services and ensure an array of providers are available to meet the needs of those receiving care.

RAE responsibilities will include:

- Accepting referrals and inquiries from members about the need for services (see Section 3.3.1);
- Using the standardized Identification Tool to identify members that need a more thorough assessment or intensive services (see Section 3.3.3);
- Connecting members that need an ESA to a qualified provider (see Section 3.4.1);
- If the ESA determines that the CO-SOC services are needed for the member, the RAE will review the treatment recommendations for consistency and accuracy, and the RAE will connect the Member with a Certified ICC Provider for intensive care coordination;
    - If ESA determines CO-SOC is not necessary, the RAE will manage care coordination within their existing protocols;
- For Members assigned a Certified ICC Provider, the RAE will work with the Certified ICC Provider to ensure an adequate network of the CO-SOC providers are contracted with the RAE and accessible in the provider network; and
- Managing payment to providers.

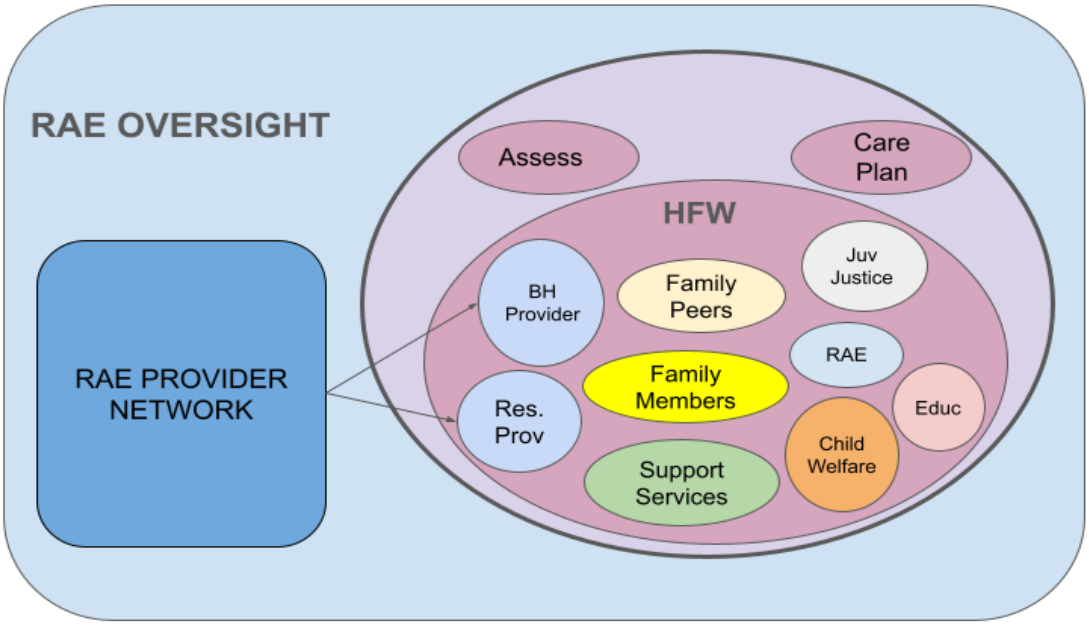
- Assist HCPF in developing network adequacy of a culturally competent provider workforce that meets the cultural and linguistic needs of Members.

The RAE will continue to stay involved before, during, and after the Members' involvement in the CO-SOC. The RAE maintains accountability for:

- Ensuring the Member has access to the services identified in the ESA that are medically necessary for the Member to ameliorate their behavioral health condition;
- Remaining an active participant on the multi-disciplinary team led by the Certified ICC Provider, to ensure continuity of care is maintained after discharging from the CO-SOC (see Figure 4);
- Having an adequate network of providers that complies with the provider to Member ratio outlined in Section 3.5.3 (see Figure 4); and
- Working with the Certified ICC Provider on any discrepancies between the treatment plan and accessible services. The RAE is expected to manage any discrepancies on medical necessity determinations. However, any unresolved disputes will need to be reviewed by HCPF and addressed via the Member appeals process (see Figure 4).

HCPF is working closely with the RAEs to assist in their understanding of their responsibilities for CO-SOC and will establish contract expectations for the provision and oversight of the CO-SOC services consistent with this plan.

Figure 4. RAE Oversight Role



System of Care Certified Intensive Care Coordination Provider

Certified ICC Provider is a new term for Colorado and serves as a descriptor for the provider type that provides intensive care coordination services. The term Certified ICC Provider will

be used in the coming years to distinguish the intensive care coordination organizations that get certified in the state approved training from the HFW and FOCUS models used in the CO-SOC from the care coordination services provided by the RAEs or CMAs. Certified ICC Providers will be regionally-based and selected and managed by the RAE in that region.

When a Member is in the CO-SOC, the Certified ICC Provider will serve as the lead care coordinating agency for behavioral health services. The Certified ICC Provider serves as lead on the treatment team; however, the RAE and other case management agencies are expected to be a part of the treatment team. Medicaid members receiving care coordination for traditional behavioral health services are different from those served by Certified ICC Providers, as they are specifically for Members who need Intensive Care Coordination. The Certified ICC Provider is responsible for ensuring that all CO-SOC services are coordinated and for escalating any access issues to the RAE. Members not in need of a CO-SOC level of care will be referred back to the RAE.

In addition to HFW or FOCUS, care coordination functions within the Certified ICC Provider include:

- Member engagement;
- HFW or FOCUS with Family Peer Supports;
- Managing flex funds (material funds);
- Determination of CHRP Referrals;
- Creation of a care plan;
- Matching Members, under the age of 21, and families with all the supports and services defined in the care plan;
- Identifying the social determinants of health (SDoH) needs and referring to the appropriate human services as needed;
- Assist residential treatment providers in appropriate and expeditious discharge planning; and
- Serving as a single point-of-contact across all agencies on care plan delivery.

Table 15. Detailed functions of Certified ICC Providers

Member Engagement	Certified ICC Providers will build relationships with Members and their families and keep them informed, motivated and connected. Member and family engagement is foundational to building trust and ensures that goals and priorities are at the forefront. It includes orienting Members and families to the ICC process, assigning a facilitator or coordinator, stabilizing crises, and preparing for initial and ongoing child-family treatment meetings.
HFW or FOCUS with family peer supports	Certified ICC Providers will help identify families and youth who have achieved the maintenance stage of services to become Family Peer Support Partners. Family Peer Support Partners are typically provided by families with lived experience as the parent or primary caregiver of a child or youth who has received mental health, substance use or behavioral services and who have also received training and

	will receive ongoing supervision throughout the process. The training is in alignment with the NWIC HFW model and FOCUS model. The function will be built out over time as more families transition to the maintenance stage.

Flex funds (material goods)	The Certified ICC Provider will be responsible for managing flex funds for material goods. Material goods are purchases that increase the Member's ability to remain at home and engage in treatment. Flex funds can be used to:
	● Purchase goods and services that would otherwise be inaccessible
	● Support families in keeping children safely at home
	● Purchase tangible items that increase the ability for the Member to remain home, e.g.:
	  o Dishes that don't shatter
	  o Windows that don't shatter
	  o Place alarms on windows
	  o Repair for damages
	● Allow children and youth to engage in specific activities such as skill building

Determination of CHRP referrals	Certified ICC Providers will help identify children and youth through the ESA who may qualify for CHRP and provide referrals for these children, youth and families. Certified ICC Providers will work to ensure referrals to Case Management Agencies for an evaluation of the Member's eligibility for long-term support waiver services. Long-term support services are specialized services to better meet the needs of youth with IDD or other disabilities.
Creation of a care plan	Partner with Members, families, and treatment team to develop a comprehensive, strengths-based care plan based on needs identified in the ESA. The plan will guide the Member, family and the team in pursuing goals identified by agencies and the Member and family.
Match the children and families with all the services and supports defined in the care plan	Certified ICC Providers will foster, develop and maintain relationships with local community resources to provide referrals for Members and families to community and support services outside the scope of the Certified ICC Provider. Certified ICC Providers will work with the family to identify the best suited provider in the RAE network for the family. It includes but is not limited to mental health services, special

	education, diagnosis and medication help, medical care, social services, etc.
Identify the social determinants of health (SDoH) needs and refer to the appropriate human service agency or community non-profit as needed	The Certified ICC Provider will identify SDoH needs in the care plan and help manage and maintain referrals for SDoH resources for Members and families receiving services to best support them in whole-person care. These can include: transportation, stable housing, food security, employment, education, emotional and community support, access to technology and other supports helpful to the Member and family. The Certified ICC Provider will assist the family in applying for benefits as appropriate and local community resources.
Liaison to residential treatment facilities	Certified ICC Providers will work with RAEs to develop formal relationships with residential treatment facilities to ensure a formalized structure for transitional support and care planning and facilitate communication regarding admissions and discharges of Members. The Certified ICC Provider will provide continuity of care for Members stepping down from residential treatment which will include establishing or re-establishing Medicaid services and community resources to support the Member and their families. The Certified ICC Provider will be actively involved in the discharge planning for all Members assigned to their organization.
Serve as a single point-of-contact across all agencies on care plan delivery	As the single point-of-contact the Certified ICC Provider will: ● Assemble a care team individualized to each Member. The care team will include family members, treatment providers, other professionals, and natural supports of the Member's choice. It may include teachers, school counselors, state agency workers, friends, relatives and other supports identified by the family; ● Be updated by all child serving organizations working with the family and call team meetings as needed, including government agencies functioning in a care delivery role or payor of services; ● Coordinate communication between all agencies and will work with the Member and their family to communicate their preferences; ● Serve as the single point-of-contact for all child-serving agencies, education and other community supports identified by the family. The Certified ICC Provider will lead the development of the care plan and collaborate

	with the team to ensure goals are being met.

ICC requires a more structured approach and responsibility beyond the requirements of care coordination under the RAE. Both the RAE (per ACC 3.0) and Certified ICC Provider play a critical role. The breakdown of responsibilities is as follows:

Table 16. RAE vs. Certified ICC Provider Care Coordination Responsibilities

Responsibility of the RAE	Responsibility of the Certified ICC Provider
• Care coordination post-CO-SOC/ICC; • Identify members through the Identification Tool who would benefit from the ESA • Determining eligibility for the CO-SOC via the ESA and other information; • Creating and maintaining an adequate networks of the CO-SOC providers; • Managing payments to providers; • Transitioning Members between varying levels of care; • Coordinating with physical health; • Working with Certified ICC Providers on any discrepancies in treatment plan for Members. • Manage referrals for treatment services recommended in the Care plan • Engage and participate in ICC team meetings as team participant • Ensuring compliance to EPSDT	• Member engagement; • HFW or FOCUS with Family Peer Supports; • Managing flex funds (material funds); • Determination of CHRP Referrals; • Creation of a care plan; • Matching Members and families with all the supports and services defined in the care plan; • Identifying the social determinants of health (SDoH) needs and referring to the appropriate human services as needed; • Serving as a liaison to residential treatment facilities; and • Serving as a single point-of-contact across all agencies on care plan delivery.

Case Management Agencies

Case Management Agencies (CMAs) currently manage all Home and Community-Based Waivers (HCBS), including the Children's Habilitation Residential Program (CHRP) waiver. CMAs help people who have disabilities or chronic illnesses and their families access long-term services and supports to assist with their daily activities. Examples of long-term support services that CMAs help to manage are life skills development, specialized support services, and habilitative residential. Benefits can be delivered in different places, such as in a person's home, in a community center, or a nursing home. CMAs identify programs within demographic areas that fit the needs of the individuals the CMA is serving and provide referrals to RAEs to connect with appropriate community programs. CMAs are not behavioral health providers, nor are they responsible for managing behavioral health capitation benefits.

Currently, the 1915(c) CHRP waiver provides services for children and youth who have an intellectual or developmental disability and very high needs. Their need for support puts them at risk, or in need of out-of-home placement. Developing and maintaining the skills needed to live in their communities is vital for these members. Legislation passed in 2024 (HB24-1038) permits HCPF to seek federal authority to expand the CHRP waiver to include children and youth who have a serious emotional disturbance that puts the child or youth at risk or in need of out-of-home placement, without an IDD diagnosis. HCPF has received federal authority to implement this expanded eligibility criteria in the CHRP waiver as of January 1, 2025.

For Members receiving services under the CHRP waiver and are a part of the CO-SOC, the RAE or Certified ICC Provider will be responsible for behavioral health care coordination dependent on the level of need. For Members in the CO-SOC, the Certified ICC Provider will coordinate all behavioral health care and the CMAs will manage the long-term support services not included in the CO-SOC. HCPF will develop policies and expectations regarding ICC Provider and CMAs roles, functions, and participation in CFTs.

Table 17. Agency Roles for CO-SOC Members

Function	Certified ICC Provider	RAE	CMA
Determine eligibility for services	Identifies which providers in the network are the best fit to the services outlined in the ESA	Review eligibility for the CO-SOC based on ESA recommendations	Determine eligibility for HCBS and CHRP waiver supports
Agency's primary role	Manage treatment team meetings and sharing and collecting information from various agencies.	Manage Medicaid Behavioral Health Capitation benefit and coordinate intersect of behavioral health and physical health	Manage HCBS and CHRP waiver supports
Role on High Fidelity Wraparound multidisciplinary team	Serves as the lead on the coordination of all services across all agencies. Utilization the CANS tool and Decision Support Matrix ongoing	Participates on treatment team and prepared to resume care coordination role when Member discharges from the CO-SOC Review eligibility for CO-SOC based on ongoing CANS and Decision Support Matrix	Participates on treatment team and ensures eligible long-term support services are available
When to refer to other agencies for additional services	To CMA when suspected disability due to IDD or high-	To CMA when suspected disability due to IDD or high-	To RAE when behavioral health concerns are

or supports	acuity behavioral health.	acuity behavioral health. To Certified ICC Providers when a Member is determined CO-SOC eligible.	prevalent and needs ESA.
Fiscal Role	None	Pay for behavioral health services.	Pays for waiver long-term support services

Behavioral Health Administration (BHA)

BHA is the state administration responsible for ensuring all people in Colorado have access to quality mental health and SUD services, regardless of where the individual lives or ability to pay. BHA is a critical partner to HCPF given its responsibility for the entire behavioral health system, including its initiatives to attract and retain a high-quality, diverse and culturally responsive workforce and oversight of the crisis system. BHA manages a number of non-Medicaid funded programs for children, youth and families, as well as substance use treatment. The programs include Crisis Resolution Teams (which provide families of youth and young adults with intensive, short-term, in-home services) and the Children and Youth Mental Health Treatment Act (CYMHTA), which allows families who do not qualify for Medicaid or CHRP to access mental health treatment. BHA oversees the BHASOs, which will oversee care coordination for children and youth funded by CYMHTA.

The BHASOs will likely have a strong public-facing presence. As a result, HCPF is working with BHA to have policies in both the BHASO and RAE contracts that prevent children, youth and families from falling into a gap between intermediaries. BHASOs will be contractually required to have concrete strategies to transition support for individuals to RAEs when it is identified the individual is a Medicaid Member.

In addition, BHA plays a key role in both behavioral health regulation and workforce development. HCPF works closely with BHA in creating regulations that set standards for quality behavioral health services. HCPF relies on these standards when paying for services. In addition, HCPF works with BHA in efforts to improve the quantity and quality of the behavioral health workforce in Colorado. BHA operates a learning management system, which will train providers on the ESA, and has several behavioral health pipelines that intersect with the CO-SOC providers, such as HFW training.

Colorado Department of Human Services

Colorado Department of Human Services (CDHS) is the state department responsible for both the Division of Child Welfare and the Division of Youth Services. The Division of Child Welfare (DCW) oversees child protection services for children and youth as well as prevention and intervention services and licensing of residential facilities. The Division of Youth Services (DYS) provides for the care and supervision of youth committed or detained by the District Court to the custody of CDHS and administers parole services for youth. Most children and youth in the child welfare system or juvenile justice system are in need of behavioral health

care and are involved in multiple agencies and systems. Cross-system collaboration between CDHS and HCPF is vital to ensuring access to CO-SOC services for children and youth who are involved in child welfare or juvenile justice. For children or youth who are involved in DCW and/or DYS, the case manager will be a part of the care team identified by the ICC facilitator.

Table 18. Intersection of Systems Serving Children and Youth

Child-Serving System	Child Welfare	Juvenile Probation	Youth Detention	Youth Commitment
Screen and referral for behavioral health needs	Yes - County agencies ensure timely care coordination with RAEs for Members who are placed in foster care to work towards timely access to necessary services	Yes, judicial districts typically screen for behavioral health needs	Yes - Colorado Youth Detention Continuum (CYDC) screens youth for needs at admission, placement and release	Yes - DYS case managers assess for needs at admission and discharge
Check for Medicaid eligibility	Yes	Not required	No	Yes
Has formal relationship with RAE	Yes	No	No	Starting July 2025
RAE/Certified ICC Provider involved in transition of child-serving system	Yes - Responsible for preparing Member for permanency or independence	Dependent on judicial district practice	HCPF is exploring more involvement pre-release	Yes - As part of CAA* and 1115 waiver work, HCPF will play a greater role in release

*Consolidated Appropriations Act, 2023 (CAA)[10]

Disputes between Agencies

There will naturally be times when there are professional disagreements about the best course of action. HCPF anticipates that the use of an ESA accompanied with a Decision Making Matrix will reduce discrepancies in recommendations for medically necessary services.

[10] https://www.govinfo.gov/content/pkg/PLAW-117publ328/pdf/PLAW-117publ328.pdf

HCPF expects that the treatment team led by the Certified ICC Provider will formulate the treatment plan based on the information. The RAE, in its role as the payor and utilization manager, will certify that the treatment plan is consistent with the ESA and medical necessity. If a discrepancy in opinion between the RAE and Certified ICC Provider cannot be resolved between the two parties, HCPF will review the medical necessity determination to resolve the dispute between the agencies. Specific policies regarding dispute resolution and timelines still need to be created by HCPF. HCPF will review Massachusetts and Ohio protocols for dispute resolutions and cross-system protocols within their systems of care.

Table 19. Agency Roles Implementation Plan Steps

Task	**Fiscal Year Due Date**
Create educational materials for IBHS providers to distinguish RAE responsibilities from Certified ICC Provider responsibilities	Q3 FY25/26
Review Massachusetts and Ohio dispute resolution policies.	Q2 FY25/26
Develop dispute resolution policy that includes process for handling grievances, appeals, and how decisions will be made by the RAE and treatment team	Q3 FY25/26
Create cross-system protocols for working with CDHS, BHA and CMAs	Q2 FY25/26
Create a policy with the RAEs for Utilization Management that promotes in-home placement for Members	Q3 FY25/26
HCPF, RAEs and relevant stakeholders will collaborate to develop CO-SOC manual to outline statewide requirements for implementing the CO-SOC	Q2 FY26/27
Identify and establish process for intersection with child welfare, juvenile justice, youth detention and youth commitment	Q2 FY26/27

3.6. Workforce

An evidence-based system of care requires a well-trained workforce that maintains fidelity to the interventions of the model. To ensure there is a statewide workforce for all the various types of providers needed to meet all the needs of Members, HCPF is working closely with the BHA to build capacity. There are two different mechanisms by which training will be delivered, a new CO-SOC WCC and BHA's Learning Management System (LMS).

