Colorado 2025 CCBHC Planning Grant Narrative

A.1. The Colorado Department of Health Care Policy & Financing (HCPF), in collaboration with the Behavioral Health Administration (BHA), plans to strategically expand access to comprehensive behavioral health care through phasing in the Certified Behavioral Health Clinic (CCBHC) model across the state. Colorado's population is 5,773,714, with a racial breakdown of 68% White, 22% Hispanic/Latino, 5% Black/African American, 2% American Indian/Alaskan Native, and 4% Asian. Nearly 10% of CO residents are in poverty. Adults ages 25-64 years make up the largest share of demographics, by age, followed by youth and older adults.[1] Approximately 9% of the population identifies as LGBTQIA+.[2]

The CO CCBHCs will serve residents of all races, ethnicities, federally recognized tribes, languages, sexes, gender identities, sexual orientations, ages, and socioeconomic statuses. Additionally, CCBHCs will serve adults with serious mental illness (SMI), children with serious emotional disturbance (SED), individuals with substance use disorder (SUD), and populations experiencing behavioral health (BH) disparities, such as Black, Latino, Indigenous and Native American persons; Asian Americans; Pacific Islanders; and other persons of color, religious minorities, LGBTQIA+ persons, persons with disabilities, rural populations, those facing poverty or inequality, and people exposed to community violence/gun violence. This includes CO residents who are un/underinsured, Medicaid-eligible, and publicly insured, regardless of condition or ability to pay. **The populations of focus (POF) for CCBHC planning are: Black, Indigenous, and other People of Color (BIPOC) across the lifespan with MH/SUD issues, specifically the Hispanic/Latino, Black/African American, and American Indian/Native/Indigenous populations; justice-involved adults; adolescents; and the LGBTQIA+ population.**

A.2. Colorado residents continue to experience a higher prevalence of BH conditions than seen nationally, with a SMI prevalence of 6.3% and adult SUD prevalence of 11.7% (compared to 4.8% and 7.4% nationally, respectively).[3] The 2023 CO Health Access Survey (CHAS)[4] found that one in four people reported poor MH, the highest number recorded in the history of the survey. Some 880,000 Coloradans (17%) reported not receiving the MH care they needed in 2023 due to lack of timely access. One in five respondents (19.8%) said they did not fill a prescription, get care from a doctor, or get specialty care, due to cost. People of Color were more likely than white Coloradans to report disrespect when getting care (7.7% versus 4.4%). Colorado's suicide rate is nearly 9% higher than the national average, with suicides by firearm (12.2 per 100,000) being nearly 5% higher than the national average.[5] Teenagers in CO are 37.4% more likely to have used drugs in the last month than the US average.[6] Rates of children/youth with an emotional, behavioral, or developmental condition increased 5% from 2020-2021.[7]

Additionally, CO residents are severely impacted by Social Determinants of Health (SDOH), with 7.1% (up from 5.6% in 2021) of Coloradans worrying they would not have stable housing in the next two months. Food insecurity increased 3% since 2021, with rural areas being hit the hardest. [8] A 2020 community needs assessment[9] found the following

regarding our POF:

- 31.4% of high school students expressed being so sad or hopeless that it impacted their functioning. Within this population,
- 62% of lesbian, gay and bisexual (LGB) students reported this feeling, compared to 27% of their heterosexual peers.
- American Indian/Alaska Native high school students had the highest prevalence among all races and ethnicities of feeling sad, at 37.5%, followed by Hispanic students at 35.2%.
- 16% of high school students reported binge drinking; 19.4% reported using marijuana in the past 30 days.
- 84% of LGBTQIA+ persons reported mental health strain in the past year
- 50% of persons with Medicaid coverage who experienced mental health strain did not receive care due to access and culturally responsive care limitations.

A 2022 statewide needs assessment performed by the CO Health Foundation[10] showed significant service needs, gaps, and disparities across the state. Of all People of Color:

- 70% of Native Americans and Indigenous Persons could not find culturally responsive care.
- 76% of Asian/Pacific Islander and Hispanic/Latino respondents said the wait for services was too long or there were no available appointments.
- 68% of Black/African Americans were unsure of how to find a provider.
- 68% of BIPOC respondents stated BH care was too expensive.

A 2020 statewide assessment of state priority populations[11] found that stakeholders reported experiencing a surge in BH concerns that are perceived to be underrepresented in data collection. These include substance use and suicide in the LGBTQIA+ population, particularly for youth, and a rising rate of schizophrenia among some tribal populations. The study also found that the **Hispanic population was identified as the most at risk racial/ethnic group, followed by Black and American Indian people (these two groups were equally disadvantaged). Adolescents were identified as the most vulnerable age group. Additionally, Black, Hispanic/Latino, and Native people were found to be overrepresented in carceral settings.[12] Fifty-four percent of LGBTQ+ adults reported poor mental health.[13]**

Currently, no providers are billing Medicaid for BH services in four of CO's 64 counties. Twenty counties have one provider billing at least one BH service, either an MH or SUD service option, but often not both. Access to BH services may require residents to travel at least 90 minutes/90 miles one-way. The need in the state has been shown to more dramatically impact rural and Tribal areas, which will be a priority for CCBHC implementation.

A.3. BH services are primarily organized, funded, and provided through collaboration of two State agencies: HCPF and BHA. HCPF is the single state agency for Medicaid and administers and oversees the delivery of care through the Accountable Care Collaborative (ACC), implemented by regional managed care entities. These entities ensure Medicaid members have access to medically necessary BH services through contracts with providers. HCPF also holds two physical health full managed care contracts, one of which includes BH services.

BHA is the single state behavioral health agency responsible for administering SAMHSA funds. BHA sets standards and monitors quality, licenses, designates, and approves provider agencies, provides training and technical assistance, problem solves and develops regional programs designed to meet local needs. BHA and HCPF create a shared strategy for public behavioral health policy, continuum of care design, and funding of services- enhancing quality of care by developing standards, quality metrics, data reporting and performance monitoring.

In SFY 2023-24, HCPF spent $1,028,527,783 of services and incentive dollars on managed BH care. CMS provides at least a 50% federal match to cover the cost of managed BH care in CO. When CO expanded Medicaid in 2014, managed BH care became the largest funder for BH services in the state. BHA is primarily responsible for funding BH services for uninsured or underinsured individuals. BHA funds may also be used to build provider capacity and fill gaps in the continuum for all Coloradans, regardless of insurance status or the ability to pay. Funding sources include SAMHSA Block Grants, other federal discretionary grants, state general funds and legislative appropriations.

BHA defines safety net providers in CO which include Comprehensive Providers (agencies who provide all BH safety net services, directly or through formal agreements) and Essential Providers (SUD or MH providers who provide one or more BH safety net services). These providers serve priority populations and comply with the safety net "no refusal" requirements, ensuring priority populations receive whole-person care through comprehensive coordination. BH services may be provided by Federally Qualified Health Centers (FQHCs), specialty clinics, inpatient and outpatient facilities, and CO's robust independent provider network. The BH managed care network includes over 12,000 unique licensed practitioners who provide psychiatric, psychological, and SUD services. Provider agencies of varying sizes, specialties, and service areas increase the diversity of potential participants for CCBHC rollout.

A.4. Covered services are defined and authorized under the CO Medicaid State Plan for required services and CO's Medicaid Capitated BH Benefit, which is authorized under a 1915(b)(3) waiver. This waiver allows CO to offer alternative BH services (in addition to those identified under the State Plan) under a regional managed care model. **Both HCPF and BHA have worked together to strengthen and expand the BH service array to meet the needs of Coloradans and ensure the payment models will enhance the delivery of required CCBHC services.** Table 1 describes the capacity to provide the required CCBHC services through various funding streams and authorities.

