Colorado System of Care (CO-SOCs) Implementation Plan Overview

Agenda

Detailed review of what is in the Implementation Plan.

- Introduction of Suzanne Fields
- Brief reminder of what is in the Settlement Agreement
- High level review of Plan layout
- Walk through the sections of the plan.
- Crosswalk of Settlement Agreement and System of Care

Implementation Plan

What Plan IS and IS NOT

- Is a strategic systems design
- Is a commitment to a framework and types of services
- Does cover all elements of the Settlement Agreement
- Is based on evidence based and best practices
- Is consistent with System of Care designs in other states
- Is designed with the aim of meeting the needs of families

- Not a budget document
- Not a regulations document: any policy recommendations are suggestive
- Not a practice or protocol manual
- Not final reflective of final decisions as it will evolve over time and committee meetings

Plan Structure

System of Care

- Pathways to Care
  - Referral process
- Intensive Services
  - Assessment, Intensive care coordination, Stabilization services, Treatment, Supports, Consultation Services
- Standards and Roles
  - Transition points
  - Timeliness
  - Agency Roles
- Workforce
  - Development and qualifications

Operations

- CQI
  - Dept Oversight & Role
- Phased Rollout
  - Phase 1
  - Future Phases
- Communications
  - Member outreach
  - Provider Outreach
  - Public Relations
  - Advisory Committees
- Budget
  - Existing Funds
  - Rate setting considerations
  - Workforce Capacity

APPENDICES

Section 1.
Executive Summary

Section 2. Background

Definitions
Settlement Overview

Plan Requirements

Develop a model and plan for delivering Intensive Behavioral Health Services articulated in an Implementation Plan and include designing and implementing

1. A systematic approach to provide medically necessary Services
2. A provider outreach plan to educate Medicaid providers regarding the availability of periodic and inter-periodic mental health screenings and the availability of services.
3. A standardized assessment process for identifying which Members qualify for services
4. Tiers of care coordination, including intensive care coordination
5. Strategies that support individual plans of care in the least restrictive setting
6. Procedures to avoid unnecessary emergency room services, hospitalizations and out-of-home placements
7. Data collection, tracking, monitoring, and quality assurance system

Section 3.
System of Care (SOC)

Eligibility & System of Care Components

Eligibility

1. Members who are under the age of 21,
2. 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
3. Eligible Members must meet medical necessity criteria
4. Members will not be excluded based on their disability or any other diagnosis

System of Care Components

Identification Tool

A tool to determine who needs an assessment.

Enhanced Standardized Assessment (ESA)

ESA, which includes the CANS, to uniformly determine a child's needs and service type.

Enhanced Intensive Care Coordination

Hands-on care coordination with high-fidelity wraparound intervention and progress monitoring.

In-Home Stabilization Services

Intensive short-term in-home services and ongoing supports for those in crisis system or EDs.

Enhanced In-Home Intensive Treatment

Evidence supported behavioral health intensive, frequent intervention in the home

Support Services

Long-term in-home services to meet the support needs of children and family and therapeutic mentoring.

Behavioral Services

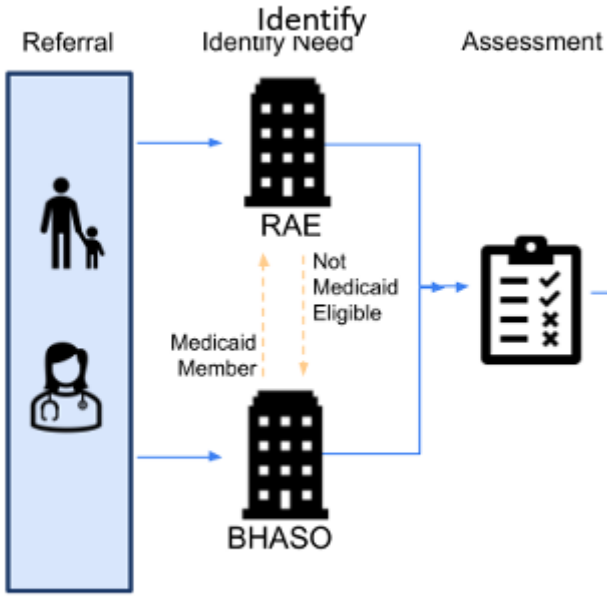
Behaviorist e-consult via doc-to-doc consultation from a behavior specialist to treating provider.

