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COLORADO
Financial Services
Department of Human Services
Division of Contracts and Procurement

Contract Amendment #1

Signature and Cover Page

State Agency
Colorado Department of Human Services
Behavioral Health Administration

Contractor
Signal Behavioral Health Network – Region 3

Current Contract Maximum Amount

Initial Term

State Fiscal Year 2025	$0.00

Extension Terms

State Fiscal Year 2026	$38,871,937.32

Total for All State Fiscal Years
$38,871,937.32

Original Contract Number
25 IBEH 195374

Amendment Contract Number
26 IBEH 196990

Contract Performance Beginning Date
January 1, 2025

Current Contract Expiration Date
June 30, 2026

Signature page begins on next page.

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COLORADO
Financial Services
Department of Human Services
Division of Contracts and Procurement

The Parties Hereto Have Executed This Amendment

Each person signing this Amendment represents and warrants that he or she is duly authorized to execute this Amendment and to bind the Party authorizing his or her signature.

Contractor

Signal Behavioral Health Network – Region 3

Signed by:
[signature]
6320F30B611E441...

By: Daniel Darting, Chief Executive Officer

Date: 6/12/2025

State of Colorado

Jared S. Polis, Governor
Colorado Department of Human Services
Michelle Barnes, Executive Director

Signed by:
Dannette R. Smith
3953D4DCDD844F5...

By: Dannette R. Smith, Commissioner
Behavioral Health Administration

Date: 6/13/2025

In accordance with §24-30-202 C.R.S., this Contract is not valid until signed and dated below by the State Controller or an authorized delegate.

State Controller

Robert Jaros, CPA, MBA, JD

DocuSigned by:
Venessa Huynh
BDAE70278CB84E3...

By: Venessa Huynh, J.D.

Amendment Effective Date: 6/16/2025

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1. Parties

This Amendment (the "Amendment") to the Original Contract shown on the Signature and Cover Page for this Amendment (the "Contract") is entered into by and between the Contractor, and the State.

2. Terminology

Except as specifically modified by this Amendment, all terms used in this Amendment that are defined in the Contract shall be construed and interpreted in accordance with the Contract.

3. Amendment Effective Date and Term

A. Amendment Effective Date

This Amendment shall not be valid or enforceable until the Amendment Effective Date shown on the Signature and Cover Page for this Amendment. The State shall not be bound by any provision of this Amendment before that Amendment Effective Date, and shall have no obligation to pay Contractor for any Work performed or expense incurred under this Amendment either before or after the Amendment term shown in §3.B of this Amendment.

B. Amendment Term

The Parties' respective performances under this Amendment and the changes to the Contract contained herein shall commence on the Amendment Effective Date shown on the Signature and Cover Page for this Amendment or July 1st 2025, whichever is later and shall terminate on the termination of the Contract.

4. Purpose

The purpose of this amendment is to renew the contract, adding $38,871,937.32 in funding for SFY26. This amendment updates Exhibit A, the statement of work, and Exhibit B, the budget and adds Exhibit D, Data and Technology Requirements, Exhibit E, Community Mental Health Services Block Grant Contract Supplement, Exhibit F, Substance Use Prevention, Treatment, and Recovery Services Block Grant Contract Supplement, and Exhibit G, the Supplemental Provisions for Federal Awards.

Behavioral Health Administrative Services Organizations ("BHASOs") are regionally informed administrative organizations with which BHA contracts to establish, administer, and maintain adequate networks of Behavioral Health Safety Net Services and Care Coordination. (C.R.S. § 27-50-401(1)). No later than July 1, 2025, the BHASO shall

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establish, administer, and maintain an adequate network of providers of Behavioral Health Safety Net Services and Care Coordination.

5. Modifications

The Contract and all prior amendments thereto, if any, are modified as follows:

A. The Contract Initial Contract Expiration Date on the Contract's Signature and Cover Page is hereby deleted and replaced with the Current Contract Expiration Date shown on the Signature and Cover Page for this Amendment.
B. The Contract Maximum Amount table on the Contract's Signature and Cover Page is hereby deleted and replaced with the Current Contract Maximum Amount table shown on the Signature and Cover Page for this Amendment.
C. REPLACE Exhibit A with Exhibit A-1, attached and incorporated by reference.
D. REPLACE Exhibit B with Exhibit B-1, attached and incorporated by reference.
E. ADD Exhibit D, attached and incorporated by reference.
F. ADD Exhibit E, attached and incorporated by reference.
G. ADD Exhibit F, attached and incorporated by reference.
H. ADD Exhibit G, attached and incorporated by reference.

6. Limits Of Effect and Order of Precedence

This Amendment is incorporated by reference into the Contract, and the Contract and all prior amendments or other modifications to the Contract, if any, remain in full force and effect except as specifically modified in this Amendment. Except for the Special Provisions contained in the Contract, in the event of any conflict, inconsistency, variance, or contradiction between the provisions of this Amendment and any of the provisions of the Contract or any prior modification to the Contract, the provisions of this Amendment shall in all respects supersede, govern, and control. The provisions of this Amendment shall only supersede, govern, and control over the Special Provisions contained in the Contract to the extent that this Amendment specifically modifies those Special Provisions.

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Part One: General Provisions

Chapter 1
Background and Overview

1.1.1. BHASOs, Defined. Behavioral Health Administrative Services Organizations ("BHASOs") are regionally formed administrative organizations with which BHA contracts to establish, administer, and maintain adequate networks of Behavioral Health Safety Net Services and Care Coordination. (C.R.S. § 27-50-401(1)).

1.1.2. BHASO Statutory Requirements. Pursuant to C.R.S. § 27-50-403(2) and C.R.S. § 27-50-301(2), a BHASO shall:

a. Proactively engage priority populations and high acuity Individuals with adequate case management and Care Coordination throughout the care continuum;
b. Incorporate, implement, and demonstrate trauma-informed care practices;
c. Accept and provide behavioral health safety net services to Individuals presenting for services in the behavioral health administrative services organization's region, even when the presenting Individual resides in a different region;
d. Promote competency in de-escalation techniques;
e. Through network adequacy and other methods, ensure timely access to treatment, including high-intensity behavioral health treatment and community-based treatment for all Individuals including children, youth, and adults;
f. Require collaboration with all state and local law enforcement and county agencies in the service area, including judicial districts, county departments of human or social services and local collaborative management programs within the service area;
g. Triage Individuals who need alternative services outside the scope of the behavioral health safety net system;
h. Promote patient-centered care, cultural awareness, and coordination of care to appropriate behavioral health safety net providers;
i. Collaborate with schools and school districts in the service area to identify gaps in services and to promote student access to behavioral health services at school and in contracting with providers to build the network of behavioral health safety net

services, inclusion of relevant programs or services eligible for federal grants or reimbursement, including relevant programs or services identified in the federal Title IV-E prevention services clearinghouse;

j. Update information as requested by the BHA about available treatment options and outcomes in each Region of the state;
k. Utilize evidence-based or evidence-informed programming to promote quality services;
l. Prioritize relevant programs or services eligible for federal grants or reimbursement, including relevant programs or services identified in the federal Title IV-E prevention services clearinghouse when contracting with providers to build the network of Behavioral Health Safety Net Services; and
m. Meet all other criteria established by the BHA in this Contract and its referenced materials.

1.1.3 Purpose. No later than July 1, 2025, the BHASO shall establish, administer, and maintain an adequate network of providers of Behavioral Health Safety Net Services and Care Coordination. Network adequacy is discussed further in Part One, Chapter 6, Article 2.

1.1.4 Objectives. The BHASO shall provide utilization and access, quality, fiscal, and data management for the Safety Net Services within its Region(s). The BHASO shall form networks to provide and coordinate behavioral health services for adults, children, youth, and families. The BHASO shall also provide some care coordination services directly. The objectives of this system are to:

1. Operate as part of a continuum of integrated services, with deep connections to community resources;
2. Operate an integrated behavioral health Safety Net System that serves the entire Region(s) and incorporates the Substance Abuse Mental Health Services Administration (SAMHSA) Practice Guidelines and Guiding Principles, as well as SAMHSA Guidelines for Trauma-Informed Care as described in section 1.3.10 below;
3. Apply a recovery and resiliency-oriented philosophy and clinical design aimed at producing tangible, improved outcomes;
4. Develop coordination across the continuum of care and improve access by linking the Safety Net System, Care Coordination, and community resources;

5. Maintain a network capable of ensuring access and continuity of all contracted services within the Region(s);
6. Provide seamless transitions as Individuals move across systems and between different levels of care, based on the Individual's needs, preferences, and rights; and
7. Partner with the Regional Accountable Entities, law enforcement, counties, Single Entry Points, System of Care collaboratives, child and adolescent serving programs, county human service agencies, Case Management Agencies and other providers to meet the goals and objectives of the Safety Net System and improve the health and well-being of Coloradans.

1.1.5 BHASOs and Colorado's Behavioral Health Safety Net.

a. As set forth in C.R.S. 27-50-301(1); the Behavioral Health Safety Net System is a comprehensive and standardized behavioral health system throughout the state that must include Behavioral Health Safety Net Services for children, youth, and adults along a continuum of care. The Behavioral Health Safety Net System represents the portion of the state's behavioral health system that is publicly funded. The Safety Net System is critical in ensuring all Individuals experiencing behavioral health challenges can access Behavioral Health Safety Net Services along the continuum of care, regardless of the severity of their need or their ability to pay.
b. BHA has three roles as it relates to the Behavioral Health Safety Net System
    i. Setting up conditions,
    ii. Directly regulating, and
    iii. Delivering funds within the Safety Net System.
c. The BHASOs are the main mechanism by which BHA delivers funds within the Safety Net System. The BHASOs utilize BHA funds to contract with a network of Safety Net Providers and the Individual Provider Network to provide the Safety Net Services.
d. BHA and the BHASOs will each have a role in monitoring the availability and quality of services that are provided to Individuals in Colorado, assessing the adequacy of funds available for care delivery, and in making recommendations on what resources are needed for an effective Behavioral Health Safety Net System.

Chapter 2

Definitions and Acronyms

Article 1 - Definitions

Article 2 - Acronyms

Article 1 - Definitions

"27-65; or 27-65 Program" - The Care and Treatment of Persons with Mental Health Disorders outlined in Colorado law (C.R.S. §27-65-101, *et seq*.). This law includes the procedures and oversight of involuntary care and treatment of individuals with mental health disorders. These services include but are not limited to 72-hour mental health holds; Involuntary Transportation Holds; Short-Term Mental Health Certifications; Long-term Involuntary Care and Treatment; Court-Ordered Evaluations; and Involuntary Medications. The State of Colorado requires all facilities that perform 27-65 procedures submit data to the Behavioral Health Administration to ensure Individual safety and maintain standards of care.

"988 / 988 Colorado Mental Health Line" - the 988 Colorado Mental Health Line, part of the National Suicide Prevention Lifeline. The 988 Colorado Mental Health Line is a national network of local crisis centers that provide free and confidential emotional support to people in suicidal crisis or emotional distress 24 hours a day, 7 days a week in the United States.

"Acute Treatment Units (ATU)" - an agency or a distinct part of an agency, with an endorsement for short-term psychiatric care, which may include treatment for substance use disorders, that provides a twenty-four-hour, therapeutically planned and professionally staffed environment for individuals who do not require inpatient hospitalization but need more intense and individualized services than are available on an outpatient basis, such as crisis management and stabilization services.

"Administrative Fee" - a fee charged by the agency responsible for administering programs to cover expenses related to record-keeping and/or additional administrative costs.

"Adult Protective Services (APS)" - APS investigates allegations of physical and sexual abuse, caretaker neglect, exploitation and harmful acts (collectively referred to as "mistreatment")

and self-neglect of at-risk adults. APS offers protective services to improve the health, safety, and welfare of at-risk adult(s) experiencing mistreatment or self-neglect. APS uses community-based services and resources, health care services, family and friends when appropriate, and other support systems while protecting the at-risk adult's right to confidentiality, self-determination, and least-restrictive intervention.

"Appropriateness" - means the provision of treatment services consistent with the Individual's identified clinical needs and level of functioning.

"Ascent" - a holistic, community-based program that implements the Coordinated Specialty Care model for First Episode Psychosis (FEP) to provide intensive outpatient treatment and support.

"Assertive Community Treatment (ACT)" - a program that offers treatment, rehabilitation, and support services using a person-centered, recovery-based approach to individuals who have been diagnosed with severe and persistent mental illness.

"Assistance Listing" - refers to the publicly available listing of Federal assistance programs managed and administered by the General Services Administration, formerly known as the Catalog of Federal Domestic Assistance (CFDA).

"At-Risk of Homelessness" - an individual or family who are experiencing housing instability such as being on the verge of losing their housing for behavioral health (i.e. serious and/or persistent mental illness, hospitalization, entering/exiting institutionalization, crisis intervention, etc.), fallen behind or unable to make their rental or mortgage payments for any given reason including lack of immediate additional resources. Individuals or families who are being displaced, or experiencing additional barriers such as lacking familial support, fleeing partner intimate violence or human trafficking, are justice involved, or have a mental/physical disability. Additionally, individuals or families who are living in hotels/motels, couchsurfing, individuals doubling-up in one household or multiple families living in one household, youth with a history of running away, unaccompanied children or youth, children and youth involved in the child welfare, foster care, or juvenile justice system, and individuals living in their vehicles including recreational vehicles (i.e. recreational vehicles, motorhomes, campervans, coaches, caravans, travel trailers, campers, or popup campers).

"Behavioral Health" - as defined in C.R.S. §27-50-101(1): An individual's mental and emotional well-being and actions that affect an individual's overall wellness. Behavioral health issues and disorders include substance use disorders, mental health disorders, serious psychological distress, serious mental disturbance, and suicide and range from unhealthy stress or subclinical conditions to diagnosable and treatable diseases. "Behavioral health" also describes service systems that encompass promotion of emotional health and prevention and treatment services for mental health disorders and substance use disorders.

"Behavioral Health Accounting and Auditing Guidelines" - guidelines for recording and reporting revenues and expenses of Colorado's behavioral health services delivery system and provide a comprehensive cost reporting system for Colorado's behavioral health providers.

"Behavioral Health Administration (BHA)" - Behavioral Health Administration was established in July 2022 by HB21-1097 to be the single entity responsible for driving coordination and collaboration across state agencies to address behavioral health needs across all payers. It is the lead entity to ensure there is a transparent and accountable system in place that results in better behavioral health outcomes for all people in Colorado.

"Behavioral Health Administration Advisory Council (BHAAC)" - The BHA Advisory Council (BHAAC) is a group of people with lived experience who applied for and were selected to ensure there is public accountability and transparency across the activities of the BHA. The inclusion of the BHAAC is codified in legislation and the BHAAC began activities in 2022.

"Behavioral Health Administration, Administrative Rule" - BHA is responsible for regulating the provision of behavioral health services in Colorado by developing and monitoring reasonable and proper rules and regulations. The State Board of Human Services passed the updated BHA Provider Rules (adopted November 3, 2023), setting the foundation for new rules and regulations to take effect for behavioral health providers beginning on January 1, 2024.

"Behavioral Health Administrative Service Organization (BHASO)" - An organization that contractually administers substance use disorder treatment services (historically managed by Managed Service Organizations), crisis services (historically managed by Administrative Service Organizations), community mental health services (historically offered by Community Mental

Health Centers), and other behavioral health related programs historically operated by the BHA. The BHASOs will manage a network to provide a continuum of Behavioral Health Safety Net Services and Care Coordination in their regions. BHASOs will also be expected to interface and align with the Regional Accountable Entities that manage services and provide Care Coordination for Medicaid members.

"Behavioral Health Entity (BHE)" - a facility or provider organization engaged in providing community-based health services, which may include behavioral health disorder services, alcohol use disorder services, or substance use disorder services, including crisis stabilization, acute or ongoing treatment, or mental health services.

"Behavioral Health Provider" - As defined in C.R.S. 27-50-101(6); a recovery community organization as defined in C.R.S. 27-80-126, a recovery support services organization as defined in C.R.S. 27-60-108, or a licensed organization or professional providing diagnostic, therapeutic, or psychological services for behavioral health conditions. Behavioral Health Providers include a residential childcare facility, as defined in C.R.S. 26-6-903(29), and a federally qualified health center.

"Behavioral Health Safety Net Provider" - Comprehensive Community Behavioral Health Providers and Essential Behavioral Health Safety Net Providers.

"Behavioral Health Safety Net Services" - As defined in C.R.S. 27-50-301(3)(a):

(a) Emergency or crisis behavioral health services;
(b) Mental health and substance use outpatient services;
(c) Behavioral health high-intensity outpatient services;
(d) Behavioral health residential services;
(e) Withdrawal management services;
(f) Behavioral health inpatient services;
(g) Mental health and substance use recovery supports;
(h) Integrated care services;
(i) Care management;
(j) Outreach, education, and engagement services;
(k) Outpatient competency restoration;
(l) Care coordination;

(m) Hospital alternatives;
(n) Screening, assessment, and diagnosis, including risk assessment, crisis planning, and monitoring to key health indicators; and
(o) Additional services that the BHA determines are necessary in a region or throughout the state.

"Behavioral Health Services" - mental health, substance use, and/or co-occurring services.

"Behavioral Health Task Force (BHTF)" - On April 8, 2019, Governor Jared Polis directed the Colorado Department of Human Services to spearhead Colorado's Behavioral Health Task Force. The mission of the task force was to evaluate and set the roadmap to improve the current behavioral health system in the state. In September 2020, the task force released its blueprint, as well as several other reports, that outline our vision for reform.

"Behavioral Health Secure Transportation" - transportation provided to individuals receiving behavioral health treatment.

"BHA Program" - a scope of work identified in Exhibit A, Part Three that may be developed and implemented to contribute to provision of each required Safety Net Service.

"Bridge Housing" - typically does not set timeframes for residences, is accompanied by tenancy supportive services (TSS), and provides a temporary place for those who have been matched with a supportive housing opportunity, Permanent Supportive Housing or Rapid Re-Housing, to safely reside while waiting to finalize the logistics necessary to utilize a voucher or other form of rental assistance.

"**Bridges Court Liaison Program"** - The Bridges Program dedicates local behavioral health professionals as court liaisons (court liaisons) in each judicial district to facilitate communication and collaboration among judicial, health care, and behavioral health systems.

"Business Associate Agreement (BAA)" - an agreement between a HIPAA covered entity and a business or individual that performs certain functions or activities on behalf of, or provides a service to, the covered entity when the function, activity, or service involves the creation,

receipt, maintenance, or transmission of Protected Health Information (PHI) by the business or individual.

"Business Day" - refers to any day in which normal business operations are conducted. This is generally considered to be Monday through Friday from 9 a.m. to 5 p.m. local time and excludes weekends and public holidays.

"Calendar Day" - refers to every day on the calendar, i.e. all 365 days of the year (366 if it is a leap year).

"Capacity / Capacity Budget" - The capacity-based business model utilizes a cost and revenue center approach whereby total costs and revenues are isolated, accumulated, adjusted by revenue recognized from other payers in accordance with GAAP. BHA covers the unfunded remainder of the costs to maintain service capacity. The unfunded costs covered by BHA are limited to the not-to-exceed amount of the Contract(s).

"Care Coordination" - services that support Individuals and families and initiate care and navigating crisis supports, mental health and substance use disorder assistance, and services that address the social determinants of health, and preventive care services.

"Care Management" - outreach-focused high-intensity support to individuals who may have complex needs, be involved in multiple systems, and/or require additional support to achieve whole person health.

"Care Navigation Line" - services include independent screening of the treatment needs of the Individual using nationally recognized screening criteria to determine the correct level of care; the identification of licensed or accredited treatment options across the continuum of care; and the availability of various treatment options for the Individual.

"Case Management Agency" - Case Management Agency means a public, private, or non-governmental non-profit agency that meets all applicable state and federal requirements and is certified by HCPF to provide Case Management services for Home and Community-Based Services waivers.

"CDPHE Opioid Antagonist Bulk Purchase Fund" - allows eligible entities to purchase opiate antagonists, such as naloxone or Narcan, at low or no cost.

"Certified Community Behavioral Health Clinic" - a type of health clinic in the United States that treats mental health and substance abuse disorders regardless of the patient's health insurance status and ability to pay for care. Certified Community Behavioral Health Clinics are funded through Medicaid or SAMHSA grants.

"Certified Recovery Coach" - a peer-based recovery service that is non-clinical and designed to engage others beyond recovery initiation through stabilization and into recovery maintenance.

"Child and Adolescent Needs and Strengths (CANS)" - a multi-purpose tool developed for children's services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. The CANS was developed to facilitate the linkage between the assessment process and the design of individualized service plans including the application of evidence-based practices.

"Children and Youth Mental Health Treatment Act (CYMHTA)" - is a program that provides access to mental health treatment to children and youth who are at risk of out-of-home placement, to prevent unwarranted child welfare involvement. Parents experience challenging circumstances when their children have significant mental health needs, which can result in a behavioral health crisis, putting children at risk of out-of-home placement.

"Children and Youth with Special Health Care Needs (CYSHCN)" - HRSA Maternal and Child Health Bureau defines Children and Youth with Special Health Care Needs as "those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally."
Link to definition:
https://mchb.hrsa.gov/sites/default/files/mchb/programs-impact/nsch-cshcn-data-brief.pdf

"Civil Forfeiture Report" - Civil forfeiture is a procedure used by the federal and state governments to seize assets without filing a criminal charge. The process is intended to disrupt

complex criminal operations, like drug trafficking rings. The Civil Forfeiture Reform Act requires State and local law enforcement agencies authorized to effect civil forfeitures to biannually report:

(a) Specified information, if known, about forfeiture cases resulting in proceeds for the agency
(b) The amount of proceeds received from such cases
(c) A categorization of the expenditure of proceeds
(d) The retained balance of the forfeiture proceeds

"Closeout Period" - begins on the earlier of ninety (90) days prior to the end of the last renewal year of the Contract or notice by BHA of non-renewal. The Closeout Period shall end on the day that BHA has accepted the final deliverable for the Closeout Period, as determined in the BHA-approved and updated Closeout Plan and has determined that the closeout is complete.

"Closeout Plan" - describes all requirements, steps, timelines, milestones and deliverables necessary to fully transition the services described in the Contract from the Contractor to BHA or to another contractor selected by BHA to be the BHASO contractor after the termination of the Contract. The Closeout Plan shall also designate an Individual to act as a closeout coordinator, who will ensure that all requirements, steps, timelines, milestones and deliverables contained in the Closeout Plan are completed and work with BHA and any other contractor to minimize the impact of the transition on Individuals and BHA.

"COACT" - a project supported by the Substance Abuse and Mental Health Services Administration (SAMHSA) to expand and sustain the System of Care approach for children and adolescents ages 0-21 with serious behavioral health challenges and their families.

"Colorado Bureau of Investigation (CBI)" - the CBI is intended to support and assist local, county and state criminal justice agencies through the provision of professional investigative and forensic laboratory services, as well as the management and administration of criminal justice records and data sharing.

"Colorado Comprehensive Assessment Record (CCAR)" - 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.

"Colorado Crisis Services (CCS)" - the statewide behavioral health crisis response system offering mental health resources, substance use, or emotional crisis help, and information and referrals.

"Colorado Daylight Partnership Learning Collaboratives" - Daylight Partnership assists local community health centers throughout Colorado in Advancing access to and enhancing behavioral healthcare services for deaf, hard of hearing and deafblind Coloradans.

"Colorado Open Records Act (CORA)" - means the Colorado Open Records Act, C.R.S. §§24-72-200.1 et. seq.

"Colorado Revised Statutes (C.R.S.)" - the codified general and permanent statutes of the Colorado General Assembly.

"Columbia Suicide Severity Rating Scale (C-SSRS)" - a suicidal ideation and behavior rating scale created by researchers at Columbia University, University of Pennsylvania, University of Pittsburgh and New York University to evaluate suicide risk.

"Commitment to Quality" - The performance monitoring strategy described in Section 1.8.2.4 of this Exhibit A, Part One.

"Community Centered Board (CCB)" - Community Centered Boards support access to long term services and supports through Medicaid waivers for Home and Community Based Services. Specific waivers require CCBs to coordinate services to Medicaid members in the least restrictive setting possible with the goal of keeping them in their homes and communities as an alternative to institutional care.

"Community Mental Health Center (CMHC)" - As formerly defined in C.R.S. 25-1.5-103; formerly, either a physical plant or a group of services under unified administration and including at least the following: Inpatient services; outpatient services; day hospitalization;

emergency services; and consultation and educational services, which services are provided principally for persons with behavioral or mental health disorders residing in a particular community in or near which the facility is situated. This designation is no longer active but is included in this agreement where necessary for historical context.

"Community Reinforcement Approaches" - a psychosocial intervention for individuals with alcohol and other substance use disorders that has been adapted for several populations, including adolescents and family members of individuals resistant or reluctant to enter treatment.

"Community Supervision Tool (CST)" - used to assess the risk of reoffending and identify criminogenic needs to assist in supervision planning.

"Competency Individuals" - individuals who the court has ordered a competency evaluation, deemed incompetent to proceed, and/or ordered to complete restoration services.

"Competency Restoration" - The process used when an individual charged with a crime is found by a court to be incompetent to stand trial, typically due to an active mental illness or an intellectual disability. A criminal defendant must be restored to competency before the legal process can continue.

"Comprehensive Community Behavioral Health Provider/Comprehensive Provider" - As defined in C.R.S. 27-50-101(11); a licensed behavioral health entity or behavioral health provider approved by the Behavioral Health Administration to provide care coordination and the following Behavioral Health Safety Net Services, either directly or through formal agreements with behavioral health providers in the community or region:

(a) Emergency and crisis behavioral health services;
(b) Mental health and substance use outpatient services;
(c) Behavioral health high-intensity outpatient services;
(d) Care management;
(e) Outreach, education, and engagement services;
(f) Mental health and substance use recovery supports;
(g) Outpatient competency restoration; and

(h) Screening, assessment, and diagnosis, including risk assessment, crisis planning, and monitoring to key health indicators.

"Conflict of Interest" - when an individual's personal interests – family, friendships, financial, or social factors – could compromise his or her judgment, decisions, or actions in the workplace.

"Contingency Management" - the systematic application of behavioral principles, discovered by laboratory researchers working in the field of the experimental analysis of behavior, to treat the problem behavior of individuals.

"Continuity of Operations Plan" - is an effort within agencies to ensure that primary functions continue to be performed during a wide range of emergencies, including localized acts of nature, accidents and technological or attack-related emergencies.

"Contract" - The agreement, including all attached exhibits, all documents incorporated by reference, all referenced statutes, rules, and cited authorities, and any future modifications thereto, that is entered into as a result of a solicitation.

"Contract Amendment" - a document making changes to, correcting, or adding to an existing contract after it has been signed.

"Contractor" – The individual or entity selected as a result of this solicitation to complete the work contained in the Contract.

"Co-Responder" - a mental or behavioral health professional who aids law enforcement in responding to calls involving people with mental health or addiction issues, or any member of such a crisis response team.

"Correctional Treatment Board" - a seven-member statewide board that was created pursuant to HB12-1310. The board was created to manage the disbursement of the treatment funds as well as address policy issues as they pertain to the effective treatment of offenders with substance abuse and co-occurring disorders.

"Corrective Action Plan" - a process of identifying and addressing the root cause of a problem or non-performance by an agency, with the goal of preventing the issue from recurring and improving performance under the Contract.

"Couchsurfing" - an individual or families who frequently move, two or more times, from one tenuous living arrangement to another within the past sixty (60) days, does not have a lease or occupancy agreement up to sixty (60) days prior to relocating, and can be experiencing sleeping arrangements that include sleeping on a couch, bed, floor, or chair.

"County Department" - in reference to a State of Colorado County or district department of human or social services.

"Crisis Intervention Training (CIT)" - a specialized police curriculum that aims to reduce the risk of serious injury or death during an emergency interaction between persons dealing with a mental health crisis and first responders. CIT is a specialized program that provides the foundation necessary to promote community and statewide solutions to assist individuals with mental illness and/or addictions. It aims to reduce the risk of serious injury or death during emergency interactions between persons with mental illness and police officers. Crisis intervention involves both verbal and physical techniques to calm, contain, control, and de-escalate individuals in crisis. It is a short-term technique used to address immediate mental health emergencies and stabilize the individual, creating a safe plan for next steps and future treatment.

"Crisis Professional" - A person who has completed the Crisis Professional curriculum made available by the BHA. This professional can lead the crisis engagement and/or intervention.

"Crisis Resolution Teams (CRT)" - multidisciplinary, specialist mental health services that offer brief intensive in-home treatment to children, youth and families experiencing a mental health crisis, with the aim of averting hospital admission wherever possible.

"Crisis Respite Services" - provide temporary or short-term care by a licensee, candidate or other personnel based on the level of care being provided and is designed for an individual that has experienced a self-defined crisis. Crisis respite is intended to be a flexible intervention or

set of services based on the presenting concerns of the individual in a self-defined crisis and must have the capacity to:

(a) Provide supports necessary to alleviate the conditions leading to the initial crisis, and
(b) Enhance an individuals' sense of safety and agency in managing their crisis.

"Crisis Stabilization Units (CSU)" - an agency, endorsed for behavioral health crisis and emergency services per Chapter 6 and that provides short-term, bed-based crisis stabilization services in a twenty-four-hour environment for individuals who cannot be served in a less restrictive environment.

"Crisis System" - an organized set of structures, processes and services in place to meet all types of urgent and emerging mental health crisis needs in a defined population or community, effectively and efficiently.

"Critical Incident" - includes but is not limited to the following:

(a) Breach of confidentiality: any unauthorized disclosure of protected health information as described in HIPAA.
(b) Death: including the death of an individual inside of or outside of the agency's physical location while an individual is receiving services or where an individual has attempted to receive services from the agency within the past thirty (30) calendar days.
(c) Elopement: absconding from a mental health hold, certification, emergency/involuntary commitment, or a secure facility where an individual is being held as a result of a court order. This includes any unauthorized absence of a child, when a child cannot be accounted for or when there is reasonable suspicion to believe the child has absconded.
(d) Any instance when an individual cannot be located following a search of the agency, the agency grounds, and the area surrounding the agency, and:
    (i) There are circumstances that place the individual's health, safety, or welfare at risk; or
    (ii) The individual has been missing for eight (8) hours.
(e) Medication diversion: any medication diversion. If the diverted drugs are injectable, the agency shall also report the full name and date of birth of any individual who diverted the injectable drugs, if known
(f) Medication error: medication error that resulted or could have resulted in harm to the individual.

(g) Medical emergency: any suicide attempt/self-injury, other form of serious injury, health emergency, overdose, or serious illness which occurred on agency premises or in the presence of agency personnel.

(h) Any instance involving physical, sexual, or verbal abuse of an individual by another individual, personnel, or a visitor to the agency.

(i) Any instance that results in any of the following serious injuries to an individual:

  (i) Brain or spinal cord injuries

  (ii) Life-threatening complications of anesthesia or life-threatening transfusion errors or reactions

  (iii) Second- or third-degree burns involving twenty (20%) percent of more of the body surface area of an adult or more fifteen (15%) percent or more of the body surface area of a child

(j) Any instance involving caretaker neglect of an individual.

(k) Any instance involving misappropriation of an individual's property, meaning patterns of loss or single incidences of deliberately misplacing, exploiting, or wrongfully using, either temporarily or permanently, an individual's belongings or money without the individual's consent.

(l) Any occurrence involving the malfunction or intentional or accidental misuse of care equipment that occurs during treatment or diagnosis of an individual and that significantly or adversely affects or, if not averted, would have significantly adversely affected an individual.

"Current Contract Expiration Date" - the date the contract expires, listed on the first page of the contract document.

"Dartmouth ACT Model (DACTS)"- The Dartmouth Assertive Community Treatment Scale (DACTS fidelity scale) helps organizations implement ACT, the evidence-based practice. ACT improves outcomes for people with severe mental illness who are most at risk of homelessness, psychiatric crisis and hospitalization, and involvement in the criminal justice system.

"Deliverable" - the specific outputs or outcomes the BHASO agrees to provide to BHA in exchange for payment. They are defined in the statement of work of the contract, and they may have deadlines, quality standards, or other criteria attached to them.

"Documented Serious and Persistent Mental Illness" - are those that are prolonged and recurrent, impair activities of daily living, and require long-term treatment. Common diagnoses include schizophrenia, bipolar disorder, and major depression.

"Drug and Alcohol Coordinated Data System (DACODS)" - the primary SUD Individual level treatment data collection instrument used by BHA.

"Effective Date" – The date on which the Contract resulting from this solicitation is approved and signed by the Colorado State Controller or designee, as shown on the Signature and Cover Page for the Contract.

"Electronic Health Record" - The systematized collection of patient and population electronically stored health information in a digital format.

"Enhanced Standardized Assessment (ESA)" - a comprehensive, clinical assessment process completed by a mental health professional to assist in making recommendations about the level of care in determining and treatment/service planning for children, youth, and their families.

"Essential Behavioral Health Safety Net Provider/Essential Provider" - As defined in C.R.S. 27-50-101(13), means a licensed behavioral health entity or behavioral health provider approved by the Behavioral Health Administration to provide care coordination and at least one of the Behavioral Health Safety Net Services:

(a) Emergency and crisis behavioral health services;
(b) Mental health and substance use outpatient services;
(c) Behavioral health high-intensity outpatient services;
(d) Behavioral health residential services;
(e) Withdrawal management services;
(f) Behavioral health inpatient services;
(g) Integrated care services;
(h) Hospital alternatives; or
(i) Additional services that the Behavioral Health Administration determines are necessary in a region or throughout the state.

"Evidence-Based Practice" - A behavioral health intervention practice whose effectiveness has been supported by research.

"Exhibit" - a document attached to and incorporated into a contract or agreement.

"Federal Poverty Line" - A measure of income issued every year by the Department of Health and Human Services. Federal poverty levels are used to determine your eligibility for certain programs and benefits, including savings on Marketplace health insurance, and Medicaid and Children's Health Insurance Program coverage.

"Finance and Data Protocols" - protocol is intended to provide BHA contractors with direction for the assignment of special studies codes to Individual-level encounter data that is submitted to BHA. It also includes eligibility requirements for each special studies code. Special studies codes are specific codes that correspond to a BHA program or funding stream that are important for BHA research, contract performance and/or reporting activities.

"Forensic Support Team (FST)" - Through Senate Bill 19-223, the Behavioral Health Administration was allocated twenty (20) staff positions to serve as the Forensic Support Team (FST). This team consists of sixteen (16) Forensic Navigators who are located within all fifty-five (55) jails across the state of Colorado and in all twenty-two (22) judicial districts. This team also includes two Program Coordinators who are licensed clinicians. The Program Coordinators provide supervision to the Forensic Navigators and ensure consistent coordination of competency restoration services. The Forensic Support Team serves as the primary point of contact for BHA competency services for stakeholders.

(a) The Forensic Navigators are automatically assigned to individuals.
(b) Waiting in jail for a competency evaluation
(c) Waiting in jail for admission to inpatient restoration
(d) Individuals participating in inpatient restoration.
(e) And to individuals returning from inpatient restoration waiting in jail to be reviewed by the court.

"Gender-Responsive Services" - Agencies providing gender-specific women's treatment which include the following components:

(a) Emotional and physical safety of individuals take precedence over all other considerations in the delivery of services;
(b) Services designed to increase women's access to care, and engagement and retention of individuals (such as comprehensive case management, transportation, childcare);
(c) Women-only therapeutic environments;
(d) Women-specific service needs and topic areas;
(e) Program services shall directly address trauma issues currently manifesting in the individual's life either through direct service provision or by referral; and,
(f) Multiple modalities that meet the specific needs of women (group and individual therapy, case management and opportunities for women to be in treatment with their children where possible).

"General Accounting Encumbrance (GAE)" - A General Accounting Encumbrance (GAE) is a pooled encumbrance in the state accounting system that is shared across multiple contracts or purchase orders. Using a pooled GAE permits the State to encumber a block of money for an entire program where the costs of operating the program are shared across more than one contract or purchase order and the amount of money that each vendor may earn is indeterminate at the time of execution of the contract or purchase order.

"General Safety Net Service Terms" - the scope of work for each Part Three chapter that defines the basic criteria for provision of a given Safety Net Service.

"Grievance" - an expression of dissatisfaction made to the BHA about the care or services received or not received by an individual, that could not be resolved to the satisfaction of the person expressing the grievance at the time of submission to BHA personnel. Grievances may be submitted by an individual or entity, including but not limited to, recipients of service, family members of recipients of service, authorized representatives of recipients of service, licensed facilities, state departments and members of the general public.

"Grievance Resolution Process" - the process through which BHA and the BHASO shall resolve reported grievances.

"Harm Reduction" - a set of practical approaches aimed to reduce the adverse consequences associated with substance use and mental health symptoms. Harm reduction approaches

recognize that individuals can be at different stages of recovery and that effective interventions should be individually tailored to each individual's stage. Such strategies have been effective in reducing morbidity and mortality for such individuals by incorporating strategies from safer use to managed use, to abstinence.

"Health First Colorado" - Colorado's Medicaid program. Health First Colorado is free or low-cost public health insurance for Coloradans who qualify for Medicaid.

"Health Information Exchange (HIE)" - A network/platform that allows health care professionals and patients to appropriately access and securely share an Individual's medical information electronically.

"Homeless" - a person who lacks a fixed, regular, and adequate night-time residence, or is in a doubled-up situation, or is in imminent danger of losing their primary night-time residence, and who lacks resources or support networks to remain in housing, or has a primary night-time residency that is:

(a) a supervised publicly or privately operated shelter designed to provide temporary living accommodations which includes safe havens, hotels, congregate shelters, and transitional housing for people with mental health conditions, but excludes prisons or other detention facilities,
(b) an institution that provides a temporary residence for individuals intended to be institutionalized, or
(c) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings, or
(d) at imminent risk of being lost from an immediate eviction without identification of a subsequent residence, which if lost would result in emergency shelter or safe haven placement.

"Housing Security" - when an individual or family maintains housing for 12-months or more, is no longer utilizing rental assistance or voucher programs, only utilizes 30 percent of their area median income (AMI) for housing costs, is not behind on mortgage or rental payments, are currently not experiencing the formal process of eviction, experiences stable employment, and is not on the verge of returning to homelessness.

"Housing Stability" - an individual or family maintains housing for 12-months or more and does not return to homelessness.

"In Custody" - individual residing in the county jail, typically pre-plea.

"Individual" - Individual means a person seeking or receiving behavioral health services.

"Individual Provider Network (IPN)" – means behavioral healthcare providers who are not Comprehensive or Essential Safety Net Providers.

"Individual Placement and Support" - an evidence based supported employment program that helps people with mental illness and/or substance use disorders find and keep competitive jobs, while at the same time providing employers with access to motivated employees.

"Intensive Case Management" - a collaborative process for assessing, planning, implementing, coordinating, monitoring and evaluating options and services to meet an individual's behavioral health needs.

"Intellectual or Developmental Disability (IDD)" - includes many severe, chronic conditions that are due to mental and/or physical impairments.

"Involuntary Commitment (IC)" - The legal process by which a person is confined in a psychiatric hospital or residential substance use disorder program because of a mental disorder, against their wishes, for up to a two hundred seventy (270) day period. During the initial stages of treatment, assessments are completed, and an ASAM level of care is determined. Course of treatment consists of Intensive Residential, followed by Transitional Residential after which they are shifted to intensive outpatient providers, then standard outpatient providers where appropriate, who follow through to the end of the commitment. The intent is to provide assistance for individuals who struggle with voluntary treatment, to successfully navigate the behavioral health and substance abuse systems with knowledgeable and qualified staff, to better ensure successful completion of the civil commitment and long-term sobriety.

"Jail Stakeholders" - may include jail administrators, jail mental health providers, jail medical providers, and others who are employed within the jail and work with the competency population.

"Jail Based Behavioral Services (JBBS)" - which provides appropriate behavioral health services to inmates while supporting continuity of care within the community after release from incarceration.