Table 1: Current capacity to provide the required CCBHC services, authorities & funding

Required Service	Current Status	Source of Payment
1. Crisis BH Services	● Current Services: 988, Colorado Crisis Services, Acute Treatment Units, Crisis Stabilization Units, 24-hour crisis intervention- including mobile crisis, respite services, crisis psychotherapy, BH secure transportation ● Authorized under the Medicaid State Plan & 1915(b)(3) waiver	● Medicaid ● Block Grants ● State general funds
2. Screening, Assessment, Diagnosis	● Authorized under the Medicaid State Plan & 1915(b)(3)waiver	● Medicaid ● Block Grants ● State general funds
3. Patient-Centered Treatment Planning	● Authorized under the Medicaid State Plan & 1915(b)(3) waiver	● Medicaid ● Block Grants ● State general funds
4. Outpatient MH/SUD Services	● Authorized under the Medicaid State Plan & 1915(b)(3) waiver	● Medicaid ● Block Grants ● State general funds
5. Outpatient Clinic Primary Care Screening and Monitoring	● 2015 State Innovation Model Grant Recipient with goal of integrated care, led to: 17 SNPs and 57 FQHCs ● $35m state funding for integrated care	● Medicaid ● Block Grants ● State general funds
6. Targeted Case Management	● Authorized under the Medicaid State Plan & 1915(b)(3) waiver ● Offered for all ages with MH/SUD ● Authorized under the Medicaid State Plan & 1915(b)(3) waiver ● Current populations authorized for TCM: all ages with a primary substance use disorder or individuals diagnosed with or being assessed for a mental health diagnosis	● Medicaid ● Block Grants ● State general funds

7. Psychiatric Rehabilitation Services	● Authorized under the Medicaid State Plan & 1915(b)(3) waiver	● Medicaid ● Block Grants ● State general funds
8. Peer Counseling and Support	● Current services: peer counseling and support services,peer-run drop-in centers, peer-run employment services, peer mentoring for children and adolescents, WRAP groups, member and family support groups, warm lines, advocacy services ● Authorized under the Medicaid State Plan & 1915(b)(3) waiver	● Medicaid ● Block Grants ● State general funds
9. Intensive MH Care for Those in the Military	● BH services for veterans are not separately specified under the Medicaid program; veterans who qualify for Medicaid have access to the full array of covered BH services. Veterans can seek services through the VA or other BH providers.	● Medicaid ● VA ● BHA

Colorado is actively working to expand and strengthen the safety net payment and delivery system and used the CCBHC model and Colorado's 2016 CCBHC Planning Grant to develop regulatory standards for BH providers that consider access, value, and quality outcomes over service volume. In addition, the CO legislature is an engaged partner, as evidenced by HB24-1384, which supports the submission of the Planning Grant. HCPF /BHA have:

- Participated in health IT roadmap and leveraging the state's analytics infrastructure.
- Updated cost reporting templates, protocols to modernize reimbursement rates for BH safety net providers.
- Developed alternative payment models and value-based payments that create and reward shared patient outcomes and health equity goals, including a PPS model.
- Reduced administrative burden through aligned data reporting. Engaged in process ensuring all process and performance measures are meaningful/actionable/aligned across state reporting.

During the Planning Grant Period, **HCPF and BHA will evaluate all policies and funding requirements connected to CCBHC services to ensure there are no regulations or other constraints that would inhibit the provision of the required services.**

B.1. Statewide expansion of the CCBHC model will increase capacity, access, and availability of comprehensive, evidence-based care across the lifespan for Coloradans, especially our POF. Colorado's primary aims in pursuing CCBHC model deployment at the State level are to 1) increase access and availability of BH services, 2) increase capacity of

BH providers and settings to meet the needs of residents, and 3) improve the quality and outcomes of BH and whole-person care. During the Planning Grant Period, the BHA and HCPF will operationalize each aim by developing measurable goal statements and quality measures and metrics to track progress towards stated goals across levels of the system (i.e., state, managed care, clinic). These measures will track progress of the general population but will have a particular focus and priority for our POF.

As an example of this work to be done, to assess Aim 1, the State plans, at this time, to track three primary measures: 1) The total number of unique individuals served within CCBHCs, 2) Plan All Cause Readmissions (PCR), and 3) Time to Services (I-SERV). Together, these three measures will allow us to see at a state, programmatic, and clinic level, how the model is impacting care access and to identify any existing or emerging disparities. During the Planning Grant Period, we will establish and project baseline and goal performance rates for PCR and I-SERV, with an overall goal of progressively decreasing any disparities identified. Using published data on CCBHC Demonstration states, which suggests a 10 percent increase in unique individuals served within CCBHCs is possible over the course of the Demonstration Period, we have preliminarily set a goal that we expect to serve 310,000 unique individuals within Colorado CCBHCs by the end of the Demonstration Period.

During the Planning Grant Period, a CCBHC Steering Committee (SC) will be formed to guide the CCBHC planning process. The SC will include representation from HCPF, BHA, providers, advocates, community partners, and individuals with personal/family lived experience. The State will ensure representation from our POF, urban, rural, and frontier communities so the SC is reflective of the State's geographic and cultural diversity. The SC will meet regularly during the Planning Grant Period to review the progress of the planning process, and to determine/provide guidance regarding training, stakeholder needs, outreach and engagement, workforce diversity, SDOH, culturally responsive care and access, certification criteria, technical assistance, de-certification criteria, required performance measures including value-based performance measures, and data collection. These varying areas of focus will be guided through the work of the following subcommittees: Populations of Focus; Stakeholder Engagement; Quality, Compliance, and Reporting; Communication; and CCBHC Operations.

The POF Subcommittee will be focused on outreach, engagement, retention, and disparity reduction for the POF. **The POF Subcommittee will serve as the state leaders in ensuring that disparity reduction is foundational to the design of the program model design, implementation, and ongoing operations.** This group will meet at least monthly during the Planning Grant Period and will utilize information gleaned from sources such as: Community Needs Assessments (CNA), local data, focus groups, surveys, and environmental scans to design recommendations regarding how **to expand the capacity, access, and availability of services to the POF.** This group's work will include a focus on linguistically appropriate care, training, and workforce diversity.

The POF Subcommittee will also use state data to **establish statewide requirements regarding ongoing, competency-based training, and evaluation regarding culturally responsive care and engagement for our POF.** These trainings will be additional to those mandated in the CCBHC Certification Criteria, incorporate CLAS standards, and be designed to improve cultural responsiveness and efficacy regarding the POF. All staff will be

required to participate in training regarding the needs and disparities of the chosen POF, culturally responsive care, and increasing outreach and engagement.

While the Phase 1 CCBHCs are being selected due to their existing CCBHC expansion site, many may expand their catchment areas and DCO partnerships to ensure statewide **access** to a CCBHC for all Coloradans. To improve access, all CCBHCs will be required to utilize stakeholder engagement techniques like focus groups or surveys to inform how their services can **increase capacity to meet the access and availability needs of their community, especially the POF.** Additionally, the Phase 1 and 2 CCBHC site selection process will evaluate areas of significant need to determine areas that have a high need for increased services and prioritize these for expansion. BHA and HCPF also embed trauma-informed user research and service design practices in their technology and data infrastructure efforts. This includes consistent co-design activities where people in communities can use their lived/living expertise to build solutions/services that truly meet their needs. Research shows that these co-design activities play a critical role in improving both individual health outcomes, and more broadly, the creation of healthy communities. This is particularly true in health conditions that experience stigma.[14]

The state will develop a CCBHC POF Subcommittee, which will work in partnership with BH providers (including CCBHCs) to analyze how access to care across the State may be inhibited by various factors like clinic hours, transportation, distance to care, linguistically accessible services, and culturally representative programs/staff. The group will utilize a combination of methods, such as qualitative focus groups and surveys, paired with existing community data to identify root causes and establish baselines from which access and availability improvement can be compared. The POF Subcommittee will author guidance for **improving access through addressing SDOH,**[15] which may be through partnerships with transportation agencies, connecting with local community resource groups, utilizing telehealth, or developing an emergency fund to help with basic needs. Other methods of increasing access may be implemented, such as increasing programming availability, ensuring programming in multiple languages, and co-locating care with partnering agencies who are already embedded in POF communities.

