DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, MD 21244-1850

State Demonstrations Group

September 2, 2025

Adela Flores-Brennan
Medicaid Director
Colorado Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

Dear Director Flores-Brennan:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of the Serious Mental Illness/Serious Emotional Disturbance (SMI/SED) Implementation Plan, inclusive of the SMI/SED Health Information Technology (Health IT) Plan, for Colorado's section 1115(a) demonstration entitled "Colorado Expanding the Substance Use Disorder (SUD) Continuum of Care" (Project Numbers 11-W-00336/8 and 21-W-00079/8). We have determined the SMI/SED Implementation Plan, inclusive of the SMI/SED Health IT Plan, is consistent with the requirements outlined in the demonstration special terms and conditions (STCs) and are therefore approving it. With this approval, the state may begin receiving federal financial participation as of the date of this letter, for the provision of Medicaid state plan services furnished to otherwise eligible individuals who are primarily receiving treatment for an SMI or SED who are short-term residents in facilities that meet the definition of an institution for mental diseases. A copy of the approved SMI/SED Implementation Plan is enclosed and will be incorporated into the STCs as Attachment F.

We look forward to our continued partnership on the Colorado Expanding the Substance Use Disorder Continuum of Care section 1115(a) demonstration. If you have any questions, please contact your project officer, Kathleen O'Malley, at Kathleen.OMalley@cms.hhs.gov.

Sincerely,

Lisa Marunycz Deputy Director, signing for
Angela D. Garner
Director
Division of System Reform Demonstrations

Enclosure

cc: Ronna Bach, State Monitoring Lead, Medicaid and CHIP Operations Group

Section 1115 SMI/SED Demonstration Implementation Plan

Overview: The implementation plan documents the state's approach to implementing SMI/SED demonstrations. It also helps establish what information the state will report in its quarterly and annual monitoring reports. The implementation plan does not usurp or replace standard CMS approval processes, such as advance planning documents, verification plans, or state plan amendments.

This template only covers SMI/SED demonstrations. The template has three sections. Section 1 is the uniform title page. Section 2 contains implementation questions that states should answer. The questions are organized around six SMI/SED reporting topics:

1. Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings
2. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care
3. Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services
4. Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration
5. Financing Plan
6. Health IT Plan

State may submit additional supporting documents in Section 3.

Implementation Plan Instructions: This implementation plan should contain information detailing state strategies for meeting the specific expectations for each of the milestones included in the State Medicaid Director Letter (SMDL) on "Opportunities to Design Innovative Service Delivery Systems for Adults with [SMI] or Children with [SED]" over the course of the demonstration. Specifically, this implementation plan should:

1. Include summaries of how the state already meets any expectation/specific activities related to each milestone and any actions needed to be completed by the state to meet all of the expectations for each milestone, including the persons or entities responsible for completing these actions; and
2. Describe the timelines and activities the state will undertake to achieve the milestones.

The tables below are intended to help states organize the information needed to demonstrate they are addressing the milestones described in the SMDL. States are encouraged to consider the evidence-based models of care and best practice activities described in the first part of the SMDL in developing their demonstrations.

The state may not claim FFP for services provided to Medicaid beneficiaries residing in IMDs, including residential treatment facilities, until CMS has approved a state's implementation plan.

Memorandum of Understanding: The state Medicaid agency should enter into a Memorandum of Understanding (MOU) or another formal agreement with its State Mental Health Authority, if one does not already exist, to delineate how these agencies will work with together to design, deliver, and monitor services for beneficiaries with SMI or SED. This MOU should be included as an attachment to this Implementation Plan.

State Point of Contact: Please provide the contact information for the state's point of contact for the implementation plan.

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Medicaid Section 1115 SMI/SED Demonstration Implementation Plan
Colorado Expanding the Substance Use Disorder Continuum of Care
Demonstration Approval September 2, 2025
Submitted on December 19, 2024

1. Title page for the state's SMI/SED demonstration or SMI/SED components of the broader demonstration

The state should complete this transmittal title page as a cover page when submitting its implementation plan.

State	Colorado
Demonstration name	Colorado Expanding the Substance Use Disorder Continuum of Care
Approval date	January 13, 2025 Amendment (approved SMI/SED etc.,)
Approval period	November 13, 2020, to December 31, 2025
Implementation date	September 2, 2025

2. Required implementation information, by SMI/SED milestone

Answer the following questions about implementation of the state's SMI/SED demonstration. States should respond to each prompt listed in the tables. Note any actions that involve coordination or input from other organizations (government or non-government entities). Place "NA" in the summary cell if a prompt does not pertain to the state's demonstration. Answers are meant to provide details beyond the information provided in the state's special terms and conditions. Answers should be concise, but provide enough information to fully answer the question.

This template only includes SMI/SED policies.

Prompts	Summary
SMI/SED. Topic_1. Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings	
To ensure that beneficiaries receive high quality care in hospitals and residential settings, it is important to establish and maintain appropriate standards for these treatment settings through licensure and accreditation, monitoring and oversight processes, and program integrity requirements and processes. Individuals with SMI often have co-morbid physical health conditions and substance use disorders (SUDs) and should be screened and receive treatment for commonly co-occurring conditions particularly while residing in a treatment setting. Commonly co-occurring conditions can be very serious, including hypertension, diabetes, and substance use disorders, and can also interfere with effective treatment for their mental health condition. They should also be screened for suicidal risk. *To meet this milestone, state Medicaid programs should take the following actions to ensure good quality of care in psychiatric hospitals and residential treatment settings.*	
Ensuring Quality of Care in Psychiatric Hospitals and Residential Treatment Settings	
1.a Assurance that participating hospitals and residential settings are licensed or otherwise authorized by the state primarily to provide mental health treatment; and that residential treatment facilities are accredited by a nationally recognized accreditation entity prior to participating in Medicaid	*Current Status:* The Colorado public behavioral health care system includes substance use and mental health services and is administered and funded primarily by three separate executive branch departments; HCPF, the Colorado Department of Human Services (CDHS) which houses the Behavioral Health Administration (BHA), as well as the Division of Child Welfare, and the Office of Civil and Forensic Mental Health (OCFMH), and CDPHE. HCPF serves as the Single State Authority (SSA) for Medicaid, the BHA is the single state authority (SSA) for substance abuse services and the state mental health authority (SMHA), and CDPHE serves as the state public health authority and leads prevention efforts for the state. BHA purchases mental health and substance use services through contracts with behavioral health providers, regulates the public behavioral health system, and provides training, technical assistance, evaluation, data analysis, prevention services, and administrative support to all behavioral health providers and relevant stakeholders. OCFMH administers the two state mental health hospitals and administers forensic mental health services for individuals with court system involvement when competency has been raised.

	Psychiatric Hospital Licensure The oversight of psychiatric hospitals under this demonstration is shared by multiple Colorado state departments, including Colorado's Department of Public Health and Environment (CDPHE) and the Behavioral Health Administration (BHA). Under the Department of Health Care Policy and Financing (HCPF) Code of Colorado Regulations 10 CCR 2505-10 8.300, a Psychiatric Hospital is defined as a psychiatric hospital licensed and CMS-certified as a Psychiatric Hospital to plan, organize, operate, and maintain facilities, beds, and treatment, including diagnostic, therapeutic and rehabilitation services, over a continuous period exceeding twenty-four (24) hours, to individuals requiring early diagnosis, intensive and continued clinical therapy for mental illness, and mental rehabilitation. Colorado assures that participating psychiatric hospitals are licensed primarily to provide mental health treatment and that the facilities are in compliance with the Medicare Conditions of Participation (CoPs). Psychiatric hospitals are included under this demonstration starting in year one. **Mental Health Residential Facilities, including Acute Treatment Unit and Crisis Stabilization Unit Licensure** The Colorado BHA is responsible for administering, licensing, and regulating the provision of community-based public behavioral health services, including the two residential mental health facility types included under this demonstration starting in year one: Acute Treatment Units (ATUs) and Crisis Stabilization Units (CSUs). Within the Colorado behavioral health system, BHA licenses behavioral health entities (BHEs). BHEs, in turn, may receive distinct endorsements from the BHA, depending on the nature of the services provided and/or the populations served. ATUs are endorsed to provide short term residential psychiatric care and CSUs are endorsed to provide brief, intensive residential care to help stabilize individuals experiencing a mental health crisis. Currently, these residential facilities are not required to be accredited. All participating BHEs are licensed by the state to treat mental illness. The BHA rules currently do not include national accreditation as a requirement for licensure.
	Future Status: HCPF will require national accreditation for qualifying mental health residential BHEs including those with an endorsement as CSUs and ATUs as a condition of HCPF Medicaid provider enrollment. Colorado acknowledges that FFP is not available under 1115 demonstration authority for services delivered in residential settings that are IMDs until the facility is accredited by a nationally recognized accreditation entity. Psychiatric hospitals, CSUs and ATUs will participate in the demonstration starting in year one.
	Summary of Actions Needed: 1. HCPF will work with BHA to update provider enrollment agreements and application materials to require national accreditation for all mental health residential BHEs including those with an endorsement as a CSU or ATU as a condition of Medicaid enrollment under this demonstration. [(Timeline: 12-24 months).] 2. HCPF will also review all currently enrolled mental health residential providers to confirm compliance with

	national accreditation requirements. These actions will be completed within the first year of the demonstration.

Prompts	Summary
1.b Oversight process (including unannounced visits) to ensure participating hospital and residential settings meet state's licensing or certification and accreditation requirements	*Current Status:* **Psychiatric Hospitals: Oversight** All participating hospitals are subject to surveys to ensure compliance with the Medicare CoPs. In addition, CDPHE oversight authority for licensed hospitals is outlined in 6 CCR 1011-1 Chapter 2, Part10. This chapter allows CDPHE and any duly authorized representatives the right to go onsite in order to determine the state of compliance with the statutes and regulations, including unannounced onsite inspections. In addition, CDPHE may utilize unscheduled or unannounced reviews to ensure a licensee's full compliance with the applicable statutory and regulatory criteria. **Mental Health Residential Facilities, including Acute Treatment Unit and Crisis Stabilization Unit Oversight** Licensed BHEs are required to have a governing body who is responsible for the high-level strategy, oversight, and accountability (BHE 2.4). In addition, the BHA has the right to conduct onsite visits to determine the state of compliance with state statutes and regulations. The BHA is also authorized under rule, to ensure a BHE's full compliance with licensing and designation criteria under its authority, and to conduct an unscheduled or unannounced review of a current BHE. In addition, BHEs must provide upon request, access to or copies of the following to the BHA for performance of its regulatory oversight responsibilities: ● Individual records ● Reports and information including but not limited to staffing reports, census data, statistical information, and other records, as determined by the BHA Oversight and enforcement activities may include review of endorsements and/or separate physical locations as necessary for the BHA to ensure the health, safety, and welfare of the individuals.
	Future Status: Colorado will continue the current oversight processes described above. In addition, the state will utilize the accrediting entity's auditing and monitoring requirements as part of maintaining accreditation.
	Summary of Actions Needed: 1. Check for current accreditation as part of other audit/oversight activities.
1.c Utilization review process to ensure beneficiaries have access to the appropriate levels and	*Current Status:* All Health First Colorado beneficiaries are assigned to a regional accountable entity (RAE). The RAEs provide utilization review for all inpatient psychiatric stays, stays in Mental Health Residential facilities, as well as CSUs and ATUs. RAE's

types of care and to provide oversight on lengths of stay	are contractually required to utilize objective, scientifically based medical necessity criteria, and clinical practice guidelines, in the context of provider or individual supplied clinical information, to determine the appropriate level of care and provide oversight on lengths of stay.
	Future Status: RAEs will continue to be responsible for utilization review for all inpatient and residential stays under the Demonstration. HCPF will require the use of statewide standardized behavioral health utilization guidelines used by all RAEs. HCPF will collaborate with BHA for input on utilization guidelines.
	Summary of Actions Needed: 1. Complete statewide standardized behavioral health utilization guidelines for Medicaid enrollees by 12/31/2025. 2. Distribute expanded statewide standardized behavioral health utilization guidelines for Medicaid enrollees on the State's website by 12/31/2025. 3. Train on the guidelines. (Timeline: 18-24 months). 4. Require the providers to use statewide standardized behavioral health utilization guidelines for Medicaid enrollees. (Timeline: 18-24 months). 5. HCPF and BHA will develop and issue rulemaking and other policies, and modify existing contracts, as necessary, to support the statewide use of standardized behavioral health utilization guidelines. (Timeline: 18-24 months).
1.d Compliance with program integrity requirements and state compliance assurance process	*Current Status:* HCPF's program integrity requirements are outlined in 10 CCR 2505-10, Section 8.076. The Colorado Attorney General's Medicaid Fraud Control Unit (MFCU) operates a statewide program designed to detect provider Medicaid fraud. The MFCU prosecutes criminal offenses relating to Medicaid fraud throughout Colorado. The unit also brings civil cases through the Colorado Medicaid False Claims Act, C.R.S. 25.5-4-303.5 et seq., which provides treble (triple) damages and substantial penalties for those who knowingly submit false Medicaid claims to the State of Colorado. The MFCU employs a professional staff of criminal investigators, an auditor, a nurse investigator, and prosecutors experienced in criminal and civil investigations. The MFCU's authority to prosecute physical abuse or neglect extends to all Medicaid-funded health care settings, including: psychiatric hospitals, residential treatment facilities such as ATUs and CSUs, personal care boarding homes, adult day care facilities, hospitals, skilled nursing centers, rehabilitation centers, long-term facilities, and some assisted living centers- regardless of whether the resident is a Medicaid recipient or not. The Unit does not investigate abuse in the home or in non-Medicaid facilities. RAEs are contractually required to report suspected fraud to the MFCU. Additionally, RAEs must follow-up on grievances, respond and investigate quality of care concerns and critical incidents. **Psychiatric Hospitals** For hospitals, quality assurance requirements are outlined in CCR 1011-1 Chapter 2 Part 4. These include that:

