Colorado CCBHC Planning Grant 2023 Narrative Proposal

A.1. Population Served by CCBHCs

Across state agencies, Colorado has recognized and focused on creating better outcomes for individuals using behavioral health services within the state. Through Colorado's investment in cross agency work led by a governor-appointed Behavioral Health Task Force, Colorado comprehensively outlined the populations needing better access to and quality of behavioral healthcare in 2020. With this planning grant, the cross-agency team is poised to utilize the entire state as its geographic focus for the Demonstration. Colorado's 2019 Census Bureau population was 5,758,000. Information shared with the Behavioral Health Task Force (BHTF) reflected the statewide need for comprehensive behavioral healthcare:

- In Spring 2021, 30.8 percent of adults in Colorado reported symptoms of anxiety and/or depressive disorder.
- In 2018, 23.2 percent of the people of Colorado (over one million people) reported mental illness in the previous year.
- In 2019, more than one in 10 people in Colorado (13.5 percent) said they were unable to get mental health care that they needed, up from 7.6 percent in 2017.
- Substance use disorders (SUDs) are a particularly critical problem in Colorado. In 2017, 11.9 percent of people ages 18 and older in Colorado reported an SUD in the past year, higher than the national rate of 7.7 percent.
- In a 2019 study, over 95,000 people of Colorado 18 and older (2.3 percent) did not get treatment or counseling to address their dependencies.

Armed with this information, the Behavioral Health Task Force set to work identifying specific population gaps for services within the state. The CCBHC Planning and later the Demonstration will utilize legislatively defined priority populations, populations identified within their 2020 Statewide Behavioral Health Needs Assessment Report as well as groups identified by a partner agency, the Colorado Health Foundation, when designing the Demonstration.

Priority populations defined in newly passed legislation and the Needs Assessment (https://cdhs.colorado.gov/2020-behavioral-health-needs) include:

- Uninsured, underinsured, Medicaid-eligible, publicly insured, or whose income is below thresholds established by the Behavioral Health Administration (from here out referred to as BHA).
- Persons presenting with acute or chronic behavioral health needs, including but not limited to individuals who have been determined incompetent to stand trial, adults with serious mental illness, and children and youth with serious emotional disturbance
- Regional or statewide underserved populations based on health equity data, including but not limited to:
    - People experiencing or at risk of homelessness
    - Children and youth at risk of out-of-home placement and their parents
    - People involved with the criminal or juvenile justice system
    - People of color
    - American Indians
    - Alaska Natives
    - Veterans

    - People who are pregnant
    - People who are lesbian, gay, bisexual, transgender, or queer or questioning
    - Individuals with disabilities as defined by the federal "Americans with Disabilities Act of 1990"
- Individuals with trauma
- Individual living in rural areas
- Adults with substance use disorder
- Refugees/undocumented individuals

The Colorado Health Foundation reports, when looking at specific groups, Hispanic people of Colorado were identified as the most at risk racial/ethnic group, followed by Black and American Indian people of Colorado (these two groups were equally disadvantaged). Adolescents were identified as the most vulnerable age group. The Colorado Health Foundation also provides some context for inequities experienced by Colorado's priority populations.

A 2022 Colorado Health Foundation poll provides additional information about the priority populations:

- Of all people of color, 70 percent of Native Americans and Indigenous Persons responded they have not been able to find a mental health care provider who would be understanding of their or their family member's background or experience. Additionally, 78 percent have concerns about privacy or having to disclose too much personal information.
- In the Asian/Pacific Islander and the Hispanic/Latino populations, 76 percent said the wait for services was too long or there were no available appointments.
- Black/African Americans said they were unsure how to find a mental health provider (68 percent).
- The greatest concern of nearly all people of color was that the out of pocket costs were too expensive (68 percent).
- Persons living with a disability are more likely to experience many challenges in obtaining behavioral health care:
    - They are unsure how to find a mental health provider.
    - There were no available appointments or the wait was too long.
    - They do not feel comfortable talking to a stranger about mental health concerns.
    - There are concerns about privacy or having to disclose too much personal information.
    - There are concerns about being judged by family members, coworkers or friends.

The 2020 Needs Assessment also elucidated service gaps in terms of demographics, providers and stakeholders.

- 15.3 percent of people in Colorado reported **poor mental health** in 2019.
- 31.4 percent of high school students in the state felt so **sad or hopeless** almost every day for two weeks or more in a row that they stopped doing some usual activities during the previous 12 months. For lesbian, gay and bisexual (LGB) students this jumped to 62.6 percent compared to 27.0 percent of their heterosexual peers. American Indian/Alaska Native high school students had the highest prevalence among all races and ethnicities at 37.5 percent, followed by Hispanic students at 35.2 percent.

- Regarding **substance use**, 16.0 percent of high school students reported binge drinking and 19.4 percent reported using marijuana on one or more of the past 30 days.
- Between 2000 and 2018, the annual age-adjusted rate of **drug overdose deaths** increased across the state by 111.5 percent (7.8 to 16.5). Non-Hispanic Whites had the highest rate among racial/ethnic groups at 17.2, followed by Black (17.1), Hispanic Whites (16.7), American Indian/Alaska Natives (11.4) and Asian or Pacific Islanders (4.1).
- Findings from the 2018 Behavioral Risk Factor Surveillance System in Colorado showed that 22.7 percent of adults reported experiencing between **one and seven days when their mental health was not good** in the past 30 days and 11 percent reported having 14 or more days in the past 30 days when their mental health was not good.
- Regarding **substance use**, 7.3 percent of adults reported heavy alcohol use and 19.2 percent reported binge drinking; 13.2 percent reported using marijuana four or more times a day.

Three in five people in Colorado say they have experienced mental health strain in the last year:

- LGBTQ (84 percent)
- Women ages 18-49 (80 percent)
- Under age 30 (79 percent)
- Native American (79 percent)
- Insured through Medicaid (74 percent)
- Live with disability (73 percent)
- Income under $50K (72 percent)
- Uninsured (72 percent)

At least 50 percent of persons with Medicaid coverage who experienced mental health strain reported that they are unable to get the mental health care they needed because:

- They are unsure how to find a mental health provider.
- There were no available appointments or the wait was too long.
- They do not feel comfortable talking to a stranger about mental health concerns.
- There are concerns about privacy or having to disclose too much personal information.
- Not being able to find a mental health care provider who would be understanding of your or your family member's background or experiences

Colorado's legislature has committed time and money to address the behavioral health needs of people of Colorado. That commitment is a statewide commitment and this application reflects Colorado's statewide focus for the Planning Grant and Demonstration Grant.

A2. Extent of the Problem

The gap between the needs highlighted above and the following information provides a window into Colorado's challenges. Between April 1, 2021 and March 31, 2022, 18.4% of approximately 1.5 million Medicaid clients accessed services for mental health and/or substance use disorder (SUD) through the capitated behavioral health benefit and through primary care settings. In 2020, there were 127,969 persons who received publicly funded mental health services from the Colorado mental health providers. Per the state's SFY 2019-20 Maintenance of Effort (MOE) reporting, Colorado expended $848 million in state and Medicaid funding (including local and federal share) for mental health services.

- 46 percent were male and 54 percent were female

- 17 percent were between the ages of 0 and 11 years of age, 11 percent were ages 12 to 17, 11 percent were ages 18 to 24, 28 percent were between the ages of 25 and 39, 28 percent were ages 40 and 64, 5 percent were over 65 years of age
- 71 percent were not of Hispanic or Latino origin, 29 percent were of Hispanic or Latino origin
- 72 percent were White, 6 percent were Black or African American, 2 percent were American Indian or Alaska Native 1 percent or under were Asian and Native Hawaiian or Other Pacific Islander and 18 percent were a race listed as Other.
- 97 percent were not a Veteran and 3 percent were Veterans
- The number of persons served includes 13,709 (11 percent) persons with alcohol or substance-related disorders.

Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. Mental Health Annual Report: 2015–2020. Use of Mental Health Services: National Client-Level Data. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2022. https://www.samhsa.gov/data/data-we-collect/mh-cld-mental-health-client-level-data

There were 68,699 publicly funded admissions to substance use treatment facilities for Substance Use Disorder in 2021.