CCBHCs will also be required to submit a **disparity reduction continuous quality improvement (CQI) plan** consisting of a baseline assessment, findings, priority areas, and goals to improve outcomes. The CQI plan will include consideration of the following disparity reduction factors: workforce diversity, addressing SDOH, strengthening community referrals, and development of services that are responsive to the diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs of the POF.

Colorado implemented legislation in 2024 that set minimum behavioral health provider standards to address accessibility of care and availability of services, capacity tracking, and quality of care, including access for priority populations. BHA established agreements with tribal governments to reduce disparities and create a no-refusal policy for safety net providers to improve access for particular groups, such as those without insurance or means to pay, high-acuity BH, multi-system involvement, and marginalized populations. These requirements dovetail with CCBHC Certification Criteria affording improved access to care and will be evaluated for efficacy during the Planning and

Demonstration Grant Periods.

CO has been diligently working to increase **workforce diversity.** Legislation in 2022 increased BHA collaboration with the Department of Higher Education, institutions of higher education, and community colleges to provide job shadowing, internship, incentives, loan repayment, scholarships, marketing, and other programs to increase the BH workforce. The program provides tuition scholarships to **rural and low-income students** to obtain credentialing in social work, addiction studies, addiction counseling, psychology, and individual and family counseling. The CO Department of Higher Education approved $5 million in grants to five universities that will provide tuition to students pursuing select degrees and certificates in BH. The State estimates the program will serve nearly 400 students within the first two years of the four-year program. These elements will be key in ensuring that CCBHCs have the workforce to staff their expanded programmatic offerings, an issue identified in national CCBHC studies.

Additionally, the State has an existing partnership with higher education institutions across Colorado to increase BH workforce capacity through training and certification services on a digital platform. The curriculum available provides continuing education credits and certification opportunities as well as expanding cultural competency and trauma-informed practices for all behavioral health workforce practitioners. The BHA's Learning Hub platform connects providers to free trainings, tracks compliance with training standards, and will help measure capacity and competency across Colorado's diverse populations. During the Planning Grant Period, the State will enhance the focus on increasing workforce diversity. Other recent accomplishments will support system-wide access and availability of services for the POF:

- From SFY2020 to SFY 2023, HCPF increased enrolled BH providers by over 50%
- Created the CO Land-based Tribe Behavioral Health Services Grant Program to fund renovation/construction of a BH facility.
- Passed 20 bills in 2022 funding and expanding the BH system which include: Integrated BH services for adults and children, Pediatric Psychiatry Consultation; increased school-based care; over $100M in community grants for diversion and criminal justice, children and youth, and general capacity building; increased residential care and crisis supports.
- Developed statewide crisis system focusing on serving children/youth, people with disabilities with mobile crisis services meeting new federal standards.
- Colorado Medicaid has also initiated multiple new initiatives, expanding coverage benefits for housing and nutrition supports, community health workers, criminal justice re-entry, and continuous eligibility for priority populations. CCBHCs will be key community partners in connecting clients to expanded benefits and coverage.

Building upon this work, the SC will provide guidance and technical assistance regarding how CCBHCs can identify and create meaningful partnerships with local educational and training institutions **to ensure that a diverse, culturally and linguistically representative pipeline of BH workforce is being developed** to work in the CCBHCs. These partnerships may include organizations like the Denver Association of Black Social Workers or the Four Corners MSW program, which offers training for rural and Tribal practice.

B.2. Colorado is home to seven agencies operating as CCBHCs. Due to their existing

experience and infrastructure, these CCBHCs will have the opportunity to seek state certification as the Phase 1 CCBHC sites in the Demonstration, with priority for rural and underserved areas. These CCBHCs have attested to meeting federal CCBHC guidelines and have clinic locations across the state and have a presence in both urban and rural counties. CO CCBHC work has already demonstrated success, with one clinic reporting clients have had a 94% improvement in daily functioning and a 50% improvement in psychological distress since implementation. Though these sites have existing federal certification through attestation as CCBHCs, it will be important that they are supported during the journey toward state certification as well.

A core activity of the Planning Grant work will be to align State regulations and the CCBHCs criteria. Foundational to this effort, BHA rewrote all BH provider regulations effective in 2024 which aligns very similarly, but not exactly, with the regulatory infrastructure for CCBHC. This infrastructure will serve as a foundation for the creation of State CCBHC certification criteria and ensure that regulations promote adoption of the model. The State will also develop audit, review, certification renewal, performance improvement, and decertification processes during the Planning Grant Period so that client health and safety are maintained and to assure certification criteria are met for the term of the grant.

HCPF and BHA will collaborate through internal workgroups and participation in the SC to develop CO State CCBHC Certification Criteria. These criteria will be rooted in the federal CCBHC Certification Criteria and will incorporate the feedback from CO residents with lived experience, promote disparity reduction, and ensure that the diverse needs of Coloradans are met in the design and implementation of CCBHC statewide services.

Colorado will offer monthly collaborative technical assistance (TA) sessions to any of the seven federally attested CCBHCs interested in being part of the State demonstration. During these sessions, the State will communicate all ongoing development of CCBHC requirements for these Phase 1t sites. The agencies will have the opportunity to provide formal and informal feedback to ensure the development of the State Certification Criteria meets the needs of the diverse communities across the state. These sessions will also be used to provide support to the potential CCBHC sites to create a strong infrastructure during the Planning Grant Period that will likely lead to certification approval.

Any of the existing federally attested CCBHCs will be considered for participation in the State demonstration and must demonstrate a commitment to family-centered, equity-based, trauma-informed and recovery-oriented care. The CCBHC will be required to submit a readiness assessment that includes a gap analysis for each provider identifying their specific needs and activities to prepare for certification and the Demonstration Grant period. Interested entities will be asked to provide a letter of interest and complete the Organizational Assessment Tool developed and shared by the National Council for Behavioral Health and apply through the BHA for certification.

As the Phase 1 CCBHCs are preparing to begin services, the State will launch a TA plan for Phase 2 and 3 providers to begin preparing for their CCBHC certification application. Through this support, potential future CCBHCs will have the opportunity to engage with the State and receive support in preparation to meet State Certification

Criteria.

B.3. The Phase 1 CCBHCs are located in a combination of urban, rural, and frontier counties. A continued focus on increasing access in rural, urban, and frontier geographies will be put in place in Phase 2 and 3 CCBHC implementation.

B.4. Colorado managed care BH contracts require safety net services statewide. The managed care organizations will be key partners in expanding capacity for a statewide CCBHC model. The current CCBHCs are in urban, rural, and frontier counties, and expansion in Phase 2 and 3 will be data-informed, with the goal of continued disparity reduction. Colorado plans to welcome CCBHCs to state certification in 3 phases, with Phase 1 launching at the beginning of the Demonstration and Phases 2 and 3 launching later in the funding period in DY2 and 3. During the Planning Grant Period, interested clinics will be invited to complete a readiness assessment to determine ability and timing to become a CCBHC. Responses will inform readiness and identify priorities for TA. The seven existing federally certified CCBHCs will be given priority for selection to be Phase 1 providers and will be in the first wave of certification. The State will provide ongoing, tailored TA to these sites to support them in preparation for State certification.