Pathways to Care

Referrals
Access
Identification Tool

Referrals

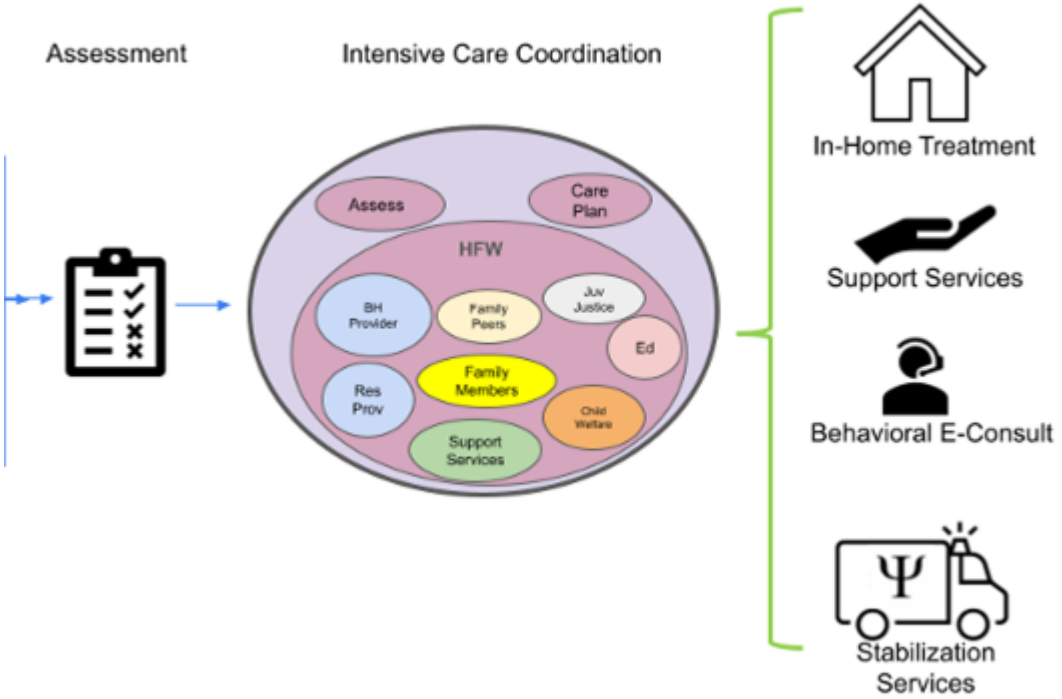
Examples of referral sources include, but are not limited to:
● Family and/or Self ● County Child Welfare ● Integrated Behavioral Health Primary Care Providers ● Non-Behavioral Health Primary Care ● Case Management Agencies ● Crisis System Hotline ● Residential Treatment Providers ● Schools ● Juvenile Justice System ● Emergency Departments ● Urgent Care ● Behavioral Health providers ● Youth Detention ● Youth Commitment



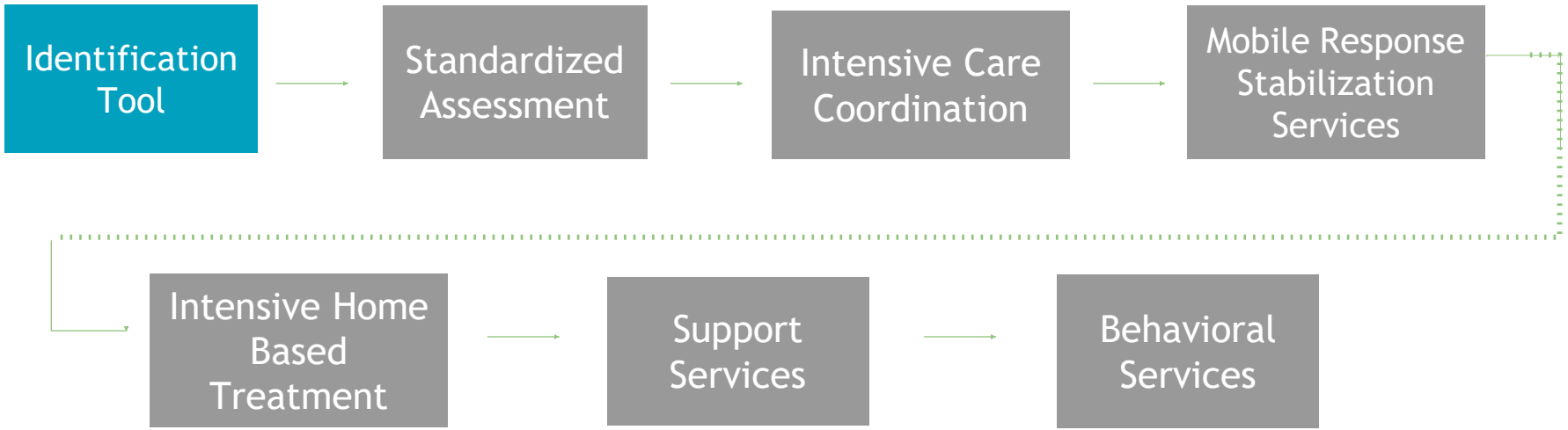
Access

1. If a Member is identified as needing a more thorough assessment (via the Enhanced Standardized Assessment (ESA)) the RAE will connect the Member with a provider.

2. The RAE will assign an intensive care coordinator to coordinate the necessary in-home treatment, mobile crisis response, support services, and/or e-consultation.



Identification Tool



Identification Tool

- Identification tool will allow RAE to identify those families that will benefit from receiving the standardized assessment. Referrals for Identification Tool can come from many sources.

- The RAE will use a standardized tool to create pathway to a full assessment to determine the child and families' treatment needs.