"Law Enforcement Assisted Diversion (LEAD)" - a pre-booking diversion program that aims to improve public health and to end the cycle of recidivism. Instead of being charged and booked following an arrest, the arresting officer identifies the arrestee as a potential participant for the diversion program and subsequently connects them with a case manager.

"Learning Hub" - See OwnPath Learning Hub.

"Level of Supervision Inventory (LSI)" - a quantitative survey of attributes of offenders and their situations relevant to level-of-supervision decisions; the LSI can be a reliable and valid assessor of offender risk and need.

"Licensee" - a psychologist, social worker, clinical social worker, marriage and family therapist, licensed professional, counselor, or addictions counselor licensed as defined in C.R.S. § 12-245-202(8).

"Licensing and Designation Database Electronic Record System (LADDERS)" - a Substance use disorder and mental health service directory which is published and maintained by BHA.

"Major Depressive Disorder" - is a mood disorder that causes a persistent feeling of sadness and loss of interest. Also called major depressive disorder or clinical depression, it affects how Individuals feel, think and behave and can lead to a variety of emotional and physical problems.

"Managed Service Organization (MSO)" - An organization responsible for managing a network of coordinated and comprehensive alcohol and drug treatment services for specific priority populations, as well as for Individuals outside the specific priority populations, and

implementing principles of managed care in the provision of such services in order to expand capacity and improve treatment outcomes while containing costs.

"Maximum Amount Available" - the maximum amount of dollars available for spending in a state fiscal year.

"Medicaid" - a joint federal and state public health insurance program that helps cover medical costs for some people with limited income and resources.

"Medicaid Management Information System (MMIS), also known as interChange (iC)" - an integrated group of procedures and computer processing operations (subsystems) developed at the general design level to meet principal objectives.

"Medical Director" - a physician who oversees the medical care and other designated care and services in a BHASO.

"Mental Health Block Grant (MHBG)"- The Community Mental Health Services Block Grant (MHBG) program makes funds available to all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and 6 Pacific jurisdictions to provide community mental health services.

"Mental Health Diagnosis" - refers collectively to all diagnosable mental disorders — health conditions involving significant changes in thinking, emotion and/or behavior and distress and/or problems functioning in social, work or family activities.

"Mental Health First Aid" - the help given to someone developing a mental health problem, experiencing a worsening of a mental health problem or in a mental health crisis. Mental Health First Aid can be given until the person has received appropriate professional treatment or the crisis is resolved. Mental Health First Aid is an evidence-based training program that teaches individuals how to identify, understand and respond to signs of mental health and substance use challenges.

"Mobile Crisis Response" - provide a timely paired mobile response to a behavioral health crisis in the community. Mobile crisis service agencies must provide referrals and facilitate

transitions to other crisis agencies, behavioral health entities, and community-based services as clinically indicated.

"Momentum Program"- this program supports the transition of children and adults from inpatient mental health institutes, hospitals, home, and other care settings to community living.

"Motivational Interviewing" - a goal-directed, consumer-centered counseling style for eliciting behavioral change by helping consumers to explore and resolve ambivalence. The operational assumption in MI is that ambivalent attitudes or lack of resolve is the primary obstacle to behavioral change, so that the examination and resolution of ambivalence becomes its key goal.

"Not to Exceed" - a cap on the time and materials stipulated in the Contract.

"Ohio Risk Assessment System (ORAS)" - a set of dynamic risk/needs assessment tools that helps identify factors that drive a person toward negative or criminal behaviors and also can help determine each person's risk of reoffending.

"Operational Start Date" - July 1, 2025, the date upon which all sections of this Contract will become operative.

"Opioid Treatment Program" - provides medication-assisted treatment (MAT) for people diagnosed with an opioid use disorder (OUD). OTPs must be certified by SAMHSA and accredited by an independent, SAMHSA-approved accrediting body.

"Outpatient Competency Restoration (OCR)" - a statewide community-based program that allows adults and juveniles in the criminal justice or juvenile justice system, who are found incompetent to proceed by the court, to receive psychoeducation services, case management, and referrals to community-based services and supports with the goal of restoring competency.

"Outpatient Treatment" - behavioral health (substance use, mental health, or co-occurring) services provided to an individual in accordance with their service plan on a regular basis in a non-overnight setting, which may include, but not be limited to, individual, group, or family counseling, peer support professional services, case management, or medication management.

"Outreach, Education, and Engagement Services" - services by an agency that have identified priority target populations and services needs in the area the agency serves that require higher levels of active engagement by the agency to produce positive behavioral health outcomes.

"Ownership" - an Individual who is a legal proprietor of an organization, including a provider or Individual who owns assets of an organization, or has a financial stake in the BHASO.

"OwnPath" - A searchable online directory that allows people in Colorado to find behavioral health providers licensed by BHA and to search for specific services or use a guided search to identify providers or resources that best meet their needs. (http://ownpath.co)

"OwnPath Learning Hub" - An online learning platform free to residents of Colorado where individuals can access behavioral health training classes in an asynchronous manner for upskilling and reskilling purposes. Some of these courses can count for college credit.

"Oxford House" - a community-based approach to addiction recovery, which provides an independent, supportive, and sober living environment.

"PEAKPro" - A state IT system for verification of an individual's eligibility and submission of an individual's application for benefits.

"Peer Navigator" - A person employed by the BHASO directly or through a contract to a Recovery Community Organization who has lived experience in recovery from a substance use disorder and is either an IC&RC Certified Peer and Family Specialist or will be eligible within one (1) year of hire.

"Peer Support Professional" - a peer support specialist, recovery coach, peer and family recovery support specialist, peer mentor, family advocate, or family systems navigator who meets the qualifications in C.R.S. § 27-60-108(3)(a)(iii).

"Peer Support Specialist/Peers" - A person who shares the experience of living with a psychiatric disorder and/or substance use disorder. Peers offer their unique lived experience

with behavioral health conditions to provide support focused on advocacy, education, mentoring, and motivation.

"Performance Hub" - A performance monitoring system, required by C.R.S. § 27-50-201, to track capacity and performance of all behavioral health providers, including those that contract with BHASOs, and inform needed changes to the public and private behavioral health system in the state.

"Permanent Supportive Housing (PSH) or Supportive Housing" - decent, safe, affordable, community-based housing that provides tenants, including homeless and persons with disabilities, to live independently with all the rights and responsibilities of tenancy and provides intensive tenancy supportive services (TSS) or supportive services. Utilizing best practices (Housing First and Progressive engagement models as well as Harm Reduction and Trauma-Informed approaches), service providers outreach to individuals and their families to provide TSS and support. This approach is designed to allow tenants to live as independently as possible as well as voluntarily request and receive TSS throughout their lifetime.

"Priority Population" - As defined in C.R.S. 27-50-101(17); Priority Populations are defined as persons who are:

(a) Uninsured, underinsured, Medicaid-eligible, publicly insured, or whose income is below thresholds established by the BHA; AND
(b) Presenting with acute or chronic behavioral health needs, including but not limited to individuals who have been determined incompetent to stand trial, adults with serious mental illness, and children and youth with serious emotional disturbance.

"Psychiatric Residential Treatment Facility (PRTF)" - an inpatient psychiatric facility for children and youth who need intensive psychiatric care but do not require the level of care of an inpatient hospital setting.

"Qualified Individual" as defined in C.R.S. in 26-6-102 (30.3) and C.R.S. 19-1-103 (87.7) means a trained professional or licensed clinician, as defined in the federal "Family First Prevention Services Act". "Qualified Individual" must be approved to serve as a qualified individual according to the state plan. "Qualified Individual" must not be an interested party or participant in the juvenile court proceeding and must be free of any personal or business relationship that

would cause a conflict of interest in evaluating the child, juvenile, or youth and making recommendations concerning the child's, juvenile's, or youth's placement and therapeutic needs according to the federal Title IV-E state plan or any waiver in accordance with 42 U.S.C. Sec. 675a.

"Qualified Residential Treatment Programs (QRTP)" - a facility that provides residential trauma-informed treatment that is designed to address the needs, including clinical needs, of children with serious emotional or behavioral disorders or disturbances.

"Quality" - the provision of treatment services, which, within the constraints of technology, resources, and Individual circumstances, will meet accepted standards and practices that improve Individual health and safety status in the context of recovery.

"Quality Assurance (QA) Work Plan" - the standard that guides business function and service delivery and applies to all programming and services at the agency.

"Regional Accountable Entity (RAE)" - A single regional entity responsible for implementing Medicaid within its region.

"Regional Advisory Committee" - A regional subcommittee designed to promote local community input pertaining to behavioral health service needs. The Regional Advisory Committee is created to directly inform the BHASO in the Region in order to improve services, accountability, and transparency in the Region. See C.R.S. § 27-50-703.

"Region(s)" - Geographic service regions in Colorado in which the BHASO will subcontract to provide all required services. A map and listing of counties in each Region can be found in Exhibit A, Part One, Chapter 4.

"Relative Value Units (RVUs)" - are a measure of value used in the United States Medicare reimbursement formula for physician services.

"Request for Application (RFA)" - a type of solicitation notice in which an organization announces that grant funding is available and solicits applications from potential grantees.

"Request for Information (RFI)" - a type of solicitation notice in which the state seeks information from the public on a certain topic.

"Request for Proposal (RFP)" - a document that announces a project, describes it, and solicits bids from qualified contractors to complete it.

"**Residential Child Care Facility (RCCF)**" - a facility licensed by the state department to provide twenty-four-hour group care and treatment for five or more children operated under private, public, or nonprofit sponsorship.

"Respondent" - An individual or organization who submits a response to questions in this RFI.

"Risk, Needs, Responsivity" - Risk: The probability that an offender will commit additional offenses. Criminogenic Need: Factors that research has shown have a direct link to offending and can be changed. Responsivity: Matching an offender's personality and learning style with appropriate program settings and approaches.

"Room and Board" - Room and board costs include provider expenses associated with food, clothing, personal incidentals, building & maintenance expenses, personnel who provide occupancy and maintenance services (e.g., maintenance staff, housekeeping/environmental staff, laundry staff), liability insurance with respect to the individual receiving room & board, and allowable administrative costs associated with these items.

"Safety Net Providers" - see *Behavioral Health Safety Net Providers.*

"Safety Net Services" - *see Behavioral Health Safety Net Services.*

"Safety Net System" - As set forth in C.R.S. 27-50-301(1); A comprehensive and standardized behavioral health system throughout the state that must include Behavioral Health Safety Net Services for children, youth, and adults along a continuum of care.

"School-Based Mental Health Specialist (SBMHS)" - provides high-quality behavioral health outreach, linkage, consultation, and collaboration between behavioral health providers and

school districts. The SBMHS can work broadly on systemic issues within schools and school districts as well as work closely with internal and external stakeholders.

"Screening, Assessment, and Diagnosis" - Screening means a brief process used to identify current behavioral health or health needs and is typically documented through the use of a standardized instrument. Screening is used to determine the need for further assessment, referral, or immediate intervention services. Assessment means a formal and continuous process of collecting and evaluating information about an individual for service planning, treatment, and referral. Assessments establish justification for services. Diagnosis is the assessment of influences on the desired patient behavior. It includes consideration of individual, social, environmental, and medical regimen factors that may either impede or facilitate behavior.

"Secure Transportation" - vehicles are equipped with safety locks, a safety mechanism that ensures vehicle driver(s) and passenger safety, and transparent safety partitions, if utilized.

"Serious Emotional Disturbance (SED)" - for an Individual under the age of 18, a diagnosable mental, behavioral, or emotional disorder in the past year, which resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities.

"Serious Mental Illness (SMI)" - for an Individual age 18 or over, a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities.

"Social Determinants of Health (SDOH)" - The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

"Social Health Information Exchange" - a network to securely share physical, behavioral, and social health information between providers involved in whole-person care, designed by the Colorado Office of eHealth Innovations.

"Special Connections" - A BHA-licensed gender-responsive treatment program designed to meet the unique needs of the federally-defined priority population of pregnant and postpartum women with substance use disorders. The program provides gender-responsive and trauma-informed substance use disorder treatment, individual and group counseling, reproductive health education, prenatal and postnatal care coordination, intensive parenting support and access to childcare, and wherever possible, allows mothers to keep their infants and young children with them during treatment.

"Standard Framework for Levels of Integrated Care" - SAMHSA's Center for Integrated Health Solutions released a new report that demonstrates how the integration of healthcare is essential to improve the individual's experience of care, improve the health of the general population, and reduce per capita healthcare costs.

"Start-Up Period" - shall begin on the Effective Date (anticipated to be January 1, 2025) and shall end on July 1, 2025, and shall allow the BHASO to complete all requirements of the Start-Up Period, including the completion and implementation of the Start-Up Plan.

"Start-Up Plan" - a plan submitted by the BHASO that describes how the BHASO shall implement all requirements of this contract.

"State" – The State of Colorado, acting by and through any State agency.

"State Behavioral Health Services Billing Manual" - HCPF and BHA have established this State Behavioral Health Services Billing Manual to provide common definitions of the program service categories and standard guidance in documenting and reporting covered Colorado Medicaid State Plan (required services), Behavioral Health Program 1915(b)(3) Waiver services (alternative or (b)(3) services), and BHA services in coding formats that are in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The clinical coding systems currently used in the United States, and which are used by HCPF and BHA, are International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM), Current Procedural Terminology (CPT®), Professional Edition, and Healthcare Common Procedure Coding System (HCPCS).

"State Fiscal Year (SFY)" – The twelve (12) month period beginning on July 1 of each calendar year and ending on June 30 of the following calendar year. If a single calendar year follows the term, then it means the State Fiscal Year ending in that calendar year.

"Statement of Work" - a document that outlines the scope, timeline, desired services outcomes, and performance standards of a funded project.

"Strategic Individualized Remediation Treatment (STIRT)" - a program which is a continuum of care designed to provide adult Individuals with a history of criminal justice involvement with safe, structured, drug and alcohol-free environments in which to define and examine their relapse and recidivism risk factors, learn alternatives to risky behaviors, implement behavior changes, and increase treatment involvement and compliance with criminal justice supervision requirements.

"Subrecipient" - a non-Federal entity that receives a subaward from a pass-through entity to carry out part of a Federal program; but does not include an individual that is a beneficiary of such program. A subrecipient may also be a recipient of other Federal awards directly from a Federal awarding agency.

"Subrecipient Performance Report and Assessment" - BHA is required annually to assess subrecipients of federal funds, which ensures subrecipients use federal funds for authorized purposes, comply with federal statutes, regulations, and the terms of the award(s), and achieve performance goals.

"Substance Abuse Mental Health Services Administration (SAMHSA)" - Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the federal U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation.

"Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRS)" - enables states and jurisdictions to provide substance abuse prevention activities, treatment and recovery support services and places an emphasis on the provision of treatment services for populations of focus, specifically, persons who inject drugs, pregnant women, and women

with dependent children. Also, the program aims to make primary prevention services available to individuals not in need of substance abuse treatment.

"System of Care (SOC)" - As defined by C.R.S. 27-69-102(8); an integrated network of community-based services and support that is organized to meet the challenges of youth with complex needs, including, but not limited to, the need for substantial services to address areas of developmental, physical, and mental health, substance abuse, child welfare, and education and involvement in or being at risk of involvement with the juvenile justice system. In a system of care, families and youth work in partnership with public and private organizations to build on the strengths of individuals and to address each person's cultural and linguistic needs so services and support are effective.

"Tenancy Supportive Services (TSS) or Supportive Services" - provides long-term housing-related activities and services that support individuals and families' ability to prepare for and transition to housing and supports them in being a successful tenant in their housing arrangement and thus able to sustain tenancy. This may include brokering connections to or coordinating with other community-based, clinical, or other specialty services or resources. Recognizing that individuals and families may initially or periodically refuse assistance or services, staff providing TSSs will assertively and creatively engage tenants, including outreaching individuals and families multiple times and in multiple settings to maximize participation in services and maintain housing. TSSs are voluntary and driven by individuals and families' choice.

A list of examples of Tenancy Supportive Services (TSS) (Supportive Services) include, but are not limited to:

(a) Care coordination to access healthcare related services including primary care, substance use treatment, behavioral health care, vision and dental care, recovery services, housing, and emergency, crisis, and inpatient services,
(b) Outreach and engagement especially in non-traditional locations,
(c) Housing search and lease-up assistance,
(d) Coordination with voucher administrative staff at lease-up and recertification,
(e) Subsidy applications and recertification,
(f) Advocacy with landlords, property owners, and/or property management staff to secure and maintain units,

(g) Master-lease and lease negotiations,
(h) Acquiring furnishings and household goods,
(i) Moving assistance,
(j) Tenancy rights and responsibilities education and support,
(k) Eviction prevention supports,
(l) Individualized housing stability plan development,
(m) Linkage to crisis and substance use services,
(n) Accessibility to peer support services and professionals,
(o) Best Practices, including Progressive Engagement, Critical Time Intervention, Harm Reduction, Housing First, Motivational Interviewing, Trauma Informed Care,
(p) Transportation assistance related to housing stability,
(q) Entitlements assistance,
(r) Independent living skills coaching,
(s) Opportunities for peer and social networks and engagement,
(t) De-escalation support,
(u) Linkages to education, job skills training, and employment support,
(v) Behavioral health and other necessary support groups,
(w) End-of-life planning, and
(x) Re-engagement and relocation support

"Title IV-E" - Title IV-E of the Social Security Act supports the Federal Foster Care Program, which helps provide out-of-home care for children until the children are safely returned home, placed permanently, or placed in other planned arrangements; and the Adoption Assistance Program, which provides funds to states to facilitate the timely placement of children.

"Trails" - Colorado's certified state-county Statewide Automated Child Welfare Information System.

"Transitional Housing" - housing designed to provide individuals and families, especially priority and underserved populations, with the interim stability and support to successfully move to and maintain permanent housing with lifelong voluntary community-based supports. Utilizing the progressive engagement model, this includes tenancy supportive services (TSS), care coordination, case management, peer support, and vocational and housing placement assistance regardless of recovery or behavioral health status.

"Trauma-Informed Care" - an approach to care that realizes the widespread impact of trauma, understands potential paths for recovery, recognizes the signs and symptoms of trauma in individuals, families, personnel, and others involved in the system, and responds by fully integrating knowledge about trauma into policies, procedures, and practices, seeking to actively resist re-traumatization.

"Tribal Nation" – a group that is located within the geographic borders of the United States, where each Tribal Nation exercises its own sovereignty. Tribal Nations may include but not limited to, clan, tribe, band, pueblo, or Native villages in the United States.

"Underserved Populations" - As established in C.R.S. 27-50-101(17)(b), underserved populations are currently considered to be individuals who meet the definition of "Priority Population" set forth above, and who are a member of one of these groups:

(a) People experiencing or at risk of homelessness
(b) Children and youth at risk of out-of-home placement and their parents;
(c) People involved with the criminal or juvenile justice system;
(d) People of Color;
(e) American Indians;
(f) Alaska natives;
(g) Veterans;
(h) People who are pregnant;
(i) People who are lesbian, gay, bisexual, transgender, or queer or questioning; and
(j) Individuals with disabilities as defined by the Americans with Disabilities Act (ADA)

"Uninsured" - Broadly, people are considered uninsured if they do not have coverage under private health insurance, Medicare, Medicaid, or public assistance.

"Underinsured" - a state when an Individual's insurance plan does not cover the cost of necessary physical or behavioral health care, leaving the Individual with out-of-pocket costs they are unable to pay.

"Universal Contracting Provisions" - Contract terms designed to provide clear, standardized requirements, to be used by all state agencies, as well as BHASOs and RAEs when contracting for behavioral health services in Colorado.

"Walk-In Centers" - Centers providing immediate and confidential, in-person crisis support, information, and referrals to any individual in need including to anyone experiencing a self-defined crisis, including Crisis Stabilization Units, Acute Treatment Units, and Mobile Crisis Services.

"Withdrawal Management" - means the services required to assist an individual experiencing withdrawal from the use of one (1) or more substances, as identified by the individual's acute intoxication and/or withdrawal potential, also known as the dimension 1 rating, from the ASAM Criteria.

"Work" - The delivery of the Goods and performance of the Services described in the Contract.

"Work Plan" - the proposed strategy and/or schedule for a particular project submitted to BHA. The Work Plan lays out the action steps needed to complete a project. It makes clear what the desired outcome is and the major streams of activities or deliverables that will accomplish that outcome.

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

Article 2 - Acronyms

"ACT" - Assertive Community Treatment

"ADA" - Americans with Disabilities Act

"AFS" - Additional Family Services

"AHRQ" - Agency for Healthcare Research and Quality

"AMA" - American Medical Association

"AoC" - Administrator on Call

"APA" - American Psychiatric Association

"APS" - Adult Protective Services

"ASAM" - American Society of Addiction Medicine

"ASD" - Autism Spectrum Disorder

"ASL" - American Sign Language

"ASO" - Administrative Services Organization

"ATU" - Acute Treatment Unit

"BAA" - Business Associate Addendum

"BHA" - Behavioral Health Administration

"BHAAC" - Behavioral Health Administration Advisory Council

"BHASO" - Behavioral Health Administrative Services Organization

"BHE" - Behavioral Health Entity

"BHST" - Behavioral Health Secure Transport

"BHTF" - Behavioral Health Task Force

"BIDM" - Business Information and Data Management

"BIPOC" - Black, Indigenous, and other People of Color

"BOCES" - Board of Cooperative Educational Services

"CANS" - Child and Adolescent Needs and Strengths

"CARR" - Colorado Association of Recovery Residences

"CAS" - Certified Addictions Specialist

"CASA" - Court Appointed Special Advocate

"CAT"- Certified Addition Technician

"CBI" - Colorado Bureau of Investigation

"CBMS" - Colorado Benefits Management System

"CCAR" - Colorado Comprehensive Assessment Record

"CCBHP" - Comprehensive Community Behavioral Health Provider

"CCS" - Colorado Crisis Services

"CDDT" - Community Dual Disorders Treatment Teams

"CDHS" - Colorado Department of Human Services

"CDL" - Commercial Driver's License

"CDPHE" - Colorado Department of Public Health and Environment

"CFR" - Code of Federal Regulations

"CIT" - Crisis Intervention Training

"CLAS" - Culturally Appropriate and Linguistic Services

"CMA" - Case Management Agency

"CMHC" - Community Mental Health Center

"CMHI" - Colorado Mental Health Hospital

"COACT" - Colorado's Trauma Informed System of Care

"CO-CANS" - Colorado Child and Adolescent Needs and Strengths

"CoCM" - Collaborative Care Model

"COLA" - Cost of Living Adjustment

"CORA" - Colorado Open Records Act

"CPA" - Child Placement Agency

"CPT"- Current Procedural Terminology

"CRAFT" - Community Reinforcement and Family Training

"C.R.S." - Colorado Revised Statutes

"CRT" - Crisis Resolution Teams

"CSC" - Coordinated Specialty Care

"C-SSR" - Columbia Suicide Severity Rating Scale

"CST" - Community Supervision Tool

"CSU" - Crisis Stabilization Units

"CYF" - Children, youth, and family

"CYMHTA" - The Children and Youth Mental Health Treatment Act

"DACODS" - Drug and Alcohol Coordinated Data System

"DACTS" - Dartmouth Assertive Community Treatment Scale

"DEA" - Drug Enforcement Agency

"DHS" - Department of Human Services

"D/HOH/DB" - Deaf, hard of hearing, and deafblind Individuals

"DORA" - Department of Regulatory Agencies

"DOS" - Drug Offender Surcharge

"DSM 5-TR"- The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition

"DUI" - Driving Under the Influence

"DVR" - Division of Vocational Rehabilitation

"DVRE" - Division of Vocational Rehabilitation Extended Services

"DYS"- Division of Youth Services

"EASA" - Early Assessment and Support Alliance

"EBP" - Evidence-Based Practice

"EC" - Emergency Commitment

"ED" - Emergency Department

"EHR" - Electronic Health Record

"EOP" - Enhanced Outpatient Services

"FCBS"- Forensic Community-Based Services

"FDA" - U.S. Food and Drug Administration

"FEP" - First Episode Psychosis

"FFPSA" - Family First Prevention Services Act

"FIFO" - First in, first out

"FPTM" - Family and Permanency Team Meeting

"FSP" - Family Support Partners

"FST" - Forensic Support Team

"FTE" - Full Time Employee

"GAE" - General Accounting Encumbrance

"GAL" - Guardian ad Litem

"GED" - General Educational Development Test

"GPRA" - Government Performance and Results Act

"GPS" - Global Positioning System

"HB - #" - House Bill - #

"HCPCS"- Healthcare Common Procedure Coding System

"HCPF" - Colorado Department of Health Care Policy and Financing

"HFW" - High Fidelity Wraparound

"HHS" - U.S. Department of Health and Human Services

"HIE" - Health Information Exchange

"HIPAA"- Health Insurance Portability and Accountability Act

"HIV/AIDS" - Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome

"HMA" - Health Management Associates

"HUD" - Housing Urban Development

"IC" - Involuntary Commitment

"iC" - interChange

"IC/RC" - International Certification and Reciprocity Consortium

"IDD" - Intellectual/Developmental Disability

"IEP" - Individualized Education Program

"IHS" - Indian Health Service

"IOP" - Intensive Outpatient Services

"IPAT" - Integration Practice Assessment Tool

"IPN" - Individual Provider Network

"IPS" - Individualized Placement and Support

"IRS" - Internal Revenue Service

"IT" - Information Technology

"JAC" - Juvenile Assessment Center

"JBBS" - Jail Based Behavioral Services

"JBC" - Joint Budget Committee

"LAC" - Licensed Addictions Counselor

"LADDERS" - Licensing and Designation Database Electronic Record System

"LCSW" - Licensed Clinical Social Worker

"LEAD" - Law Enforcement Assisted Diversion

"LEP" - Limited English Proficiency

"LGBTQIA+" - Lesbian, gay, bisexual, transgender, queer and/or questioning, intersex, asexual/aromantic/agender, and the + holds space for the expanding and new understanding of different parts of the very diverse gender and sexual identities.

"LMFT" - Licensed Marriage and Family Therapist

"LMS" - Learning Management System

"LOS" - Length of Stay

"LPC" - Licensed Professional Counselor

"LPN" - Licensed Practical Nurse

"LSI" - Level of Supervision Inventory

"LSI-R" - Level of Service Inventory - Revised

"LSW" - Licensed Social Worker

"MAT" - Medication Assisted Treatment

"MD" - Doctor of Medicine

"MDT" - Multidisciplinary team

"MHBG" - Mental Health Block Grant

"MHU" - Mental Health Unit

"MMIS" - Medicaid Management Information System

"MOTP"- Mobile Opioid Treatment Provider

"MOU" - Memorandum of Understanding

"MOUD" - Medications for Opioid Use Disorder

"MSO" - Managed Service Organization

"MSW" - Master of Social Work

"NARR" - National Association for Recovery Residences

"NEMT" - Non-Emergency Medical Transport

"NGRI" - Not Guilty by Reason of Insanity

"NOMs" - National Outcomes Measures

"OBOTs" - Office Based Opioid Treatment

"OCFMH"- Office of Civic and Forensic Mental Health

"OCR" - Outpatient Competency Restoration

"OEF" - Office of Employment First

"OIT" - Office of Information Technology

"ORAS" - Ohio Risk Assessment System

"OTP"- Opioid Treatment Provider

"OUD" - Opioid Use Disorder

"PCBH" - Primary Care Behavioral Health Model

"PEAKPro" - Program Eligibility and Application Kit Pro

"PHI" - Protected Health Information

"PHP" - Partial Hospitalization Program

"PRTFs" - Psychiatric Residential Treatment Facilities

"PSH" - Permanent Supportive Housing

"PsyD" - Doctor of Psychology

"QRTP" - Qualified Residential Treatment Programs

"RAE" - Regional Accountable Entity

"RCCFs" - Residential Child Care Facilities

"RCO" - Recovery Community Organization

"RFA" - Request for Application

"RFI" - Request for Information

"RFP" - Request for Proposal

"RN" - Registered Nurse

"RNR" - Risk, Needs, Responsivity

"ROI" - Release of Information

"RSA" - Rehabilitation Services Administration

"RVU" - Relative Value Units

"Rx" - Prescription

"SAMHSA" - Substance Abuse Mental Health Services Administration

"SB-#" - Senate Bill (#)

"SBIRT" - Screening, Brief Intervention, Referral and Treatment

"SBMHS" - School Based Mental Health Specialist

"SCRAM" - Secure Continuous Remote Alcohol Monitoring

"SDOH" - Social Determinants of Health

"SED" - Serious Emotional Disturbance

"SEES" - Supported Employment and Education Specialist

"SFA" - Services and Financial Agreement

"SFY" - State Fiscal Year

"SHIE" - Social Health Information Exchange

"SMI" - Serious Mental Illness

"SOA-R" - Standardized Offender Assessment-Revised

"SOC" - System of Care

"SOW" - Statement of Work

"SPARS" - SAMHSA's Performance Accountability and Reporting System

"SPARS IPP" - SAMHSA's Performance Accountability and Reporting System, Infrastructure Development, Prevention and Mental Health Promotion

"SSI" - Supplemental Security Income

"STI" - Sexually Transmitted Infection

"STIRT" - Strategic Individualized Remediation Treatment

"STIRT CC" - Strategic Individualized Remediation Treatment Continuing Care

"SUPTRS" - Federal Substance Use Prevention, Treatment, and Recovery Services Block Grant

"SUD" - Substance Use Disorder

"SWS" - Specialized Women Services

"TA" - Technical Assistance

"TaaM" - Tough as a Mother

"TB" - Tuberculosis

"TCM" - Targeted Case Management

"TSS" - Tenancy Supportive Services

"UA" - Urine Analysis

"U.S.C." - United States Code

"USCSM" - Uniform Service Coding Standards Manual

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"WBLI" - Work Based Learning Initiative

"WM" - Withdrawal Management

"UCP" - Universal Contracting Provisions

"YSP" - Youth Support Partners

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Chapter 3
General Provisions and Requirements

1.3.1 Party Name Convention.

a. Throughout this Contract, terms may reference "The BHASO" or "The BHASO Network." "The BHASO shall" precedes a task that is presumed to be the duty of the BHASO organization directly. "The BHASO Network shall" precedes a task that is presumed to be the duty of direct service providers subcontracted in the BHASO's network, but for which the BHASO is ultimately accountable.

b. In the context of Part Two and Part Three statements of work, "The BHASO Network" refers to those providers who are subcontracted with the BHASO to deliver that service.

1.3.2 Precedence.

a. If any provision of this Contract conflicts with any provision in the Colorado Revised Statutes or any Rule adopted by BHA, the provisions of those statutes or rules prevail.

1.3.3 Contract Term.

a. This Contract expires on the Current Contract Expiration Date listed on the first page of this Contract document. Any task, goal, service, deliverable, or obligation listed in this Contract beyond the Current Contract Expiration Date is for informational purposes only. Required performance is contingent upon extension of the Current Contract Expiration Date to cover the relevant period.

1.3.4 Request for Proposal.

a. The BHASO shall comply with all the provisions and requirements of RFP IBEH 2024000335 and with the BHASO's solicitation response thereto.

1.3.5 Priority and Underserved Populations

a. Per C.R.S. §27-50-101(17), Priority Populations are defined as persons who are:

    i. Uninsured, Underinsured, Medicaid-eligible, publicly-insured, or whose income is below 300% of the Federal Poverty Line; AND

ii. Presenting with acute or chronic behavioral health needs, including but not limited to Individuals who have been determined incompetent to stand trial, adults with Serious Mental Illness, and children and youth with Serious Emotional Disturbance.

b. For SUD services, BHASO Network providers receiving Federal Substance Use Prevention, Treatment, and Recovery Services (SUPTRS) Block Grant dollars shall demonstrate that people who are members of the following populations shall receive priority admission to services in the following order:
   i. Women who are pregnant and using drugs by injection;
   ii. Women who are pregnant;
   iii. Persons who use drugs by injection;
   iv. Women with dependent children;
   v. Persons who are involuntarily committed to treatment (see section III.B. of this exhibit)

c. As established in 45 CFR § 96.120 through 96.137, BHASO Network Providers receiving SUPTRS shall comply with all activities relating to:
   i. Intravenous drug use, pursuant to §96.126
   ii. Tuberculosis services, pursuant to §96.127
   iii. Pregnant women receiving preference in admission to treatment centers as provided in §96.131 and are provided interim services as necessary and as required by law.

d. As established in C.R.S. §27-50-101(17)(b), "Underserved Populations" are persons who are part of a priority population and are currently considered to be:
   i. Individuals experiencing or at risk of homelessness;
   ii. Children and youth at risk of out-of-home placement and their parents/guardians;
   iii. Individuals involved with the criminal or juvenile justice system;
   iv. People of Color;
   v. American Indians;
   vi. Alaskan natives;
   vii. Veterans;
   viii. Individuals who are pregnant;
   ix. Individuals who are lesbian, gay, bisexual, transgender, or queer or questioning; and

x. Individuals with disabilities as defined by the Americans with Disabilities Act (ADA).

1.3.6 Eligibility for Services Funded Under this Contract.

a. The BHASO Network shall prioritize availability and delivery of services to Priority Populations. Individuals who participate in BHA Programs must be eligible for those services as defined by program specifications.
b. The BHASO Network shall determine Individuals' eligibility status. Eligibility status will be described per the terms of the BHA Finance and Data Protocol #1, Special Studies Codes & Program Eligibility, as may be amended.
c. Pursuant to C.R.S. § 24-76.5-103, lawful presence in the United States is not a requirement of eligibility for services under this Contract.
d. The BHASO shall establish policies and procedures with all other BHASOs to ensure continuity of care for all Individuals transitioning into or out of the BHASO's Region, guaranteeing that an Individual's services are not disrupted or delayed.
e. Location of Service Policy. Individuals seeking services from the BHASO Network can receive those services regardless of where in Colorado the Individual lives at the time services are engaged.
    i. The exception is Care Coordination services provided directly by the BHASO. For the purposes of Care Coordination, BHASOs have primary responsibility for services for the Individuals who live in its Region. If an Individual who does not reside in the BHASO's Region seeks Care Coordination services from the BHASO, the BHASO shall provide a warm hand-off (staying on a live call to connect the Individual or attending an in-person meeting to connect the Individual) to the Individual's home BHASO.

1.3.7 Placement of Individuals Seeking Services into the Appropriate Levels of Care.

a. Substance Use Disorder Treatment. The BHASO Network shall use a standardized placement protocol based upon the State's most recent approved edition of "The ASAM Criteria," published by the American Society of Addiction Medicine (ASAM) to accurately assess each Individual for the most appropriate level of care.

b. Mental Health and Crisis Levels of Care. In State Fiscal Year 2026, BHASOs shall collaborate to compose standardized clinical necessity/placement guidelines based on clinical standards, best practices, and service availability in Colorado. BHA must approve the guidelines prior to their use in the BHASO Network. These guidelines will become a primary resource for the provision of Care Coordination within the BHASO Network.
    i. DELIVERABLE: Mental Health and Crisis Clinical Necessity Guidelines
    ii. DUE DATE: January 31, 2026
    iii. DESTINATION: cdhs_BHASO_deliverables@state.co.us
    iv. FILE NAME: BHASO - All Regions - Mental Health and Crisis Clinical Necessity Guidelines
c. See Exhibit A, Part Three, Chapter 11 for more information on Screening, Assessment and Diagnosis.

1.3.8 Individuals Served; Access to Care Standards

The BHASO Network shall serve persons in need of behavioral health care services in its Region, subject to a specific prohibition on denial of safety net service delivery for any of the reasons prohibited by C.R.S. §27-50-301(4); (C.R.S. §27-50-403(1)(f)).

a. Comprehensive Community Behavioral Health Providers must provide the Safety Net Services listed in C.R.S. §27-50-101(11) to Priority Populations as defined in Exhibit A, Part 1, Section 1.3.5.
b. Except as provided in C.R.S. §27-50-303, Essential Behavioral Health Safety Net Providers shall provide the Safety Net Service(s) that they contract with the BHASO to provide to Priority Populations. The BHASO's contracts with Essential Behavioral Health Safety Net Providers must identify the specific Priority Populations that the provider serves.
c. In accordance with C.R.S. §27-50-301(4), except as provided in C.R.S. §27-50-303, Behavioral Health Safety Net Providers shall not refuse to treat an Individual based on the Individual's:
    i. Insurance coverage, lack of insurance coverage, or ability to pay;
    ii. Clinical acuity level related to the Individual's behavioral health condition or conditions, including whether the Individual has been certified for short-term

treatment or long-term care and treatment pursuant to article 65 of C.R.S. title 27;

iii. Readiness to transition out of the Colorado Mental Health Hospital at Pueblo, the Colorado Mental Health Hospital at Fort Logan, or any other mental health institute or licensed facility providing inpatient psychiatric services or acute care hospital providing stabilization because the Individual no longer requires inpatient care and treatment;

iv. Involvement in the criminal or juvenile justice system;

v. Current involvement in the child welfare system;

vi. Co-occurring mental health and substance use disorders, physical disability, or intellectual or developmental disability, irrespective of primary diagnosis, co-occurring conditions, or if an Individual requires assistance with activities of daily living or instrumental activities of daily living, as defined in C.R.S. §12-270-104(6);

vii. Displays of aggressive behavior, or history of aggressive behavior, as a symptom of a diagnosed mental health disorder or substance use disorder;

viii. Clinical presentation or behavioral presentation in any previous interaction with a provider;

ix. Place of residence; or

x. Disability, age, race, creed, color, sex, sexual orientation, gender identity, gender expression, marital status, national origin, ancestry, or tribal affiliation.

d. Behavioral Health Safety Net Providers in the BHASO Network shall use standard criteria, as determined by BHA in Part 12.4.3.C (for Essential Behavioral Health Safety Net Providers) or Part 12.5.3.C (for Comprehensive Community Behavioral Health Providers) of 2 CCR 502-1, for determining whether an agency's clinical scope of practice or treatment capacity are appropriate to meet the needs of the Individual.

i. If a Priority Population Individual's needs exceed the treatment capacity or clinical expertise of an Essential Behavioral Health Safety Net Provider, the provider shall refer the Individual to another appropriate provider.

ii. If a Priority Population Individual's needs exceed the treatment capacity or clinical expertise of a Comprehensive Community Behavioral Health Provider, the provider must ensure that the Individual has access to interim behavioral health services in a timely manner until the Individual is either admitted to the

Comprehensive Community Behavioral Health Provider or connected and admitted to the most appropriate provider for ongoing care. This may include use of providers within the network of the BHASO or the regional managed care entity.

1. The Comprehensive Community Behavioral Health Provider shall obtain approval from the BHASO under which the provider is operating prior to referring a Priority Population Individual to alternative services; except that an Individual experiencing a behavioral health crisis may be referred to crisis services without prior approval.

e. When referring an Individual to alternative services, a Behavioral Health Safety Net Provider shall assist the Individual in identifying and initiating services with an appropriate provider for ongoing care. As appropriate, the Behavioral Health Safety Net Provider shall use the BHASO for Care Coordination.

f. Alternative Service Referral Report.

i. Behavioral Health Safety Net Providers shall track the following information for all Individuals who were referred to alternative services pursuant to this section:

1. Individual demographics;
2. Standardized descriptions of the needs of the Individual that could not be met and require the Individual to be referred to another provider;
3. The outcome and timeliness of the referral; and
4. Any other information required by the BHA.

ii. The provider shall submit the report to the BHASO under which the provider is operating. Please reference Data Dictionary described in Exhibit D, Appendix 1, as may be amended, to verify most up-to-date format and requirements.