Up to 10 additional providers in each additional phase will be invited to participate in planning and eventually to seek certification as Phase 2 or 3 CCBHCs. An additional TA plan and timeline will be developed by the SC and provided for those who are interested in being in Phases 2 and 3 of the expansion. It is expected that Phase 2 and 3 providers will likely need higher levels of detailed training and support, given they are not likely to be current CCBHCs. This TA will be offered with the intent of ensuring that Phase 2 and 3 providers are well-prepared to seek certification in DY2 and DY3. TA topics may include training on timelines, certification criteria requirements, programming, disparity reduction, data collection, DCO agreements, among others.

BHA will be responsible for identifying which providers will be invited to apply for certification as a CCBHC and in which phase they will enter the program.

B.5. To aid in the transition from Planning Grant to the Demonstration, the SC will ensure all components of the Demonstration are ready to go live by the end of the Planning Grant Period. During the Planning Grant Period, the SC will develop and manage a four-year work plan that will be included as a cornerstone of the Demonstration application, ensuring all components necessary for successful demonstration are operational upon the determined Demonstration Project start date. This will include major work paths around:

- Hiring and onboarding staff for the operation of the Demonstration.
- Certification plan and process for existing and potential new CCBHCs with a strong focus on performance metrics, reporting, and measurement.
- Stakeholder engagement plan to ensure regular feedback channels are operational and effective to inform the Demonstration.
- Effective date for the PPS and details for all steps leading up to its use including, process manual updates, and training for clinics.
- Legislative requests for solidifying the state match component.
- Demonstration and national evaluation data collection processes, manuals, and methodologies.

The SC, and all associated subcommittees, will continue to operate throughout both the

Planning and Demonstration phases to ensure continuity through planning and implementation. All involved providers will have opportunities to collaborate in this process to ensure alignment between the State and Phase 1 providers so that service launch can begin according to plan.

B.6. As of July 1,2024, Comprehensive BH Safety Net Providers in CO are paid under a daily PPS encounter rate. The use of this payment model is the result of a multiyear stakeholder engagement process running in parallel with statewide BH reform efforts. The stakeholder engagement process determined that an encounter rate would allow for the flexibility needed to modify care delivery models to be more efficient and to better use limited BH resources. The model is most closely aligned with CC PPS-1. The State is well positioned to pay CCBHCs under the CC PPS-1 model via the infrastructure in place. PPS-1 also allows for the possibility of paying quality performance bonuses, which is of interest to stakeholders and the State. During their review of this application, stakeholders indicated support for exploring both PPS-1 and PPS-3 during the Planning Grant Period.

HCPF will be using the federal CCBHC cost reporting structure and will have the cost reports audited. The cost reports and reported utilization through managed care encounter and fee-for-service data will be used to derive the encounter rate. Currently, Comprehensive Providers' PPS encounter rates are calculated based on audited cost reports. While some modifications may be necessary for Colorado to align with the CCBHC cost report, the State's experience with BH cost reporting, auditing processes, and using these as an input to PPS rate setting will support the State in its success with CCHBCs. Achieving alignment between current processes and CCBHC will be a key planning activity. HCPF will be integrating CCBHC payment into the current managed care infrastructure.

Some FQHCs have identified interest in the CCBHC model as partners or as CCBHCs and will assist in exploring how to minimize duplicative cost reporting. FQHCs in CO currently have a separate BH daily encounter rate and have experience in isolating related BH costs.

B.7. Consistent with the current PPS guidance for CCBHC PPS-1, the PPS rate setting process will generate provider-specific, cost-based rates for at least the comprehensive scope of CCBHC services, and all CCBHCs will be paid this way. The provider-specific rate will apply uniformly to all CCBHC services, including those provided through direct contract agreements.

HCPF and its actuaries will use the CCBHC cost template to collect cost and daily visit information from each CCBHC, including the costs and visit information for direct contracted services, and allocation of indirect costs. The cost reports will be audited by a qualified vendor. The PPS rate for each CCBHC will be the allowable costs divided by the number of allowable encounters.

The State's actuary will evaluate national cost trends (MEI), historical cost reports for a CCBHC, and work with each CCBHC to understand local factors that would influence PPS payment period costs. This information will be used to develop trend factors for each CCBHC to adjust the encounter rate identified through the cost reporting process. The trend factor will account for patterns of cost trends identified in historical cost reports when available and as appropriate. The State and its actuary will ensure the data,

assumptions, and calculation methodology used will adhere to actuarial sound principles for the data, assumptions, and calculation methodology.

As with current cost-based rates for BH providers, the State will rebase rates annually using the prior year's cost experience. The rebased rates will be adjusted for trends consistent with actuarially sound principles as described above. This will align with both the CMS annual update and rebasing requirements.

B.8. Collaboration and input from persons/family with lived experience is a primary focus of CCBHC Planning, implementation, and ongoing operations. The State already requires that existing comprehensive community BH providers have strong representation from people with lived experience accessing services for MH/SUD or be parents who have supported their children in accessing these services.

The CCBHC SC will design formal policies to direct the establishment and maintenance of a statewide CCBHC governance board. Within this guidance will be specific requirements regarding the percentage of members with direct lived experience, those who are parents of those who have sought treatment services, those who are people in recovery, those who are members of the POF, and relevant community partners.

In addition to the CCBHC State governance board, all CCBHCs will be required to have local advisory boards whose responsibility is to collaboratively inform the implementation and ongoing development of their local CCBHC and its programming and outreach. The advisory boards will meet at least quarterly and will provide input regarding Community Needs Assessments, programming, outreach, local partnerships, and CCBHC CQI. The SC will determine and offer guidance regarding the membership makeup of the advisory boards including guidance regarding members who are consumers of services, family members who have helped a loved one navigate care, persons in recovery, and members of the POF.

B.9. The success of the CCBHC model is largely dependent on ongoing feedback from, and communication with consumers, family members, providers, and other stakeholders including American Indian/Native Alaskans. To date, HCPF and BHA have informed clients, providers, and stakeholders about the intent to pursue the Planning Grant and will continue that practice throughout the Planning and Demonstration Grants. Over the past several months, the State has held several stakeholder engagement sessions to ensure consumer and provider input informs the Planning Grant application.

HCPF and BHA are committed to ensuring that the CCBHC planning and demonstration approaches are informed by **meaningful input by consumers, persons in recovery, and family members.** The foundation for this input is already in place through several initiatives already utilized by HCPF and BHA as described in Table 2.

Table 2: Initiatives for gathering meaningful input

Group	Agency	Description
BHA Advisory Council (BHAAC)	BHA	● Members: people with lived experience ● Purpose: Public accountability, accountability,

		transparency regarding BHA activities ● Legislatively codified, launched 2022
The Member Experience Advisory Council (MEAC)	HCPF	● Members: Current Medicaid or Child Health Plan *Plus* (CHP+) clients or parent/caregivers of clients ● Purpose: Engaging clients and family members of Health First Colorado and Child Health Plan *Plus* (CHP+) to improve client experience and deepen person and family-centered practices and culture ● Childcare, transportation costs, and stipends are offered for participation
Program Improvement Advisory Committee (PIAC)	HCPF	● Members: members, providers, managed care staff, community partners ● Purpose: engaging stakeholders and obtaining guidance on how to improve the health, access, cost, and satisfaction of clients and providers ● Monthly statewide program improvement meetings

Per State statute, BHAAC will have Regional Advisory Councils reflecting the concerns and needs of each region of the State. Membership of the regional subcommittees must include:

- At least one individual with expertise in the BH needs of children and youth.
- At least one individual representing a BH safety net provider that operates within the region.
- A county commissioner of a county situated within the region.