Intensive Behavioral Health Services

Enhanced Standardized Assessment

Intensive Care Coordination

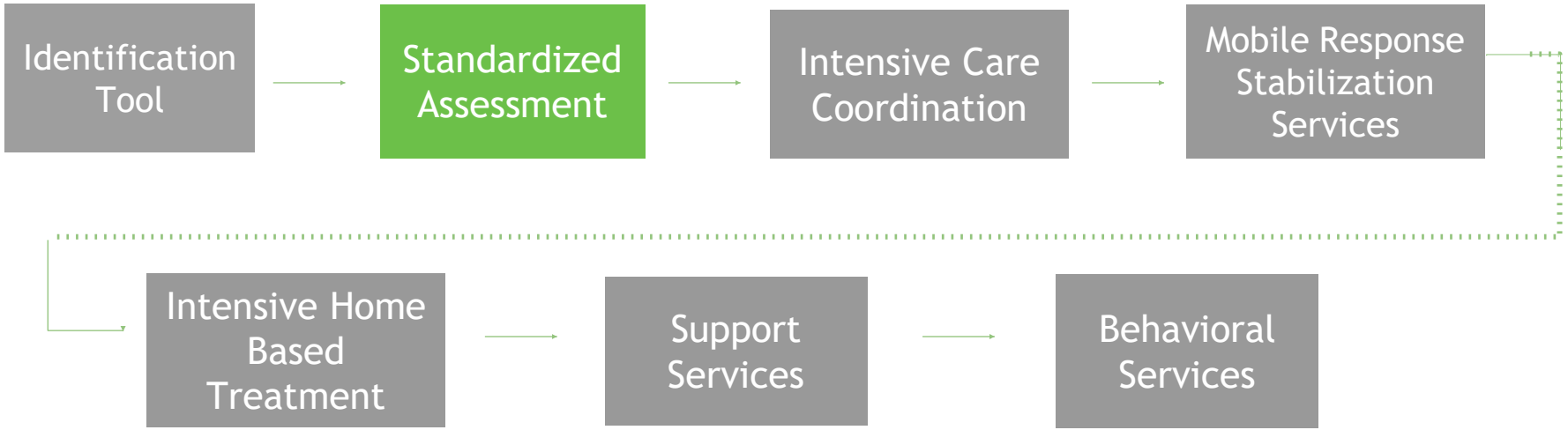
Crisis Mobile and Resolution Services

Intensive Home-Based Treatment

Support Services

Behavioral Consultation Services

Enhanced Standardized Assessment



Enhanced Standardized Assessment (ESA)

ESA will inform treatment decisions, the development of care plans, identify the specific needs of the family, and identify those families that will benefit from SOC. Provides key information to all agencies and providers involved in working with the family.

ESA provides key information for RAEs in making medical necessity determinations.

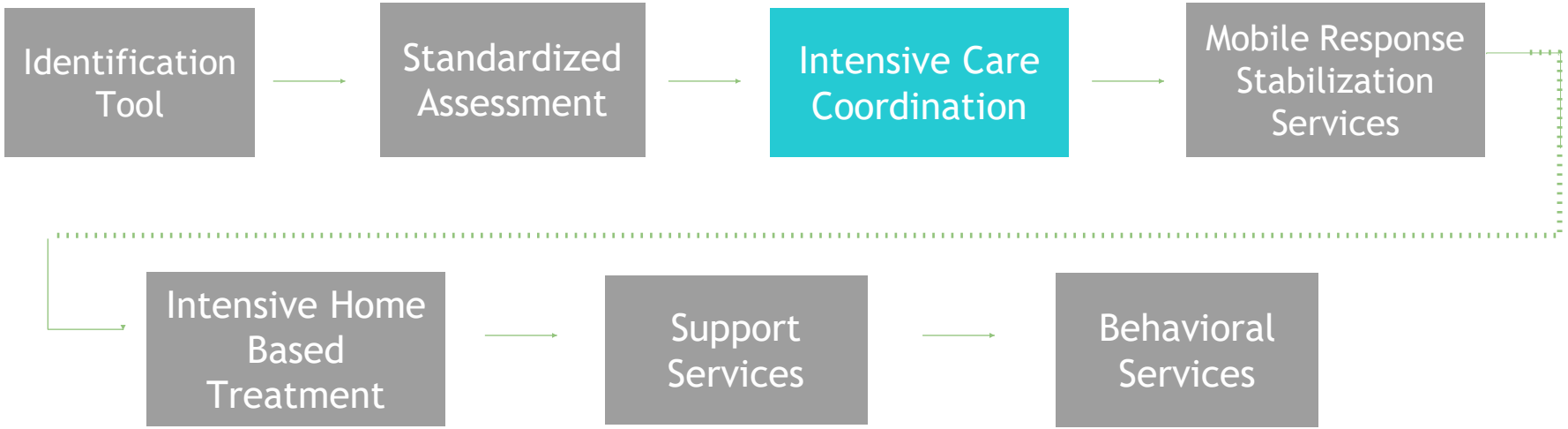
ESA consist of biopsychosocial and CANS.

Assessors

BHASO Independent Assessors

Certified BH Provider

Intensive Care Coordination



Intensive Care Coordination

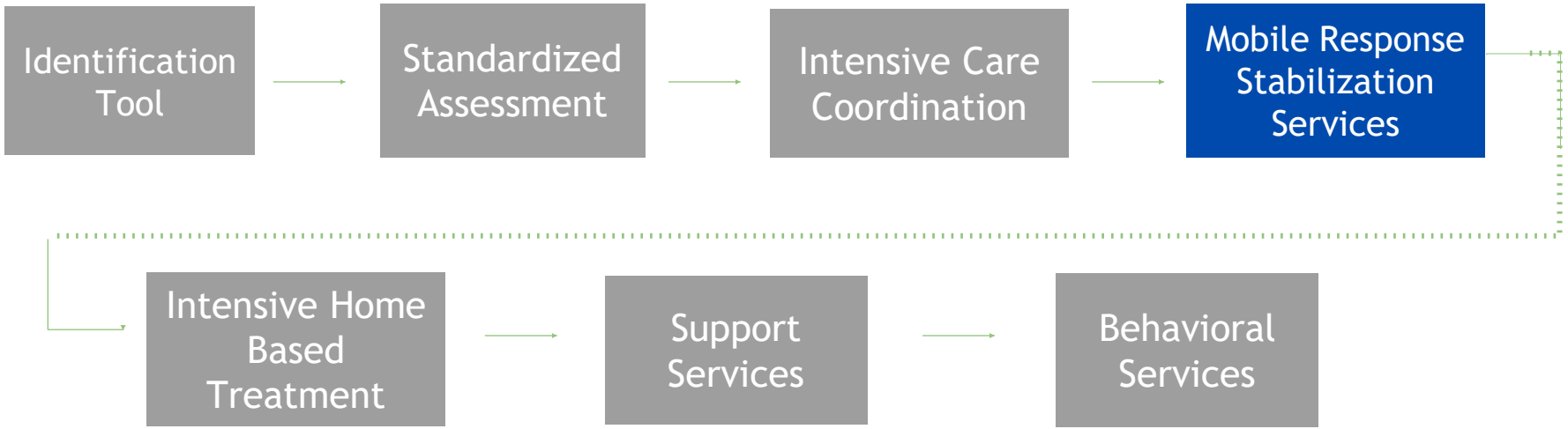
Intensive Care Coordination (ICC) is the tier of care coordination that requires a more intense approach beyond general population care coordination practice. It should be delivered via a high fidelity wrap model or FOCUS.