	● Every facility or agency must have a quality management program (QMP) designed to improve client safety and well-being. The client safety component of the program must implement improvements in response to patterns and trends associated with service delivery errors and potential for error. The client well-being component of the program shall implement improvements that are not necessarily tied to errors or potential for error but instead to the continuous quality improvement principle that opportunities always exist to enhance service delivery. (4.1.1). ● The QMP must be implemented in accordance with a quality management plan that is reviewed and approved annually by the governing body, or if the facility or agency is not required to have a governing body, by the administrator or the administrator's designee(s). The plan must include a process for identification of quality management projects. For the client safety component of the program, the plan shall identify: (a) The types of service delivery errors and potential for error that will be monitored, which may shall be based, at minimum, on a review of negative client outcomes that are unanticipated, client grievances, deficiencies cited by regulatory agencies, occurrences and/or errors, and potential for errors reported by staff; (b) A process for staff to report service delivery error and potential for error within a prescribed period of time and a plan for how staff will be trained regarding such reporting; (c) The methods used to collect and analyze data in order to find patterns and trends. The plan shall also include how the governing body, if applicable, and the administrator will be informed of such patterns and trends; (d) The method(s) used to select quality management projects; and (e) The method(s) for selecting the service delivery practice(s) that will be reviewed. ● The plan must also include how improvement strategies will be developed. This may include identifying the personnel that will be involved in designing the intervention, opportunities for client input, and the administrative approvals needed to finalize the intervention design. (4.1.2). ● CDPHE may audit a licensee's quality management program to determine its compliance and if CDPHE determines that an investigation of any incident or client outcome is necessary, it may, unless otherwise prohibited by law, investigate and review relevant documents to determine actions taken by the licensee. (4.1.4). ● CDPHE completes survey and certification functions, as delegated by CMS, to determine if facilities meet Medicare/Medicaid Conditions of Participation requirements. **Mental Health, Residential Facilities, including Acute Treatment Units and Crisis Stabilization Units** Every BHE is required by the BHA to have a QMP designed to improve individual safety and well-being. The individual

	safety component of the QMP must implement improvements in response to patterns and trends associated with service delivery errors and potential for error. The individual well-being component of the QMP must implement improvements that are not necessarily tied to error or potential for error but instead to the continuous quality improvement principle that opportunities always exist to enhance service delivery (BHA 2.17). Additionally, in order to receive reimbursement under Medicaid, participating IMDs must be enrolled to participate in Colorado Medicaid. Provider enrollment processes fully comply with 42 CFR Part 455 Subparts B&E. As RAEs have been reimbursing IMDs as an in lieu of service and are only permitted to contract with Colorado Medicaid screened and enrolled providers.
	Future Status: Continued operation of current requirements and processes.
	Summary of Actions Needed: 1. NA/Milestone met
1.e State requirement that psychiatric hospitals and residential settings screen beneficiaries for co-morbid physical health conditions, SUDs, and suicidal ideation, and facilitate access to treatment for those conditions	*Current Status:* **Psychiatric Hospitals** Patient assessment requirements for psychiatric hospitals are outlined in 6 CCR 1011-1 Chapter 4, Part 29 - Psychiatric Services. For purposes of Part 29, psychiatric care specifically requires screening for suicide risk (safety), co-morbid physical health conditions and substance misuse when providing assessments. **Mental Health Residential Facilities, including Acute Treatment Units and Crisis Stabilization Units** The BHA outlines screening, initial assessment, and comprehensive assessment requirements for all BHEs found in 2 CCR 502-1, Part 2.12. These regulations require facilities to screen for physical health conditions, substance use disorders, and suicidal ideation. CSUs are required to perform the comprehensive assessment within 24 hours of admission. The assessment informs level of care determinations and next steps in treatment. ATUs must assess individuals every three days for continued appropriateness for treatment within an ATU setting. When an individual is identified as having co-morbid substance use or physical health needs, it is reflected in their treatment plan, and the ATU or CSU ensures the individual is aware of and has access to treatment for these conditions while in their care and is aware of and linked to SUD and physical health services in the community. Individuals admitted to an ATU or CSU experiencing suicidal ideation are routinely monitored during their stay for any changes in risk scoring. Interventions are tailored to the individual to ensure their on-going safety, and can include closer staff supervision throughout the day, in addition to additional support from prescriber/psychiatric staff and individual and group therapy. At transition, ATU or CSU staff may support the individual in completing a safety plan to help reduce

	suicide risk. ATU and CSU staff additionally reflect this need in the individual's transition plan, and coordinate care with on-going behavioral health supports in the community. In addition, BHEs, including ATUs and CSUs, are required to document assessments of individuals, as applicable, including risk factors associated with acquiring and transmitting HIV/AIDS, TB, Hepatitis A, B, and C, and other infectious diseases and provide appropriate testing and pre and post-test counseling must be offered on-site or through referral.
	Future Status: The State will evaluate current processes for psychiatric hospitals and residential facilities including ATUs and CSUs, to determine whether modifications to existing processes are needed and make any necessary adjustments.
	Summary of Actions Needed: 1. The State will evaluate the effectiveness of the current processes in place to assess individuals with SMI/SED for suicidality, co-morbid substance use and physical health needs, as well as the requirements for coordinating care to address these co-morbid needs. (Timeline: 12-18 months). 2. The State will develop and issue rules and/or policies as necessary to ensure that individuals receiving care in psychiatric hospitals or residential treatment facilities are screened for suicidality, co-morbid conditions and linked to services for co-morbid care. (Timeline: 18-24 months).

Prompts	Summary
1.f Other state requirements/policies to ensure good quality of care in inpatient and residential treatment settings.	*Current Status:* **Psychiatric Hospitals** The state has a performance incentive associated with compliance with licensure requirements that is outlined in 6 CCR 1011-1 Chapter 2, 2.13. Licensees are eligible for a performance incentive if the CDPHE on-site re-licensure inspection demonstrates that: ● The licensee has no significant deficiencies that have negatively affected the life, safety, or health of its clients; ● The licensee has fully and timely cooperated with the CDPHE during the on-site inspection; ● CDPHE has found no documented actual or potential harm to clients; and ● If significant deficiencies are found that do not negatively affect the life, safety, or health of clients, the licensee has submitted, and CDPHE has accepted a plan of correction and the CDPHE has verified that the deficient practice was corrected within the period required by the CDPHE. (2.13.1). The incentive payment is calculated at ten percent (10%) of the licensee's renewal license fee and applies when: ● The inspection is completed with the full and timely cooperation of the licensee; ● Inspection findings do not document harm or potential harm to clients; and ● Correction of the deficient practice is verified by CDPHE on or prior to the respective due dates. The incentive payment is paid to the licensee within sixty (60) days following the acceptance of the validation of correction of all cited deficiencies, or within sixty (60) days of the inspection exit date if no deficiencies were cited. (2.13.2). **Mental Health Residential Facilities, including Acute Treatment Units and Crisis Stabilization Units** For each BHE that is eligible, the BHA will either extend the standard licensure survey cycle up to three (3) years or utilize a tiered licensure inspection system. To be eligible, the BHE must meet all of the following criteria: ● Licensed for at least three (3) years; ● No conditions imposed on the license within the three (3) years prior to the date of the survey; ● No patterns of rule violations, which occurs when a BHE commits the same class of rule violation three (3) or more times in consecutive inspections, as documented in the inspection and survey reports issued by the BHA within the three (3) years prior to the date of the inspection; and ● No substantiated complaint resulting in the discovery of significant deficiencies that may negatively affect the life, health, or safety of individuals of the BHE within the three (3) years prior to the date of the survey.

	The BHA may expand the scope of a tiered inspections to an extended or full survey if the BHA finds rule violations during the tiered inspection process.
	Future Status: Continued operation of current requirements and processes. The Accountable Care Collaborative (ACC) is the primary delivery system for Health First Colorado (Colorado's Medicaid program). The ACC contracts with Regional Accountable Entities (RAEs) who are responsible for coordinating primary and behavioral health services for Health First Colorado in specific regions. The scope and objectives of the ACC have changed over time. Phase 3.0 which is scheduled to launch on July 1, 2025, makes significant changes to the RAE contracts. The draft contract includes a section on Provider Support Practice Transformation. This section includes requirements that RAEs must provide support on clinical tools and integrated care, which can include providing practice support on continuous quality improvement coaching and education on the delivery of evidence-based medicine and adopting best practices in the delivery of behavioral health care in accordance with standards established by the BHA. RAEs will also be required to submit an annual provider support and transformation report to the BHA that includes the type of information and provider trainings they provided, as well as practice support and transformation activities they implemented that support the Department's efforts, and successes and lessons learned from the previous year. The draft contract also contains language requiring that the RAE ensures trainings are made available to providers every six months covering a variety of topics, including principles of recovery and psychiatric rehabilitation and trauma informed care. Draft language requires RAEs to have a compliance plan that ensures routine monitoring is completed to detect and prevent aberrant billing practices, potential fraud, waste and program abuse, and to ensure that any potential compliance issues are promptly addressed. This can include conducting prospective, concurrent, and/or post-payment reviews of claims to ensure services billed by providers were actually rendered.
	Summary of Actions Needed: 1. Implementation of ACC Phase 3.0 on July 1, 2025.
SMI/SED. Topic_2. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care	
Understanding the services needed to transition to and be successful in community-based mental health care requires partnerships between hospitals, residential providers, and community-based care providers. To meet this milestone, state Medicaid programs, must focus on improving care coordination and transitions to community-based care by taking the following actions.	
Improving Care Coordination and Transitions to Community-based Care	
2.a Actions to ensure psychiatric hospitals and residential settings carry out intensive pre-discharge	*Current Status:* RAEs are responsible for promoting physical and behavioral health for individuals (members) enrolled in Health First Colorado and are a key resource in the discharge planning process. Case Management Services are included in the

planning, and include community-based providers in care transitions.	benefits and services provided by the RAEs. Health First Colorado defines case management as: assistance provided by a case management agency on behalf of an eligible member, which includes referral of needed services and supports that enable the member to remain in his/her community-based setting. The RAEs are contractually required to work with appropriate treatment providers in their region in order to transition individuals from hospitals to safe and alternative step-down environments (e.g., home, residential, etc.). RAEs must meet with appropriate treatment providers to develop and maintain protocols and procedures for how these transitions will take place in order to ensure continuity of care and continuation of services. In addition, HCPF has a Behavioral Health Incentive Plan that includes an indicator for *Follow-up Appointment Within 7 Days After an Inpatient Hospital Discharge for a Mental Health Condition.* Many of the existing BHA programs provide some level of care coordination services for Coloradans who do not have Medicaid. In addition to existing programs, the BHA, through the establishment of new regional and community based Behavioral Health Administrative Service Organizations (BHASOs) as a point of entry for all behavioral health needs, Coloradans who are Medicaid recipients will be connected to RAEs to receive services and other-Medicaid Coloradans will receive similar services directly through the BHASOs. An additional service the BHASOs provide to broadly benefit behavioral health care in Colorado includes establishment of regional advisory boards across the state. Both psychiatric hospitals and RAEs have a contractual responsibility to complete timely pre-discharge planning. This must include an assessment of the individual's housing and other needs and connection to relevant community-based housing and other resources, as well as transitioning individuals to lower levels of care in the community at discharge. RAEs are also required to engage community providers as individuals transition from psychiatric hospitalization to community care and step-down environments. Working in concert with the care managers at facilities described above, Rocky Mountain Human Services **(RMHS) Momentum and Transition Programs are specialty programs which** provide community transitions to individuals across the state who are transitioning from inpatient behavioral health, substance use, and criminal justice settings into community living. Similar to tiered case management services, the RMHS Momentum and Transition Programs employ clinical care managers and certified Peer Support Specialists that work with individuals and their family/natural supports using a person-centered approach, to identify needs, define goals, and access resources. A goal of both the Momentum and Transition programs is to build and connect to community resources to support a successful transition. Program eligibility is as follows: ● **Momentum Program:** For purposes of this demonstration, Momentum program services focus on individuals who are currently in a psychiatric hospital who have high psychiatric hospitalization utilization in the past 12 months. ● **Transition Program:** Transition program services are designed to support individuals receiving services in an

	emergency department, hospital, ATU, CSU, or withdrawal management provider that have a significant mental health or substance disorder and are not currently engaged in consistent behavioral health treatment.
	Future Status: While previously RAEs have been able to create their own definitions for complex members, HCPF plans to create a standardized, baseline definition that can be monitored across all RAEs through Universal Contracting Provisions. The Universal Contracting Provisions is a joint project planned between HCPF and the BHA to define expectations for behavioral health providers and state agencies when contracting for behavioral health services and will standardize contract expectations for both providers and RAEs. As part of this initiative, requirements surrounding discharge planning expectations will be included in the contracts. In ACC Phase 3.0, all beneficiaries transitioning out of psychiatric hospital or residential care receive intensive discharge planning from the RAE in addition to each institution's discharge planning. HCPF aims to improve care coordination and case management within the system by enhancing and standardizing the requirements for RAEs. Stakeholders have recommended alignment of care coordination standards with the BHA. This has led to joint development of a tiered approach to care coordination to be implemented in ACC Phase 3.0. There will be three care coordination tiers: Tier 1 – emphasis on prevention and wellness promotion and education, available to all members, Tier 2 – for members with rising risk, including but not limited to condition management, and Tier 3 – for members with complex needs, including those with physical and behavioral health and social needs, and high utilization. Tier 3 Coordination will ensure appropriate longitudinal evidence-based and proven programs that involve multi-disciplinary care approaches are provided to maintain or improve the individual's health. Coordinating care at tier 3 will include increased accountability for assisting hospitals in coordinating the discharge of members with complex behavioral health conditions and other complex needs into step down levels of care or home care that includes proper support.
	Summary of Actions Needed: 1. RAE contracts and Universal Contracting Provisions will be updated July 1, 2027, with changes implemented in a phased approach. (Ongoing). 2. RAEs will review ADT data from all Colorado Health Information Exchange platforms to identify members who have been hospitalized in a behavioral health care setting or who are utilizing mental health residential services to prioritize transition of care interventions. (Timeline: 12-18 months). RAEs are required to participate in care coordination, intensive discharge planning, adult and pediatric complex