The Stakeholder Engagement (SES) and Communication Subcommittees (CS) will be responsible for ensuring that consumer and provider voice and preference is present for all stages of the Planning and Demonstration Periods and throughout the ongoing operations of the CCBHC model in CO.

These subcommittees will meet regularly throughout the Planning Grant Period to create meaningful strategies for ongoing two-way communication regarding development and implementation of CCBHC. This communication and feedback will inform activities, changes, and processes related to the project. **The Stakeholder Engagement Subcommittee will be comprised of at least 51% people with lived experience as a consumer or family member.**

The SES and CS will work together to ensure that communication regarding CCBHC planning and implementation is widely disseminated, especially to the existing State committees in Table 2 that engage feedback from those with lived experience. These groups will also be invited to participate in feedback and input sessions held during the Planning and Demonstration Periods to ensure that client voices are represented. Feedback opportunities will include written surveys and forms, in-person and virtual events, meetings outside of work hours, and reimburse attendees for their time and effort within allowable policy.

Clients, persons with lived experience, family members, providers, and other stakeholders, including American Indian/Native Alaskans, can be members of BHAAC, MEAC, and PIACs. The four standing committees and their subcommittees will provide a space

where CCBHC Planning Grant activities can be shared consistently. It will be the responsibility of these groups to disseminate information learned to key stakeholders in their communities. Input received from these listening activities will be shared with the SC to be incorporated into planning and implementation of the CCBHC model.

The State held CCBHC Planning Grant webinar in December 2023 and in July, August, and September 2024 that provided an opportunity for providers and stakeholders statewide to learn about the CCBHC model, to hear why HCPF and BHA are pursuing this grant, and to promote interest throughout the State. The State agencies have also presented to the Interagency BH Council for the State's Cabinet on the CCBHC, presented to State legislators, created a State-specific fact sheet, met with multiple existing and CCBHC providers, and met with other CCBHC Demonstration grant states to inform the Planning Grant application. **C.1.** Colorado has been exploring the CCBHC model since 2015 and has implemented significant transformations to the State's BH system designed to align with the evidence-based,

nationally-supported CCBHC model. Multiple BH reform initiatives have been supported through legislation, including the statutory expansion of the behavioral health safety net in 2019. In addition, State Opioid Response and ARPA funds supported the expansion of SUD screening, treatment services, and recovery supports. Below is a description of those reforms and other actions the State has taken to develop a CCBHC model.

- HCPF and BHA are collaborating to develop a BH quality framework which includes some CCBHC measures.
- BHA and HCPF invested in workforce training programs for Qualified BH Aides, Community Health Workers, Peer Support Professionals and those providing High Fidelity Wraparound for children and youth.
- HCPF voluntarily collects and reports on CMS Core Measure Sets for Adults and Children.
- HCPF and BHA worked with stakeholders to develop alternative payment methodologies and value-based payments for BH safety net providers that are currently being implemented. The goals of this effort are to enhance the sustainability of safety net providers, increase payment levels for providers delivering core safety net services, improve BH care quality, incent providers to participate in the new provider type approvals, and expand the access to safety net services. Comprehensive Providers receive cost-based PPS.
- BHA established new and revised safety net provider types with revised rules for licensure and approval designations. These provider types expand the number of providers delivering core safety net services. Comprehensive Safety Net Provider and Essential Safety Net Provider types standardized the services providers need to deliver and raise quality expectations and have set the stage for alignment with CCBHC criteria. This regulatory framework is similar to the CCBHC model.
- HCPF and its BH providers have many years of experience with capitated reimbursement. This experience gives Medicaid administrators, providers, and key partners a depth of knowledge about rate setting, transparency, accountability, and feedback.
- The basis of HCPF's managed care program, called the Accountable Care Collaborative (ACC), has been in existence since 1995. HCPF will be awarding new managed care contracts in July 2025. RFP requirements include use of the PPS model, expanded access to intensive outpatient services, and support of providers

in expanding capacity to meet safety net requirements which are based on the CCBHC model.

- The CO Legislature passed House Bill 22-1302 in May 2022 with the goal of supporting, improving, and expanding integrated BH services in CO. HCPF distributed $31M in ARPA funds for integrated BH services in primary care settings. These integrated care expansions will be crucial for CCBHC implementation, for both CCBHCs and DCO partners.
- HCPF invested over $50M in provider grants, through ARPA funds, to promote AI/AN health, children and youth wraparound services; intensive outpatient services; crisis care; and transition services.
- HCPF and BHA partnered to align CO's mobile crisis response with the federal standards.
- CMS approved CO's 1115 SUD waiver, effective through December 31, 2025, providing the State with authority to deliver clinically appropriate treatment, in accordance with the full ASAM continuum, to members with SUD. Colorado is in the process of completing a renewal package, along with two pending amendments, to expand services to include MH IMD stays up to 60 days, re-entry services for members leaving incarceration, and health-related social needs, including housing and nutrition services. In addition to services, eligibility expansion is being requested to include continuous coverage for children from birth through three years as well as 12 months of coverage for those leaving incarceration.
- Seven clinics are currently receiving CCBHC grant funding. While preparing this Planning Grant application, HCPF and BHA met with each, as well as other key stakeholders, to get feedback on applying for the Planning Grant and adopting the CCBHC model statewide.
- HCPF and BHA hold a CCBHC Stakeholder Forum, which meets every two weeks. The forum is to strengthen collaboration and partnership with BH providers, care centers, and advocates from across CO, as HCPF prepared this Planning Grant application. The forum will continue as a space for all stakeholders to provide updates, lessons learned, challenges, and ideas informing CO's CCBHC demonstration grant application and CCBHC structure.
- Colorado has been collaborating with SAMHSA, CMS, the National Association of Medicaid Directors, and State agencies in Maine, Missouri, Nevada, and Minnesota to ensure that adoption of the CCBHC model in CO goes smoothly, with special focus on integrating the model with our existing managed care system.

C.2. The Memorandum of Agreement lists major roles and responsibilities of BHA and those of HCPF. The document also contains BHA and HCPF shared responsibilities with a focus on strong cross-agency communication and a shared commitment to working in a coordinated fashion to meet the grant requirements and deliverables. The team will also work together to obtain client, family members and other stakeholder input regarding the CCBHC program development, implementation, and monitoring at the state and local levels. HCPF will serve as the primary point of contact with SAMHSA and CMS. HCPF will also lead the development and approval of the PPS and provide insight on CMS requirements as they relate to CCBHC, managed care, and payment. BHA will lead the development of regulatory policies and procedures to certify clinics as well as lead the development of data reporting, collection, and sharing strategies. BHA will provide feedback to HCPF regarding all clinical aspects of

the grant. Both BHA and HCPF are committed to a successful Planning Grant year that will transition into a successful Demonstration period. Numerous stakeholders have written letters of commitment in support of CO's application for CCBHC planning funds. The letters of commitment and support are described in the tables below.