3.6.1. Workforce Capacity Development

3.6.1.1. Workforce Capacity Center

Intensive Behavioral Health Services (IBHS) require specialized skills and expertise that are currently lacking in Colorado, as well as in many other states. Although the state currently has an LMS and an existing credentialing process that can be leveraged to assist in expanding and enhancing the workforce, additional initiatives will be needed to grow the workforce needed. HCPF plans to work with a state university to develop the WCC.

Initially, HCPF is exploring entities like Colorado State University's (CSU) School of Social Work as possible locations for a WCC. This is because the Colorado State University College of Health and Human Services focuses on rural engagement via extension programs, looking at how to meet the needs of the community, specifically related to behavioral health in rural areas. CSU Extension provides structure to implement programming in all counties in the state and fosters connections with community health and education stakeholders. CSU has also been dedicated to working with other college systems and state agencies in expanding their reach to rural Colorado via their Extensions Program.

The WCC will also oversee training and technical assistance support for providers and developing standards for credentialing. Specifically, the WCC will provide:

- **Certification and Credentialing.** Delivering IBHS will require new provider types or an expansion of skill sets. The WCC will confirm interested individuals meet all the requirements of the provider type;
- **Training/Technical Assistance.** Some provider types will be required to be trained by the WCC to deliver the services in the proper manner; and
- **Fidelity Monitoring.** Certain services require fidelity to the model for them to be effective. The WCC will need to identify a sample subset of providers and ensure the providers are delivering models to fidelity through documentation, fidelity metrics and observation.

Workforce Capacity Center specifics:

High Fidelity Wraparound and FOCUS

The WCC will contract with the National Wraparound Implementation Center (NWIC), which supports states, communities, and organizations, to implement HFW and FOCUS effectively. The work is tailored to build sustainable local capacity to provide model-adherent HFW and FOCUS, thereby increasing positive outcomes for children and their families. NWIC's training and coaching support is designed to build sustainability in a state or community for the local wraparound workforce. The WCC will be the agency trained by NWIC and ensure statewide training is available for future years.

Intensive Home-based Treatment

The package includes a series of core training courses for practitioners, supervisors, administrators, and community stakeholders with more intensive training for local staff identified as candidates for certification and/or supervisors. The WCC will also manage

credentialing for MST and FFT therapists as well as Colorado's model. Specifically, WCC will manage the contract with the proprietary companies that own MST and FFT to ensure the respective workforce is trained and certified. Long-term the WCC will create, manage and deliver the training for the CO-IHBT model.

Behavioral E-Consultation Services

The WCC will manage the contract for behavioral management consultation services. The consultation is for the IHBT team to utilize the resources and expertise of a behavior specialist via an e-consult. Consultation services are expected to be available during regular training center business hours. (See Section 3.4.6).

3.6.1.2. BHA Learning Management System

BHA launched a comprehensive online resource focused on providing free educational courses for behavioral health professionals, crisis and peer professionals and any other interested individuals. The learning platform, known as OwnPath Learning Hub[11] is intended to help providers expand their knowledge base on mental health and care topics. OwnPath Learning Hub was created in response to Senate Bill 21 -137[12].

Child and Adolescent Needs and Strengths

The Praed Foundation maintains the certification process for the CANS tool (one of the components of the ESA). The WCC will be responsible for maintaining an up-to-date list of individuals who are certified in administering the CANS. Initial plans are for the WCC to be responsible for tracking the certification and credentialing of ESA providers within the LMS.

Crisis Training

OwnPath Learning Hub provides a variety of modules for training including the crisis professional's curriculum required of any individual who wants to become a crisis professional. Crisis professionals, including those who are involved in mobile crisis response, are required to take six hours of courses focused on providing crisis intervention to children and youth. The course is designed for behavioral health service providers, social workers, counselors, peer support specialists, and other professionals, who support individuals with substance use and behavioral health conditions. The following courses specific to children and youth include:

- Introduction to Supporting Children, Youth and Families in Crisis
- Supporting Children, Youth and their Families in Crisis: Consent Laws and Boundaries
- Supporting Children, Youth and their Families in Crisis: De-Escalation and Stabilization
- Supporting Children, Youth, and Their Families in Crisis: Screening and Assessment
- Supporting Children, Youth, and Their Families in Crisis: Safety Planning and Bridging

[11] https://learninghub.ownpath.co/

[12] https://leg.colorado.gov/bills/sb21-137

3.6.1.3. Other workforce training

There are providers who are not part of the CO-SOC service array but will interact with Certified ICC Providers or IHBT team members. For these providers (such as residential providers, school-based clinicians, or other outpatient providers), HCPF will work with the BHA to disperse relevant information about CO-SOC and how to navigate the system through the Certified ICC Provider. Furthermore, HCPF will work with CDHS to update residential provider regulations to require those providers to permit Certified ICC Providers to participate in discharge treatment planning of Members. See Section 4.3.1 for more information regarding HCPF's plan for educating providers about the CO-SOC.

3.6.2. Provider Requirements

Providers will be certified or credentialed to demonstrate that the necessary training has been completed, and the provider holds the necessary license or certification to provide the applicable services. The CO-SOC WCC will certify or credential providers for HFW, FOCUS, MST, FFT, Colorado's IHBT (CO-IHBT) model, and therapeutic mentoring. For respite and family peer supports, HCPF still needs to determine which entity, the WCC or otherwise, is the appropriate agency to credential and certify providers.

Table 20. Provider Requirements by Provider Type

Service	Qualification	Certification Req.	Training Source
ESA (initial)	Licensed for Behavioral Health by state and Praed Certified	Yes	BHA LMS
CANS (on-going)	HFW or FOCUS Certified	Yes	BHA LMS
HFW	Bachelors in Human Services	Yes	WCC
FOCUS	Bachelors in Human Services	Yes	WCC
Family Peer Support	Lived experience	Yes	TBD
MST	Licensed for Behavioral Health by the state	Yes	MST Company via WCC
FFT	Licensed for Behavioral Health by the state	Yes	FFT Company via WCC
CO-IHBT (primary)	Licensed for Behavioral Health by state	Yes	WCC
CO-IHBT (secondary)	QBHA	Yes	WCC
Therapeutic Mentor	QBHA	Yes	TBD
Respite	TBD	Yes	TBD

3.6.3. Fidelity Monitoring

It is important to ensure providers are consistently applying the key components of the CO-SOC interventions. It is particularly true of interventions that rely on multiple components, such as engaging multiple systems (family, school, peers) or utilizing a collaborative approach

with caregivers. Some services that do not have established fidelity monitoring processes will require their development.

CANS/ESA

HB24-1038 included funding for one full-time HCPF employee for implementation. The position will provide oversight of policies related to quality and fidelity of the CANS and ESAs. HCPF, in collaboration with stakeholders, RAEs, and other state departments and agencies, will develop a fidelity checklist for ESAs. HCPF will develop a policy for random sampling of providers to evaluate to ensure the provider is administering the CANS to fidelity.

HFW and FOCUS

Fidelity monitoring for HFW and FOCUS will be completed by local coaches in the WCC who have been certified by the National Wraparound Implementation Center (NWIC). The WCC will incorporate NWIC principles and HFW/FOCUS practice improvement tools. WCC will develop and utilize NWIC support tools and fidelity monitoring processes.

Intensive Home Based Treatment

Fidelity monitoring to the specific IHBT interventions is based on the model chosen. The proprietary organizations that certify MST and FFT play a key role in oversight of fidelity to the intervention. For MST and FFT, WCC will play a role in ensuring fidelity of MST/FFT and how it functions within the CO-SOC protocols and policies. For CO-IHBT, WCC will be the certifying agency and oversee all fidelity monitoring for that intervention.

- MST/FFT
  Fidelity to these intensive home-based treatment models will be executed through the following:
  - Requiring supervisors of MST/FFT teams to engage in periodic observations therapy sections and evaluate the therapist against a fidelity checklist;
  - Supervisors review treatment plans, documentation, and progress notes to assess if MST principles are being incorporated; and
  - WCC conducts a review of practice for fidelity to the CO-SOC protocols based on requests from providers asking for technical assistance specific to the fidelity of the CO-SOC implementation.
- CO-IHBT model
  The design of Colorado's own IHBT model will require extensive fidelity monitoring for several years. Prior to the launch of CO-IHBT, HCPF will rely on the WCC to develop the necessary tools to monitor providers' fidelity to the proposed model. The WCC will:
  - Develop checklists to be used for reviewing treatment plans, documentation, and progress notes to assess if the principles of the model are being incorporated;
  - Create therapist self-report tools by using questionnaires to assess provider perception of their adherence to model practices;
  - Develop a checklist to be used for the implementation of CO-IHBT model for an agency which would include things such as: staff ratios, training/certification,

clinical supervision, on-call response times, and other tenets found in evidence-based practices (EBPs);
    - Conduct reviews of practices for fidelity to the model in alignment with other EBPs and best practices.; and
    - Create an evaluation tool for Members and their family to report on the therapist's adherence to the principles of the model being incorporated.

- Therapeutic Mentoring within CO-IHBT
  Fidelity to therapeutic mentoring treatment models will be executed through the following:
    - Requiring supervisor/licensed clinician of the IHBT team to engage in periodic observation of therapy sessions and evaluate the therapist against a fidelity checklist;
    - Supervisor/licensed clinician of the IHBT team to review treatment plans, documentation, and progress notes to assess if MST and FFT principles are being incorporated; and
    - WCC conducts a review of practice for fidelity to the model based on requests from providers asking for technical assistance.

Table 21. Workforce Implementation Plan Steps

Task	**Fiscal Year Due Date**
Develop policy and protocols for HFW fidelity development and monitoring	Q2 FY25/26
Develop policy and protocols for MST and FFT fidelity development and monitoring	Q2 FY25/26
Develop policy and protocols for FOCUS Model Fidelity development and monitoring	Q2 FY26/27
Develop policy and protocols for CO-IHBT model fidelity development and monitoring	27/28
HCPF and WCC will develop process for how to manage contracts for behavioral e-consultation services	28/29
Develop educational information with BHA on how to disperse relevant information about the CO-SOC for providers not in CO-SOC service array but those who will interact with Certified ICC Providers or IHBT team	Ongoing

4. Operations

4.1. Continuous Quality Improvement

HCPF will establish a process to monitor, evaluate, and improve key performance measures for the delivery of services to Members served by the CO-SOC. As the CO-SOC matures, additional measures will be added. Measures include process measures, structural measures, and outcome measures. Measures collect information on the state's implementation of the CO-SOC, providers delivering services, Members' improvement through care, the experiences of Members and families receiving care, and the effectiveness of the CO-SOC services. The CO-SOC will be implemented in a phased approach across the state (See Section 4.2). Not all measures will be collected in SFY 25/26.

Quality Assurance Oversight

HCPF will establish a committee to oversee the implementation and effectiveness of the CO-SOC and will be accountable for the quality plan. The quality assurance (QA) process will be on-going with the goal of monitoring and improving the implementation of the CO-SOC and outcomes for Members. The quality plan will summarize how HCPF plans to engage stakeholders in the QA process. The proposed list is expected to evolve as additional data becomes available, and as learning from implementation develops. Metrics will be disaggregated for internal quality assurance oversight. Public-facing data will not identify specific providers to any data, or certain demographic characteristics of Members. Measures may not be reported if sample size is small to protect the identity of beneficiaries. Over time, the quality process will support the ability to identify gaps in care, promote improved engagement of different subpopulations of children and their families, enhance ability to identify high/low-performing providers and manage performance, and improve the ability to track progress over time.

Proposed Metrics

The measures under consideration for inclusion in the quality plan are structural, process, and outcome measures. Additionally, HCPF will also review utilization and spending for Members, under the age of 21, in the CO-SOC. It includes HCPF's oversight and statewide monitoring of progress, and HCPF's direction (via ACC 3.0 contract language) to the RAEs to monitor over- and underutilization of services, and the use of emergency departments and out-of-home placements to identify new beneficiaries that may benefit from enrollment in the CO-SOC. The review will include all Medicaid behavioral health services (not just the CO-SOC specific services).

Metrics that HCPF plans to collect and report include but are not limited to:

- Increased capacity within the CO-SOC
- Implementation effectiveness, efficiency, cost-effectiveness, and timeliness
- Stratified data by different demographic and geographic characteristics to monitor quality, timeliness and impact of care
- Number of children screened for the CO-SOC

- Number of Members engaged in the CO-SOC
- Number of Members referred to the CO-SOC interventions
- Number of Members utilizing the CO-SOC interventions
- Regional, demographic, and health equity data demonstrating a reduction in disparity

Member- and family-specific outcomes will be tracked to assess the overall effectiveness of the CO-SOC. Examples of outcome measure HCPF will track include but are not limited to:

- Utilization of in-home treatment as compared to residential treatment
- Rate of behavioral health-related emergency dept. visits
- Average length of stay in residential treatment
- Frequency of out-of-state placements
- Re-entry into higher levels of care such as residential and inpatient

HCPF will also be tracking some key metrics that demonstrate that the pathways to care within the CO-SOC are functioning as intended. These metrics include, but are not limited to:

- Percentage of positive identification screens that result in completed ESAs
- Percentage of ESAs that indicate the need for and result in the CO-SOC intensive care coordination involvement
- Frequency in which treatment recommendations are incongruent between RAE and the Certified ICC Provider.
- Percentage of Members who go into residential, crisis stabilization units, or inpatient while in the CO-SOC

Ongoing quality improvement will help ensure all Members and families are provided with timely, effective, high-quality, and individualized care that is appropriate in scope, intensity, and duration to meet their needs.

RAEs will be required to submit reports to HCPF that include how many members, under the age of 21, have received the ESA, how many were referred to ICC, timeliness for access to IBHS services, etc. Reports will include:

- Number of members engaged
- Number of members denied services
- Number of Members referred to HFW vs. FOCUS
- Time between when a Member was determined to need ICC level of care and when services began

Table 22. CQI Implementation Plan Steps

Task	**Fiscal Year Due Date**
HCPF will establish a committee to oversee the effectiveness of the CO-SOC who will also be accountable for the quality plan.	Q4 FY24/25
Finalize the metrics and outcomes to be tracked in the CO-SOC	Q2 FY25/26

Develop a quality plan for how metrics can be collected and analyzed, including an assessment of any technology solutions that need to be developed,	Q2 FY25/26
Finalize the policy and data collection procedures that RAEs will be required to contractually abide by.	Q2 FY25/26
Finalize the policy and data collection procedures that Certified ICC Providers will be required to contractually abide by.	Q3 FY25/26
Finalize the policy and data collection procedures that WCC will be required to contractually abide by.	Q3 FY25/26

4.1.1. Department Oversight and Roles

Part of continuous quality improvement is HCPF's role in maintaining oversight of the implementation of the CO-SOC and resolving any barriers that occur. HCPF will take an active role in managing its vendors to ensure that the CO-SOC care delivery is operating as intended. Specifically, HCPF will be required to lead oversight functions in the following areas:

- Manage adherence to the RAE contracts with its vendors. Contracts will clearly delineate the RAEs' requirements in executing their CO-SOC functions by:
    - Ensuring medically necessary services are accessible in a timely manner;
    - Ensuring Members are appropriately assigned to an ESA provider and Certified ICC Provider when indicated;
    - Supporting Certified ICC Providers in their ICC functions, including participating on ICC teams;
    - Adhering to network adequacy requirements established by HCPF;
    - Actively participating in the transition of Members into and out of the CO-SOC services programs; and
    - Submitting data, programing, and administrative information as contractually obligated
- The RAE contract for ACC 3.0 (starting July 1, 2025) currently has language and expectations for SFY 25/26 (see section 4.2.1). HCPF will be responsible for enforcing contract language.
- Manage discrepancies in treatment determinations as needed. It is particularly important when there is a disagreement between the Certified ICC Provider, CMA or RAE on the contents of the treatment plan and what services are accessed (see Section 3.5.4).
- Actively participate in the development of workforce capacity for the CO-SOC providers. HCPF will need to both enforce network adequacy standards and take an active role in enforcing expectations on clinician to Member ratios per region (see section 3.5.3).
- Manage and oversee the vendor operating the WCC. In addition to working with the WCC on selecting curriculums for the CO-SOC provider training, HCPF will work with the WCC and BHA on setting expectations of provider types and qualifications in the CO-SOC (see section 3.6.2).

- HCPF policy and finance teams will work collaboratively internally and with the RAEs to establish which the CO-SOC services need directed payments to ensure reimbursement reflects the rigor of the evidence-based models included. This will ensure there is an adequate workforce available to deliver the CO-SOC services.
- HCPF is responsible for executing Continuous Quality Improvement (CQI) functions per Section 4.1.
    - HCPF will use the CQI process to evaluate consistency across RAE regions.

Table 23. Department Oversight Implementation Plan Steps

Task	Fiscal Year Due Date
Develop policy on ensuring timely and appropriate reimbursement for services, ensuring implementation of the CO-SOC in compliance with state policies and procedures	Ongoing
Update RAE contracts for compliance for fiscal year 26/27 and beyond.	Q1 FY26/27
Update HCPF CQI policies as needed to reflect adherence to the standards and roles in the CO-SOC.	Q3 FY26/27

4.1.2. Consumer Feedback

HCPF plans to use consumer feedback as part of its CQI process for the CO-SOC. HCPF will work with the three committees outlined in Appendix F to create specific guidelines for frequency and methods of obtaining feedback. The 3 committees are the Lived Experience Committee, the IBHS Implementation Advisory Committee and the Leadership Committee. HCPF will seek feedback on the quality of the services and the effectiveness of pathways to access care. The feedback will assist HCPF to make systemic or service enhancements as needed. HCPF, RAEs and Certified ICC Providers will collect data from Members and families regarding their experience of receiving services through the CO-SOC. The Certified ICC Provider and RAE will be responsible for gathering semi-annual Member and family satisfaction reports that focus on their insights in fidelity to current models, including HFW, MST or FFT, and areas for improvement. HCPF will be responsible for providing oversight monitoring to the success of outreach and feedback efforts by these entities. In addition, there will be an established set of performance and outcome standards related to Members and their families. Measures will be used to monitor how the providers within the CO-SOC are carrying out their roles and responsibilities and meeting their standards.