	solutions complex care groups to facilitate team coordination across state agencies. Require RAEs take responsibility to elevate cases. Demonstration participants meet the requirements for discussion in these groups to ensure facilitated and comprehensive planning solutions for discharge. Requirements are written into the ACC Phase 3.0 RAE contracts, which are effective July 1, 2025, and will be implementation will be ongoing thereafter. (Timeline 12 months) HCPF and BHA will develop and issue rulemaking and policies, to address any identified gaps in transition planning services as currently defined, however, there are not any currently identified gaps. (Timeline 12 - 24 months from implementation date). HCPF and BHA will modify existing contracts, as necessary.
2.b Actions to ensure psychiatric hospitals and residential settings assess beneficiaries' housing situations and coordinate with housing services providers when needed and available.	*Current Status:* **Psychiatric Hospitals** Current licensure requirements include consideration of a patient's ability to comply with the medication regimen, as well as to live independently (6 CCR 1011-1 Chapter 4 Part 29.12(C)). Providers are expected to conduct housing need assessments and connect members with relevant housing resources. Additionally, RAE's are contractually required to establish relationships and communication channels with community organizations that provide resources such as food, housing, energy assistance, childcare, education and job training in the region to promote linkage for Medicaid enrollees. **Acute Treatment Units and Crisis Stabilization Units** All ATUs and CSUs under the demonstration are required to assess the beneficiaries housing situation prior to discharge and coordinate with housing providers when needed (2 CCR 502-1-12.3.3.C.1.c). **Housing Coordination and Services** Regardless of whether the beneficiary is receiving care in a psychiatric hospital or residential facility, Colorado has numerous programs in place to meet housing needs. All beneficiaries receiving care in an IMD are eligible for case management services. The case manager assists in making referrals for affordable housing upon discharge. Some of the housing options available in the community include supportive transitional housing, supportive permanent housing, and independent housing. When transitional or independent supportive housing is not part of the immediate discharge plan, the case manager secures a residential placement in a facility that is less restrictive than the hospital and meets the needs of the individual. In addition, the Momentum Program mentioned above assigns a case manager to assist in securing the appropriate type of affordable housing upon discharge from inpatient hospital settings, for members who qualify. For all levels of care including ATUs and CSUs under the Demonstration, while HCPF and the BHA do not fund housing, they coordinate and partner with the Department of Local Affairs (DOLA), which manages the housing

	voucher and all other housing programs. Additionally, individuals may be eligible for housing supports through the Health Related Social Needs (HRSN) 1115 demonstration. HCPF reimburses for care coordination for members including connecting members with housing support services. Although housing may be a service provided by a safety net provider, housing services are mainly run through DOLA, who operates multiple housing programs listed below, which are accessible to providers seeking housing support for individuals transitioning out of inpatient, ATU or CSU care. ● ***The Veterans Affairs Supportive Housing (VASH) program*** is a national initiative sponsored by the HUD and the U.S. Department of Veterans Affairs (VA). The goal of the VASH program is to provide housing choice voucher rental assistance and intensive case management and clinical services to enable homeless veterans access to permanent housing while leading healthy, productive lives in the community. ● ***Family Unification Program (FUP)*** which DOLA partners with the Colorado Division of Child Welfare and local service providers to administer this unique housing choice voucher program to assist homeless youth, aging out of the foster care system (ages 18 through 21) and families where available housing is an obstacle to full custody of their children. ● ***Permanent Supportive Housing (PSH):*** The division, in partnership with the Colorado Housing and Finance Authority (CHFA), provides assistance to homeless citizens and other special needs populations. The resources offered by both agencies include Project-Based Vouchers (PBVs), gap funding and tax credit allocations. ● ***State Housing Voucher (SHV) Program:*** DOLA collaborates with the BHA to provide rental assistance for hard-to-serve homeless persons and those in jeopardy of becoming homeless. The program serves persons with disabilities, mental illness and those with mental illness and a co- occurring substance use disorder, and their families. The SHV Program allows for a variety of housing choices and a range of supportive services funded by other sources. ● ***DOH Next Step Tenant Based Rental Assistance (TBRA) Program:*** TBRA is a rental subsidy that helps make up the difference between what a renter can afford to pay and the actual rent for a home. TBRA grantees provide rental assistance and supportive case management services for low-income families. The funding follows a transitional housing program model targeting homeless families with school-aged children. Intensive case management for families in this program addresses the causes of their homelessness and leads toward a higher degree of self-sufficiency and academic stability with the goal of permanent housing at the end of the program. ● ***Fort Lyon Supportive Residential Community:*** DOLA helps fund the operations at the Fort Lyon Supportive Residential Community. DOLA also collaborates with Otero Junior College, Lamar Community College, Southeast Mental Health Services, Prowers Medical Center and Valley-Wide Health Systems, Inc. to provide recovery-oriented transitional housing for homeless individuals. The facility combines housing with counseling, educational, vocational and employment services for up to 250 homeless and formerly homeless persons from

	across Colorado, with an emphasis on serving homeless veterans. ● ***Housing Opportunities for Persons with AIDS (HOPWA):*** DOLA provides funding to the Colorado AIDS Project, which distributes funds to the Boulder County AIDS Project, Northern Colorado AIDS Project, Southern Colorado AIDS Project and Western Colorado AIDS Project according to need in their respective areas. The funding is primarily used to provide rental assistance and supportive housing services. The BHA also administers ***Projects for Assistance in Transition from Homelessness (PATH),*** leveraging SAMHSA funding to assist homeless persons with serious mental health needs. PATH is designed to provide funds to each state to support services for persons with serious mental illnesses, as well as individuals with co-occurring substance use disorders, who are homeless or at risk of becoming homeless.
	Future Status: Continued operation of current programming and requirements. Expand coordination efforts with housing services providers through partnerships with DOLA, CDHS and HCPF. RAE contracts and Universal Contracting Provisions will be updated effective July 1, 2027, which includes the RAE's responsibility to establish relationships and work jointly with existing community organizations that provide housing resources and the RAE's requirement to provide care coordination to members who are homeless or at risk of homelessness and connect such members to housing services. Colorado has an active HRSN demonstration live as of July 2025. Colorado is also expanding Mental Health Transitional Living (MHTL) homes to allow all IMDs to refer to them, currently referrals are limited. HCPF will continue to process-map care transitions and develop education for providers, members, and others to ensure that procedures both at the state level and facility level are efficient and effective at placing members post discharge from psychiatric hospitalization. HCPF will continue to share updated and new resources as available to providers and Stakeholders. HCPF will leverage existing meetings, including provider forums, to connect stakeholders with additional resources and supports to enhance continuums of care. HCPF will coordinate with internal offices/divisions/teams, as appropriate, to disseminate information to providers during these forums. HCPF will work with RAEs to ensure they are monitoring residential and psychiatric hospital providers. Discharge planning assessments include a review of the individual's housing status, care coordination requirements, as part of intensive discharge planning, include providing referral and warm handoffs for housing supports as needed and applicable.
	Summary of Actions Needed: 1. HCPF to identify and outreach potential new HRSN housing providers to include in the quarterly provider forums (Timeline: 18-24 months). 2. HCPF to coordinate with RAEs regarding monitoring the existing residential and inpatient provider requirements to assess for and coordinate (as needed and applicable) linkage to housing supports (Timeline:

	18-24 months). 3. HCPF to continue the facilitation of the quarterly provider forums, including IMDs. Ongoing. 4. Intensive discharge planning and care coordination in ACC Phase 3.0 implementation as described in milestone 2.a.- beginning July 1, 2025, and ongoing thereafter.

Prompts	Summary
2.c State requirement to ensure psychiatric hospitals and residential settings contact beneficiaries and community-based providers through most effective means possible, e.g., email, text, or phone call within 72 hours post discharge	*Current Status:* RAEs currently undertake the primary responsibility for assuring enrollees access follow-up care following discharge. They are contractually required to ensure its network is sufficient to provide outpatient follow-up appointments within seven days of discharge; there is an incentive payment tied to this metric. RAEs must track ED utilization and follow-up with discharged enrollees to ensure the enrollee understood discharge instructions, schedule follow-up visits in accordance with the discharge plan, and ensure prescriptions have been filled in accordance with the discharge plan.
	Future Status: Beginning in July 2025, HCPF will require RAEs to include in their contracts with all IMDs participating in the Demonstration a requirement to follow-up with beneficiaries and community-based providers within 72 hours post discharge. The Universal Contracting Provisions are a new a joint project between HCPF and the BHA to define expectations for behavioral health providers and state agencies when contracting for behavioral health services and will standardize contract expectations for both providers and RAEs beyond the current RAE-HCPF contract process The requirement for follow-up within 72 hours post-discharge will be included in provider contracts and is intended to be addressed through Universal Contracting Provisions when released. Upon ACC Phase 3.0 implementation, RAEs will be required to monitor providers' compliance with completing a discharge plan, crisis follow-up plan, crisis safety plan, Inpatient Hospital Transitions Program (IHT) documentation, and other relevant care plans. These plans should be uploaded to the RAE's care coordination platform, when feasible. Through these contract amendments and the Universal Contracting Provisions, the IMDs will be responsible for tracking residential and hospital utilization, and HCPF will monitor compliance annually.
	Summary of Actions Needed: 1. RAE contracts will be updated to include requirement that all beneficiaries and community-based providers be contacted within 72 hours of discharge from a psychiatric hospital or residential treatment facility (July 1, 2025). 2. BHA and HCPF will begin reviewing compliance to the ACC Phase 3.0 contract 12 months after execution (July 1, 2026).
2.d Strategies to prevent or decrease lengths of stay in EDs among beneficiaries with SMI or SED prior to admission	*Current Status:* The RAEs are contractually required to provide and to promote the Colorado Crisis Services among providers and members to ensure members receive timely access to behavioral health interventions during a crisis and must also establish arrangements with the Colorado Crisis Services vendors, through RAEs for Medicaid members and BHASOs for underinsured and uninsured Coloradans, for the coordination of follow-up care for Medicaid members. As a result, Medicaid beneficiaries are made aware of resources available in the event of mental health crisis, and when a crisis does occur, the beneficiary is provided support to prevent a worsening crisis that might lead to unnecessary ED visits or hospitalizations. EDs use ADT software to alert the RAEs to member ED utilization.

	Momentum is a program that provides support to children and adults transitioning from inpatient mental health institutes, hospitals, home and other care settings to community living. Current inpatient psychiatric patients or individuals in an acute hospital setting and certain other residential programs for 30 days or longer and individuals with at least two prior psychiatric admissions in a 12 month period are eligible for the Momentum Program. The program is designed to provide intensive supports to individuals who face significant challenges and prevent repeat admissions or ED visits. Additional current initiatives intended to prevent or decrease ED utilization include: ● ***Medication Consistency:*** Provides continuous access to the same set of effective medications, including psychotropic medications, to maintain mental wellness and successfully transition between the criminal or juvenile justice system and mental health services providers without the need to visit the ED for mental health crisis. ● ***Crisis Services:*** Offers people mental health, substance use, or emotional crisis help, information and referrals. The program provides confidential, professional, and immediate support on the phone, text, or in person at walk-in centers. ● **Mobile Crisis Response:** Provides in-person community-based response to behavioral health crisis within 1 hour for urban regions and 2 hours for rural/frontier regions. Response provided by multi-disciplinary team of crisis professionals who have completed BHA Crisis Professional Training, which provides specialized training on crisis de-escalation, stabilization, and care coordination. By responding to member crises in the community, this program decreases the need for members to access crisis care in the ED. When an individual clinically needs more intensive services and supports than the mobile crisis response team can provide, the team can transport the individual to a behavioral health crisis facility when one is available in the community, or to an ED if a community-based crisis facility is not in the service area. ● ***Co-Responder Programs:*** Pairs law enforcement and behavioral health specialists to intervene and respond to behavioral health-related calls for policy services. These teams utilize the combined expertise of the officer and the behavioral health specialist to de-escalate situations and help link individuals with behavioral health services. When an individual clinically needs more intensive services and supports than the co-responder program can provide, they can transport the individual to a behavioral health crisis facility (which can include CSUs), when one is available in the service area, to divert the individual from an ED. ● ***Behavioral Health Secure Transportation:*** Provides transportation from the site of the behavioral health crisis to the closest, most appropriate facility, which may include EDs, but can also include CSU or walk-centers. This service also provides interfacility transport, resulting in more timely transportation from EDs to behavioral health treatment facility, thus decreasing ED length of stay. ● ***Safety Net Providers:*** Provides crisis services in the form of either 24/7 walk in center or mobile crisis response services, as per BHA requirement, both of which are described above as an alternative to EDs yet also offer a suite of outpatient services to ensure holistic care as members behavioral health needs vary in acuity.

	Comprehensive Providers (called Comprehensive Community Behavioral Health Providers) are subject to no refusal requirements. Safety Net Providers include both comprehensive and essential.
	Future Status: ACC 3.0 will require that RAEs support community care by providing care navigation. Care navigation will include follow up with the member to ensure the member is connected to ongoing behavioral health care after a crisis, which will include discharge from EDs and hospitalizations. It will also require that an appointment with a licensed health care provider is scheduled within seven days of discharge from an emergency department or hospital. RAEs are required to participate in care coordination, discharge planning, adult and pediatric complex solutions (adult) complex care groups to facilitate team coordination across state agencies. There is a requirement for RAEs to take responsibility to elevate cases. RAE contracts and Universal Contracting Provisions were updated July 1, 2025 to include prioritized care coordination that obligates RAEs to participate in hospital discharges. This change will be implemented on an ongoing basis. RAEs will also review ADT data from all Colorado Health Information Exchange platforms, to identify members who have received services in the emergency department, who have been hospitalized in a physical or behavioral health care setting or who are utilizing mental health residential services to prioritize transition of care interventions. HCPF also plans to foster collaboration with co-responder programs and local behavioral health crisis providers to identify ways to support diversion from EDs.
	Summary of Actions Needed: 1. Implementation of ACC Phase 3.0 requirement for RAEs to provide care navigation beginning July 1 and continuing throughout the demonstration period. 2. HCPF to collaborate with co-responder programs and local behavioral health crisis providers to explore ways to improve connections to increase direct admissions, when clinically necessary, and support diversion from EDs- within 24 months of implementation. 3. RAE Universal Contracting Provisions which were updated July 1, 2027 will begin requiring ADT to review and follow-up with the member when a member has been hospitalized or seen in an ED. (Ongoing). 4. RAEs will review ADT data from all Health Information Exchange platforms, to identify members who have received services who have been hospitalized in a physical or behavioral health care setting or who are utilizing mental health residential services to identify interventions that are most likely to advert ED visit within 24 months of implementation.