Table 3: Colorado CCBHC Letters of Commitment

Organization	Description	Commitment to Projects
Colorado Department of Human Services, Office of Civil and Forensic MH	State agency serving people who are at the intersection of the criminal justice and BH systems	Technical support and consultation, post-discharge referral, and coordination for justice-involved individuals
Valley-Wide Health Systems	FQHC	Technical support and consultation, integrating whole person health services, establishing partnerships with local partners
Mental Health Colorado Aurora MH and Recovery	Advocacy organization Federally Certified CCBHC	Represent those with lived experience as part of the planning and demonstration processes Provide CCBHC services upon certification
Colorado BH Council	Provider Organization	Participate in planning process, support CCBHC in legislature
Jefferson Center	BH Provider	Services for veterans, LGBTQ+, and Spanish language/culturally responsive care for Hispanic/Latino clients
Sol Vista Health	Federally Certified CCHBC	Provide CCBHC services upon certification; specialized focus of adolescents with low socioeconomic status, LGBTQ+ adolescents, LatinX/Spanish speaking adolescents.
Centennial MH Center	BH Provider	Seek CCBHC certification and focus on service delivery to BIPOC individuals across the lifespan, including Hispanic/Latino, Black/African American, American Indian/Native/Indigenous, and LGBTQ+ populations.
Colorado Office of Civil and Forensic MH	State Agency overseeing inpatient MH and	Participate in planning process

	Forensic Services	
Diversus Health	BH Provider	Seek CCBHC Certification
Colorado Provider's Association	BH Trade Organization	Participate in planning process
Valley-Wide Health Systems, Inc.	FQHC	Participate in planning process

Table 4: Colorado CCBHC Letters of Support

Organization	**Description**	**Commitment to Projects**
All Health Network	BH Provider	Seek certification as CCBHC
Health Solutions	Physical Health and BH Provider	Participate in planning process
San Luis Valley BH Group	BH Provider	Seek CCBHC certification; Provide culturally responsive care to Hispanic/Latino, Black/African American, American Indian/Native/Indigenous populations, justice-involved adults, adolescents, and the LGBTQIA+ community
Axis Health System	CMHC, FQHC, Federally Certified CCBHC	Apply to be CCBHC, focus on Latino/Hispanic population, LGBTQIA+, Veterans, Adults with SMI/SUD
Sarah Parady	Denver City Council Member	Offer support of SUD reduction efforts
Javier Mabrey		entative Offer support for CCBHC tion efforts
Mental Health Colorado		Group Offer advocacy support for ementation
Wellpower	BH Provider	Seek CCBHC Certification

Steven L. Woodrow		entative Offer support for CCBHC tion
SEIU Local 105	Healthcare Union	Offer support for CCBHC implementation

In addition, several organizations have registered in support of the Colorado CCBHC legislation, HB24-1384, which supports the submission of the Planning Grant. The organizations include NAMI, Inseparable, Silver Key, Harmony Foundation, Children's Hospital, Denver Health, and the Fraternal Order of Police.

C.3. Melissa Eddleman will serve as the Project Director. Melissa holds Master of Public Administration, Master of Social Work, and Bachelor of Social Work degrees with over 20 years of experience in the BH field. As the HCPF BH Policy and Benefits Division Director, she provides leadership, strategic direction, and project management support for all BH policy and benefit development and implementation for the State's Medicaid and CHP+ programs. Her experience as a clinician has given her opportunities to supervise CQI efforts, coordinate care with other community-based providers, and work across multiple systems providing services and supports across the lifespan to veterans, justice-involved individuals, and BIPOC communities in both urban and rural communities. She will coordinate with and have access to State decision-makers responsible for making the necessary decisions and commitments to implement a CCBHC demonstration program. Melissa reports to Cristen Bates, Senior Executive and Director of the Medicaid BH Initiatives and Coverage Office. Melissa's second level director is Kim Bimestefer, HCPF Executive Director and member of the Governor's Cabinet. Melissa will be responsible for overseeing and managing all grant-required activities and deliverables. Melissa will coordinate the activities of the HCPF cross-office CCHBC team, manage contractors, communicate with internal and external partners, including HCPF leadership and directly with the SAMHSA Grant Project Officers, and ensure coordination with BHA. In addition, she will participate in at least 70% of all stakeholder engagement opportunities and lead the successful transition from the planning year to the Demonstration Period.

The table below lists the additional key personnel who will be supported by the grant.

Table 5: Key Personnel Supported by the CCBHC Planning Grant

Role, Name	Effort	Qualifications & Experience
HCPF CCBHC Grant Administrator, Phoebe Hawley	100%	● Bachelor of Science degree in human development and family studies ● Master's degree in health care administration ● Certificates in Gerontology and dementia care ● 27 years of experience in a variety of health care roles ● Clinical services management and outreach program management experience, including tracking, monitoring, and reporting outcomes ● $115M in ARPA grant management expertise, including documentation of project status, risks, issues, and decisions, workflow guidance, and team communications
BHA CCHBC Grant Administrator, New Hire	100%	● Seven total years of professional experience in health care, grant management, project management, community or health care-based programming, or an occupation field closely related. OR ● Bachelor's degree from an accredited institution on social work, health care administration, public health or a field of study related to the work assignment AND three years of professional experience administering a grant, project managing, behavioral health care operations, or an occupational field closely related.
BHA CCBHC Data Analyst, New Hire		Six (6) years of relevant experience in behavioral health data analysis, data collection and reporting, and the calculation and oversight of performance measurements. OR ● A combination of related education and/or relevant experience in behavioral health data analysis, data collection and reporting, and the calculation and oversight of performance measurements equal to six (6) years.

Phoebe Hawley will serve as the HCPF CCBHC Grant Administrator. Phoebe will assist the Project Director in defining, planning, documenting, managing, and monitoring the project scope of work, the project schedule, procurements, budget, risks, issues, quality, decisions, communication needs, and resource requirements. She will participate in

all portions of the CCBHC Planning Grant, designated workgroups, and meetings that will lead to the drafting a CCBHC Demonstration application. Phoebe will serve as a liaison and resource for the program with both internal and external stakeholders through the Planning Grant Period and will manage the CCBHC reporting system upload and other reporting requirements for the team in eRA Commons.

A full time equivalent **CCBHC Grant Administrator** will be hired by BHA. This person will assist the BHA team with project management practices related to the implementation of the CCBHC model with a focus on BHA areas of responsibility including data collection, quality metrics, outcome tracking and certification standard development. They will participate in all portions of the CCBHC Planning Grant, designated workgroups, and meetings that will lead to the demonstration grant metric design, certification process, and outcomes tracking. This includes identifying resource requirements, and contractual needs for a multi-year demonstration. They will serve as a liaison and resource for both internal and external stakeholders through the Planning Grant Period and facilitate conversations that will be used to design the certification and data collection processes.

A full time equivalent **CCBHC Data Analyst** will be hired by BHA. This person will serve as the lead CCBHC data analyst and will be responsible for overseeing the development of the data collection process and the oversight and calculation of CCBHC performance measurements. In addition, this person will oversee training and technical assistance related to provider data quality and reporting standards, identify and report on trends and areas of opportunities for quality improvement and monitor data to ensure CCBHC goals and outcomes are being met.