HCPF will collaborate with RAEs to create a process by which local agencies and providers who serve Members, under the age of 21, can submit periodic feedback on the quality and effectiveness of the CO-SOC services. HCPF will create a report card structure for these communities to provide the necessary feedback on the timeliness of services, the availability and accessibility of services, and provider adherence to the proposed model of services. In all, HCPF plans to receive regionally based feedback from local agencies working with the CO-

SOC on providing services within the CO-SOC and collaborating with other agencies and providers in the delivery of the CO-SOC to Members and their families.

New models and interventions will be developed and implemented through the phased approach, including CO-IHBT, support services, and increasing access to crisis services. HCPF will therefore create a feedback tool for Members and their families to report on fidelity to the standards of each service. The focus will be on assessing the relevance, efficacy, and accessibility to Members and their families. The tool will include feedback for alignment with their needs, strengths of the models and interventions, and areas for improvement.

Table 24. Consumer Feedback Implementation Plan Steps

Task	Fiscal Year Due Date
Create standard operating procedures for receiving, collecting and analyzing feedback from users in the CO-SOC. Create any necessary tools to receive such information.	Q3 FY26/27
Create protocols for using the Lived Experience Committee as a mechanism for reviewing consumer feedback	Q2 FY26/27
Create a process for collecting information from partner agencies (i.e. child welfare, juvenile justice, consumer associations, etc.) on the quality of the CO-SOC services being delivered in their community. Create a report card system for tracking local effectiveness of services.	27/28

4.2. Phased Rollout

4.2.1. 6-Year Plan

The magnitude of implementing a system the size and scope of the CO-SOC requires a thoughtful and deliberate rollout plan. HCPF plans to roll out the CO-SOC in 6 years in addition to the current planning year. The aim is to align the years with the state fiscal years to the best of HCPF's ability with the initial year beginning July 1, 2025. Table 25 outlines when each of the seven components will be rolled out over the years, with additional services being introduced alongside these components (e.g. therapeutic mentoring as a component of CO-IHBT in FY 27/28) throughout the timeline. Additionally, the CO-IHBT will be developed in FY 27/28.

HCPF is proposing a targeted approach to rolling out the program by fiscal years. Specifically, HCPF is systematically expanding the population by growing the targeted eligible population each year. For example, FY 25/26 will target children exiting residential treatment settings and FY 26/27 will target the same population and add those children discharging inpatient settings and at risk for re-entry. Each subsequent year will include new populations with the final fiscal year including all Members that meet medical necessity for the services in the CO-SOC.

Table 25a. Tentative Plan for Rollout of the CO-SOC Services

Fiscal Years	FY 25/26	FY 26/27	FY 27/28	FY 28/29	FY 29/30	FY 30/31
Pop Estimate	< 1,000	1,700	2,800	5,200	8,000	10,000 plus
# of SOC Components	3 of 7	4 of 7	6 of 7	6 of 7	7 of 7	7 of 7
Service Type	Assessment HFW In-Home Tx -MST -FFT	Assessment HFW In-Home Tx -MST -FFT Stabilization -Mobile	ID Tool Assessment HFW/FOCUS In-Home Tx -MST -FFT -CO-IHBT -IHBT for children and youth under 8, I/DD and transition-aged youth Stabilization -Mobile Supports -Material Goods	ID Tool Assessment HFW/FOCUS In-Home Tx -MST -FFT -CO-IHBT -IHBT for children and youth under 8, I/DD and transition-aged youth Stabilization -Mobile Supports -Respite -Material Goods	ID Tool Assessment HFW/FOCUS In-Home Tx -MST -FFT -CO-IHBT -IHBT for children and youth under 8, I/DD and transition-aged youth Stabilization -Mobile -CRT Supports -Respite -Material Goods Behavioral	ID Tool Assessment HFW/FOCUS In-Home Tx -MST -FFT -CO-IHBT -IHBT for children and youth under 8, I/DD and transition-aged youth Stabilization -Mobile -CRT -CSU Supports -Respite -Material Goods Behavioral

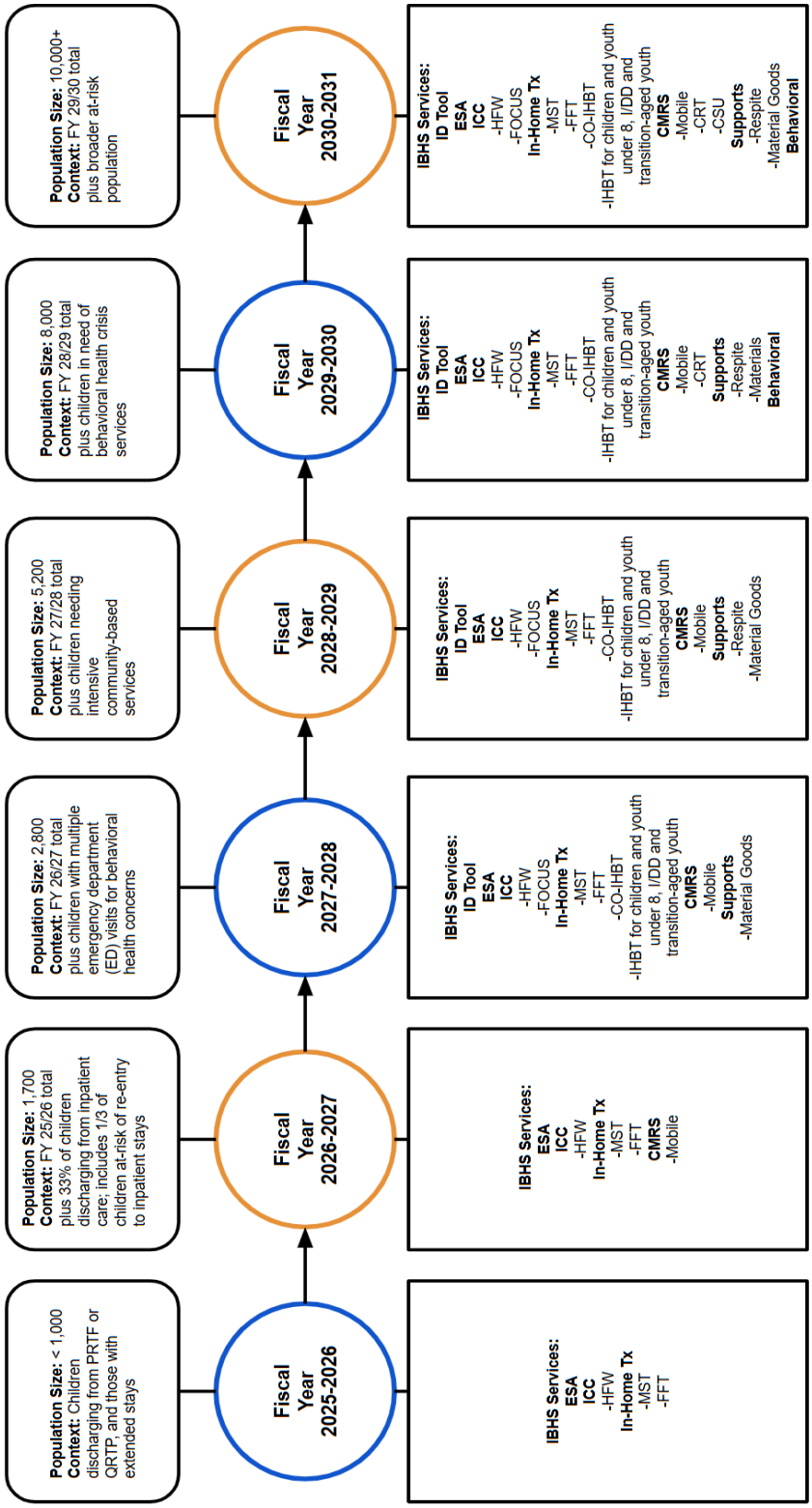
The table below outlines projected growth in the number of children served annually through the CO-SOC over a six-year period, beginning in FY 25/26. These projections are based on a phased approach to expanding services, starting with children discharging from high-acuity settings and gradually including additional populations with complex behavioral health needs. The projections account for children at-risk of re-entry into residential care, those with frequent emergency department visits, and youth in need of intensive community-based and crisis services.

Table 25b. Tentative Population Rollout for those Served under the CO-SOC

Fiscal Year	Children Served	Context

FY 25/26	<1,000	Children discharging from PRTF or QRTP, and those with extended stays
FY 26/27	1,700	FY 25/26 total plus 33% of children discharging from inpatient care; includes 1/3 of children at-risk of re-entry to inpatient stays
FY 27/28	2,800	FY 26/27 total plus children with multiple emergency department (ED) visits for behavioral health concerns
FY 28/29	5,200	FY 27/28 total plus children needing intensive community-based services
FY 29/30	8,000	FY 28/29 total plus children in need of behavioral health crisis services
FY 30/31	10,000+	FY 29/30 total plus broader at-risk population

A timeline that combines the information from Table 25a and Table 25b is displayed as follows:

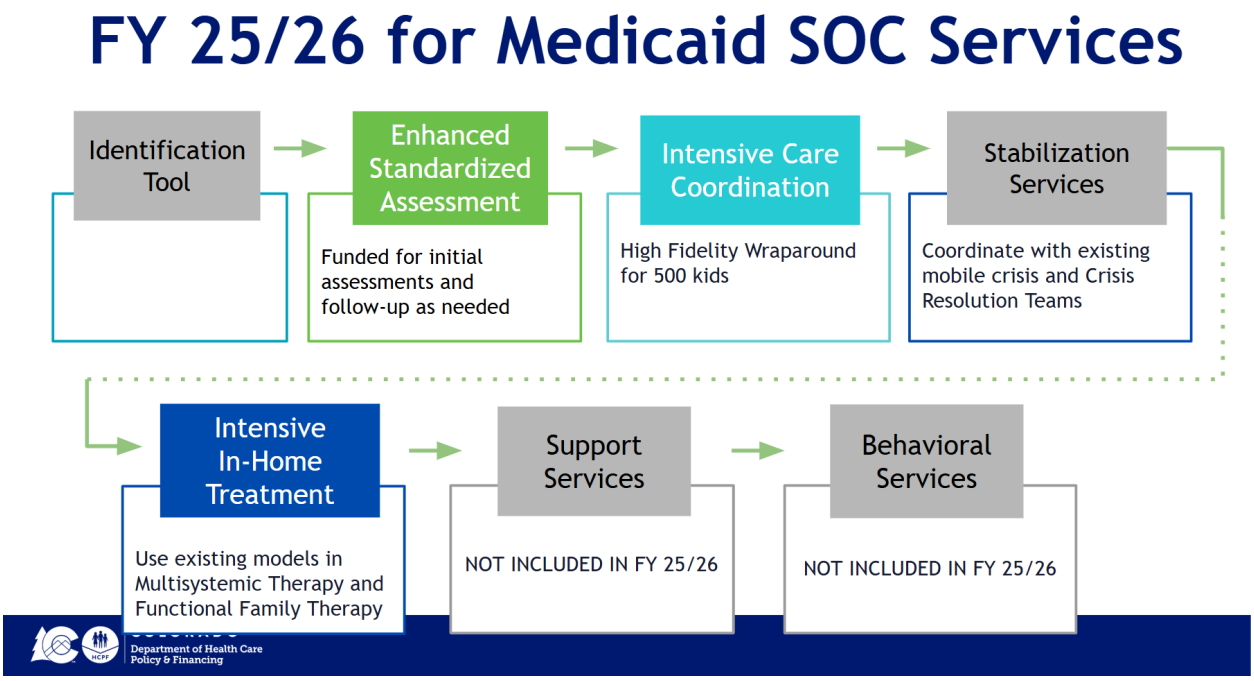


4.2.2. Initial Rollout for the System of Care

HCPF plans to begin providing services within the CO-SOC starting July 1, 2025. FY 25/26 of the rollout includes three services:

- Enhanced Standardized Assessment,
- Enhanced High Fidelity Wraparound, and
- Enhanced Multi-Systemic Therapy or Functional Family Therapy.

Figure 5. FY 25/26 Summary



The Members identified for FY 25/26 include Medicaid-eligible Members stepping down from treatment residential services or those in extended stay or boarding situations. The following is a recent data pull of the calendar year 2023. For FY 25/26, HCPF plans to use the data to make estimates on the number of Members to be served. Due to the MST and FFT interventions not being evidence-based for all age groups, FY 25/26 will be limited to those age groups in which these interventions have been determined to be appropriate based on the standards of the evidence-based criteria for MST and FFT interventions.

Table 26. FY 25/26 Estimated Member Size

Member Location	# Members
PRTF	284
QRTP	206
Extended Stay	75

FY 25/26 will require a new policy to be added to the ACC 3.0 contract requiring all RAEs to ensure Members discharging from residential treatment or needing to exit an extended stay setting will receive an ESA, intensive care coordination via enhanced HFW, and intensive in-home based treatment through either MST or FFT. The delivery of services to Members in FY 25/26 is anticipated to start on Oct. 1, 2025.

In addition to the population identified in FY 25/26, FY 26/27 will include ESAs for all children discharged from inpatient and HFW to children discharged from inpatient at risk for re-admission. As per national data, 30% of children who are discharged from inpatient care are likely to be readmitted within a year.

Table 27. Estimated Members Served by Services in SFY 25/26

Services	**Members Served**
ESA	928
Enhanced HFW	464
Enhanced MST	348
Enhanced FFT	116

Table 28. Estimated Members Served by Services in SFY 26/27

Services	**Members Served**
ESA (inclusive of the CANS)	3,126
Enhanced HFW	1,563
Enhanced MST	782
Enhanced FFT	781

FY 25/26 Workforce

Workforce Capacity Development through a WCC to sustain statewide training, curriculum, credentialing and any other identified needs.

- The WCC will be established by July 1, 2025, between HCPF and a state university.
- For FY 25/26, the WCC will contract with the National Wraparound Implementation Center to develop a training site for HFW. WCC will also contract with MST Services and FFT LLCs to coordinate and certify providers who have been trained and approved to the models.

- HCPF will work with BHA to have their LMS ready to provide training on the ESA. The WCC will track certification management for the CO-SOC providers.
- Table 29 outlines the targeted goal for the number of providers trained and Members served in FY 25/26.

Table 29. Year 1 and 2 Goals for Training (Approximate)

CO-SOC Service	Providers Trained	Members Served
ESA	100	928
HFW	90	464
MST	40	348
FFT	20	116

4.2.3. Fiscal Year 26/27 and Ongoing

During fiscal year 26/27 and ongoing, more services will be added to the CO-SOC, including:

- The creation and utilization of the Identification Tool;
- Increasing the number of members who will receive the ESA;
- Including FOCUS as a model for intensive care coordination;
- Enhancing the mobile crisis and stabilization services continuum;
- Creating and credentialing providers in the Colorado model for intensive home-based therapy;
- Building and training a workforce for support services to expand respite services and include family support partners and therapeutic mentoring and increasing the workforce for FFT and MST via the WCC.

Throughout the 6 years, the population of members who will be eligible for the CO-SOC will continue to increase. To determine who these members will be, HCPF has engaged in an analysis of current data to assist with its initial planning and budgeting. The data analysis included Medicaid Members who were included in the following fields:

- Emergency department (ED) visit within 12 months
- Inpatient Behavioral Health Encounters
- Intensive Community-Based Service
- Inpatient SUD
- PRTF in 12 months
- QRTP in 12 months
- SUD Residential Service
- Child Welfare Involvement - Foster Care
- Creative Solutions

In addition, the unique populations as outlined in Section 3.1.1 will require consideration for appropriate interventions. Due to these considerations, services for these populations (members with IDD or under the age of six, or 18 to 21 years of age) may have services rolled out in different fiscal years than other members as determined by the interventions identified for those populations.

As the years develop, the workforce will continue to expand via the WCC and services will continue to reach more children and youth across Colorado. Table 30 below details projected years for anticipated services to become live and targeted number of Members to be served.

The Plan is not intended to be a detailed work plan for each implementation activity, but rather, it presents activities in sufficient detail to describe how the state will accomplish the requirements of the Agreement. The assignment of the responsibility for achieving implementation tasks will be addressed in the internal work plans developed by the state throughout implementation.

The timeline for implementing the CO-SOC is as follows:

Table 30. The CO-SOC Implementation Timeline

Settlement Agreement	YEAR 1 Feb 2024 to Jan 2025	YEAR 2 Feb 2025 to Jan 2026	YEAR 3 Feb 2026 to Jan 2027	YEAR 4 Feb 2027 to Jan 2028	YEAR 5 Feb 2028 to Jan 2029	Year 6 Feb 2029 to Jan 2030	Year 7 Feb 2030 to Jan 2031
Contract with a national expert consultant to assist in refining and drafting the next iteration of this Plan							
Define the population to be served							
Engage subject matter expert to develop decision support matrix for the CANS							
Develop and launch a communications plan for all partners and stakeholders, which will include when and how referrals to IBHS are made							
Engage families to design and stakeholders to solicit input on IBHS approach							
Draft and complete the Implementation Plan inclusive of the							

point of entry, service definitions, medical necessity criteria, quality & monitoring plan								
Launch HFW to provide services to 600 children, including training for selected providers, and "test Certified ICC Provider"								
Work with newly awarded RAEs to incorporate IBHS services into their contract and provide technical assistance in using the ESA and CANS decision support model								
Select regional Certified ICC Providers to be managed by the RAEs								
Continue to train providers on HFW and FOCUS to continue expansion of HFW/FOCUS								
Implement behavioral e-consultation								
Implement CO-IHBT								
Expand respite								
The CO-SOC (and IBHS) is 100% live								

Table 31. Workforce Capacity Training Timeline

Training	Source	Year 1 (Planning)	Year 2 FY 25/26	Year 3 FY 26/27	Year 4 FY 27/28	Year 5 FY 28/29	Year 6 FY 29/30	Year 7 FY 30/31
ESA/ CANS	BHA's LMS	Develop	Go Live					
HFW	WCC	Develop	Go Live					
FOCUS	WCC			Develop	Go Live			
MST	WCC		Go Live					
FFT	WCC		Go Live					

CO-IHBT	WCC				Develop	Go Live	
Interventions for children and youth under 8, with IDD or those who are transition-aged	WCC		Develop		Go Live		
Respite	TBD					Develop	Go Live
Mentoring	WCC			Develop		Go Live	
Family Peer Supports	TBD			Develop	Go Live		

Table 32. Rollout Implementation Plan Steps

Task	Fiscal Year Due Date
Develop plan for family peer support implementation	Q4 FY26/27
Develop plan for mentoring implementation	27/28
Develop plan for respite implementation	28/29

4.2.4. Risks and Considerations of Plan Rollout

There are factors external to HCPF's control that are needed to make the execution of the Plan successful. The systemic shift proposed in the Plan is significant, and successful execution of the Plan cannot occur in a vacuum. This section outlines factors that need to be considered and mitigated to successfully implement. As outlined in section 6.1 *Intent of the Parties* of the Settlement Agreement, it is HCPF's intent to work with all stakeholders involved to mitigate risks and successfully create a system of care for families. These factors are merely highlighted in order to strategize the appropriate mitigation strategies. The considerations include:

- The state is undertaking some significant shifts in its oversight and delivery of behavioral health services that will impact the CO-SOC. HCPF is modernizing its managed care structure for the next generation of care delivery and management, and the next iteration goes into effect with ACC 3.0 starting July 1, 2025, through 2032. In addition, the state is also introducing Behavioral Health Administration Service Organizations to serve underinsured and uninsured individuals. The success of these two initiatives are imperative to making sure the CO-SOC, which is a subpart of the larger Medicaid managed care system, is also successful.
- There is a national behavioral health workforce capacity shortage. To be clear, the Plan introduces workforce solutions HCPF believes will meet the CO-SOC workforce

needs. However, these solutions do not come without potential risk. The CO-SOC is contingent on providers committing to participate in Medicaid, building out a new training and certification program on a scale that has not been done before for behavioral health in Colorado, and creating a market for the workforce that is competitive with other industries that may offer more lucrative salaries.