ICC Providers are entities that provide ICC and coordinate the intensive behavioral health service providers and support service providers. ICC Provider's will serve as the care coordination point agency on dually/multi-involved youth.

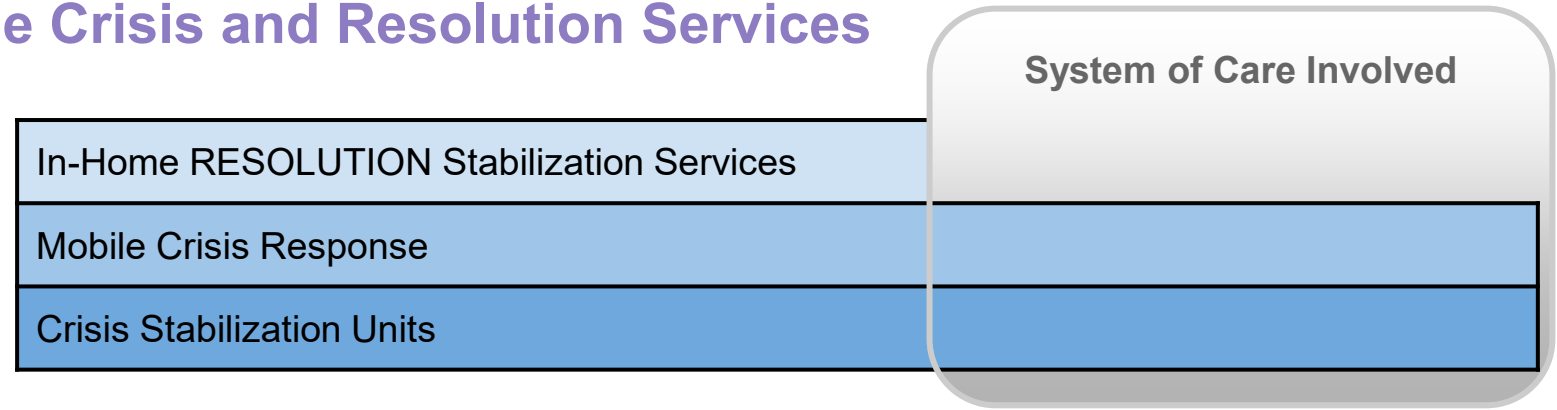
ICC Provider Functions

1. Member engagement
2. High Fidelity Wrap w/ Family Peer Supports OR Intensive Treatment Facilitation
3. Material Goods (flex $)
4. Determine CHRP referrals
5. Create Care Plan
6. Match w/ all services and supports defined in care plan.
7. Identify SDoH Needs and refer to human services as appropriate
8. Liaison to residential treatment facilities
9. Serves as point across all agencies on care plan delivery

Mobile Crisis and Resolution Services (aka stabilization services)



Mobile Crisis and Resolution Services



Resolution Services

Intensive, short-term in-home services to prevent out of home placement until in-home treatment team begins.

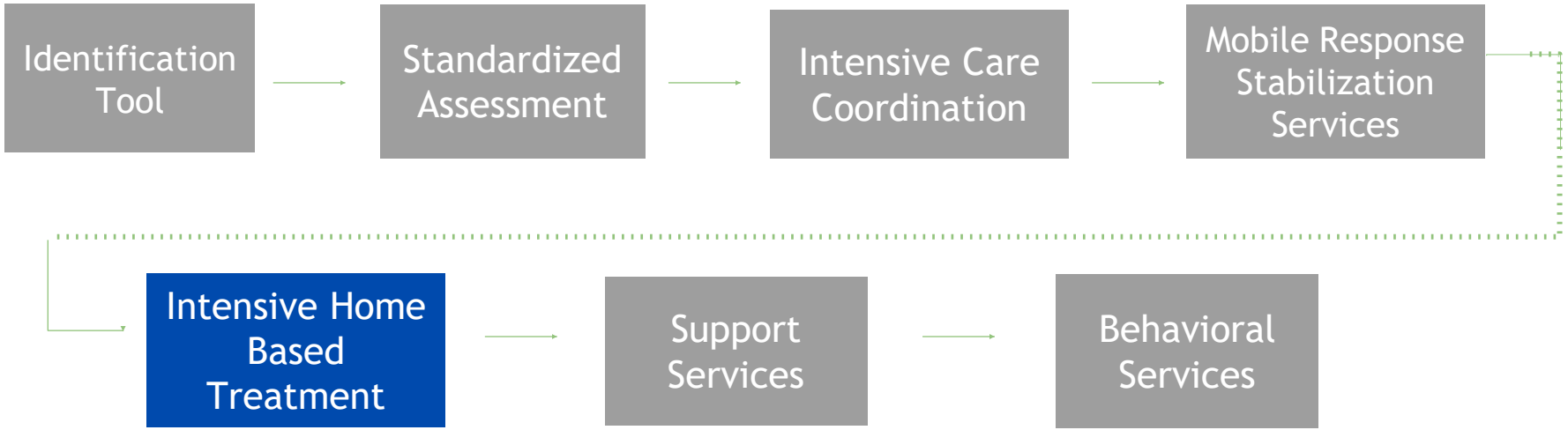
Mobile Crisis

1. Mobile teams to address crisis for families 24/7.
2. Mobile teams dispatched by IBHT providers during treatment.

CSU

Intensive, short-term beds to assist in stabilization and return child home.