- 38 percent were referred for treatment by an individual/self-referral and 29 percent were by criminal justice.
- 69 percent of the admissions were male and 31 percent were female.
- 71 percent of admissions were White, 7 percent were Black or African American, 5 percent were American Indian, and the race of 15 percent was unknown.
- 63 percent were not of Hispanic origin, 18 percent were Mexican, 12 percent were Hispanic with the origin not specified and 6 percent were of other specific Hispanic origin
- 49 percent had 12 years of education or GED, 29 percent had 13 to 16 years of education or vocational school, 14 percent had 9 to 11 years of education, 4 percent had 1 to 8 years and 2 percent had either less than 1 grade completed or 17 years or more completed.
- 56 percent of the admissions were unemployed, 26 percent worked full time, 11 percent were not in the labor force and 7 percent worked part time.
- 26 percent first used a substance before 15 years of age, 27 percent first used between 15 and 17 years of age and 40 percent first used between the ages of 18 and 34.
- 47 percent had a co-occurring mental health disorder
- 5 percent were veterans
- 60 percent had an independent living arrangement and 24 percent were homeless
- 87 percent waited 0-5 days for treatment

**Data reflects admissions rather than individuals. Some people could have more than one admission.*
Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. Treatment Episode Data Set (TEDS): 2020. Admissions to and Discharges

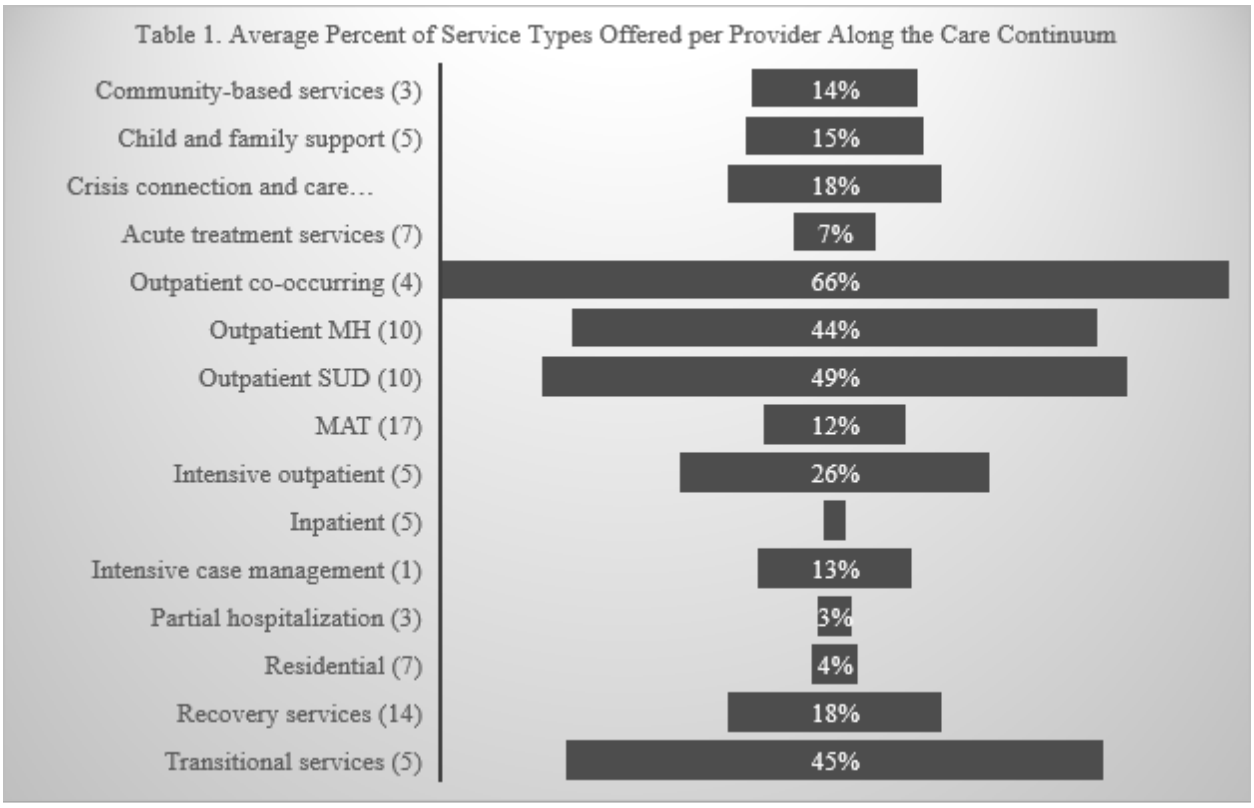
from Publicly Funded Substance Use Treatment Facilities. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2022.
https://www.samhsa.gov/data/data-we-collect/teds-treatment-episode-data-set

Currently there are no providers billing Medicaid for behavioral health services in seven of Colorado's 64 counties. There are 26 counties with one provider billing behavioral health services. In areas where there is a single provider agency, individuals likely do not have a choice in providers. Hundreds of individuals who shared their experience with the behavioral health system via public testimonies in 2019-2020 shared how this lack of choice can contribute to lack of ongoing engagement in treatment in cases where conflicts arise between clients and individual providers. Lack of choice may also prohibit those seeking care for whom trauma leads to specific requests associated with providers such as gender, race, English as a second language, etc.

The Service Profile in Table 1 below reveals that, on average, outpatient mental health and/or SUD treatment and transitional service providers have the most robust service offerings (i.e., the greatest number of service types offered per provider within each continuum category) across the state. The least robust service offerings are those for the most acute needs, including inpatient, partial hospitalization and residential services. Stakeholders, including those with lived experience receiving services for behavioral health conditions, family members, county government personnel and community-based organizations such as homeless shelters and others, provided feedback indicating outpatient services are the most common and that more specialized and intensive services are needed. Stakeholders across the state highlighted the need for more transitional services and particularly those for individuals moving from acute services back into the community. The state is committed to providing as many services as appropriate in a community-based setting and preventing hospitalizations and residential stays unless required.

As a state with dedicated participation across agencies, including the voices of stakeholders and the perspective of providers, Colorado has invested time and resources to identify service and quality gaps impacting the people of Colorado. The years spent laying this groundwork will aid the CCBHC planning team to quickly focus on the mechanical aspects needed to operationalize changes to implement the model and ultimately- better access and quality of care across the state.

Table 1. Behavioral Health Provider Service Profile



Source: 2020 Behavioral Health Needs Assessment. The number of services per continuum category included in the analysis are provided in parenthesis (#) and it reflect the average percent of service types offered per provider along the care continuum. Source: SAMHSA Locator, March 2020

A3. Organization, Funding, and Methods of Providing Health Services in Colorado

From 2019 to 2022, the Colorado General Assembly passed a set of historic behavioral health transformation laws, aimed to create a coordinated, cohesive, and effective behavioral health system that improves the lives of all those in need. These bills updated the state's behavioral health system and included a significant investment in initiatives to expand and strengthen the behavioral health safety net, address behavioral health workforce shortages, expand public networks, increase the number of beds and community based behavioral health services, and build out access to quality mental health and substance use care for clients and families. The CCBHC planning team will quickly activate the participation of its internal and external partners to determine the appropriate finance and program pathways for success.

Organization

Behavioral health services are organized, funded and provided by two State agencies: the Colorado Department of Health Care Policy and Financing (HCPF) and the Behavioral Health Administration (BHA). HCPF administers the Medicaid program providing health care coverage – such as medical, prescription drugs and behavioral health – to one in every four people of Colorado, or more than 1.6 million people, through its safety net coverage programs. BHA is the

single state behavioral health agency responsible for administering SAMHSA funds and licensing providers.

HCPF maintains eight contracts with Managed Care Entities (MCEs), which are responsible for administering, managing, and operating the Medicaid capitated behavioral health benefit by ensuring clients have access to medically necessary covered behavioral health services. Seven Regional Accountable Entities (RAEs) and a managed care organization for one county, are contracted with HCPF to do this for most the state's public behavioral health services.

The current system in Colorado lies at the intersection of the RAEs and the CCBHC criteria. Care coordination, outreach and engagement to access benefits, relationships with local emergency departments and social service agencies, quality measurement, and client satisfaction surveys are some of the RAE responsibilities. The RAEs ensure access to vital services and operations through contracts and direct supports, which are essential, especially for smaller providers. Some of these RAE services are also CCBHC listed services. As a state with a mature behavioral health care and physical health care managed care system, we are looking forward to using the Planning Grant period to further strengthen our system and better understand the relationship and expectations between the RAEs and providers to deliver quality services, with an eye toward ensuring efficient use of public funds, alignment for quality standard, and contracting oversight.