- HCPF must work with the Governor's Office to craft the Governor's balanced budget in accordance with the state constitution, and then work with the General Assembly of Colorado to finalize the state's budget. The General Assembly has the authority to appropriate funds–or not–needed to implement this Plan. The General Assembly has to contend with needs from all state agencies within a state that has a Taxpayers' Bill of Rights (TABOR) amendment to the state constitution. TABOR limits the state's ability to collect and retain certain tax revenues to support state initiatives without voter approval.
- To qualify for federal Medicaid matching funds, the state needs to meet the mandatory requirements of the federal Medicaid Act.
- In addition to shaping the state's budget, the General Assembly also may pass legislation that supports or impedes HCPF's ability to implement the Plan. The General Assembly has led and shaped behavioral health care in Colorado through the passage of 38 bills since 2020 related to mandatory benefits, provider regulation, and spending.

HCPF sees the Plan as the path forward to helping Members and their families access necessary behavioral health services through a tailored Colorado system of care. It is a major advance to the current behavioral health system that will require new workforce training, additional state FTE, expert consultants, new policies and a major increase in the behavioral health workforce across very unique skill sets, certifications, capabilities and geographies. HCPF acknowledges that Members and families are in need of intensive services but also recognizes that rolling out the services identified in the Plan by end of FY30/31 is ambitious and comes with the reality of unavoidable delays, especially in the areas of workforce cultivation, training and development. HCPF is committed to rolling out a successful system of care by mitigating delays and addressing errors that may arise from the complexity of implementing all components in the CO-SOC. HCPF will work with the parties to the Settlement Agreement, as outlined in section 6.3 *Timelines* of the Agreement, if adjustments to rollout timelines are needed.

Table 33. Risk and Considerations of Plan Rollout Steps

Tasks	Fiscal Year Due Date
HCPF will develop a plan to educate and remind the General Assembly of federal EPSDT obligations to ensure future legislation does not impede progress towards implementing CO-SOC	Q4 FY25/26

4.3. Communication

4.3.1. Education and Outreach

4.3.1.1. Member Outreach

HCPF, RAEs and Certified ICC Providers will consider the various populations who will be receiving services within the CO-SOC to appropriately outreach members on how to access the CO-SOC services. With so many entities involved in the health and whole-person care of high-acuity children and youth, it is vital to appropriately inform each party of how to effectively access these services. Effective outreach strategies will vary from HCPF, to the RAEs and the Certified ICC Providers as HCPF considers the target demographic, available resources for informing these groups in the community, and the most effective methods for communication. It will begin with going to the families of individuals receiving care and distributing the most up-to-date information. The RAEs will need to engage Medicaid Members in a clear manner that is accessible, intentional and personalized to them. The outreach may include availability of documentation and information in multiple languages, audio recordings, large print, interpretation or relay services, text messages, phone calls or mail.

- Materials will be developed between HCPF, RAEs and BHASOs that include the information described above for Medicaid Members and their families.
    - Materials will need to be updated as services are added and the population is expanded throughout the fiscal years.
- Outreach will be disseminated to Medicaid Members about the CO-SOC to include:
    - Sharing information through a variety of platforms, online, print and in-person to meet the needs of the Medicaid Members. Communication will occur in RAE and BHASO regions.
    - Consistent content across regions and providers.
    - All outreach will be developed and delivered in a way that is accessible for all seeking to understand the CO-SOC, including recognition of cultural, communication and linguistic differences of Medicaid Members.

4.3.1.2. Provider Outreach

Providers will also need to be informed of how to access the CO-SOC, provide referrals, and become involved in the system if the provider chooses. Various forums will be utilized as well as social media, webinars, emails, and other avenues. Due to the various providers that will provide services either directly or indirectly within the CO-SOC, it is vital that information is tailored to each provider type and disseminated in a manner that is beneficial to them. Strategies to accomplish the objective include:

- Develop accessible information about the CO-SOC for providers serving the CO-SOC population, to include:
    - Who the CO-SOC is intended to serve;
    - What services are provided in the CO-SOC;

    - How to make a referral or self-referral for the Identification Tool;
    - How medical necessity is determined for services; and
    - How providers can be involved in providing feedback.
- Trainings and Outreach will be given to educate Medicaid providers regarding the availability of periodic and inter-periodic mental health screenings through EPSDT:
    - Education shall include a comprehensive understanding of EPSDT and screening schedule
    - How to refer to a RAE for the Identification Tool based on assessed needs of the member
    - Regular updates to providers to ensure consistency with guidelines
    - Trainings shall be conducted through a variety of platforms and modules
- Materials will be developed between HCPF, RAEs and BHASOs that include the information described above for the systems and providers involved.
    - Materials will need to be updated as services are added, and the population is expanded throughout the fiscal years.
- Outreach will be disseminated to systems and providers about the CO-SOC.
    - Share information through a variety of platforms, online, print and in-person to meet the needs of the providers. Communication will occur in RAE and BHASO regions.
    - Information will need to be relayed in a consistent manner and content across regions and providers.
    - All outreach will be developed and delivered in a way that is accessible for all seeking to understand the CO-SOC, including recognition of cultural, communication and linguistic differences of providers.
- Process for determining effectiveness of communication and strategies to improve.

Table 34. Outreach Implementation Plan Steps

Task	Fiscal Year Due Date
Develop outreach materials for each respective stage	Ongoing
Train providers on identification and referral process to the CO-SOC	Ongoing
Train providers on difference between EPSDT mental health screenings and referral for high acuity services	Ongoing

4.3.2. Progress Reporting

Plaintiffs

HCPF will annually review its progress executing the Plan and present its progress publicly, describing: (1) activities completed and in-process; (2) planning for activities to be completed or begun in the next year; (3) identification of potential or actual problems as well as remedial efforts to address them; and (4) CQI information and results. HCPF shall provide the Plaintiffs' counsel with an opportunity to review and comment upon any proposed updates or amendments to the Plan in advance of any updates or amendments. HCPF and the plaintiffs shall work collaboratively to resolve any objections or amendments to the Plan.

Quarterly Reporting

Starting January 1, 2025, and continuing quarterly, HCPF shall provide updates on the development and implementation of the CO-SOC to the Joint Budget Committee as defined in C.R.S. 25.5-6-2001(7)(b).

Committees and Reporting

HCPF plans to use a series of committees to report on the status of the rollout of CO-SOC. All committees will be open to the public and be effective for a minimum of 7 years. The three committees will be:

- Lived Experience Committee
- Implementation Committee
- Leadership Committee

Lived Experience Advisory Committee (youth and families):

HCPF will partner with Mental Health Colorado (MHC) on the Lived Experience Advisory Committee for the CO-SOC. The Lived Experience Advisory Committee will be composed of Medicaid Members and their families. The committee is intended to ensure the voices and perspectives of members and their families with current or past lived experiences with the behavioral health system of Colorado are included in ensuring a successful the CO-SOC. The committee will share recommendations and feedback on their experiences accessing services and ways to improve the system. As of February 2025, HCPF has received all applications for the Lived Experience Advisory Committee, and the applications are currently under review to determine committee membership.

The goals of the committee are to:

- Ensure public accountability and transparency when co-creating the CO-SOC
- Provide expertise and insight on the challenges of accessing behavioral health services in order to implement positive changes
- Provide diverse lived experience input on challenges, gaps and potential solutions to improving the CO-SOC

Implementation Advisory Committee

This committee of subject matter experts and state leaders started convening in September 2024, and will convene every other month to review the policies developed through the creation of the CO-SOC. The committee is composed of advocates, counties, providers, RAEs, state agencies, and people with lived experience. The Implementation Advisory Committee will be focused on the fundamentals and essentials for the CO-SOC. The group will be responsible for monitoring progress and providing guidance on gaps in establishing the CO-SOC as well as providing feedback as each year is implemented for high-acuity Members. Additional details on who will comprise the Implementation Advisory Committee are located in the Appendix F.

Statewide Leadership Advisory Committee

This committee of state leaders began convening in October 2024, with an official launch in February 2025. The committee will meet at least twice annually, or as needed, to review the overall direction of the CO-SOC development, assess reports from the Implementation Advisory Committee, and evaluate the impact of the CO-SOC on state healthcare systems. The committee is composed of leadership from state agencies, statewide advocacy organizations, providers, county commissioners, and representation of individual(s) with lived experience. The committee is responsible for providing input and direction of the CO-SOC for Members who have complex behavioral health needs. Additional details on who is expected to represent the Leadership Advisory Committee from House Bill 24-1038 are located in the Appendix F.

To support the needs of each committee, HCPF shall provide updates regarding the progress and execution of the CO-SOC at each scheduled meeting.

Table 35. Reporting Requirements Implementation Plan Steps

Task	**Fiscal Year Due Date**
Develop a template report for having a quarterly report in the status of the CO-SOC implementation.	Q2 FY24/25
Create protocols of communicating to and from committees of reference	Q3 FY24/25
Develop format to reporting out status update to Plaintiffs	Q3 FY24/25

4.3.3. Public Communications

Partner & Stakeholder Engagement

HCPF is committed to regularly engaging partners throughout the implementation of the Plan. A Partner Advisory Committee formed by HCPF will include advocates, counties, providers, state agencies, and people with lived experience. Ongoing outreach and communication will be made to behavioral health organizations and providers, Colorado Association of Family and Children's Agencies (CAFCA), community corrections, counties, court services, criminal justice, the Child and Youth Mental Health Treatment Act (CYMHTA) board, hospitals, juvenile justice, law enforcement, primary and physical care providers, probation, public health, social determinants of health providers, and school-based health centers.

HCPF is taking a two-phased approach to partner and stakeholder engagement:

- **Phase One (August - September 2024):** HCPF led a statewide tour hearing from partners in all areas of the state (as well as held a handful of virtual sessions). Partners were encouraged to share their thoughts and suggestions after hearing about the initial approach to creating the CO-SOC. In addition to launching a Lived Experience Advisory Council, HCPF will review the proposed approach with HCPF's Program Improvement Advisory Committee (PIAC), HCPF's Member Experience Advisory Council (MEAC), RAEs, and counties. HCPF will create a summary of the themes from the meetings and conversations and post it to the website once completed.

- **Phase Two (February 2025 - February 2026):** HCPF will continue to co-design the CO-SOC with MHC and its Lived Experience Advisory Groups. It will regularly initiate discussions with PIAC, MEAC, RAEs, CMAs, and counties and hold ongoing virtual public updates. HCPF will carefully develop and roll out an educational campaign to communicate an overview of IBHS to children and families, which will outline expectations, how and when services will be available, how to access them, etc.

Other State Agencies

The state will continue to take a cross-agency approach. BHA– the entity responsible for all of behavioral health in Colorado – and the Office of Children, Youth, and Families (OCYF) within CDHS were engaged to provide insights into their available programs, new or enhanced initiatives, and processes in engaging children and families. These agencies also have served on and will continue to serve on the internal full project team meeting to hear regular updates and provide input as appropriate. Additional details can be found in the Appendix I.

Newsletter, Listserv, and Webpage

HCPF has created a CO-SOC website that reflects the work, resources, and stakeholder involvement to date. The website will be updated as the work in the CO-SOC develops. The website also contains information on the three advisory committees, including links for those who want to join from the public. HCPF developed a CO-SOC newsletter which will provide updates, share information on the advisory committees, and increase transparency around the work. Future state may include sharing member and family stories regarding their CO-SOC. Cadence for the newsletter was determined in January 2025 and will be released no less than quarterly. Once developed, anyone will be able to sign up to receive the newsletter via HCPF listserv sign-up.

HCPF is identifying a centralized email address which will be made available on the website and included in the CO-SOC Newsletter. The email address will provide an opportunity for members, stakeholders, advocates, providers, etc., to ask questions and provide information related to the CO-SOC. The email inbox will be monitored daily by HCPF staff.

As the Plan Evolves

Additionally, throughout the implementation of the Plan, HCPF will engage with stakeholders to identify their concerns and recommendations. Most importantly, a Lived Experience Advisory Council will provide feedback, advice, expert opinions, and suggestions regarding implementation. It will continuously assess the effectiveness of the implementation and programs/services and offer direction to HCPF for improvements. As the state monitors feedback on the progress in implementing the Plan, there may be a need to adjust or amend the Plan to best provide services to Members and families in the least restrictive setting appropriate to meet treatment goals and needs. The practices or services included in the Plan may be revised in the future to include different or modified practices or services as necessary to improve the system and better address the needs of Members and families. HCPF will continue to leverage existing connections and recurring meetings to update stakeholders. Specifically, this will include MEAC and PIAC. HCPF will work closely with the RAEs to inform

providers and Members about what the services are within the CO-SOC and how to access these services.

Table 36. Public Communications Implementation Plan Steps

Task	Fiscal Year Due Date
Hold follow up meeting with stakeholders on final Implementation Plan	Q4 FY24/25
Create a Newsletter, Listserv, and Webpage	Q2 FY24/25
HCPF will create communications plan to continuously engage stakeholders of the CO-SOC services and inform about any updates	Q3 FY24/25
Develop a plan for educating General Assembly and Parties on the System of Care	Q2 FY25/26

4.4. Budget

4.4.1. Services

Rates

Rates will impact the workforce and its interest in providing IBHS. HCPF will finalize its service definitions and then work with CMS and its guidelines to establish appropriate rates. To cover the costs providers incur as a result of providing evidence based models to fidelity for a high acuity population, HCPF needs to review the:

- Length of the units used for rates (15-, 30- or 50-minute blocks or monthly encounter units)
- Determine if directed payments are needed and submit necessary approvals through CMS..

HCPF is responsible for developing a budget for the Plan. HCPF will leverage existing funds (when possible), assess needed funds, develop the process to acquire funds, and create a list of other resources it will need to successfully implement the CO-SOC.

As the budget is developed, there are several different timelines that are important to note:

- The annual timeframe for the settlement agreement is February through January each year.
- The state's fiscal year begins every July 1.
- ACC 3.0 will go into effect on July 1, 2025, just as the beta test for the CO-SOC is preparing to launch, and the ESA is ready for use.

SB19-195 Child and Youth Behavioral Health System Enhancements bill

Senate Bill 19-195 requires HCPF, in partnership with CDHS, to develop and implement wraparound services for children and youth at risk of out-of-home placement or in an out-of-home placement. It also requires wraparound services to be covered under Medicaid. HCPF

received $9.3M to provide HFW Services, which is incorporated in ACC 3.0 RAE capitation budget.

HB24-1038 High Acuity bill

House Bill 24-1038, "Concerning Addressing the High-Acuity Crisis for Children and Youth in Need of Residential Care" includes $7.3M in funding to train and implement the ESA. The ESA will be used to make referrals to the appropriate level of care necessary to meet the child's treatment needs and inform the child's treatment planning. HB24-1038 also includes $5.4M for intensive care coordination which is incorporated in the ACC 3.0 RAE capitation budget.

Table 37. Existing Funding Sources Summary (as of December 30, 2024)

Funding Source	**FY 25/26**	**FY 26/27 and ongoing**
High Fidelity Wraparound through Senate Bill 19-195	$9.3M	$9.3M
High Fidelity Wraparound through House Bill 24-1038	$3.6M	$5.5M
Assessments through House Bill 24-1038	$4.8M	$7.5M
RAE Roles in ACC 3.0 for high acuity Members	Captured in ACC administrative budget	Captured in ACC administrative budget
TOTAL	$22.4	$29.8

Table 38. Services Budget Implementation Plan Steps

Task	**Fiscal Year Due Date**
Create rates and funding mechanism for fiscal year 25/26 that covers cost of providers to deliver services	Q4 FY24/25
Create a detailed budget for each of the fiscal years	Q4 FY24/25
Review rates for fiscal year 26/27 and beyond for adequacy in covering provider costs.	Ongoing
Determine for each fiscal year and service type, if length of the units used for rates (15-, 30- or 50-minute blocks or monthly encounter units)	Ongoing
Determine for each fiscal year and service type, whether directed payments are needed, and submit necessary approvals to CMS for non-EPSDT services.	Ongoing

4.4.2. Workforce Capacity

ARPA Investments

HCPF had two ARPA-funded projects that expired in 2024 and assisted capacity expansion of high-intensity behavioral health services:

- A $5.1M investment in Behavioral Health Transition Supports will increase the workforce capacity to help members transition from institutions back to the community.
- $17M of microgrants for High Intensity Outpatient Treatment will increase the capacity of the number of providers for intensive treatment services to members.

The CO-SOC will maximize the impact of these investments, both in the short-term and long-term.

Table 39. Workforce Capacity Budget Implementation Plan Steps

Task	Fiscal Year Due Date
Determine workforce capacity development budget based on the standards and ratios set for the CO-SOC	Q3 FY24/25
Create a detailed budget for WCC to reflect the extent of training and monitoring needed in each fiscal year	Q3 FY24/25
With the BHA, create a detailed budget for BHA to reflect the extent of training needed in each fiscal year	Q4 FY24/25

4.4.3. Oversight and Overhead

HCPF and BHA will need adequate resources to meet the requirements of the settlement agreement that require the state to provide adequate oversight for the development, rollout, and execution of the CO-SOC. In addition, HCPF is charged with demonstrating the services being provided are meeting the needs of Members in a timely and quality manner. The oversight role in addition to program management will require resources for both HCPF and BHA.

Table 40. Oversight Budget Implementation Plan Steps

Task	Fiscal Year Due Date
Create a detailed budget for HCPF to reflect the extent of program oversight that is needed in each fiscal year	Q3 FY24/25
With the BHA, create a detailed budget for the BHA to reflect the extent of oversight of treatment standards that are needed in each fiscal year	Q4 FY24/25

5. Conclusion

Members with complex behavioral health needs experience unique challenges and require specific supports and interventions that are not the same as adult services. CO-SOC is intended to improve the quality of services to high-acuity Medicaid Members and their families by providing intensive in-home based services and reducing out-of-home stays. A comprehensive system of care is crucial to ensure accessible, coordinated, family-driven services are provided in the least restrictive manner. This approach empowers Members and families to be active participants in decision-making while ensuring collaboration between various systems and agencies occurs to reduce and eliminate fragmentation in care and optimize positive outcomes. The key points outlined in the Plan are designed to accomplish HCPF's goals for CO-SOC. The Plan is just the beginning of the work HCPF is rolling out for Members and their families and adjustments to the Plan can and will be made annually.