1. DELIVERABLE: Alternative Service Referral Report
2. DUE DATE: Monthly, on the 15th day of each month following the reported month.
3. DESTINATION: encrypted email to the BHA Director of Care Coordination.
4. FILE NAME: BHASO Region[X] - [BHASO] - FY[XX][Month] - Alternative Service Referral Report

1.3.9 Sliding Fee Scale Requirements

a. There is no requirement for the BHASO Network to charge fees to Individuals who qualify for BHA funding for the services described herein.
b. Optionally, the BHASO may permit the BHASO Network to charge fees to Individuals based on a sliding fee scale. If the BHASO Network chooses to use a sliding fee scale, the scale shall include zero-dollar fees, or, have a process by which the full fee can be waived. Fees shall be reasonable and are subject to review by BHA.
c. The BHASO shall assess an Individual's ability to pay based on a standardized sliding fee discount schedule addressing Individuals whose income is at or below three hundred percent (300%) of the federal poverty line. Individuals qualifying for a sliding fee discount will be expected to pay the discounted rate.
d. Individuals under the age of eighteen (18) (minors) who are admitted to treatment with the knowledge and consent of their parents may have fees charged to their family/guardians based on their family/guardians' income and number of dependents.
e. Individuals under the age of eighteen (18) (minors) who are admitted to treatment without the knowledge and consent of their parents may have fees charged based on their income.
f. The BHASO Network shall publicize the availability of the sliding fee scale. Fees must be communicated to Individuals in writing as part of the admission process or, in the case of Withdrawal Management, as soon as possible thereafter.
g. The lack of ability to pay an intake or sliding scale fee may not be used as a barrier to admission to treatment for Individuals accessing Crisis Services, Individuals who are involuntarily committed to treatment, or Individuals who are pregnant. After admission, fees can be charged per the sliding fee.

1.3.10 SAMHSA Guidelines for Trauma-Informed Care. The BHASO shall implement the SAMHSA Guidelines for Trauma-Informed Care in its practices, including:

a. *Safety* - Throughout the organization, staff and the Individuals they serve feel physically and psychologically safe.
b. *Trustworthiness and transparency* - Organizational operations and decisions are conducted with transparency and with a goal of building and maintaining trust among staff, Individuals, and family members of those receiving services.

c. *Peer support and mutual self-help* - These are integral to the organizational and service delivery approach and are understood as a key vehicle for building trust, establishing safety, and empowerment.
d. *Collaboration and mutuality* - True partnering and leveling of power differences between staff and Individuals served and among organizational staff from direct care staff to administrators. There is recognition that healing happens in relationships and in the meaningful sharing of power and decision-making. The organization recognizes that everyone has a role to play in a trauma-informed approach. One does not have to be a therapist to be therapeutic.
e. *Empowerment, voice, and choice* - Throughout the organization and among the Individuals served, Individuals' strengths are recognized, built on, and validated and new skills developed as necessary. The organization aims to strengthen the staff's, Individuals', and family members' experience of choice and recognize that every person's experience is unique and requires an Individualized approach. This includes a belief in resilience and in the ability of Individuals, organizations, and communities to heal and promote recovery from trauma. This builds on what Individuals, staff, and communities have to offer, rather than responding to perceived deficits.
f. *Cultural, historical, and gender issues* - The organization actively moves past cultural stereotypes and biases (e.g., based on race, ethnicity, sexual orientation, age, geography), offers gender-responsive services, leverages the healing value of traditional cultural connections, and recognizes and addresses historical trauma.

1.3.11 Individual Rights. Each Individual or, when applicable, the Individual's designated representative, has the right to:

a. Participate in all decisions involving the Individual's care or treatment.
b. Be informed about whether the BHASO Network provider is participating in teaching programs, and to provide informed consent prior to being included in any clinical trials relating to the Individual's care.
c. Refuse any drug, test, procedure, service, or treatment and to be informed of risks and benefits of this action.
d. Receive care and treatment, in compliance with state statute, that is free from discrimination on the basis of physical or mental disability, race, ethnicity, socio-economic status, religion, gender expression, gender identity, sex, sexuality, culture,

and/or languages spoken; and that recognizes an Individual's dignity, cultural values and religious beliefs; as well as provides for personal privacy to the extent possible during the course of treatment.

e. Be informed of, at a minimum, the first names and credentials of the personnel that are providing services to the Individual. Full names and qualifications of the service providers must be provided upon request to the Individual or the Individual's designated representative or when required by the department of regulatory agencies.

f. Receive, upon request:
    i. Prior to initiation of non-emergent care or treatment, the estimated average charge to the Individual. This information must be presented to the Individual in a manner that is consistent with all state and federal laws and regulations.
    ii. The BHASO Network provider's general billing procedures.
    iii. An itemized bill that identifies treatment and services by date. The itemized bill must enable Individuals or their legal representatives to validate the charges for items and services provided and must include contact information, including a telephone number, for billing inquiries. The itemized bill must be made available either within ten (10) business days of the request, thirty (30) days after discharge, or thirty (30) days after the service is rendered – whichever is later.

g. Give informed consent for all treatment and services. The personnel must obtain informed consent for treatment they provide to the Individual. Informed consent includes:
    i. A written agreement executed between the BHASO Network provider and the Individual or the Individual's legal representative at the time of admission. The parties may amend the agreement if there is written consent of both parties. No agreement will be construed to relieve the BHASO Network provider of any requirement or obligation imposed by law or regulation.
    ii. Individual consents must include consent to treatment. If the Individual is refusing treatment or an aspect of treatment, the BHASO Network provider must have the Individual sign a form to confirm their refusal.
    iii. If the governor or local government declares an emergency or disaster, a BHASO Network provider may obtain documented oral agreements or consents in place of written agreements or consents. Documented oral agreements and consents may only be used as necessary because of circumstances related to

the emergency or disaster. The BHASO Network provider shall send a hard copy or electronic copy of the documented agreement or consent to the Individual within two (2) business days of the oral agreement or consent.

h. Register disputes with the BHASO Network provider and grievances with the BHA and to be informed of the procedures for registering complaints and grievances including contact information.
i. Be free of abuse and neglect.
    i. The BHASO Network provider must develop and implement policies and procedures that prevent, detect, investigate, and respond to incidents of abuse or neglect. This includes suspected physical, sexual, or psychological abuse; exploitation and/or caretaker neglect; as well as child abuse, neglect and/or child safety issues, which must include definitions of abuse and neglect under the C.R.S. §19-1-103, and that are consistent with the reporting of child abuse allowed under federal law. Policies and procedures must also be consistent with definitions and mandated reporting requirements for mistreatment, abuse, neglect, and exploitation of at-risk adults under C.R.S. §26-3.1-101, §26-3.1-102, §18-6.5-108).
        A. Prevention includes, but is not limited to, adequate staffing to meet the needs of the Individuals, screening personnel for records of abuse and neglect, and protecting Individuals from abuse during investigation of allegations.
        B. Detection includes, but is not limited to, establishing a reporting system and training personnel regarding identifying, reporting, and intervening in incidences of abuse and neglect.
    ii. The BHASO Network provider shall investigate all allegations of abuse or neglect against BHASO Network provider personnel, or made against an Individual, when the allegation occurs during service provision or on BHASO Network provider premises. The BHASO Network provider shall implement corrective actions in accordance with such investigations.
j. Be free from the improper application of restraints or seclusion. Restraints or seclusion may only be used in a manner consistent with Part 2.14 of 2 CCR 502-1.
k. Expect that the BHASO Network provider in which the Individual is admitted can meet the identified and reasonably anticipated care, treatment, and service needs of the Individual.

l. Receive care from the BHASO Network provider in accordance with the Individual's needs.
m. Have the confidentiality of their Individual records maintained.
    i. A BHASO Network provider must comply with all applicable state and federal laws and regulations for release of information including but not limited to 42 C.F.R. Part 2, C.R.S. §27-65-123 and HIPAA.
    ii. When obtaining informed consent or an authorization for release of information, the signed release must state, at a minimum:
        A. Persons who may receive the information in the records;
        B. The purpose for obtaining this information;
        C. The information to be released;
        D. That the release may be revoked by the Individual, or legal representative at any time; and
        E. That the release of information is only valid for a time period specified but such time cannot exceed two (2) years from the date of signature.
n. Receive care in a safe setting.
o. Be notified if referrals to other providers are to entities in which the BHASO Network provider has a direct or indirect financial benefit, including a benefit that has financial value, but is not a direct monetary payment.
p. Formulate medical and psychiatric advance directives and have the BHASO Network provider comply with such directives, as applicable, and in compliance with applicable state statute.
q. When the BHASO Network provider is aware that an Individual has developed advance directives, the BHASO Network provider shall make good faith efforts to obtain the directives, and the directives must become part of the Individual's record.
r. The BHASO Network provider shall disclose the policy regarding Individual rights to the Individual or the Individual's designated representative prior to treatment or upon admission, where possible. For any services requiring multiple Individual encounters, disclosure provided at the beginning of such care or treatment course must meet the intent of the regulations.

1.3.12 Services to Persons Who are Deaf or Hard of Hearing. The BHASO Network shall comply with the following specifications of the Americans with Disabilities Act (ADA):

a. Treatment services provided to persons who are deaf or hard of hearing shall comply with the Americans with Disabilities Act (ADA), (ADA Regulations, Title III, Regulation 28 CFR Part 36, Subpart C, Section 36.303).
b. When an interpreter is the appropriate auxiliary aid or service, the sub-contractor shall provide a "qualified interpreter" per ADA Regulations, Title III, Regulation 28 CFR Part 36, Appendix B, and ADA Regulations, Title III, Regulation 28 CFR Part 36 Subpart A, Section 36.104, which specify that if a friend or family member is offered as an interpreter, a non-family, non-friend interpreter must also be offered as a choice to the Individual.
c. Subcontractors "may not place a surcharge on a particular Individual with a disability to cover the cost of measures, such as the provision of auxiliary aids or program accessibility, that are required to be provided that Individual or group with the nondiscriminatory treatment" (ADA Regulations, Title III, Regulation 28 CFR Part 36, Subpart C, Section 36.301(c).
d. The BHASO may fund the BHASO Network's operation of and participation in Colorado Daylight Partnership Learning Collaboratives to develop and expand sustainable statewide capacity to deliver consistent, high quality, accessible mental health and substance abuse services to deaf, hard of hearing, and deafblind (D/HOH/DB) Individuals.

1.3.13 Nondiscrimination. In addition to other nondiscrimination language contained in this Contract, the BHASO and the BHASO Network may not discriminate against Individuals with any of the following characteristics:

a. Race
b. Limited English proficiency
c. Sex
d. Gender identity / gender expression
e. Sexual orientation
f. Involuntarily committed to treatment pursuant to C.R.S. §27-81-112 and C.R.S. §27-82-108;
g. Pregnancy status

h. Use of drugs by injection
i. Presence of co-occurring psychiatric disorders
j. Use of prescribed psychotropic medications
k. Use of medication for the treatment of opioid disorder
l. Deaf or Hard of Hearing
m. HIV positive status
n. AIDS diagnosis
o. High risk behavior
p. Aid to the needy disabled recipient
q. Use of drugs other than alcohol
r. Disabled as defined by the Americans with Disabilities Act
s. Veteran or active military
t. Socioeconomic status
u. Education level
v. Ethnicity

1.3.14 Cultural Responsiveness in Service Delivery

a. The BHASO Network shall include services that address the language, ability, and cultural barriers, as necessary, to serve communities of color and other Underserved Populations.
b. To ensure the provision of culturally and linguistically appropriate services, the BHASO and the BHASO Network shall:
    i. Ensure all methods and procedures used to assess and evaluate an Individual are able to be provided in the preferred language and/or communication method of frequently encountered limited English proficiency (LEP) groups.
    ii. Develop and maintain general knowledge about the racial, ethnic, and cultural groups in the service area, including each group's diverse cultural health beliefs and practices, preferred languages, health literacy, and other needs in order to inform the provision of culturally and linguistically appropriate services and improve access and quality of services for these groups.
    iii. Collect and maintain updated information to help understand the composition of the communities in the service area, including the primary spoken languages

in order to inform the provision of culturally and linguistically appropriate services and improve access for these communities.

iv. Be able to provide oral and written notice to Individuals with limited English proficiency in the preferred language and/or communication method of frequently encountered limited English proficiency (LEP) groups of the agency to inform them of their right to receive language assistance services and how to do so. Language assistance services must be free of charge to the Individual, be accurate and timely, and protect the privacy and independence of the Individual receiving services.

v. Provide documents or messages vital to an Individual's ability to access services (for example, registration forms, sliding scale fee discount schedule, after-hours coverage, signage) in languages common in the community served, taking account of literacy and developmental levels and the need for alternative formats. Such materials shall be provided at intake.

vi. Provide interpretation and translation services in a manner that meets the needs of the Individual.

1. The BHASO and the BHASO Network shall not require or suggest using family or friends as interpreters. This requirement exists in order to ensure complete, accurate, impartial, and confidential communication. An Individual shall not be required to provide their own interpreter. The BHASO/The BHASO Network shall not rely on an adult accompanying an Individual with limited English proficiency (LEP) to interpret or choose to facilitate communication except:
    a. In an emergency involving an imminent threat to the safety or welfare of an Individual or the public, where there is no qualified interpreter for the Individual with limited English proficiency immediately available.
    b. Where the Individual with limited English proficiency specifically requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide such assistance, and reliance on that adult for such assistance is appropriate under the circumstances.

c. Personnel should suggest that a trained interpreter be present in these instances to ensure accurate interpretation and should document the offer and declination in the Individual's record.

2. Minor children must not be used as interpreters, nor be allowed to interpret for their parents when the minor is the Individual receiving services, unless there is an emergency involving an imminent threat to the safety or welfare of an Individual or the public when no other interpreter is available.
3. To the extent interpreters are used, and an interpreter is not provided by the Individual, the interpreters must be trained to function in a medical and/or behavioral health setting, adhere to accepted interpreter ethics principles, including Individual confidentiality and be able to interpret effectively, accurately, and impartially.

vii. Provide auxiliary aids and services needed for effective communication, that are Americans with Disabilities Act (ADA) compliant and responsive to the needs of Individuals with disabilities (e.g., sign language interpreters, videophones).

viii. Implement strategies to recruit, support, and promote personnel that are representative of the demographic characteristics, including primary spoken languages of the communities in the agency's service area.

ix. The BHASO/the BHASO Network are responsible for training personnel on interpretation and translation services available to facilitate services. This includes training personnel on the procedures to access and use such services.

c. The BHASO shall have a strategy for addressing health disparities by meeting one of the following:

i. If the BHASO has completed an equity plan that identifies how it will address health equity, the BHASO shall submit its equity plan to BHA; or

ii. The BHASO shall submit to BHA a completed Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS) Checklist that follows the HHS format found at the U.S. Department of Health and Human Services (HHS) Think Cultural Health website: https://thinkculturalhealth.hhs.gov/clas/standards

d. The equity plan or CLAS Checklist should reflect how to improve treatment access and/or outcomes for priority and underserved populations. In Year One, the BHASO shall submit the equity plan or CLAS checklist. Subsequent annual submissions shall include any updates to the plan or checklist and a description of progress on the Equity Plan or CLAS checklist advancements.
   i. DELIVERABLE: Equity Plan or CLAS Checklist and Updates
   ii. DUE DATE: August 31 annually
   iii. DESTINATION: cdhs_BHASO_deliverables@state.co.us
   iv. FILE NAME: BHASO Region[X] - [BHASO] - FY[XX] [Month]- Equity Plan [OR] CLAS Checklist.
e. The BHASO shall require the BHASO Network to submit an Equity Plan or a CLAS Checklist per the terms in this subsection c. to the BHASO.

1.3.15 Social Determinants of Health

a. The BHASO shall demonstrate an understanding of the health disparities and inequities in its Region and develop plans with the BHASO Network providers, Individuals, and community stakeholders to optimize the whole person health of Individuals in its Region.
b. Recognizing that the conditions in which Individuals live also impact their health and well-being, the BHASO shall establish relationships and collaborate with economic, social, educational, justice, recreational and other relevant organizations to promote the health of local communities and populations.
c. BHASO shall uphold the expectation that, in the creation or promotion of programs, priority emphasis is placed on stigma reduction and harm reduction, creating a culture of support that aligns with these crucial objectives.

d. The BHASO shall know, understand, and implement initiatives to build local communities to optimize health and well-being, particularly for those Individuals with complex needs that receive services from a variety of agencies.
e. The BHASO shall 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.
f. The BHASO shall collaborate with school districts and schools to coordinate care, provide resources, and develop programs to support the behavioral health of children and youth.
g. The BHASO shall coordinate with its Region's RAE to leverage the statewide Community Resource Inventory (CRI) through the SHIE infrastructure, when available.
h. The BHASO shall identify and promote community engagement with evidence-based and promising initiatives operating in the Region that address the social determinants of health. The BHASO shall work with community organizations to remove roadblocks to access to programs and initiatives, particularly evidence-based/promising practice programs in the Region, leveraging the SHIE infrastructure, when available.
i. The BHASO shall share information with BHA and with community organizations in the Region about identified community social service gaps and needs.
j. The BHASO shall engage with hospitals and local public health agencies regarding their community health needs assessments to develop and implement collaborative strategies to reduce health inequities and disparities in the community.
k. The BHASO shall collaborate with BHA, other state agencies, and regional and local efforts in order to expand the community resources available to Individuals.

1.3.16 Non-Traditional Service Locations

a. Unless otherwise prohibited by this Contract, Rule, the service code, fidelity model, or best practice, services may be delivered in non-traditional locations / methods with the goal of increasing access to services, such as:
    a. By telehealth
    b. In-home
    c. Community settings such as
        i. Schools
        ii. Community centers including resource and day centers
        iii. Congregate and emergency shelters

iv. Faith-based settings

d. Supportive housing locations, including:
   i. Permanent supportive housing
   ii. Transitional housing
   iii. Rapid rehousing
   iv. Oxford and recovery living communities
   v. Bridge housing
e. Outdoor settings including services provided by co-responder and street medicine and outreach teams,

b. Providing the option for an Individual to choose to access services in non-traditional locations is especially encouraged when serving Individuals with geographical, disability, or transportation barriers to accessing services in an office setting. Telehealth may not be considered a replacement for in-person services, and Individual choice must be centered in the decision to receive care in nontraditional locations/methods.

1.3.17 Evidence Based Practices.

a. Purpose and Goal
   i. As a deliverable of the Mental Health Block Grant, SAMHSA annually tracks Evidence Based Practice (EBP) programming for the treatment of behavioral health disorders throughout the states receiving Mental Health Block Grant funding. For the purposes of this Contract, Evidence-based interventions are defined by inclusion in one or more of the three categories below:
      1. Included in Federal registries of evidence-based interventions;
      2. Reported with positive effects on the primary targeted outcome in peer-reviewed journals; or
      3. Documented effectiveness supported by other sources of information and the consensus judgment of informed experts.
   ii. BHA is required to submit an annual report to SAMHSA detailing EBPs utilized in the State as well as number of Individuals served under each EBP. As a result, the Contractor shall submit the deliverables identified below by the associated deadline.

b. Activities/Services.

i. Data Reporting. The BHASO shall submit an annual EBP flat file per specifications in the most recent version of the Colorado Behavioral Health Administration Guidelines for reporting Evidence Based Practices. Please reference Data Dictionary described in Exhibit D, Appendix 1, as may be amended, to verify most up-to-date format and requirements.

1. The annual data submission shall include all allowable EBPs utilized by the BHASO and funded by BHA.
2. DELIVERABLE: EBP Flat File
3. DUE DATE: Data for the prior contract year are to be submitted by 5 PM on July 31 annually.
4. DESTINATION: CCAR or Unified Data Model Platform
5. FILE NAME: "BHASOID_FY##.EBP"

1.3.18 Access to Medication-Assisted Treatment. In accordance with C.R.S. §27-50-403(e), BHASOs are prohibited from purchasing treatment modality services from providers that deny or prohibit access to any medically necessary treatment, including medication-assisted treatment, as defined in C.R.S. §23-21-803, for SUD.

a. Funds may not be expended through the grant or a subaward by any agency which would deny any eligible Individual, patient or Individual access to their program because of their use of FDA-approved medications for the treatment of substance use disorders (e.g., methadone, buprenorphine products including buprenorphine/naloxone combination formulations and buprenorphine mono product formulations, naltrexone products including extended-release and oral formulations or long acting products such as extended release injectable or implantable buprenorphine.)

b. Specifically, Individuals must be allowed to participate in methadone treatment rendered in accordance with current federal and state methadone dispensing regulations from an Opioid Treatment Program and ordered by a physician who has evaluated the Individual and determined that methadone is an appropriate medication treatment for the Individual’s opioid use disorder.

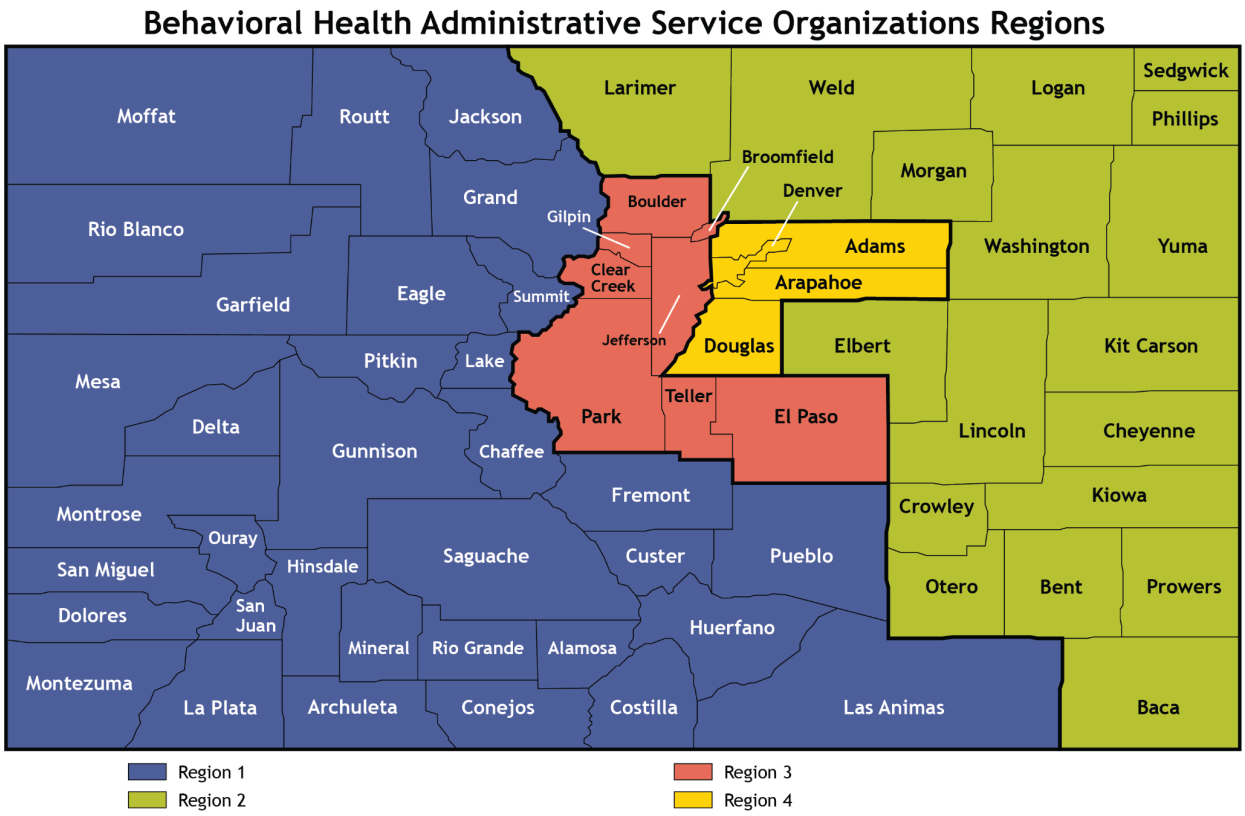
c. Similarly, medications available by prescription or office-based implantation must be permitted if it is appropriately authorized through prescription by a licensed prescriber or provider.
d. In all cases, MAT must be permitted to be continued for as long as the prescriber or treatment provider determines that the medication is clinically beneficial.
e. The BHASO shall assure that Individuals will not be compelled to discontinue MAT as part of the conditions of any programming if stopping is inconsistent with a licensed prescriber's recommendation or valid prescription.

1.3.19 Prohibition on Marijuana. Funds may not be used, directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana. Treatment in this context includes the treatment of opioid use disorder. Grant funds also cannot be provided to any Individual who or organization that provides or permits marijuana use for the purposes of treating substance use or mental disorders. See, e.g., 45 C.F.R. § 75.300(a) (requiring HHS to "ensure that Federal funding is expended . . . in full accordance with U.S. statutory . . . requirements."); 21 U.S.C. §§ 812(c)(10) and 841 (prohibiting the possession, manufacture, sale, purchase or distribution of marijuana). This prohibition does not apply to those providing such treatment in the context of clinical research permitted by the DEA and under an FDA-approved investigational new drug application where the article being evaluated is marijuana or a constituent thereof that is otherwise a banned controlled substance under federal law.

1.3.20 Accessibility of Documents.

a. The BHASO's written deliverables are expected to comply with all applicable provisions of C.R.S. §§24-85-101, et seq., and the Accessibility Standards for Individuals with a Disability, as established by the Governor's Office of Information Technology (OIT), pursuant to §24-85-103(2.5), C.R.S. See https://oit.colorado.gov/standards-policies-guides/guide-to-accessible-web-services/accessible-pdfs-and-documents.
b. BHASO shall also comply with all State of Colorado technology standards related to technology accessibility and with Level AA of the most current version of the Web Content Accessibility Guidelines (WCAG), incorporated in the State of Colorado technology standards. See https://oit.colorado.gov/accessibility.

Chapter 4
BHASO Structure



1.4.1 BHASO Regions

Geographic Region	BHASO	Counties
Region 1	Rocky Mountain Health Plans ("RMHP")	Alamosa, Archuleta, Chaffee, Conejos, Costilla, Custer, Delta, Dolores, Eagle, Fremont, Garfield, Grand, Gunnison, Hinsdale, Huerfano, Jackson, Lake, Las Animas, La Plata, Mesa, Mineral, Moffat, Montezuma, Montrose, Ouray, Pitkin, Pueblo, Rio Blanco, Rio Grande, Routt, Saguache, San Juan, San Miguel, Summit

Region 2	Signal Behaviora Health Network ("Signal")	Baca, Bent, Cheyenne, Crowley, Elbert, Kit Carson, Kiowa, Larimer, Lincoln, Logan, Morgan, Otero, Phillips, Prowers, Sedgwick, Washington, Weld, Yuma
Region 3	Signal	Boulder, Broomfield, Clear Creek, El Paso, Gilpin, Jefferson, Park, Teller
Region 4	Signal	Adams, Arapahoe, Denver, Douglas

1.4.2 Attribution of Individuals Seeking Services. The BHASO Network shall serve Individuals regardless of the Individual's home address, if other eligibility criteria are met.

1.4.3 BHASO Ownership and Control; Conflict of Interest.

a. Definitions. As used in this section 1.4.3, unless the context otherwise requires:
   i. "Medical Director" means a physician who oversees the medical care and other designated care and services in a BHASO. The Medical Director may be responsible for helping to develop clinical quality management and utilization management.
   ii. "Ownership" means an Individual who is a legal proprietor of an organization, including a provider or Individual who owns assets of an organization, or has a financial stake in the BHASO.

b. In order to promote transparency and accountability, each BHASO that has twenty-five percent or more Ownership by providers of behavioral health services shall comply with the following conflict of interest policies:
   i. Providers who have Ownership or board membership in a BHASO shall not have control, influence, or decision-making authority in how funding is distributed to any provider or the establishment of provider networks.
   ii. BHA shall quarterly review a BHASO's funding allocation to ensure that all providers are being equally considered for funding. BHA is authorized to review any other pertinent information to ensure the BHASO is meeting state and federal rules and regulations and is not inappropriately giving preference to providers with Ownership or board membership.
   iii. An employee of a contracted provider of a BHASO shall not also be an employee of the BHASO unless the employee is a medical director for the BHASO. If the

Medical Director is also an employee of a provider that has board membership or Ownership in the BHASO, the BHASO shall develop policies, approved by the commissioner of the behavioral health administration, to mitigate any conflict of interest the Medical Director may have.

iv. A BHASO's board shall not have more than fifty percent of contracted providers as board members, and the BHASO is encouraged to have a community member on the BHASO's board.

v. Conflict of Interest Policy.

i. The BHASO shall have a Conflict-of-Interest policy that addresses potential conflicts relating to the Contract requirements of the BHASO. The policy must include a description of how the BHASO will address potential conflicts of interest with any health care provider that may have an ownership or controlling interest in the operation of the BHASO. The policy must also require the BHASO to disclose financial conflicts of interest if they occur (e.g. the BHASO or an employee of the BHASO has received financial compensation such as gifts or reimbursements from a provider). The policy must provide a method to monitor and manage financial conflicts of interest.

1. DELIVERABLE: Conflict of Interest Policy
2. DESTINATION: cdhs_BHASO_deliverables@state.co.us
3. DUE DATE: May 31, 2025, and upon update or upon BHA request thereafter.
4. FILE NAME: BHASO Region[X] - [BHASO] - FY[XX] - Conflict of Interest Policy

ii. Any entity, political subdivision, or Individual may file a complaint with BHA if the entity, political subdivision, or Individual believes there is an actual or perceived conflict of interest within the BHASO's organization.

1.4.4 BHASO Roles

a. The BHASO shall appropriately staff the BHASO to accomplish the services and activities required by this Contract. BHASOs shall staff efficiently.

b. Roles shall include:

i. Project Director

ii. Contract/Data Manager responsible for ensuring program compliance and contractual oversight
iii. Quality Assurance / Improvement Manager
iv. Clinical Director shall be contracted or staffed to develop protocols and ensure clinical oversight of the program
v. Fiscal Officer
vi. Network Development Staff
vii. Delivery System Quality Assurance Staff
viii. Care Navigator Staff

c. Recommended but not required roles include:
   i. payment specialists (Individual facing),
   ii. intergovernmental liaisons (state agency/city/county facing)
   iii. community resource navigators (Individual facing).
   iv. The BHASO may also employ/subcontract with a board-certified Physician as necessary to establish medical necessity criteria and protocols.
d. Staff may be shared FTE.
e. The following positions should be hired at the BHASO but shall be directly charged to the corresponding Safety Net Service or BHA Program, and will not to be paid out of the BHASO's Administrative Fee:
   i. CYMHTA Clinical Care Coordinator
   ii. CYMHTA Liaison

1.4.5 Background Checks. The BHASO Network's staff who have direct contact with vulnerable persons, including but not limited to staff of the Outpatient Competency Restoration program, shall complete and submit a background check with the Colorado Bureau of Investigation in accordance with C.R.S. §27-90-111. No contact with Individuals shall take place until the background check is completed and passed.

1.4.6 Conflicts of Interest for BHASO Providers. A conflict of interest occurs when an individual or organization has a personal or business interest that conflicts with their professional obligations or responsibilities. If a conflict, the appearance of a conflict, or uncertainty as to if conflict or the appearance of conflict arises either for the BHASO or for a subcontracted BHASO Network provider, the BHASO and/or the BHASO Network provider, as

applicable, shall submit a Conflict of Interest Disclosure Form to BHA as a disclosure statement for BHA's consideration. The BHASO shall follow BHA's direction in regard to the conflict.

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Chapter 5

BHASO Functions

Article 1 - General Functions

Article 2 - Funding and Administrative Costs

Article 3 - Financial Services and Monitoring

Article 4 - Financial Reporting

Article 1 - General Functions

1.5.1.1 Workforce Development

a. Program Description and Objectives

i. Colorado, like many other states, faces a shortage of qualified behavioral health professionals. These workforce shortages are especially acute in rural areas and among priority and underserved populations, where lack of access to services intensifies disparate outcomes and further drives inequity. Further, where social determinants of health such as economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context are often more acute in these populations and contribute to both physical and mental health.

ii. The BHASO shall engage in appropriate workforce expansion and development interventions, as appropriate in its community and based on available funding. Workforce Expansion and Development encompasses recruitment and retention, cultivating a culturally-responsive workforce, and work-based learning to develop career pipelines into behavioral health. The objective of these initiatives is for every person in Colorado to have improved and more reliable access to equitable, high-quality behavioral health care at every stage of life through a strengthened and expanded behavioral health workforce.

b. Activities and Services

i. Promote trainings to upskill and advance the behavioral health workforce, including utilizing the Learning Management System (OwnPath Learning Hub) created by BHA.

ii. Monitor employee attrition and implement mitigation efforts when deemed appropriate by BHASO and employers.

iii. Employ CLAS standards to promote equitable hiring processes.

iv. Build and strengthen career pipelines to move individuals into quality jobs as defined by Colorado Workforce Development Council (CWDC).

v. Develop the workforce to best reflect the community where the services are delivered.

vi. Promote building multidisciplinary teams as appropriate to ensure that individuals are operating at the top of their credentialing.

vii. Network Workforce Studies, The BHASO may be required to participate in future workforce studies initiated by BHA to examine vacancy rates, rates of pay / living wage prevalence, and other market analyses within its Network.

1.5.1.2 Peer Support Professionals

a. BHASOs should encourage and promote ethical peer professional roles in the BHASO Network.

b. Peer Support Professionals, generally.

i. Peer support can be defined as the process of giving and receiving nonprofessional, nonclinical assistance from Individuals with similar conditions or circumstances to achieve long-term recovery from psychiatric, alcohol, and/or other drug-related conditions.[1]

ii. By sharing their own lived experience and practical guidance, Peer Support Professionals help Individuals to develop their own goals, create strategies for self-empowerment, and take concrete steps towards building fulfilling, self-determined lives for themselves. They support Individuals in recovery to connect with their own inner strength, motivation, and desire to move forward in life, even when experiencing challenges.[2]

iii. Peer Support Professionals offer different types of support, including emotional (empathy and camaraderie), informational (connections to information and

[1] Tracy, K. and Wallace, S. *Benefits of peer support groups in the treatment of addiction.* (2017). Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5047716/

[2] Peers Supporting Recovery from Mental Health Conditions. (SAMHSA, 2017). Available at: https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/peers-supporting-recovery-mental-health-conditions-2017.pdf

referrals to community resources that support health and wellness), instrumental (concrete supports such as housing or employment), and affiliation support (connections to community supports, activities, and events).[3]

iv. Peer support is valuable not only for the person receiving services, but also for behavioral health professionals and the systems in which they work. Peer workers educate their colleagues and advance the field by sharing their perspectives and experience in order to increase understanding of how practices and policies may be improved to promote wellness and resiliency. This is particularly important in mental health systems, where historical oppression, violence, and discrimination present significant barriers to recovery for many Individuals. Peer workers play vital roles in moving behavioral health professionals and systems towards recovery orientation.[4]

c. Boundaries for the proper use of Peer Support Professionals. Peer Support Professionals may not be required to complete the following tasks/activities:
   i. Monitoring urinalysis
   ii. Janitorial duties
   iii. Performing clinical/diagnostic assessments, service planning, or treatment
   iv. Medication work monitoring or suggestions
   v. Restraints
   vi. Assessments outside of recovery services
   vii. Give legal advice
   viii. Serve as twelve-step (mutual aid) sponsors
   ix. Any task that the Peer Support Professional has not received sufficient training to complete.

d. If the BHASO Network intends to engage Peer Support Professionals in delivering a billable service, the BHASO Network provider must verify that the Peer is eligible to perform the service per the State Behavioral Health Services Billing Manual produced by HCPF and BHA. This review process may require analysis about how, when, and why to utilize different types of professionals and paraprofessionals in a specific intervention.

[3] (SAMHSA, 2017).
[4] (SAMHSA, 2017).

e. Minimum standards
    i. Certification as a Colorado Peer and Family Specialist is encouraged.
    ii. Reimbursement or stipends for the costs of certification as a Colorado Peer and Family Specialist is an allowable expense of this Contract, as funding allows.
    iii. At minimum, Peer Support Professionals employed by the BHASO or BHASO Network must complete training in the IC&RC Domains of peer recovery[5] and core competencies. Training does not necessarily need to be provided by IC&RC but must be given additional culturally relevant training. Training consists of sixty (60) total hours of training within each of the domains:
        1. Ten (10) hours of Advocacy
        2. Ten (10) hours of Mentoring and Education
        3. Ten (10) hours of Recovery and Wellness Support
        4. Sixteen (16) hours of ethics
        5. Fourteen (14) hours of additional training
            A. Trauma informed care,
            B. Cultural sensitivity,
            C. Whole health,
            D. Substance use,
            E. Mental health, and
            F. Family support if not already covered.

f. The BHASO and the BHASO Network shall promote development and retention of Peers by strategies including but not limited to:
    i. Offer a living wage / competitive pay;
    ii. Invest in Peers' professional development, including creating career pipelines;
    iii. Equipping Peers with effective supervision with effective tools

1.5.1.3 Training and Learning Hub.

a. The BHASO shall maintain annual documentation of all clinical training it provides to its subcontractors, including type of training, training content, total hours completed, and the names and number of participants. All training agencies external to OwnPath Learning Hub must be BHA-approved to establish and provide statewide standards of

[5] *ICandRC Domains of Peer Recovery,* available at https://icaada.org/wp-content/uploads/2021/11/ICRC-Domain-Explanation.pdf .

care. If training modules are developed and provided internally at the BHASO, training content must be submitted to BHA, with as much advance notice as practical prior to the target implementation date for review and approval before providing the training to staff. BHA may review this documentation as part of its monitoring reviews.

b. Training and OwnPath Learning Hub.
    i. BHA operates a learning management system called the OwnPath Learning Hub (Learning Hub). Learning Hub will serve as a central location to provide ongoing, accessible training for the behavioral health workforce in Colorado. Training content will primarily focus on increasing and reinforcing knowledge of Licensed Behavioral Health Providers within the state. Non-licensed support professionals can also access the entire course catalog to increase their knowledge, gain community college credits towards an Associate's degree*, and demonstrate competency required by the BHASO for its Network.
        1. *Not all courses contribute towards associate degrees.
    ii. The BHASO and the BHASO Network shall use the Learning Hub as directed by the BHA in guidance that may be released during the performance period, as amended.
    iii. Learning Hub trainings may be used to meet baseline standard professional development proficiency in the subject matter of the trainings. Where trainings from outside Learning Hub are used, the BHASO shall monitor and audit the trainings to baseline standard professional development proficiency.
        1. Learning Hub trainings must be kept current as BHA, DORA, HCPF or the relevant licensing bodies require.

c. The BHASO shall establish training plans for staff of the BHASO and for staff in the BHASO Network. Staff shall be trained in the following modalities, as appropriate for their position:
    i. Best Practices
        1. Trauma-informed care and trauma resolution
        2. Individual-centered care
        3. Vicarious trauma and burnout of staff
        4. Employee wellness
        5. Tools for understanding progress and barriers to progress, and at a broader level of condition management and outcomes.
        6. Best practices in documentation

7. Crisis Intervention Training (CIT)
8. Intensive family intervention
9. Mental Health First Aid
10. Suicide prevention
11. Telehealth
12. Family and peer support training
13. Conflict resolution
14. Addressing stigma
15. Emergency response and crisis planning
16. Harm reduction
17. BHA Priority Populations - definitions, special considerations, and no-refusal policies
18. Gender-Responsive Services
19. BIPOC centered approaches
20. Cultural competency
21. Implicit and explicit bias
22. Availability and access of linguistic/translation services, including interpreters for the deaf and hard of hearing
23. LGBTQ+ competency, including serving transgender or gender non-conforming Individuals
24. Social-emotional therapies for understanding STI and HIV diagnosis
25. Children and youth best practices
26. Older adults
27. Inclusive disability practices for staff and Individuals served
28. Criminal justice proceedings and competency/competency restoration requirements (required for BHASO Network providers serving justice-involved Individuals
29. Intellectual and Developmental Disabilities, dementia and cognitive disabilities and how to distinguish from a behavioral health crisis

ii. BHASO / Provider Operations

1. Ethical and legal considerations
2. Interprofessional collaboration
3. Quality improvement
4. Resource availability (both behavioral health and SDOH)

5. RAE vs. BHASO role
6. Child welfare - case workers' roles vs. BHASO/provider roles

1.5.1.4 Network Communication. The BHASO shall maintain consistent communication, both proactive and responsive, with the BHASO Network and promote communication among BHASO Network providers.