HCPF and BHA will leverage a team of existing leadership and subject matter experts within their current roles to support the CCBHC Planning and Demonstration. The grant will have two senior executives that sponsor all selections made for payment models and data collection and will review all stakeholder analyses used to formalize work for the demonstration period. **Cristen Bates, Medicaid Behavioral Health Initiatives and Coverage Office Director, and the deputy Medicaid Director will provide senior executive oversight of the Planning Grant on behalf of HCPF.** Cristen has over 20 years of experience as a public health professional and policy advisory at the federal, state and local levels, including leading statewide policy and strategy for BH reform, the opioid crisis and serving CO's most vulnerable populations, including veterans, seniors and those with SMI and SUD. Cristen, as a person with lived family experience, also was the lead on CO's statewide anti-stigma campaign and previously worked in Washington D.C. training providers on how to engage consumers in quality and governance in health care. **Erin Wester, BHA Deputy Commissioner, will provide senior executive oversight of the Planning Grant on behalf of BHA.** Erin has experience as a direct service provider and is a seasoned BH care administrator who has provided oversight of a SAMHSA CCBHC Implementation Grant and was responsible for activities associated with the four-year implementation of the federal criteria. Cristen and Erin, in addition to those identified below, will support this effort at no additional cost and at 5% of their time.**Thom Miller, Division Director of Quality and Standards** at BHA, will oversee all work leading to new Certification of CCBHC standards in CO. He will manage the contractor completing the work and ensure it aligns with CCBHC standards and finalize the implementation plan during the demonstration period as it relates to certification.**Janell Schafer Cody, Acting Division Director of Technology and Data** at

BHA, and **Jordan Bass, Director of Data Science**, will create the data reporting process alongside the HCPF data team to design a cross-agency data reporting system for the demonstration grant period. They will provide oversight and work collaboratively with the BHA CCHBC Data Analyst to identify data currently available, data sharing needs to finalize prior to the demonstration and the roles and responsibilities across the two agencies to ensure all methodology is sound and standard reporting can occur. **Meghan Shelton, Division Director of Intergovernmental and Community Engagement** at BHA, will incorporate the planning year's stakeholder engagement plan into her team's interface with the BH Council and existing CCBHCs' stakeholder feedback loops. She will be responsible for ensuring the voices of those with lived experience are incorporated into the implementation plan. Meghan and her team will incorporate opportunities for limited English proficient individuals to participate and provide feedback. Meghan has over 20 years of experience in BH and has served on multiple advisory boards and steering committees that have focused on improving BH care for children, youth, and families in CO. **Steven Ihde, Deputy Director of Managed Care and Financial Review** at HCPF, will oversee the actuary contractor and general payment model implementation design for the new payment model. Steven's experience and expertise includes overseeing HCPF's managed care rate setting process, implementation of the State's payment reform initiatives, and

collaboration with providers, MCEs, and federal and state partners.**Jennifer Holcomb, Behavioral Health Benefits Section Manager** at HCPF, will provide subject matter expertise and oversee the development and implementation of policies and guidance related to CCBHC services and benefits. Jennifer has more than 30 years of experience spanning research and organizational management as well as direct service provision to vulnerable populations.**Sally Langston, Director of Data Analytics** at HCPF, will share oversight and coordination responsibilities related to all CCBHC data-related requirements, including support for the BHA data analyst. Sally has 23 years of Medicaid analytics experience, 19 of which include specific expertise in BH and currently leads a team of analysts who provide analysis, reporting and data visualization products to manage HCPF's $16B budget.**Carly Donohue-Torres, Behavioral Health Alignment Advisor** at HCPF, currently serves as a CCBHC subject matter expert and will assist the Project Director and the CCBHC Grant Administrators with coordination across BHA and HCPF offices and divisions and perform contractor management and oversight functions.

D.1 Colorado is well-positioned to participate in the CCBHC program and leverage existing resources to meet SAMHSA data collection, management, analysis, and reporting program requirements. As described in more detail above, the state of CO has made significant strides to bolster the state's BH and whole-person care systems. These infrastructure investments include the establishment of strong BHA and HCPF quality and data analytics teams, cross-functional operations protocols, technology and data system modernization, and transparent data reporting efforts.

HCPF and BHA have experience with collecting and reporting on the majority of the required CCBHC quality measures. Colorado has a long history of collecting and reporting quality data to meet federal program reporting requirements, such as the Medicaid Core Sets and SAMHSA SUD and MH block grants. Existing system infrastructure exists to submit accurate and timely data to federal systems, including the Transformed Medicaid Statistical Information System (T-MSIS), SAMHSA's Performance Accountability and Reporting System

(SPARS), and the Universal Reporting System (URS), as well the use of data collection tools such as the Government Performance and Results Act (GPRA) and the National Outcome Measure System (NOMS). Colorado also has experience submitting data via custom program worksheets, such as those required by SAMHSA for CCBHC measure reporting. Altogether, HCPF and BHA have developed an infrastructure that can scale to collect and report required state measures for populations served by CCBHCs. HCPF and BHA are able to stratify quality measures as required in measure specifications, including age, race, and ethnicity, as well as stratifications of interest, including sex, disability status, and geographic location (i.e., urban, rural, frontier). During the Planning Grant Period, HCPF and BHA data and analytics teams will work to scale infrastructure to capture and report on the required measures not yet built into existing systems, as well as ensure stratification by payer is possible for all measures. The Planning Grant Period will be used to identify any additional quality measures and measure stratifications of interest for state- and clinic-level reporting and monitoring of State and POF set CCBHC goals.

HCPF and BHA currently can calculate most State- and clinic-level quality measures at the clinic level using unique identifiers usingNPI numbers. This ability is due to HCPF and BHA access to a wide variety of data sources, including T-MSIS (paid and unpaid Medicaid claims), claims for the uninsured and underinsured individuals covered by BHA, enrollment data, survey data (e.g., the Mental Health Statistics Improvement Program (MHSIP) and the Youth Service Survey for Families (YSS-F)), state registry data, state HIE data, vital statistics data, and EHR

data from some current and prospective CCBHCs. During the Planning Grant Period, HCPF and BHA will work together to identify existing gaps in required data necessary to calculate all measures for individuals served by the CCBHC model. HCPF and BHA will also examine existing sampling and protocol processes and procedures for the Patient Experience of Care (PEC) and Youth/Family Experience of Care (Y/FEC) surveys, which are currently administered by the BHA to satisfy SAMHSA MH block grant criteria, to meet CCBHC survey measure criteria.

D.2. The Planning Grant Period will be used to establish supportive performance measurement and quality improvement processes, procedures, and resources at the State level to assist current and prospective CCBHCs with successfully implementing the CCBHC model and positively impacting health outcomes for people of CO. CO has already undertaken several foundational steps to understand existing quality data infrastructure, collection, sharing, and analytics capacity of existing and future CCBHCs.

HCPF recently completed a series of interviews with 17 community mental health centers (CMHCs) across the state, of which seven were currently participating in the CCBHC Expansion Grant program and eight were interested or prospective CCBHC sites. These interviews highlighted a few areas where CCBHCs will benefit from tailored state support and investment, including support for improvement to data sharing and interoperability practices and systems, data feedback loops and benchmarking across clinics within the state participating in the CCBHC program, technical assistance and collaboration across both state entities and CCBHCs, staffing and training support, and IT infrastructure funding and support. Additionally, CO has embarked on a series of State-wide CCBHC Stakeholder Forums to solicit input from providers, clinics, state entities, and others on what resources

are needed to successfully implement the CCBHC model within the State.

HCPF and BHA have vast experience assisting and supporting providers with building and maintaining performance measurement and CQI infrastructure and processes via BH licensing rules and service delivery contracts. Colorado will use the Planning Grant Period to expand a robust training and technical assistance program for CCBHCs and prospective CCBHCs. This will include education and training for providers and clinic staff on quality measure requirements, data infrastructure and exchange best practices, quality improvement requirements, and data-driven quality improvement and clinical decision-making best practices. Additionally, during the Planning Grant Period, a structure for regular State/CCBHC quality oversight meetings and reports will be developed. These will be used to ensure constant communication between the State and CCBHCs and open forums for feedback and requests for support. Finally, as described in detail above, during the Planning Grant Period, the State will stand up multiple CCBHC Steering Committee subcommittees and Regional Advisory Councils. These groups will include stakeholders, such as those with lived experience, consumers, family members, local government, managed care entities, and providers. This will ensure a strong feedback loop exists between individuals and communities served by CCBHCs, CCBHC providers and staff, managed care behavioral health plans, and the state. The groups will meet regularly and have processes and procedures for identifying opportunities for state support of CCBHCs.