Funding
In fiscal year 2020-21 HCPF spent $798 million or 7.5 percent of its medical spend on managed behavioral health care. CMS provides an approximately 50 percent federal match to cover the cost of managed behavioral health care in Colorado. When Colorado expanded Medicaid in 2014, managed behavioral health care became the largest funder for behavioral health services in the state.

Providing Health Services
The BHA is committed to address social and structural determinants of behavioral health while coordinating comprehensive care through contracts with providers and administrative service organizations. Regardless of severity of need, ability to pay, disability, languages spoken, geographic location, racial or ethnic identity, socioeconomic status, sexual orientation, age, or gender identity, BHA supports the behavioral health system through:

- Payment for comprehensive, effective, and equitable care for individuals who are uninsured;
- Setting standards for all behavioral health safety net providers as the primary regulatory oversight and compliance agency for safety net behavioral health provider agencies;
- Providing clear statewide guidance on how to access care when, where, and how people need it;
- Ensuring oversight and monitoring for trauma-informed and culturally and linguistically responsive care;
- Funding the Colorado statewide crisis system, providing access to a 988 hotline, walk-in centers, mobile crisis, respite services for the people of Colorado regardless of payer source;

- Supporting innovation, capacity expansion, prevention, and necessary care through capacity funding;
- Maintaining statewide data on behavioral health needs and service utilization;
- Providing affordable access to high-quality behavioral health screenings and treatment services for those incarcerated and connected to the criminal justice system; and
- Supporting a behavioral health workforce dedicated to the transformation of behavioral health service delivery practiced with cultural humility.

Colorado has embraced the SAMHSA values that promote positive behavioral health care. BHA actively supports trauma-informed, recovery-oriented, equity-based services through training and consultation throughout the year. HCPF and BHA work in concert providing access to care, regional supports, provider contracting, data collection and reporting, reimbursement, and several other crucial programs such as preparing for this planning grant.

A4. Current CCBHC Service Capacity in Colorado

Under Colorado's 1915(b)3 waiver authority, HCPF covers extensive community-based behavioral health services, which includes the services required of CCBHCs. These B3 alternative services include crisis intervention, screening (for both mental health and SUD) and assessment, targeted case management, psychosocial rehabilitation services, and peer support services in addition to our outpatient mental health and SUD services. The majority of these alternative services are provided by our state's safety net providers around the state. In the last several years, Colorado has passed legislation to further strengthen and expand our behavioral health service array and better ensure quality services in the safety net.

Colorado has seven existing federally certified CCBHCs and does not anticipate the need to amend the state plan or request waivers to provide the services listed in the certification criteria or associated oversight or payment models.

A5. Behavioral Health Payment and Service Delivery in Colorado

Medicaid Behavioral Health Payment Systems
The Colorado payment and service delivery system crosses the work of HCPF and BHA and shifts based on provider type and population. When looking at strengths within the current structure and how it will aid the creation of a Certification process, the team's recent work to enroll new providers and build out cross agency health IT infrastructure offers needed capacity and structure to ensure required CCBHC outcomes can be tracked alongside payment.

HCPF holds managed care contracts with the Regional Accountable Entities (RAEs) in a prospective per-member-per-month (PMPM) agreement that includes full risk behavioral health services and primary care and case management. Actuarially sound rates are determined on an incurred basis with program adjustments and trending. Each of the seven RAEs then pays their network of providers and incurs administrative expenses for operations, claims processing, and care coordination. Providers contract with the RAEs and can negotiate the rates for services. HCPF also holds two physical health full managed care contracts, one of which includes behavioral health services. The Medicaid system includes over 10,000 behavioral health providers, not including primary care providers, and that number rose 10.6 percent in the last

state fiscal year. During SFY 20921, the volume of services provided by the Independent Provider Network (IPN) increased by 24 percent, representing this provider access expansion and the Medicaid members that needed lower acuity behavioral health services.

BHA uses state and block grant funds to pay for activities that benefit the community such as disaster recovery support, Individual Placement Support (IPS), Assertive Community Treatment (ACT), tenancy supports, and other programs. BHA interacts with the Medicaid system to provide this additional funding, when applicable, for individuals ineligible for Medicaid coverage. Both HCPF and BHA provide cost-based reimbursement for approved safety net providers to ensure that funding is sufficient for the sustainability of the programs. For these programs in a Demonstration, the state will use cost reports to evaluate reimbursement obtained across payers and assist providers with non-reimbursed costs for operating the program.

The state is actively working to expand and strengthen the state safety net payment and delivery system. In FY 2022-23, HCPF and BHA are working on four key areas: (1) Updating cost reporting templates, protocols and technical assistance to modernize reimbursement rates for community mental health centers; (2) Creating universal contract provisions that define obligations of safety net providers in meeting the needs of their communities while also holding payers like HCPF and BHA more accountable to behavioral health providers; (3) Developing alternative payment models and value-based payments that align with the universal contract provisions and create and reward shared patient outcomes and health equity goals, including a PPS model; and (4) Identifying opportunities to reduce providers' administrative burden, such as aligned data reporting. The state sees this work as aligning clearly with the CCBHC Planning Grant and has used the CCBHC model to develop several legislative and regulatory standards for BH providers that consider access, value, and quality outcomes over service volume. Colorado's experience collecting and verifying cost reports, and setting rates based on those reports enhance the state's likelihood of success in developing and implementing a PPS model. Our existing state statutes support use of quality and access data to connect these payments to incentives and value-based risk models.

Behavioral Health Delivery Systems

Publicly funded behavioral health services, per state statute, have been historically provided primarily by CMHCs. Legislation passed in 2022 included policies that help expand the number and types of behavioral health providers receiving state funds, cost-based reimbursement, and created new definitions for "Comprehensive" and "Essential" Safety Net Provider (SNPs)' and for substance use and mental health. In addition to the currently licensed CMHCs (soon to be licensed under the comprehensive safety net provider definition), care providers such as Federally Qualified Health Centers (FQHCs), specialty clinics, inpatient and outpatient facilities, and large substance use or mental health providers will expand the number and types of potential participants for the Planning and Demonstration Grants.

Currently, services are provided by SNPs in each of their defined service areas across the State, thus ensuring that clients can receive behavioral health services anywhere in the state regardless of where they reside. With the expansion of behavioral health providers via the recent legislation, clients will have more choices to access services and treatments in a more timely, accessible manner with providers who look and communicate like they do. Small and medium sized

providers will be able to access safety net funding based on cost and quality. The 2022 legislation also outlines that clients must be accepted for necessary services or treatment regardless of their diagnosis, living status, race, ethnicity, gender, gender identity, legal status, socioeconomic situation, or age.

Services listed in the Protecting Access to Medicare Act (PAMA), as cited in the CCBHC certification criteria, nearly mirror those in Colorado's 2022 legislation defining the services Comprehensive Safety Net Providers must provide. Colorado statutes require the safety net program include High-Intensity Behavioral Health services in addition to the services listed in PAMA. Although state statutes do not separately identify Veterans, BHA has the authority to determine "priority populations" that SNPs must serve and began a new program for Veterans in May 2020. The program will work with hospitals and other health care providers across the state to identify veterans who have experienced a mental health or substance use crisis involving suicidal ideation and could benefit from additional support. Veterans will be paired with a trained crisis or peer support specialist, who is a fellow veteran, to ensure they continue care, begin outpatient treatment, and receive support during a period of heightened risk.

Many of Colorado's SNPs have been highly engaged in transformation efforts, including the integration of behavioral health, substance use disorder treatment and recovery, and integrated primary care services as well as focusing on assessing and being responsive to Social Determinants of Health (SDOH) related needs. HCPF and BHA meet with the SNPs at least quarterly to discuss major initiatives, such as the four aforementioned work streams, legislation, and payment structure changes for behavioral health. BHA also attends the CMHC trade association board meeting one to two times per year. Seven of Colorado's SNPs have been CCBHC certified or are in the process of CCBHC certification. Five of the CCBHCs report innovative changes in care delivery that improve access for underserved populations or affords clients the opportunity to move into lower levels of care, freeing up time for higher acuity appointments. Across the five federally certified CCBHCs, 9,925 National Outcome Measures System (NOMS) interviews have been collected between January 2019 and September 2022. Daily Functioning, Social Connectedness, Overall Health, and Quality of Life improved on average by over 25% from baseline to reassessment, with over 40% improvement in functioning. Psychological Distress and Emergency Department utilization greatly decreased, with nearly 50% reduction in distress and over 67% reduction in ED use. These numbers have been reported only through NOMS and during the Planning Year the state will work to develop data veracity and verification procedures.