Intensive Home-Based Treatment



Intensive Home Based Treatment

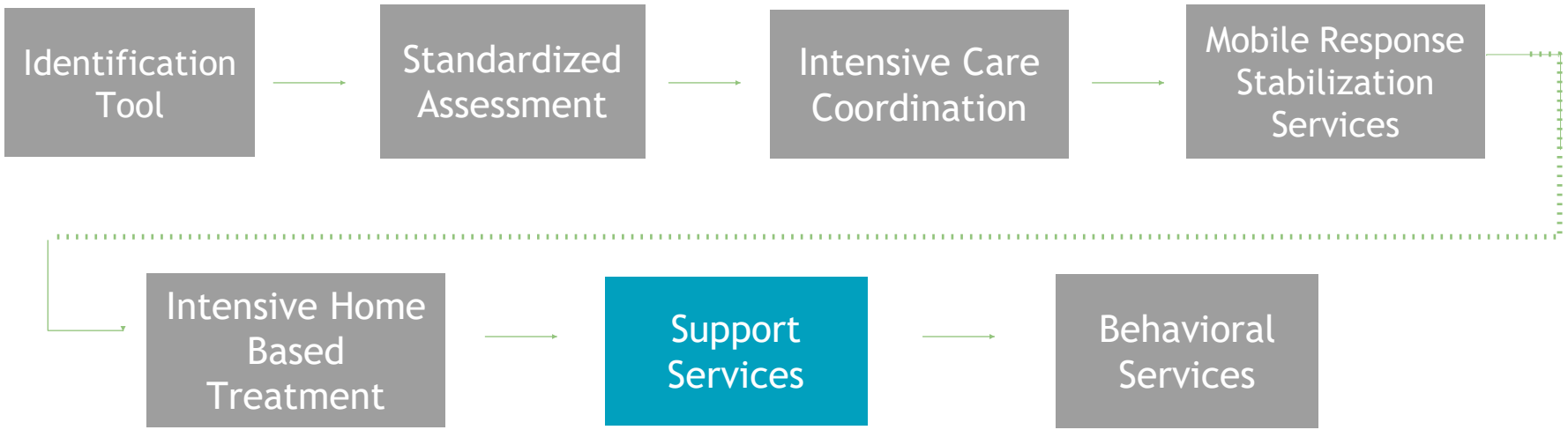
Intensive Home Based Treatment consist of a few select state approved models in which services are frequent and hands-on with both the family and child or youth. Providers are to be trained and credentialed.

Colorado plans to develop its own in-home intensive behavioral health treatment model.

A total of 5 or 6 models will be identified, including a model best suited for younger children, young adults 18 to 21, and those with significant trauma symptoms.

Intensive Home Based Treatment
(certified provider)
—----------
MultiSystemic Therapy
Functional Family Therapy
Colorado Model (tbd)

Support Services



SUPPORT SERVICES

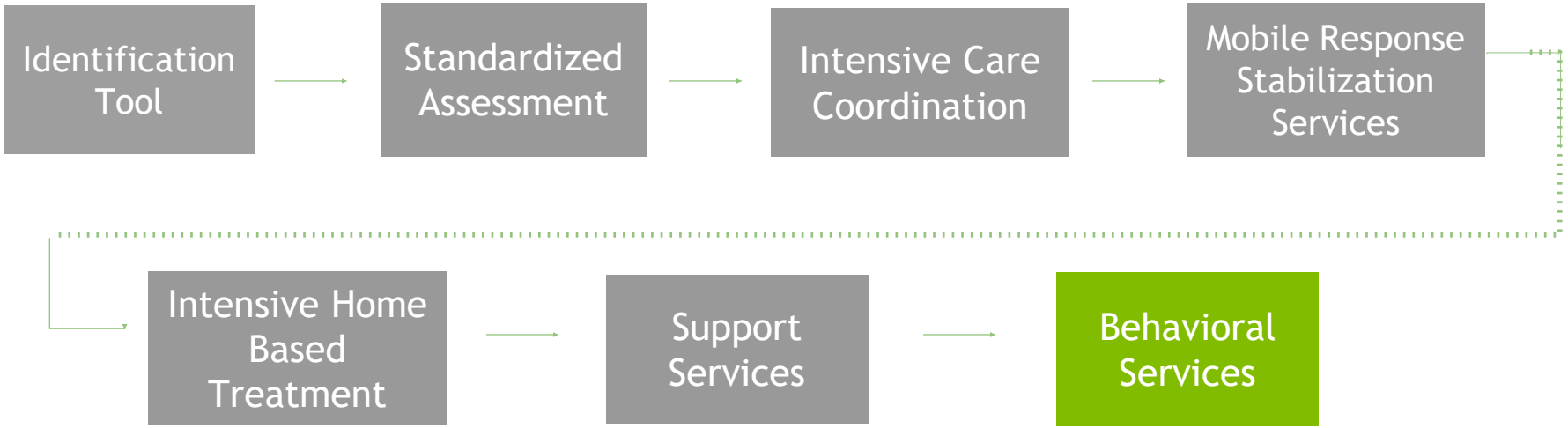
Support services are supplemental services that are needed for the child and family to successful engage in treatment and increase the effectiveness of the clinical intervention.

Respite Services are providers who afford family members an opportunity to have time independent of a young person with intensive needs and allows those care-takers an opportunity to partake in activities outside of the home.

Therapeutic Mentoring is a paraprofessional who mentors/coaches a youth in their community environment and assists in the application of the techniques they have learned in therapy to real life settings.

Family Peer Support Partners are individuals with lived experience as the parent or primary caregiver of a child/youth who has received behavioral health services.

Behavioral Management Consultation Services



Behavioral Management Consultation Services

Behavior Consultation

In-home Behavioral Health Treatment team can utilize the expertise of a behavior specialist via e-consultation. The behavioral specialist will assist treatment providers in applying behavioral strategies in the child and families' treatment plan.