2.e Other State requirements/policies to improve care coordination and connections to community-based care	*Current Status:* **Improve Perinatal Access, Coordination, and Treatment (IMPACT-BH)** Improve Perinatal Access, Coordination, and Treatment (IMPACT-BH) provides pregnant and postpartum cross-systems interventions with continuity of care and universal behavioral health and social needs screening in the healthcare delivery system. It also provides inpatient access to and coordination of Medications for Opioid Use Disorder (MOUD) services and community-based perinatal navigation and increased access to behavioral health and social needs related resources. IMPACT-BH brings together hospitals, primary healthcare services, and community-based organizations as active collaborators and partners in providing wrap-around support and care navigation to pregnant and postpartum people and their families.
	Future Status: Continued operation of current programming.
	Summary of Actions Needed

Prompts	Summary
SMI/SED. Topic_3. Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services	
Adults with SMI and children with SED need access to a continuum of care as these conditions are often episodic and the severity of symptoms can vary over time. Increased availability of crisis stabilization programs can help to divert Medicaid beneficiaries from unnecessary visits to EDs and admissions to inpatient facilities as well as criminal justice involvement. On-going treatment in outpatient settings can help address less acute symptoms and help beneficiaries with SMI or SED thrive in their communities. Strategies are also needed to help connect individuals who need inpatient or residential treatment with that level of care as soon as possible. To meet this milestone, state Medicaid programs should focus on improving access to a continuum of care by taking the following actions.	
Access to Continuum of Care Including Crisis Stabilization	
3.a The state's strategy to conduct annual assessments of the availability of mental health providers including psychiatrists, other practitioners, outpatient, community mental health centers, intensive outpatient/partial hospitalization, residential, inpatient, crisis stabilization services, and FQHCs offering mental health services across the state, updating the initial assessment of the availability of mental health services submitted with the state's demonstration application. The content of annual assessments should be reported in the state's annual demonstration monitoring reports.	*Current Status:* Colorado submitted a needs assessment with its 1115 demonstration application.

	Future Status: Colorado HCPF in partnership with BHA will develop a timeline for the completion of the annual BH availability assessment required by the SMI/SED 1115 Demonstration. This could include stakeholder engagement focused on informing stakeholders of the requirement and process, to include the need for current and accurate service availability. HCPF and BHA will coordinate with RAEs and BH providers to submit an updated availability assessment on an annual basis. HCPF will compile annual availability assessment data through existing systems, through Medicaid Management Information System (MMIS) system and LADDERS. ACC Phase 3.0 contract identifies behavioral health provider contracting requirements, to include ensuring there is adequate coverage and accessible services.
	Summary of Actions Needed: 1. State of Colorado HCPF in partnership with BHA, Department of Regulatory Agencies (DORA), and CDPHE will submit an updated availability assessment annually and conduct provider outreach and engagement efforts in areas where gaps in services exist. (Ongoing). 2. Develop a work plan for completion of BH availability assessment 3. 3.Complete appropriate stakeholder engagement, to include RAEs and BH providers (Ongoing). 4. HCPF and BHA will work with other State agencies to continually improve the data for future assessments. (Ongoing).
3.b Financing plan	*Current Status:* Please refer to the Financing Plan below.
	Future Status: Please refer to the Financing Plan below.
	Summary of Actions Needed: Please refer to the Financing Plan below.
3.c Strategies to improve state tracking of availability of inpatient and crisis stabilization beds	*Current Status:* Colorado's BHA currently operates a Client Care Search (previously referred to as the Behavioral Health Bed Capacity Tracker) within EMResource, Colorado's communication and resource management system that streamlines communications between medical response teams and health care providers. The Client Care Search is an online centralized registry that provides updated (at least daily) information on mental health and substance use disorder residential, inpatient and crisis stabilization beds at facilities across Colorado. The Client Care Search displays bed availability and inclusion/exclusion criteria for treatment. The platform is designed to decrease the

	amount of time that individuals wait in emergency rooms, ensure that existing resources are maximized, and increase the likelihood that individuals in crisis receive services closer to their community and to allow behavioral health providers and other providers of social services to gather accurate residential and inpatient treatment availability information and better facilitate the referrals and placement process.
	Future Status: In future iterations, the BHA may expand the scope to include outpatient services as well as other services that support social determinants of health.
	Summary of Actions Needed: 1. HCPF to support continued stakeholder engagement regarding the Client Care Search and Referrals platform to identify areas of improvement. (Timeline: 18-24 months).
3.d State requirement that providers use a widely recognized, publicly available patient assessment tool to determine appropriate level of care and length of stay	*Current Status:* Colorado's behavioral health provider rules (2.12.1 – 2.12.2) establish the minimum requirements for screening and initial assessments. All licensed and designated behavioral health providers, as well as the Colorado State Mental Health Hospitals (Pueblo and Ft. Logan) are required to submit Colorado Client Assessment Record (CCAR) data to the BHA as specified in their annual contract. The CCAR is a clinical instrument designed to assess the behavioral health status of a consumer in treatment. The tool can be used to identify current clinical issues facing the consumer and to measure progress during treatment. The CCAR consists of an administrative section and an outcomes section. The administrative section contains questions related to a consumer's demographics and the outcomes section contains questions related to a consumer's daily functioning on 25 clinical domains. The behavioral health data obtained through the CCAR (submitted to the BHA on, or before, the last business day the month following the admission/update/discharge) in order for BHA to: • Determine SED/SMI (target status), • Satisfy federal reporting requirements for block grant funding of behavioral health providers in the State, • Inform the State Legislature regarding policy, service quality, effectiveness, etc., • Answer questions posed by major stakeholders and special interest groups (e.g., Mental Health Planning and Advisory Council, Colorado Behavioral Healthcare Council, HCPF, Safety Net Providers, Clinics, RAEs, etc.) about a variety of behavioral health issues.

	Future Status: The State of Colorado understands that the current tool, CCAR does not fully meet the need for a widely recognized, publicly available patient tool to determine appropriate level of care and length of stay for adults. To support alignment with youth assessments including completion of the Child and Adolescent Needs and Strengths (CANS), the state intends to move to use of the Adult Needs and Strengths Assessment (ANSA) being placed in facilities under the demonstration including CSUs/ATUs or psychiatric hospitals for inpatient stays. The state plans to engage stakeholders in this choice and consider alternative options in the first 24 months of the SMI/SED demonstration to meet the intent of this milestone by doing the following: Under the ACC Phase 3.0 the Colorado System of Care, the use of the independent assessment process will expand to an Enhanced Standardized Assessment, which is a comprehensive, clinical assessment completed by a licensed or licensure candidate behavioral health provider that includes a robust biopsychological assessment, the CANS tool and the CANS Decision Support Matrix to for children/youth with complex behavioral health needs and/or Medicaid needs which may warrant intensive community-based services and intensive care coordination/high fidelity wraparound. In addition, the Enhanced Standardized Assessment will support in identifying QRTP and PRTF level of care treatment needs for children and youth. HCPF has partnered with the BHA to contract with the PRAED Foundation through the University of Kentucky on the development of a Colorado Decision Support Matrix specific to the CANS in Colorado. The Decision Support Matrix will focus on strengthening level of care determinations, service and treatment planning and outcome measures. In the future all inpatient youth mental health facilities will be required to utilize the CANs tool to determine appropriate level of care and length of stay. Training of all providers and RAEs on the use of the tool.
	Summary of Actions Needed: 1. Colorado's BHA and HCPF will explore options for an alternative tool to replace the CCAR (Timeline: 12-18 months). 2. Promulgation of requirements for all facilities to utilize the tool to determine appropriate level of care and length of stay (Timeline: 18-24 months). 3. Training of all providers and RAEs on the use of the tool. (Timeline: 18-24 months).

	4. Updates to Medical Records and Utilization criteria of RAEs to adopt the Decision Support Model (Timeline: 18-24 months). 5. Monitoring through utilization review by RAEs to ensure that lengths of stay match the chosen tool outcomes no later than 12/31/2027. (Timeline: 18-24 months). 6. All facilities and RAEs (through contract revision) will be required to utilize the new tools no later than 12/31/2027 to determine appropriate level of care and length of stay. (Timeline: 18-24 months).

Prompts	Summary
3.e Other state requirements/policies to improve access to a full continuum of care including crisis stabilization	*Current Status:* Senate Bill 21-154 established the 988 Crisis Hotline Enterprise in the Department to impose a 988 surcharge and a prepaid wireless 988 charge; fund the 988 crisis hotline; work with third parties to provide crisis outreach, stabilization, and acute care; authorize and issue revenue bonds payable from the newly created 988 Crisis Hotline Cash Fund; and adopt, amend, or repeal policies to regulate its affairs. 988 is a free, confidential service available to anyone in Colorado experiencing a mental health, substance use, or emotional crisis. People can reach out for themselves or for someone they are concerned about, such as a friend, neighbor, or loved one. Colorado has a mobile crisis response (MCR) benefit, that aims to provide community crisis care, which includes crisis assessment and coordination with culturally responsive referrals to appropriate resources, including health, social, and other services and supports. The MCR benefit was created in collaboration with the BHA; MCR is available to all people in Colorado 24 hours a day, 7 days a week, 365 days a year, regardless of insurance status, age, residency, or previous service utilization, and is delivered by a multidisciplinary MCR team with requisite training and expertise. MCR responses offer de-escalation, stabilization, safety planning, referrals, and follow up support. HCPF also created a behavioral health secure transportation (BHST) benefit on July 1, 2023, which aims to support increased access to the behavioral health crisis continuum of care by providing transportation from the community to a behavioral health facility and between behavioral health care facilities, as needed for further behavioral health stabilization and treatment. As allowed by the passage of HB 22-1303, the Department added a new service type, mental health transitional living (MHTL) homes. These homes will be used as a transition to a less restrictive setting for individuals with severe mental health conditions. Clients may stay as long as medically necessary with an ultimate goal of reintegrating clients successfully into the community. The focus is to provide clinical services and continued support with social and life skills development based on the client's individual needs.
	Future Status: The future state of ACC 3.0 also establishes that RAEs support community care by providing care navigation. Care navigation will include follow up with the member to ensure the member is connected to ongoing behavioral health care after a crisis, which will include discharge from EDs and hospitalizations. It will also require that an appointment with a licensed health care provider is scheduled within seven days of discharge from an emergency department or hospital. HCPF is also partnering with the BHA to standardize behavioral health crisis care as evidenced by the creation of rules that define a crisis professional (including training and scope of practice) and the creation of a standard BHA crisis assessment tool.

	Summary of Actions Needed: 1. Establishment of care navigation by RAEs to support community care will be implemented by HCPF in RAE contracts in DY5. 2. Create Rules that define crisis profession (including training and scope of practice) and creation of standard crisis assessment tool by BHA, in partnership with HCPF by end of DY 6.
SMI/SED. Topic_4. Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration	
Critical strategies for improving care for individuals with SMI or SED include earlier identification of serious mental health conditions and focused efforts to engage individuals with these conditions in treatment sooner. To meet this milestone, state Medicaid programs must focus on improving mental health care by taking the following actions.	
Earlier Identification and Engagement in Treatment	
4.a Strategies for identifying and engaging beneficiaries with or at risk of SMI or SED in treatment sooner, e.g., with supported employment and supported programs	*Current Status:* **Individual Placement and Support (IPS)** is a model of supported employment for people with serious mental illness (e.g., schizophrenia spectrum disorder, bipolar, depression). IPS supported employment helps people living with behavioral health conditions work at regular jobs of their choice. Although variations of supported employment exist, IPS refers to an evidenced based practice in supported employment and is incorporated into the following eight principles: open to anyone who wants to work (Zero Exclusion); focus on competitive employment; rapid job search; targeted job development; client preferences guide decisions; individualized long-term supports; and integrated with treatment. Colorado currently has 17 IPS teams housed within Comprehensive Providers, in both rural and urban settings, and these teams have matched national levels of employment outcomes. Colorado has two treatment centers providing IPS and three of the Comprehensive Providers are working with the Substance use population as well as the mental health population. Colorado currently supports the provision of these services with a braided funding strategy by way of Mental Health, Division of Vocational Rehabilitation, and Medicaid resources. In addition to the IPS programing outlined, Colorado also has ACT, CCBHC, and other programs that assist with identifying and engaging beneficiaries with or at risk of SMI or SED in treatment sooner. - Assertive Community Treatment (ACT) - Assertive Community Treatment (ACT) is a service-delivery model that provides comprehensive, community-based treatment to adults with serious behavioral health diagnoses. Services ae highly individualized and are available 24 hours a day, seven days a week, 365 days a year, to clients who need significant assistance and support to overcome the barriers and obstacles that confront them. ACT teams provide case management, initial and ongoing BH assessments, psychiatric services, employment and housing assistance, family support and education, and substance use disorder services. The ACT model also includes a supported employment