D.3. HCPF and BHA are committed to meeting all reporting requirements of this Planning Grant, including collecting and submitting all data outlined in Section 1-5 of the SAMHSA CCBHC NOFO. Infrastructure Development, Prevention, and Mental Health Promotion (IPP) indicator data to be collected and submitted to SAMHSA quarterly, via SPARS, include the number and percentage of work group, advisory group, and council members represented by consumers or family members; the number of organizations collaborating, coordinating, or sharing resources with other organizations as a result of the CCBHC award; the number of organizational changes made to support improvement of mental health related practices and activities consistent with the goals of the CCBHC grant; and the number of people in the mental health and related workforce trained in MH-related practices and activities consistent with the goals of the CCBHC award. HCPF and BHA will submit quarterly Programmatic Progress Reports (PPRs) to describe progress on required and planned activities, barriers and challenges encountered to-date, and strategies for overcoming named obstacles. Within the first 60 days of the Planning Grant Period, HCPF and BHA will come to a consensus on how to monitor the impact of the CCBHC program on BH disparities outlined in our final Disparity Impact Statement. HCPF and BHA will submit data on all required State- and clinic-level quality measures annually, via the SAMHSA-provided worksheets. The Planning Grant Period will be used to develop processes, procedures, and infrastructure to support all reporting requirements.

D.4. HCPF and BHA have begun the work to identify and proactively address potential challenges related to collecting data required for the national CCBHC evaluation. Through these proactive steps, several potential challenges have been identified and will be addressed during the Planning Grant Period. First, through interviews with current and prospective CCBHCs, we have learned that analytic and support team staffing, and technology costs are the top challenges faced by practices. Colorado is focused on developing a robust education and technical assistance program to assist these practices.

During the Planning Grant Period, HCPF and BHA will design a comprehensive suite of supports, including schedules for regular quarterly support meetings, liaison assignments for state/CCBHC one-on-one assistance, technical trainings on CCBHC measurement and reporting requirements, technical trainings for quality improvement requirements and reporting, and quality improvement resources. The State will also consider opportunities for cross-CCBHC sharing of best practices and collaboration, to promote system-wide learning and model adoption. BHA is also conducting research related to understanding current pain points in provider data collection and submission and will be rolling out a condensed data model alongside technology modernization efforts to reduce time spent on administrative burden.

Regarding resourcing, the state is working to provide support to providers by investing in innovative models to split or share employees and resources across CCBHCs and contract with short-term vendor experts to supplement planning activities. Further, the State will use the Planning Grant Period to continue to explore technological advancements to improve data sharing, efficiency, and capacity for CCBHCs and the safety net. One of these possible areas for exploration is the Social Health Information Exchange (SHIE) currently being developed and implemented by Colorado's Office of eHealth Innovation (OeHI), which through its unifying architecture will establish a data sharing infrastructure and framework that exchanges data across sectors and silos to enable the delivery of data-driven, responsive whole-person care and aid in quality monitoring and reporting.

Another anticipated challenge is joining data from various payer sources at the State level. HCPF and BHA are currently partnering to build a quality framework to support population health goals and create alignment and coordination across quality measurement and improvement activities across the State. The Planning Grant Period will be used by HCPF and BHA to establish processes, procedures, workflows, and infrastructure to ensure all necessary

data for quality measurement and improvement purposes is joined together to provide a comprehensive picture of quality at the CCBHC level, regardless of payer.

D.5. HCPF and BHA both collect and maintain a significant amount of administrative, enrollment, registry, and patient experience survey data from contracted entities, including CCBHCs and prospective CCBHCs. Specific CCBHCs can be identified in data via unique identifiers and NPI to ensure both clinic-level and State-level quality measures are reported at the clinic level. Further, HCPF is beginning to receive patient clinical data for physical health services from provider EHRs (data exchanged through CCDs via HIEs). These data are used to supplement claims data in administrative reporting of CMS Adult and Child Core Measures and are anticipated to be an important data source for CCBHC reporting as well. A key challenge is Colorado's HIE and its affiliates do not support BH data models in the same manner as physical health data models at this time. BHA, HCPF, and OeHI are involved in exploring implementing a BH data model to fill this gap while also continuing to engage with Colorado's HIE and its affiliates on advancing future support for BH health data exchange. The Planning Grant Period will be used to ensure both HCPF and BHA have supportive infrastructure in place to calculate all State- and clinic-level required quality measures and ensure required stratifications are possible.

HCPF has a long history of synthesizing data from multiple sources to meet continued

needs to understand how the payment of services relates to client outcomes for those with Medicaid. Both HCPF and BHA have strong analytic teams to support quality data collection, maintenance, and oversight practices and currently report required quality data to federal partners. HCPF and BHA have taken significant steps to enhance collaboration to produce a cross-payer data strategy and public-facing performance monitoring system called the Performance Hub. The Performance Hub is intended to measure performance on the accessibility and quality of behavioral health services regardless of payer source, demographics, or region. BHA is currently working to reduce data fragmentation through secure data sharing and centralized data systems that will bring together data from across an individual's care team following client consent. During the Planning Grant Period, HCPF and BHA will continue to work with current and prospective CCBHCs to understand existing challenges and limitations of data collection and exchange for the purposes of CCBHC quality reporting and improvement.

Colorado 2025 CCBHC Planning Grant Narrative Citations

[1] https://data.census.gov/profile/Colorado?g=040XX00US08

[2] https://www.coloradohealthinstitute.org/research/2023-chas-lgbtq-health#:~:text=Nearly%2040 0%2C000%20Colorado%20adults%20identified,8.9%25%20of%20the%20adult%20population.

[3] https://www.samhsa.gov/data/data-we-collect/mh-cld-mental-health-client-level-data

[4] https://www.coloradohealthinstitute.org/sites/default/files/2024-02/2023%20Colorado%20Health %20Access%20Survey.pdf

[5] https://www.kff.org/statedata/mental-health-and-substance-use-state-fact-sheets/colorado/

[6] https://drugabusestatistics.org/teen-drug-use/#colorado

[7]https://datacenter.aecf.org/data/tables/10668-children-who-have-one-or-more-emotional-behavioral-or-developmental-conditions?loc=7&loct=2#detailed/2/7/false/2043,1769,1696,1648/any/20457,20456

[8] https://drive.google.com/file/d/1c7KRvR19bcAPlEidmI1ynxWBs2m-U7b6/view

[9] https://cdhs.colorado.gov/2020-behavioral-health-needs

[10]https://www.google.com/url?q=http://www.copulsepoll.org/sites/default/files/2022-06/HealthAccess-MentalHealth_FactSheet_Pulse_FINAL_ENGLISH.pdf&sa=D&source=docs&ust=1725476021974536&usg=AOvVaw1dzDzN9yf3mrwMVc-JytTp

[11] https://drive.google.com/file/d/1c7KRvR19bcAPlEidmI1ynxWBs2m-U7b6/view

[12]https://www.prisonpolicy.org/profiles/CO.html#:~:text=Colorado%20has%20an%20incarceration%20rate,incarcerated%20in%20Colorado%20and%20why.

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[14]https://eprints.lse.ac.uk/15227/1/__lse.ac.uk_storage_LIBRARY_Secondary_libfile_shared_repository_Content_Campbell%2C%20C_Campbell_Community_%20health_%20psychology_Campbell_Community_%20health_%20psychology_2004.pdf

[15]https://eprints.lse.ac.uk/2587/1/Health%2C%20community%20and%20development%20%28lsero%29.pdf