Doc-to-Doc Behavioral Management eConsult

Standards and Roles

Transition Points and Re-referrals
Timeliness
Clinician Ratios and Provider Networks
Agency Roles

Transition Points

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

- The Member has successfully completed treatment and ICC
- 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;
- 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;
    - Depending on the length of stay, care coordination will move back to the RAEs.

For 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.

Re-referrals

- 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.

Timeliness

REVIEW TABLE ON page 44

Clinical 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

Provider Networks

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.

Agency Roles

- RAES
  - Need to develop CO-SOC Manual
  - Care Coordination Requirements
  - Responsibilities within CO-SOC
- ICC Provider
  - Member engagement
  - High Fidelity Wrap w/ Family Peer Supports
  - Material Goods (flex $)
  - Determine CHRP referrals
  - Create Care Plan
  - Liaison to residential treatment facilities
  - Serves as point across all agencies on care plan delivery

REVIEW TABLE 17 on page 54
REVIEW TABLE 18 on page 56

Workforce

WORKFORCE CAPACITY CENTER

Workforce expansion includes the training of both licensed and unlicensed individuals. These providers must get trained and certified in evidence-based interventions that have been proven to work with populations that have high acuity needs.

Certification/Credentialing

This work will require new provider types or an expansion of skill sets of existing provider types that require an agency to certify qualifications of providers.

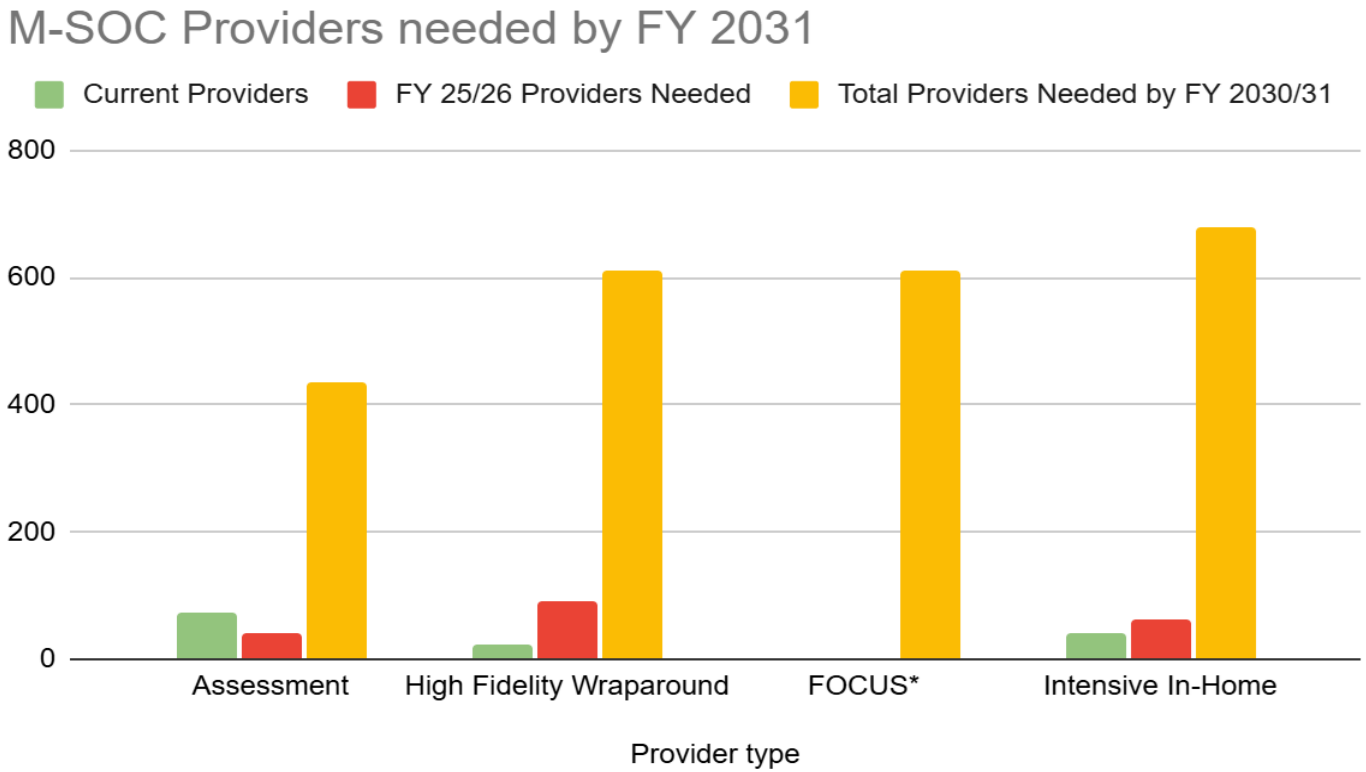
Training / TA

Some provider types require to be trained in order to deliver services in the proper manner.

Fidelity Monitoring

For certain services to be effective, they require fidelity to the model, an agency will need to sample and ensure fidelity.

Workforce Needed for CO-SOC



Provider Requirements

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

Section 4. Operations

Continuous Quality Improvement

Department Role and Oversight
Consumer Feedback

Department Role and Oversight

- Responsible for executing Continuous Quality Improvement
  - Proposed Metrics
  - Manage adherence to RAE contracts
- Manage discrepancies in treatment determinations as needed

Consumer Feedback

Action items to be completed”

- Create standard operating procedures for receiving, collecting and analyzing feedback from users in the CO-SOC.
- Create any necessary tools to receive such information.
- Create protocols for using the Lived Experience Committee as a mechanism for reviewing consumer feedback
- 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.