	component. - CCBHC – Colorado was awarded a SAMHSA planning grant for CCBHCs on December 31, 2024. The one year planning grant provides federal funds to support Colorado in exploring how the CCBHC, including early detection of mental health issues and supported employment) will benefit communities and people around the state in need of behavioral health services and will strengthen the provider network. - COACT - Colorado high fidelity wraparound provides intensive care coordination and supportive services to help families with a child with mental health challenges within a trauma-informed system of care. - ASCENT Colorado is a community-based program to support youth and young adults who may be experiencing an early onset of psychosis. Services include individual, group and family therapy, family education and support, case management, specialized education and employment services, medication management, and peer support. It's a program focused on stabilizing young people and providing mental health care for approximately two years including integrated services and supports to help young people on the worksite or in an educational setting. - Child First is an evidence-based practice, providing intensive in-home services for young children and their parents or caregivers to protect children from the impact of trauma and chronic stress. Colorado established CDPHE's School-Based Health Center (SBHC) Program, and through a partnership with the BHA launched the SBIRT in School-Based Health Centers Project (SBIRT-SBHC Project), which focuses on providing substance use and mental health screening and early intervention services to adolescents in school-based health centers. Through universal screening for mental health and substance use concerns, the project hopes to intersect with adolescents before mental health symptoms or substance use becomes problematic.
	Future Status: Establishment of tiered care coordination and case management tiers for target populations by RAEs to support community care will be implemented by HCPF in RAE contracts in the first year of the SMI/SED demonstration. The State will explore establishing or expanding Peer-Operated Centers, which can provide mutual support, self-help, advocacy, education, information, and referral services. Peer-Operated Centers can engage individuals with or at risk of SMI or SED in treatment sooner, and support a self-directed recovery approach, based on the lived experience of the staff. The State will explore requiring that Supported Employment and Education (SEE) Specialists on Coordinated Specialty Care/First Episode Psychosis teams complete training in the IPS evidence-based practice and will be required to provide services to individuals in a way that aligns with the evidence-based practice. The State will continue to expand access to IPS, with two Comprehensive Providers in the process of hiring to implement, and Colorado Coalition for the Homeless is implementing as well. Additional efforts the State is making to improve early identification of SMI/SED and coordination of behavioral health

	care in primary care settings are detailed in 4.b., the State will review current PHQ-9 and GAD-7 screening requirements in pediatric offices. HCPF supports several initiatives specific to early identification and access to care for children and adolescents detailed in Section 4.c.
	Summary of Actions Needed: 1. Stakeholder engagement regarding tiered care coordination and case management. (Timeline: 18-24 months). 2. Development of policies/rules for tiered care coordination and case management. (Timeline: 18-24 months). 3. Stakeholder engagement regarding Peer-Operated Centers (Timeline: 18-24 months). 4. Review and possible revision of CSC/FEP policy to include SEE Specialist position (Timeline: 18-24 months).
4.b Plan for increasing integration of behavioral health care in non-specialty settings to improve early identification of SED/SMI and linkages to treatment	*Current Status:* Established through Senate Bill 19-222, Colorado, led by HCPF, is developing a framework to support integrated behavioral health and primary health care including integrated behavioral health in primary care settings. Through 25 community stakeholder sessions, primary care providers were engaged and provided feedback regarding priority populations, value-based payments, and care coordination to support safety net providers in this effort. Integration of primary care to behavioral health is a challenging, yet desired outcome of the safety net approach. The goal of Senate Bill 19-222 is "improved access to a high-quality behavioral health system that serves individuals regardless of payer type or acuity level and that has a full continuum of behavioral health treatment services". The model is designed with the acknowledgement that an individual's need for treatment is based both on acuity (how severe are a client's symptoms) and complexity (how a client's behavioral health needs intersect with medical and social needs). As this program is implemented across the state and further assessed, the continued efforts to integrate primary and behavioral health is highly regarded and will further inform the BHA on additional needs, requirements and shifting of resources necessary to make it a reality. As part of their health care practice transformation (House Bill 22-1302), HCPF provided $31 million in short term grant funding for physical and behavioral health care providers looking to implement or expand access to care and treatment for mental health and substance use disorders using an evidence-based integrated care model. Grant funds could be used for projects designed to: 1) Develop infrastructure for primary care, pediatric, and behavioral health professionals to better serve individuals with behavioral health needs in outpatient health care settings; 2) Increase access to quality health care for individuals with behavioral health needs; 3) Expand early intervention tactics that reduce escalation and exacerbation of behavioral health conditions; 4) Address the shortage of the behavioral health care workforce; Develop and implement alternative payment models, including protocols, processes, workflow, and partnerships; 6) Support for small capital

	expenditures, including IT and data-sharing technology; 7) Train primary care and behavioral health providers in trauma-informed care, adverse childhood experiences, and trauma recovery. In parallel with the 1302 pilot and informed by the Sustainability Report, which laid out a sustainable reimbursement model for Integrated Care, HCPF submitted a budget request included in the Governor's Budget proposal for SFY 25/26 to implement the first phase of an Integrated Care Benefit (ICB). The ICB includes opening the Collaborative Care Management (CoCM) codes as well as the Health and Behavior Assessment and Intervention (HBAI) codes to be billed by PCMPs. The ICB will go live July 1, 2025, as a key component of ACC 3.0. Included in this design is a statewide assessment tool that RAEs will use to evaluate PCMPs for their level of integration. Based on the assessment, additional funding could be available to PCMPs by the RAEs to support Integrated Care.
	Future Status: Colorado will require RAEs to facilitate practice transformation activities for providers that include supporting network providers with implementing new or improving existing integrated physical and behavioral health care activities through the ACC Phase 3.0 contracts and also support integrated care payment for practices that meet standards regarding the integration of primary care and behavioral health care, using the PCMP Practice Assessment Tool. Colorado will implement an integrated care benefit under ACC Phase 3 to increase BH services in primary care settings. This benefit will enhance physical and behavioral health services through the provision of early intervention, pre-diagnosis support, and ongoing care for beneficiaries with lower acuity and maintenance needs. Goals include: integration of physical and behavioral health, early intervention and prevention, and improved access and quality. Colorado will also expand the use of PHQ-9 and GAD-7 into primary care settings to support early identification and intervention efforts.
	Summary of Actions Needed: 1. Implement the Integrated Care Benefit to increase BH services in primary care setting will be completed by HCPF in the first two years of the demonstration. DY5. 2. Identify current initiatives/requirements for PHQ-9 and GAD-7 completion in primary care settings. Complete stakeholder engagement to determine if there are barriers to increasing/improving screening completion. Identify best practices to support increased screening and linkage to treatment (when appropriate) (Timeline: 18-24 months). 3. Research models of care focused on improving access to behavioral health care in rural/frontier settings. Complete stakeholder engagement, focused on rural and frontier areas, to review research and models identified. (Timeline: 18-24 months).

Prompts	Summary
4.c Establishment of specialized settings and services, including crisis stabilization, for young people experiencing SED/SMI	*Current Status:* In January 2023, the BHA launched the Crisis Resolution Team Pilot Program (CRT) in 17 counties. The CRT program supports families with youth and young adults who are experiencing behavioral health challenges and would benefit from intensive, short-term (6-8 weeks), in-home services and connection to ongoing support. CRT services are available to Colorado youth and young adults ages 0 – 21. HCPF and BHA ensure a culturally competent and trauma-informed approach in collaboration with state and local, **child-and youth-serving agencies** in the state to provide a comprehensive array of core mental health services for children, youth, and families. In addition, CDHS, Division of Child Welfare, provider services unit provides oversight and monitoring of the quality of child-serving programs and services. Health First Colorado provides a full continuum of mental health services for children/youth, including mental health care. The full continuum of service includes but is not limited to case management services, individual and group therapy, prevention/early intervention services, residential mental health services (psychiatric residential treatment facility (PRTF)), school-based and day treatment services, among others. In addition, through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program, children and youth, members aged 20 and under, have access to comprehensive and preventive mental health services through Health First Colorado. Benefits available through EPSDT include physical, mental, developmental, dental, hearing, vision, and other screenings and arrangement for corrective treatment as determined by child health screenings. **Colorado established CDPHE's School-Based Health Center (SBHC) Program** in state statute (C.R.S. 25-20.5-501-503) in 2006. Under this program, CDPHE supports school-based health centers located in schools or on school property throughout Colorado that provide integrated care, including primary and behavioral health care services. Colorado's school-based health centers are based in schools that serve families with limited household income and/or who are underinsured. **Trauma-Informed Approaches** BHA implements community-based trauma-informed care for children and adolescents to improve child, youth and family outcomes through the implementation of a researched best practices trauma-informed care approach to behavioral health services. The program assesses clients for trauma and adverse experiences, understanding the impact of trauma on mental health and substance abuse disorders, incorporates the treatment of trauma at all levels of service delivery, and utilizing peer support to improve patient outcomes within the community behavioral Health provider network.

	Colorado has a robust approach to implementing trauma-informed care across our provider network that informs all parts of all experiences for all persons and in all interactions within our systems. Key Service Components include: training the workforce with the BHA's trauma-responsive web based learning series and behavioral health related practices; peer advocates with lived experience with behavioral health services are trained to support children, youth and their families in services; utilization of evidence based care coordination models, such as High Fidelity Wraparound; and clinical care coordination; implementation of a statewide assessment tool, the CANS; and the BHA provides trauma-informed technical assistance to providers serving children, adolescents and their families. Under the CYMHTA, families can access mental health treatment services for their child or youth. CYMHTA is an alternative to child welfare involvement when a dependency and neglect isn't warranted. CYMHTA funding can be available when there is not an appropriate funding source for treatment. The child or youth must have a mental health diagnosis, risk of out-of-home placement, not be eligible for Medicaid, access prior to their 18th birthday, and doesn't have a pending or current dependency or neglect action with child welfare. For access to CYMHTA, a robust biopsycho-social assessment is completed which includes a face-to-face clinical assessment, record review, collateral information and the CANS tool. **Children with SED** Because children and youth with Serious Emotional Disturbance (SED) often require intensive services and are often involved in multiple parts of the behavioral health system, the BHA ensures a comprehensive and trauma-informed system of care approach in collaboration with other state and local, child- and youth-serving agencies in the state. The goal is to provide the necessary core mental health services to children and youth with SED. These services include independent assessments, utilizing the CANS, care coordination, supportive services (including peer and family support services and respite services), school based services, outpatient mental health and SUD services, medication management, intensive outpatient mental health and SUD services (including high fidelity wraparound and first episode psychosis), home-based services (including Child First), therapeutic foster care services, residential treatment services (including QRTP, residential SUD treatment services, withdrawal management services, and PRTF, crisis services (including crisis line, mobile crisis, crisis walk-in, crisis stabilization, crisis respite, and crisis resolution teams), and inpatient services (including psychiatric hospitals). Comprehensive Community Providers throughout Colorado, through contracts with the BHA and reimbursement by Medicaid, provide comprehensive outpatient mental health services, medication management, school-based services, and ASCENT first episode psychosis. I Matter provides up to six free telehealth or in-person therapy sessions for children and youth up to 18 years of age or up to 21 years of age if receiving special education services. I Matter is available in English and Spanish, and the program requires minimal clinical screening and no formal diagnosis, so access is quick and easy. Child First, an evidence-based practice, provides intensive in-home services for young children and their parents or caregivers. COACT Colorado high fidelity

	wraparound provides intensive care coordination and supportive services within a trauma-informed system of care to children and adolescents diagnosed with SED. Per SB23-174, effective July 1, 2024, HCPF stood up a benefit to cover select OP behavioral health services for members under 21 years old without a clinical diagnosis, as long as services are Medically necessary. This is intended to address social determinants of health and provide early intervention support for factors that impact a youth's functioning before explicitly meeting the full clinical criteria of a mental health diagnosis. HCPF continues to work with providers to stand up adolescent CSUs to ensure appropriate settings and services for young people. This has included 1-on-1 guidance to navigate HCPFs Behavioral Health Campus Policy as well as facilitating discussions with multiple state agencies that have component responsibilities for such settings. HCPF will continue to explore current access to and utilization of established specialized services for children and adolescents. This review will include how services align to best practices (if applicable), current authorization requirements, funding, referral process, etc. to determine if there are any systems or requirements creating unintentional barriers to children/adolescents receiving these services. HCPF will also use this information to create a current map of the specialized child and adolescent service array.
	Future Status: Continued operation of current programming. ACC Phase 3.0 contract language requires contractor's care coordination program to be person and family centered, trauma informed, and culturally responsive. HCPF will seek stakeholder feedback, to include family, guardians, school systems, etc., to identify current strengths and gaps in the child/adolescent BH service array. HCPF will research implementing peer support services focused on children, adolescents, and transition aged youth. HCPF will explore the feasibility of developing standards for mobile crisis response services that service children, adolescents and their families/caregivers. HCPF will explore the feasibility of expanding Coordinated Specialty Care for First Episode Psychosis to more teams and conduct a cost benefit analysis of covering the complete model under Medicaid.

	Summary of Actions Needed: 1. HCPF will complete stakeholder engagement to support the identification of system strengths and gaps. (Timeline: 18-24 months). 2. HCPF will identify funding that could support the creation or expansion of services for children/adolescents, as needed. (Timeline: 18-24 months). 3. HCPF will develop and issue rules or policies as necessary and needed to expand or enhance the child and adolescent behavioral health service array. (Timeline: 18-24 months). 4. HCPF will explore the feasibility of expanding Coordinated Specialty Care for First Episode Psychosis to more teams and conduct a cost benefit analysis of covering the complete model under Medicaid. (Timeline: 18-24 months).
4.d Other state strategies to increase earlier identification/engagement, integration, and specialized programs for young people	*Current Status:*
	Future Status
	Summary of Actions Needed:

Prompts	Summary
SMI/SED.Topic_5. Financing Plan	
State Medicaid programs should detail plans to support improved availability of non-hospital, non-residential mental health services including crisis stabilization and on-going community-based care. The financing plan should describe state efforts to increase access to community-based mental health providers for Medicaid beneficiaries throughout the state, including through changes to reimbursement and financing policies that address gaps in access to community-based providers identified in the state's assessment of current availability of mental health services included in the state's application.	
F.a Increase availability of non-hospital, non-residential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, observation/assessment centers, with a coordinated community crisis response that involves collaboration with trained law enforcement and other first responders.	*Current Status* After the 2014 Aurora theater shooting, Colorado implemented a statewide crisis response system, guaranteeing that all Coloradans have access to behavioral health care regardless of ability to pay. The coordinated behavioral health crisis response system improves access to the most appropriate resources and crisis interventions via a statewide hotline, mobile crisis response, and walk-in crisis services across the state. These services ensure early interventions for individuals in crisis and promote wellness and engagement with the behavioral health care system. Crisis services work to decrease the number of unnecessary involuntary civil commitments, utilization of hospital emergency departments, jails, and other wraparound programs for individuals experiencing a behavioral health emergency. The components of the system are required to reflect a continuum of care from crisis response through stabilization and treatment and safe return to the community, with adequate support for transitions to each stage. The following key service components are completely state funded: ● ***Statewide 24-Hour crisis help line:*** A twenty-four-hour telephone crisis service that is staffed by trained professionals and peers who are capable of assessing crisis situations and making the appropriate referrals to resources and treatment. ● ***Statewide awareness campaign and communication:*** multi-media campaign/branding and communication to increase awareness of behavioral health resources. The communication plan includes a website (988colorado.com), social marketing, billboards, brochures, television, and radio ads. ● ***Walk-in crisis services:*** Walk-in crisis services provide walk-in services, many 24/7, with the capacity for immediate clinical intervention, triage, and stabilization. The walk-in crisis services employ an integrated health model based on evidence-based practices that consider an individual's physical and mental health, are a part of a continuum of care, and are linked to mobile crisis services and crisis respite services. ● ***Crisis stabilization unit(s)***: CSUs are facilities, using a restrictive egress alert device, which serve individuals requiring 24-hour intensive behavioral health crisis intervention for up to five days. CSUs employ an integrated health model based on evidence-based practices that consider an individual's physical and emotional health, are a part of a continuum of care, and are linked to mobile crisis services.