1.5.1.5 Continuity of Operations Plan

a. In the event of an emergency resulting in a disruption of normal activities for longer than three business days, BHA may request that the BHASO provide a plan describing how the BHASO will ensure the execution of essential functions of the Contract, to the extent possible under the circumstances of the inciting emergency ("Continuity of Operations Plan" or "Plan").
b. The Continuity of Operations Plan must be specific and responsive to the circumstances of the identified emergency.
c. BHA will provide formal notification of receipt of the Continuity of Operations Plan to the BHASO.
d. Any necessary budget or contract term changes will be incorporated by a Contract Amendment. The BHASO's performance will be held to the same standards and requirements as the original Contract terms, unless otherwise specified in the Continuity of Operations Plan.
e. Any submitted Continuity of Operations Plan will serve as an amendment to the contract for the timeframe identified and agreed to by BHA and the BHASO.
f. The BHASO shall communicate, in a format mutually agreed upon by BHA and BHASO staff, on a frequency that supports the monitoring of services under the Continuity of Operations Plan. If adjustments are needed to the Plan, such adjustments will be made in writing and accompanied by written notice of receipt from BHA.
    1. As part of the BHA/BHASO communication during the emergency, the BHASO and BHA will evaluate whether the emergency has been resolved such that normal operations may be resumed.
    2. The BHASO and BHA will agree in writing when the emergency situation is sufficiently resolved and agree to a closeout period that is four weeks or less.

3. BHA will submit a notice accepting the termination of the Continuity of Operations Plan to the BHASO as the final action for any qualifying emergency response.

1.5.1.6 Licensing and Designation Database Electronic Record System (LADDERS). The BHASO Network shall use LADDERS (https://www.colorado.gov/ladders) as needed and/or as required by rule to submit applications for BHA licensing and designation, keep current all provider directory details, update daily bed counts (as applicable based on contract requirements), and submit policies and procedures. (Parts 2.18, 2.20, and 2.23 of 2 CCR 502-1). BHA will provide the BHASOs with access to LADDERS provider licensing applications to verify standards, and to avoid duplicate reporting of this information by providers.

1.5.1.7 Outreach and Marketing.

a. Reports or Evaluations. All reports or evaluations funded by BHA must be reviewed by BHA staff, including but not limited to the program, data, and communications teams. The BHASO shall provide a draft version of their report or evaluation in an editable Word or Google document no fewer than fifteen (15) business days before the final deliverable date for BHA staff review. If report design is included as part of the deliverable, the BHASO shall clearly communicate the deadline by which the draft with any edits and feedback must be returned by BHA staff to the BHASO so they may have the appropriate amount of time to design the final, approved content. The BHASO shall make documents accessible and are encouraged to utilize resources from the Colorado Office of Information Technology (OIT) at oit.colorado.gov/standards-policies-guides/guide-to-accessible-web-services/accessible-pdfs-and-documents. The BHASO may be asked to place a report or evaluation on a BHA template and the report or evaluation may be required to display the BHA logo with an attribution such as "Funding provided for this [work/report/evaluation] by". The BHASO shall submit the finished document to BHA in its final format (e.g. a PDF file) and as an editable Word or Google document. Reports and evaluations may be posted on the BHA website.
b. Press Releases. All press releases about work funded by BHA must note that the work is funded by the Colorado Department of Human Services, Behavioral Health Administration. Press releases about work funded by BHA must be reviewed and approved by BHA program and communications staff.

c. Media Requests. To the extent BHA has access to information in the BHASO's possession or control per this Contract, if BHA receives a media request for this information, the BHASO must provide the requested information by the deadline provided, unless the requested information is protected by HIPAA or statutory rules.
    i. When the BHASO receives media requests about BHA funded services or programs, the BHASO shall include BHA to review and approve responses. The BHASO shall not respond on behalf of BHA or do media interviews on BHA-funded programs or services without BHA approval.
d. All Other Documents. All other documents published by the BHASO about its BHA-funded work, including presentations or website content, should mention or identify the Colorado Department of Human Services, Behavioral Health Administration as a funder.
e. Opinion of BHA. BHA may require the BHASO to add language to documents that mention BHA reading: "The views, opinions and content expressed do not necessarily reflect the views, opinions or policies of the Colorado Department of Human Services, Behavioral Health Administration."
f. Colorado Open Records Act (CORA): The BHASO acknowledges that BHA may receive CORA requests to which the BHASO holds responsive records. BHASO must engage in timely communication, timely respond to inquiries from BHA, and timely produce responsive records or a cost estimate to ensure BHA can meet statutory deadlines.

Article 2 - Funding and Administrative Costs

1.5.2.1 Annual Budget

a. Exhibit B - Budget represents the annual budget provided by BHA to the BHASO encompassing all BHASO costs for the administration of the system and for the provision of all services within its Region.

1.5.2.2 Annual Network Proposal.

a. The BHASO shall draft a proposal prior to the beginning of each fiscal year to communicate which BHA Programs will be provided in the BHASO region and to project an approximate budget dedicated to each safety net serviced and BHA program
    a. DELIVERABLE: Network Draft

b. DUE DATE: mutually determined by BHA and BHASO following BHA's annual Figure Setting session.
c. DESTINATION: cdhs_BHASO_deliverables@state.co.us
d. FILE NAME: BHASO Region [X] – [BHASO] – [FYXX] – Network Draft

1.5.2.3 Budget Reallocations. The BHASO may reallocate funds between the budget categories of this Contract, up to twenty percent (20%) of the total Contract budget amount, upon written approval by BHA, without a contract amendment. Any allowable reallocation is still subject to the limitations of the Not to Exceed and the Maximum Amount Available per Fiscal Year. Budget Reallocations that exceed the 20% threshold must be requested and approved by BHA no later than May 15. Requests that are submitted later than this may not be able to be considered.

1.5.2.4 Regional Work Plan. The BHASOs shall submit a Regional Work Plan that details their approach to Part Two – Care Coordination, and Part Three – Safety Net Service Networks. The Plan shall include, at minimum: Description of services, related to each Chapter and Article of programming; focused efforts or goals; client count goals and goal progress; areas of success; areas of challenge; capital project description, if applicable; and mechanism for collecting data submitted by provider, which may include BHASO resources or BHA managed data systems. Regional Work Plans shall be submitted quarterly and include updates relevant to each quarter.

a. DELIVERABLE: Regional Work Plan – Updated Quarterly
b. DUE DATE: Original Work Plan is due 6/30; Quarterly Updates are due close of quarter post 30 days.
c. DESTINATION: cdhs_BHASO_deliverables@state.co.us
d. FILE NAME: Region[X] - [BHASO] - FY[XX] - Regional Work Plan

1.5.2.5 Funding Allocation Matrix.

a. The BHASO shall submit a funding allocation matrix of its subcontractor allocations on the template developed with BHA.
b. The matrix shall account for all funding contributing to the services described in this Contract received from this Contract.

c. Providers of all direct services must be identified. If any subcontractors in turn subcontract for direct services with BHA funding, those subcontractors must also be identified in the matrix.
d. The matrix shall indicate the payment methodology for each service (e.g. fee for service, capacity).
e. The matrix shall include the BHASO's Administrative Fee for each budget line item in the Contract.
    i. DELIVERABLE: Funding Allocation Matrix
    ii. DUE DATE: August 31 annually
    iii. DESTINATION: cdhs_BHASO_deliverables@state.co.us
    iv. FILE NAME: BHASO Region[X] - [BHASO] - FY[XX] - Funding Allocation Matrix
f. The sum of this matrix shall equal the total contract dollars as specified in Exhibit B - Budget of this contract.
g. The BHASO shall update and resubmit the matrix quarterly.
    i. DELIVERABLE: Updated Funding Allocation Matrix
    ii. DUE DATE: end of quarter plus one week.
    iii. DESTINATION: cdhs_BHASO_deliverables@state.co.us
    iv. FILE NAME: BHASO Region[X] - [BHASO] - FY[XX]Q[X] [Month] - Updated Funding Allocation Matrix

1.5.2.6 Funding Sources.

a. BHA will provide a source funding matrix identifying the various state funds and federal grants which fund the BHASO's contract. BHA will also provide a funding manual detailing allowable expenses and grant terms and conditions. See also Exhibits E-H for federal funding terms and conditions.
b. The BHASO shall identify all funds delivered to subcontractors as state general fund, state cash funds, or federal grant dollars in the subcontract's budget. If the subcontractor receives federal grant dollars, the BHASO shall communicate the assistance listing number in the appropriate subcontracts and ensure compliance with 2 CFR 200.332.
c. The BHASO may braid or leverage Contract funds with other funding sources in order to enhance services and/or expand capacity to serve Individuals in its Region.

d. If the BHASO uses any BHA funds for matching purposes, the BHASO shall bear all risk when matching funds; and BHA shall not guarantee ongoing match for the BHASO's grant match programs. Federal funds may not be used as a match for Federal funds.

1.5.2.7 BHASO Administrative Fee.

a. The BHASO may apply an Administrative Fee for purposes of managing the Contract, in the percentage rate established in Exhibit B, Budget, but in no event greater than ten percent (10%) of the BHASO's expended contract amount, unless the administrative or indirect rate for a particular funding stream is limited for other reasons. The BHASO shall invoice for the Administrative Fee in its quarterly invoice. The administrative fee shall be reconciled upon the report of quarterly actual expenditures pursuant to Part 1, Chapter 5, Article 3 - Financial Services and Monitoring.
b. The Administrative Fee supports the costs of:
    i. Network development and maintenance
        1. Monitoring and responding to changes in service needs and barriers
    ii. Operation of the Care Navigation Line described in Exhibit A, Part Two, Article 1 - Care Coordination.
    iii. Data collection, analysis, and reporting
    iv. Quality monitoring and improvement
    v. Community and provider outreach and education
    vi. Fiscal management and timely payment services
    vii. Overhead such as legal, human resources, insurance, information technology, and other expenses of the BHASO organization.
c. The BHASO administrative fee is inclusive of all indirect costs and no additional indirect cost recovery shall be charged.
d. On a quarterly basis, the BHASO administrative fee will be reconciled to the agreed upon administrative fee percentage, unless a particular funding stream is limited, of the expended contract amounts based upon the Quarterly Expenditure Reconciliation Report in section 1.5.3.2.

1.5.2.8 Cost Allocation Plan. If income from BHA for BHASO services is less than 80% of the BHASO's total income the BHASO must develop and report to the BHA a cost allocation plan for distribution of salaries, operating, and other indirect costs.

1. DELIVERABLE: Cost Allocation Plan
2. DUE DATE: December 30 annually
3. DESTINATION: cdhs_BHASO_deliverables@state.co.us
4. FILE NAME: BHASO Region [x] - [BHASO] - FY[XX] Cost Allocation Plan

1.5.2.9 Invoicing Process

a. Fund advance invoicing
    i. On a quarterly basis, BHASOs will invoice BHA for a fund advance.
    ii. The fund advance shall be stored in a separate fund and/or account on its financial statements and shall be considered unearned revenue.
    iii. The fund advance creates a fund from which the BHASO shall pay provider invoices.
    iv. The BHASO Administrative Fee is earned as it is applied to the total amount of each provider invoice paid. Administrative Fee is not earned at the time of the fund advance.
        A. Any Administrative costs of the BHASO which are separate from the administrative fee applied to each invoice shall be earned on a monthly basis based on actual costs.
b. Fund Advance Invoicing process and schedule
    i. The BHASO shall submit invoices on a template provided by BHA.
        A. The invoice must be specific and reference each commodity line that is intended to be drawn down.
        B. The BHASO must employ systems that allow the BHASO to track each dollar by BHA commodity line.
    ii. The BHASO shall invoice BHA on the following schedule:
        A. July 1: 20% of annual contract value
        B. October 1: 20% of annual contract value
        C. January 1: 20% of annual contract value
        D. April 1: 20% of annual contract value
        E. Final end of year invoice: 20% of annual contract value.
            1. The final end of year invoice is due September 15.
            2. The final end of year invoice will be used to reconcile payments against the advance payments in past quarters. Payment will be

contingent upon satisfactory performance of the terms and conditions of this Contract through the end of the Fiscal Year.

3. Invoiced amounts may be adjusted based on findings from reconciliation process.

c. BHA may authorize a payment outside of the advance payment structure described above if the BHASO can describe and demonstrate the need. The BHASO must submit a written request for out-of-sequence payment that identifies the services to be provided, the appropriations from which payment would be made, the amount of the payment requested, and a plan identifying why the out-of-sequence payment will not have adverse impact on spending for the remainder of the contract period. The request must be submitted at least 30 calendar days before the BHASO needs to receive funds. Nothing in this section guarantees payment to be made in a period shorter than the 45-day state statutory invoice payment window. BHA will consider the request and provide an approval, disapproval, or request for more information within three (3) business days. Nothing in this section permits total payment to exceed the Maximum Contract Amount identified on the cover page for this Contract.
d. GAE Invoicing. Invoices against the General Accounting Encumbrances associated with this Contract are due to BHA by the last day of the month following the month of service.

1.5.2.10 Reconciliation Process

a. BHA will develop a Reconciliation File based on the BHASO's Funding Allocation Matrix.
b. On a monthly basis, the BHASO will report actual expenditures on the Monthly Actuals Expenditures template within 45 days after the month of service.
c. The expenditure reconciliation will contain detailed information pertaining to the payments made to subcontractors inclusive of references to the related Funding Allocations for each Contract Statement of Work Article and corresponding commodity line.
d. In addition to the Monthly Actuals Expenditures being submitted on a monthly basis, BHASOs shall be allowed to "cure" the quarter within 75 days post quarter by submitting a "version b" of the Monthly Actuals Expenditure template for the month where a necessary adjustment needs to be made.

e. In a circumstance where BHASO has missed the 75-day post quarter cure date, and requires an adjustment, BHASO will contact BHA's fiscal reviewer to request approval to submit a late adjustment.

f. Desk Audit. Each month, the BHA BHASO team and BHA Accounting team will identify a sampling of transactions to desk audit, inclusive of financial and programmatic information. BHASOs shall comply with the BHA desk audit procedural manual.

g. BHASO Network Payment Reconciliation Exception Process.

   i. BHASO Network providers may request that BHASO not reconcile their payments under the following terms and limitations.

   ii. The request must:

      A. Identify the Article(s) in Part 2 or Part 3 of this Agreement for which payment reconciliation is requested to be waived.

      B. Provide justification for the request.

      C. Identify an action plan with specific commitments and timelines to come into compliance so that reconciliations may be performed per the standard process identified in 1.5.2.10(a-f) above.

         1. Reconciliation Milestones. Providers that receive waivers will work towards these reconciliation milestones. If a BHASO Network provider has not achieved any given milestone at the time of the waiver request, the action plans in the request shall provide a plan to remediate the issue.

            a. Encounter submissions are properly submitted and are timely and accurate.

            b. Cost centers and applicable offsets and revenue streams are identified for each waived Article to support capacity budgeting.

            c. Provider's fiscal processes, capabilities and staffing demonstrate readiness to perform standard reconciliation.

            d. Provider has established financial readiness to accept reconciled payment.

   iii. BHASO and BHA will review the request and must both agree to approve.

   iv. The increment of time for non-reconciliation shall not exceed one quarter per request. Requests for each quarter must be submitted separately.

v. Provider payments will move to standard reconciliation as of the State Fiscal Year 2027 beginning July 1, 2026.

vi. BHASO Network provider must still deliver all available documentation, including capacity budgets, invoices, and encounters as required under the Articles included in the request for non-reconciliation.

1.5.2.11 Indirect Rates for Providers

a. If a network provider has a federally-negotiated indirect rate, the BHASO must use that rate in its subcontracts, unless otherwise limited by statute or a federal grant.
b. If a network provider has a State-negotiated indirect rate, the BHASO must use that rate in its subcontracts, unless otherwise limited by statute or a federal grant.
c. If a network provider has never had a federally-negotiated indirect rate, the BHASO may use a fifteen (15%) percent de minimis rate.
d. If an indirect rate is limited by statute or funding regulations, that rate shall prevail.

1.5.2.12 Payor of Last Resort.

a. The BHASO shall ensure that all billable services are submitted to Medicaid and other third-party payors and that BHA funding is used to reimburse providers as the payor of last resort. BHASO Network providers may not use BHA funds to pay for Medicaid-covered services for Medicaid-enrolled individuals.
b. If the BHASO contracts with a provider for a Medicaid covered service that is not yet Medicaid enrolled, the provider must obtain Medicaid enrollment within six months, at which point the BHASO must terminate its agreement if enrollment has not been achieved. The BHASO may request an extension from BHA in the event of extenuating circumstances. The BHASO must provide details on the attempts to enroll in Medicaid and the extenuating circumstances regarding the enrollment process.

1.5.2.13 Capital Expenditures.

a. Unless otherwise stated in the Statement of Work, capital costs are not allowable expenses.
b. When capital costs are allowable expenses, the following terms apply:
    i. The BHASO Network provider shall track and be able to identify grant-purchased capital assets separate from their own non-grant related capital assets. The BHASO Network provider is required to contact and confirm with

the BHASO and BHA in any circumstance where they intend to dispose of the asset(s).

ii. BHASO Network provider may obtain, or renovate a facility to house the programming, or purchase capital assets if permissible by the terms of the program's Statement of Work and included in the approved budget.

iii. For capital projects or investments exceeding $50,000, BHASO Network provider shall draft a capital investment work plan and detailed budget for the expansion or renovation project identifying timelines, necessary zoning, licensing, fire safety, and budgetary execution milestones due 30 calendar days after contract / amendment execution initiating such work to the BHASO.

iv. The BHASO shall coordinate monthly progress calls with the BHA BHASO Region Manager regarding the project management timeline and any barriers to completing the project on-time.

v. The BHASO shall notify BHA BHASO Region Manager when the capital project is delayed from the agreed upon project work plan. BHASO Network provider must receive approval for initiating next steps with a delayed project work plan. The BHASO Network provider's contract must also revise and receive approval for the work plan to accommodate the change in schedule.

vi. The BHASO Network provider must allow BHASO and BHA to conduct site visits as necessary.

vii. The BHASO shall provide an annual property inventory report summarizing all BHA capital investments in its Region, including item description, what it is used for, purchase price, condition, asset number, and address.

   A. DELIVERABLE: Property Inventory Report
   B. DUE DATE: 30 days following the end of the Fiscal Year, including at final closeout.
   C. DESTINATION: cdhs_BHASO_deliverables@state.co.us
   D. FILE NAME: BHASO Region [x] - [BHASO] - FY[XX] Property Inventory Report

viii. The BHASO shall collect proof of acceptance by the BHASO Network provider and/or operability of the capital investment prior to receipt of final payment for capital item.

ix. During the period of performance, a BHASO Network provider may use property, supplies, or equipment purchased with BHA funding for a purpose

other than the purpose for which it was purchased or improved if such other purpose is also consistent with the funding requirements.

x. If a BHASO Network provider changes the use of an asset to an ineligible use or sells the asset prior to the end of the period of performance, then the recipient must follow the disposition procedures in the Uniform Guidance. See 2 CFR 200.311, 200.313, 200.314, and 200.315.

xi. After the period of performance, the property, supplies, or equipment must be used consistent with the purpose for which it was purchased or for any other eligible purpose in alignment with the funding source.

xii. If an asset's use shifts within the parameters of the eligible purpose after the period of performance, no repayment would be required.

xiii. If an asset's use shifts outside the parameters of the eligible purpose after the period of performance, then the subrecipient must follow the disposition procedures in the Uniform Guidance. See 2 CFR 200.311, 200.313, 200.314, and 200.315. Contact BHA Fiscal officials for disposition instructions for items with a per unit fair market value of $5,000 or more at time of disposition.

xiv. Recipients are responsible for being able to substantiate their determinations on whether the use of an asset is authorized and maintain a record of that determination in accordance with the requirements set forth in the financial assistance agreement accepted in connection with their award. Subrecipients are not required to seek or obtain the approval of Treasury prior to changing the use within the parameters of the authorized purpose.

xv. The BHASO Network provider shall maintain property records for the duration of the award and at minimum three (3) years after final report which at a minimum include:

A. a description of the property
B. a serial number or other identification number
C. the source of funding for the property (including the FAIN)
D. who holds title
E. the acquisition date(s)
F. cost of the property
G. percentage of Federal participation in the project costs for the Federal award under which the property was acquired.
H. the location, use and condition of the property.

l. Any ultimate disposition data including the date of disposal and sale price of the property.

Article 3 - Financial Services and Monitoring

1.5.3.1 BHASO Network Payment.

a. The BHASO shall establish and apply efficient, timely, and accurate billing and payment procedures affecting the BHASO Network.
b. The BHASO shall track services and costs incurred by funding source and be capable of supporting costs with source documentation.
c. The BHASO shall review invoices from the BHASO Network for accuracy and compliance with terms of the contract and any federal award funding.
d. The BHASO shall remit payment to the BHASO Network within thirty (30) days of receipt of a correct and complete invoice from a BHASO Network provider. This timeliness requirement does not apply if the provider is under audit or corrective action by the BHASO or if the provider is delinquent in providing deliverables.

1.5.3.2 Finance and Data Protocols. The BHASO and the BHASO Network shall comply with the Behavioral Health Administration's (BHA) most current Finance and Data Protocols and the Behavioral Health Accounting and Auditing Guidelines, made a part of this Contract by reference.

1.5.3.3 Provider Audits

a. The BHASO is responsible for the collection and review of:
    1. the provider's single audit, if the provider meets the threshold; or
    2. the provider's audited financials, if available; or
    3. unaudited financial statements if single audit does not apply.
b. The audit requirements listed in 1.5.3.4.a does not apply to BHASO subcontractors who are not classified as subrecipients.
c. The BHASO shall collect one copy of each subrecipient's audit report, together with associated special reports, the management letter, and any auditor's opinion letter no later than nine months after the close of the subcontractor's fiscal year.

d. The BHASO shall require a special audit test/auditors' statement as part of single audit reviews or financial review statements that state that the provider has adhered to all SUPTRS fiscal expenditure restrictions and requirements.
e. The BHASO need not submit copies of the subrecipient audits to BHA, though they should be available upon request.
f. BHA will provide a Desk Review Checklist (template provided by BHA) to track the subcontractors' audits.
    1. DELIVERABLE: Desk Review Checklist.
    2. DUE DATE: May 31 annually.
    3. DESTINATION: cdhs_BHASO_deliverables@state.co.us
    4. FILE NAME: BHASO Region [x] - [BHASO] - FY[XX] Desk Review Checklist

1.5.3.4 Fiscal Contract Monitoring Instrument

a. For federally funded programs and services, the BHASO Network providers are considered subrecipients and the BHASOs are passed through subrecipient monitoring responsibilities in accordance with 2 CFR 200.332(d).
b. The BHASO shall conduct at least one financial review using the fiscal contract monitoring instrument of each subrecipient provider receiving federal funds on the template provided by BHA.
    i. When the BHASO executes subcontracts with BHASO Networks providers during the Start-Up Period, the BHASO shall complete a fiscal contract monitoring instrument for each subcontractor throughout the annual Term but no later than May 31.
    ii. BHASO Network providers who are determined to be low-risk in the initial fiscal contract monitoring review may be visited at a minimum every three years after the initial review.
    iii. Providers with previous adverse findings or higher needs for technical assistance should be visited more frequently than the minimum requirement. BHASOs may enforce and implement additional monitoring activities and requirements based upon their implementation of 2 CFR 200.332(d).
    iv. The BHASO shall submit Fiscal Contract Monitoring Instruments per the instructions below

1. DELIVERABLE: copy of the completed Fiscal Contract Monitoring Instrument
2. DUE DATE: within fourteen (14) calendar days of the time that the BHASO sends the reports to the audited subcontractor, no later than May 31 each year.
3. DESTINATION: cdhs_BHASO_deliverables@state.co.us
4. FILE NAME: BHASO Region [x] - [BHASO] - FY[XX] [Provider] Fiscal Contract Monitoring Instrument

c. For wholly state-funded agreements and for federal subrecipient agreements for programs and services receiving under twenty thousand dollars ($20,000) annually, the BHASO shall ensure that BHASO Network providers have adequate internal controls, are financially sound, services billed to the state align with required statutes, are reasonable in cost, and maintain adequate supporting documentation for the expense.

1.5.3.5 Subrecipient Performance Report and Assessment. BHA is required annually to assess subrecipients of federal funds using the Subrecipient Performance Report and Assessment. The BHASO will receive this assessment from BHA annually, in Spring (fourth quarter of the State Fiscal Year). The BHASO must complete the assessment and return to BHA no later than the deadline listed in the assignment.

1. DELIVERABLE: Subrecipient Performance Report and Assessment
2. DUE DATE: listed in assignment email
3. DESTINATION: online form with certification to cdhs_BHASO_deliverables@state.co.us
4. FILE NAME: BHASO Region [x] - [BHASO] - FY[XX] [Provider] Subrecipient Performance Report and Assessment

1.5.3.6 Program Income. Program income generated through federal grant funded programs is additive funding that must be utilized for a consistent purpose as outlined in 2 CFR 200.307(e)(2). If the BHASO or the BHASO Network charges and receives fees for services, or otherwise receives income associated with the sponsored program (such as sliding scale fees assessed on federally-funded programs), this is considered program income and is required to be tracked and managed in accordance with the conditions of the award.

1.5.3.7 Prior Approval.

a. The BHASO shall obtain BHA approval prior to incurring the following costs at the BHASO or provider level: gift cards; incentive payments to clients; costs that may be considered entertainment; promotional items; fines, penalties, or damages; other costs the BHASO is concerned may be subsequently disallowed.

1.5.3.8 Start-up Costs.

a. If BHA reimburses the BHASO for any start-up costs for the BHASO or for a BHASO Network provider, and the BHASO/BHASO Network closes the program or facility within three years of opening, or longer if specified by the funding source, the BHASO shall reimburse BHA for one-hundred percent (100%) of said start-up costs within sixty (60) days of the closure.
b. If BHA reimburses the BHASO for any start-up costs for the BHASO or for a BHASO Network provider, and the BHASO/BHASO Network closes the program or facility within five (5) years of opening, or longer if specified by the funding source, the BHASO shall reimburse BHA for fifty percent (50%) of said start-up costs within sixty (60) days of the closure.
c. The BHASO is not required to reimburse the State for start-up costs if the facility or program closure is due to BHA eliminating funding to that specific program and/or budget line item.

Article 4 - Financial Reporting

1.5.4.1 Medicaid Management Information System (MMIS)

a. The BHASO shall enroll in the Medicaid Management Information System (MMIS), also known as “interChange (iC)") within thirty (30) days of contract execution.
b. BHASO Network Providers are also required to enroll in the MMIS, if not already enrolled, and add the BHA Payer. The BHASO will assist BHASO Network Providers with this process.
c. If required by the BHASO, enrolled BHASO Network Providers must update their provider information in the MMIS portal to affiliate with the BHASO during the time that the contractor enrolls in MMIS.

1.5.4.2 Medicaid Eligibility, generally. The BHASO Network shall verify if an Individual is Medicaid eligible within one business day of a non-emergency service. If the Individual is found to be Medicaid eligible and not yet enrolled, the BHASO Network shall offer to assist the Individual to enroll in Medicaid. BHASO and BHASO Provider Network shall utilize the PeakPro System, or the MMIS Provider Portal, to review Medicaid eligibility, and attempt to enroll the Individual if they have not applied within the last 12 months. If an Individual is Medicaid eligible and enrolled and Medicaid covers the services, Medicaid must be billed for those services.

1.5.4.3 PeakPro System. The BHA is implementing the utilization of PeakPro for Providers of BHA services. This is a tool offered to providers to streamline Medicaid eligibility verification as well as Individual enrollment into Medicaid and the BHA services. BHASOs and BHASO Network Providers will be required to utilize PeakPro to (1) verify Medicaid eligibility, (2) assist with enrollment into the Medicaid program when requested or appropriate, and/or (3) obtain a state identifier for an individual.

Training and access for PeakPro will be provided by the BHA. Contractors and subcontractors will participate in applicable workgroups, training, and testing activities. Upon access and training, subcontracted providers shall begin to implement PeakPro into operations. BHASOs and the BHASO Network Providers are required to reference either the Medicaid ID or the state identifier on encounter submissions.

1.5.4.4 Financial Statement. The BHASO shall provide the financial information below to BHA. BHA will post the financial information below on its website using plain language that is easy for Individuals and members of the public to understand:

a. A Federal form 990 of the BHASO
    i. If the BHASO is not a nonprofit organization, the BHASO shall provide its publicly audited financial statements within fifteen (15) days of the federal submission deadline.
b. The percentage and aggregate dollar amount of expenses that go toward indirect and administrative functions.

c. The BHASO's audited financial statement including balance sheet, income statement, and statement of cash flows, to disclose the amount of money in the BHASO's reserves.
    i. If the BHASO is a for-profit organization, the BHASO shall have a major program audit conducted on SAMHSA major programs listed in the annual compliance supplement by an independent CPA firm. The program audit shall be submitted to the BHA within (30) days of receipt.
d. The BHASO may include an Annual Report to improve upon the understandability of the financial statements from the perspective of the Individual.
    i. DELIVERABLE: Financial Statement
    ii. DESTINATION: cdhs_BHASO_deliverables@state.co.us
    iii. DUE DATE: within 30 days of BHASO's 990 filing, or if the BHASO is not a nonprofit organization, the BHASO shall provide its publicly audited financial statements within 15 days of the federal submission deadline.
    iv. FILE NAME: BHASO Region[X] - [BHASO] - FY[XX] - 990 [OR] Audited Financial Statement

1.5.4.5 Unit Cost Report. The BHASO will ensure that each Comprehensive Community Behavioral Health Provider submits an annual unit cost report. BHASO must ensure that CCBHPs within their network collaborate and cooperate with the HCPF identified cost report auditor, including areas of auditability and/or allowable/unallowable expense"

a. DELIVERABLE: Unit Cost Report
b. DUE DATE: November 30 annually
c. DESTINATION: cdhs_BHASO_deliverables@state.co.us
d. FILE NAME: BHASO Region[X] - [BHASO] - FY [Prior year FY] - [Provider] - Unit Cost Report

1.5.4.6 Civil Forfeiture. Pursuant to C.R.S. §16-13-311 (3)(a) (VII) (B) and §16-13-701 (4), the BHASO shall submit an annual Civil Forfeiture Report detailing the amount of annual and historical forfeiture revenue received for the previous state fiscal year by judicial district; and the amount of annual and historical expenses by treatment provider and by judicial district.

a. DELIVERABLE: Civil Forfeiture Report

b. DUE: August 31 annually
c. DESTINATION: cdhs_BHASO_deliverables@state.co.us
d. FILE NAME: BHASO Region [x] - [BHASO] - FY[XX] Civil Forfeiture Report

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Chapter 6
Network Development

Article 1 - Establishing a Network
Article 2 - Network Adequacy and Access to Care Standards

Article 1 - Establishing a Network

1.6.1.1 Network Procurement. The BHASO shall adhere to the following terms in selecting providers for its Network:

a. BHA deems providers of behavioral health services as subrecipients for the purposes of §200.331, § 200.333, and 2 C.F.R. § 200.320.
b. The BHASO shall have a fair and reasonable way to evaluate its subawards. The BHASO shall provide justification of individual awards or non-awards at BHA request.
c. The BHASO Network providers must be paid according to terms in payment exhibit/SOW payment terms.
d. BHASO shall regularly give the community the opportunity to express interest in joining the Network.
e. BHA retains the right to have final approval of subawards.

1.6.1.2 Service Delivery

a. The BHASO shall establish, administer, and maintain adequate networks of all Behavioral Health Safety Net Services and Care Coordination in its Region.
b. The BHASO shall form a network of providers that collectively offer a full continuum of Behavioral Health Services in its Region.
c. The Behavioral Health Safety Net Services are:
    i. Emergency or crisis behavioral health services;
    ii. Withdrawal management services;
    iii. Mental health and substance use outpatient services;
    iv. Outpatient competency restoration;
    v. Behavioral health high-intensity outpatient services / Hospital alternatives;
    vi. Behavioral health residential services;

vii. Behavioral health inpatient services;
viii. Integrated care services;
ix. Mental health and substance use recovery supports;
x. Outreach, education, and engagement services;
xi. Care management;
xii. Screening, assessment, and diagnosis, including risk assessment, crisis planning, and monitoring to key health indicators;
xiii. And additional services that the BHA determines are necessary in a Region or throughout the state and based on available funding.

d. BHASO must make each Safety Net Service reasonably available (determined by BHA System Rule) in its Region. BHASOs have flexibility to meet this requirement by providing any service that 1) meets the requirements of the "General Safety Net Service Terms" Article in each Chapter in Parts Two and Three and 2) is tailored to meet the behavioral health needs of its population and/or the communities it serves. Examples of programs that may be developed and implemented to meet each required Safety Net Service can be found in the "BHA Program" scopes of work in each service's Chapter, as funded by the budget and directed by BHA in order to meet a standard of reasonable availability determined by BHA. BHA may require participation in certain BHA Programs, funding permitting. BHA may require shifts in funding between services or Regions to address reasonable availability of Safety Net Services or other state priorities.

1.6.1.3 Considerations in Forming a Network

a. The BHASO shall take the following into consideration when establishing and maintaining the BHASO Network:
i. The anticipated number of Priority Population Individuals in the Region.
ii. The expected utilization of services, taking into consideration the characteristics and behavioral health care needs of specific communities represented.
iii. The numbers and types (in terms of training, experience and specialization) of providers required to furnish the Safety Net Services.
iv. The numbers of participating providers who are accepting new Individuals.

v. The geographic location of providers and Individuals in the Region, considering distance, travel time, the means of transportation ordinarily used by Individuals, Individuals' access to transportation and whether the location provides physical access and accessible equipment for Individuals with disabilities.

vi. The BHASO shall develop and implement a strategy to recruit and retain qualified, diverse and culturally responsive providers including, but not limited to, providers who represent racial and ethnic communities, the deaf and hard of hearing community, the disability community and other culturally diverse communities who may be served.

vii. The BHASO may use mechanisms such as telemedicine to address geographic barriers to accessing clinical providers from diverse backgrounds or accessing services for Individuals with geographic/transportation barriers to treatment.

1.6.1.4 Subcontracting for a Network / Prioritization of Safety Net Providers.

a. Except where this Contract states explicitly that a service must not be subcontracted, the BHASO may enter into subcontracts or other forms of legally binding agreements with appropriately licensed and State-approved entities for the performance of services required under this contract.
    i. The BHASO shall be responsible for the delivery of all services set forth in this contract
b. In accordance with C.R.S. §27-50-304, the BHASO must establish and follow a procedure to prioritize subcontracts with Comprehensive Behavioral Health Safety Net Providers approved by BHA.
c. The BHASO may contract with an Essential Behavioral Health Safety Net Provider to provide a Safety Net Service or services, including those determined necessary pursuant to C.R.S. §27-50-301(3)(a)(XV), to only one or more specific underserved populations within the Priority Populations.
d. The BHASO may contract with non-Safety Net Providers as needed.
e. Wherever possible, to decrease administrative burden, the BHASO is encouraged to braid multiple funding streams (and associated requirements) on one Contract to a provider, rather than maintaining separate contracts for same or similar services paid by different funding sources.

1.6.1.5 Subcontract Procedure.

a. The BHASO shall amend subcontracts when necessitated by amendments to this Contract within sixty (60) Calendar Days of execution of the amendment to this Contract.

b. The BHASO shall submit a copy of any subcontract or agreement, or amendments thereto, to BHA. Subcontract terms shall include but are not limited to:

   i. Name, address, and type of organization.

   ii. Statement of ownership, including full disclosure of BHASO employees or related parties with a financial interest in the subcontracted organization.

   iii. Description of services to be provided, Priority Populations to be served, admission requirements, Individual rights and accessibility to services, rates of reimbursement, billing procedures, timetables, remedies for late payment, and other applicable matters.

   iv. Procedures for transmittal to the BHASO of data and information on the services provided and recipients served, including a reproduction of the most recent CDHS version of the HIPAA Business Associates Addendum.

   v. Procedures the BHASO will use in monitoring the performance of the subcontractor.

   vi. Provision to hold BHA harmless in the event of any dispute between the BHASO and the subcontractor.

   vii. The BHASO shall incorporate all Exhibits to this Contract by reference or attachment to all subcontracts between the BHASO and the subcontractors. Any and all subcontracts receiving federal block grant funding must include the applicable Block Grant or Discretionary Grant Contract Exhibits, reproduced in its entirety, and must incorporate by reference the applicable terms and conditions of this Contract.

      1. DELIVERABLE: Subcontracts
      2. DUE DATE: within fourteen (14) days of execution
      3. DESTINATION: cdhs_BHASO_deliverables@state.co.us

c. The BHASO shall not contract with a provider or organization that is debarred from receiving federal funding. The BHASO must have a procedure to check SAM.gov and/or HHS exclusions database annually prior to executing or renewing subcontracts.

d. The BHASO shall be responsible for the performance of any subcontractor, and failure of the subcontractor to provide services in accordance with the requirements of this contract shall be the responsibility of the BHASO. No subcontract shall operate to terminate the legal responsibility of the BHASO to assure that all activities carried out by the subcontractor conform to the provisions of this Contract.
e. BHA reserves the right to require renegotiation of, or reject, BHASO's contracts with any subcontractor. Upon request by BHA, all subcontracts for direct services entered into by the BHASO are subject to prior review and written approval by BHA.
f. Subcontractor/Partnership Termination. The BHASO shall notify the BHA within 3 business days of the termination of a provider agreement that the BHASO assesses as likely to impact its Network Adequacy obligations. Any time a provider agreement is terminated, the BHASO shall coordinate necessary transitions of care.

1.6.1.6 Changes to the BHASO Network.

a. The BHASO shall notify BHA, in writing, of BHASO's knowledge of an unexpected or anticipated material change to the BHASO Network or a network deficiency that could affect service delivery, availability or capacity within the BHASO Network. The notice shall include:
    i. Information describing how the change will affect service delivery.
    ii. Availability, or capacity of covered services.
    iii. A plan to minimize disruption to care and service delivery.
    iv. A plan to correct any network deficiency.
    v. DELIVERABLE: Network Changes and Deficiencies Notification
    vi. DUE DATE: Within five (5) days after the BHASO's knowledge of the change or deficiency.
    vii. DESTINATION: cdhs_BHASO_deliverables@state.co.us
    viii. FILE NAME: [BHASO Region] - [BHASO] - Network Changes and Deficiencies Notification [Month, Year]

1.6.1.7 BHE Licensing. When subcontracting for treatment services with providers who are required by law and 2 CCR 502-1 Behavioral Health Rules to hold Behavioral Health Entity

licenses, such subcontracts are predicated on state licensing compliance and Good Standing status. It is unlawful for any person, partnership, association, or corporation to conduct or maintain a Behavioral Health Entity, including a substance use disorder program or alcohol use disorder program, without having obtained a license from the BHA.

1.6.1.8 Credential Waivers. BHA, at its discretion, may modify or waive required staff credential requirements. Such a waiver must be given in writing. In no event may such a waiver contradict state licensing or Department of Regulatory Agencies requirements.

1.6.1.9 Develop Standardized Policies and Procedures.

a. The BHASO shall ensure that any statewide standardized policies and procedures are adopted and adhered to by the BHASO Network to deliver uniform care across Colorado.
b. The BHASO shall ensure that clinical standards of care are defined, standardized clinical protocols are developed, and best practices are used to deliver care.
c. The BHASO shall ensure compliance with all applicable Americans with Disabilities Act (ADA) regulations in all Safety Net Services.
d. The BHASO shall develop and employ protocols, policies, and procedures for responding to children, adolescents, and families in crisis, as well as Individuals with Intellectual and Developmental Disabilities and caregivers in crisis, including coordination with county child welfare and Adult Protective Services on all modalities.
e. The BHASO shall develop and employ protocols for providing or coordinating clinically appropriate transportation for Individuals between levels of care throughout the treatment episode, leveraging all payer sources, including Medicaid.
    i. See Part Two, Chapter 12 for information on the Transportation General Accounting Encumbrance.
f. All policies and procedures developed and employed by the BHASO shall be adhered to by the BHASO Network.