Phased Rollout

6 Year Plan
Initial Rollout of the System of Care
Fiscal Year 2026/27 and ongoing
Risks and Considerations of the Rollout

Rollout of services by end of FY 30/31

Fiscal Years	FY 25/26	FY 26/27	FY 27/28	FY 28/29	FY 29/30	FY 30/31
Pop enrolled	<1,000	1,700	2,800	5,200	8,000	10,000 plus
Service Type	Assessment HFW In-Home Tx	Assessment HFW In-Home Tx Stabilization -Mobile	Screener Assessment HFW/FOCUS In-Home Tx Stabilization -Mobile Supports -Material Goods	Screener Assessment HFW/FOCUS Fam Peers In-Home Tx Stabilization -Mobile Supports -Respite -Material Goods	Screener Assessment HFW/FOCUS Fam Peers In-Home Tx Stabilization -Mobile -CRT Supports -Respite -Materials Behavioral	Screener Assessment HFW/FOCUS Fam Peers In-Home Tx Stabilization -Mobile -CRT Supports -Respite -Materials Behavioral

*** This is total costs, of which approximately 50% is federal match.**

New Services to Medicaid

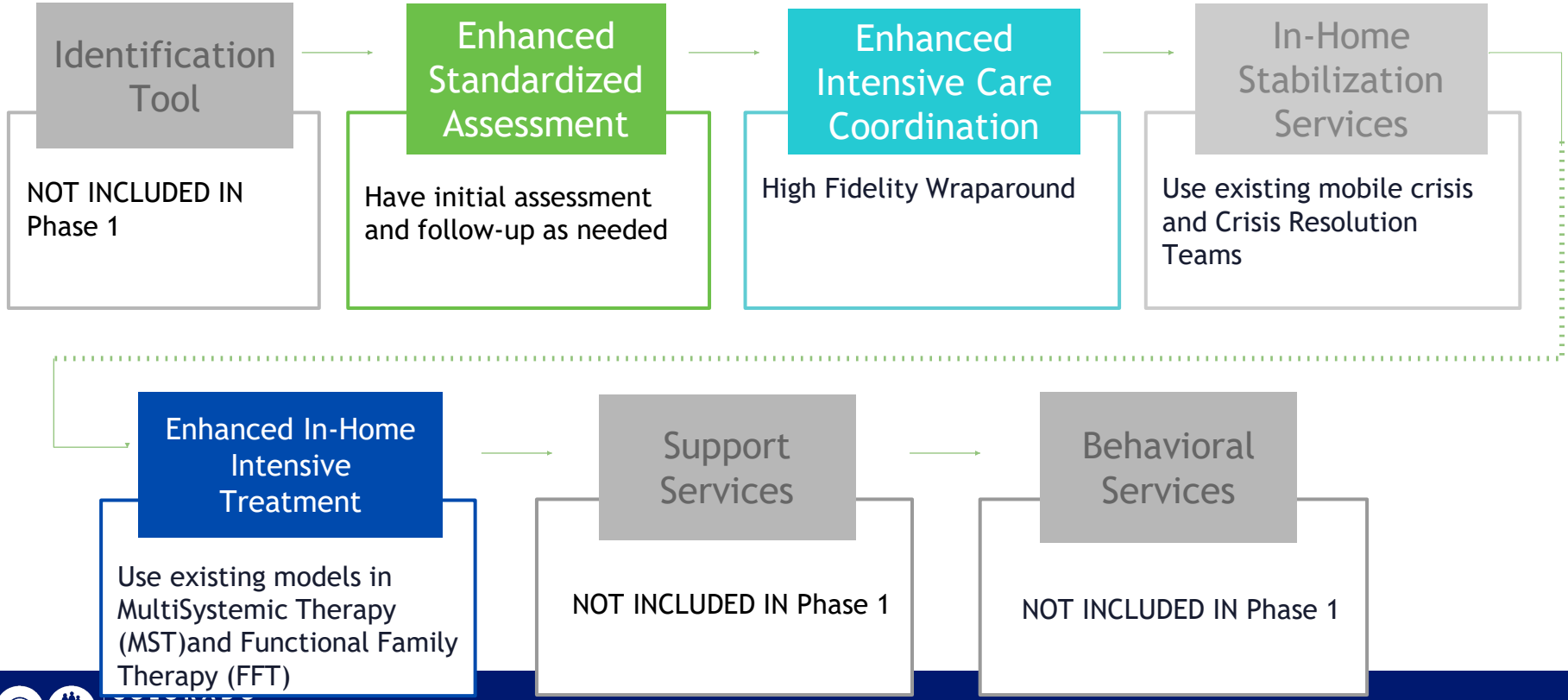
6 Year Rollout Plan

- HCPF will have until end of FY 2030/31
- Year 1 of services starts FY 2025/26

Rollout by Population

	Children Served	Context
FY 25/26	900	Children discharging from PRTF or QRTP, and extended stay
FY 26/27	1,700	FY 26 plus 33% children discharging from inpatient. 1/3 of children are at risk of re-entry from inpatient stays.
FY 27/28	2,800	FY 27 plus children with multiple ED visits for BH
FY 28/29	5,200	FY 28 plus children needing intensive community services
FY 29/30	8,000	FY 29 plus children needing BH crisis services
FY 30/31	10,500	FY 30 plus at risk population

Initial Rollout



Initial Rollout Population

- Medicaid Members between the ages of 11 and 17 years of age who meet the following criteria:
- Eligible for either Enhanced MST or Enhanced FFT in accordance with model fidelity guidelines, and
- Is either:
    - Anticipated to be discharged from QRTP or PRTF within at least the next 60 calendar days, or
    - In out of state residential treatment facility upon discharge back home to Colorado, or
    - In an Extended Stay or boarding situation as defined by C.R.S. 27-50-101(13.5)

Fiscal Year 2026/27 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.