Every child deserves to thrive in their own home and community. Members require distinct supports and interventions to meet their unique needs and challenges. The families, people with lived experience, partners, other state agencies, and all HCPF's stakeholders will play a critical role in bringing the vision to fruition. Working together, Colorado will collectively embrace the new CO-SOC that coordinates the various services and agencies to ensure that every child has an opportunity to flourish. With this vision, it is important to consider factors outside of the Department's control that are necessary to ensure the successful execution of the Plan within the given timeframe. The systemic shift proposed in the Plan is significant, and successful execution of the Plan cannot occur in a vacuum. Proper steps need to be taken to address workforce shortages and budgetary limitations. HCPF's goal, in conjunction with other state agencies and our partners, is to create a system of services that meets the needs of young people with significant behavioral health needs and to do so while giving every opportunity for them to remain in their homes and communities.

Appendix A: Colorado Legislative and Regulatory Context

TABOR

In 1992, voters in Colorado approved of the Taxpayer's Bill of Right (TABOR) Amendment. The amendment limits the amount of revenue the state can retain and spend. A formula dictates the excess revenue that must be refunded to taxpayers annually. The TABOR revenue limit is generally equal to the prior fiscal year's limit plus the rate of inflation and population growth in Colorado. It means that material fiscal decisions are not in the hands of elected officials but, rather, made by voters. As a result, the ability to invest in communities and public services is limited.

General Assembly

Colorado's legislature – also known as the Colorado General Assembly – is one of three branches of the state's government (the other two being the Executive and Judicial Branches). Colorado is unique in that it has a strong legislative budget process. The General Assembly's permanent fiscal and budget review agency, the Joint Budget Committee (JBC), sponsors the annual appropriations bill for the operations of state government. The JBC has a significant amount of influence as it is statutorily charged with analyzing the management, operations, programs, and fiscal needs of state government. The state Constitution requires a balanced budget. The JBC holds hearings and reviews the executive budget request, and the budget requests submitted by each state agency and institution.

While the primary authority to write and adopt the state budget falls to the legislature, the governor's office, and executive agencies, play an important role in directing funding priorities and administering the budget over the course of the fiscal year. Colorado's fiscal year begins July 1, and the budget process is a collaboration between the legislative and executive branches over the entire year.

CMS Approval

HCPF has submitted a 1915(b)(4) Waiver for ACC 3.0 to CMS. HCPF included CO-SOC services in our 1915(b)(4) to utilize selective contracting authority afforded under 1915(b)(4) of the waiver. The state is utilizing selective contracting authority to limit the CO-SOC provider network in order to ensure fidelity and validity to the evidenced based/informed practices. HCPF wanted to maintain transparency with our federal partners.

Appendix B: Role of ACC and RAEs

The Accountable Care Collaborative (ACC) is the core of the state's Medicaid program. The ACC provides the framework in which other health care initiatives, such as health information technology and payment reform, can thrive, as the ACC works to better serve members and create value. HCPF created the ACC in 2011 to address HCPF's mission to improve health care access and outcomes for members while demonstrating sound stewardship of financial resources. The ACC was designed with a long-term vision in mind and the understanding that in order to meet members' complex health needs, delivery system changes must be iterative to keep up with an evolving health care system.

In July 2018, Phase II of the ACC established the Regional Accountable Entities (RAEs) to both operate the Capitated Behavioral Health Benefit and manage Fee-for-Service programs under single regional entities. The RAEs, authorized under a 1915(b) waiver, are responsible for promoting an integrated, whole-person approach to members' physical and behavioral health. The fundamental premise of the ACC is that regional communities are in the best position to make the changes that will cost-effectively optimize the health and quality of care for all members. The RAEs must administer the Capitated Behavioral Health Benefit by maintaining a network of Providers and providing or arranging for the delivery of medically necessary mental health and substance use disorder services utilizing a community-based continuum of care that adapts to a member's changing needs and provides appropriate access to care.

RAEs must ensure whole person care coordination is available to and provided for its members, implementing a comprehensive care coordination program that addresses the full range of members' physical health, behavioral health, oral health, and health-related social needs. RAEs must deliver Care Coordination within what is currently a three-tiered model that categorizes the types of care coordination services that should be made available to members.

The next iteration of ACC – ACC 3.0 – will improve how services are delivered for Medicaid Members. ACC 3.0 is constructed to achieve five goals:

- Improve quality care for members.
- Close health disparities and promote health equity for members.
- Improve care access for members.
- Improve the member and Provider service experience(s).
- Manage costs to protect member coverage, benefits, and Provider reimbursements.

To achieve these goals, the ACC is focused on reducing complexity and administrative burden through simplifying systems. It is intended to create more consistency and standardization by centralizing elements of the ACC that will improve the member and Provider experience(s) while generating measurable efficiencies. The ACC 3.0 iteration incorporates, complements, and expands on policies and programs being implemented by HCPF and other state agencies, to advance health care throughout Colorado.

In ACC 3.0, the RAEs will be a collaborative partner in the development of policies, procedures and the operationalization of the CO-SOC. HCPF will ensure that the policies, procedures and operations meet the requirements reflected in the Plan and increase

consistency across all four regions. RAEs will also develop reporting and monitoring tools in alignment with HCPF's quality management strategy.

RAEs in ACC 3.0 will implement and monitor the CO-SOC as a program of the Capitated Behavioral Health Benefit. The RAEs will design the delivery system to be consistent with the system of care values and principles, including intensive care coordination via High Fidelity Wraparound (HFW). RAEs will be in charge of establishing a Child and Youth CO-SOC Plan that includes:

- Member communication and outreach;
- Network Provider development and oversight;
- Necessary system updates;
- Care coordination;
- Utilization Management;
- Coordination with Workforce Capacity Center; and
- Continuity of care.

The following services that will be included at a minimum are:

- Enhanced Standardized Assessment (ESA), which RAEs will be responsible for utilizing the results of the ESA to:
    - Authorize treatment services in accordance with the CANS Decision Support Matrix designed for Colorado
    - Assist in the development of care plans.
    - Identify the specific needs of the family.
    - Identify members who would benefit from the Child and Youth CO-SOC.
    - Arrange for Enhanced HFW
    - Establish Certified ICC Provider's Care Coordination plan.
- Enhanced High Fidelity Wraparound (this will be reimbursed at an enhanced rate as defined in the State Behavioral Health Services Billing Manual[13])
    - RAEs shall authorize and make available Enhanced HFW for Members identified through the Enhanced Standardized Assessment process.
    - RAEs shall establish contracts with Providers approved by the BHA or Workforce Capacity Center to deliver Enhanced HFW.
    - RAEs shall ensure Enhanced HFW Providers offer services in accordance with requirements established by the BHA, the National Wraparound Implementation Center, and through the Workforce Capacity Center in order to support Members in achieving the best outcomes.
- Intensive in-home treatment through Enhanced Multisystemic Therapy (MST) or Enhanced Functional Family Therapy (FFT)
    - RAEs shall authorize and make available Enhanced MST and Enhanced FFT as defined in the State Behavioral Health Services Billing Manual for members, under the age of 21, identified through the Enhanced Standardized Assessment process in order to safely maintain Members in the least restrictive, most normative environment.

[13] https://hcpf.colorado.gov/sites/hcpf/files/SBHS%20Billing%20Manual%20January%202025.pdf

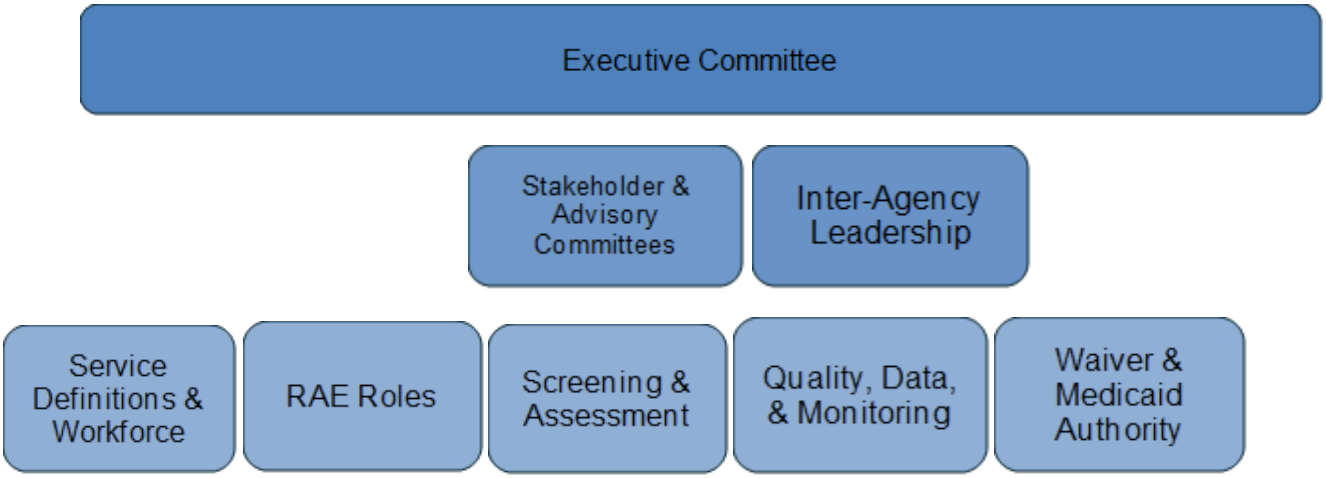
    - RAEs shall establish contracts with Enhanced MST and Enhanced FFT Providers approved by the workforce capacity center and/or in alignment with requirements in the most recent State Behavioral Health Services Billing Manual.

RAEs will be responsible for providing Care Coordination in compliance with Complex Care Management Care Coordination requirements as part of the Enhanced HFW treatment team. RAEs' Care Coordination role within HFW shall include as a minimum, all of the following:

- Coordinating the treatment services from the Child and Family Centered Plan.
- Liaising between the Providers, family and treatment team and the RAE Utilization Management, billing and Provider relations teams.
- Engaging with the treatment team/family as a participant of the treatment team, not as the facilitator or primary point of contact.
- Ensuring that they provide and facilitate the delivery of services in a culturally competent manner to all Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, individuals with disabilities, and regardless of gender, sexual orientation or gender identity, in compliance with 42 CFR § 438.206(c)(2).

Appendix C: Developing the Implementation Plan

In June 2024, HCPF established 5 internal work groups as well as two external workgroups to assist with co-designing the Implementation Plan:



External:

- In addition to HCPF, the Inter-Agency Leadership group includes BHA (lead agency on statewide behavioral health systems, including standards), OCYF within CDHS (child welfare and youth corrections), the Colorado Department of Higher Education and the Community College system (to provide guidance on expanding the workforce), and the Attorney General's office. The group is developing cross-system protocols to identify and serve children and families across different child-serving agencies. Additional state agencies will likely join the Inter-Agency Leadership Group in the future.
- The Stakeholder & Advisory Committees include advocates, counties, providers, state agencies, and people with lived experience and will regularly provide input on the development of the Plan and its implementation. HCPF is partnering with Mental Health Colorado to work with three groups to provide input and insights for the work and will also lean into existing children and family groups that can provide their insights and recommendations.

Internal:

- The Screening & Assessment group will work with a national subject matter expert to develop the screening tool and the decision support matrix that will inform the ESA.
- The Service Definitions & Workforce group developed the service descriptions, functions, provide requirements, eligible populations, documentation requirements, and other criteria for the services offered within IBHS. The group assessed the capacity of current providers and developed a plan to develop the workforce needed to deliver IBHS.
- The RAE Roles work group will identify and set expectations for the roles of the RAEs in implementing IBHS.
- The Waiver & Medicaid Authority group will identify what we need to adjust within our current waivers and authority as HCPF rolls out the Plan.

- The Quality, Data, & Monitoring group has been essential in identifying the number of youth who will be served in the coming years. The group will continue its work in developing a continuous quality improvement plan, as well as outlining the data collection and analysis needed to ensure implementation of the Plan is meeting expected outcomes.

The Executive Committee includes all of the work group leads and meets on a weekly basis to hear updates on the progress made to date and discuss any challenges that need to be addressed. Among other things, it is also responsible for cross-Department collaboration to ensure alignment of implementation with other current/ongoing work, communicating the strategy internally and externally, and developing the finance strategy and budget projections.

Appendix D: Waivers

A Home and Community-Based Services (HCBS) waiver is an extra set of Medicaid benefits that are available based on a person's disability and living situation. Colorado has six waiver programs for adults and four waiver programs for children. Each program has its own eligibility rules around types of disabilities, personal needs, housing, and financial situation. The four waiver programs for children are:

- The Children with Life Limiting Illness Waiver (CLLI), which is for children with disabilities who are 18 years old or younger and at risk of needing to live in a hospital setting.
- The Children's Extensive Support Waiver (CES), which is for children 17 years old or younger with developmental disabilities who need a level of care normally provided in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID).
- The Children's Habilitation Residential Program Waiver (CHRP), which is for children 20 years old or younger with developmental disabilities who need a level of care normally provided in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID). HB24-1038 expands the CHRP waiver to include children and youth who have serious emotional disturbance that puts the child or youth at-risk or in need of out-of-home placement.
- The Children's Home and Community-Based Services Waiver (CHCBS), which is for children with disabilities who need a level of care normally provided in a skilled nursing facility or an acute care hospital.

Appendix E: Service Descriptions

Service definitions are brief narratives of the common or generally accepted method(s) of accomplishing the procedure or service indicated by the procedure code description.

Enhanced Standardized Assessment

Provider Qualifications

Must have at a minimum a master's degree, which can include:

- Unlicensed Master's Level
- Unlicensed Psychologist, PhD, PsyD, EdD
- Licensed Psychologist, PhD, PsyD, EdD
- Licensed Behavioral Health Clinician (LAC, LCSW, LPC, LMFT)

Service Definition

The Enhanced Standardized Assessment (ESA) is a non-medical encounter conducted by a non-physician licensed or licensure candidate behavioral health professional. The ESA is a comprehensive, clinical assessment process completed by a behavioral health provider to assist in determining appropriate treatment/service recommendations for children, youth, and families. The process must include the following components and activities:

- Face-to-face clinical assessment of the child/youth
- CO CANS Assessment Tool
- CO CANS Decision Support Model
- Review of records (see notes)
- Collateral interviews & information (see notes)
- DSM-5 diagnosis
- Completion of the BHA-provided and approved Standardized Assessment Narrative Template which includes, but is not limited to, the following elements:
    - Child/Youth Identifying Information & Demographics
    - Tools used during the Assessment (e.g., required CO CANS, Columbia, PHQ-9, GAD-7, etc.)
    - Documentation Review
    - Date(s) and name(s) or all individuals interviewed or outreached for the SA (see list in notes)
    - Chief Complaint/Presenting Problem Narrative
    - Life Functioning Narrative
    - Intellectual/Developmental Narrative
    - School Behaviors and Educational Information
    - Youth Behavioral/Emotional Narrative and Symptom Profile
    - Traumatic/Stressful Life Events Narrative
    - Adjustment to Trauma Narrative
    - Substance Use Narrative
    - Danger to Self Narrative
    - Danger to Others Narrative
    - Cultural Factors Narrative
    - Mental Status Exam

    - Caregiver Needs and Resources Narrative
    - Caregiver Health Narrative
    - Youth Strengths Narrative
    - Current/Previous Medications
    - History of or current child welfare involvement and DYS commitment, including prior placement
    - Psychiatric Hospitalization(s)
    - Current and Previous Behavioral Health Services
    - Current or Pending Legal or Juvenile Justice Concerns
    - Diagnosis History
    - Current Barriers to Treatment
    - Risk of being a victim of human trafficking
    - Current diagnosis/diagnoses
    - Significant Findings of the Child and Adolescent Needs and Strengths (CANS) Tool
- Recommendations of clinical justifications for recommended treatment/services

The population receiving CO-SOC services will be determined by the ESA or medical necessity determines that CO-SOC is needed to ameliorate clinical concern. Eligibility includes the following:

- Child or youth has a primary mental health or substance use disorder diagnosis and may have a co- occurring diagnosis of intellectual and developmental disability

OR

- Child or youth may have a primary intellectual or development disability diagnosis and a co-occurring diagnosis of mental health or substance use disorder;

AND

- There is a medically necessary need for services in the Colorado System of Care (CO-SOC);
  OR
- Member's symptoms and behaviors are unmanageable at home, school, or in other community settings without specialized support due to their mental health or substance use disorder condition AND, per medical necessity, are at risk of needing a psychiatric residential treatment facility (PRTF), qualified residential treatment programs (QRTP) placement.

Training

Training and certification will occur under BHA's learning management system OwnPath Learning Hub. Re-certification will occur every 2 years.

Rate Methodology

The initial Enhanced Standardized Assessment will be paid per assessment.

While Independent Assessment had previously been paid through the administrative costs, in ACC 3.0 Enhanced Standardized Assessments, inclusive of the CANS, will be paid as a service out of the behavioral health capitation. Any additional components of the assessment that

go beyond the Enhanced Standardized Assessment and are needed to meet FFSPA or courts will not be paid from the capitation.

High Fidelity Wraparound

Provider Qualifications:

Wraparound Facilitator

- Must have, at minimum, a bachelor's in social services, human services, or an equivalent field
- All new wraparound staff (facilitators, family support partners, youth support partners, coaches, and supervisors) are required to complete the NWIC Model training;

Wraparound supervisor or coach

- Must complete all the above requirements; NWIC coaching/supervisor training; and
- Have a bachelor's degree in social services, human services, or an equivalent field with a minimum of two (2) years' experience working with the target population and/or HFW program and supervision.