Colorado received a State Innovation Model (SIM) grant in 2015 with the goals of integration of physical health care and behavioral health care to better identify and serve the community, leading to 17 SNPs and 57 FQHCs with robust integrated care programs. The state also prioritized federal stimulus dollars to create a $35M integrated grants expansion program. This widespread experience will be shared with Demonstration Grant clinics, if the selected clinics do not have integrated care. One risk of the Planning grant will be how to integrate the CCBHC model into the state's existing behavioral health transformation efforts. Timing, technology, and large grants from federal stimulus also provide an environment where it will be hard to attribute systems changes to a single specific program, making evaluation difficult.

Technology Enabled Progress

Many system changes in behavioral health rely on data sharing, provider technology, and integration onto state health information structures. Colorado's Office of eHealth Innovation (OeHI) is responsible for defining, maintaining, and evolving Colorado's Health IT strategy concerning care coordination, data access, healthcare integration, payment reform and care delivery. OeHI is responsible for coordinating statewide initiatives via the 2021 Colorado Health Information Technology Roadmap, which charts a path for harnessing and expanding the digital tools and services that support the health of all those in need of services. Roadmap goals include: (1) Individuals, providers, payers, community partners, state, local, and Tribal agencies share data and have equitable access to needed health and social information; (2) Individuals access high quality in-person, virtual, and remote health services that are coordinated through information and technology systems; and (3) Colorado improves health equity through inclusive and innovative use of trusted health IT and digital health solutions. The Department and BHA are actively engaged in advancing and leveraging the state's Health IT roadmap as shown below.

Contexture, Quality Health Network (QHN), and Colorado Community Managed Care Network (CCMCN), are non-profits that play unique roles stewarding Colorado's health information exchange and analytic infrastructure. Providers and organizations registered with Contexture and QHN can electronically share data and information with one another to support patient care. CCMCN, the technology organization for the Federally Qualified Health Centers (FQHCs) and other community partners, is leading efforts statewide to establish interoperable technical systems focused on health outcomes and critical analytics that inform the coordination of care for whole person and population health needs. These organizations will be crucial in supporting CCBHC data exchanges, especially in the case that FQHCs apply for certification.

Provider feedback has identified an opportunity to address the issue of administrative burden. HCPF and BHA are working with providers to decrease the burden to the extent possible given state reporting responsibilities within the State and to the federal government. Part of the planning process will build on this work to ensure that all process and performance measures are meaningful and actionable, and aligned across state reporting.

The resources afforded in this Planning Grant would allow thorough policy development, certification, payment model and complimentary State initiatives can be designed then implemented during the Demonstration Grant period.

B1. Expansion of Capacity, Access, and Availability of Services

HCPF and BHA will maximize the planning year to design the Demonstration period that focuses on increased access to services for Colorado's identified populations experiencing the most need for effective services and builds on existing state efforts.

Through creating a strong certification process, value-based prospective payment model, and Demonstration implementation plan, HCPF and BHA will incorporate client and community needs and increased funding. To participate as a CCBHC within the demonstration, Colorado will require local outreach and engagement plans, completion of all required CCBHC training as well as trauma informed training. HCPF and BHA will work with each participating and prospective CCBHC to more closely work on the needs for their unique populations with a focus

on recruiting a diverse workforce, expanding the BH network, and having culturally responsive services that match their community.

Colorado is also working to implement recent legislation that requires the BHA to set minimum provider standards by July 2024 that address key metrics regarding accessibility of care and availability of services, capacity tracking, and quality of care including triage and access for priority populations. The legislation also requires BHA to establish agreements with tribal governments that have behavioral health resources to solve challenges in the behavioral health system. These legislative requirements dovetail with Certification Criteria affording improved access to care but will need to be carefully reviewed for areas of incompatibility or inconsistency. The Planning Grant period will provide the opportunity to obtain client, community, and provider input in determining the provider performance standards and policies. The BHA and HCPF have several existing stakeholder outreach efforts that will be utilized to connect with targeted stakeholders including Medicaid member and lived experience advisory committees, local and statewide multi-stakeholder policy advisory groups and steering committee. The state grant leads will also work with a vendor to engage with specific provider partners, advocates, and community organizations to review the policy, payment, and client standards developed for the CCBHC Demonstration grant. The state agencies are committed to ensuring community partner engagement and only moving forward if there is full community support for implementation.

Recent legislation and state investments through multiple state agencies support solutions to address issues of staff training and workforce diversity. The legislation requires 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 behavioral health workforce. The program provides tuition scholarships to rural and low-income students to obtain a credential in certain behavioral health programs. The programs include degrees in social work, addiction studies, addiction counseling, psychology, and individual and family counseling. The Colorado Department of Higher Education approved $5 million in grants to five universities that will provide tuition to students pursuing select degrees and certificates in behavioral health. The state estimates the program will serve nearly 400 students in the first two years with the program lasting four years. 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.

BHA is also required to collaborate with state agencies to improve behavioral health care provider workforce numbers, reduce administrative burdens, and develop criminal justice-related training sessions. In conversations with other states about CCBHC implementation, they indicated that instead of taking a statewide approach to workforce development, community involvement and dialogue will be critical to addressing regional strengths and needs. Thus, robust stakeholder engagement and throughout the Grant term will be critical to address the workforce shortage.

Colorado has been working diligently to increase the number and types of behavioral health providers available in the state. Following are examples of recent initiatives that the Colorado CCBHC Demonstration will build from:

- Enrolled additional behavioral health providers by 10 percent in state fiscal year 2022.
- Strengthening and expanding the number of providers that are eligible to receive state funds to include comprehensive safety net providers and essential safety net providers.
- Created the central registry for the Opioid Treatment Program (OTP). The new cloud-based central registry allows providers to interact with other OTPs and BHA in order to provide better access and safer treatment for their clients through a platform available to them 24 hours a day, 7 days a week.
- A 2022 statute created the Colorado Land-based Tribe Behavioral Health Services Grant Program in DHS to fund the renovation or construction of a behavioral health facility. The Southern Ute Indian tribe, the Ute Mountain Ute tribe, or any authorized Behavioral Health department, division, or affiliate are eligible for grant funding.
- Colorado passed 20 bills funding and expanding the public behavioral health system through a legislative Behavioral Health Transformational Task Force. Efforts include: behavioral health-care integration services for adults and children, Pediatric Psychiatry Consultation child the School-based Health Center Grant Program; over $100M in community grants for diversion and criminal justice, children and youth, and general capacity building; and multiple residential care and crisis supports.
- Colorado has a statewide crisis program, which has recently expanded with a focus on services that support children and youth and individuals with disabilities.

When looking to address Social Determinants of Health and culturally responsive services, the CCBHC planning grant also will utilize existing work to streamline and build a certification process that meets clients' needs. Existing efforts that will be leveraged include:

- Section 9817 ARPA Grant funds available to behavioral health providers to expand the use of health information technology and to translate outreach materials and education materials into various languages available through 2024
- In July 2022, BHA released OwnPath (OwnPath.co) as a searchable online directory that allows people to search for specific services or use a guided search to identify providers or resources that best meet their needs; OwnPath was released in English and Spanish (MiProprioSenda.co) initially and has plans to add additional languages in phases to the site, including navigation supports for behavioral health and SDOH services.

The proposed Certification process and election of sites to participate in the Demonstration will take into consideration the needs of potential sites and how they have leveraged other funding sources to meet both SDOH and culturally relevant services to their community when solidifying its Demonstration implementation plan, directly or through contract. The CCBHC sites will also be required to work very closely with the state's Medicaid managed care entities (MCEs), which will maintain the payment and data reporting contracting. The BHA also is in process of developing Behavioral Health Administrative Service Organizations that will provide care coordination and contract with CCBHC and other safety net providers for crisis, SUD and MH services for individuals who are uninsured. Since the MCEs operate under a fully capitation BH payment model, the CCBHC payment model and associated incentives and value-based payments will flow through the MCE. The MCE, BHASO, CCBHC relationships will be a central focus of the planning period and must operate in concert to ensure a successful demonstration model.

Colorado's desire to improve behavioral health outcomes has generated a lot of activity and resources from which HCPF and BHA can harness strength during the planning year. The attraction of the Planning Grant lies in realizing the certification criteria and payment model. Implementing a certification process is essential to meeting and resolving some of the challenges identified in this application. The Planning Grant tasks will double the effectiveness of efforts currently underway for Planning and Demonstration Grant requirements and HCPF and BHA initiatives.