1.6.1.10 Additional Funds. BHA may identify additional state-administered, county-administered, or federal grant funds related to the prevention, treatment, recovery, and harm reduction for behavioral health services. The BHASO shall prioritize Safety Net Providers for expanded programming with these funds per the requirements of SOW Part 1, Chapter 6,

Article 1. Nothing in this section limits the ability of BHA to award contracts or grants for the procurement of behavioral health services directly to any county, city and county, municipality, school district, health service district, or other political subdivision of the state or any county, city and county, district, or juvenile court, or to any nonprofit or for-profit organization in accordance with applicable law.

1.6.1.11 Pilot Programs. BHA or the BHASO may propose pilot programs to evaluate potential solutions or enhancements to BHASO services. Pilots must be time-bound. BHA may waive conflicting contract terms for the duration of the pilot period as needed to allow for services to proceed according to the pilot proposal terms. If a pilot program is deemed successful at the conclusion of the pilot period, the parties may negotiate an amendment to this Contract to the extent necessary to accommodate the pilot activities.

Article 2 - Network Access and Adequacy Standards

1.6.2.1 Network Access and Adequacy.

a. The BHASO shall ensure that its Network satisfies network adequacy standards required by 2 CCR 502-5 (Behavioral Health System Rules). Such standards will include, but will not necessarily be limited to, network access and adequacy requirements for safety net service provision at the community and regional levels, and compliance mechanisms to address identified Network inadequacies in the BHASO service delivery area.
b. Updates to Behavioral Health System Rules may trigger contract negotiations between BHA and BHASOs.
c. The BHASO shall ensure that its Comprehensive Behavioral Health Safety Net Providers are able to provide clinical services, including medication management, within one business day if an established/known Individual presents with an urgent need.

1.6.2.2 Assessing Regional Network Adequacy.

a. The BHASO shall regularly assess the Safety Net Services available regionally and statewide.
b. In the Assessment, the BHASO shall:
    i. Provide statistics on availability of each Safety Net Service in its Region;

ii. Identify gaps where a Safety Net Service is not available per the network adequacy standards regulatorily established by BHA in 2 CCR 502-5 (Behavioral Health System Rules), including standards specific to children and youth, when appropriate;
    i. The BHASO shall monitor and report on the safety net system and safety net providers to support accountability in connecting Individuals to services and the delivery of those services to individuals with the highest needs (C.R.S. §27-60-204(c)).
iii. Analyze the current adequacy of funding and estimate the resources that would be necessary to improve service availability.
iv. If a Safety Net Service is not available per the network adequacy standards regulatorily established by BHA, the BHASO shall provide an improvement plan, with proposed benchmarks and timelines, that can achieve improvement towards reaching the network adequacy standards even in the absence of additional funding. Any available capacity building funding from this Contract must be prioritized to address identified gaps and deficiencies.
v. Identify any issues reported in the BHASO Network regarding connecting Individuals to services and the delivery of those services to Individuals with the highest needs and describe how the BHASO Network is held accountable when issues arise.
vi. The BHASOs may collaborate and submit a single Assessment, the BHASOs may submit Individually, or both.

c. DELIVERABLE: Quarterly Network Adequacy Assessment
d. DUE DATE: Quarterly, on the 15th day of each month following the reported quarter.
e. DESTINATION: cdhs_BHASO_deliverables@state.co.us
f. FILE NAME: BHASO Region [X] - [BHASO] - FY[XX]Q[X] - Network Adequacy Assessment

1.6.2.3 Clinically Necessary Residential Care. The BHASO shall employ a utilization review process (for example, retrospective quality review sampling) to assure that only clinically necessary non-crisis Residential services are provided. For SUD services, the BHASO Network shall apply ASAM criteria to determine level of care needed. ASAM justification must be provided for placement in SUD residential services.

1.6.2.4 Interruption in Service, Closures, and Diversion.

a. For all 24/7 modalities, in the event there is any interruption in service provision lasting longer than eight (8) hours the Contractor shall notify the identified BHA BHASO Region Manager by email within one (1) business day with details of the disruption, including time of onset and which services were impacted. By 5pm Mountain Time the next business day after the disruption has been resolved, a second email shall be sent to the address above indicating the interruption of service has been resolved.
    a. DELIVERABLE: Interruption in Service Report
    b. DUE DATE: As needed, within one (1) Business Day
    c. DESTINATION: BHA BHASO Region Manager
    d. FILE NAME: BHASO Region[X] - [BHASO] - FY[XX] [Month] - Interruption in Service Report
b. If a twenty-four (24) hour facility in the BHASO Network must divert Individuals for a period over four hours, BHASO or subcontractor shall contact the BHA BHASO Manager by email to alert BHA of the status and the steps taken to clear the divert status.
c. Diversion to services in other BHASO Regions is allowable.
d. If a provider service location will be closed permanently, Contractor shall notify the BHA BHASO Region Manager in writing within one business day after the BHASO is made aware of the decision to close. The BHASO shall provide a proposed transition plan and timeline within five (5) business days of the notice of closure.
e. If the BHASO or any BHASO Network provider intends to conduct a reduction in force which affects a program funded through this Contract, the BHASO shall notify the BHA BHASO Region Manager upon knowledge of the layoffs. As soon as is practical after this notification, BHA and the BHASO shall renegotiate the BHASO's work plan and budget accordingly.
f. Diversions Report.
    a. The BHASO shall maintain and provide a quarterly report of incidents where services have gone on divert, including:
        i. the name of the facility,
        ii. the service on divert,
        iii. length of service gap,
        iv. the reason for the diversion status (e.g. inadequate staffing,

emergency), and

v. the number of known Individuals affected by the diversion.

1. DELIVERABLE: Quarterly Diversions Report
2. DUE DATE: fifteen (15) days after the end of the reported quarter
3. DESTINATION: cdhs_BHASO_deliverables@state.co.us
4. FILE NAME: BHASO Region [x] - [BHASO] - FY[XX] [Quarter] Diversions Report

1.6.2.5 Critical Incidents. BHASO Network providers that are licensed or regulated by BHA shall adhere to the most current State Behavioral Health Services Critical Incident rules in Part 2.16 of 2 CCR 502-1, made a part of this Contract herein by reference. BHASO Network must also supply critical incidents related to services funded under the BHASO contract to the BHASO.

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Chapter 7
Regional Committees and Cooperation

Article 1 - Regional Councils
Article 2 - Regional Connections and Cooperation

Article 1 - Regional Councils

1.7.1.1 Formation. The BHA shall create a regional committee structure as part of the BHASOs to promote local community input pertaining to behavioral health service needs. The Regional Council structure aligns with the BHASO Region Map in Statement of Work, Part One, Section 1.4.1.

1.7.1.2 Purpose. The Regional Council is created to directly inform the BHASO in the Region in order to improve services, accountability, and transparency in the Region.

1.7.1.3 Meetings. The BHASO shall coordinate and staff all Regional Council meetings, which shall meet a minimum of six times a year and allow for public comment during each meeting. The BHASO shall engage with the Regional Council, at a minimum, on the following areas:

a. When determining what services are needed to establish a full continuum of care in the Region;
b. When addressing barriers to Individuals accessing quality and timely care in the Region;
c. When developing the statewide care coordination infrastructure; and
d. When identifying needed specialty services for Priority Populations.

1.7.1.4 Public Meeting. The Regional Council is considered a “state public body” and therefore is required to meet the provisions of C.R.S. §24-6-402 - Open Meetings

1.7.1.5 Bylaws. The Regional Council shall operate under standard statewide bylaws established by BHA.

1.7.1.6 Membership.

a. Regional Council members are appointed for three-year terms; except that initial terms may be for two years. The Regional Council shall consist of nine members. BHA will coordinate formation of the inaugural Regional Council. Members should live or work in the Region for the Committee on which they sit. The BHASO shall coordinate with the identified appointing party to replace members when members resign or their terms end. Where BHA is not the appointing party, BHA must confirm the appointed member. Membership of the Regional Councils must include:
    i. One Individual with expertise in the behavioral health needs of children and youth appointed by a local or regional public health or human service agency within the Regional Council's Region;
    ii. One Individual who represents a Behavioral Health Safety Net Provider that operates within the Region appointed by a local or regional public health or human service agency within the Regional Council's Region;
    iii. A county commissioner of a county situated within the Region appointed by the BHA;
    iv. One Individual with a connection to a kindergarten through twelfth grade school district within the Regional Council's Region appointed by a local or regional public health or human service agency within the Regional Council's Region;
    v. One Individual with the criminal justice system within the Regional Council's Region appointed by a local or regional public health or human service agency within the Regional Council's Region;
    vi. One Individual with lived experience or a community member who is not also a behavioral health provider appointed by a local or regional public health or human service agency within the Regional Council's Region;
    vii. One Individual with lived experience appointed by the BHA; and
    viii. Two Individuals with lived experience not associated with a behavioral health treatment provider, appointed by the BHASO.
b. For year one, the BHASO shall provide its recommendations for the members it appoints to the BHA Commissioner for approval before appointments are made.
c. Unless committee membership is established pursuant to state or federal law, the Regional Council membership shall maintain a majority of members who represent

Individuals with lived behavioral health experience or families of Individuals with lived behavioral health experience.

d. Regional Council members shall not be employees of or individuals with a financial interest in the BHASO organization.

1.7.1.7 Conflict of Interest Training. The BHASO shall train and inform council members on conflict of interest to ensure members recuse themselves from any vote that would have a monetary or personal benefit to the member.

1.7.1.8 Member Compensation. Members with lived experience shall receive compensation for meeting attendance and participation.

1.7.1.9 Reporting Process. The Regional Council shall draft an annual Letter of Recommendation due to the BHASOs by September 1st of each year beginning in 2027. The BHASOs will be required to include these Letters of Recommendation (one from each Council) in their Annual Report due to the BHA on September 30th. The Letter of Recommendation shall include recommendations about:

a. The services that are needed to establish a full continuum of care in the region;
b. The barriers that individuals encounter that prevents them from accessing quality and timely care in the region; and
c. The specialty services that are needed in the region for priority populations.

1.7.1.10 BHA Attendance and Support. BHA will send one or more representatives to each Regional Advisory Council meeting in an observation role.

1.7.1.11 Workgroups. The Regional Council has the authority to create Regional Council workgroups focused on topics of need as determined by the Regional Council workgroups in collaboration with the BHASOs. These workgroups may involve members from multiple Regions' Regional Council.

1.7.1.12 Interaction with BHAAC. The Behavioral Health Administration Advisory Council (BHAAC) shall establish a process to receive direct feedback from the Regional Council

throughout the year to consider including in BHAAC's annual report required pursuant to C.R.S. §27-50-701(2)(d).

1.7.1.13 Interaction with HCPF / RAE Advisory Councils. The BHASO and BHA shall work with HCPF to determine appropriate mutual engagement in BHASO and RAE regional and statewide advisory councils.

Article 2 - Regional Connections and Cooperation

1.7.2.1 Inter-BHASO Collaboration

a. BHASOs are expected to coordinate and collaborate with BHASOs in other Regions for the purposes of coordinating care, sharing best practices and strategies to improve the quality of care delivered, and aligning policies and procedures to improve continuity of provider and Individual experience within the BHASO system.

1.7.2.2 Stakeholder Input Process and Report

a. The BHASO shall develop a process to solicit and respond to input from stakeholders about behavioral health services. The BHASO shall, at a minimum, engage the following stakeholders within the service area:
    i. Individuals receiving behavioral health services and their families;
    ii. Behavioral Health Safety Net Providers;
    iii. Counties;
    iv. Law enforcement;
    v. Judicial districts;
    vi. Tribal governments, if applicable;
    vii. Hospitals and hospital stakeholder groups in BHASO's Region;
    viii. Physical health providers;
    ix. State Agencies:
        1. Colorado Department of Human Services (CDHS)
        2. CDHS Office of Civic and Forensic Mental Health
            A. All State mental health hospitals
        3. CDHS Division of Child Welfare
        4. Department of Health Care Policy and Financing
        5. Colorado Department of Public Health and Environment

6. Colorado Department of Regulatory Agencies (DORA)
7. DORA, Division of Insurance
8. BHA will hold introductory meetings with the BHASOs and the appropriate contacts at the state agencies within the first sixty (60) days following Contract execution;

x. Programs serving unhoused Individuals; and

xi. Other community resources.

b. The BHASO may also engage stakeholders in neighboring service areas, as appropriate.

c. The BHASO shall publicly post an annual report that includes:

i. A report on the stakeholder input received in the prior year, anonymized and aggregated to protect Individual privacy;

ii. Descriptions of how the BHASO has responded to, or plans to respond to, stakeholder input from the prior year, including descriptions of policy or practice changes or explanations of why no changes were made; and

iii. The plan for stakeholder engagement for the upcoming year.

1. DELIVERABLE: Stakeholder Engagement Outcomes & Future Planning
2. DUE DATE: September 30th annually
3. DESTINATION: BHASO website and linked on BHA website

d. The BHASO shall work collaboratively with its subcontractors to develop a community engagement strategy to inform partners and Individuals about availability of services in its Region, including how to access services, what to expect in service delivery, and how to submit grievances.

e. The BHASO shall contact and establish communication with all Colorado county jails in its Region holding BHA Jail Based Behavioral Health Services contracts for the purposes of facilitating referrals and Care Coordination.

f. The BHASO for Region 1 shall conduct regular outreach to the Southern Ute Indian Tribe (SUIT) and Ute Mountain Ute Tribe (UMUT) to offer services and foster collaboration. Each Tribal government will determine the extent of its engagement in services and participation based on its specific needs. Key responsibilities include:

i. Building trust in the crisis response system by engaging with Tribal behavioral health teams and Tribal Council representatives.

ii. Identifying opportunities to leverage available funding to expand crisis services for Tribal populations.

iii. Strengthening connections to local resources, including both internal and external service providers.
iv. Ensuring crisis resolution team services are accessible to both SUIT and UMUT.
v. Offering and facilitating regular meetings with Tribal services and government- including schools, the Tribal Council, detention centers, behavioral health services, and local safety net providers- to enhance coordination and service delivery.

1.7.2.3 BHASOs and RAEs.

a. The BHASO shall negotiate formal agreements with RAEs to establish coordination and cooperation between BHASOs and RAEs, which must include:
   i. Policies and procedures to ensure continuity of care for all Individuals transitioning into or out of Medicaid enrollment, guaranteeing that an Individual's services are not disrupted or delayed
   ii. Definition of roles in Care Coordination to reduce duplication
   iii. Methods to leverage resources within Medicaid and BHA to optimize funding for needed services
   iv. Participation on/attendance at each other's Councils, as appropriate
   v. Procedures to monitor equity and outcomes within the region and share data with one another
   vi. Procedures to share quality and information relevant to monitoring the provider network
   vii. Methods to Support provider quality improvement through shared or coordinated training and technical assistance
   viii. Procedures to discuss provider concerns or performance issues as a part of discussion with HCPF and BHA
   ix. Methods to determine wraparound service eligibility
   x. Coordinated intake processes
   xi. Execution of data sharing agreements such as Business Associate Agreements

Chapter 8

Quality Assurance and Improvement

Article 1 - Quality Assurance

1.8.1.1 Quality Assurance Work Plan.

a. Annually, the BHASO shall submit a Quality Assurance (QA) Work Plan for monitoring the BHASO Network throughout the Region, including assessment of service quality; accessibility of services; mechanisms for retrospective quality review samplings of service appropriateness; provision of clinical supervision; appropriateness of peer support utilization, in-community crisis management, and cultural responsiveness. The QA Work Plan shall include a process for addressing issues of non-compliance and reporting to the State. The QA Work Plan will apply to monitoring of all subcontract providers regardless of funding.
    i. DELIVERABLE: QA Work Plan
    ii. DUE DATE: June 30, 2025, for the present year, and March 31 annually in years thereafter for the upcoming year
    iii. DESTINATION: cdhs_BHASO_deliverables@state.co.us
    iv. FILE NAME: BHASO Region[X] - [BHASO] - FY[XX] - QA Work Plan
b. The BHASO shall adhere to the goals and processes set in its Quality Assurance Work Plan throughout the year.

1.8.1.2 Enhanced Payments. Subject to performance and available funds, BHASOs shall provide Behavioral Health Safety Net Providers with opportunities for quality incentives, value-based payment, or other enhanced payments or preferred contract statuses.

1.8.1.3 BHASO Network Monitoring Visits. The BHASO shall monitor its subcontractors' performance to ensure compliance with every element of this exhibit and the statements of work in this exhibit. The BHASO shall create a risk evaluation and monitoring plan for each subcontractor. The plan will establish a monitoring frequency and methodology (e.g. on-site or remote). BHA may request to review the plan and may require edits to the plan.
BHASO shall conduct a minimum of one virtual or onsite visit to each subcontractor every two years to review its compliance with BHA-BHASO Contract terms. The BHASO shall submit

documentation of having monitored subcontractors' compliance with all contract terms, as well as the results of each monitoring visit. If the BHASO identifies a compliance issue or a potential violation of BHA rules through monitoring activities, it shall send the information and concern to the BHA Grievance and Enforcement Team at: CDHS_BHA_complaint@state.co.us. The BHASO may include items identified as rule compliance as part of quality monitoring, corrective action, or other communications with BHASO Network, in addition to notifying BHA. BHA may require an onsite monitoring visit if indicated by the circumstances.

a. DELIVERABLE: On-Site Monitoring Results
b. DUE DATE: Within 30 days of the site visit, no later than May 31 annually
c. DESTINATION: cdhs_BHASO_deliverables@state.co.us
d. FILE NAME: BHASO Region [X] - FY[XX] - [Subrecipient Name] On-Site Monitoring Results

1.8.1.4 Active Contract Management and Corrective Action

a. If the BHASO becomes aware through a financial audit, on-site monitoring visit, or any other means that a BHASO Network provider is not meeting the terms of the Contract, the BHASO shall engage with the BHASO Network Provider to address the issue via active contract management. If active contract management has failed to correct performance or the non-compliance is significantly impactful in the judgement of the BHASO, the BHASO shall place the BHASO Network provider on a Corrective Action Plan to remediate contract non-compliance. Corrective Action is a significant adverse action against the contract.
b. The BHASO shall provide a copy of any Corrective Action Plan to BHA.
    a. DELIVERABLE: Corrective Action Plan
    b. DUE DATE: As needed, within five (5) Business Days of creation of the Corrective Action Plan.
    c. DESTINATION: cdhs_BHASO_deliverables@state.co.us
    d. FILE NAME: BHASO Region [X] - FY[XX] - [Subrecipient Name] Corrective Action Plan
c. The BHASO shall require the BHASO Network to submit to the BHASO notice of adverse actions taken on their license by BHA.

1.8.1.5 Grievance Process.

a. The BHASO may investigate and resolve complaints and grievances that it receives as necessary to conduct appropriate contract monitoring and management.
b. If the BHASO receives a complaint or grievance and identifies a compliance issue or a potential violation of BHA rules through monitoring activities, it shall send the information and concern to the BHA Grievance and Enforcement Team at: CDHS_BHA_complaint@state.co.us.
c. On an annual basis, the BHASO will provide BHA a complaint and grievance data report using a BHA-prescribed form.
    i. DELIVERABLE: Annual Complaint and Grievance Report
    ii. DUE DATE: July 31 annually, for the previous fiscal year.
    iii. DESTINATION: encrypted email to cdhs_BHA_complaint@state.co.us
    iv. FILE NAME: BHASO Region [X] – FY[XX] – Annual Complaint and Grievance Report

1.8.1.6 Federal Block Grant Deliverables.

a. Block Grant Monitoring Checklist. As a requirement of the federal block grant awards, the BHASO shall complete a Block Grant monitoring checklist for any BHASO Network provider receiving Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRS) or Mental Health Block Grant (MHBG) funds. Desired outcomes of this tool include:
    1. Block grant-funded providers will increase their awareness of and compliance with block grant requirements.
    2. BHA will have improved systems for stipulating, enforcing, and accounting for provider compliance with block grant requirements.
        i. DELIVERABLE: Block Grant Monitoring Checklist
        ii. DUE DATE: June 1 annually
        iii. DESTINATION: cdhs_BHASO_deliverables@state.co.us
        iv. FILE NAME: BHASO Region [X] - FY[XX] - [Subrecipient Name] [MHBG/SUPTRS] Monitoring Checklist
b. Block Grant Financial Reporting. As a requirement of the federal block grant awards, BHASO shall report actual expenditures, categorized by assistance listing as well as block grant expenditure categories. BHA and BHASO will collaborate on a mutually agreeable template for this report.

1. DELIVERABLE: Block Grant Annual Expenditure Report
2. DUE DATE: Oct 1 annually
3. DESTINATION: cdhs_BHASO_deliverables@state.co.us
4. FILE NAME: BHASO Region [X] - FY[XX] - [Subrecipient Name] [MHBG/SUPTRS] Block Grant Annual Expenditure Report

c. Charitable Choice Report. Summarize all network providers that operate a faith-based program or any program that has faith-based elements. Include the number of Individuals attending such programs. Further details regarding charitable choice may be found in Exhibit F, Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRS) Contract Supplement.
   1. DELIVERABLE: Charitable Choice Report
   2. DUE DATE: June 1 annually
   3. DESTINATION: cdhs_BHASO_deliverables@state.co.us
   4. FILE NAME: BHASO Region [X] - FY[XX] - Charitable Choice Report

d. Outreach Plan for SUPTRS Priority Populations.
   1. The BHASO shall conduct outreach activities and campaigns to encourage awareness of and engagement in services by the SAMHSA SUPTRS priority populations listed below:
      i. Women who are pregnant and using drugs by injection;
      ii. Women who are pregnant;
      iii. Persons who use drugs by injection;
      iv. Women with dependent children;
      v. Persons who are involuntarily committed to treatment (see section III.B. of this exhibit)
   2. Qualifying engagement campaigns include, but are not limited to, the Tough as a Mother campaign for pregnant and parenting individuals impacted by substance use disorder.
   3. Other campaigns and special projects can be approved in writing by the BHA BHASO Region Manager.
   4. The BHASO shall submit an outreach to Priority Populations work plan describing activities that will take place in the upcoming Contract year.
      i. DELIVERABLE: Outreach to Priority Populations work plan, which may be included in the BHASO region work plan.
      ii. DUE DATE: June 1 annually

iii. DESTINATION: cdhs_BHASO_deliverables@state.co.us

iv. FILE NAME: BHASO Region [X] - FY[XX] - Priority Pops Outreach Plan

1.8.1.7 Independent Peer Review.

a. The BHASO shall participate in an independent peer review process designed to assess the quality, appropriateness, and efficacy of treatment services provided in each Region.

b. The purpose of independent peer review is to review the quality and appropriateness of treatment services. The review will focus on treatment programs and the Safety Net System rather than on the Individual practitioners. The intent of the independent peer review process is to continuously improve the treatment services to Individuals with Substance Use Disorder within the Safety Net System.

c. Definitions:

i. "Quality," for purposes of this section, is the provision of treatment services, which, within the constraints of technology, resources, and Individual circumstances, will meet accepted standards and practices that improve Individual health and safety status in the context of recovery.

ii. "Appropriateness," for purposes of this section, means the provision of treatment services consistent with the Individual's identified clinical needs and level of functioning.

d. Each BHASO will review one other BHASO's providers for each block grant during the contract period. BHA will determine which providers are eligible for review during the contract period. BHA will communicate peer review assignments to BHASO by September 30 annually.

i. In the event that one annual review per BHASO for each block grant does not equate to five (5) % of service providers in the BHASO Network, BHA will assign additional reviews.

e. The independent peer reviewers shall be Individuals with expertise in the field of Individuals with substance use disorders treatment. Because treatment services may be provided by multiple disciplines, the BHASO will make every effort to ensure that Individual peer reviewers are representative of the various disciplines

utilized by the program under review. Individual peer reviewers must also be knowledgeable about the modality being reviewed and its underlying theoretical approach to addictions treatment and must be sensitive to the cultural and environmental issues that may influence the quality of the services provided.

f. As part of the independent peer review, the reviewers shall review an unbiased representative sample of Individual records to determine quality and appropriateness of treatment services, while adhering to all Federal and State confidentiality requirements, including 42 CFR Part 2. The reviewers shall examine the following:
    i. Admission criteria/intake process;
    ii. Assessments;
    iii. Treatment planning, including appropriate referral, e.g., prenatal care and tuberculosis and HIV services;
    iv. Documentation of implementation of treatment services;
    v. Discharge and continuing care planning; and
    vi. Indications of treatment outcomes.
g. The BHASO shall ensure that the independent peer review will not involve practitioners/providers reviewing their own programs or programs in which they have administrative oversight and that there is a separation of peer review personnel from funding decision makers.
h. BHA will provide the BHASO with the Peer Review template to be used as part of this process.
    i. DELIVERABLE: Peer review report
    ii. DUE DATE: May 31 annually
    iii. DESTINATION: cdhs_BHASO_deliverables@state.co.us
    iv. FILE NAME: BHASO Region [x] - [BHASO] - FY[XX] Peer Review of [Reviewee]

Article 2 - Quality Improvement

1.8.2.1 Accountability Core Values

a. A key purpose of the BHASO system is to elevate quality of and access to behavioral health services. BHA expects the BHASOs to make gradual improvements in these areas. The critical areas that BHA seeks to address in the behavioral health system include:

i. Access: Access to a continuum of behavioral health services that anticipates all levels of need regardless of ability to pay, age, disability, linguistics, geographic location, or racial or gender identity.

ii. Affordability: Financially accessible care for all, made possible by administrative efficiencies across the system and payment models that incentivize and drive improved outcomes. BHASOs will ensure that all other payors are accurately and maximally utilized, and that state dollars are only accessed after other funding sources are appropriately utilized.

iii. Workforce and support: A sufficient, supported, culturally responsive and diverse behavioral health workforce that delivers high-quality healthcare access to all people in Colorado.

iv. Accountability: Collaboration across stakeholders to ensure that people in Colorado are receiving the quality care that they need.

v. Lived experience and local guidance: Engaged community stakeholders who provide guidance on how best to meet local behavioral health needs.

vi. Whole person care: Physical and behavioral health care that is integrated, with the social determinants of health adequately addressed.

b. The first year of the BHASO system will be largely focused on measuring the current state of these focus areas. The BHASO shall participate in data collection in MMIS and other systems to measure and monitor these and other performance indicators. Performance targets with accountability consequences will be set for these and other performance indicators over the course of the five years of the initial BHASO system.

1.8.2.2 Performance Hub

a. Performance Hub - Established. BHA will establish a performance monitoring system, referred to as the Performance Hub, to track capacity and performance of all behavioral health providers, including those that contract with BHASOs, and inform needed changes to the public and private behavioral health system in the state. C.R.S. § 27-50-201.

b. Minimum Performance Standards. BHA will set minimum performance standards for treatment of children, youth, and adults that address key metrics for behavioral health providers and BHASOs, including but not limited to:

i. Accessibility of care, including:

1. Availability of services;
2. Timeliness of service delivery; and
3. Capacity tracking consistent with C.R.S. §27-60-104.5; and

ii. Quality of care, including appropriate triage and access based on client need and for priority populations.

c. Collaboration on Minimum Performance Standards.

i. In setting minimum performance standards, the BHA shall collaborate with state agencies to consider:

1. Evidence-based and promising practices;
2. Themes identified through Grievances;
3. Input from the Behavioral Health Administration Advisory Council (BHAAC);
4. Alignment with existing state and federal requirements;
5. Alignment with the BHA's comprehensive state plan developed pursuant to C.R.S. §27-50-105(2); and
6. Reducing the administrative burden of data collection and reporting for behavioral health providers.

ii. BHA will incorporate the Children and Youth Working Group Framework developed pursuant to C.R.S. §27-50-201(3.5) in setting minimum performance standards for children and youth.

iii. BHA will collaborate with the Department of Health Care Policy and Financing (HCPF) to align performance metrics and standards for providers, managed care entities, and BHASOs.

d. High Quality, Limited Impact Metrics. BHA will collaborate with HCPF to establish data collection and reporting requirements that align with the performance standards established in this section and that are of a high value in promoting systemic improvements. In establishing data collection and reporting requirements, BHA must consider the impact on behavioral health providers and clients and state information technology systems.

e. Health Information Exchanges. Where applicable, BHA and the BHASOs will coordinate with the Health Information Exchanges (HIEs) to prioritize leveraging the HIE infrastructure to meet the requirements of this section and to promote the interoperable exchange of data to improve the quality of patient care.

f. Public-Facing Platforms. BHA will analyze the data collected from the BHASOs and the BHASO Network pursuant to this section and create public-facing system accountability platforms (e.g. dashboards) to report on performance standards for BHASOs and the BHASO Network.

g. Compliance with Privacy Law. BHA will provide documentation to the BHASOs identifying how the BHA's activities conducted pursuant to this section comply with state and federal privacy laws and standards.

h. Implementation. The Performance Hub described in this Article will be operational in State Fiscal Year 2025. BHA will collaborate with the selected BHASO vendors to develop terms and procedures to be operational in the BHASO's State Fiscal Year 2025-26 Contract.

i. Adequacy Standards. In addition to evaluating the performance of BHASOs and the BHASO Network, the Performance Hub will support establishment of statewide, regional, and local behavioral health network adequacy standards, including standards specific to children and youth, when appropriate.

1.8.2.3 Commitment to Quality Program.

a. The BHASO shall strive to achieve all the standards agreed to in section 1.8.2.5.b below by investing in adequate administrative staff, functions, processes, and technology.

   The BHASO shall commit to excellence in achieving these standards by contributing funding to a holding account in the amounts detailed in section 1.8.2.5.c below when the BHASO does not achieve an established standard. BHA does not intend to begin this requirement until State Fiscal Year 2026-27. BHA will provide six months' notice prior to beginning this requirement.

   i. The BHASO and BHA will agree on how the funding that is contributed to the holding account shall be distributed no later than six months following the BHA's acceptance of the BHASO's state fiscal year quarter four Quarterly Expenditure Reconciliation Report.

   ii. Funds shall only be used for intents enumerated in this Contract, such as but not limited to, improving access to care, improving behavioral health of Individuals in its Region, or efforts to achieve Contract standards or other stated goals. Funds shall not be used to enhance BHASO Network provider reimbursement beyond 100% of their contractual terms for timely payment.

iii. The BHASO financial contributions made for missing the Commitment to Quality Program standards shall be made from the BHASO's profit margin, as defined by the difference between total revenue earned through this Contract and total expense for annual performance periods as reported through the quarterly financial review process and in alignment with the BHASO's annual financial forecasted expense allocations.

iv. The BHASO shall bear the responsibility of proving that reimbursements are deducted from the BHASO's profit margin during the quarterly performance review meetings with BHA. See Section 1.9.5 below.

v. The BHASO shall not pass on the cost of these contributions to the Commitment to Quality Program to BHASO Network providers or other subcontractors that support the Contract. The BHASO shall not absorb the cost of this reimbursement by reducing staff or resources dedicated to this Contract.

b. Metrics subject to the Commitment to Quality Program:

i. The BHA and Contractor shall collaborate to establish minimum thresholds related to the outcomes generated by the utilization of the Administrative Fee

i. Timeliness for BHASO Provider Network payments

ii. Timeliness and accuracy of financial expenditure reconciliation

iii. Timeliness and accuracy of data reporting requirements

iv. Other measures as established by BHA with six-month's notice minimum

c. Funding the Commitment to Quality Program

i. The BHASO shall contribute the following amount of funding to the Commitment to Quality Program holding account following a determination by BHA of the number and percent of the Performance Standards the BHASO achieved during the previous State Fiscal Year:

i. 0% of the BHASO's profit margin if it meets 90% or more of the Performance Standards.

ii. 5% of the BHASO's profit margin if it meets 85-89% of the Performance Standards.

iii. 10% of the BHASO's profit margin if it meets 80-84% of the Performance Standards.

iv. 15% of the BHASO's profit margin if it meets less than 80% of the Performance Standards.

Chapter 9
BHA and BHASO communication and Standard Operating Procedures (SOP)

1.9.1 Contract Contact Procedure. The BHASO shall submit all requests for BHA interpretation of this Contract or for amendments to this Contract to the BHA Director of Contracts and Procurement.

1.9.2 BHA Monitoring.

a. BHA has the right and obligation to monitor and audit the BHASO's and the BHASO Network's performance and resolve Individual grievances.
    i. Such monitoring may include onsite as well as off-site review and audit in areas including but not limited to level of care appropriateness, clinical quality, outcome indicators, service efficiency, administrative proficiency, and financial performance.
    ii. The BHASO shall comply with all audit or review protocol and actions plans set forth throughout the audit or review process.
b. BHA shall send copies of all audits or reports regarding providers that are in the BHASO Network to the BHASO within thirty (30) days of completion of the visit.
c. The BHASO shall respond with a plan to correct deficiencies within the time frames specified during the site review process and perform in accordance with said plan until all deficiencies are corrected.
d. Non-performance with said action plans may lead to performance and compliance remedies within this Contract.
e. MEETING: The BHASO shall participate in operational meetings facilitated by BHA, as needed. Non-emergency required meetings will be scheduled a minimum of five (5) Business Days in advance, unless waived by the BHASO.

1.9.3 BHA Technical Assistance. The BHA will provide statewide technical assistance specific to strengthening and expanding the Behavioral Health Safety Net System and increasing provider participation within the publicly funded Behavioral Health Safety Net Provider network. The BHASO may submit requests for technical assistance to the BHA Safety.

Net Team or BHA Statewide Programs team on behalf of its BHASO Network providers or to the relevant BHA BHASO Region Manager for itself.

1.9.4 Quarterly Performance Review Meetings

a. The BHASO and BHA shall schedule quarterly performance review meetings to discuss spending and progress toward goals set in Part One, Chapter 8, Article 2, including the Performance Hub. The BHASO shall draft a written update including performance metrics' progress to goal and record of spending against the contract to date including year-end projections.
    i. MEETING: Quarterly Performance Review
    ii. TIMING: following the end of each quarter, scheduled by BHA
    iii. DELIVERABLE: Quarterly Performance Review Update
    iv. DUE DATE: Three (3) Business Days before the scheduled Quarterly Performance Review.

1.9.5 Audit Results Sharing

a. The BHASO grants permission for BHA to share the results and findings of BHA performance data, audits, and site visits of the BHASO with other BHASOs.
b. BHA will provide no less than three (3) Business Days' notice to the audited BHASO before it shares results.

1.9.6 Deliverables Standards

a. The BHASO shall submit each deliverable to cdhs_BHASO_deliverables@state.co.us for review and approval, unless another destination is specified.
b. The BHASO shall employ an internal quality control process to ensure that all deliverables are complete, accurate, easy to understand and of high quality. The BHASO shall provide deliverables that, at a minimum, are responsive to the specific requirements for that deliverable, organized into a logical order, contain accurate spelling and grammar, are formatted uniformly, and contain accurate information and correct calculations. The BHASO shall retain all draft and marked-up documents and checklists utilized in reviewing deliverables for reference as directed by the BHASO.

c. BHA will review the deliverable and may direct the BHASO to make changes to the deliverable. The BHASO shall make all changes within ten (10) Business Days following BHA's direction to make the change unless BHA provides a longer period in writing.
d. All modifications shall include version control and tracked changes.
e. Changes BHA may direct include, but are not limited to, modifying portions of the deliverable, requiring new content of the deliverable, requiring resubmission of the deliverable or requiring inclusion of information or components that were left out of the deliverable.
f. BHA may also direct the BHASO to provide clarification or provide a walkthrough of any deliverable to assist BHA in its review. The BHASO shall provide the clarification or walkthrough as directed by BHA.
g. Once BHA has received an acceptable version of the deliverable, including all changes directed by BHA, BHA will notify the BHASO of its acceptance of the deliverable in writing. A deliverable shall not be deemed accepted prior to BHA's notice to the BHASO of its acceptance of that deliverable.
h. If any due date for a deliverable falls on a day that is not a Business Day, then the due date shall be automatically extended to the next Business Day, unless otherwise directed by BHA.
i. All due dates or timelines that reference a period of days, months or quarters shall be measured in calendar days, months and quarters unless specifically stated as being measured in Business Days or otherwise. All times stated in the Contract shall be considered to be in Mountain Time, adjusted for Daylight Saving Time as appropriate, unless specifically stated otherwise.
j. No deliverable, report, data, procedure or system created by the BHASO for BHA that is necessary to fulfilling the BHASO's responsibilities under the Contract, as determined by BHA, shall be considered proprietary.
k. If any deliverable contains ongoing responsibilities or requirements for the BHASO, such as deliverables that are plans, policies or procedures, then the BHASO shall comply with all requirements of the most recently approved version of that deliverable. The BHASO shall not implement any version of any such deliverable prior to receipt of BHA's written approval of that version of that deliverable. Once a version of any deliverable described in this subsection is approved by BHA, all requirements, milestones and other deliverables contained within that deliverable shall be considered to be requirements, milestones and deliverables of this Contract.

l. Any deliverable described as an update of another deliverable shall be considered a version of the original deliverable for the purposes of this subsection.

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Chapter 10

Close-Out Period

Article 1 – Close-Out Period

1.10.1.1 The Closeout Period shall begin on the earlier of ninety (90) days prior to the end of the last renewal year of the Contract or notice by BHA of non-renewal. The Closeout Period shall end on the day that BHA has accepted the final deliverable for the Closeout Period, as determined in the BHA-approved and updated Closeout Plan and has determined that the closeout is complete.

1.10.1.2 This Closeout Period may extend past the termination of the Contract. BHA will perform a closeout review to ensure the BHASO has completed all requirements of the Closeout Period. If the BHASO has not completed all of the requirements of the Closeout Period by the date of the termination of the Contract, then any incomplete requirements shall survive termination of the Contract. BHA will not reimburse expenses incurred past the termination date of the Contract.

1.10.1.3 During the Closeout Period, the BHASO shall complete all of the following:

a. Implement the most recent Closeout Plan or Closeout Plan Update that has been approved by BHA, and complete all steps, deliverables and milestones contained in the most recent Closeout Plan or Closeout Plan Update that has been approved by BHA.
b. Provide to BHA, or any other contractor at BHA's direction, all reports, data, systems, deliverables and other information reasonably necessary for a transition as determined by BHA or included in the most recent Closeout Plan or Closeout Plan Update that has been approved by BHA.
c. Ensure that all responsibilities under the Contract have been transferred to BHA, or to another contractor at BHA's direction, without significant interruption.
d. Notify any Subcontractors of the termination of the Contract, as directed by BHA.
e. Publicize that the BHASO will no longer be the Region's BHASO as directed by BHA. The BHASO shall create these announcements and deliver them to BHA for approval.

Once BHA has approved the announcements, the BHASO shall publicize the announcement, but in no event shall the BHASO deliver any such announcements prior to approval of that announcement by BHA.

i. DELIVERABLE: Public Notifications
ii. DUE DATE: Sixty (60) days prior to termination of the Contract

f. Notify all BHASO Network providers that the BHASO will no longer be the Region's BHASO as directed by BHA. The BHASO shall create these notifications and deliver them to BHA for approval. Once BHA has approved the notifications, the BHASO shall deliver these notifications to all providers, but in no event shall the BHASO deliver any such notification prior to approval of that notification by BHA.
   i. DELIVERABLE: Provider Notifications
   ii. DUE: Sixty (60) days prior to termination of the Contract
   iii. DESTINATION: BHASO Network providers
g. Continue meeting each requirement of the Contract as described in the BHA-approved and updated Closeout Plan, or until BHA determines that specific requirement is being performed by BHA or another contractor, whichever is sooner. BHA will determine when any specific requirement is being performed by BHA or another contractor and will notify the BHASO of this determination for that requirement.