Risk and Considerations

- Rollout of ACC 3.0 along with CO-SOC
- There is a national behavioral health workforce capacity shortage.
- Colorado is a TABOR state
- Needs to be a joint effort with the legislative branch of Colorado

Communication

Education and Outreach
Progress Reporting
Public Communication

Education and Outreach

Member Outreach on how to access the CO-SOC services

- Materials will be developed that include the information for Medicaid Members and their families.
- 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.
  - 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,

Provider Outreach

- How providers access the CO-SOC, provide referrals, and become involved in the system if the provider chooses

Progress Reporting

- Plaintiffs
- Quarterly Reporting
- Committees and Reporting
- Lived Experience Advisory Committee
- Implementation Advisory Committee
- Statewide Leadership Advisory Committee

Public Communication

- Partner and Stakeholder Engagement
- Other state agencies
- Newsletter, Listserv, and Webpage

Budget

Services
Workforce Capacity
Oversight and Overhead

Services (*budget*)

- Rates
  - Billable unit durations (15 min v. 60 min v. monthly)
  - Amount per unit
- SB19-195 Child and Youth Behavioral Health System Enhancements bill
- HB24-1038 High Acuity bill

Workforce Capacity (*budget*)

- MST, FFT and HFW workforce capacity increase
    - Funded for two years (FY 2025/26 and FY 2026/27)
- Future year workforce capacity development budget based on the standards and ratios set for the CO-SOC
- Create a detailed budget for WCC to reflect the extent of training and monitoring needed in each fiscal year
- With the BHA, create a detailed budget for BHA to reflect the extent of training needed in each fiscal year

Oversight and Overhead (*budget*)

- HCPF is charged with demonstrating the services being provided are meeting the needs of Members in a timely and quality manner.
- A need to create a detailed budget to reflect the extent of program oversight that is needed in each fiscal year
- With the BHA, need to create a detailed budget for the BHA to reflect the extent of oversight of treatment standards that are needed in each fiscal year

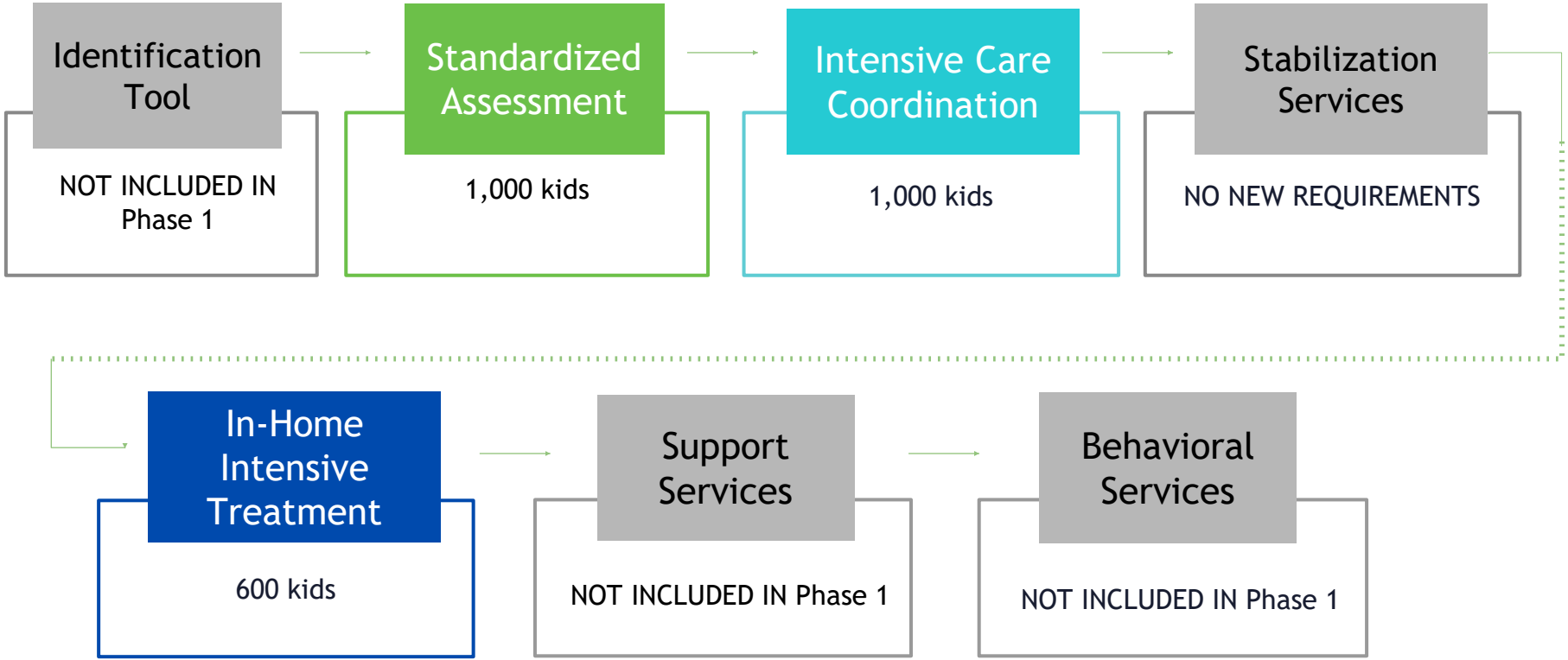
Section 5. Conclusion

MSOCs Rollout Phases

	Phase 1	Phase 2	Phase 3	Phase 4*
Pop enrolled	<1,000	2,500	5,000	10,500
SOC Part	3 of 7	4 of 7	7 of 7	7 of 7
Service Type	Assessment HFW In-Home Tx	Assessment HFW In-Home Tx Stabilization -Mobile	Screener Assessment HFW In-Home Tx Stabilization -Mobile Supports -Respite -Material Goods Behavioral	Screener Assessment HFW In-Home Tx Stabilization -Mobile -CRT -CSU Supports -Respite -Mentoring -Material Goods Behavioral

* This is based on current Feb 2029 go live date, with extension an extra phase can be added.

Phase 1 with existing funds



Overview SOC and Agreement Requirements

Agreement Requirements via SOC [Sect. 4.6.1]