Colorado's CCBHC Planning Grant process will focus on creating plans that close gaps in care, increasing the number of providers, expanding access to services, and ensuring that all residents have access to the right care at the right time and in the least restrictive setting. The CCBHC Planning Grant will provide the platform for a productive collaboration between agencies, the MCEs, providers, clients and communities throughout Colorado to further plan the future of behavioral health in Colorado. The state looks forward to exploring ways to further evolve our current managed care system into the next generation that includes high quality behavioral health care, CCBHCs, and managed care entities. Below is a table of how HCPF and BHA will utilize a planning year to complete required activities to move into a demonstration period.

Table 2: Planning Year High Level Work Plan

TASK	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Workstreams													
Policy and Stakeholder Work	Procure and negotiate				Initial gaps report			Present to stakeholders to inform certification			Incorporate feedback		Finalize cert process
CCBHC Certification Design	Procure and negotiate				Initial framework								
Data Design for Demonstration	Procure and negotiate				Identify sources of data			Design cross agency collection				Create Training	
Rates Analysis Contract						Procure & negotiate		Actuarial and rates work			Systems updates and training design		
Draft Demonstration App											Write Application		
Staffing Needs													
Hire Temp Staff		Hiring process			Active management of data process, application development, and rates development								Transition
Stakeholder Engagement													
Finalize Engagement Plan													
Finalize Provider Feedback on Certification and Metrics													
Quarterly BH service User Feedback Opportunities													
Complete Grant Reporting													

B2. Selection and Development of Prospective CCBHCs

Colorado does not currently certify CCBHCs. There are seven CCBHCs in Colorado at the present time. Eligibility for these planning grants included already certified CCBHCs and those clinics expected to achieve CCBHC status within 4 months of the grant. Several other providers have shown considerable interest in certification. The federally certified CBHCs have clinic locations in urban and rural counties. BHA, as the state's behavioral health licensing and designation agency, will lead the certification development and regulatory oversight. HCPF will update payment and certification standards for the Medicaid network providers, and support the provider engagement and training, including training on cost reporting and contracting.

A Steering Committee composed of approximately a dozen individuals will guide the CCBHC planning process including representation from HCPF, BHA, existing and interested providers, advocates, community partners, and individuals with personal or family lived experience. The state will also ensure membership from urban, rural and frontier counties so the Committee is reflective of the State's geographic diversity. The Committee will meet at least quarterly to review the progress of the planning process and work plan and to discuss and provide guidance regarding certification criteria, de-certification criteria, required performance measures including value-based performance measures, and data collection. The Steering Committee will help identify existing and potential clinics best equipped to participate in Colorado's Demonstration Grant representing locations across the state, which will receive assistance from the state to participate in the demonstration. Any provider interested in participation will be considered and must demonstrate a commitment to family-centered, equity-based, trauma-informed and recovery-oriented care and services to ensure growth in these critical aspects of care. The CCBHC applications must include a gap analysis for each provider identifying their specific needs and activities to prepare for certification and the Demonstration Grant period. The BHA is in process of setting provider criteria for safety net providers, which include this gap analysis as well as many of the CCBHC federal criteria. 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.

A core activity of the Planning Grant work will be to develop and disseminate criteria that applicants must meet to pursue certification under the terms of the planning grant and eventual demonstration. Information on the Colorado CCBHC demonstration application process including the opportunity for CCBHC certification, eligibility criteria, and levels of qualification that will be used to evaluate applicants for participation will be widely distributed. The BHA is currently in process of rewriting all the behavioral health provider standards over the next year, which will align with the need to create a regulatory infrastructure for CCBHC. The state's statutory timeline for updated provider standards is slightly ahead of the CCBHC grant timeline, so there is a need to determine how existing standards will interplay with the CCBHC standards on timing of application. The state will be working with our regional and national federal partners from CMS and SAMHSA to inform the updated CCBHC criteria and data standards, with a particular focus on preventing duplication of state-funded services for care coordination, crisis services, and network contracting. The implementation of the CCBHC model must allow participation of SNPs, FQHCs, large mental health and substance use clinics, hospital clinics, and other entities that are newly licensed with a safety net designation. Information provided by applicants will be analyzed to assess and compare levels of qualifications against the CCBHC

criteria, state licensing and approval standards, utilization patterns and penetration rates for specific populations, and examining relative levels of capacity.

HCPF and BHA have considerable experience in assessing federal and state compliance and quality oversight. This experience will be an asset in the planning process and during the Demonstration Grant for defining, assessing, improving or refining internal and provider processes. HCPF conducts annual site reviews for MCEs based on Section 438 of the federal regulations and directs the MCE in quality oversight for the Medicaid provider networks. BHA licenses all programs that use controlled substances to treat substance use disorder, including medically managed withdrawal management and opioid treatment programs, regardless of public or private funding. BHA also designates and approves provider programs and facilities based on provider regulations for patient rights, involuntary and voluntary treatment, and peer recovery professionals. As per standard procedure, any provider agency seeking licensure shall submit an initial application to determine fitness and if license is granted, the licensee shall be subject to unannounced visits for investigation into complaints, adverse licensing action should regulatory violations not be cured and yearly renewal application for ongoing licensure status. During the site review process, policies and procedures, operational reports, provider and informational materials as well as performance measure data may be reviewed. Suggestions for improvement, if needed, are discussed and a plan for corrective action could be required.

The state agencies will use contracts, technology, and regulatory systems to set data collection and standards procedures. The community providers will need to build data capacity to collect and report specific performance and quality measures not currently reported. A certification capacity assessment will be conducted as part of the certification process; we will revisit the self-assessment completed by each clinic at the start of the planning period including cultural, linguistic, and treatment capacity, staffing and adherence to evidence based practices. One critical focus will be the extent to which certification candidates have implemented standards and processes for care coordination designed to address the needs of Colorado's diverse populations.

B3. Inclusion of CMHCs in Rural, Frontier, and Urban Counties

Through its participation in the planning grant and demonstration program, Colorado aims to increase access to the right behavioral health services needed by individuals. Colorado recognizes its rural areas of the state are harder to serve and as such, have more limitations. Colorado will create its application process to value both capacities to start up CCBHC programming as well as the communities' need for services. Individuals and families with unmet needs are located throughout the state and the state will be working to recruit SNPs located in urban, rural and frontier counties. Already certified CCBHCs have clinics located in urban, rural, and frontier counties.

B4. Scope and Growth of the CCBHC Demonstration

During the planning year, the team will welcome interested clinics to complete a readiness assessment to determine their ability to become a CCBHC. The team will work to invite behavioral health providers such as FQHCs, CMHCs, large mental health or substance use providers and large specialty clinics to participate in planning and provide technical assistance as needed. The sites might be able to start applications by the end of the Planning Grant, but the

state will not move forward with applications until the Demonstration Grant is awarded. Part of the additional federal match will go to fund the needed ongoing staff to provide compliance oversight and provider support for CCBHCs. If the state shows large rural gaps for CCBHCs, the team will work with providers in those areas providing technical assistance and build buy-in for participation. The state will also develop a decertification process during the planning phase so that client health and safety is maintained and to assure certification criteria are met for the term of the Grant, which will be essential for accountability.

B5. Transition from Planning Grant to Demonstration Grant

To aid in the transition from planning grant to the demonstration period, the team will ensure all components of the demonstration are ready to go live by July 1, 2024. The team will actively manage a four-year work plan that will be included as a cornerstone of the Demonstration application. The transition plan will include major work paths around:

- Onboarding staff for the operation of the Demonstration, including ongoing staff for the duration of the grant. The state anticipates that the temp Planning Grant staff would be able become permanent staff under the Demonstration Grant.
- 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 request work plan for solidifying the state match component.
- Demonstration and national evaluation data collection processes, manuals, and methodologies are finalized

To ensure the effective transition of the project, the Project Director will remain in their role through at least the first quarter of the Demonstration period if not longer. All work group meetings will continue through a transition period ensuring all work is actively happening as the team's application is being reviewed.