	● ***Mobile crisis response services*** can initiate a timely response to a behavioral health crisis, and link to the walk-in crisis services and crisis respite services. 24-hour mobile crisis response teams are required to respond within one hour in urban and two hours in rural areas to a behavioral health crisis in the community for immediate clinical intervention, stabilization, and connection to services. Effective July 1, 2023, the mobile crisis response (MCR) benefit was expanded to adopt standards in alignment with requirements under Section 9813 of the American Rescue Plan Act (ARPA) of 2021. https://www.congress.gov/congressional-report/117th-congress/house-report/7/1 ● ***Adult Treatment Unit:*** An ATU is a facility or distinct part of a facility for short-term psychiatric care, which may include treatment for substance use disorders, that provides a 24-hours therapeutically planned and professionally staffed environment for persons who do not require inpatient hospitalization but need more intense and individual services than are available on an outpatient basis, such as crisis management and stabilization services. Crisis Respite/Residential: Residential and respite crisis services are linked to the walk-in crisis services and crisis respite services that include a range of short-term crisis residential services, including but not limited to community living arrangements. There is no maximum length of stay for crisis respite, however length of stay determinations must be ongoing, transparent to the individual and family to the extent allowable under state and federal privacy laws, and jointly determined by the individual, family, respite provider, and treatment team. ● Residential or community-based respite care services include a range of short-term services twenty-four (24) hours per day, seven (7) days per week, and 365 days per year. Respite care services shall be flexible to ensure that the individual's daily routine is maintained. https://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=11259&fileName=2%20CCR%20502-1 In 2019, five years after the system was created, OBH (now BHA) worked with community partners to address the gaps in the crisis system and put out a request for proposal for seven regions, aligning with the service regions for the state's Medicaid managed care program. Each region is managed by an ASO responsible for ensuring their region has a comprehensive set of crisis services. The BHA now contracts with Solari to operate a 24 hour/7 days a week/365 days a year statewide crisis line, 844-493-8255, as well as 988. The statewide crisis line has been in existence since 2014. The BHA launched the Crisis Resolution Team Pilot Program, described in 4c, that supports Colorado youth and young adults ages 0-21. Additional current initiatives that involve collaboration with trained law enforcement and other first responders ● ***Co-Responder Programs:*** Pairs law enforcement and behavioral health specialists to intervene and respond to

	behavioral health-related calls for policy services. These teams utilize the combined expertise of the officer and the behavioral health specialist to de-escalate situations and help link individuals with behavioral health services. When an individual clinically needs more intensive services and supports than the co-responder program can provide, they can transport the individual to a behavioral health crisis facility (which can include CSUs), when one is available in the service area, to divert the individual from an ED. ● Crisis Intervention Teams (CIT) this initiative provides law enforcement offices specialized training in crisis intervention, which supports them in responding to individuals experiencing a mental health crisis and focusing on de-escalation ● Community Assistance Response and Engagement (CARE) is a collaborative program between mental health professionals, law enforcement, and other community organizations, to help individuals find and use resources. CARE was launched in Boulder, and triages calls that do not present as serious safety or medical concerns, and allows behavioral health and medical professionals to respond and divert individuals away from potential criminal justice involvement and towards mental health and social support services.
	Future Status: HCPF seeks an integrated behavioral health crisis continuum, for a single point of triage and dispatch while also coordinating appropriate referrals as the "front door" to the behavioral health care system. Colorado has developed resources for behavioral health staff working in the crisis response system to identify potential barriers that children, youth, families, and pregnant and parenting people may encounter when experiencing a behavioral health crisis, and ensure the system is responsive to the individual's needs. This crisis response toolkit includes sections covering the handoff from the crisis hotline to the mobile crisis team, things to cover while en route, intervention, and what's next.
	Summary of Actions Needed 1. HCPF in partnership with BHA is continuing to integrate and support behavioral health crisis continuum with considerations to prioritize 988 messaging and standardized triage. The transition began July 1, 2025 and will be continually refined to be more responsive to beneficiaries needs thereafter. (Ongoing).
F.b Increase availability of on-going community-based services, e.g., outpatient, community mental health centers, partial hospitalization/day treatment,	*Current Status* Colorado has a robust Independent Provider Network (IPN) that includes everything from a single licensed BH provider with an independent solo practice, as well as larger organizations with multiple sites across the region or the state. To serve Health First Colorado members, providers must be enrolled with Medicaid and contracted with at least one RAE. Each IPN may contract for a scope of services they wish to provide to Health First Colorado members up to the level

assertive community treatment, and services in integrated care settings such as the Certified Community Behavioral Health Clinic model.	they are licensed to provide. Over 60% of outpatient behavioral health services are provided by an independent provider. The Colorado behavioral health system includes extensive safety net providers. There are two types of safety net providers each described below. ***Essential Safety Net Provider*** - A licensed behavioral health entity or behavioral health provider approved by the BHA to provide care coordination and at least one of the following services: •Emergency or crisis behavioral health services •Behavioral health outpatient services •Behavioral health high-intensity outpatient services •Behavioral health residential services •Withdrawal management services •Behavioral health inpatient services •Integrated care services •Hospital alternatives or •Additional services that the BHA determines are necessary in a region or throughout the state ***Comprehensive Safety Net Provider*** - A licensed behavioral health entity or behavioral health provider approved by the BHA to provide care coordination and all of the following behavioral health safety net services, either directly or through formal agreements with behavioral health providers in the community or region: •Emergency and Crisis Behavioral Health Services •Mental Health and Substance Use Outpatient Services •Behavioral Health High-Intensity Outpatient Services •Care Management •Outreach, Education, and Engagement Services •Mental Health and Substance Use Recovery Supports •Outpatient Competency Restoration •Screening, Assessment, and Diagnosis, Including Risk Assessment, Crisis Planning, and Monitoring to Key Health Indicator Required services can be provided directly by the center or through partnership agreements with other providers, such as inpatient psychiatric hospitals. Specialty clinics provide all core services except residential, vocational and emergency services and serve specific populations. In addition to the core services, state and local planning efforts have resulted in the development of certain specialized programs for individuals with other unique needs in addition to their mental illness. The specialty clinics in the state provide a variety of core services primarily targeted at special populations such as members of racial, ethnic or linguistic minority groups. Colorado also leverages 175 FQHCs to expand access to behavioral health services. FQHCs must provide clinical

	psychologist services and clinical social worker services to be offered as a benefit. Colorado currently 8 community behavioral health providers awarded SAMHSA Certified Community Behavioral Health Clinic (CCBHC)-E grants. The CCBHC funding enables the seven centers to expand access to a full continuum of integrated behavioral health services. In July 2024, Colorado leveraged CCBHC planning grant insights to develop a Comprehensive Community Behavioral Health Provider (Comprehensive Providers) type. Comprehensive Providers mimic CCBHCs in that they must provide crisis services, care coordination, a suite of outpatient care, which includes outpatient competency restoration support. Further, Comprehensive Providers must serve priority populations, must follow no refusal requirements, and are reimbursed using a prospective payment system. In December 2024, Colorado was awarded a SAMHSA CCBHC Planning Grant. Colorado currently has two accredited clubhouses in the state, in Greeley, Fort Collins, and one unaccredited clubhouse in Colorado Springs. Clubhouses provide community-based services to adults with serious mental illness to support and empower them living and thriving in their community. The program uses psychosocial rehabilitation to create opportunities for employment, socialization, education, skill development, housing, and improved wellness. Colorado also supports drop-in centers, which provide a club like setting where members can participate in activities and social events. Colorado is currently establishing MHTL homes providing an added layer of services with the Colorado behavioral health continuum of care. These homes will be used as a transition to a less restrictive setting for individuals with severe mental health conditions. Client length of stay is determined by medical necessity with the goal of stabilizing members sufficiently to allow them to step down to community-based level of care support to allow for reintegrating clients successfully in the community. The focus is to provide clinical services with continued support with social and life skills development based on the client's individual needs. There are 24 state-run and 101 community-based-run beds that opened May of 2024. HCPF is leveraging the RAEs and the flexibility of the capitated behavioral health benefit to expand the provider network. This will include creating new Health First Colorado provider definitions and types that align with the BHA's new licensing strategies, with an emphasis on those providers that can enhance behavioral health service availability and continuity of care. Most of these new provider definitions and types will be linked to the new payment framework to support the long-term sustainability of the behavioral health safety net. The BHA requires that all Comprehensive Safety Net Providers offer ACT services. Some providers offer ACT services according to the Dartmouth Assertive Community Treatment Scale (DACTS fidelity scale) and each Comprehensive

	Community Provider has an annual review of the services being delivered. Our comprehensive safety net is statewide, there are 19 comprehensive safety net providers who all offer ACT services.
	Future Status On September 11, 2024, HCPF, in partnership with the BHA, submitted an application to SAMHSA for the 2024 CCBHC Planning Grant. SAMHSA awarded a 2025 Certified Community Behavioral Health Center Planning Grant to Colorado on December 31, 2024. The one-year planning grant will provide federal funds to support Colorado in exploring how the CCBHC model will benefit communities and people around the state in need of behavioral health services and will strengthen the provider network. Colorado indicated it intends to invite up to 10 additional providers in each additional phase, and support those participating providers seek certification as Phase 2. Phase 1 CCBHCs are located in a combination of urban, rural, and frontier counties, and HCPF intends to continue to focus on increasing access in rural, urban, and frontier counties in Phase 2 and 3 implementation. Additionally, as part of ACC Phase 3.0, HCPF anticipates implementing payment reforms to reduce barriers to provider participation and increase access across the behavioral health continuum. As part of ACC Phase 3.0, behavioral health alternative payment models (APMs) are being designed in collaboration with the BHA to support the implementation and sustainability of new behavioral health safety net providers throughout the state. For Comprehensive Providers that will be accountable for delivering the greatest range of services for members, HCPF has designed a cost-based, prospective payment model. This funding arrangement is designed to ensure that Comprehensive Safety Net Providers can provide the full continuum of services to members, even those services that may not be used frequently but are considered essential treatment models, especially for those diagnosed with serious mental illness. Additionally, the state is working to develop APMs for Essential Safety Net Providers. HCPF and the RAEs have begun work to improve the availability of high intensity outpatient services utilizing ARPA funding. For ACC Phase 3.0, HCPF will partner with the RAEs to develop solutions that fill gaps in the continuum of high intensity outpatient services, to improve transitions between levels of care, and to add care levels that better reflect member needs. Using a combination of strategies that include new payment models, lessons learned from the ARPA project will be leveraged to implement strategies that support the long-term sustainability of these higher-cost services. Strategies will be designed to encourage existing providers, particularly those working in traditionally underserved areas, to become Health First Colorado providers, add new services, and expand service availability and quality. Additionally, where possible, HCPF is implementing processes to reduce administrative burden faced by providers to allow for more equal participation among different sized practices, especially for independent behavioral health care

	providers. For example, HCPF is considering strategies to centralize the credentialing process for all providers. Currently, providers are credentialed separately by each RAE. In ACC Phase 3.0, providers would be credentialed through a single entity and those credentials would be accepted by each RAE. The goal is to reduce the administrative burden that comes from credentialing with multiple entities to encourage more providers to participate in the ACC. HCPF will leverage information from the behavioral health annual availability assessment, combined with stakeholder feedback and review of pertinent data (e.g. utilization management data, rehospitalization rates after crisis service utilization, percent of appointments made for individuals within 7 days of discharge from a hospitalization or ED stay) to identify potential gaps in community behavioral health services.
	Summary of Actions Needed 1. The roadmap to implementing CCBHCs in Colorado is expected to include: ● ***Monthly CCBHC Stakeholder Meetings*** – last Wednesday of the month, from January 2025 through October 2025 ● ***CCBHC Steering Committee Meetings (open to the public)*** - last Monday of each month, from March 2025 through December 2025 ● ***CCBHC Planning Grant Subcommittees*** - all subcommittees meet monthly, starting March 2025 through December 2025, and include: Prospective Payment System and Finance, Certification and Provider Readiness, and Quality Measure Data Management, ● April 2025 - January 2026 CCBHC System changes begin ● October 2025 – CCBHC Certification Process Implementation Begins ● December 30, 2025 – Planning Grant End Date ● January 2026 CCBHC State Certification Process implemented ● Jan-July 2026 – Optional, no-cost grant extension ● April 1, 2026 – CCBHC Demonstration Program proposals due to SAMHSA ● July 1, 2026 – States added to Demonstration Program on or after July 1, 2026 2. The ACC Phase 3.0 Implementation timeline is as follows: ● Implement behavioral health alternative payment models (APMs) to support the implementation and sustainability of new behavioral health safety net providers throughout the state, including a cost-based prospective payment model and APMs for Essential Safety Net Providers. (As of July 1, 2025 with the transition

	to ACC Phase 3.0, implementation is underway the state anticipates implementation to be an iterative process with ongoing review and adjustments over the next two fiscal years). ● Implement strategies that support the long-term sustainability of higher-cost services; expand Health First Colorado providers, add new services, and expand service availability and quality. (As of July 1, 2025 with the transition to ACC Phase 3.0, implementation is underway the state anticipates implementation to be an iterative process with ongoing review and adjustments over the next two fiscal years). ● Reduce administrative burden faced by providers to allow for more equal participation among different sized practices, including independent behavioral health care providers by centralizing the credentialing process for all providers. (As of July 1, 2025 with the transition to ACC Phase 3.0, implementation is underway the state anticipates implementation to be an iterative process with ongoing review and adjustments over the next two fiscal years).