Service Definition:

High Fidelity Wraparound (HFW): High Fidelity Wraparound (HFW) is a team based, evidence-informed, structured approach to care coordination that adheres to required procedures for child and family engagement, individualized care planning, identifying and leveraging strengths and natural supports while monitoring progress and fidelity to the model. The goal of HFW is to help children and youth, under the age of 21, and families reach success while remaining in their home communities. The process involves a facilitator, regular team meetings that include the child, youth, family, friends, community resources, and professionals. HFW includes a broad set of activities designed to assess, plan, and monitor the service needs of the child and family. These include:

- Engagement and outreach to children and families, including education on Systems of Care and Wraparound processes;
- Organization and facilitation of a child and family treatment team that meets on a regular basis;
- Reviewing and updating the individual's Integrated Assessment and care plan, which includes the identification of needs and strengths and the development of a service plan;
- Crisis assessment, safety and prevention planning;
- Coordination and consultation with providers and formal and informal supports involved with the child's care;
- Referring, linking, and following-up with service providers and social service agencies for services recommended by the child and family treatment team on the service plan; and,
- Assisting children in transitioning from an institutional setting to a community-based living arrangement
- Assisting children with community-based services and supports so the child or youth can remain in their home or in the community

Service Eligibility Criteria

All of the following are necessary for admission to this level of care:

The youth currently has, or at any time during the past year has had, a diagnosable mental, behavioral, or emotional disorder to meet the diagnostic criteria specified within ICD-10 or DSM-5-TR (and subsequent revisions) of the American Psychiatric Association with the exception of other V codes, substance use, and developmental disorders, unless these disorders co-occur with another diagnosable disturbance. All of these disorders have episodic, recurrent, or persistent features; however, these disorders vary in terms of severity and disabling effects.

The diagnosable disorder identified above has resulted in functional impairment that substantially interferes with or limits the youth's role or functioning in family, school, or community activities. Functional impairment is defined as difficulties that substantially interfere with or limit the youth in achieving or maintaining developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills. Functional impairments of episodic, recurrent, and continuous duration are included unless the impairments are temporary and expected responses to stressful events in the environment.

Youth who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are included in the definition.

Additionally,

1. The person(s) with authority to consent to medical treatment for the youth voluntarily agrees to participate in HFW. The assent of a youth who is not authorized under applicable law to consent to medical treatment is desirable but not required.
2. For youth in a hospital, skilled nursing facility, psychiatric residential treatment facility or other residential treatment setting who meet the above criteria, the admission to HFW may occur 30 days prior to discharge from the above settings.

Exclusion Criteria:

Any of the following criteria is sufficient for exclusion from HFW:

1. The person(s) with authority to consent to medical treatment for the youth does not voluntarily consent to participate in HFW.
2. The youth is in a hospital, skilled nursing facility, psychiatric residential treatment facility, DYS, or other residential treatment setting at the time of referral and is unable to return to a family setting or community setting with community-based support.

Continued Stay Criteria:

The following criteria must be considered for continued treatment at this level of care:

1. The CANS indicates continuation of services is medically necessary;
   OR

2. The Care Plan Team (CPT) decides
    a. the youth's clinical condition(s) continues to warrant HFW services in order to coordinate the youth's involvement with state agencies and special education or multiple service providers

    AND

    b. The following:
        i. Progress toward Individualized Care Plan (ICP) identified goals is evident and has been documented based upon the objectives defined for each goal, but the goals have not yet been substantially achieved

        OR

        ii. Progress has not been made, and the CPT has identified and implemented changes and revisions to the ICP to support the goals of the youth and family.

Discharge criteria

Any of the following criteria are sufficient for discharge from the level of care:

1. The youth no longer meet the criteria for HFW.
2. The CPT, including family and youth, determines that the youth's documented ICP goals and objectives have been substantially met and continued services are not necessary to prevent worsening of the youth's behavioral health condition.
3. Consent for treatment is withdrawn.
4. The youth and parent/caregiver are not engaged in treatment. Despite a minimum of 3 documented attempts to address engagement, the lack of engagement is of such a degree that it implies withdrawn consent or treatment at this level of care becomes ineffective or unsafe.
5. The youth is placed in a hospital, skilled nursing facility, psychiatric residential treatment facility, committed to DYS or other residential treatment setting and is unable to return to a family setting or a community setting with community-based supports, or unable to continue the HFW process. The youth will still have access to HFW for up to 30 days within admission to one of these settings and 30 days prior to discharge from these settings if they are able to return to a family setting.
6. The youth turns 21

Training

The provider's training plan must include provisions for ongoing training specific to the identified training needs of the staff as it relates to the population served, including attention to cultural competency, changing demographics, trauma informed care, new knowledge or research, and other areas identified by the agency.

The provider must demonstrate that each High Fidelity Wraparound supervisor receives training specific to the clinical and administrative supervision of the service.

The provider shall obtain satisfactory fidelity reviews based on the NWIC model of HFW criteria every twelve months. The review will be documented on a fidelity scoring instrument.

NWIC Model Training:

Phase 1: Orientation Phase

- Basic history and overview of wraparound
- Introduction to skills/ competencies
- Intensive review of the process
- Ends when tell, show, practice is complete

Phase 2: Apprenticeship Phase

- Observation by the apprentice
- Observation of the apprentice
- Observations are completed with a score that exceeds threshold on a knowledge test

Phase 3: Ongoing coaching and supervision

- Ongoing coaching, informed by data
- Periodic observation
- Document review
- Ongoing as needed.

Rate Methodology

ICC services such as HFW will be paid in a monthly encounter code to cover the cost of providers to deliver all nine services listed in Table 15 on page 47. A funding source will need to be identified for material goods along with permission from CMS for such an expenditure.

FOCUS

Provider Qualifications

FOCUS Care Coordinators

- Individuals are eligible to provide and supervise within their professional scope of practice those services certified by the workforce capacity center.
- Must have, at minimum, a bachelor's in social services, human services, or an equivalent field.
- Successful Completion of NWIC FOCUS - Local Coach Candidate Training.
- Supervisors are required to meet all the above standards, and NWIC FOCUS supervision certification training.

Service Definition

FOCUS is a community-based program that offers a care coordination approach to families needing assistance gaining access to care for children and youth who have behavioral health needs including crisis concerns. Using evidence-informed model approaches, the overall goal of FOCUS is to provide individualized and strength-based support for children, youth, and families in reaching their goals or "family visions" with a decrease in need for higher levels of care, including out of home placements.

- For children, youth, and families just entering the child serving system and hoping to avoid further, deeper system involvement or institutional settings.

- FOCUS is a less intensive model than High Fidelity Wraparound (HFW). FOCUS is intended for individuals that need support but do not meet the risk criteria of HFW.
- FOCUS care coordination links families to services immediately so the Member and their family can start accessing care.
- Families needing assistance in beginning to access care.
- Behavioral health needs and/or crisis concerns are beginning to develop or become concerning.
- Family and Care Coordinator develop the plan collaboratively with the family driving the planning process.
- Approximately 6-9 months
- Assisting children in transitioning from an institutional setting to a community-based living arrangement

Service Eligibility Criteria

The youth is under the age of 21 and one or more of the following exist:

1. Individual has shown risk of functional impairment in the past one hundred and eighty (180) days, as evidenced by one of the following:
    a. Indication or report of significant and repeated impulsivity and/or physical aggression, with poor judgment and insight, and that is significantly endangering to self or others, OR
    b. Recent pattern of substance use behaviors with no demonstrated ability of child/youth or family to restrict use, OR
    c. Clear and persistent inability, given developmental abilities, to maintain physical safety and/or maintain a safe environment.
2. The clinical documentation supports the need for the safety and structure of treatment provided the individual's behavioral health issues are impaired as evidenced by:
    a. Documented history of admissions to psychiatric settings or of psychiatric crises encounters, OR
    b. Have experienced a placement out of home or change in residence and caretaker/ family within the last 24 months due to behavioral health needs in home, home school community, OR,
3. Individual and/or family has history of attempted, but unsuccessful follow through with elements of a Resiliency/ Recovery Plan which has resulted in specific mental or emotional behaviors that place the recipient at risk for disruption of current living arrangement including a lack of follow through with:
    a. Taking prescribed medications; OR
    b. Following a crisis plan; OR
    c. Maintaining family and community-based integration

Exclusion Criteria

Any of the following criteria is sufficient for exclusion from FOCUS:

1. The person(s) with authority to consent to medical treatment for the youth does not voluntarily consent to participate in FOCUS.

2. The youth is in a hospital, skilled nursing facility, psychiatric residential treatment facility, or other residential treatment setting at the time of referral and is unable to return to a family setting or community setting with community-based support.

Continued Stay Criteria
The following criteria must be met for continued treatment at this level of care:
The following criteria must be considered for continued treatment at this level of care:

3. The CANS indicates continuation of services is medically necessary;
   OR
4. The Care Plan Team (CPT) decides
   a. the youth's clinical condition(s) continues to warrant FOCUS services in order to coordinate the youth's involvement with state agencies and special education or multiple service providers

   AND
   b. The following:
      i. Progress toward Individualized Care Plan (ICP) identified goals is evident and has been documented based upon the objectives defined for each goal, but the goals have not yet been substantially achieved

      OR
      ii. Progress has not been made, and the CPT has identified and implemented changes and revisions to the ICP to support the goals of the youth and family.

Discharge Criteria
Any of the following criteria is sufficient for discharge from this level of care:
1. The youth no longer meets the criteria for FOCUS.
2. The Care plan team determines that the youth's documented ICP goals and objectives have been substantially met and continued services are not necessary to prevent worsening of the youth's behavioral health condition.
3. Consent for treatment is withdrawn.
4. The youth and parent/caregiver are not engaged in treatment. Despite a minimum of 3 documented attempts to address engagement, the lack of engagement is of such a degree that it implies withdrawn consent or treatment at this level of care becomes ineffective or unsafe.

Training
NWIC FOCUS Certificate program, which the first training will begin in Spring of 2025.

Rate Methodology
ICC services such as FOCUS will be paid in a monthly encounter code to cover the cost of providers to deliver all nine services listed in Table 15 on page 47 of this document. A funding source will need to be identified for material goods along with permission from CMS for such an expenditure.

Enhanced Multisystemic Therapy

Provider Qualifications

MST Therapist

Providers of MST must meet the specific training and supervision requirements.

- One week Training
- Quarterly Booster Sessions
- Weekly Consultation with an MST Consultant/Expert

And must be:

- Bachelor Level
- Unlicensed master's Level
- Unlicensed EdD/ PhD/PsyD
- LCSW
- LPC
- LMFT
- Licensed EdD/PhD/PsyD
- LAC

Service Definition

MST: An intensive, home-, family- and community-based treatment focusing on factors in an adolescent who is between the ages of 12-17 and their environment that contribute to his/her anti-social behavior, including adolescent characteristics, family relations, peer relations, and school performance.

- Strategic family therapy
- Structural family therapy
- Behavioral parent training
- Cognitive behavior therapies

Notes: Usual duration of MST treatment is approximately 4 months. MST is provided using a home-based model of service delivery. Providers of MST must meet the specific training and supervision requirements. MST can be used for youth ages 10-11 based on severity of behaviors on a case-by-case basis.

Service Eligibility Criteria

Youth must meet all of the following criteria for admission to MST:

1. The youth must be between the ages of 10-17.
2. The youth has an assessment completed that shows evidence of symptoms and functional impairment that the youth has met criteria for a primary diagnosis consistent with the most recent version of Diagnostic and Statistical Manual that falls within the categories of disruptive behavior, mood, substance use or trauma and stressor-related disorders. There may be additional primary behavioral health diagnoses that may benefit from the interventions of MST that may be considered on a case-by-case basis
3. Within the past 30 calendar days, the youth has demonstrated at least one of the following that puts the youth at risk of an out-of-home placement:
    a. Persistent and deliberate attempts to intentionally inflict serious injury on another person.

b. Ongoing dangerous or destructive behavior that is evidenced by repeated occurrences of behaviors that are endangering to self or others, are difficult to control, cause distress, or negatively affect the youth's health.
c. Increasing and persistent symptoms associated with depression (e.g. chronic irritability, anhedonia, significant changes in sleep/eating, disrupted emotion regulation, …) or anxiety (e.g. rumination, panic attacks, hypervigilance, dissociation), in combination with externalizing problems (e.g. physical and verbal aggression, truancy, stealing, property destruction, lying, etc.) that have contributed to decreased functioning in the community.
d. Ongoing substance use or dependency that interfere with the youth's interpersonal relationships and functioning in the community.
e. The youth is returning home from an out-of-home placement and MST is needed as step down service from an out-of-home placement.

4. The youth's successful reintegration or maintenance in the community is dependent upon an integrated and coordinated treatment approach that involves intensive family/caregiver partnership through the MST model. Participation in an alternative community-based service would not provide the same opportunities for effective intervention for the youth's problem behaviors.
5. There is a family member or other committed caregiver available to participate in the intensive service.
6. Arrangements for supervision at home/community are adequate to ensure a reasonable degree of safety and a safety plan has been established or will be quickly established by the MST program as clinically indicated.

Exclusion Criteria:

Youth who meet any one of the criteria below are not eligible to receive MST:

- The youth is currently experiencing active suicidal, homicidal or psychotic behavior that requires continuous supervision that is NOT available through the provision of MST.
- The youth is living independently, or the provider cannot identify a primary caregiver for participation despite extensive efforts to locate all extended family, adult friends and
  other potential surrogate caregivers.
- The youth's presenting problem is limited to sexually harmful or dangerous behavior in the absence of other externalizing behaviors.
- The youth's functional impairment is solely a result of Developmental Disability

Continued Stay Criteria

Within the past thirty (30) calendar days, MST continues to be the appropriate level of care for the youth as evidenced by at least one of the following:

- The youth's symptoms/behaviors and functional impairment persist at a level of severity adequate to meet admission criteria;
- The youth has manifested new symptoms that meet admission criteria and those have been documented in the treatment plan

- Progress toward identified treatment plan goal(s) is evident and has been documented based upon the objectives defined for each goal, but not all of the treatment goal(s) have been achieved.

Discharge Criteria

The youth meets discharge criteria if any of the following are met:

- The youth's documented treatment plan goals have been met and the discharge plan has been successfully implemented
- The youth and family are not engaged in treatment despite documented efforts to engage and there is no reasonable expectation of progress at this level of care;
- The youth is placed in an out of home placement, including, but not limited to a hospital, skilled nursing facility, psychiatric residential treatment facility, or therapeutic group home and is not ready for discharge within 30 consecutive calendar days to a family setting or a community setting with community-based support.
- Required consent for treatment is withdrawn.

Training

Providers of MST must meet the specific training and supervision requirements.

- One week Training
- Quarterly Booster Sessions
- Weekly Consultation with an MST Consultant/Expert
- Newly hired MST clinicians on already established teams can see clients within the first 2-4 weeks.

Rate Methodology

IHBT models such as MST are most effective when paid by a monthly encounter claim for the services. HCPF still needs to finalize what the necessary rates are to cover the cost to providers and have a sustainable network of certified IHBT providers.

Enhanced Functional Family Therapy (FFT)

Provider Qualifications

Providers of FFT must meet the specific training and supervision requirements.

AND must be:

- Bach Level
- Intern
- Unlicensed Master's Level
- Unlicensed EdD/ PhD/PsyD
- LCSW
- LPC
- LMFT
- Licensed EdD/PhD/PsyD
- LAC

FFT's recommendation is to use at least master's level therapists unless extraordinary circumstances require the use of bachelor's level therapists. It is the responsibility of the provider to meet or exceed local licensure and certification requirements. Any person trained as an FFT supervisor must have a minimum of a master's degree, have completed all Phase I training, have seen two cycles of families, and have been successful in an FFT externship.

Service Definition

Functional Family Therapy (FFT) is a systematic, evidenced-based, manual driven, family-based treatment program used for a wide range of problems (including drug use and abuse, conduct disorder, mental health concerns, truancy, and related family problems) affecting youth ages 11-18 and their families. FFT is provided using a home-based model of service delivery. Providers of FFT must meet the specific training and supervision requirements.

Service Eligibility Criteria

Youth must meet the following criteria for admission to FFT:

- The youth must be between the ages of 11-18.
- The initial assessment provides evidence of symptoms and functional impairment that the youth has met criteria for a primary diagnosis consistent with the most recent version of Diagnostic and Statistical Manual that falls within the categories of disruptive behavior, mood, substance use or trauma and stressor-related disorders.

Within the past 30 calendar days, the youth has demonstrated at least one of the following that puts the youth at risk of out of home placement:

- Persistent and deliberate attempts to intentionally inflict serious injury on another person;
- Ongoing dangerous or destructive behavior that is evidenced by repeated occurrences of behaviors that are endangering to self or others are difficult to control, cause distress, or negatively affect the youth's health;
- Increasing and persistent symptoms associated with depression or anxiety in combination with externalizing problems (e.g. physical and verbal aggression, truancy, stealing, property destruction, lying, etc.) that have contributed to decreased functioning in the community;

- Ongoing substance use or dependency that interfere with the youth's interpersonal relationships and functioning in the community.

OR,

The youth is returning home from out-of-home placement and FFT is needed as step down service from an out-of-home placement.

- The youth's successful reintegration or maintenance in the community is dependent upon an integrated and coordinated treatment approach that involves intensive family/caregiver partnership through the FFT model.
- There is a family member or other committed caregiver available to participate in the intensive service.
- Arrangements for supervision at home/community are adequate to ensure a reasonable degree of safety and a safety plan has been established or will be quickly established by the FFT program as clinically indicated.

Exclusion Criteria

Youth who meet any one of the criteria below are not eligible to receive FFT:

- The youth is currently experiencing active suicidal, homicidal or psychotic behavior that requires continuous supervision that is NOT available through the provision of FFT.
- The youth is living independently, or a provider cannot identify a primary caregiver for participation despite extensive efforts to locate all extended family, adult friends and other potential surrogate caregivers.
- The youth's presenting problem is limited to sexually harmful or dangerous behavior in the absence of other externalizing behaviors.

Discharge Criteria

The youth meets discharge criteria if any of the following are met:

- The youth's documented treatment plan goals and objectives have been substantially met and all FFT phases have been completed;

The youth no longer meets admission criteria due to the following:

- The youth's needs can be met at a lower level of care;
- The youth's current level of function requires a higher level of care
- The youth or the youth's family have not benefited from FFT despite multiple documented efforts to engage the youth or family and there is no reasonable expectation of progress at this level of care despite treatment plan changes or the youth or the youth's family has achieved maximal benefit from this level of care;
- The youth is placed in a hospital, skilled nursing facility, residential treatment facility, or other residential treatment setting and is not ready for discharge within 30 consecutive calendar days to a family setting or a community setting with community-based support;
- Required consent for treatment is withdrawn;

Training

Phase 1: Clinical Training

The initial goal of the first phase of FFT implementation is to ensure that the site builds a lasting infrastructure that supports clinicians to take maximum advantage of FFT training/consultation. During phase 1, staff are trained on the core constructs, assessment, and intervention techniques of FFT, and how to use FFT's Clinical Services System (CSS) to gather data. Additional time is spent in addressing site-specific implementation challenges (i.e.— referral criteria, referral process, integration of services, working with referral agents, supervision, computers, etc.). It is expected that Phase I will be completed in one year, but not any longer than 18 months. By the end of Phase I, FFT's objective is for clinicians to demonstrate strong adherence and high competence in the FFT model.