B6. PPS-Rate Setting Methodology for CCBHCs

HCPF has been working for two years with CMHCs and other SNPs on developing an alternative payment plan and plans on using the PPS-1 model. The daily rate is similar to how HCPF currently sets and pays FQHC PPS rates. PPS-1 also allows for the possibility of paying quality performance bonuses. HCPF and the Managed Care Entities are not properly set up for monthly payments or for specialty populations as required in PPS-2. HCPF will be integrating the CCBHCs into the current managed care infrastructure. Currently, CMHCs rates are calculated based on audited cost reports, so this part of the model will be easily implemented under existing processes. HCPF will be using the federal CCBHC cost reporting structure and have the cost reports audited. The cost reports and reported utilization through encounter data will be used to derive the encounter rate. Some FQHCs have identified interest in the CCBHC model as partners or as CCBHCs and will assist in exploring how to minimize double cost reporting.

B7. PPS for Behavioral Health Services in CCBHCs

HCPF and its actuaries will be using previous encounter data, following the PPS methodology, to calculate the number of encounters for the denominator. HCPF will also use previous encounter data for any Designated Collaborating Organizations that the CCBHC intends to contract with. For the numerator, HCPF will require submission of CCBHC cost reports. These cost reports will be audited by an independent auditor and are already required by statute. The PPS will be the allowable costs divided by the number of allowable encounters.

Colorado has traditionally used the cost-based model, utilizing cost reports, that has been applied to 17 CMHC SNPs. Changes to the system seek to protect the need for safety net funding but improve the way the State determines or calculates those respective cost-based rates and to expand the number of safety net providers with access to them. This includes improving the cost reports that determine the cost-based reimbursements, allowing for greater flexibility of funds, connecting the funding to outcomes to build accountability, and expanding the number of providers able to access these funds thereby creating competition and choice across geographies. Some of the changes needed, like modernized legislative definitions and updates to cost-reporting standards, are already underway. The changes will take time but will create a more appropriate difference between the Medicaid reimbursements to independent providers and the safety net providers. New statutory provider definitions create an opportunity for small, medium, and specialty clinics that are truly providing safety net services, including whole-person team-based care, to participate in safety net reimbursement rates and related reporting as an "essential behavioral health safety net provider." The state will easily be able to execute on the standard cost reporting processes based on this experience, and many existing and potential CCBHCs have experience submitting cost reports.

HCPF has engaged outside consultants to help design and implement a pilot value-based payment (VBP) model to ensure the creation of "equitable payment and payment models that minimize inappropriate payment variation" per state statute. The intention of this model is to reduce possible disparities in payment structures for a behavioral health provider between differing MCE, improve transparency, and connect reimbursements to quality outcomes. This model design considers access and quality metrics to improve outcomes and equity in payments. Initial stakeholder engagement has been completed on this project and HCPF is now in the process of engaging actuaries to begin the buildout of the financial model. HCPF is working to launch the initial pilot with a select group of providers in State Fiscal Year 2024. This pilot, including cost-based payment with additional performance payments, is consistent with the PPS 1 model with VBP. The state staff, local interested providers, advocates, and other relevant stakeholders have all participated in the planning for a new payment model and are prepared for this development.

B8. Expansion of Capacity, Access, and Availability of Services

The transformation of Colorado's behavioral health system, led by the recently formed BHA, provides the ideal setting for CCBHC planning grant and demonstration grant initiatives. The following chart demonstrates concrete steps HCPF and BHA will take to ensure the Demonstration is successful.

Table 3: Planning Year steps to Expand Capacity, Access and Availability

Demonstration Need	Colorado Approach
Expand capacity, access and availability of services	● Ensure new CCBHC certification requirements are marketed to regions of the state currently not served by CCBHCs ● Create certification requirements that address availability of services ● When agencies are invited to sign up for the Demonstration, the selection process will focus on priority populations, rural and urban locations, and look to agencies that have a history of expanding services ● Expand and increase tele-behavioral health services through the Demonstration ● Align with existing state efforts that work to expand the workforce, types of behavioral health services, and general availability of services across the state
Conduct outreach and engagement	Colorado has had a robust stakeholder engagement process for the past few years and will continue to solicit input from the community on how best to meet the local behavioral health needs. The CCBHC planning year will ensure quarterly meetings with direct clients and providers and have more in-depth sessions when reviewing contract deliverables that will inform the future Certification process.
Staff Training	The CCBHC Planning Grant will set forth new standard training for clinics to become certified. The training will include federal and state requirements that are evidenced-based. By the end of the planning year, training will have included billing processes and procedure training on the selected PPS model. Within the planning period's final product of a Work Plan for the Demonstration, there will be a strong outline of training gaps for proposed sites and a schedule to incorporate all new requirements, inclusive of a process to operationalize the ongoing process for having new staff meet requirements within CCBHC models.
Address workforce diversity	CCBHC planning grant will dovetail with existing initiatives to address workforce diversity including: ● Support and fund the use of non-traditional workforce, especially peers ● Outreach to enhance workforce diversity ● Targeted recruitment

B9. Developing Processes for CCBHCs to Solicit Stakeholder Feedback

The sole focus of several HCPF and BHA councils and committees is to have discussions with clients, persons with lived experience, providers, caregivers and community organizations and others to obtain meaningful and timely stakeholder feedback. The operational and organizational lessons HCPF and BHA have learned through these committees will be shared with the CCBHCs during the Planning and Demonstration Grants period. During the planning process, HCPF and BHA will work with these committees and councils to see if there is the bandwidth to obtain feedback for the Planning Grant tasks around certification, continual stakeholder feedback processes during the demonstration, and other identified needs. If additional input is needed, HCPF and BHA may also tap direct feedback loops established by clinics interested in the certification process and create specific events and feedback opportunities for targeted stakeholders, beyond established groups.

BHA invites those with lived behavioral health experience to co-create and inform the BHA's vision and strategic plan. The BHA Advisory Council (BHAAC) is a group of people with lived experience who applied for and were selected to ensure there is public accountability and transparency across the activities of the BHA. The inclusion of the BHAAC is codified in legislation and the BHAAC began activities in 2022.

BHAAC meetings are open to the public and are held quarterly. Meeting dates/times, agendas, meeting minutes, membership, and working group information are posted for future reference. BHAAC's first meeting was held in August 2022. Members of the BHAAC have the following responsibilities:

- Providing diverse community input on challenges, gaps, and potential solutions to inform the BHA's vision and strategic plan
- Providing expertise, on-the-ground perspective, and insights on implementation challenges as part of working groups to support the BHA in problem solving and developing solutions
- Ensuring there is public accountability and transparency through reviewing the BHA's public-facing activities

Updates on Planning Grant progress and solicitation for feedback will be provided to the BHAAC at each meeting to ensure that we are designing a comprehensive system that meets the needs of everyday people in Colorado. Progress reports will be given to the Regional Advisory Councils for discussion at regional meetings.

The Member Experience Advisory Council (MEAC) is made up of people who are current Medicaid or Child Health Plan *Plus* (CHP+) clients or parent/caregivers of clients. MEAC members come together monthly to learn, give input and ultimately affect positive change in our programs. Grant program updates will be provided for information and to obtain input from MEAC members. Members share their honest experiences and provide feedback as a guide for the future. Childcare, transportation costs, and stipends for time well spent are offered for clients' participation.

The MEAC mission is: 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. The MEAC objectives include:

- Continue to build understanding and commitment for person- and family-centeredness, which means we respect and value individual strengths, preferences and contributions, and work with clients, not doing things to or for them.
- Provide opportunities for collaboration between HCPF and clients with the goal of improving client experience and the relationship between HCPF and all clients.
- Provide a way for HCPF staff to test with clients whether programs and policies are working as designed and having the desired outcome.
- Build staff empathy and skills by engaging with actual clients and their lived experience, accessing meaning behind data, not just relying on what's easy to collect and analyze.

HCPF also requires statewide program improvement meetings called Program Improvement Advisory Committee (PIAC). The PIAC is the committee focused on engaging stakeholders and obtaining guidance on how to improve the health, access, cost, and satisfaction of clients and providers. Responsibilities of the statewide PIAC include reviewing and providing feedback regarding RAE performance data, program policy changes, and client materials. This Committee meets monthly.

In addition to the statewide PIAC, there are quarterly regional PIACs. Each regional meeting reflects the RAE's region of responsibility within the state. Membership of the regional PIAC includes clients, stakeholders, caregiver, providers, and persons representing related community organizations, such as local public health or child welfare organizations. Key Personnel identified in the RAE contract attend the statewide PIAC meeting in addition to one representative from each regional PIAC. Grant program updates will be provided for information and to obtain input from statewide and regional PIAC members.