1.10.1.4 Closeout Plan

a. The BHASO shall create a Closeout Plan that describes all requirements, steps, timelines, milestones and deliverables necessary to fully transition the services described in the Contract from the Contractor to BHA or to another contractor selected by BHA to be the BHASO contractor after the termination of the Contract. The Closeout Plan shall also designate an Individual to act as a closeout coordinator, who will ensure that all requirements, steps, timelines, milestones and deliverables contained in the Closeout Plan are completed and work with BHA and any other contractor to minimize the impact of the transition on Individuals and BHA. The BHASO shall deliver the Closeout Plan to BHA for review and approval.
   i. DELIVERABLE: Closeout Plan
   ii. DUE: January 16, 2026
   iii. DESTINATION: cdhs_BHASO_deliverables@state.co.us
   iv. FILE NAME: BHASO Region[X] - [BHASO] - Closeout Plan

b. The BHASO shall update the Closeout Plan, at least annually, to include any technical, procedural or other changes that impact any steps, timelines or milestones contained in the Closeout Plan and deliver this Closeout Plan Update to BHA for review and approval.
   i. DELIVERABLE: Closeout Plan Update
   ii. DUE: Annually, by July 31st of each year
   iii. DESTINATION: cdhs_BHASO_deliverables@state.co.us
   iv. FILE NAME: BHASO Region[X] - [BHASO] - Closeout Plan Update v[X]

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Part Two: Care Coordination

Article 1 - Care Navigation, Care Coordination, & Care Management

Article 2 - Substance Use Disorder Pre-Release Case Manager

Article 1: Care Navigation, Care Coordination & Care Management

2.1.1 Definitions and Descriptions:

a. Care coordination is a set of services that deliberately synchronizes and organizes the delivery of an Individual's health care from multiple providers and specialists to facilitate the appropriate delivery of health care services. Care coordination focuses on the whole-person health needs of the Individual and facilitates easy access to a range of health care services and providers, good communications between providers and the Individual, clear and simple information that Individuals can understand and effective care plan transitions between providers.
b. The BHASO shall collaborate with BHA to standardize aspects of the delivery of care coordination services within a three-tiered model that categorizes the types of care coordination services that should be made available for Individuals based on Individual acuity and identifies criteria for stratifying Individuals into each tier. See Part Two, Article 1, section 2.1.5 for a discussion of care coordination tiers.
    i. Tier 1 Care Navigation: brief screening of care needs, referral facilitation to identified service and support needs, and warm hand-off to RAEs.
    ii. Tier 2 Care Coordination: intensive care coordination for complex behavioral health care needs.
    iii. Tier 3 Care Management: intensive care coordination for high utilizers of bed-based levels of behavioral health care including services within the Colorado Crisis Services.

2.1.2 Statutory and Rule Citation:

a. Standard care coordination expectations of BHA-licensed providers
    i. The BHASO Network shall provide care coordination in accordance with Part 12.3.3 of 2 CCR 502-1.

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ii. The BHASO and the BHASO Network shall provide care coordination in accordance with C.R.S. § 27-50-404 and C.R.S. § 27-60-204.

b. The BHASO Network Comprehensive Behavioral Health Safety Net Providers shall perform Care Management in accordance with Part 12.5.7 of 2 CCR 502-1.

2.1.3 General Requirements.

a. Population Served. The BHASO shall ensure that care coordination services are delivered at the appropriate tier to Individuals who contact the BHASO for care navigation services or who are screened by BHASO Network providers to benefit from care coordination services.

b. The BHASO shall oversee that the full continuum of care coordination interventions is available for Individuals, whether delivered by the BHASO or the BHASO Network.

i. The BHASO's comprehensive care coordination program shall include care coordination activities delivered by the BHASO and BHASO Network and will coordinate with other state and community partners, including but not limited to the BHA, RAEs, CMAs and other agencies for related or complementary work.

ii. The BHASO may subcontract care coordination activities to the BHASO Network but shall be responsible for monitoring care coordination standards and requirements set by this Contract.

iii. Care coordination services shall include local partners, when appropriate, such as counties, school districts, and local Care Management Agencies.

iv. The BHASO shall develop and implement policies, procedures and best practice guidelines for the delivery of care coordination services by the BHASO and the BHASO Network. These will be shared with the BHA.

c. The BHASO shall facilitate the development and execution of BAAs/QSOAs with RAEs to allow for sharing of PHI for the purpose of care coordination. Where there is no BAA/QSOA between agencies and coordination is not permitted under health care operations without consent, the BHASO or BHASO Network will work with Individuals receiving care coordination and request the Individual's consent through a signed release of information to coordinate care with RAEs, and other entities.

1. External Agreements. The BHASO shall collaboratively establish policies and procedures with behavioral health hospitals (as they are willing), residential programs, and crisis providers regarding care transition

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services that meet the unique needs of Individuals, meet requirements of individual settings and systems, and avoid duplication of services. Required agreements could include HIPAA Business Associate Agreements (BAA), Qualified Service Organization Agreement (QSOA), memoranda of understanding (MOU), or Data Sharing Agreements (DSAs). The exception is that all information regarding a substance use disorder or substance use treatment is required by 42 CFR Part 2 to have written consent from the Individual.

d. The BHASO's care coordination program shall support the delivery of care coordination activities at the point of care and by those entities who have the strongest relationship with or most consistent engagement with an Individual.
e. The BHASO's care coordination program shall have the goals of:
    i. Improving Individuals' experience of care.
    ii. Preventing increase in severity / frequency of symptoms.
    iii. Providing culturally and linguistically appropriate care
    iv. Reducing unnecessary, avoidable, and duplicative care coordination service utilization, and costs.
    v. Improving coordination of care and reducing gaps in care across behavioral health programs and social supports.
f. Standardized Policies and Procedures. The BHASO shall implement (in the case of BHA-originated processes) or establish (in the case of BHASO-originated processes) objective and standardized processes for care coordination services including but not limited to:
    i. BHASOs will develop a standardized care coordination assessment, in collaboration with the BHA.
    ii. Coordination between the BHASOs and other care coordination entities, BHA, RAEs, CMAs, counties, and other BHASOs, to ensure continuity of care across shared populations.
    iii. Referral processes between entities, including the BHASO's responsibility to coordinate care is provided to an Individual transitioning care from the BHASO.
    iv. Guidance and processes for BHASO Network to ensure efficient and person-centered care coordination services for Individuals who have acute and complex needs, including Individuals involved in the civil involuntary treatment system, Individuals transitioning out of treatment settings or acute care settings; and

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Individuals involved in the child welfare, juvenile justice, or criminal justice system.

v. BHASO and BHASO Network policies and procedures shall include referral coordination and solutioning when indicated services are not readily available, and transition of care protocol between levels of care and between providers or systems.

vi. The BHASOs and/or the BHASO Network shall be proactive in identifying impending care transitions and shall implement these procedures any time that the BHASO and/or the BHASO Network is made aware that a care transition is occurring, as applicable. The BHASO shall document in the Individual's record the discharging/transitioning entity, the discharge plan, crisis follow-up plan, crisis safety plan, and any other relevant care plans or documentation, as applicable.

vii. If a BHASO Network provider is terminated from the network, the BHASO shall assist in providing care coordination for those Individuals who were receiving care from the terminated provider until the Individual is connected to a new provider for treatment and care coordination

viii. <u>Transitioning from Inpatient and Residential Levels of Care:</u>

The BHASO's care coordination policies and procedures will include standards for:

1. Discharge planning beginning the day of admission and these planning considerations will be documented in the Individual's record.
2. Discharge follow-up to the Individual and/or the Individual's caregiver within 1 calendar day.
3. For Individuals receiving ACT services, the expectation is that the Individual shall be outreached within one (1) business day after the Individual's discharge and discharge progress note is provided to the ACT provider within 24 hours. See Part Three, Chapter 5, Article 2, Assertive Community Treatment, for full ACT terms and conditions.
4. BHASOs will develop monitoring protocol for when Individuals no longer meet criteria for a bed-based level of care and are having challenges with discharging. BHASOs will assist BHASO Network providers with care coordination solutioning in these situations.

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a. DELIVERABLE: Required care coordination policies/ procedures, above.
b. DUE DATE: June 1, 2025, with updates due upon the BHA's request. Other future policies must be sent to BHA for approval 30 days before intended enactment of policy.
c. DESTINATION: cdhs_BHASO_deliverables@state.co.us

g. The BHASO and RAEs have the shared responsibility of ensuring the provision of care coordination services in a manner consistent with article 60 of title 27 § C.R.S. for Individuals utilizing the Behavioral Health Safety Net System.
    i. If a Medicaid-enrolled Individual contacts the BHASO for care navigation (Tier 1), the BHASO shall notify the Individual's appropriate RAE for a referral for care coordination services through a warm-handoff.
        1. The BHASO is legally permitted to coordinate care with the RAE under health care operations without the written consent of the Individual due to the Treatment/Payment/Operations exemption in HIPAA. The exception is that all information regarding a substance use disorder or substance use treatment is required by 42 CFR Part 2 to have written consent from the Individual.
        2. If the Individual is determined to have high risk for admission to a bed-based level of care (i.e., CSU, ATU, inpatient psychiatric hospitalization, withdrawal management, residential treatment for mental health and/or substance use disorder) the BHASO will continue providing care coordination services until the RAE confirms they are actively assuming care coordination responsibilities for the Individual.
h. The BHASO shall provide Care Navigation (Tier 1) for Individuals with commercial insurance for cases where the commercially-insured Individual or family are engaged in crisis response system services or is otherwise identified as high risk. The BHASO shall work with the Individual or family in contacting their commercial insurer to discuss care coordination needs with the aim of commercial insurance coverage.
i. The BHASO and BHA will develop a strategy for identifying, monitoring and reporting on Individuals who are overutilizing crisis and acute care services.
j. For the purposes of Care Navigation provided directly by the BHASO, BHASOs have primary responsibility for services for the Individuals that live in its Region. The BHASO shall require contracted providers to use OwnPath and the Client Care Search

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(encompassing Bed Tracking and Referrals) when possible for identifying behavioral health providers and services.

k. The BHASOs are responsible for referrals, transitions, and warm hand-offs whether the Individual is moving to a different BHASO region, between Network providers, and with a RAE.

l. If an Individual is discharging from a Colorado Mental Health Hospital (CMHH) and returning to the community with intent to establish residency in the BHASO region the BHASO will coordinate with the CMHH or other systems or programs, such as Momentum or Transition Specialist Program, to establish care with a BHASO Network provider.

m. The BHASO and BHASO Network will provide care coordination services for Individuals to initiate timely access to care that is person-centered, trauma-informed, and culturally and disability competent with attention to connection to quality crisis supports; mental health and substance disorder services; and preventative care services including services that address the social determinants of health.

n. BHA may require the BHASO to represent the BHA on standing committees, including, but not limited to:
    i. Continuum of Care (CoC)
    ii. Bridges of Colorado commissions.

o. Staff Credentials and Training
    i. The BHASO and BHASO Network staff providing care coordination directly shall complete BHA Care Navigator Training pursuant to C.R.S. §27-60-204(4)(a). BHASO Network providers conducting care coordination services will maintain a record of staff completion of required trainings which is accessible to the BHASO and BHA upon request. The BHASO will maintain a record of staff completion of required training which is accessible to the BHA upon request. Personnel with the BHASO and BHASO Network may provide care coordination for populations in which they have received training.
    ii. The BHASO and the BHASO Network shall have written policies and procedures outlining the initial and ongoing training for personnel delivering care coordination. The written policies and procedures shall identify the frequency of ongoing training.

p. External Agreements. The BHASO will work with hospitals and inpatient facilities to establish standard operating procedures or policies for care coordination interactions.

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2.1.4 Service Hours

a. The BHASO and the BHASO Network shall set service hours that are responsive to Individual needs and preferences, following these guidelines:
    i. BHASO and BHASO Network websites will provide information about how to contact Colorado Crisis Services and 988 for emergent 24/7 services.
    ii. BHASO Network will provide publicly accessible information on their website and via telephone for how to access available urgent care or crisis care.
    The BHASO and BHASO network will be available to respond to routine requests (Monday-Friday 8:00AM-5:00PM). If a care navigator/coordinator is not immediately accessible, response will occur within one (1) business day.

2.1.5 Overview of Tiered Care Coordination Structure

a. The BHASO shall collaborate with BHA to standardize aspects of the delivery of care coordination services within a three-tiered model that categorizes the types of care coordination services that should be made available for Individuals based on Individual acuity and identifies criteria for stratifying Individuals into each tier.
    i. The BHASO shall allow the BHASO's or the BHASO Network's clinical care coordination staff the discretion to move Individuals in and out of tiers based on clinical assessment of Individuals and in line with Individual needs and preferences, regardless of an Individual's diagnosis.
        1. The BHASO may incorporate their own unique stratification requirements within the guidelines and/or policies established by the BHA to achieve the BHASO's specific goals based on the BHASOs analysis of Individuals receiving care coordination services.
    ii. The BHASO's care coordination program shall consist of the following three-tiers:
        1. Tier 1: Care Navigation: brief screening of care needs, referral facilitation to identified service and support needs, and warm hand-off to RAEs.
        2. Tier 2: Care Coordination: intensive care coordination for complex behavioral health care needs.
        3. Tier 3: Care Management: intensive care coordination for high utilizers of bed-based levels of behavioral health care including services within the Colorado Crisis Services.

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b. The BHASO and the BHASO Network shall reduce duplication of efforts and overburdening Individuals and providers by leveraging existing screenings, assessments, and treatment plans to develop to identify the best services and supports to meet the Individual's needs and connect them to care
c. When care coordination and care management services exceed thirty (30) consecutive calendar days, the BHASO policy and procedure shall include the assigned care coordinator with either the BHASO or BHASO Network review the Individual's screened/assessed needs, verification that those needs are either fully addressed or being addressed as evidenced by the care coordination documentation, and determination if continued care coordination is indicated. If there are unmet care coordination needs, the care coordinator will adjust the care plan with action steps toward resolution. If needs are met, the care coordination will be successfully closed.

2.1.6 Tier 1: Care Navigation

a. Definition:
    i. Tier 1 Care Navigation focuses on helping Individuals navigate the healthcare system and refers to activities aimed at connecting Individuals and families to the right BHASO Network providers for assessment, treatment and care coordination, as appropriate.
    ii. Care Navigation may be problem solving around specific barriers to care such as transportation and language accessibility to assist Individuals and connection to the services needed to meet their needs.
    iii. Care Navigation involves brief, temporary support in connecting to services for their behavioral and physical health as well as preventative care.
    iv. Care Navigation is expected to be completed within 30 days, some extensions may be appropriate based on barriers in connecting to indicated services and supports.
    v. Care Navigation must be carried out with the Individual's expressed preferences and with the involvement of the Individual's chosen support system, which may include family, parent/guardian, legal representative, advocate, caregiver, or other supports identified by the Individual.
b. Eligibility.
    i. Tier 1 Care Navigation supports any Individual, family member or friend that reaches out for assistance, focused on triaging and short-term assistance.

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c. Activities

i. The care navigator will conduct a brief screen to include presenting concern, requested service or support, and insurance provider/carrier.

ii. The care navigator will provide the Individual with specific resources for assessment, treatment and recovery providers based on the identified needs and preferences of the Individual.

iii. The care navigator will provide the Individual with specific resources for other community and system to address identified social determinants of health based on the identified needs and preferences of the Individual.

iv. If the individual does not have insurance, the care navigator will connect the Individual to Health First Colorado for assistance in applying for Medicaid or CHP+ coverage.

v. If the Individual is a Medicaid Member, the care navigator will link the Individual to the Individual's RAE for ongoing care coordination. This linkage will be conducted through a warm telephonic connection to the RAE.

vi. If the Individual is a Child Health Plan (CHP+) Member, the care navigator will link the Individual to the appropriate CHP+ plan administrator. This linkage will be conducted through a warm telephonic connection to the CHP+ health plan.

vii. If the Individual has commerce insurance, the care navigator will link the Individual to the insurance plan member services, or if available their care management team.

1. If the Individual indicates barriers to accessing care through their insurance plan and would like assistance, the care navigator will refer the Individual to a care coordination team member at the BHASO who can assist the Individual in navigating their health plan in effort to access care. This care coordination team member will also consider other publicly funded programs that may help to meet the Individual's needs.

viii. If the Individual's care needs are not met during the initial interaction, the care navigator will determine with the Individual a follow-up plan to reassess their connection to care and any assistance needed in addressing barriers to care. This follow-up shall occur within five (5) business days.

ix. All coordination efforts and action steps will be documented in the Individual's record.

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x. If Individual presents with potential need for immediate crisis intervention, the care navigator will provide a warm hand-off connection to 988 crisis response system.

xi. If the Individual presents with an active public safety concern or medical emergency, the care navigator will contact 911 emergency response system.

d. BHASO Responsibilities. The BHASOs shall perform or subcontract the following tasks:

i. Care Navigation Line:

1. The BHASO shall operate, staff, and publicize a toll-free phone number and email address (the "Care Navigation Line") to provide basic care navigation to assist Individuals in obtaining access to services including but not limited to finding a provider and scheduling an appointment.
2. The BHASO shall provide the other BHASOs' Care Navigation Lines with referral pathways to its BHASO Network providers.
3. The BHASO shall require the BHASO Network to publicize the BHASO's Care Navigation line. The BHASO will provide written guidance to the BHASO Network for purposes of standardized messaging
4. The Care Navigation Line must be linguistically accessible and must comply with this SOW's provisions 1.3.12 Services to Persons Who are Deaf or Hard of Hearing and 1.3.14 Cultural Responsiveness in Service Delivery.
5. For Individuals with commercial insurance the BHASO's will provide Care Navigation by referring the Individuals to their health plan for care coordination assistance.
6. For the purposes of Care Navigation provided directly by the BHASO, BHASOs have primary responsibility for services for the Individuals that live in its Region. If an Individual who does not reside in the BHASO's Region seeks Care Navigation services from the BHASO, the BHASO shall provide a warm hand-off to the BHASO responsible for where the individual resides.
7. Target Population. The BHASO shall provide Care Navigation Line services to any Individual who contacts the Care Navigation Line, regardless of payer source, if the Individual identifies Medicaid as their payer source, then the BHASO will provide a warm hand off to the appropriate RAE.

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8. Service Hours. The Care Navigation Line shall be operational during standard business hours (Monday – Friday 8:00AM – 5:00PM).
9. Payment. The Care Navigation Line shall be funded in the BHASO's operational budget.

ii. The BHASO Quality Assurance plan will include monitoring of Care Navigation provided by BHASO Network providers in accordance with Standardized Policies and Procedures for care navigation/coordination tiers.

e. BHASO Network Responsibilities. The BHASO Network shall perform the following tasks:
   i. The BHASO Network will adhere to all requirements of care navigation as outlined in this Care Coordination Exhibit.
   ii. The BHASO Network provider will outreach the Individual within seven (7) calendar days of receiving a referral for care navigation from the BHASO and will assist the Individual in connecting to care.
   iii. The BHASO Network will conduct a minimum of three (3) outreach attempts over fourteen (14) calendar days using different methods (i.e., phone, email), as available, to connect with the Individual. If the care navigator is unable to reach the Individual after these attempts, or the Individual declines care navigation support, this will be documented in the Individual's health record and the care coordination referral will be closed.
   iv. If there remains unmet needs after fourteen (14) calendar days, the care navigator will evaluate if the Individual should be elevated to a different tier of care coordination. Extensions may be appropriate if certain resources in the service plan require a longer period of time receiving Tier 1 Care Navigation.

f. Staffing
   i. Staff providing care navigation must complete BHA required training.
   ii. Personnel shall have a minimum of a high school diploma or equivalent with relevant paraprofessional work experience and/or lived experience.

2.1.7 Tier 2 - Care Coordination

a. Definition
   i. Tier 2 Care Coordination provides intensive care coordination for Individuals with complex behavioral health related care coordination needs. The focus is to promote integrated whole person care across the spectrum of health

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services. An individualized service plan must always be developed at this tier, arranging for continuity of care, and coordinating the array of services necessary for appropriately treating Individuals identified as needing Tier 2 support.

ii. Care Coordination services shall be provided to support Individuals and families to aid in initiating care, navigating crisis supports, provide mental health and substance use disorder (SUD) assistance, provide and coordinate preventative care services, and coordinate or provide services necessary to address an Individual's social determinants of health.

b. Eligibility

i. Tier 2 Care Coordination supports adults without insurance who are at risk of needing crisis services, psychiatric inpatient hospitalization, or residential levels of care for mental health or substance use disorders.

ii. Tier 2 Care Coordination supports all youth aged 20 and younger whose needs are not met through Tier 1 Care Navigation.

iii. Tier 2 Care Coordination is available to and provided for Individuals and families in the following circumstances:

a. Individuals engaged in crisis response system services;
b. Individuals engaged in CYMHTA services;
c. Individuals engaged in COACT services;
d. Individuals under emergency / involuntary commitments for substance use disorder services;
e. Individuals receiving civil and involuntary outpatient treatment;
f. Individuals who are recently discharged from an inpatient psychiatric facility;
g. Individuals involved in child welfare, juvenile justice, and the criminal justice system with behavioral health needs;
h. Individuals involved with forensic community based services or competency restoration;
i. Youth at risk of out-of-home placement due to behavioral health needs and their families;
j. Individuals living with severe mental illness and/or co-occurring mental health, physical health, and/or substance use disorders;

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k. Individuals experiencing homelessness with behavioral health needs,
l. Individuals experiencing high acuity behavioral health needs; and
m. Individuals involved in any other BHASO program that has Care Coordination services embedded within the program.

c. Activities

i. All activities listed under Tier 1 Care Navigation.
ii. Conduct a standardized care coordination assessment to create and support comprehensive care plans.
iii. Develop individualized care plan in collaboration with the Individual, and the family, care givers, and providers, as applicable. Care plans address:
    1. Measurable, time-bound, relevant Individual-identified goals for whole person care.
    2. List of all entities and Individual providers involved in the Individual's care, including identification of the lead care coordinator.
    3. Individual-specific criteria for successful discharge from care coordination.
    4. Identified needs, barriers, and Individual goals and preferences
    5. Referrals to services and supports to address social determinants of health
    6. Peer supports around Activities of Daily Living (ADLs) and attending appointments and typical developmental responsibilities (school, work, etc.).
        a. For youth, this includes educational supports like 504 Plans and Individualized Education Plans (IEP).
        b. For adults and transition age youth, this includes connections to vocational and employment related supports.
    7. Warm connection to behavioral health treatment and recovery services, including but not limited to family therapy and wrap around services.
    8. Where another agency's care coordinator/case manager is the lead, the care coordinator shall follow and complement the goals of the other agency's care plan to avoid duplication, and advocate for updates to the care plan if additional gaps in care are identified.

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9. The care coordinator shall document a copy of a lead agency's care plan in the Individual's health record.

iv. Referral and connection to community support services and treatment programs including but not limited to:

a. For adults:
a. Assertive Community Treatment (ACT)
b. First Episode Psychosis (ASCENT) (15-29 years)
c. Intensive Outpatient Treatment (IOP)
d. Housing security services
e. ASAM level 3 residential programs
f. Vocational Rehabilitation and other employment and/or job training supports.
b. For youth:
a. CYMHTA
b. COACT or High Fidelity Wraparound
c. MST
d. FFT
e. Intensive Outpatient Program
f. QRTP
g. PRTF
h. For transition age youth, employment/vocational and/or job training supports

v. Deliver care coordination interventions

1. Outreach to other appropriate agencies and/or providers that may be able to assist the Individual with their unique needs.
2. Problem-solving challenges or barriers to care that do not meet eligibility for existing programs.
3. Advocacy
   a. Education to equip the Individual with information through means that are accessible and appropriate for the Individual based on their needs and preferences
   b. Self-management support including educating the Individual about their behavioral health conditions and daily living skills

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including but not limited to medication use, personal hygiene, transportation use, shopping, and budgeting

4. Collaboration and coordination shall include various health, social service, community-based providers, and additional systems that the person may be involved. Collaboration shall include the Individual and their chosen supports as an inclusive decision-making process.
5. Support the Individual to develop psychiatric advance directives, with the support of appropriate physical and behavioral health professionals, so the Individual's preferences for behavioral health treatment and recovery supports are known in the event of a behavioral health crisis.
6. As the Individual needs change, the care coordinator will reassess needs and preferences and will transition the Individual to a higher or lower care coordination tiers.

d. BHASO Responsibilities. The BHASOs shall perform or subcontract the following tasks:
   i. The BHASO will adhere to all requirements of care coordination as outlined in this Care Coordination Exhibit
   ii. The BHASO Quality Assurance plan will include monitoring of Care Coordination provided by BHASO Network in accordance with Standardized Policies and Procedures for care coordination tiers.

e. BHASO Network Responsibilities. The BHASO Network shall perform the following tasks:
   i. The BHASO Network will adhere to all requirements of care coordination as outlined in this Care Coordination Exhibit.
   ii. The BHASO Network will outreach the Individual within three (3) business days of receiving a referral for care navigation from the BHASO and will assist the Individual in connecting to care.
   iii. The BHASO Network will conduct a minimum of three (3) outreach attempts over fourteen (14) calendar days using different methods (i.e., phone, email), as available, to connect with the Individual. If the care coordinator is unable to reach the Individual after these attempts, or the Individual declines care coordination support, this will be documented in the Individual's health record and the care coordination referral will be closed.

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iv. Care plans must be reviewed and updated and shall not exceed ninety (90) calendar days. If there remains unmet needs after ninety (90) calendar days, the care coordinator will revise the care plan. If a significant change occurs prior to end date of the current care plan, the care coordinator will collaborate with the Individual to update the care plan to meet the current needs and will reassess if the Individual is in the most appropriate tier of care coordination.

f. Staffing

i. Staff providing care coordination must complete BHA required training.

ii. Care coordination shall be provided in accordance with the required training and credentials per program specifications, such as with CYMHTA, COACT, and other intensive behavioral health program models.

2.1.8 Tier 3 Care Management

a. Definition

i. Tier 3 Care Management is the highest level of continuum of care for Individuals with complex and unmet behavioral health needs and is focused on, but not limited to, Individuals in Tier 2 Care Coordination with a combination of historical and current risk of admission to bed-based levels of care and/or increase risk of criminal justice involvement due to the Individual's behavioral health needs.

ii. Care management focuses on the most complex and high-risk members experiencing physical and/or behavioral health conditions. Care management requires a more robust and intensive individualized service plan. Coordinating care and individualized care plans at this tier includes increased accountability for assisting acute levels of care (i.e., ED, CSU, ATU, inpatient psychiatric hospitalization, residential levels of care for substance use and mental health) in coordinating the discharge of Individuals with complex behavioral health conditions and other complex needs into lower levels of care including home-based services for the Individual and caregivers.

b. Eligibility

i. Referral from Tier 2 Care Coordination.

c. Activities

i. All activities listed under Tier 1 Care Navigation and Tier 2 Care Coordination.

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ii. Care management requires a higher frequency of weekly connection with and/or on behalf of the Individual. A minimum of three (3) care coordination activities per week in effort to connect to appropriate service and supports in effort to stabilize the Individual's behavioral health.

a. If an Individual is enrolled in another program that provides intensive care coordination services, including but not limited to, Crisis Resolutions Teams, High Fidelity Wraparound, etc., these weekly care coordination activities may be less frequent as they would be duplicative.

iii. Accompanying the Individual within the community or other setting to access services which the Individual may not be able to access independently, per C.C.R. 502-1, 12.5.7, B, 3, d.

iv. Address access to acute and chronic physical and behavioral health care, peer support networks, social services including income supports, health insurance, housing, educational systems, and employment opportunities as necessary to facilitate wellness and recovery of the whole person in alignment with an Individual's assessed needs and expressed goals.

v. Follow up care management activities are performed until the Individual is connected to appropriate care and community supports and demonstrates stability in home and community.

d. Staffing

i. Care Management is performed by an unlicensed master's level clinician. An unlicensed master's level clinician has a master's degree in a mental health field (including, but not restricted to, counseling, family therapy, social work, psychology, etc.) from an accredited college or university. LSW and unlicensed psychotherapist fall in the unlicensed master's level clinician category. This professional shall be supervised in the provision of services by a licensed mental health care provider (including, but not limited to, LCSW, LPC, LMFT).

ii. Personnel providing care management shall have clearly defined scopes of work that do not exceed their level of training and scope of practice.

e. BHASO Responsibilities. The BHASOs shall perform or delegate the following tasks:

i. Support the BHASO Network in ensuring continued connection with the safety net system after an Individual is discharged from hospitalization, the criminal justice system, an emergency department, or other behavioral health facilities, including withdrawal management facilities and jails.

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ii. Participates in and assists the BHASO Network with complex cases that involve staffings with multiple agencies or providers, when requested by the BHASO Network provider.

iii. For Individuals receiving Tier 3 Care Management, the BHASO's Standardized Policies and Procedures shall require comprehensive care plans are established within thirty (30) days after an Individual's referral for Care Management and updated at least every ninety (90) days but may be completed more frequently depending on the Individual's changing needs and identified risk factors.

iv. The BHASO shall document a copy of a lead agency's care plan in the BHASO's care coordination platform for Individuals receiving Tier 3 Care Management.

f. BHASO Network Responsibilities. The BHASO Network shall perform the following tasks:

i. The BHASO Network will adhere to all requirements of care coordination as outlined in this Care Coordination Exhibit.

ii. In the event that a BHASO Network provider is unable to identify appropriate services or supports, they can request support from the BHASO in facilitating connections to community partners and supports.

iii. Assistance with finding inpatient psychiatric hospitalization as clinically indicated.

iv. Assistance with finding residential admission as clinically indicated.

2.1.9 Reporting

a. Performance Outcome Metrics. The BHASO shall collect the following data for any individual that screens into care coordination services provided by the BHASO and/or the BHASO Network.

i. Number of Individuals served within each Tier.

ii. Number of Individuals referred to the RAEs from any care coordination Tier.

b. Reports to BHA

i. The BHASO shall submit quarterly reports on the performance outcome metrics identified in 2.1.9.a.

1. The BHASO shall develop and maintain mechanisms to collect the performance outcome metrics from BHASO and BHASO Network.
2. The BHASO shall submit care coordination service data to the BHA in a standardized format determined in by the BHA in collaboration with the BHASO.

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3. The BHASO shall submit an aggregated quarterly report by region with a BHASO and BHASO Network provider disaggregation.

ii. In addition to providing performance outcome measures the BHASO shall also provide system improvement recommendations to BHA to assist with continual improvements to the system.

Article 2 - Substance Use Disorder Pre-Release Case Management

2.2.1 Program Description & Objectives

a. The BHASO shall create or subcontract for pre-release case managers positions to serve competency-involved incarcerated Individuals with moderate to severe substance use disorder. The clinical case managers will partner with the Office of Civic and Forensic Mental Health Forensic Support Team (OCFMH FST) to coordinate substance use disorder treatment, housing, and outpatient restoration services. A case manager will provide participants with access to dual-diagnosis treatment, connect them to outpatient restoration, explore housing solutions, ensure medication consistency, help navigate community systems, and with benefit acquisition. Upon release from incarceration, the clinical case managers will stay involved with transitioning Individuals ensuring a strong community connection and engagement in both treatment and outpatient restoration.

2.2.2 Target Population

a. Defendant must be in custody and found incompetent to proceed.
b. Meet DSM-V-TR diagnostic criteria for moderate to severe substance use disorder.
c. Documented Serious and Persistent Mental Illness, such as but not limited to:
    i. Schizophrenia or Schizoaffective-Disorder
    ii. Bipolar with Psychosis
    iii. Post-Traumatic Stress Disorder
    iv. Major Depressive Disorder with a history of suicidality or psychosis
    v. Other - mental illness is clearly a barrier to addressing criminogenic needs.
d. Not currently charged with a felony or misdemeanor sex offense or history thereof.
e. The Individual should be willing and able to actively participate in established treatment plans (including medications).

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2.2.3 Activities and Services

a. Pre-release Substance Use Disorder Case Management

i. The BHASO Network shall provide essential transitional care coordination services, including pre-release contacts, day-of-release warm handoffs, assessments and service planning, and assistance with entitlements, housing, vocational, independent living skills, linkage to community supports (e.g., mental health, substance use, medical providers), advocacy, crisis response, and case conferences.

1. Upon receipt of OCFMH FST referrals and within two (2) business days schedule an Individual intake, process, and request necessary paperwork.
2. Within five (5) business days conduct an intake interview with the Individual.
3. Maintain a caseload of twenty (20) Individuals and conduct at least six (6) face-to-face services per month for all Individual's pre-release and up to sixty (60) days post-release.

ii. The BHASO shall promote the highest level of program standards and communication and follow any quality assurance measures adopted by the OCFMH FST.

iii. The BHASO shall meet with the OCFMH FST and relevant jail stakeholders including JBBS as needed for case management communication including team meetings and group or individual meetings as needed.

iv. The BHASO shall provide OCFMH FST access to copies of service manuals, guides, case plans, or other tools as requested. If materials are copyrighted, the BHASO will make materials available to review on site or in person.

v. The BHASO shall obtain appropriate release of information, when required.

vi. The BHASO shall provide transition progress reports and discharge reports to the FST, relevant jail stakeholders including JBBS which must include the following information:

1. Initial intake date
2. Information regarding the number of case management contacts and resource acquisition plans.
3. Recommendations for adjunct services (as needed)
4. Barriers to release from jail or community re-entry
5. Any additional information to the successful transition

Docusign Envelope ID: A018446B-4183-425B-8517-E056CDFA047E

a. DELIVERABLE: Transition Progress Report
b. DUE DATE: Quarterly on the thirtieth (30th) day following the end of the quarter
c. DESTINATION: cdhs_BHAdeliverables@state.co.us
d. FILE NAME: BHASO Region [X] - [BHASO] - FY[XX] - Transition Progress and Discharge Report

vii. The BHASO shall report any changes in intake times, discharge plans in writing via email prior to the actual change to OCFMH FST, relevant jail stakeholders including JBBS.

viii. Whenever possible, when making a referral to outside services, the BHASO shall inform the OCFMH FST about any referrals for adjunct services/needs.

ix. The BHASO will notify the OCFMH FST within twenty-four (24) hours, via phone call, email, if the referred Individual fails to attend initial services and/or is discharged from case management services (both successfully and unsuccessfully).

b. Responsibilities of the OCFMH FST

i. The OCFMH FST will be responsible for the referral of Individuals to the BHASO for services, but there is no guarantee of referral or a specific number of referrals to the BHASO.

ii. The OCFMH FST will obtain all necessary Release of Information (ROI) and provide the BHASO with pertinent Individual information.

iii. The OCFMH FST will participate in developing the plan for each referral.

iv. The OCFMH FST will work with the BHASO to reduce barriers to success.

v. The OCFMH FST shall respond to all correspondence requesting contact from the BHASO within a reasonable timeframe.

vi. The OCFMH FST will inform the BHASO of concerns related to Individuals (significant life changes, barriers to release, changes to criminogenic risk or clinical acuity).

vii. The OCFMH FST does not have a duty or obligation to refer Individuals to the BHASO; however, once a referral to the BHASO is made, all duties stated herein for the BHASO and OCFMH FST shall be performed.

c. Assessments and Documentation

i. The OCFMH FST will provide the BHASO with the Individual's competency evaluation and related assessments (LSI-R) information (according to policy and

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release of information) to assist with identifying the Individuals protective factors, strengths, and criminogenic risks/needs.

2.2.4 Standards and Requirements

a. Responsibilities of the Pre-release Substance Use Disorder Case Manager
    i. The BHASO Network shall collaborate professionally and effectively with Jail Based Behavioral Health Services, county jail mental health providers, jail medical providers, the Forensic Support Team including forensic navigators and program coordinators, Bridges -court liaisons and other relevant stakeholders (jail deputies, probation officers, pretrial services, community mental health, outpatient restoration providers).
    ii. The BHASO Network shall return any phone calls or electronic communications from OCFMH FST and relevant jail stakeholders including JBBS within five (5) business days.

2.2.5 Staff Credentials and Training

a. Bachelor's degree in counseling, Psychology, Social Work, Criminal Justice OR Human Services related fields preferred.
b. One year experience working with behavioral health and criminal justice populations is preferred.
c. Ability to learn rules, regulations and security procedures required by the county jail.
d. Ability to pass jail background check and orientation.
e. Must be able to work in diverse environments such as homeless shelters, service facilities, streets, offices, and all other locations as necessary to fulfill program objectives.
f. Knowledge and skill in the application of Harm Reduction, Critical Time Intervention, Motivational Interviewing, Trauma-Informed Care, and Housing First Principles.

2.2.6 Performance Outcome Measures

a. Utilizing the BHASO Networks discharge summaries, the OCFMH FST will track reasons for both successful and unsuccessful discharges, the average length of time an Individual receives case management services and use this information to make recommendations for changes in service delivery and to document promising practices. As described in the activities and services section discharge summaries will consist of:

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i. Unsatisfactory discharge summaries will identify the following:
    1. Reason for discharge
    2. Date of discharge
ii. Successful discharge summaries will identify the following:
    1. Sustainability plan
    2. Date of discharge
iii. Activities, treatment, and other relevant groups the Individual has completed or in which they continue to participate.

2.2.7 Payment

a. This service reconciles to a capacity reimbursement model. The BHASO shall negotiate and record an annual capacity-based budget with each provider utilizing a capacity-based payment methodology. The BHASO shall keep budget current with providers, and budgets shall be available to BHA upon request.

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Part Three: Safety Net Services

Chapter 1
Emergency or Crisis Behavioral Health Services

Article 1 - Emergency and Crisis Behavioral Health Services - General Safety Net Service Terms
Article 2 - Mobile Crisis Services (MCR) - BHA Program
Article 3 - Walk-In Crisis Services (WIC) - BHA Program
Article 4 - Crisis Stabilization Services - BHA Program
Article 5 - Crisis Respite Services - BHA Program

Article 1 - Emergency and Crisis Behavioral Health Services - General Safety Net Service Terms

3.1.1.1 Program Description and Objectives

a. The BHASO shall develop and execute a comprehensive and statewide Crisis System that includes Mobile Crisis Response, Walk-In Centers, Crisis Stabilization Units, Crisis Respite Services, and Acute Treatment Unit services system capable of serving children, adolescents, and adults in behavioral health crisis situations.
b. Mobile Crisis Response, Walk-In Centers, Crisis Stabilization Unit/ Acute Treatment Units, Crisis Respite Services, and the separately-contracted Crisis Line are collectively known as “Colorado Crisis Services.”

3.1.1.2 Statutory and Rule Citation

a. Emergency and Crisis Services shall be pursuant to C.R.S. § 27-65-103 and § 27-60-104
b. Emergency and Crisis Services shall be performed in accordance with Chapter 6 of 2 CCR 502-1.
c. The BHASO must adhere to C.R.S. § 27-60-103 (1)(a)(1) through (7).

3.1.1.3 Target Population

a. Emergency and crisis services shall serve all people in Colorado and the sovereign indigenous regions within Colorado and no population shall be ruled out.
b. All modalities within the behavioral health crisis response system must be capable of serving:
    i. Children, adolescents, adults and older adults,
    ii. Individuals with behavioral health and/or co-occurring conditions, including:
        1. Mental health conditions,
        2. Substance use disorders,
        3. Physical Health needs,
        4. Intellectual or developmental disabilities,
        5. Physical disabilities,
        6. Traumatic brain injuries, or
        7. Dementia.
    iii. Individuals demonstrating aggressive behavior that can be safely managed in an unsecure setting,
    iv. Individuals who are uninsured or unable to pay for services, and
    v. Individuals who may lack Colorado residency or documented immigration status.
c. The BHASO shall develop and employ clinical protocols, policies, and procedures for the management and appropriate disposition of high-acuity populations including:
    i. Individuals who are actively physically aggressive,
    ii. Individuals with co-occurring substance use disorder and mental health condition,
    iii. Individuals who are referred by law enforcement,
    iv. Individuals with criminal justice involvement and/or a history of violence,
    v. Individuals on an M-1 hold,
    vi. Individuals who present as altered by a substance (e.g. drug/alcohol), and/or
    vii. Individuals who are at imminent safety risk who may be suicidal, homicidal, or gravely disabled.
d. The BHASO shall develop and employ protocols, policies, and procedures for responding to children, adolescents, and families in crisis, as well as Individuals with Intellectual

and Developmental Disabilities and caregivers in crisis, including coordination with county child welfare and Adult Protective Services on all modalities.

e. There are no children- and youth-specific statements of work under this Chapter, though all treatment modalities in this Chapter shall serve children and youth unless the modality is contraindicated for children and youth.