Phase 2: Supervision

The goal of the second phase is to assist the site in creating greater self-sufficiency in FFT, while also maintaining and enhancing site adherence/competence in the model. During phase 2, FFT trains a site's extern to become the onsite supervisor. The intensive, hands-on, training experience focuses on clinical supervision techniques for FFT. After initial training, the onsite supervisor is then supported by FFT via monthly phone consultations and a one-day follow-up training. In addition, FFT provides any ongoing consultation as necessary and reviews the site's FFT Clinical Services System (CSS) database to measure site/therapist adherence, service delivery trends, and outcomes. Phase II is a year-long process.

Phase 3: Maintenance Phase

The goal of the third phase of FFT implementation is to move into a partnering relationship to ensure ongoing model fidelity and staff development, interagency linking, and program expansion. FFT provides annual training activities and consultation services to support the site's continuous education and competence in FFT. The annual oversight and consultation practices are considered necessary for an FFT site to remain certified.

Rate Methodology

IHBT models such as FFT are most effective when paid by a monthly encounter claim for the services. HCPF still needs to finalize what the necessary rates are to cover the cost to providers and have a sustainable network of certified IHBT providers. *Crisis Resolution Teams*

Provider Qualifications

The team composition can be flexible if the roles and requirements are met, and may be selections from the following:

1. Master's Level/Licensed Clinician,
2. Bachelor's Level Clinician/Case Manager,
3. Peer Specialist,
4. Prescriber (Required),
5. Family Skills Coach/Advocate,
6. Behavioral Coach/Analyst.

Service Definition

Crisis Resolution Teams (CRT) supports families with youth and young adults who are experiencing behavioral health challenges and would benefit from intensive, short-term (4-6 weeks), in-home services and linkage to ongoing supports.

- Teams are currently capped at 7 families at any time
- Frequency of the services are offered at a minimum of 3 days per week, up to a variety of services multiple times daily depending on clinical need.

Services offered shall include, as clinically appropriate:

a) Consultation with a referring team when high-needs individual/family presents for crisis assessment, to ensure adherence with the program goal of reducing referrals to higher levels of care.
    a. Team members or local supervisors shall be available for case consultation and referral determination.
b) Intake and needs assessment for each individual AND family accepted into the program.
c) Standardized suicide assessment scale (C-SSRS) for each individual at service initiation and program discharge
d) Service planning
e) Case management and care coordination for the entire family
    a. Connection to community-specific support services
        i. Provider may use the resources in the BHA-created CYF Toolkit
    b. Connection to and coordination of benefits
    c. Coordination with other providers / agencies / organizations that are involved with the individual and/or family
f) Crisis management
    a. Providers shall develop procedures to manage individuals and families in crisis.
    b. Providers shall continue to provide support and guidance during a crisis episode.
g) Peer support throughout the duration of the program for the young person and the family
h) Family skill building including coaching.
i) Individual and family therapy
j) Group therapy
k) Community connection
l) Psychiatry and medication management
m) Discharge planning and referrals to ongoing support
    a. Discharge shall only occur once functional improvements are achieved, and individual/family are enrolled and participating in relevant ongoing care.
    b. Referrals to the continuum of care including but not limited to, High-Fidelity Wraparound; The Child and Youth Mental Health Treatment Act; outpatient therapy and psychiatry; group therapy; and support groups

n) Seven-, fourteen-, and twenty-one-day post-program discharge follow-up to ensure ongoing stabilization, adequate coping with transition of care, and adherence to ongoing services.

Service Eligibility Criteria

Clients served will be children, youth, and families who present to the crisis system and/ or emergency departments with high acuity needs, who have received a crisis evaluation and are determined to be safe to remain in the home or community to receive intensive, short-term stabilization interventions.

Training

All CRT staff shall complete the Crisis Professional Curriculum within 6 months of being made available by the BHA and/or 6 months within new hire. Required training must cover the following topics, but is not limited to:

- Initial Telephonic Screening and Standardized Dispatch Protocol
- Suicide Screening, Risk Assessment and Safety Planning
- Evidence-based and Promising Practices in Crisis Intervention, including De-escalation Strategies
- Crisis Plan Development and Use of Advanced Directives
- Harm Reduction Strategies and Use of Naloxone and Other Supplies to Address Overdoses
- Non-violent Crisis Intervention
- Psychiatric Medications and Side Effects
- Trauma-Informed Care including responding to victims of interpersonal and gender-based violence
- National Standards for Culturally and Linguistically Appropriate Services (CLAS), Including BHA CLAS Standards Policies and Communications Technology
- Federal and state Requirements and Privacy and Confidentiality of Patient Information
- Training for adult or transition age youth peer support professionals or family advocate members and their supervisors to support paired response by clinical/peer teams
- Using accessibility related tools including telehealth and communication devices or other language resources

Required Training to Ensure CRT Services are Tailored to Meet the Needs of Key Populations:

- Cultural Awareness and Responsiveness including responding to individuals from racially and ethnically diverse backgrounds
- American Indians/Alaska Natives
- Child, Youth and Family Crisis Interventions
- Co-Occurring Disorders
- Deaf, Hard of Hearing, and Deaf/Blind care
- Dementia and other age-related needs
- Gender-responsive Services
- Intellectual and Developmental Disabilities
- Lesbian, Gay, Bisexual, Transgender, Queer/questioning and other (LGBTQ+) youth and adult related needs

- Mental Health Conditions (including Serious Mental Illness, Serious Emotional Disturbance)
- Neurodivergence, including Autism Spectrum Disorders
- Non-English speakers and those for whom English is not their first language
- Substance Use Disorders
- Traumatic Brain Injuries

Mobile Crisis Response

Service Definition:

The service definition[14] outlines key components that comprise the MCR benefit and is intended for use by MCR teams that are eligible for Behavioral Health Administration (BHA) endorsement and enrollment as a Colorado Medicaid provider. MCR teams will deliver services to all people in Colorado in crisis regardless of insurance status. The service definition reflects national best practices and Colorado's unique needs for service delivery and provider performance. The definition details the following elements of the MCR benefit:

- Engagement with Community
- Service Activities
- Provider/Agency Requirements, Enrollment, and Billing
- Staffing Requirements
- 24/7/365 Availability, Timeliness, and Location of Service Standards, and
- Use of Telehealth and Other Technology

Provider Qualifications

Paired Response. All mobile crisis responses shall be paired and include two members of the MCR team. Teams are not restricted to behavioral health professionals with specific credentials. All members of a MCR team must complete the BHA Crisis Professional Curriculum. Teams must have at least one of the following licensed providers available during a crisis via telehealth or in person for further member assessment: Psychologist (PhD, PsyD, EdD), Behavioral Health Clinician (ACD/LAC, CSW, LPC, MFT), Nurse Practitioner, Physician or Osteopath.

Service Eligibility Criteria

The Colorado Crisis Service (CCS) Mobile Crisis Response (MCR) is intended to offer de-escalation and stabilization to individuals in a self-defined behavioral health crisis to decrease the use of the emergency department, inpatient care, and unnecessary arrest for individuals whose needs can be met in the community. MCR under the CCS program is available:

- To all people in Colorado 24 hours a day, 7 days a week, 365 days a year,
- Regardless of insurance status, age, residency, or previous service utilization, and
- To be delivered by a multidisciplinary MCR team with requisite training and expertise.

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

MCR is not a replacement for ongoing mental health and/or substance use disorder treatment as scheduled services are critical to both address a client's behavioral health needs and to prevent crises. MCR is used to address an emergent and unforeseen crisis. In the hours and days after an immediate crisis has been addressed, MCR teams provide or arrange for appropriate transportation to a facility if needed, coordinate follow up care, facilitate behavioral health referrals as clinically indicated, and may provide home-based or telemedicine follow up visits. MCR providers may only provide transport if appropriately licensed and holding the necessary vehicle permits as defined by Behavioral Health Secure Transportation.

Training

All MCR staff shall complete the Crisis Professional Curriculum within 6 months of being made available by the BHA and/or 6 months within new hire. Required training must cover the following topics, but is not limited to:

- Initial Telephonic Screening and Standardized Dispatch Protocol
- Suicide Screening, Risk Assessment and Safety Planning
- Evidence-based and Promising Practices in Crisis Intervention, including De-escalation Strategies
- Crisis Plan Development and Use of Advanced Directives
- Harm Reduction Strategies and Use of Naloxone and Other Supplies to Address Overdoses
- Non-violent Crisis Intervention
- Psychiatric Medications and Side Effects
- Trauma-Informed Care including responding to victims of interpersonal and gender-based violence
- National Standards for Culturally and Linguistically Appropriate Services (CLAS), Including BHA CLAS Standards Policies and Communications Technology
- Federal and state Requirements and Privacy and Confidentiality of Patient Information
- Training for adult or transition age youth peer support professionals or family advocate members and their supervisors to support paired response by clinical/peer teams
- Using accessibility related tools including telehealth and communication devices or other language resources

Required Training to Ensure MCR Services are Tailored to Meet the Needs of Key Populations:

- Cultural Awareness and Responsiveness including responding to individuals from racially and ethnically diverse backgrounds
- American Indians/Alaska Natives
- Child, Youth and Family Crisis Interventions
- Co-Occurring Disorders
- Deaf, Hard of Hearing, and Deaf/Blind care
- Dementia and other age-related needs
- Gender-responsive Services
- Intellectual and Developmental Disabilities
- Lesbian, Gay, Bisexual, Transgender, Queer/questioning and other (LGBTQ+) youth and adult related needs

- Mental Health Conditions (including Serious Mental Illness, Serious Emotional Disturbance)
- Neurodivergence, including Autism Spectrum Disorders
- Non-English speakers and those for whom English is not their first language
- Substance Use Disorders
- Traumatic Brain Injuries

Rate Methodology

HCPF will need to look into increasing the costs of MCR services to include the increased dispatch frequency for Mobile Crisis Response due to the IHBT provider's request. In addition, to be consistent with standards that MCR will provide child and youth specialized interventions, a contract will need to be established for 24/7/365 e-consultation with a youth clinician and accessible to any MCR across the state by phone or video. Current rates for MCR are based on an initial 60 minute rate with additional 15 minute service unit rates.

Respite

Provider Qualifications

Respite services can be provided by the following individuals:

- Peer Specialists;
- Qualified Behavioral Health Aide (QBHA);
- Qualified Medication Administration Personnel (QMAP);
- Bachelor's level in social services;
- Intern;
- Unlicensed Master's Level;
- Unlicensed EdD/PhD/PsyD;
- Licensed Clinical Social Worker (LCSW);
- Licensed Professional Counselor (LPC);
- Licensed Marriage and Family Therapist (LMFT);
- Licensed EdD/PhD/PsyD;
- Certified Addiction Technician (CAT);
- Certified Addiction Specialist (CAS);
- Licensed Addiction Counselor (LAC);
- Licensed Practical Nurse/Licensed Vocational Nurse (LPN/LVN);
- Registered Nurse (RN);
- Advanced Practice Nurse (APN).

Service Definition

Services rendered in the member's home, community, or other place of service as a temporary relief from stressful situation/environment or to provide additional support in home environment in order to maintain the member in an outpatient setting. Services include observation, support, direct assistance with, or monitoring of the physical, emotional, social and Behavioral Health needs of the member by someone other than the primary caregivers. Respite care should be flexible to ensure that the member's daily routine is maintained.

- Support to assure the safety of member (e.g. developing safety plan, identifying triggers and resources, WRAP plan development, etc.).

- Referral to and establishing a stronger connection to community resources
- Relationship building with natural environmental support system
- Assistance with/monitoring/prompting of activities of daily living (ADLs), routine personal hygiene skills, self-care by obtaining regular meals/healthy diet options, housekeeping habits, etc.
- Assistance implementing health status and physical condition instructions
- Assistance with implementing medication reminders and practically addressing medical needs
- Assistance/supervision needed by member to participate in social, recreational/community activities

Service Eligibility Criteria

Respite is available on a short-term basis because of the absence or need for relief of those persons normally providing care. Respite can be provided in a variety of settings based on the member's needs and service delivery options on each waiver. Respite services are available in multiple HCBS waivers and can be provided through different service delivery options to meet the needs of the individual. Individuals or their family members can contact their CMA for assistance in applying for respite services.

Rate Methodology

Respite services are either paid per 15 minute units or per diem depending on the length of time the service is provided. Respite care up to 4 hrs. and 7 mins (16 units maximum) is reported as T1005; respite care over 4 hrs. 7 mins is reported as H0045 (per diem).

Appendix F: Advisory Committees

Statewide Leadership Advisory Committee

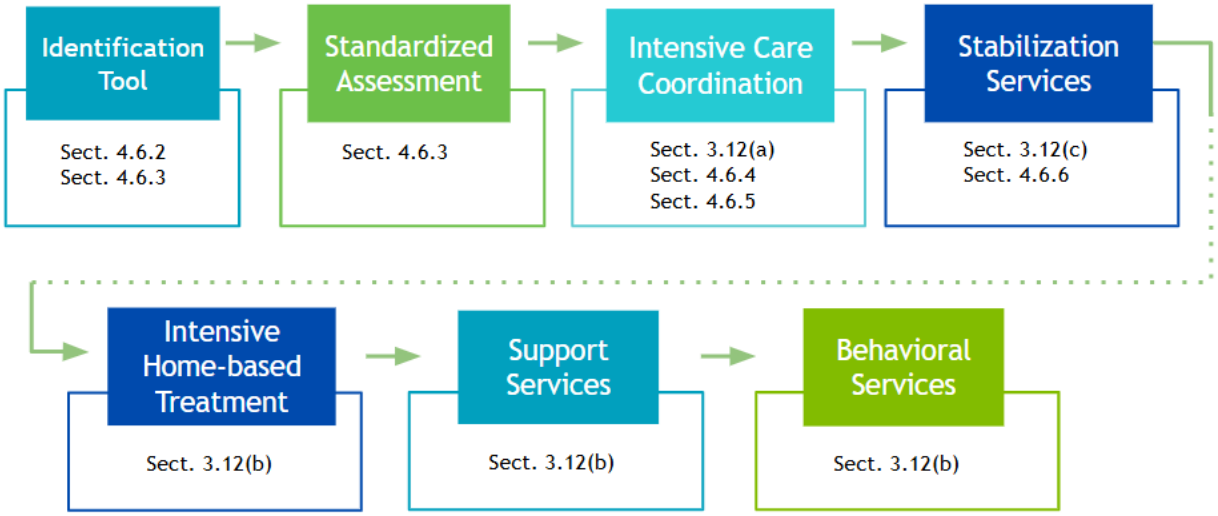
1. No later than November 1, 2024, the Department of Health Care Policy and Financing (HCPF) shall convene a leadership team that is responsible for the decision-making and oversight of the system of care for children and youth who have complex behavioral health needs.
2. The leadership team has the following duties and responsibilities:
    a) To evaluate the performance and effectiveness of the state department in the development of the system of care for children and youth with complex behavioral health needs;
    b) To oversee and advise the strategic direction of the development of the system of care; and
    c) To provide fiscal oversight of the state department's development and oversight of the system of care.
3. The leadership team consists of the following members:
    a) The Executive Director of the state Department, or the Executive Director's Designee;
    b) The Executive Director of HCPF of Human Services, or the Executive Director's Designee;
    c) The Commissioner of the Behavioral Health Administration in the Colorado Department of Human Services, or the Commissioner's Designee;
    d) The Executive Director of the Colorado Department of Public Health and Environment, or the Executive Director's Designee;
    e) The Commissioner of the Colorado Department of Education, or the Commissioner's Designee;
    f) The Executive Director of the Colorado Department of Early Childhood, or the Executive Director's Designee;
    g) (The Commissioner of the Division of Insurance in the Colorado Department of Regulatory Agencies, or the Commissioner's Designee;
    h) One County Commissioner, or the County Commissioner's Designee, from the Eastern Region, the Front Range Region, the Mountain Region, the Southern Region, and the Western Region, as Designated by the statewide Organization that Represents County Commissioners;
    i) One County Commissioner at large, or a County Commissioner's Designee;
    j) One Director of a County Department of Human or Social Services at large, or the Director's Designee, as Designated by the statewide Organization that Represents County Department of Human or Social Services Directors;
    k) One or more Families or Individuals with Lived
    l) Experience using Children's or Youth's Behavioral Health Services, Appointed by the Commissioner of the Behavioral Health Administration; and
    m) One or more Representatives from a Consumer Advocacy Organization, Appointed by the Commissioner of the Behavioral Health Administration.

Implementation Advisory Committee

1. No later than October 1, 2024, HCPF shall convene an Implementation Team that shall create a plan to implement the system of care for children and youth who have complex behavioral health needs
2. The Implementation Team shall consist of the following:
    a) The Executive Director of the state Department, or the Executive Director's designee;
    b) The Executive Director of the Colorado Department of Human Services, or the Executive Director's designee;
    c) The Commissioner of the Behavioral Health Administration in HCPF of Human Services, or the Commissioner's designee;
    d) The Executive Director of the Colorado Department of Public Health and Environment, or the Executive Director's designee;
    e) The Commissioner of the Colorado Department of Education, or the Commissioner's designee;
    f) The Executive Director of the Colorado Department of Early Childhood, or the Executive Director's designee;
    g) The Commissioner of the Division of Insurance in the Colorado Department of Regulatory Agencies, or the Commissioner's designee;
    h) One or more county Commissioners, as designated by the statewide organization that represents county Commissioners;
    i) One or more directors of a county Department of Human or Social Services, or the director's designee, as designated by the statewide organization that represents county department of human or social services directors;
    j) One or more families or individuals with lived experience using children's or youth's behavioral health services, appointed by the Commissioner of the Behavioral Health Administration;
    k) One or more representatives from a consumer advocacy organization, appointed by the Commissioner of the Behavioral Health Administration;
    l) A representative of the statewide association that represents child welfare agencies, appointed by the director of the association;
    m) A representative of the statewide association that represents hospitals, appointed by the director of the association; and
    n) A representative of the statewide association that represents comprehensive behavioral health providers, appointed by the director of the association.