BHA, HCPF, the RAEs, the SNP network highlighted here provide a rich resource to establish lessons learned guidance for grant participants.

B10. Demonstration Stakeholder Feedback and Dissemination of Information

HCPF and BHA have informed clients, providers, and stakeholders about the Planning Grant and will continue that practice throughout the Planning and Demonstration Grants. Clients, persons with lived experience, family members, providers, and other stakeholders can be members of the BHAAC, MEAC, and PIACs. The four standing committees and their subcommittees will provide a space where CCBHC planning grant activities can be shared on a consistent basis. Input received from these listening activities will be shared between HCPF and BHA.

Per state statute, the 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 behavioral health needs of children and youth
- At least one individual who represents a behavioral health safety net provider that operates within the region
- A county commissioner of a county situated within the region

- BHA may create committees within the Advisory Council, as necessary

The state held a CCBHC planning grant webinar in early December 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 Behavioral Health 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 to inform the Planning Grant application.

Section C: Staff and Organizational Experience

C1. Existing States towards CCBHC Adoption

Colorado has been exploring the CCBHC model since 2015. Colorado Medicaid has an authority structure that supports implementation of the CCBHC, and the state is engaged in overall reform efforts that resonate with CCBHC related work, including:

- HCPF and BHA are working together to develop a behavioral health quality framework that will include the use of some CCBHC measures.
- BHA has existing and increasing responsibilities for licensing and approving behavioral health entities; this affords them with the authority and infrastructure to provide a State certification for CCBHCs.
- HCPF has collaborated with BHA and other stakeholders to understand the needs of the State as we consider how to implement alternative payment models.
- Both BHA and HCPF have committed workforce training dollars to developing skills within the current and future workforce.
- HCPF voluntarily collects data and reports on CMS Core Measure Sets for Adults and Children.
- HCPF and its behavioral health providers have many years' experience with capitated reimbursement. This experience gives Medicaid administration and its providers 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 on seven-year state contracts with significant updates in 2011 and 2018. Planning for ACC 3.0 has begun and the opportunity to align with CCBHC criteria is another reason to be Planning and Demonstration Grantees. Objectives of the ACC, listed below, mirror many of the CCBHC values:
    - Join physical and behavioral health under one accountable entity
    - Strengthen coordination of services by advancing Team-based Care and Health Neighborhoods
    - Promote client choice and engagement
    - Pay providers for the increased value they deliver
    - Ensure greater accountability and transparency

Recent legislation closely aligns with CCBHC criteria. Colorado has seven clinics that have been awarded CCBHC grants with seven active grantees. While preparing for the Planning Grant, HCPF and BHA met with several key stakeholders in the state to get feedback on applying for the planning grant and adopting the CCBHC model statewide, including existing CCBHCs. In addition, Colorado has been collaborating with SAMHSA, CMS, and the Missouri, Nevada, and

Minnesota Health Departments to ensure that adoption of the CCBHC model in Colorado goes smoothly, with special focus on integrating the model with our existing managed care system. Other states suggested the need for a CCBHC disenrollment process and Colorado will include that important aspect of care. Colorado has been preparing for this Planning Grant formally and informally, through initiatives, legislation, and listening sessions for many years.

C2. Partner Organizations

BHA is a partner organization in the Application as discussed previously. The Application 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, approval the CCHC certification process and demonstration data collection process, and design of the demonstration implementation plan. 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 level.

Input from most safety net providers has been positive; some expressed “excitement”. Although not partners in the Planning and Demonstration Grants, there are additional active and interested efforts that align with CCBHC criteria, shown below.

BHA knows that strong, ongoing, effective partnerships with advocacy organizations, providers, counties, and other cabinet members and agencies is critical to the development of a responsive, streamlined, and coordinated strategy. In the development of BHA organizational structure, a new division was created to focus on engagement and partnership with identified groups and promote the vision of networked governance. These partnerships are critical because they aim to reduce silos that exacerbate health inequities and ensure BHA is promoting and employing strengths, expertise, and unique roles in a combined effort to enhance and improve behavioral health services.

Recent legislation also established that the BHA Commissioner shall chair a regular meeting of executive directors of state agencies to ensure regular engagement and align state programs, resource allocation, priorities, and strategic planning efforts. The Interagency Council launched in August 2022 with the expectation of monthly meetings. The Interagency Council initially focused on understanding the existing reform efforts, receiving status updates on BHA launch and implementation, and sharing updates on efforts across agencies. Key priorities for collaboration include the care directory, shared grievance process, strategic planning, and workforce development initiatives. The meeting agendas are designed collaboratively between BHA and partnering agencies. For example, September’s meeting focused on workforce and was planned with the Colorado Division of Higher Education who co-presented and led discussion on the Healthy Minds Campuses initiative. Upcoming opportunities will focus on funding and solutions for the child and youth mental health crisis and coordination around federal funding opportunities among other priorities.

C3. List of Project Staff

Below are descriptions of staff supporting the Planning Grant:

- The Principal Investigator for this project will be Scott Bennett, Project Manager at HCPF, under the oversight of the Medicaid Behavioral Health Policy and Benefits Division Director, and the Deputy Medicaid Director. Due to the high work volume involved with this planning year grant, Scott will dedicate 60% of his time to this project. Having two years of experience managing the behavioral health parity work, Scott is strongly positioned to lead this project with a lens for equitable practices focused on Colorado's policies to serve its diverse clients that use behavioral health services. Scott will manage the Policy Analysis and Stakeholder Contract, all coordination with the Behavioral Health Administration and coordination with the internal rates and data team. Scott will review all final deliverables to make the project successful including the CCBHC Certification standards, the implementation of the PPS model, finalization of data collection methodologies, participate in 70% of stakeholder engagement meetings, and transition the team from the planning year to the demonstration period. Resume attached.
- Temp Grants Specialist- this person will manage grant reporting requirements, provide project management for the planning year such as scheduling, note taking, and project plan updates. This staff person will be responsible for authoring the application for the Demonstration of Colorado's CCBHC project. This will be a full time FTE.
- Temp Data Analyst- this person is responsible for ensuring a strong data process, collection, methodologies, and sharing protocols are set up within the planning year to be successful during the demonstration. This will be full time FTE.

Due to the short nature of a planning year grant and the longer timelines it takes state agencies to hire on staff, many leadership members across HCPF and BHA will provide their leadership and expertise within their current role. The grant will have two senior executives that sponsor all selections made for payment models, data collection, and will review all stakeholding analysis 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 year grant on behalf of HCPF. Summer Gathercole, BHA Deputy Commissioner of Operations, will provide senior executive oversight of the planning year grant on behalf of BHA. These and the below leaders will support this effort at no additional cost and at 5% of their time.

- Thom Miller, Division Director of Quality and Standards at the Behavioral Health Administration will oversee all work leading to new Certification of CCBHC standards in Colorado. 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.
- Christen Lara, Division Director of Health Information Technology for BHA, alongside the incoming BHA Chief Data and Analytics Officer, will create the data reporting process alongside HCPF Data Team to design a cross agency data reporting system for the Demonstration period of the CCBHC demonstration grant. She will 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 for four years of demonstration.

- Yumiko Dougherty, Division Director of Strategy and Engagement at BHA will incorporate the planning year's stakeholder engagement plan into her team's Behavioral Health Council work as well as share standards with existing CCBHCs stakeholder feedback loops to ensure the lived experience of those using the network of behavioral health services is incorporated into the implementation plan. Yumiko's team is well positioned to incorporate opportunities for limited English proficient individuals to participate in sessions as well as creating population specific opportunities (ex: Youth, Veterans, etc.) to provide feedback to both HCPF and BHA around the project.
- Steven Ihde, BH Rates Manager, will oversee the actuary contractor and general payment model implementation design for the new payment model.

D1. Performance Measures and Data Collection Plan

Colorado feels well positioned to participate in the CCBHC Demonstration since the state requires similar data collection to that required in the Demonstration Grant. During the planning period, the team will work with existing and interested CCBHCs regarding data collection and reporting processes, successes, challenges, and lessons learned. HCPF will add Value Based Measures to the Grant performance measures; these measures have not yet been identified.

HCPF has a long history of collecting and reporting quality data related to national performance measures (with a specific focus on CMS Adult and Child Core Measures) which means the ability exists, in terms of data collection and reporting mechanisms. HCPF's Planning Grant Project Manager and Grant Specialist will create a grant performance monitoring plan that reflects reporting requirements related to number and percentage of work group/advisory group/council members who are consumers/family members, the number of organizations collaborating/coordinating/sharing resources with other organizations, and the number of organizations or communities that demonstrate improved readiness to change their systems in order to implement mental health–related practices that are consistent with the goals of the award within the reporting period. BHA will assist with reporting on grant performance measures in alignment with HCPF's Grant performance monitoring plan.