3.1.1.4 Activities and Services

a. Each component within the behavioral health crisis response system must provide services in a trauma-informed, with cultural and disability competent and responsive manner.
b. Agencies must incorporate peer support professionals into the services they provide, when clinically appropriate.
c. The Crisis Services system must include the following crisis service components:
    i. Mobile Crisis Services include face-to-face behavioral health screening and risk assessment, triage, de-escalation, crisis stabilization/intervention, safety planning, crisis placement care coordination if needed, and either face-to-face or telephonic follow-up post discharge. Services are provided within one hour in urban areas, and within two hours in rural and frontier areas.
    ii. Crisis Walk-In Services to include screening, assessment, triage, crisis intervention/stabilization, support, resource linkage, disposition, and follow-up services for Individuals in a behavioral health crisis. The BHASO Network provider shall initiate screening with an Individual within fifteen minutes of arrival.
    iii. Crisis Stabilization Services to include crisis intervention/stabilization, individual, group, and family therapy and psychiatric services, case management, resource and referral and disposition for admitted individuals. Crisis Stabilization services may be achieved by leveraging existing psychiatric bed capacity investments, described as Crisis Stabilization Units, as well as other psychiatric bed capacity. Crisis Stabilization Units may be paired with Walk-in services.
    iv. Crisis Respite Services to include crisis intervention and stabilization, case management, resource and referral and disposition for Individuals or families in a behavioral health crisis.
d. Community and Stakeholder Engagement

i. The BHASO shall perform outreach and communication to establish working partnerships with hospitals, law enforcement, child welfare, programs for individuals who are unhoused behavioral health providers including comprehensive and essential safety net providers, Substance Use providers, existing System of Care providers, and other community resources.

ii. The BHASO shall work collaboratively with their subcontractors to develop a community engagement strategy to inform partners and individuals about availability of mobile crisis response in their region, including how to access services, what to expect, and how to submit grievances.

iii. The BHASO shall partner with BHA to develop statewide protocols, policies, and procedures addressing the following:

    1. How Mobile Crisis staff shall approach a scene when requested by law enforcement and work collaboratively with law enforcement to create a plan of action.
    2. Define and standardize when, why, and how law enforcement is called to provide a civil assist/civil standby on scene for a mobile call or at a Walk-In Center.
    3. Disposition of calls that have both Crisis Services and Co-Responder involvement, when confidentiality laws allow information sharing or patient consent was obtained.

iv. The BHASO shall collaborate with law enforcement agencies to develop education materials and/or training for the community, schools, and family members regarding strategies for responding to behavioral health crises and when to call 988 for support or for assistance from a mobile crisis response team.

v. The BHASO shall collaborate with providers and community partners to develop strategy about access to Behavioral Health Secure Transportation and communication across involved entities.

vi. MEETING: The BHASO shall meet with 988/Crisis Line contractor on a regular cadence to be determined by the BHASO and the 988/Crisis Line contractor and approved by BHA, to discuss clinical best practices, challenges, and status updates.

3.1.1.5 Standards and Requirements

a. The BHASO Network shall ensure and maintain records that all crisis providers required to be crisis professionals have completed the Crisis Professional Curriculum (CPC) within six months of it being made available by BHA and/or within six months of new staff hire. All staff who have completed the CPC and/or are not required to take the CPC, the Contractor shall adhere to the current training plan.
b. The Contractor shall ensure training is standardized and that Direct Service staff are trained in the following, as well as other topics that the State finds critical in delivering crisis services across all modalities (e.g., Walk-in Services, Mobile Crisis Services, Crisis Stabilization Unit/Acute Treatment, and Respite Services).
    i. Cultural Competency and responsiveness
    ii. Disability competency and responsiveness
    iii. Trauma-Informed Care
    iv. Evidence-based and Promising Practices in Crisis Intervention
    v. Child, Adolescent, and Family Crisis Interventions
    vi. Suicide Screening, Assessment, and Safety Planning
    vii. Mental Health Conditions
    viii. Substance Use Disorders
    ix. Co-Occurring Disorders
    x. Intellectual and Developmental Disabilities
    xi. Traumatic Brain Injuries
    xii. Dementia
    xiii. Screening and Risk Assessment
    xiv. Psychiatric Medications and Side Effects
    xv. Non-violent Crisis Intervention
    xvi. Gender-Responsive Services
    xvii. National Standards for Culturally and Linguistically Appropriate Services (CLAS) including BHA CLAS standards policies
    xviii. Colorado Mobile Crisis Training materials
c. The BHASO's clinical director and/or contracted physician shall develop a clinical procedure for medical screening when an Individual requires a higher level of care (i.e.: Crisis Stabilization Unit, Acute Treatment Unit, inpatient psychiatric hospital) with final approval by The BHASO medical director. The BHASO shall also establish clearance

protocols with emergency medical services to mitigate unnecessary emergency room utilization.

d. The BHASO shall develop and employ standard protocols, policies, and procedures to address the following presenting issues when assessing risk:
    i. Acute intoxication
    ii. Acute physical health issues
    iii. Violent or aggressive behavior despite efforts to de-escalate.
e. The BHASO shall develop and employ protocols, policies, and procedures to ensure crisis interventions meet the community need and include partnerships with emergency medical services, emergency departments, and law enforcement.
f. Each component within the Colorado Crisis System must provide services in a culturally and disability competent manner.

3.1.1.6 Network Adequacy

a. Network Development and Access
    i. The BHASO shall subcontract and maintain a provider network capable of ensuring access and continuity of all required behavioral health crisis services described in this Contract within its Region(s).
        1. The BHASO must ensure Crisis Stabilization Services; Mobile Response; Walk-in assessment and Respite Services for children, adolescents and adults to mitigate behavioral crises are accessible 24/7/365 in the BHASO's Region or by coverage by MOU/Contract with a neighboring Region.
        2. The BHASO shall guarantee that case management and coordination of care are delivered by the subcontractor or the contracted network to ensure continuity of care as clinically indicated. The BHASO shall ensure that individuals evaluated and assessed through the crisis system are connected to appropriate ongoing services (e.g., confirming a scheduled appointment with a behavioral health care provider). This may be delegated to the network providers as deemed necessary to ensure appropriate services are billed to Medicaid and/or commercial insurance.

3.1.1.7 Licensing Requirements

a. Agencies within BHASO Network shall maintain a BHE License with all appropriate crisis endorsements and sub-endorsements for mental health and substance use disorder services including:
    i. Walk-in crisis endorsement
    ii. Mobile crisis endorsement
    iii. Community-based respite endorsement
    iv. Acute treatment unit endorsement
    v. Crisis stabilization unit endorsement
    vi. Residential respite endorsement
b. Agencies only providing Mobile Crisis Response services may obtain an Essential Safety Net Approval if they do not meet the requirements for a BHE license.

3.1.1.8 Data Submissions

a. 837 Encounter data shall be delivered in accordance with the terms of Exhibit D, as may be amended, Article 2. Encounter data shall be delivered to BHA for each modality of the Crisis System: Crisis Stabilization Unit, Walk-in Crisis, Crisis Respite, or Mobile Crisis Services.
b. The BHASO Network shall complete a CCAR/DACODS record or Treatment Episode Report Unified Data Model submission (the successor to former CCAR/DACODS submissions) for each applicable Individual per the technical specification guidelines provided by BHA to BHASOs.
c. Data Dictionary
    i. The BHASO shall submit monthly data in accordance with the CCS Data Dictionary by the 15th of the month following
    ii. Quarterly analysis reports on regional trends and the quality of data reported by Contractor's subcontracted providers, including staffing ratios and narrative regarding how the BHASO worked to ameliorate data quality issues.
        i. DELIVERABLE: Quarterly Data Analysis Report
        ii. DUE DATE: Last day of the month following the end of the quarter
        iii. DESTINATION: cdhs_BHASO_deliverables@state.co.us

iv. FILE NAME: BHASO Region[X] - [BHASO] - FY[XX][Quarter] - Crisis Quarterly Data Report

iii. Annual analysis reports on regional trends and the quality of data reported by Contractor's subcontracted providers, including staffing ratios and narrative regarding how the BHASO worked to ameliorate data quality issues.

i. DELIVERABLE: Annual Data Analysis Report

ii. DUE DATE: Last day of the month following the end of the quarter

iii. DESTINATION: cdhs_bhaso_deliverables@state.co.us

iv. FILE NAME: BHASO Region[X] - [BHASO] - FY[XX][Quarter] - Crisis Annual Data Report

3.1.1.9 Payment

a. The BHASO shall negotiate and record an annual capacity-based budget with each provider utilizing a capacity-based payment methodology. The BHASO shall keep budget up-to-date with providers, and budgets shall be available to BHA upon request.

Article 2 - Mobile Crisis Services - BHA Program

3.1.2.1 Program Description and Objectives

a. The BHASO Network shall develop a network of Mobile Crisis Response providers to serve all Individuals determined by the Colorado Crisis Line/988 or the BHASO to be in need of in person risk assessment.

b. Colorado Crisis Services Mobile Crisis Response is intended to meet the needs of an Individual in the community presenting in crisis and in need of, or requesting, in person crisis assessment, brief intervention, and connection and/or referral to community resources.

3.1.2.2 Statutory and Rule Citation

a. Mobile Crisis Services shall be performed in accordance with C.R.S. §27-60-103 (1)(b)(III) and Part 6.5 of 2 CCR 502-1.

b.

3.1.2.3 Target Population and Dispatch

a. All dispatch requests shall be accepted in accordance with BHA-provided dispatch criteria, and no population shall be ruled out.

b. Mobile Crisis Response services shall serve, but are not limited, to the following populations:
    i. Children, adolescents, adults and older adults,
    ii. Individuals with behavioral health and/or co-occurring conditions,
    iii. Individuals demonstrating aggressive behavior that can be safely managed in an unsecure setting,
    iv. Individuals who are uninsured or unable to pay for services,
    v. Individuals who may lack Colorado residency or documented immigration status,
    vi. Third (3rd) parties on scene who can provide information about the crisis, or individuals who would benefit from crisis intervention and resources, and
    vii. Individuals who are under the influence of drugs, alcohol, or other substances.
c. Mobile Crisis Response Providers shall respond to dispatch requests made by the 988/Colorado Crisis Line, in partnership with emergency responders.
d. The BHASO Network shall implement ways to accept the Mobile Crisis Response dispatch request if there are supports on scene such as:
    i. Family and secondary supports;
    ii. Emergency medical services;
    iii. Law enforcement;
e. If a dispatch request is rejected or canceled, the 988 Suicide and Crisis Lifeline is responsible for follow-up with the individual to ensure service needs are being met in another capacity.

3.1.2.4 Activities and Services

a. The BHASO and/or the BHASO Network shall prioritize mobile response as the primary intervention for the crisis system.
b. Mobile Crisis Response services shall reduce or mitigate the current crisis of Individuals and families in the community presenting in a behavioral health crisis who are in need of in-person crisis assessment, brief intervention, and connection and/or referral to community resources.
c. Mobile Crisis Response providers shall provide necessary crisis interventions and other necessary supports for Individuals and families where the crisis occurs.
d. The BHASO Network shall dispatch Mobile Crisis Response upon assessment and referral from the Colorado Crisis Line or 988 Colorado Mental Health Line.

i. If Mobile Crisis Response services were initiated by the Colorado Crisis Line or the 988 Colorado Mental Health Line, the Mobile Crisis Response provider shall update the Mobile Crisis Response dispatch portal with data and disposition of response within twenty-four (24) hours of dispatch.
    1. If the Mobile Crisis Response provider is unable to make contact with the individual requesting the service from the statewide Crisis Line or the 988 Suicide and Crisis Lifeline, the Mobile Crisis Response provider shall utilize the Mobile Crisis Response dispatch portal to inform the statewide Crisis Line at the time such a determination is made.
    2. All rejected or canceled dispatches must be appropriately documented in the mobile crisis response dispatch portal operated by the Colorado Crisis Line/988 call center.

ii. The statewide Crisis Line and the 988 Colorado Mental Health Line shall make such data accessible to the BHASO for the purposes of data collection, payment determinations, and care coordination.

e. If Mobile Crisis Response dispatch is requested by a source other than the Colorado Crisis Line or the 988 Colorado Mental Health Line:
    i. Standard Colorado Crisis Services dispatch protocol shall be utilized to dispatch Mobile Crisis Response providers. Dispatch protocol shall be developed in collaboration by the 988 Colorado Mental Health Line, the BHASOs and BHA.
    ii. The resulting Mobile Crisis Response service must be reported to BHA through the mobile crisis response dispatch portal operated by the 988 Colorado Mental Health Line.
    iii. The BHASO shall coordinate billing and payment from the appropriate payer source.

f. Mobile Crisis Response providers shall respond with the least restrictive interventions possible, only involving law enforcement when necessary, according to the Statewide Policy and Procedure developed in partnership with BHA and document the circumstances in the EHR.

g. Mobile Crisis Response providers shall respond to location within one hour or less from the time that the request is received in urban areas, and two (2) hours or less in rural and frontier communities.

i. The following city limits within otherwise rural areas require a one (1) hour response time:
    1. Greeley
    2. Fort Collins
    3. Colorado Springs
    4. Pueblo
    5. Grand Junction

h. The Mobile Crisis Response intervention shall include the following steps documented in the EHR, with the intention of promoting robust community response and prioritizing lower levels of care, in alignment with the Crisis Professional Scope of Practice:
    i. Complete the approved Columbia Suicide Severity Rating Scale (C-SSRS) on all individuals
        1. The C-SSRS shall be documented in the EHR
    ii. Perform BHA Colorado Crisis Assessment in accordance with the Crisis Services as established in 2 CCR 502-1 and including all data points on the form provided by BHA
    iii. Perform individualized safety planning as determined by the BHA Colorado Crisis Assessment
        1. All safety planning shall utilize the patient safety plan template available from BHA
        2. The safety plan shall be documented in the EHR as a separate and clearly identifiable form
    iv. Complete the lethal means restriction template if indicated as a risk mitigation measure
        1. The lethal means restriction shall be documented in the EHR
    v. Provide brief intervention and stabilization, intended to maintain stability in the community and reduce unnecessary higher level of care referrals, which may include but are not limited to the following:
        1. Interventions outlined in the Child, Youth and Family Crisis Toolkit;
        2. Skill-building;
        3. Recovery services;
        4. Peer support services;
        5. Provide resources and referrals to the individual;

a. Resources provided shall always include the 988 Suicide and Crisis Lifeline number and the 988 Suicide and Crisis Line text number;
b. All referrals provided shall be documented in the Individual's electronic record and shall include, at a minimum, the provider's name and date/time of the appointment;

6. Care coordination efforts shall be clearly documented in the EHR to reflect collateral information obtained as part of the BHA Colorado Crisis Assessment and intervention, connection to community resources and risk mitigation
    a. Care coordination may include resources from the Child, Youth and Family toolkit;
    b. Care coordination shall include community and local resources that may be outside the typical treatment providers;
    c. Providers are responsible for ensuring that they have access internally or through MOUs to a variety of experts in specialty populations to help respond to Mobile Crisis Response requests or be available for consultations shortly after. This can be managed at a regional level through the BHASO. These specialty populations include but are not limited to the populations identified C.R.S. 27-60-301.

i. Coordinate appropriate transportation between levels of care throughout the crisis episode. Colorado Crisis Services shall not fund transportation otherwise funded by Medicaid or other commercial insurance.
j. Mobile Crisis Response services critical incident reporting shall be performed in accordance with Part 2.16 of 2 CCR 502-1.
k. Deliverables
    i. The BHASO shall maintain and provide a monthly report, using the approved BHA template, of incidents where services have gone on divert, including:
        1. the name of the facility or provider,
        2. the service on divert,
        3. length of service gap,
        4. the reason for the diversion status (e.g. inadequate staffing, emergency), and

5. the number of known Individuals affected by the diversion.

ii. Referral to services in other BHASO Regions is allowable.

3.1.2.5 Standards and Requirements

a. The Mobile Crisis Response providers shall utilize the Mobile Crisis Response dispatch portal to update the Colorado Crisis line/988 Colorado Mental Health Line with the outcome of their visit within twenty-four (24) hours.

b. Location of Service

i. The geographically nearest, most available, and most appropriate Mobile Crisis Response provider should be dispatched regardless of BHASO Region, county lines, payer source, or other catchment distinctions. The BHASO shall develop an approach for covering adjacent BHASO regions and communicate that with the Hotline.

ii. The Mobile Crisis Response provider shall perform a self, vehicle, and ecosystem assessment (available from BHA) before and during each Mobile Crisis Response.

iii. The BHASO must be capable of managing simultaneous requests for services throughout the Region.

iv. Mobile Crisis Response providers shall not respond to locations where services and clinically trained behavioral health clinicians are already available and Mobile Crisis Response services would be duplicative, including - inpatient hospitals, physical health hospitals, inpatient psychiatric hospitals, emergency departments, Psychiatric Residential Treatment Facilities, Residential Child Care Facilities, Qualified Residential Treatment Programs, inpatient alcohol and drug rehabilitation centers, jails/prisons, and in settings that offer crisis services, such as Certified Community Behavioral Health Clinics or Comprehensive Community Behavioral Health Providers.

i. Location of service data point shall be tracked in the portal data and is monitored as an outcome measure. Failure to meet the outcome measure shall be grounds for funding decrease and/or contract termination.

c. Mobile Crisis Response services critical incident reporting shall be performed in accordance with Part 2.16 of 2 CCR 502-1.

3.1.2.6 Service Hours

a. Every BHASO region shall have Mobile Crisis Response available, covering every county, 24/7/365. BHASOs are responsible for maintaining a flexible network of providers in the region to meet this requirement.

3.1.2.7 Network Adequacy

a. The BHASO Network shall employ an integrated care model, based on evidence and promising practices that consider an Individual's physical and emotional health.
b. The BHASO shall verify that providers and potential providers have passed the readiness review and/or are appropriately licensed and endorsed to provide Mobile Crisis Response by BHA, hold the appropriate BHE license with mobile crisis response endorsement AND be a Health First Colorado approved specialty provider type with the Colorado Department of Health Care Policy and Financing before entering a contract.
    i. The BHASO, and/or the BHASO Network's subcontracted providers, shall conduct eligibility screening for Medicaid and bill Medicaid for Mobile Crisis Response services provided to eligible Medicaid members (using appropriate codes) prior to billing BHA.
c. Mobile Crisis Response shall not serve an administrative function for medical necessity determinations for insurance providers.
d. Should additional resources become available, the BHASO shall employ technology to allow information and data to be shared throughout the continuum of Colorado Crisis Services in real time, that facilitate communication between the various Crisis services providers, and that help standardize data collection and reporting that may include the following:
    i. Coordination with 911/co-responder programs that shall interface with Colorado Crisis Line, 988 Colorado Mental Health Line, and Mobile Crisis Response;
    ii. Interface with Health Information Exchanges (HIEs);
    iii. Mobile Crisis Response providers may have GPS enhanced mobile devices to allow for concurrent documentation.
e. The BHASO Network shall be available to respond to community corrections, courts, pretrial services, probation and parole offices, and any other adult or juvenile justice

service in the community unless similar services are already offered in that location and would create duplicative application of services.

f. The BHASO and the BHASO Network shall collaborate with Co-Responder and Law Enforcement Assisted Diversion (LEAD) programs in the BHASO's Region.

3.1.2.8 Licensing Requirements

a. Agencies within the BHASO Network shall maintain a BHE License with Mobile Crisis Endorsement. May also be an Essential Safety Net Provider instead of BHE with Mobile Crisis Endorsement if a BHE license is not otherwise required.

3.1.2.9 Staff Credentials and Training

a. Mobile Crisis Response providers operate Mobile Crisis Response Teams, who conduct the Mobile Crisis Response. Teams consist of two people and one of whom must be a crisis professional who can lead the crisis assessment and intervention. Mobile Crisis Response teams ideally have both responders in-person. It is required that at least one responder is in-person. It is permissible that the second responder is participating in the crisis response utilizing tele-video.
b. Mobile Crisis Teams must have immediate access to a licensed professional for consultation and possibly assessment for involuntary hold determination. It is permissible for the licensed professional to be telehealth.

3.1.2.10 Data Submission

a. 837 Encounter data shall be delivered in accordance with the terms of Exhibit D, as may be amended, Article 2. Encounter data shall be delivered to BHA for each modality of the Crisis System: Crisis Stabilization Unit, Walk-in Crisis, Crisis Respite, or Mobile Crisis Services.
b. The BHA will ensure that the 988/Colorado Crisis Line Vendor provides Mobile Crisis Data, to the BHASO. The BHASO shall incorporate the data received into Crisis data reporting to BHA. Data Sharing Agreements between the BHASO and the 988/Colorado Crisis Line vendor are recommended.
c. The BHASO shall submit monthly data in accordance with the CCS Data Dictionary by the 15th of the month following

d. Quarterly analysis reports on regional trends and the quality of data reported by Contractor's subcontracted providers, including staffing ratios and narrative regarding how the BHASO worked to ameliorate data quality issues.
    a. DELIVERABLE: Quarterly Data Analysis Report
    b. DUE DATE: Last day of the month following the end of the quarter
    c. DESTINATION: cdhs_BHASO_deliverables@state.co.us
    d. FILE NAME: BHASO Region[X] - [BHASO] - FY[XX][Quarter] - Crisis Quarterly Data Report
e. Annual analysis reports on regional trends and the quality of data reported by Contractor's subcontracted providers, including staffing ratios and narrative regarding how the BHASO worked to ameliorate data quality issues.
    a. DELIVERABLE: Annual Data Analysis Report
    b. DUE DATE: Last day of the month following the end of the quarter
    c. DESTINATION: cdhs_BHASO_deliverables@state.co.us
    d. FILE NAME: BHASO Region[X] - [BHASO] - FY[XX][Quarter] - Crisis Annual Data Report

3.1.2.11 Payment

a. This service reconciles to a capacity reimbursement model. The BHASO shall negotiate and record an annual capacity-based budget with each provider utilizing a capacity-based payment methodology. The BHASO shall keep budget up-to-date with providers, and budgets shall be available to BHA upon request.
b. The BHASO Networks shall utilize Mobile Crisis Response service funding only to fund Mobile Crisis Response teams or portions of mobile crisis response teams which exclusively provide community-based compliant mobile crisis response as outlined above in Article 3.1.2.4.
c. The BHASO shall track the proportional allocation of funds for 988, Colorado Crisis Line, and self-dispatch calls and proportional idle time. 988 dollars may only fund 988 capacity expenses.

Article 3 - Walk-in Crisis Services - BHA Program

3.1.3.1 Program Description and Objectives

a. The BHASO shall subcontract for Walk-In Crisis Services for the Region for all Individuals in a self-defined behavioral health crisis who are in need of in-person assistance, support, referrals, and/or information.

3.1.3.2 Statutory and Rule Citation

a. Walk-in Crisis Services shall be performed in accordance with C.R.S. §27-60-103 (1)(b)(II) and Part 6.3 of 2 CCR 502-1.

3.1.3.3 Target Population and Dispatch

a. Walk-in Services shall be provided to, but not limited to, the following:
    i. A Walk-in Center must be capable of serving:
        1. Children, adolescents, adults and older adults;
        2. Individuals with behavioral health conditions
    ii. Individuals demonstrating aggressive behavior that can be safely managed in an unsecure setting;
    iii. Individuals who are uninsured or unable to pay for services; and,
    iv. Individuals who may lack Colorado residency or documented immigration status.
b. A Walk-in Center must have written policies in place to manage high acuity Individuals, such as, but not limited to:
    i. Individuals aged 12 or older without a parent or guardian present;
    ii. Individuals who have a history of aggressive behavior but are not currently physically aggressive;
    iii. Individuals with co-occurring substance use disorders and mental health conditions;
    iv. Individuals who are referred by law enforcement;
    v. Individuals on a seventy-two (72) hour mental health (M-1) hold;
        1. This policy must address elopement prevention
    vi. Individuals who present as altered by a substance (e.g. drug/alcohol); and
    vii. Individuals who are at imminent safety risk who may be suicidal, homicidal, or gravely disabled.
c. Walk-in Services shall be available to anyone that presents with a self-defined crisis. A referral to another level of care may be indicated:
    i. If acute intoxication interferes with the Individual's ability to engage in an

assessment:

1. It is the responsibility of the Walk-in-Center to refer the Individual to the appropriate intervention, ideally with a warm handoff.

ii. If acute medical issues require immediate attention prior to initiating services:

1. Referrals to emergency departments should be reserved for Individuals with acute physical health issues, such as high-acuity Individuals or an Individual needing immediate medical attention.

iii. Violent behavior of the Individual despite efforts to de-escalate as evidenced by the risk assessment.

iv. It is the responsibility of the provider to assure the Individual receives the appropriate level of care; outright refusal of services is not acceptable.

d. Notwithstanding any other provision of this section to the contrary, Emergency and Crisis Services must be available to any individual who is experiencing a behavioral health crisis, regardless of whether the individual is a priority population.

3.1.3.4 Activities and Services

a. Provide screening as defined in Exhibit A, Statement of Work, Part Three, Chapter 11, to any Individual who presents with a self-defined behavioral health crisis.

b. Prior to an individual leaving a walk-in crisis agency, screenings must be reviewed by a crisis professional who is licensed or a candidate receiving supervision from a licensee. Walk-in crisis agencies shall refer all individuals seeking crisis services to appropriate resources based on the Level of care indicated by the screening or crisis assessment.

c. The Crisis Professional on staff must conduct the Colorado Crisis Assessment provided by BHA if indicated by the initial screening in Rule Part 2.12.1 of 2 CCR 502-1.

d. Ensure that all Individuals determined by screening to require full assessment are seen by a Crisis Professional within one (1) hour of arrival at the Walk-In Center.

e. Complete the Columbia Suicide Severity Rating Scale on all Individuals presenting in crisis:

i. Provide individualized safety and risk planning as determined by the Colorado Crisis Assessment. All safety planning shall utilize the patient safety plan template, available from BHA Program Staff

f. Complete the lethal means restriction template if clinically indicated as a risk mitigation measure.

g. Provide a medical health screen if clinically indicated.
h. Provide brief intervention and stabilization, intended to maintain stability in the community and reduce unnecessary higher level of care referrals, which may include, but are not limited to, the following:
    i. Up to twenty-three (23) hour observation if clinically indicated to determine higher level of care needs, or if awaiting placement.
    ii. Skill-building
    iii. Recovery services
    iv. Peer support
    v. Interventions outlined in the Child, Youth and Family toolkit.
    vi. Provide resources and referrals:
        1. Resources provided shall always include the statewide Crisis Line phone and text information.
        2. All resources and referrals provided shall be documented in the Individual's record and shall include, at a minimum, the provider's name, and date/time of the appointment(s). If the Walk-in Service occurs outside of regular business hours of an outpatient provider, staff shall follow up with the Individual the next business day of the provider to assist the Individual in scheduling an appointment.
i. Care coordination efforts shall be clearly documented in the EHR to reflect collateral information and support, connection to community resources and risk mitigation,
j. Law enforcement drop off at a Walk-in Center must be accepted, with the following exceptions:
    i. Level of intoxication from alcohol or other drugs that hinders the Individual's ability to participate in an assessment as evidenced by disorientation to person, place, or time; and/or inability to answer questions.
    i. Acute medical issues that require immediate attention prior to initiating services.
        1. Referrals to emergency departments shall be reserved for Individuals with acute physical health issues.
    ii. Physically violent behavior of an Individual, despite efforts to de-escalate as evidenced from the risk assessment.
k. Coordinate clinically appropriate transportation between levels of care throughout the

Crisis episode. Colorado Crisis Services shall not fund transportation otherwise funded by Medicaid.

l. Assessments and Documentation
    i. The BHASO Network shall complete the screening, the Colorado Crisis Assessment, the Columbia Suicide Severity Rating Scale, the medical health screening if clinically indicated, the safety plan if applicable, disposition plan, and resources/referrals and document in the Individual's electronic record.
    ii. The BHASO Network shall perform the Colorado Crisis Assessment if not previously completed by a Mobile Crisis Response team.
    iii. Individuals presenting for Walk-in Services shall not be required to complete paperwork for admission to an associated provider as a prerequisite to receiving Walk-in Services.

m. Walk-in Center staff shall initiate follow-up activities following the assessment:
    i. Follow-up telephone calls shall be attempted the calendar day following the crisis episode of care for all Individuals of the initial crisis contact for those Individuals discharged home. If no contact is made, a second attempt shall be initiated on the second day following the crisis episode
    i. Follow-up shall include but is not limited to:
        1. reassessing risk,
        2. reviewing/updating immediate and short-term safety plans,
        3. collaborating with immediate/available supports,
        4. providing ongoing support, and
        5. expressing continued care and concern.
    ii. Staff shall place a minimum of one phone call based on contact information the Individual provided to attempt to reach each Individual meeting these criteria. Staff shall document call attempts in the Individual's electronic record.
    iii. If the Individual does not have short-term plans to engage in behavioral health care, a second follow-up call shall be attempted within five (5) calendar days of the initial crisis contact.

3.1.3.5 Standards and Requirements

a. A Walk-in Center must employ an integrated care model based on evidence-based and promising practices that consider the Individual's physical and behavioral health.
b. A Walk-in Center must be designated pursuant to Title 27, Article 65, C.R.S. Care and Treatment of Persons with Mental Illness, and be in compliance with Chapter 11 and Part 6.3 of 2 CCR 502-1.
c. Should additional resources become available, the BHASO shall employ technology systems that allow information and data to be shared throughout the continuum of Colorado Crisis Services in real time, that facilitate communication between the various Crisis services providers, and that help standardize data collection and reporting that may include the following:
    i. Coordination with 911/Co-Responder programs that shall interface with Colorado Crisis Line/988 and Mobile Crisis Response Teams.
    ii. The use of an EHR or another BHA-prescribed data system
    iii. Interface with Health Information Exchanges (HIEs)
d. The BHASO Network shall conduct eligibility screening for Medicaid and bill Medicaid for all covered services prior to billing BHA.

3.1.3.6 Service Hours

a. All Walk-In Centers must be operational 24/7/365.

3.1.3.7 Licensing Requirements

a. Agencies within the BHASO Network shall maintain a BHE License with Walk-in-Center Crisis Endorsement
b. Agencies within the BHASO Network shall be required to maintain a 27-65 designation.

3.1.3.8 Staff Credentials and Training

a. Prior to an Individual leaving a Walk-in-Center, screenings must be reviewed by a crisis professional who is licensed or a candidate receiving supervision from a licensee.
b. A Walk-in-Center must always be staffed by a crisis professional and a licensee or a candidate who is receiving supervision from a licensee.
c.

3.1.3.9 Data Submission

a. 837 Encounter data shall be delivered in accordance with the terms of Exhibit D, as may be amended, Article 2. Encounter data shall be delivered to BHA for each modality of the Crisis System: Crisis Stabilization Unit, Walk-in Crisis, Crisis Respite, or Mobile Crisis Services.

3.1.3.10 Payment

a. This service reconciles to a capacity reimbursement model. The BHASO shall negotiate and record an annual capacity-based budget with each provider utilizing a capacity-based payment methodology. The BHASO shall keep budget up-to-date with providers, and budgets shall be available to BHA upon request.

Article 4 - Crisis Stabilization Units - BHA Program

3.1.4.1 Program Description and Objectives

a. The BHASO shall subcontract for regional Crisis Stabilization Services with the capacity to serve all Individuals determined to require a higher level of care. Crisis Stabilization Units (CSU) provide behavioral health treatment that can include individual therapy, group therapy and/or psychiatric evaluation, in a locked or unlocked unit for up to five days. Crisis Stabilization Services shall serve Individuals who require intensive behavioral health crisis intervention and treatment, including medication evaluation and management, and who cannot be accommodated in a less restrictive environment.

3.1.4.2 Statutory and Rule Citation

a. Acute Treatment Unit services shall be performed in accordance with Part 6.7 of 2 CCR 502-1.
b. Crisis Stabilization Services shall be performed in accordance with C.R.S. §27-60-103 (1)(b)(II) and Part 6.4 of 2 CCR 502-1.

3.1.4.3 Target Population

a. Crisis Stabilization Services shall serve the following for all license types, including but not limited to:
    i. Children, adolescents, adults and older adults;
    ii. Individuals with co-occurring conditions
    iii. Individuals demonstrating aggressive behavior that can be safely managed in an unsecure setting;

iv. Individuals who are uninsured or unable to pay for services;
v. Individuals who may lack Colorado residency or documented immigration status
i. Individuals on a seventy-two (72) hour mental health (M-1) hold;
vi. Individuals who present as altered by a substance (e.g. drug/alcohol); and
vii. Individuals who are at imminent safety risk who may be suicidal, homicidal, or gravely disabled.

b. Crisis Stabilization Units shall have the ability to accept voluntary and involuntary admissions.
c. Notwithstanding any other provision of this section to the contrary, Emergency and Crisis Services must be available to any Individual who is experiencing a behavioral health crisis, regardless of whether the Individual is a Priority Population.

3.1.4.4 Activities and Services

a. The BHASO Network shall:
    i. Complete the lethal means restriction template if clinically indicated as a risk mitigation measure.
    ii. Provide a physical health screen if clinically indicated.
    iii. Full psychiatric evaluation must be completed:
        1. By a physician or other professional authorized by statute to order medications; and,
        2. Within twenty-four (24) hours of admission.
    iv. Provide peer support
    v. Provide treatment, which may include:
        1. Individual counseling; and/or,
        2. Group counseling
    vi. Coordinate with physical health services as needed.
    vii. Provide case management
    viii. Provide service coordination and referral.
    ix. Provide discharge planning to include provision of resources and referrals.
b. Assessments and Documentation
    i. The BHASO Network shall perform an assessment of each Individual to determine the level of intervention and supervision required, including medication management, behavioral health services, and stabilization prior to returning to

the community.

1. Telehealth services may be permissible in accordance with policies and procedures approved by the BHASO Medical Director.

ii. The BHASO Network Crisis Stabilization Units shall complete a clinical assessment and incorporate the information gathered from the assessment into service planning, safety planning, referrals, and follow-up activities.

iii. The BHASO Network Crisis Stabilization Units shall collect basic demographic information from Individuals to enable monthly Medicaid billing.

iv. The BHASO Network Crisis Stabilization Units shall document the clinical assessment, service plan, safety plan, and resources/referrals in the Individual's record.

c. Follow Up Services

i. Crisis Stabilization Unit staff shall initiate follow-up activities following the Individual's discharge:

1. Follow-up telephone calls shall be attempted the day following discharge:
    a. Follow-up shall include but is not limited to reassessing risk, reviewing/updating immediate and short-term safety plans, collaborating with immediate/available supports, providing ongoing support, and expressing continued care and concern.
    b. Staff shall place a minimum of one phone call based on contact information the Individual provided to attempt to reach each Individual meeting these criteria. Staff shall document call attempts in the Individual's electronic record.
2. If the Individual does not have short-term plans to engage in behavioral health care, a second follow-up call shall be attempted within five (5) calendar days of the Individual's discharge.

3.1.4.5 Standards and Requirements

a. Crisis Stabilization Units shall employ an integrated care model based on evidence-based practices that consider the Individual's physical and emotional health.

b. The BHASO Network may utilize Residential Child Care Facility beds that meet Crisis Stabilization Unit requirements to ensure capacity for stabilization for children and adolescents.

c. Coordinate clinically appropriate transportation between levels of care throughout the Crisis episode. Colorado Crisis Services shall not fund transportation otherwise funded by Medicaid.
d. The BHASO Network shall conduct eligibility screening for Medicaid and bill Medicaid for all covered services prior to billing their BHASO.
e. The BHASO shall employ technology systems that allow information and data to be shared throughout the continuum of Colorado Crisis Services in real time, that facilitate communication between the various Crisis services providers, and that help standardize data collection and reporting, should additional resources become available, that may include the following:
    i. The use of an Electronic Health Record or another BHA-prescribed data system
    ii. Interface with Health Information Exchanges (HIEs)
f. The Individual's clinical presentation is voluntary or involuntary, active intent to harm themselves during treatment, need intensive de-escalation, or have difficulty understanding and/or responding to verbal requests or redirection.

3.1.4.6 Service Hours

a. Crisis Stabilization Units must be open twenty-four (24) hours a day, seven (7) days a week, 365 days a year.

3.1.4.7 Licensing Requirements

a. Agencies within the BHASO Network shall maintain a BHE with appropriate endorsement for CSU and any population-specific endorsements if needed.
b. If the BHASO Network provider maintains an endorsement for Acute Treatment Unit, additional requirements are identified in Part 6.7 of 2 CCR 502-1.
c. Crisis Stabilization Units shall be licensed by the Colorado Department of Health and Environment (CDPHE) as an Acute Treatment Unit (ATU) pursuant to 6 CCR 1011-1, chapter 6 or a Community Clinic (CC) pursuant to 6 CCR 1011-1, chapter 9. Crisis Stabilization Units hold a BHE and carry a CSU endorsement once their current ATU or CC expire.

3.1.4.8 Staff Credentials and Training

a. The BHASO Network shall comply with Crisis Stabilization Unit staffing requirements in

accordance with Part 6.4.3 of 2 CCR 502-1.

b. The BHASO Network Crisis Stabilization Units shall employ sufficient staff to ensure that the provision of services meets the needs of the community and the Individual. The facility must have a minimum of two (2) staff on-site at all times.
c. If a Crisis Stabilization Unit is staffed by a licensure candidate receiving supervision from a licensee, a licensed mental health professional shall be on call and able to respond within thirty (30) minutes, either in person or via telehealth.
d. Crisis Stabilization Units daily staffing must include Peer Support Professionals deployed in a therapeutic role with the ability to provide peer support when clinically indicated or requested by the Individual in crisis.
e. Crisis Stabilization Units with Walk-in capacity shall also follow the walk-in crisis service staffing requirements listed in Part 6.3.4 of 2 CCR 502-1.
f. If licensed as an Acute Treatment Unit, additional requirements are identified in Part 6.7 of 2 CCR 502-1.
g. In addition to the staffing requirements listed in Part 6.4.3 of 2 CCR 502-1, Crisis Stabilization Units shall have:
    i. Access to a physician or other professional authorized by statute to order medications upon admission; and,
    ii. At minimum, one on-site staff member qualified to administer medications as identified in licensure requirements.
h. The BHASO shall provide all direct service Crisis Stabilization Unit staff with the training plan and provider manual.

3.1.4.9 Data Submissions

a. 837 Encounter data shall be delivered in accordance with the terms of Exhibit D
b. , as may be amended, Article 2. Encounter data shall be delivered to BHA for each modality of the Crisis System: Crisis Stabilization Unit, Walk-in Crisis, Crisis Respite, or Mobile Crisis Services.
c. The BHASO Network shall complete DACODS or a Treatment Episode Report Unified Data Model submission for each applicable Individual per the technical specification guidelines provided by BHA to BHASOs.

3.1.4.10 Payment

a. The BHASO may negotiate with BHASO Network providers for reimbursement on a capacity basis or on a fee-for-service basis.
    a. If Capacity, the BHASO shall negotiate and record an annual capacity-based budget with each BHASO Network provider utilizing a capacity-based payment methodology. The BHASO shall keep the capacity-based budgets up-to-date with BHASO Network providers as required, and all budgets shall be available to BHA upon request.
    b. If Fee-For-Service, this service reconciles to rates found in Exhibit B, Rate Schedule, Section 1.1.

Article 5 - Crisis Respite Services - BHA Program

3.1.5.1 Program Description and Objectives

a. The BHASO shall subcontract to provide in-home Respite and reasonably accessible regional residential Respite Services. Crisis Respite Services shall be provided in-home or in residential facilities to offer additional support in a safe and neutral environment. A referral to Respite Services requires an assessment at a Walk-in Center, Crisis Stabilization Unit, or by Mobile Crisis Response provider services. Residential Respite Services must be staffed twenty-four (24) hours per day and can be staffed by Peer Support Professionals or paraprofessionals, with clinical staff available for supervision and oversight of the treatment plan as indicated. Admission criteria for Respite requires an ongoing acute behavioral health crisis, and Respite may not be used exclusively to provide housing.