Appendix G: Settlement Agreement and Plan Crosswalk

Settlement Agreement Requirement Sections and MSOC Crosswalk



Settlement Agreement and Plan Crosswalk

Settlement Agreement Reference	Provision Included in Settlement Agreement	Implementation Plan Component that addresses Settlement Agreement Provision
4.6.1	A systematic approach through which Medicaid Members will be provided the Medicaid-authorized, medically necessary IBHS Services needed to correct or ameliorate their mental health or behavioral disorders.	Section 3
4.6.2	A provider outreach plan to educate Medicaid providers regarding the availability of periodic and inter-periodic mental health screenings of Medicaid Members and the availability of IBHS.	Part 4.3.1.2
4.6.3	A standardized assessment process for identifying which Medicaid Members qualify for particular IBHS services, and	Part 3.3.3 and Part 3.4.1

	the intensity (scope and frequency) of service delivery. A standardized assessment process may include a standardized assessment tool that can be used to establish eligibility for IBHS.	
4.6.4	Tiers of care coordination, including intensive care coordination, and a method for assigning and delivering care coordination levels to Medicaid Members within the standardized assessment process.	Part 3.4.2 and Part 3.5.4
4.6.5	Strategies that support individual plans of care for each Medicaid Member. The individual plans of care will address and describe the necessary IBHS to be provided to each Medicaid Member in the least restrictive setting appropriate to meet the Medicaid Member's treatment goals and needs.	Part 3.4.2
4.6.6	Procedures to avoid unnecessary emergency room services, hospitalizations and out-of-home placements for Medicaid Members through the provision of IBHS.	Section 3
4.6.7	A data collection, tracking, monitoring, and quality assurance system to analyze mental and behavioral health services, including IBHS, and network capacity to Medicaid Members.	Section 4
4.7.1	Specific tasks, timetables, goals, programs, plans, strategies and protocols.	Located at the bottom of every section and Appendix J
4.7.2	Descriptions of set standards for the timely provision of IBHS to Medicaid Members.	Part 3.5.2
4.7.3	Descriptions for hiring, training, and supervising personnel.	Appendix E
4.7.4	Descriptions of the activities required to support the development and	Section 4

	availability of IBHS. This includes, but is not limited to: 4.7.4.1 Collecting and analyzing Medicaid claims data to determine provider capacity needed and funding necessary to provide IBHS as required by this Agreement. 4.7.4.2 Developing cross-system protocols to identify and serve Medicaid Members across different child-serving agencies, including child welfare and juvenile justice/probation. 4.7.4.3 Identifying and using quality management tools to measure and assess the effectiveness of IBHS.	
4.7.5	Descriptions for monitoring, reviewing, and revising, as necessary, managed care entity contracts to include obligations to provide timely access to necessary IBHS to Medicaid Members (e.g., timely access and time/distance and travel time standards for delivery of IBHS services).	Part 4.1.1
4.7.6	Descriptions of how information will be disseminated to Medicaid Members and Medicaid providers, the process by which Medicaid Members may request services, and the manner in which HCPF will maintain records of Medicaid Members' service requests.	Part 4.3.1

Appendix H: Acronyms and Definitions

ACC	Accountable Care Collaborative
ADA	The Americans with Disabilities Act
ASO	Administrative Service Organization
BHA	Behavioral Health Administration
BHASO	Behavioral Health Administrative Service Organizations
CANS	Child & Adolescent Needs and Strengths
Certified ICC Provider	System of Care Certified Intensive Care Coordination Provider
CHRP	Children's Habilitation Residential Program Waiver
CMA	Case Management Agency
CMRS	Crisis Mobile and Resolution Services
CO-SOC	Colorado System of Care
CRT	Crisis Resolution Team
CSU	Crisis Stabilization Unit
CYMHTA	Children and Youth Mental Health Treatment Act
EPSDT	Early and Periodic Screening, Diagnostic and Treatment
ESA	Enhanced Standardized Assessment
FFT	Functional Family Therapy
FOCUS	Families are experiencing meaningful connections, outcomes, coordination, unconditional positive regard, and short-term process
HFW	High Fidelity Wraparound
IBHS	Intensive Behavioral Health Services
ICC	Intensive Care Coordination
I/DD	Intellectual and Developmental Disabilities
IHBT	Intensive Home-Based Treatment
MCR	Mobile Crisis Response
MH	Mental Health
MST	Multisystemic Therapy
PRTF	Psychiatric Residential Treatment Facilities
QRTP	Qualified Residential Treatment Programs
RAE	Regional Accountable Entity
SUD	Substance Use Disorder
WCC	Workforce Capacity Center

Definitions

"Agreement" means the G.A. vs Bimestefer Settlement Agreement

"Early and Periodic Screening, Diagnostic and Treatment (EPSDT)" is a benefit that provides comprehensive and preventative health care services for children under 21 who are enrolled in Medicaid. EPSDT is key to ensuring children and adolescents receive appropriate preventative, dental, mental health and specialty services.

- Early: assessing and identifying problems early
- Periodic: checking children's health at periodic, age-appropriate intervals

- Screening: providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems
- Diagnostic: performing diagnostic tests to follow-up when a risk is identified, and
- Treatment: control, correct or reduce health problems found.

"Intensive Behavioral Health Services" or "IBHS" means a continuum of Medically Necessary mental health and support services or interventions, as required and authorized by the Social Security Act, provided in the most integrated setting appropriate to the needs of Medicaid Members, as identified by HCPF in consultation with the Consultant and as mutually agreed to by the Parties in the Implementation Plan. IBHS will include, but are not limited to, the following:

1. Intensive Care Coordination Services provided to Medicaid Members to facilitate assessment, care planning, coordination of services, authorization of services, and monitoring of services and supports. Such services are guided by the needs of the Medicaid Member and ensure a single point of accountability for ensuring necessary services are accessed, coordinated, and delivered to Medicaid Members.
2. Intensive-In-Home and Community Services provided to Medicaid Members in their homes or community settings in order to correct or ameliorate their behavioral health condition(s). Such services include educational opportunities, behavior management, therapeutic services, and clinical services.
3. Mobile Crisis Intervention and Stabilization Services provided to Medicaid Members in their homes or community settings, and which will be available 24 hours a day, 7 days a week. Such services include crisis planning, stabilization, referral and coordination, and prevention and post-crisis follow-up services.

"Regional Accountable Entities" or "RAE" means the organization or their successor entities awarded a contract by HCPF to serve a particular region of Colorado, and that is responsible for coordinating care for Medicaid Members residing in that region, connecting Medicaid Members with mental health services, and ensuring that certain necessary Medicaid covered services are delivered to Colorado's Medicaid Members.

"Social Determinants of Health (SDoH)[15]" are non-medical conditions and factors that affect a person's health, well-being and quality of life. It can include:

- Conditions (circumstances in which people are born, grow, work, live and age);
- Forces and Systems: broader forces and systems that shape daily life, such as:
    - Economic Policies
    - Development Agendas
    - Social Norms
    - Social Policies
    - Political Systems
    - Racism
    - Climate Change

[15] https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1

Appendix I: Stakeholder Feedback

HCPF partnered with Mental Health Colorado (MHC), the state's advocacy organization for people in Colorado who are experiencing a mental health or substance use condition to facilitate three different lived experience groups who provided input on the Plan. Lived Experiences groups were provided both in-person and virtually. In-person locations occurred in Grand Junction and Denver and 3 virtual sessions occurred.

Additionally, HCPF hosted general in-person and virtual sessions along with a stakeholder meeting with those working or advocating for the treatment of young children. The in-person sessions were located in the following cities or towns:

- Frisco,
- Steamboat Springs,
- Craig,
- Grand Junction,
- Ridgway,
- Durango,
- Alamosa,
- Denver,
- Colorado Springs,
- Longmont,
- Greeley,
- Pueblo,
- Lamar,
- Burlington, and
- Sterling.

Stakeholder feedback is currently under review and key themes are being identified. The feedback will be posted to the website once completed.

Appendix J: Implementation Plan Steps

*This appendix consolidates all the task items outlined in each section of the Implementation Plan.

Section 3.1: Population Specific Decision-Making Steps	
Task	**Fiscal Year Due Date**
Identify appropriate pathways to care and interventions for families with children under the age of 8 and develop relevant policies and protocols.	Q2 FY26/27*
Identify appropriate pathways to care and interventions for families with Members who have an Intellectual or Development Disability and develop relevant policies and protocols.	Q2 FY26/27
Create policies and procedures for how the CO-SOC will interact with current systems for Members under 8, Members 18-20 and Members with IDD (i.e.. interactions with CDEC, CMAs, familial supports)	Q2 FY26/27
Identify appropriate pathways to care and interventions for Members 18 to 20 years and 364 days of age and develop relevant policies and protocols.	27/28
Section 3.3.2: Referral Steps	
Work with BHA to develop policies and procedures for referral process to BHASOs for individuals who are not Medicaid-eligible and ensure a robust provider network of providers who bill Medicaid and providers who accept alternative payment options (i.e.. grants, the Children and Youth Mental Health Treatment Act (CYMHTA), etc.)	Q2 FY25/26
Plan for educating members on the existence of services	Q3 FY26/27
Plan for educating members on how and where to make a referral	Q3 FY26/27
Develop process to educate providers and public agencies on how and where to make a referral	Q3 FY26/27
Section 3.3.3: Identification Tool Steps	
Create Service Definition for Identification Tool	Q3 FY25/26
Create Identification Tool	Q1 FY26/27
Train RAEs on use of Identification Tool	Q3 FY26/27
Ensure RAE outreach measures inform providers of comprehensive EPSDT screening requirements vs. Identification Tool	Q3 FY26/27
Update utilization management protocols to include use of tool and include tracking metrics	Q4 FY26/27

Section 3.4.1: Enhanced Standardized Assessment Steps	
HCPF and BHA will create ESA and related policies and protocols	Q4 FY24/25
Create provider training on completing the standardized assessment and referral process to receive appropriate treatment	Q4 FY24/25
Create provider certification process to track those trained and approved to provide ESA	Q2 FY25/26
Ensure RAE contracts outline process for identifying providers and referring to WCC or LMS for training to ensure network adequacy	Q2 FY25/26
Section 3.4.2: Intensive Care Coordination Steps	
Create policy for RAE contracts on identifying and selecting Certified ICC Providers to ensure network adequacy	Q4 FY24/25
HCPF will determine and seek any needed federal authority to implement and pay for ICC services.	Q4 FY24/25
Generate regional estimated capacity per fiscal year for the RAEs and establish guidance on expected number of Members served in each region and associated provider amount needed	Ongoing
Create Workforce Capacity Center to develop ICC training	Q1 FY25/26
Create provider training on HFW and FOCUS	Q2 FY25/26
Create provider certification process to track those trained and approved to provide ICC	Q2 FY25/26
Define Certified ICC Provider as a certification type	Q2 FY25/26
Identify funding source for material goods and process for administrating	27/28
Section 3.4.3: Crisis Mobile and Resolution Services Steps	
HCPF will collaborate with the BHA to develop policies and protocols for both the CO-SOC providers and crisis providers on how these two services will interact.	Q4 FY25/26
Develop service and policy enhancements to crisis services to better meet the needs of children and youth in the CO-SOC	Q1 FY26/27
Create training for Certified ICC providers on how they will connect with connection with CMRS services	27/28
Create process and identify funding for ensuring a youth clinician is available and accessible with any MCR via telephone or virtual platform	27/28
HCPF and BHA will work to enhance provider workforce to increase CRT availability	28/29

HCPF and BHA will work to expand available CSUs for youth	29/30
Section 3.4.4: Intensive In-Home Based Treatment Steps	
Identify appropriate in-home intervention model with children under the age of 8.	Q4 FY26/27
Identify appropriate in-home intervention model for Members 18 to 21 years.	Q4 FY26/27
Identify appropriate in-home intervention model for Members who have an Intellectual or Development Disability.	Q4 FY26/27
Implement in-home intervention models for children under 8, Members 18 to 21 and Members who have an Intellectual or Developmental Disability	27/28
Create Service Definition for CO Model	27/28
Build and train providers on CO Model	27/28
Identify and create a policy for determining whether the IHBT model will consist of 1 or 2 providers including collaborating with BHA to identify whether usage of QBHAs is appropriate and available	27/28
Create provider tracking process on those trained and approved to provide IHBT services	27/28
Create a service definition for therapeutic mentoring	27/28
Develop policies and guidance to ensure that each child receives the most appropriate IHBT model to meet their needs.	27/28
HCPF will explore a monthly encounter rate for funding IHBT models, including those under 8, 18-21, I/DD and the CO-IHBT model	27/28
Section 3.4.5: Support Services Steps	
Apply for Medicaid waiver to pay for any support services not covered under capitation	28/29
Build support service workforce capacity	28/29
Determine best funding mechanism to have a sustainable workforce	28/29
Section 3.4.6: Behavioral Supports Steps	
Create a service definition for Behavioral Management Consultation	28/29
Establish contractors for behavioral support via CO-SOC Workforce Capacity Center	28/29
Section 3.5.1: Transition Policies Steps	
Create transition policies and educate providers on how to implement policies	Ongoing

Develop re-referral policies for Members and educate providers on process	27/28
Section 3.5.2: Timeliness Policy Steps	
Develop policy for Intensive Home-Based Treatment in which timelines will be determined, including for emergent, urgent and routine timeliness for each service.	Q3 FY24/25
Develop policy for support services in which the timelines will be determined	28/29
Develop policy for Behavioral Consult Services in which timelines will be determined	28/29
Section 3.5.3: Provider Ratio Policy Steps	
Establish client to provider and provider to supervisor ratios for Family Peer Support	Q4 FY26/27
Establish client to provider and provider to supervisor ratios for respite	28/29
HCPF will develop policies to identify appropriate workforce capacity and work with the RAEs to establish expectations for the number of trained and certified providers in each region to meet the needs of Members receiving the CO-SOC services.	Ongoing
Section 3.5.4: Agency Roles Steps	
Create educational materials for IBHS providers to distinguish RAE responsibilities from Certified ICC Provider responsibilities	Q3 FY25/26
Review Massachusetts and Ohio dispute resolution policies.	Q2 FY25/26
Develop dispute resolution policy that includes process for handling grievances, appeals, and how decisions will be made by the RAE and treatment team	Q3 FY25/26
Create a policy with the RAEs for Utilization Management that promotes in-home placement for Members	Q3 FY25/26
Create cross-system protocols for working with CDHS, BHA and CMAs	Q2 FY25/26
HCPF, RAEs and relevant stakeholders will collaborate to develop the CO-SOC manual to outline statewide requirements for implementing the CO-SOC	Q2 FY26/27
Identify and establish process for intersection with child welfare, juvenile justice, youth detention and youth commitment	Q2 FY26/27
Section 3.6.3: Workforce Steps	
Develop policy and protocols for HFW fidelity development and monitoring	Q2 FY25/26
Develop policy and protocols for MST and FFT fidelity development and monitoring	Q2 FY25/26

Develop policy and protocols for FOCUS Model Fidelity development and monitoring	Q2 FY26/27
Develop policy and protocols for CO-IHBT model fidelity development and monitoring	27/28
HCPF and WCC will develop process for how to manage contracts for behavioral e-consultation services	28/29
Develop educational information with BHA on how to disperse relevant information about the CO-SOC for providers not in the CO-SOC service array but those who will interact with Certified ICC Providers or IHBT team	Ongoing
Section 4.1: Continuous Quality Improvement Steps	
HCPF will establish a committee to oversee the effectiveness of the CO-SOC who will also be accountable for the quality plan.	Q4 FY24/25
Finalize the metrics and outcomes to be tracked in the CO-SOC	Q2 FY25/26
Develop a plan for how metrics can be collected and analyzed, including an assessment of any technology solutions that need to be developed,	Q2 FY25/26
Finalize the policy and data collection procedures that RAEs will be required to contractually abide by.	Q2 FY25/26
Finalize the policy and data collection procedures that Certified ICC Providers will be required to contractually abide by.	Q3 FY25/26
Finalize the policy and data collection procedures that WCC will be required to contractually abide by.	Q3 FY25/26
Section 4.1.1: Department Oversight Steps	
Develop policy on ensuring timely and appropriate reimbursement for services, ensuring implementation of the CO-SOC in compliance with state policies and procedures	Ongoing
Update RAE contracts for compliance for fiscal year 26/27 and beyond.	Q1 FY26/27
Update HCPF CQI policies as needed to reflect adherence to the standards and roles in CO-SOC.	Q3 FY26/27
Section 4.1.2: Consumer Feedback Steps	
Create standard operating procedures for receiving, collecting and analyzing feedback from users in the CO-SOC. Create any necessary tools to receive such information.	Q3 FY26/27
Create protocols for using the Lived Experience Committee as a mechanism for reviewing consumer feedback	Q2 FY26/27

Create a process for collecting information from partner agencies (i.e. child welfare, juvenile justice, consumer associations, etc.) on the quality of the CO-SOC services being delivered in their community. Create a report card system for tracking local effectiveness of services.	27/28
Section 4.2.3: Rollout Steps	
Develop plan for family peer support implementation	Q4 FY26/27
Develop plan for mentoring implementation	27/28
Develop plan for respite implementation	28/29
Section 4.2.4: Risks and Considerations Steps	
HCPF will develop a plan to educate and remind the General Assembly of federal EPSDT obligations to ensure future legislation does not impede progress towards implementing CO-SOC	Q4 FY25/26
Section 4.3.1: Outreach Steps	
Develop outreach materials for each respective stage	Ongoing
Train providers on identification and referral process to the CO-SOC	Ongoing
Train providers on difference between EPSDT mental health screenings and referral for high acuity services	Ongoing
Section 4.3.2: Reporting Requirements Steps	
Develop a template report for having a quarterly report in the status of the CO-SOC implementation.	Q2 FY24/25
Create protocols of communicating to and from committees of reference	Q3 FY24/25
Develop format to reporting out status update to Plaintiffs	Q3 FY24/25
Section 4.3.3: Public Communications Steps	
Hold follow up meeting with stakeholders on final Implementation Plan	Q4 FY24/25
Create a Newsletter, Listserve, and Webpage	Q2 FY24/25
HCPF will create communications plan to continuously engage stakeholders of the CO-SOC services and inform about any updates	Q3 FY24/25
Develop a plan for educating General Assembly and Parties on the System of Care	Q2 FY25/26
Section 4.4.1: Services Budget Steps	

Create rates and funding mechanism for fiscal year 25/26 that covers cost of providers to deliver services	Q4 FY24/25
Create a detailed budget for each of the fiscal years	Q4 FY24/25
Review rates for fiscal year 26/27 and beyond for adequacy in covering provider costs.	Ongoing
Determine for each fiscal year and service type, if length of the units used for rates (15, 30 or 50 minutes blocks or monthly encounter units)	Ongoing
Determine for each fiscal year and service type, whether directed payments are needed and submit necessary approvals to CMS	Ongoing
Section 4.4.2: Workforce Capacity Budget Steps	
Determine workforce capacity development budget based on the standards and ratios set for CO-SOC	Q3 FY24/25
Create a detailed budget for WCC to reflect the extent of training and monitoring needed in each fiscal year	Q3 FY24/25
With the BHA, create a detailed budget for BHA to reflect the extent of training needed in each fiscal year	Q4 FY24/25
Section 4.4.3: Oversight Budget Steps	
Create a detailed budget for HCPF to reflect the extent of program oversight is needed in each fiscal year	Q3 FY24/25
With the BHA, create a detailed budget for the BHA to reflect the extent of oversight of treatment standards is needed in each fiscal year	Q4 FY24/25

* Given the comprehensive nature of this Implementation Plan, only the first two fiscal years will be outlined on a quarterly basis, with the details for subsequent fiscal years to be determined later.