Prompts	Summary
SMI/SED. Topic_6. Health IT Plan	
As outlined in State Medicaid Director Letter (SMDL) #18-011, "[s]tates seeking approval of an SMI/SED demonstration … will be expected to submit a Health IT Plan ("HIT Plan") that describes the state's ability to leverage health IT, advance health information exchange(s), and ensure health IT interoperability in support of the demonstration's goals."[1] The HIT Plan should also describe, among other items, the: ● *Role of providers in cultivating referral networks and engaging with patients, families and caregivers as early as possible in treatment; and* ● *Coordination of services among treatment team members, clinical supervision, medication and medication management, psychotherapy, case management, coordination with primary care, family/caregiver support and education, and supported employment and supported education.* *Please complete* all *Statements of Assurance below—and the sections of the Health IT Planning Template that are relevant to your state's demonstration proposal.*	
Statements of Assurance	
Statement 1: Please provide an assurance that the state has a sufficient health IT infrastructure/ecosystem at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration. If this is not yet the case, please describe how this will be achieved and over what time period	Yes. The State continues to align with the electronic health record (EHR) adoption and health information exchange (HIE) technical connectivity goals of Colorado's State Medicaid Health IT Plan (SMHP). Many system changes in behavioral health rely on data sharing, provider technology, and integration onto state health information structures. The Governor'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. HCPF and the state's BHA are actively engaged in advancing and leveraging the state's Health IT roadmap. 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 (the state's two Health Information Exchanges) can electronically share data and information with one another to support patient care. Leveraging the existing statewide

	infrastructure that has been created by Contexture, QHN and CCMCN (the technology organization for the FQHCs), and other community partners, OeHI 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. 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. In addition to these efforts, in late 2022 the aforementioned HIE partners began having clinical data integration work with Safety Net Providers prioritized on their technical connection plans. Four of the 17 Comprehensive Safety Net Providers are currently under contract to become technically connected with the HIEs. Two Safety Net Providers (one of which is the state's largest provider serving Medicaid members receiving behavioral health services) have had technical connections established since this effort began. At HCPFs direction, six additional Safety Net Providers are currently actively engaged in negotiations with the HIEs. While HCPF is excited about the progress that has been made, it is HCPF's intention to continue to prioritize this important work and have all Comprehensive Safety Net Providers connected to the HIE within five years. Once a Safety Net Provider is technically connected, the patient information will be integrated (when possible, with particular attention to the 42 CFR Part 2 regulations) into larger supplemental data feeds produced by the HIE partners that HCPF uses to supplement our claims data regarding Colorado's Reporting of the CMS Core Sets Quality Measures for both adults and children. This is particularly critical regarding the behavioral health measures which are mandatory. This data is used by HCPF to better plan, execute, and course correct programs in support of behavioral health patients, families and caregivers. Safety Net Providers becoming technically connected to the HIEs results in clinical data becoming readily available to providers across the state who are also technically connected via the HIE. This information is critical to ensure successful coordination between treatment team members, clinical supervision, medication and medication management, psychotherapy, case management, coordination with primary care, family/caregiver support and education, and supported employment and supported education.

[1] See SMDL #18-011, "Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance." Available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf.

Prompts	Summary
Statement 2: Please confirm that your state's SUD Health IT Plan is aligned with the state's broader State Medicaid Health IT Plan and, if applicable, the state's Behavioral Health IT Plan. If this is not yet the case, please describe how this will be achieved and over what time period.	The State confirms these Health IT Plans are aligned with the former SMHP and the more current Colorado Health IT Roadmap. The Colorado State Medicaid Health IT Plan (SMHP) was approved by CMS in 2022 and is no longer required post-HITECH. As an alternative, the Governor's OeHI issued a Colorado Health IT Roadmap with the last update in April 2025. The latest update included changes to improve accessibility and outcomes.
Statement 3: Please confirm that the state intends to assess the applicability of standards referenced in the Interoperability Standards Advisory (ISA)[2] and 45 CFR 170 Subpart B and, based on that assessment, intends to include them as appropriate in subsequent iterations of the state's Medicaid Managed Care contracts. The ISA outlines relevant standards including but not limited to the following areas: referrals, care plans, consent, privacy and security, data transport and encryption, notification, analytics and identity management.	HCPF confirms that it intends to assess the applicability of standards referenced in the Interoperability Standards Advisory (ISA)[2] and 45 CFR 170 Subpart B and based on that assessment, intends to include them as appropriate in subsequent iterations of the state's Medicaid Managed Care contracts. HCPF has already assessed the applicability of the Interoperability Standards Advisory and 45 CFR 170 and incorporated the relevant standards into HCPF's standards were applicable. HCPF has also incorporated the requirement for MCOs to comply with the Interoperability Rule. The State will ensure this requirement is maintained in any future contract actions.

[2] Available at https://www.healthit.gov/isa/.

Prompts	Summary
To assist states in their health IT efforts, CMS released SMDL #16-003 which outlines enhanced federal funding opportunities available to states "for state expenditures on activities to promote health information exchange (HIE) and encourage the adoption of certified Electronic Health Record (EHR) technology by certain Medicaid providers." For more on the availability of this "HITECH funding," please contact your CMS Regional Operations Group contact.[3] *Enhanced administrative match may also be available under MITA 3.0 to help states establish crisis call centers to connect beneficiaries with mental health treatment and to develop technologies to link mobile crisis units to beneficiaries coping with serious mental health conditions. States may also coordinate access to outreach, referral, and assessment services—for behavioral health care--through an established "No Wrong Door System."*[4]	
Closed Loop Referrals and e-Referrals (Section 1)	
1.1 Closed loop referrals and e-referrals from physician/mental health provider to physician/mental health provider	*Current State:* With the end of HITECH funding in September 2021, HCPF transitioned HITECH efforts for technical connectivity, including CEHRT connectivity to Colorado's two HIEs, Contexture and QHN, to MMIS funding identified in section 1903(a)(3) of the Act and defined in regulation at 42 CFR 433.111, including HIE Certification in October 2021. With MMIS funding, HCPF continues to leverage the enhanced administrative match with an emphasis on Behavioral Health (BH) providers, starting with a focus on Safety Net Providers connectivity to the HIEs. Overall HIE participation can be found here - https://contexture.org/colorado-hie-participant-data/ and https://qualityhealthnetwork.org/products-services/hie-to-hie-data-exchange/ During the EHR Incentive Program years 2012-2121, a total of 25 hospitals participated and attested to the Adoption, Implementation or Upgrade (AIU) to a CEHRT. The Colorado Health IT Roadmap 2021 Executive Summary reflects the State's plan to expand affordability, access, and equity in health care through health information technology. Both Contexture and QHN can support closed loop referrals. However, the explicit closed loop functionality from physical health providers to BH providers needs to be expanded. Closed loop referral systems are technology that connects individuals through efficient and easy-to-navigate software to behavioral health providers, while protecting privacy and tracking outcomes and closed-loop referrals. A key benefit of closed loop referral systems is its ability to allow healthcare providers to see the most complete view of an individual's social care history and current status – to make certain individuals are being served in the most efficient manner possible – while guarding their privacy and ensuring unrivaled protection of their personal information.

	The Colorado Health IT Roadmap 2021 identifies that providers (rural safety net providers, behavioral health, oral health, LTSS) are not able to share info broadly through the state's HIEs due to affordability, lack of technical workforce, and outdated systems. The roadmap also concludes that providers are not consistently incentivized/required to participate with the state's HIEs. The Health IT Roadmap progress tracker reports progress on the following: • Provider Directory 'front door' project underway • Recommendations from Local Public Health Agencies to establish data strategy for system improvements • $26 million grant opportunities for technology upgrades for BH and HCBS providers- • Development of standardized processes and data standards to collect health data elements • Complete proof-of-concept for consent management to progress toward centralized consent management
	Future State: HCPF will continue to support the HIEs relationships with the Comprehensive Safety Net Providers as we expand the programmatic needs for behavioral health data. HCPF will continue to support the HIEs relationships with the Comprehensive Safety Net Providers as we expand the programmatic needs for behavioral health data. In the future, Colorado will engage stakeholders to determine the feasibility and current progress/status of Safety Net Provider's connectivity to HIEs and to include sending and receiving closed loop referrals from physicians, hospital emergency departments, inpatient facilities to ambulatory behavioral health providers. Under the Demonstration, HCPF and BHA will work with the policy makers to develop incentives for more BH provider integration to the HIE.
	Summary of Actions Needed: 1. Engage stakeholders to determine the feasibility and current progress/status of BH provider connectivity to HIEs and to include sending and receiving closed loop referrals from physicians, hospital emergency departments, inpatient facilities to ambulatory behavioral health providers. (Timeline: 18-24 months). 2. Work with the policy makers to develop incentives for more BH provider integration to the HIE.

[3] See SMDL #16-003, "Availability of HITECH Administrative Matching Funds to Help Professionals and Hospitals Eligible for Medicaid EHR Incentive Payments Connect to Other Medicaid Providers." Available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd16003.pdf.
[4] Guidance for Administrative Claiming through the "No Wrong Door System" is available at https://www.medicaid.gov/medicaid/finance/admin-claiming/no- wrong-door/index.html.

Prompts	Summary
1.2 Closed loop referrals and e-referrals from institution/hospital/clinic to physician/mental health provider	*Current State:* The CO Health IT Roadmap indicates that a majority of hospitals are connected to the HIE.
	Future State: Colorado will explore opportunities to improve the coordination of care through optimizing interoperability, connectivity, and data exchange between hospitals, the HIE, MH providers, and other ambulatory behavioral health providers. This could include improved coordination of care/use of closed loop referrals through increasing the number of psychiatric hospitals linking discharged members to ambulatory behavioral health care providers. Additional education and outreach will be initiated to physicians and mental health providers, as well as MCEs, on the benefits of closed loop referral systems to integrate and coordinate care. HCPF and BHA will work with MCEs to increase the number of behavioral health providers linked to and using the HIE, as well as the number of MCEs with closed loop referral systems for their provider networks. Part of the state's continuous quality improvement plan will include improving data quality, streamline connections, and strengthening Colorado's HIE ecosystem.
	Summary of Actions Needed: 1. Initiate additional education and outreach to physicians and mental health providers, as well as MCEs, on the benefits of closed loop referral systems to integrate and coordinate care. 2. Work with MCEs to increase the number of behavioral health providers linked to and using the HIE, as well as the number of MCEs with closed loop referral systems for their provider networks.
1.3 Closed loop referrals and e-referrals from physician/mental health provider to community based supports	*Current State*: Received future planning APD funding under MMIS authority in September 2023.
	Future State: APD funding was approved in September 2023 to leverage the existing statewide infrastructure that has been created by Contexture, QHN and CCMCN and other community partners, OeHI and HCPF are 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. This will include closed loop referrals and e-referrals from physician/mental health provider to community-based support.

	This initiative will include improved coordination of care/use of closed loop referrals through increasing the number of psychiatric hospitals and ambulatory behavioral health care linking discharged members to community-based providers of social determinants of health.
	Summary of Actions Needed: 1. Initiate additional education and outreach to physicians and mental health providers, as well as MCEs, on the benefits of closed loop referral systems to integrate and coordinate care. 2. Work with MCEs to increase the number of behavioral health providers linked to and using the HIE, as well as the number of MCEs with closed loop referral systems for their provider networks.
Electronic Care Plans and Medical Records (Section 2)	
2.1 The state and its providers can create and use an electronic care plan	*Current State:* Among the state's acute care hospitals and non-acute care hospitals, nearly all have an electronic health record. Electronic care plans are developed in all hospitals with electronic health records. According to healthit.gov/data/quickstats and the Office of the National Coordinator for Health Information Technology Adoption of Electronic Health Records by Hospital Service Type 2019-2021, Health IT Quick Stat #60, April 2022., as of 2021, 84% of psychiatric hospitals had any EHR, with 67% having a 2015 Edition certification. This is compared to general hospitals of which 96% had any EHR with 86% having a 2015 Edition certification.
	Future State: Over time care plan standards will evolve based on input from key stakeholders and the development of national data standard-setting organizations. This may initially be based on the CDA standard for care plans but could improve based on emerging standards such as FHIR STU 3. The State will utilize the Interoperability Standards Advisory for guidance on these standards.
	Summary of Actions Needed: *1.* HCPF will ensure that electronic care plan requirements convey national care plan requirements.

Prompts	Summary
2.2 E-plans of care are interoperable and accessible by all relevant members of the care team, including mental health providers	*Current State*: Received future planning APD funding under MMIS authority in September 2023. At present, electronic care plans are not shared using a consistent technology platform or standards-based approach.
	Future State: APD funding was approved in September 2023 to leverage the existing statewide infrastructure that has been created by Contexture, QHN and CCMCN and other community partners, OeHI and HCPF are 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.
	Summary of Actions Needed: *1.* The state will implement the APD 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.
2.3 Medical records transition from youth-oriented systems of care to the adult behavioral health system through electronic communications	*Current State: Medical records for youth-oriented systems of care are currently transitioned to the adult behavioral health system via standard, paper-based methods.* Medical records for youth-oriented systems of care are currently transitioned to the adult behavioral health system via standard, paper-based methods. Colorado has current consensus and requirements for providers when transitioning youth to adult systems of care outlined in the Continuity of Care Documents Content standards (p. 55) as outlined in the Colorado Health Information Governance Guidebook September 2021 Version 1.3.
	Future State: As HIE and electronic transmission of records expands across the State, the transition of records between pediatric and adult mental health services will be facilitated by easier access to information. As children's providers engage in bi-directional data exchange with other HIEs, the interoperability of youth-oriented systems of care and the exchange of electronic records is anticipated to become easier over times. Under the Demonstration, Colorado will increase the number of youth-oriented systems of care using/entering information into the HIE.
	Summary of Actions Needed: *1.* Colorado will convene key stakeholders and the HIE board to consider recommendations to advance electronic communications around transitions between youth-oriented care and adult care.