Table 4 outlines which current CCBHC measures are captured in Colorado

Core BH Measurement 2022 Items	CCBHC Measurement and Acronym	Measured by (in CCBHC model)	HCPF collects data	BHA collects data
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD)	Yes IET-BH	State	No	Maybe
Medical Assistance With Smoking and Tobacco Use Cessation (MSC-AD)	Yes TSC	BHC (Behavioral Health Clinic)	No	No
Antidepressant Medication Management (AMM-AD)	Yes AMM-BH	State	Yes	No

Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)	Yes ADD-BH	State	Yes	No
Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH)	Yes Part of CDF-BH	BHC	Yes	No
Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)	Yes Part of CDF-BH	BHC	Yes	No
Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17 (FUH-CH)	Yes FUH-BH-C	State	Yes	No
Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)	Yes FUH-BH-C	State	Yes	No
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)	Yes SSD	State	Yes	No
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Yes SMI-PC	State	Yes	No
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)	Yes	State	No	No
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Ages 13 to 17 (FUA-CH)	Yes Part of FUM & FUA	State	No	No
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Age 18 and Older (FUA-AD)	Yes Part of FUM & FUA	State	No	No
Follow-Up After Emergency Department Visit for Mental Illness: Ages 6 to 17 (FUM-CH)	Yes Part of FUM & FUA	State	Yes	No
Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD)	Yes Part of FUM & FUA	State	Yes	No
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)	Yes SAA-BH	State	Yes	No

Because BHA integrated Colorado's former Community Behavioral Health Division when BHA was established, BHA also has a long history of collecting and reporting to SAMHSA as required for the Government Performance and Results Act (GPRA), the National Outcome Measure System (NOMS) and the Universal Reporting System (URS) using 837 encounter data as well as Colorado specific clinical mental health and substance use data.

This experience means that HCPF and BHA will be able to work with SAMHSA and participating providers during the Planning Grant period to develop a plan to put in place the mechanisms for data collection and reporting for the Demonstration performance measures. Specifically, HCPF and BHA will collaborate with the national evaluation planning team and provide input on lessons learned from the Colorado CCBHCs, the evaluation design, data sources, and performance measures (including CMS Adult and Child Core measures). We will work with the Department of Health and Human Services personnel and the evaluation planning team to ensure that claims from CCBHCs can be identified and correspond to CMS-64 reporting. For quality measure counts of CCBHC clients and required cost reports, a cross-agency process and protocols will be solidified with participating clinics to ensure timely submission. Staff from all teams will be available for any follow-up questions regarding the submissions. Institutional Review Board approval will be obtained as necessary to fulfill national evaluation reporting requirements.

D2. State Support of CCBHC Performance Measurement and Quality Improvement

HCPF and BHA routinely establish and enforce requirements and expectations via behavioral health licensing rules and service delivery contracts. The contracts require Medicaid managed care organizations participate in quality improvement processes, including performance improvement projects and performance measure reporting. The expectation that behavioral health providers, including CCBHCs, participate in performance measurement and quality improvement activities was further solidified through recent legislation. The legislation established BHA as the state's single entity responsible for driving coordination and collaboration across state agencies to address behavioral health needs, including being responsible for establishing a performance monitoring system for tracking capacity and performance of behavioral health providers, determining performance standards, addressing accessibility of care and quality of care. Furthermore, it requires BHA to collaborate with HCPF and other state agencies in determining standards.

HCPF and BHA are currently partnering to build a quality framework to support population health goals. The goal of this initiative is to create purposeful alignment and coordinated quality measurement activities that consider each entity's sphere of influence while keeping a line of sight to shared goals. This empowers stakeholders to make informed decisions and minimizes burden across state, managed care, and provider levels. This initiative also aligns BHA work with HCPF's CMS Behavioral Health Core Measure Set Reporting Requirements. The CCBHC planning and demonstration grants are an opportunity to further develop and refine a behavioral health quality framework for Colorado. It supports CCBHCs in developing capacity to both report on those performance measures and implement processes to improve performance on those measures over time. This new requirement is an additional instance where Planning Grant participation and State requirements align.

D3. Performance Assessment Plan

HCPF is committed to meeting all reporting requirements of this planning grant, submitting timely quarterly reports on progress, and developing and implementing a project performance assessment. A key component of the team's planning year work will be to create a data collection and reporting plan that outlines protocols and roles and responsibilities across HCPF, the BHA and participating sites. Both HCPF and BHA employ strong data collection and analytics teams with experience creating and completing multi-year demonstration data reporting. As part of the project performance assessment plan, a point person will be identified at each participating clinic to ensure required data is collected and reported following approved protocols. Outputs from the project performance assessment will follow all grant submission requirements. We anticipate that quarterly review of the data will provide a timely look at the direction performance takes so that adjustments can be made and positive outcomes realized.

D4. Potential National Evaluation Challenges

We look forward to collaborating with the national evaluation planning team and providing input on the evaluation design, data sources, and performance measures. To date, potential participating providers have expressed skepticism about the data requirements from the national evaluation, voicing concerns about additional client level data collection and reporting.

Because of Colorado's depth of experience in producing behavioral health performance reports from claims and encounter data we look forward to seeing the proposed national evaluation data set and the timeframes for submission. Ideally the time frames correspond to already developed schedules. Both HCPF and BHA have experience in collaborating with behavioral health providers in developing and detailing numerators, denominators, exceptions, and definitions for undefined measures used internally.

One potential challenge that Colorado is well poised to manage is having comparison non-CCBHC providers who report on a set of similar performance measures as CCBHC demonstration provider participants, if that will be required. HCPF and BHA are collaborating on a statewide behavioral health quality framework through which all HCPF and BHA-funded behavioral health providers would be required to participate. During the planning grant period, we have the opportunity to identify and align the quality framework with at least some provider-level performance measures selected via the national evaluation for comparison and in alignment with the CMS Core Measures for Behavioral Health.

D5. Data Collection for National Evaluation

HCPF and BHA both receive and process data from claims, encounters, patient records, and registry data from its contractors daily. HCPF receives patient experience data on an annual basis. HCPF and BHA have the capacity to collect data for the national evaluation of the CCBHC Demonstration program. HCPF is beginning to receive patient clinical data for physical health services from Electronic Health Records (EHR) from providers, through Continuity of Care Documents (CCDs) sent through the regional Health Information Exchanges that are connected to provider EHR Systems to supplement claims data in administrative reporting of

CMS Adult and Child Core Measures. 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. On the behavioral health side, HCPF is working with the existing CCBHCs to receive some patient record data. This work may dovetail alongside the Planning Year efforts to be incorporated into the Demonstration timeline.

BHA receives Mental Health and Substance Use Disorder information used to complete federal block grant reporting such as the Treatment Episode Dataset (TEDS), NOMS, and the URS tables. BHA currently allows providers to submit their data through a web-based data form for providers without an electronic health record (EHR) or the ability to extract the information from their EHR and submit in a batch format. One of the major drivers for the creation of BHA was the fragmentation of data collection systems, processes, and sources of truth across the state's behavioral health landscape. BHA has a multi-year strategy for rapidly growing and evolving a modern behavioral health technology ecosystem in Colorado that provides people-first behavioral health services. A critical component of this strategy is modernizing BHA's data-sharing strategy. BHA is in the process of building a new and more flexible data strategy. This will provide BHA with new capabilities such as secure data sharing (which will reduce fragmentation); it will improve availability of client-level data for those who need it while protecting data without individual consent and addressing whole-person care while centralizing existing data system, and it will increase capacity of BHA to exchange information between BHA-owned systems and behavioral health provider EHRs.

HCPF and BHA will work with selected sites to complete required data reporting that they have on hand regarding patient records, chart-based/registry data and patient experience. When looking at current sites operating CCBHC grants, they gather patient experience data by collaborating with local county departments, hospitals, and primary care providers, to utilize data from established assessments and special interest research. Demonstration sites will be included in all conversations to ensure site-based chart and patient experience data can be folded into the process. Harnessing the gathering momentum to create more standardized data collection, HCPF and BHA together with awarded sites will meet all CCBHC data collection and national evaluation needs.