2.4 Electronic care plans transition from youth-oriented systems of care to the adult behavioral health system through electronic communications	*Current State:* The Children's Hospital of Colorado enumerates current consensus and requirements for providers when transitioning youth to adult systems of care. The standards are comprehensive and provide specific recommendations regarding the development and transfer of care plans but do not explicitly mention electronic care plans. Childrenscolorado.org/doctors-and-departments/departments/pediatric-transition-to-adult
	Future State: Care plans are consistently transitioned electronically or are accessible between youth-oriented systems of care to the adult behavioral health system in a timely and secure manner.
	Summary of Actions Needed: 1. Specify a list of action items, milestones and responsible individuals/departments needed to make progress in moving from the current to future state. 2. Convene key stakeholders and the HIE to consider recommendations to advance electronic communications around care plan to ensure these transitions between youth-oriented care and adult care.

Prompts	Summary
2.5 Transitions of care and other community supports are accessed and supported through electronic communications	*Current State:* HCPF receives admission, discharge, and transfer (ADT) notifications from the HIEs in addition to the direct interfaces between the HIEs and the RAEs. The ADT notifications for admissions, transfers, or discharges support linkages and communication across providers that are subscribed to the notification service.
	Future State: APD funding under MMIS authority was approved in September 2023 to leverage the existing statewide infrastructure that has been created by Contexture, QHN and CCMCN and other community partners, OeHI and HCPF are 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. This will include closed loop referrals and e-referrals from physician/mental health provider to community-based support. In the future, Colorado will be aligning several IT systems to facilitate the access and exchange of data regarding transitions of care. There will be more opportunities to expand program requirements that will ensure providers have access to high quality information to support individual transitions of care. Centralized data management and e-referrals will reduce data entry and improve data consistency and quality of care coordination information across programs. Based on the data and subscription for notification, providers may receive an alert for a client with whom they have a relationship.
	Summary of Actions Needed: *1.* Specify a list of action items, milestones and responsible individuals/departments needed to make progress in moving from the current to future state: Colorado will implement the APD to expand access to alerts across providers including behavioral health providers. Workplans will support interoperability among systems to the extent feasible.
Consent - E-Consent (42 CFR Part 2/HIPAA) (Section 3)	
3.1 Individual consent is electronically captured and accessible to patients and all members of the care team, as applicable, to ensure seamless sharing of sensitive health care information to all relevant parties consistent with applicable law and regulations (e.g., HIPAA, 42 CFR part 2 and state laws)	*Current State:* Received future Planning Advanced Planning Document (PAPD) funding under MMIS authority in December 2022. All clients must complete and sign a standard consent form. This includes any care coordination programs for physical health and behavioral health. Colorado's HIE governance approach allows an opt-out process at the provider level. Individual consent is not required for data exchange, provided the provisions of the Health Insurance Portability and Accountability Act (HIPAA) are met by providers and the HIE. The HIEs do not currently have a consent management system in place; individuals who submit an opt-out request are simply opted out of all HIE services. The exchange of mental health data is a recent occurrence. Counseling and 42 CFR part 2 information may not be

	exchanged without notice.
	Future State: Received APD funding under MMIS authority in September 2023 to leverage the existing statewide infrastructure that has been created by Contexture, QHN and CCMCN and other community partners, OeHI and HCPF are 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. This will include closed loop referrals and e-referrals from physician/mental health provider to community-based support. Colorado is in the process of updating Notice of Privacy Practices to allow for exchange of mental health encounter information and to clarify provider policies and allow beneficiaries to opt out of HIE services. Colorado has future plans to focus on approaches to consent management.
	Summary of Actions Needed: *1.* Colorado will examine its consent practices and engage stakeholders in the development of appropriate governance policies to guide implementation of notice and opt out for HIE services. Colorado will work with participating HIEs and policy makers to consider and recommend approaches to consent management.
Interoperability in Assessment Data (Section 4)	
4.1 Intake, assessment and screening tools are part of a structured data capture process so that this information is interoperable with the rest of the HIT ecosystem	*Current State:* The state received future planning under our PAPD funding under MMIS authority in December 2022. Colorado has several assessment tools and requirements for their use in behavioral health services. Under the Demonstration, Colorado will release practice standards on the use of comprehensive assessments as required under this implementation plan. Guidance will include a discussion of EHR's role. However, the assessment tools may not be interoperable with the broader Health IT ecosystem at present with barriers including cost for EHRs, redundancy in reporting requirements, poor vendor service and lack of accountability with EHRs, and disjointed systems (HIE to EHR, and HIE to HIE).
	Future State: Received future planning APD funding under MMIS authority in September 2023 to leverage the existing statewide infrastructure that has been created by Contexture, QHN and CCMCN and other community partners, OeHI and HCPF are 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. This will include closed loop referrals and e-referrals from physician/mental health provider to community-based support.

	As more behavioral health providers participate in HIE, the ability to exchange mental health screening information for admission to IMDs and to community behavioral health providers upon discharge in an interoperable manner will expand. Given the sensitivity of mental health information exchange, HCPF, BHAs, and HIEs participating in the State's HIE will proceed cautiously to implement mental health information sharing as appropriate and in line with stakeholder feedback. This will proceed in concert with plans to evaluate issues of patient notice and consent. Governance processes to manage the exchange of mental health assessment and screening data will likely be incorporated into the discussion and recommendations from the group in the context of implementing consent requirements.
	Summary of Actions Needed: *1.* Implement workplans to increase behavioral health provider participation in HIE and facilitate data exchange. Conduct regular policy governance discussions and develop recommendations with key stakeholders including subcommittees on consent, privacy, and large health systems that are active users of HIE.

Prompts	Summary
Electronic Office Visits – Telehealth (Section 5)	
5.1 Telehealth technologies support collaborative care by facilitating broader availability of integrated mental health care and primary care	*Current State:* Colorado provides telemedicine reimbursement for behavioral health services in both the FFS and managed care programs. Colorado's Medicaid telemedicine and telehealth policies itemize broad categories of services covered via telemedicine and are permitted in both FFS and managed care. MCOs reimburse for services delivered via telemedicine in more cases than in FFS. HCPF's telemedicine policy outlines services that FFS covers via telemedicine, including behavioral health services. The majority of Medicaid FFS billing for tele-medicine is for tele-psych visits for individuals or families. Many telehealth claims are submitted by providers participating in care coordination programs. Colorado has multiple telehealth resources offered in, and for the support of, integrated care. One of our RAEs offers a Virtual Integrated Care Initiative (VICI) that provides access to behavioral health providers and psychiatric consultation to primary care providers. Additionally, Colorado created a funding pathway to support a statewide pediatric psychiatric consultation service for PCPs as well. A key part of the Integrated Care Benefit (ICB) that will become effective with ACC 3.0 will accommodate contracted relationships by PCPs for psychiatric consultation and community-based BH services.
	Future State: Colorado providers have expressed strong interest in continuing to expand telehealth modalities of care, both to minimize travel burden for patients and improve efficient use of provider time. HCPF is evaluating the extent to which future, approved uses of telemedicine will continue to include the home as an originating site of care. Telemedicine can also be used as an effective modality of care to provide MAT. HCPF is monitoring the use of MAT through telehealth under the SUD portion of the Demonstration.
	Summary of Actions Needed: 1. HCPF will continue to support effective utilization of telehealth and telemedicine. *2.* HCPF will continue to support MCE contract modifications to clarify telemedicine policy. HCPF will clarify policies and continue to share best practices implementing telemedicine for SMI/SED.
Alerting/Analytics (Section 6)	
6.1 The state can identify patients that are at risk for discontinuing engagement in their treatment, or have stopped engagement in their treatment, and can notify their care teams in order to ensure treatment continues or resumes (Note:	*Current State: Describe the current state of the health IT functionalities outlined below:* *Example: The state is planning to conduct beneficiary phone surveys and track beneficiaries who are not reporting hours due to technical difficulties. If the state identifies a substantial number of beneficiaries are not reporting hours due to technical difficulties, the state will consider providing additional notices to beneficiaries and/or training CE partner entities who help beneficiaries enter hours into the state's online portal.* HCPF and its MCEs provide providers with access to advanced analytic reports for population health management through the MCE contracts incentive programs. This capability supports care coordination and panel management and is based on both claims and clinical data for the provider's panel of patients. Over the course of the Demonstration, MCEs will expand the number of providers who have access to these analytic tools and provide training at practice sites.

research shows that 50% of patients stop engaging after 6 months of treatment[5])	*Future State: Describe the future state of the health IT functionalities outlined below:* Practices can enroll with the HIE to support providers and provide health information such as: • A patient's recent visits, procedures, and medications, in addition to a detailed list of organizations, providers and care managers who have an existing relationship with the patient. Practices can enroll in encounter notification services (ENS) which enables providers and care coordinators to receive real-time alerts when a patient has a hospital encounter. Organizations can customize ENS to receive the alerts that are most relevant to them, such as hospital admission, hospital discharge, or emergency room visits. Practices can also enroll in member notifications for such things as: • Missed appointment notifications • Missed/skipped prescription pick ups • Missed care coordination/case management contacts Practices can also identify specific notices that could help them track and outreach/engage members that are slowing/not engaging in treatment, as well as how HIE/telehealth could be leveraged to keep members engaged. Stakeholders will work together to create additional reports and enhanced analytics capability to support care coordination and panel management, using claims and clinical data. Enhancements will allow staff and providers to address health issues in specific patient populations, thus delivering appropriate and targeted medical services when they are most needed. For example, alerts can notify clinicians and discharge planners when a patient enrolled in a care management program such as an MCE case manager has an ambulance ride, emergency room visit, or hospital admission.
	Summary of Actions Needed: 1. The State will continue to develop analytics to notify MCE care managers of significant health events of members.

[5] Interdepartmental Serious Mental Illness Coordinating Committee. (2017). *The Way Forward: Federal Action for a System That Works for All People Living With SMI and SED and Their Families and Caregivers*. Retrieved from https://www.samhsa.gov/sites/default/files/programs_campaigns/ismicc_2017_report_to_congress.pdf

Prompts	Summary
6.2 Health IT is being used to advance the care coordination workflow for patients experiencing their first episode of psychosis	*Current State:* At present, only acute hospitals currently electronically exchange information on emergency psychiatric episodes. Practices are just beginning to implement new notice processes to share information on mental health diagnoses which is required to electronically exchange information via HIE. The encounter notification service (ENS) can alert practices when their patients are admitted, discharged, or transferred to/from regional hospitals.
	Future State: Describe the future state of the health IT functionalities outlined below: Colorado will implement technology to deploy specific care alerts for conditions or situations within the HIE, such as first episode of psychosis. HCPF and BHA will work with appropriate stakeholder groups and the State HIE networks to explore the potential of implementing such an alert via the state's HIEs.
	Summary of Actions Needed: 1. Implement workplans and timelines for the HIE to increase behavioral health provider participation in HIE. 2. Provide technical assistance to effectively use HIE services to coordinate care and workflow for patients experiencing their first episode of psychosis. 3. Facilitate policy governance discussions with key stakeholders, including policy makers and the HIE, to consider specific care alerts for initial episodes of psychosis and training for providers to use alerts.
Identity Management (Section 7)	
7.1 As appropriate and needed, the care team has the ability to tag or link a child's electronic medical records with their respective parent/caretaker medical records	*Current State:* Secured funding to leverage identity management that occurs with the HIEs for data sharing and to interoperate with state systems. The ability to link parent-child relations is a feature of some certified EHRs, however, this is not a current feature of HIE or broadly available in the State's health system.
	Future State: Per the Office of Civil Rights (OCR) Request for Information (RFI) in December 2018 on modifying HIPAA rules to improve coordinated care (https://www.federalregister.gov/documents/2018/12/14/2018-27162/request-for-information-on-modifying-hipaa-rules-to-improve-coordinated-care), it is clear that there is great federal interest in the potential to link parent and child medical records. Colorado will pay close attention to proposed rulemaking by OCR on this topic and follow federal guidance as issued.
	Summary of Actions Needed: 1. As comments from OCR and rulemaking are released, HCPF will raise comments and recommendations with state stakeholders in relevant venues such as HIE policy forums. 2. Pending further guidance at the federal level, HCPF will implement local requirements.

7.2 Electronic medical records capture all episodes of care, and are linked to the correct patient	*Current State:* Secured funding to leverage identity management that occurs with the HIEs for data sharing and to interoperate with state systems. Most Colorado health care providers and hospitals are connected to one of the state's two health information exchanges (HIEs). Contexture or QHN. The Colorado Regional Health Information Organization (CORHIO) is an independent, nonprofit organization that manages one of the largest HIE networks in the country reported that over 6,800 office-based providers and 73 hospitals were connected via that HIE alone.
	Future State: Colorado will continue to leverage the APD to fund activities in Colorado including program support and technical assistance to expand access to certified EHR technology, HIE connectivity, and technical assistance to promote interoperability and effective care coordination using health information. Concurrent investment in value-based purchasing initiatives and technical assistance to support care coordination programs will encourage provider participation. Over time, this suite of investments will enable participating behavioral health providers to have confidence in the identify and relative completeness of patient records.
	Summary of Actions Needed: *1.* Implement work plan and timeline for program support and technical assistance to maintain and evolve data and information exchange standards for value-based purchasing and other initiatives.

Section 3: Relevant documents

Please provide any additional documentation or information that the state deems relevant to successful execution of the implementation plan. This information is not meant as a substitute for the information provided in response to the prompts outlined in Section 2. Instead, material submitted as attachments should support those responses.