3.1.5.2 Statutory and Rule Citation

a. Crisis Respite Services shall be performed in accordance with Part 6.6 of 2 CCR 502-1 and C.R.S. §27-60-103 (1)(b)(IV).

3.1.5.3 Target Population and Dispatch

a. Respite must be capable of serving, but is not limited to:
    i. Children, adolescents, adults and older adults;
    ii. Individuals with behavioral health and co-occurring conditions
    iii. Individuals demonstrating aggressive behavior demonstrating aggressive behavior that can be safely managed in an unsecure setting;

iv. Individuals who are uninsured or unable to pay for services; and,
v. Individuals who may lack Colorado residency or legal immigration status.

b. Individuals who meet emergency procedure criteria outlined in C.R.S. §27-65-105, Care and Treatment for Persons with Mental Illness cannot receive Respite services.
c. Individuals must:
   i. present a minimal risk of significant withdrawal complications;
   ii. cooperate with the program guidelines and expectations; and
   iii. be able and willing to participate in creating a service plan or discharge plan or, if a child, have a legal guardian able and willing to participate in creating a service plan.
d. In-home Crisis Respite Services:
   i. Individuals must be in agreement to allow Respite staff into their home.
   ii. Others residing at the same address as the Individual receiving services must be notified and cooperative.
   iii. Individuals and families must be able and willing to participate in formulating a service plan.
e. Notwithstanding any other provision of this section to the contrary, Emergency and Crisis services must be available to any Individual who is experiencing a behavioral health crisis, regardless of whether the Individual is a Priority Population.

3.1.5.4 Activities and Services

a. All Respite services shall consist of the following:
   i. Structure and supervision;
   ii. Protective environment;
   iii. Coordination of services with on-going community behavioral health services;
   iv. Respite providers shall make efforts to obtain a release of information to communicate with community providers and participate in treatment planning;
   v. Length of services shall be determined in coordination with the referring Walk-In Center, Mobile Crisis Response, Crisis Stabilization Unit, the Individual, the family if applicable, treatment team, and ongoing Respite provider;
   vi. The need for services shall be evaluated daily by the Individual, family if applicable, respite provider, outside treatment team, and other applicable Individuals;

vii. For children under the age of 18 and not accompanied by a parent or guardian, the parent or guardian must receive daily updates, have access to speak with the child in accordance with the policies and procedures of the facility, and be involved in discharge planning;

viii. Facility age requirements: For children under the age of eighteen (18),

1. the facility must be a Residential Child Care Facility (RCCF) licensed by CDHS; or
2. the child may attend a non-RCCF facility but must be accompanied by a parent or guardian; or
3. the child may attend a non-RCCF facility but must be fifteen (15) years or older and consent for their own services.

b. In-Home Respite Services shall consist of the following (in addition to the services in article 3.1.5.4.a. above):

i. In-home Respite Services are available for up to fourteen (14) total calendar days and can be utilized over twenty-one (21) calendar days.

ii. For children aged seventeen (17) or under, services shall be no more than three (3) non-consecutive days over twenty-one (21) calendar days.

c. Follow-up Services

i. Respite staff shall initiate follow-up activities following the discharge:

1. Follow-up telephone calls shall be attempted the day following discharge the day following discharge.

i. Follow-up shall include but is not limited to reassessing risk, reviewing/updating immediate and short-term safety plans, collaborating with immediate/available supports, providing ongoing support, and expressing continued care and concern.

b. Staff shall place a minimum of one phone call based on contact information the Individual provided to attempt to reach each Individual meeting these criteria. Staff shall document call attempts in the Individual's electronic record.

ii. If the Individual does not have short-term plans to engage in behavioral health care, a second follow-up call shall be attempted within five (5) calendar days of the discharge from Respite.

d. Assessments and Documentation
    i. For In-home Respite Services, progress notes, treatment plan, safety plan, and resources/referrals shall be documented in the Individual's record.
    ii. For residential and facility-based Respite, progress notes, treatment plan, safety plan if applicable, and resources/referrals shall be documented in the Individual's electronic record.

3.1.5.5 Standards and Requirements

a. Respite Services must be available in each Region.
b. Crisis Respite Services are intended as a brief intervention following a crisis episode:
    i. Length of stay determinations must be ongoing, transparent to the Individual and family, and jointly determined by the Individual, family, respite provider, and treatment team.
c. Services must be intended to improve or maintain the condition and functional level of the Individual and prevent relapse or hospitalization while providing a safe environment to address precipitating factors to the crisis. Services must include structure, support, and care coordination.
d. Facility-based Respite Services shall have at least one staff member present at all times when there is a census, with a ratio of one to ten (1:10), unless the facility licensure sets staffing requirements.
e. The BHASO shall employ technology systems that allow information and data to be shared throughout the continuum of Colorado Crisis Services in real time, that facilitate communication between the various Crisis services providers, and that help standardize data collection and reporting, should additional resources become available, that may include the following:
    i. The use of an Electronic Health Record or another BHA-prescribed data system.
    ii. Interface with Health Information Exchanges (HIEs).

3.1.5.6 Service Hours

a. Respite Services shall be available 24/7/365.
    i. Access to clinical staff consultation via phone or in-person shall be available 24/7/365
b. Facility-based Crisis Respite Services shall be available 24/7/365.

3.1.5.7 Licensing Requirements

a. Agencies within the BHASO Network shall maintain a BHE license and carry a crisis respite endorsement, as well as any population specific endorsements as needed.

3.1.5.8 Staff Credentials and Training

a. Crisis Respite Services shall employ an array of providers, including but not limited to case managers, Peer support professionals, and para-professionals.
b. In-home Crisis Respite Services staff shall be supervised by a Crisis Professional or licensee.
c. All Crisis Respite staff with training in accordance with the BHASO training plan developed per Exhibit A, Part One, Chapter 5, Section 1.5.1.3, as well as any other topics that BHA deems critical in operating Respite Crisis Services.

3.1.5.9 Data Submissions

a. 837 Encounter data shall be delivered in accordance with the terms of Exhibit D, as may be amended, Article 2. Encounter data shall be delivered to BHA for each modality of the Crisis System: Crisis Stabilization Unit, Walk-in Crisis, Crisis Respite, or Mobile Crisis Services.
b. The BHASO Network shall complete a CCAR/DACODS record (as applicable for the type of treatment) or Treatment Episode Report Unified Data Model submission (the successor to former CCAR/DACODS submissions) for each applicable Individual per the technical specification guidelines provided by BHA to BHASOs.

3.1.5.10 Payment

a. This service reconciles to a capacity reimbursement model. The BHASO shall negotiate and record an annual capacity-based budget with each BHASO Network provider utilizing a capacity-based payment methodology. The BHASO shall keep the capacity-based

budgets up-to-date with BHASO Network providers as required, and all budgets shall be available to BHA upon request.

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Chapter 2
Withdrawal Management - General Safety Net Service Terms

3.2.1 Purpose

a. The purpose of this Chapter is to provide Withdrawal Management and treatment linkage services to Individuals who are intoxicated or in withdrawal from substances, as well as expand youth withdrawal management beds and ensure continuity of care across the withdrawal management continuum of care.

3.2.2 Statutory / Rule Citation

a. Withdrawal Management Services shall be performed in accordance with requirements set forth in Part 5.6 of 2 CCR 502-1 (ASAM Level 3.2-WM) and/or Part 5.10 of 2 CCR 502-1 (ASAM Level 3.7-WM) as well as all applicable regulations in Chapter 2 and Chapter 5 of 2 CCR 502-1.

3.2.3 Target Population:

a. The BHASO Network shall serve Individuals who are intoxicated and/or in withdrawal in appropriately BHA-licensed settings. This includes Individuals on Emergency Commitment (EC) holds.
b. The BHASO shall create, develop, or contract for Withdrawal Management beds for youth at ASAM Level 3.7WM.
c. There are no children- and youth-specific statements of work under this Chapter, though all modalities in this Chapter shall serve children and youth unless the modality is contraindicated for children and youth.

3.2.4 Activities and Services

a. The BHASO may contract with any combination of crisis stabilization units, acute treatment units, Withdrawal Management facilities, and/or clinically managed residential withdrawal management centers to increase access to withdrawal

management services in a less restrictive setting in which Withdrawal Management can safely be accomplished.

b. The BHASO Network shall screen and/or assess all Individuals receiving withdrawal management services for treatment and support needs. A comprehensive biopsychosocial and ASAM assessment shall be completed as soon as is reasonable upon admission and no later than one (1) week after admission into services with the noted exceptions:
    i. Acute Treatment Unit (ATU) and Crisis Stabilization Units (CSU): within twenty-four (24) hours of admission.
    ii. Withdrawal Management facilities, and 3.7WM treatment facilities within seventy-two (72) hours of admission.
c. For Individuals who have been assessed as appropriate for the Involuntary Commitment (IC) process, the BHASO Network shall work collaboratively with BHA and the BHASO to facilitate timely treatment admission, service provision, and continuity of care, by utilizing facilities offering the appropriate ASAM level approved by the BHA Involuntary Commitment (IC) Team. See Part Three, Chapter 13, Article 6 - Involuntary Commitment Services (SUD).
d. At or prior to discharge the BHASO Network shall provide a written referral with information about recommended services and supports for ongoing care.
e. At or prior to discharge the BHASO Network shall schedule an intake appointment, if clinically indicated, for follow up services. If follow up services are not clinically indicated BHASO Network shall refer to an RCO.
    i. If an Individual refuses an intake appointment, the BHASO Network shall document this in the Individual's medical record.
f. At or prior to discharge the BHASO Network shall screen for barriers to ongoing care and provide case management services to help reduce these barriers.
g. The BHASO Network shall have a minimum of two naloxone kits on site with staff trained for emergency response.
h. The BHASO Network shall engage in naloxone education and distribution to high-risk Individuals.
i. For withdrawal management programs serving more than two thousand five hundred (2,500) withdrawal management admissions per year, the top three percent (3%) of most frequent users shall receive specialized services to address motivation to change and facilitate engagement in continuing care. This can include MAT/MOUD, intensive case

management services, employment assistance, housing assistance, benefits acquisition, and harm reduction interventions. Examples of interventions include Assertive Community Treatment, Individualized Placement and Support, Intensive Case Management, Community Reinforcement Approaches, women's gender responsive treatment, and other evidence-based practices designed for Individuals who are difficult to engage in recovery.

i. For withdrawal management programs with less than two thousand five hundred (2,500) admissions per year, Individuals admitted more than three (3) times within six (6) months shall be offered these same services.

j. The BHASO shall track and provide a quarterly WM report, using the template mutually agreed upon by BHA and the BHASO, indicating:

i. The number of Individuals the WM program referred to BHE-licensed treatment programs and Recovery Support Organizations and the number of Individuals who have more than one admission to WM during the quarter. Please reference Data Dictionary described in Exhibit D, Appendix 1, as may be amended, to verify most up-to-date format and requirements.

1. DELIVERABLE: WM Quarterly Referral Report
2. DUE DATE: Quarterly, 15th of the month following the reported month.
3. DESTINATION: cdhs_bhaso_deliverables@state.co.us
4. FILE NAME: BHASO Region[X] - BHASO - FY[XX][Quarter] - WM Quarterly Referral Report

3.2.5 Standards and Requirements

a. Involuntary inpatient mental health services provided by 27-65 designated facilities must be performed in accordance with Chapter 11 of 2 CCR 502-1.

3.2.6 Service Hours

a. All funded residential withdrawal management facilities shall have services available twenty-four (24) hours per day, seven (7) days per week.

3.2.7 Network Adequacy

a. BHASOs will contract for WM services to achieve network capacity targets as identified with BHA and create contingency plans for appropriate placement of individuals in need

of WM services if local WM centers are at capacity or otherwise unavailable to accept Individuals.

3.2.8 Licensing Requirements

a. License requirements: Program must obtain a Behavioral Health Entity (BHE) License with endorsements for Substance Use Disorder Services ASAM Level 3.2 WM or 3.7 WM, Clinically Managed Residential Withdrawal Management, and case management services must be provided at ASAM Level 1, Outpatient Services. Staff credentials shall follow standards set forth in Part 5.2 and Part 5.2.2 of 2 CCR 502-1.

3.2.9 Data Submissions

a. 837 Encounter data shall be delivered in accordance with the terms of Exhibit D, as may be amended, Article 2.
b. The BHASO Network shall complete a Treatment Episode Report Unified Data Model submission (the successor to former CCAR/DACODS submissions) for each applicable Individual per the technical specification guidelines provided by BHA to BHASOs.

3.2.10 Payment

a. Individuals deemed appropriate for the IC process shall not be charged for WM services per IC contract.
b. This service reconciles to a capacity or fee-for-service reimbursement model, at the election of the BHASO.
c. For programs reconciling to Capacity budgets:
    i. The BHASO shall negotiate and record a Capacity based budget with each provider utilizing a capacity-based payment methodology. The BHASO shall keep budget up-to-date with providers, and budgets shall be available to BHA upon request.
d. For programs reconciling to Fee For Service, see rates in Exhibit B - Rate Schedule, Section 2.1.

Chapter 3
Mental Health and Substance Use Outpatient Services

Article 1 - Outpatient Behavioral Health Services - General Safety Net Service Terms
Article 2 - Medications for Opioid Use Disorder - BHA Program
Article 3 - Overdose Prevention - BHA Program
Article 4 - Contingency Management - BHA Program
Article 5 - Child First Model Implementation - BHA Program

Article 1 - Behavioral Health Outpatient Services - General Safety Net Service Terms

3.3.1.1 Program Description and Objectives

a. The BHASO Network shall provide Outpatient Treatment in its network. “Outpatient Treatment” means behavioral health (substance use, mental health, or co-occurring) services provided to an Individual in accordance with their service plan on a regular basis in a non-overnight setting, which may include, but not be limited to, individual, group, or family counseling, peer support professional services, case management, or medication management.
b. For the purposes of this section, unless otherwise stated, “behavioral health services” includes mental health, substance use, and/or co-occurring services.

3.3.1.2 Statutory / Rule Citation

a. C.R.S. Title 27, Articles 80-82 governs the provision of behavioral health services.
b. Outpatient services are regulated pursuant to Chapter 4 of 2 CCR 502-1.
    i. Enhanced Outpatient Services (EOP) are regulated pursuant to Section 10.2 of 2 CCR 502-1.
c. Opioid Treatment Provider services are regulated pursuant to the Certification of Opioid Treatment Programs, 42 CFR §8.

3.3.1.3 Target Population / Eligibility

a. Outpatient services are generally intended for Individuals who are assessed as not appropriate for more intensive levels of care. Outpatient services may also be a step-down from a higher level of care or offered when an Individual is in early stages of change and declines participation in the higher level of care indicated by the assessment.
b. The treatment services provided using these funds are available to Uninsured/Underinsured Individuals earning under three hundred percent (300%) of the Federal Poverty Line value. Eligibility shall be determined in accordance with the BHA Finance and Data Protocol #1, Special Studies Codes & Eligibility, as may be amended.
c. Outpatient Services for Individuals involved in the criminal justice system.
    i. Individuals involved in the local and/or State criminal or juvenile justice system(s) who are clinically appropriate for outpatient level of care.
d. There are no children- and youth-specific statements of work under this Chapter, though all treatment modalities in this Chapter shall serve children and youth unless the modality is contraindicated for children and youth.

3.3.1.4 Activities and Services

a. Generally
    i. The BHASO Network shall base outpatient services on a comprehensive and coordinated individualized and recovery-oriented treatment/service plan that utilizes multiple concurrent services and treatment modalities rendered by a multidisciplinary treatment team.
    ii. For a patient at risk of or with a history of psychiatric hospitalization, services shall focus on maintaining and improving functional abilities.
    iii. The BHASO shall assure availability of substance use treatment services at ASAM levels of care 1 (outpatient) and 2.1 (intensive outpatient) through the BHASO Network.
    iv. The BHASO shall require that all funded programs develop and adhere to quality management programs as specified in Section 2.17 of 2 CCR 502-1 Behavioral Health Rules.
    v. Modalities allowable under this section (including but not limited to):
        1. Early intervention

2. Outpatient treatment
3. Enhanced Outpatient (mental health services only)
4. Medications for Opioid Use Disorder (MOUD)
5. Non-opioid Medication Assisted Treatment
6. Overdose Prevention
7. Mobile Health Units for MOUD Prescription
8. Mobile Opioid Treatment Programs

vi. Allowable activities:

1. Individual therapy,
2. Group therapy,
3. Family therapy,
4. Supported employment,
5. Psychoeducation,
6. Case management,
7. Behavioral health screenings and assessments,
8. Referrals and warm hand-offs,
9. Psychiatric evaluations,
10. Peer services,
11. Psychiatric medications, medication assisted treatment (MAT), administration, and prescriber time,
    A. BHASOs shall support the cost of medications for a diagnosed mental health or Substance Use Disorder (SUD) for those who are uninsured and below three hundred percent (300%) of federal poverty including the following;
        i. Medications
        ii. Medical prescriber time
        iii. Nurse time to administer medications
        iv. Any required laboratory tests needed for either induction or maintenance of the prescribed medication.
    B. All efforts to find the lowest prices, including that available to Federally Qualified Health Clinics through 340B Pricing are expected.

12. Coordination with county departments of human services / social services,
13. Treatment/service planning,
14. Family support,
15. Wraparound services,
16. Case management, including but not limited to social determinants of health support and transitional services
17. Vocational services,
18. Disaster or tragedy response, including coordination, triage, and community crisis debriefing, and
19. Other evidence-based or best/promising practice activities approved by BHA.

b. Outpatient Services for Individuals involved in the criminal justice system
   i. The BHASO shall fund treatment and support services for children, youth, and adult uninsured/underinsured Individuals with criminal and/or juvenile justice involvement, including (but not limited to) Individuals who are required through criminal court orders to complete SUD treatment.
   ii. Providers of SUD outpatient services for Individuals involved in the criminal justice system must be endorsed by BHA for services to Individuals involved in the criminal justice system pursuant to Chapter 10 of 2 CCR 502-1.
   iii. Providers of outpatient services for Individuals involved in the criminal justice system shall conduct ongoing coordination with appropriate and applicable criminal justice entities (such as jail, probation, parole, and pretrial services) and/or criminal justice related providers, such as co-responder teams, to ensure continuity of services and care.
   iv. The BHASO shall ensure providers have the specialized knowledge to address the criminogenic risks and needs of Individuals involved in the criminal justice system. The BHASO shall ensure applicable providers complete any relevant OwnPath Learning Hub training for this population.
   v. The BHASO shall ensure that criminal justice involvement and issues related to involvement with the criminal justice system is incorporated into ongoing treatment planning and care coordination activities.
   vi. Correctional Treatment Board funds

1. Correctional Treatment Board funds can only be used for
    A. Individuals referred from criminal justice entities; or
    B. Individuals adjudicated Not Guilty by Reason of Insanity (NGRI) who are returned to the community through temporary physical removal or community placement (C.R.S. §16-8-118) or conditional release (C.R.S. §16-8-115).
2. Allowable expenses with justice-involved SUD and Correctional Treatment Board funds are limited to:
    A. Alcohol and drug testing,
    B. Substance abuse education and training,
    C. Treatment for assessed substance abuse and co-occurring disorders,
    D. Recovery support services (including recovery housing), and
    E. Case management services. Individuals involved in the criminal justice system typically require significantly more case management services. Examples of supports include:
        i. Obtaining identification,
        ii. Coordinating with probation, parole, or DHS,
        iii. Locating housing,
        iv. Providing resources for employment,
        v. Coordinating referrals to medication assisted therapy,
        vi. Helping transition Individuals to community-based services, and
        vii. Other such activities.
3. The BHASO shall track the number of Individuals served with Correctional Treatment Board funds.

vii. Assessments and Documentation

1. Risk Needs Responsivity as defined in Part 1.2 of 2 CCR 502-1.

3.3.1.5 Level of Care and Licensing Requirements

a. The BHASO shall subcontract only with treatment providers who are licensed as Behavioral Health Entities (BHEs) to provide SUD treatment services as specified in 2

CCR 502-1 Behavioral Health Rules. Services may be delivered by agencies endorsed by BHA for any of the following levels of care:

i. ASAM Level 1 (Outpatient Treatment)
ii. ASAM Level 2.1 (Intensive Outpatient Treatment)

b. The BHASO shall subcontract only with treatment providers who are appropriately licensed to provide MH treatment services as specified in 2 CCR 502-1 Behavioral Health Rules. If subcontracted MH providers carry a BHE license, they must carry the following endorsements:

i. Outpatient Treatment

3.3.1.6 Staff Credentials and Training

a. SUD clinical supervision shall be provided and documented as set forth in C.R.S. §12-245-801-806, Addiction Counselor Certification and Licensure, and Part 2.5.1 of 2 CCR 502-1.

3.3.1.7 Service Goals

a. For Individuals receiving outpatient services, it would be expected to see:

i. Reduction in use of substances,
ii. Increased levels of psychosocial functioning,
iii. Reduced use of emergency medical, and correctional and human service dollars,
iv. Increased stability in housing,
v. Decreased family conflict and stress, and
vi. Increased stability in vocational settings.

3.3.1.8 Data Requirements

a. The BHASO Network shall complete a CCAR/DACODS record or Treatment Episode Report Unified Data Model submission (the successor to former CCAR/DACODS submissions) for each applicable Individual per the technical specification guidelines provided by BHA to BHASOs.

b. 837 Encounter data shall be delivered in accordance with the terms of Exhibit D, as may be amended, Article 2.

3.3.1.9 Payment

a. Mental Health Outpatient - This service may be paid on a fee for service and/or capacity basis.
    i. If this service is paid on a fee for service basis, this service reconciles to rates found in Exhibit B, Rate Schedule, Section 3.1.
    ii. If this service is paid on a capacity basis, the BHASO shall negotiate and record an annual Capacity-based budget with each provider utilizing a capacity-based payment methodology. The BHASO shall keep budget up-to-date with providers, and budgets shall be available to BHA upon request.
b. Substance Use Outpatient
    i. If this service is paid on a case rate basis, this service reconciles to case rates found in Exhibit B – Rate Schedule, Section 3.2.
    ii. If this service is paid on a fee for service basis, this service reconciles to rates found in Exhibit B - Rate Schedule, Section 3.1.
    iii. If this service is paid on a capacity basis, the BHASO shall negotiate and record an annual Capacity-based budget with each provider utilizing a capacity-based payment methodology. The BHASO shall keep budget up-to-date with providers, and budgets shall be available to BHA upon request.

Article 2 - Medications for Opioid Use Disorder - BHA Program

3.3.2.1 Program Description and Objectives

a. Medications used for Medication Assisted Treatment (MAT) are evidence-based treatment options, and the Federal Drug Administration (FDA) has approved several different medications to treat opioid use disorders (MOUDs). The primary purpose is to provide MOUD to uninsured Coloradans by OTPs and other MAT providers offering buprenorphine, methadone, or depot-naltrexone treatment within BHASO regions to remove cost barriers of accessing treatment.

3.3.2.2 Target Population and Eligibility

a. The intended Individuals for this project are people with a current or historic diagnosis of stimulant or OUD who qualify for treatment at an OTP facility or other MAT provider who are also underinsured/uninsured in accordance with the BHA eligibility protocol.

3.3.2.3 Activities and Services

a. Medications for Opioid Use Disorder (MOUD)
    i. MOUD services are provided at either specially licensed OTP facilities or medical providers with the proper prescription authority to people with opioid use disorder.
    ii. The BHASO shall contract with OTPs and other providers of one or more of the FDA-approved medications for the maintenance treatment of opioid use disorder (methadone, buprenorphine/ naloxone products, buprenorphine products including sublingual tablets/film, buccal film, and extended release, long-acting injectable buprenorphine formulations and injectable naltrexone) to support costs of treatment for those people who meet the BHA definition of uninsured/underinsured (up to three hundred percent (300%) of Federal Poverty Level).
        1. The subcontracts shall provide funding for comprehensive treatment that includes required medical screening and testing, physicals and evaluations, counseling services, including individual or group counseling, medication dosing, and the cost of either naltrexone, depot naltrexone, a variety of buprenorphine products or methadone as determined by the OTP medical team or the medical provider.
        2. This funding can also be used to provide depot naltrexone or buprenorphine outside of OTP facilities, including lockboxes and other safe storage needs. Specifically, medical offices may also provide these services, if the Individual is uninsured/underinsured and has no other payer.
        3. Buprenorphine should only be provided in the context of a thorough treatment assessment where a prescriber is either attached to a treatment program or there is a written agreement between a treatment agency and a prescriber that includes verifying the Individual receives concurrent psychosocial counseling.
    iii. The BHASO Network shall offer appropriate concurrent psychosocial counseling in addition to the medications.
b. Opioid Treatment Program (OTP)

i. The BHASO shall include entities licensed to provide Opioid Treatment Program (OTP) services in its network.
ii. Subject to available funding, the BHASO shall offer a contract to every BHA licensed OTP facility within their respective Region to support treatment costs for underinsured or uninsured people who meet the BHA definition of uninsured/underinsured (up to three hundred percent (300%) of Federal Poverty Level).
iii. The intended recipients of OTP services include Individuals dependent on opiates or opioids for whom the OTP physician has determined that medication maintenance is appropriate and likely to help the Individual recover.
iv. OTP services shall include all aspects of care required within OTPs including physical examination of the Individual, required medical screening tests, individual, group and family therapy, medication dispensing and observation, urine specimen collection, testing and counseling, case management and peer recovery coaching.
v. All funded facilities must maintain the controlled substance license and the Opioid Treatment Program license.
vi. The services provided shall only be delivered at the ASAM Level OTP level of care.
vii. OTP facilities provide services in accordance with BHA, SAMHSA, and Drug Enforcement Agency (DEA) rules.

3.3.2.4 Licensing Requirements

a. OTP facilities receiving funding under this contract must be licensed by BHA as a Behavioral Health Entity (BHE) with an SUD Treatment endorsement at any ASAM Level. Additionally, these facilities must maintain the following:
    i. BHA controlled substance license
    ii. Drug Enforcement Agency registration
    iii. SAMHSA accreditation
b. BHA shall notify all BHASOs within five (5) business days of any change in license status of any OTP facilities.

3.3.2.5 Data Submission

a. The BHASO Network shall complete a CCAR/DACODS record or Treatment Episode Report Unified Data Model submission (the successor to former CCAR/DACODS submissions) for each applicable Individual per the technical specification guidelines provided by BHA to BHASOs.
b. 837 Encounter data shall be delivered in accordance with the terms of Exhibit D, as may be amended, Article 2.

3.3.2.6 Payment

a. For Non-OTP MAT Services: This service reconciles to a fee-for-service reimbursement model, reconciling to rates found in Exhibit B - Rate Schedule, Section 3.4.
b. OTP facilities and other providers may charge a weekly copay of up to twenty-five dollars ($25) for Individuals whose income is between two hundred and three hundred percent (200% and 300%) of the Federal Poverty Level, and a weekly copay of up to ten dollars per week ($10/week) for Individuals whose income is up to two hundred percent (200%) of the Federal Poverty Level.
c. For OTPs Only: The BHASO shall receive reimbursement for each unique month of service delivered. This funding is intended to cover:
    i. The BHASO management,
    ii. Provider GPRA administration,
    iii. Provider GPRA data collection
    iv. Provider data entry of the initial GPRA survey
    v. The full cost of care, including
        1. Medications,
        2. Dosing,
        3. Counseling,
        4. Laboratory tests, and
        5. Other services considered to be a part of OTP care or MAT care with buprenorphine or depot-naltrexone.
    vi. See Exhibit B-2 Rate Schedule Section IV.
d. Funding may support MOUD for Individuals within county jails if continuity of care, including Medicaid or other funding support post release, is in place prior to initiating someone on MOUD.

e. This service is covered by Medicaid through the Regional Accountability Entities (RAEs), and all providers must be enrolled with one or more RAE and able to successfully bill those RAEs for Individuals with Medicaid.
f. All subcontracted providers of MAT are expected to serve Individuals with Medicaid or commercial insurance.

Article 3 - Overdose Prevention - BHA Program

3.3.3.1 Program Description and Objectives

a. The goal of this program is to reduce deaths in Colorado due to opiate/opioid overdose by providing a fund to purchase naloxone, a medication that reverses an opiate overdose, and fentanyl and xylazine test strips ("Test Strips"), which are used to detect the presence of fentanyl and xylazine in substances to reduce their risk of opioid overdose.
b. The BHASO shall ensure its Network and other stakeholders in its region have adequate and appropriate stock of naloxone and Test Strips to meet the needs of the OUD population in the region.

3.3.3.2 Target Population

a. The BHASO shall purchase and assure distribution of naloxone and Test Strips to:
    i. The BHASO Network; and
    ii. Stakeholders in its region that work with people who are at high risk opioid overdose and that do not qualify for the CDPHE Opioid Antagonist Bulk Purchase Fund (see https://www.colorado.gov/pacific/cdphe/opioid-prevention for more information).

3.3.3.3 Activities and Services

a. Purchasing
    i. The BHASO shall purchase overdose reversal kits of naloxone nasal spray ("naloxone") and Test Strips for distribution to its network. The BHASO shall coordinate with each recipient to have the supplier ship naloxone and Test Strips on an as-needed basis throughout the contract year.
    ii. No organizations receiving naloxone or Test Strips, either for distribution to high-risk people or for facility use, shall sell the naloxone or Test Strips.

3.3.3.4 Level of Care and Licensing Requirements:

a. License requirements: The BHASO must require all funded facilities maintain appropriate BHA treatment facility licenses as specified in 2 CCR 502-1.
b. Level of program and care:
    i. MAT services shall be delivered by agencies licensed by BHA for any of the following levels of care.
        1. OTP (Opioid Treatment Program)
        2. ASAM Level 1 (Outpatient Treatment)
        3. ASAM level 2.1 (Intensive Outpatient Treatment)
        4. ASAM Level 2.5 (Partial Hospitalization)
        5. ASAM Level 3.1 (Clinically Managed Low-Intensity Residential Services)
        6. ASAM Level 3.5 (Clinically Managed High-Intensity Residential Services)
        7. ASAM Level 3.7 (Medically Monitored Intensive Inpatient Services)
        8. ASAM Level 3.2 WM (Clinically Managed Residential Withdrawal Management)
        9. ASAM Level 3.7WM
    ii. Overdose reversal using naloxone shall be provided by any contracted facility licensed by BHA for SUD services at any level of care and/or agencies and organizations that serve Coloradans at risk of overdose.

3.3.3.5 Staff Credentials and Training:

a. No certification exists for naloxone training. Training for administering naloxone can be completed by an entity that specializes in naloxone and/or a harm reduction agency, health care organization, or overdose prevention setting.

3.3.3.6 Payment

a. The BHASO shall reimburse its network for the purchase of naloxone and Test Strips at the market rate.

Article 4 – Contingency Management – BHA Program

3.3.4.1 Program Description and Objectives

a. The purpose of this Article is to create a contingency management grant program to provide grants to substance use disorder treatment programs that implement a contingency management program for individuals with a stimulant use disorder.
b. The goal of Contingency Management (CM) is to reinforce positive consequences to clients when treatment goals are met and withhold positive consequences when clients engage in negative behavior.
c. The objective of this Article is to establish and maintain evidence-based Contingency Management models within existing outpatient behavioral health providers/centers.
d. "Contingency Management Program" as defined in C.R.S. 27-50-805, means an evidence-based treatment program that provides motivational incentives to treat individuals with a stimulant use disorder.

3.3.4.2 Target Population and Eligibility

The target population are individuals with a stimulant use disorder. "Stimulant Use Disorder" means a substance use disorder as defined in C.R.S. 27-80-203 (23.2), involving a class of drugs that includes cocaine, methamphetamine, or prescription stimulants, but does not exclude use of other substances.

3.3.4.3 Activities and Services

a. Grant Process: BHASO shall draft the grant application, review applications and administer and process the grant awards. BHASO shall prioritize applicants that reside in a jurisdiction with demonstrated need to help mitigate overdose deaths. In lieu of a grant process, the BHASOs will work with BHA Program Manager to identify and determine the subrecipients who have a presence in areas with demonstrated need to help mitigate overdose incidents and overdose deaths. Subrecipients must be licensed by BHA.
b. Specific Program Parameters: Subrecipients may use the money received through the grant program for staffing, training, supplies, administrative costs, the costs of vouchers and prizes up to five hundred ninety-nine dollars ($599.00) per client during the treatment period, and other related expenses as approved by the BHA Program Manager. Any funding received through the grant program must supplement and not supplant

existing substance use disorder treatment and other health-care services. Grant recipients shall not use money received through the grant program for ongoing or existing executive and senior staff salaries or services already covered by Medicaid or a client's insurance.

c. Activities and Services:
    i. The BHASO Network shall support training and implementation of CM.
    ii. Training - The counselors and supervisors identified to deliver the model shall be trained in the delivery and sustainability of CM.
    iii. Overall Function - Carry out the services of CM by awarding clients for positive behaviors related to treatment plans.
    iv. BHA Role - BHA will support the BHASOs in their facilitation of monthly meetings with CM providers to provide technical assistance and support. BHA will provide support to the BHASOs in their technical assistance with CM providers and assist with identifying eligible training resources.
d. Specific Program Requirements
    i. Within 60 days of the start of the BHASO contract, the BHASO shall provide a timeline, based on the subcontracting process, for CM training, delivery, and tracking of incentives, which must comply with the special terms of the grant:
        1. The recipient's organization must maintain written documentation in the patient's medical record that includes:
            a. The type of CM model and incentives offered that are recommended by the client's licensed health care professional.
            b. A description of the CM incentive furnished.
            c. An explanation of the health outcome or target behavior achieved; and
            d. A tally of incentive values received by the patient to confirm that per incentive and total incentive caps are observed.
        2. Receipt of the CM Incentive is contingent upon achievement of a specified target behavior, consistent with the beneficiary's treatment plan that has been verified with objective evidence.
        3. The CM Incentive is recommended by the client's treating clinician, who is licensed under applicable state law.

4. The CM Incentive is not cash, but may be tangible items, vouchers, or payment of bills that are of equivalent value to the individual's total or accrued incentive earnings.
5. No person may market the availability of a CM Incentive to induce a patient to receive federally reimbursable items or services or to receive such items and services from a particular provider or supplier.

ii. The BHASO shall record funding for this section in the Funding Allocation Matrix.

iii. BHASOs will provide updated and ongoing information to the BHA Program Manager, and through updates to their Contingency Management Goals and Outcomes Report and Funding Allocation Matrix.

3.3.4.4 Standards and Requirements

The CM counselors shall be properly credentialed by the Colorado Department of Regulatory Agencies (DORA) to counsel independently in an outpatient program licensed by BHA for SUD services. The Contractor shall participate in data reporting and program evaluation activities in collaboration with BHA.

3.3.4.5 Licensing Requirements

CM Providers must be licensed with BHA as an outpatient SUD provider.

3.3.4.6 Staff Credentials and Training

a. Staff and Contingency Management ready clinics shall complete BHA-approved Contingency Management training through OwnPath Learning Hub.
b. The BHASO shall submit implementation activity reports on a template created by the BHASO. Template to be approved by the Contingency Management BHA Program Manager.

3.3.4.7 Performance Outcome Measures

a. Demonstrated reduction in substance abuse for populations engaged in CM.
b. Demonstrated retention in treatment over a 12-week period.
c. Contingency Management Implementation Activity Reports shall be due on a quarterly basis.

d. The BHASO shall participate in BHA's formal evaluation of the Contingency Management program.

3.3.4.8 Payment

a. This Article reconciles to a capacity reimbursement model. The BHASO shall negotiate and record an annual Capacity-based budget with each provider utilizing a capacity-based payment methodology. The BHASO shall keep budget up-to-date with providers, and budgets shall be available to BHA upon request.

Article 5 - Child First Model Implementation – BHA Program

3.3.5.1 Program Description and Objectives

a. The purpose of this article is to implement Child First programming, a national, evidence-based, two-generation, trauma-informed, home-visiting model that works with young children and their caregivers who are most impacted by systemic and structural inequities through intensive, home-based services. By intervening early to serve high-risk pregnant and parenting families with children 0-5, the Child First intervention promotes nurturing and protective relationships which can both prevent and heal damage to the developing brain due to trauma and adversity.
b. Child First services will be delivered by a cohort of affiliate agencies who will benefit from critical backbone implementation support, provided through a sub-contractor who is well-equipped to monitor fidelity of the national Child First model.

3.3.5.2 Target Population

a. Those eligible for wraparound Child First services are young children, prenatal through age 5, experiencing any number of emotional, behavioral, learning, or developmental problems, with or at risk for abuse or neglect in their homes. Caregivers of these young children are facing multiple challenges including poverty, intimate partner violence, substance use, homelessness, depression and/or other mental health issues. These young children and their caregivers are the population of focus. Focused referrals for this program will be pregnant and parenting families impacted by Substance Use Disorder.

3.3.5.3 Activities and Services

a. The BHASO shall work with the BHASO Network who will support efforts to hire, train, reflectively supervise, implement, and assure the quality of the Child First program with a cohort of agencies who will deliver an evidence-based, dyadic and intensive home-visiting mental health intervention to support children and their caregivers who are impacted by trauma, with a particular focus on children impacted by caregiver substance use disorder. Under the supervision of a Child First Program Director, clinical teams delivering Child First programming will include a bachelor's level care coordinator and a Master's level mental health clinician. Based on available funding, the BHASO shall help the BHASO Network build the internal capacity needed to successfully delivery Child First to fidelity, including the following activities:
    i. Support affiliate agencies in hiring and training staff to implement the Child First program to fidelity;
    ii. Provide weekly and monthly reflective supervision and consultation to Child First affiliate agencies in Colorado, ensuring fidelity to the proven model and in support of staff seeking endorsement as Infant/ Early Childhood Mental Health professionals;
    iii. Guide Clinical Supervisors and Senior Leaders through the Child First accreditation process;
    iv. Manage centralized referral system for Child First;
    v. Provide prioritized and streamlined access to Child First programming for families impacted by substance use disorders;
    vi. Monitor and enhance Medicaid reimbursement for the Child First program on an agency and state level;
    vii. Coordinate local efforts with the National Service Office for Child First;
    viii. Develop relationships with public partners to align the Child First program with existing systems;
    ix. Engage and collaborate with local communities and State partners in service to high-quality and sustainable delivery of the Child First program;
    x. Identify public funding streams;
    xi. Collaborate with sites on program staff hiring and monitoring of progress; and
    xii. Develop a sustainable public financing model.

b. The BHASO Network shall work towards enhancing the Infant and Early Childhood workforce by building awareness of infant and early childhood mental health workforce needs across the state.

3.3.5.4 Standards and Requirements:

a. C.R.S. Title 27, Articles 80-82 governs the provision of behavioral health services.
b. Outpatient services are regulated pursuant to Chapter 4 of 2 CCR 502-1.
    i. Enhanced Outpatient Services (EOP) are regulated pursuant to Section 10.2 of 2 CCR 502-1.

3.3.5.5 Performance Outcome Measures

a. Report on progress towards completion of activities and services, on a template to be provided by BHA.
    i. DELIVERABLE: Quarterly Child First Implementation Progress Report
    ii. DUE DATE: 30 days after the close of each quarter
    iii. DESTINATION: cdhs_bhaso_deliverables@state.co.us
    iv. FILE NAME: BHASO Region[X] - [BHASO] - FY[XX] Q[X] - Quarterly Child First Implementation Progress Report

3.3.5.6 Payment

a. Payment reconciles to a capacity reimbursement model. The BHASO shall negotiate and record an annual capacity-based budget with each provider utilizing a capacity-based payment methodology. The BHASO shall keep budget up-to-date with providers, and budgets shall be available to BHA upon request.

Chapter 4

Outpatient Competency Restoration (OCR) - General Safety Net Service Terms

3.4.1 Program Description & Objectives

The purpose of Outpatient Competency Restoration (OCR), operated exclusively by the Colorado Department of Human Services, is to provide competency restoration services to adults and juveniles involved in the criminal or juvenile justice systems and deemed by a court to be incompetent to proceed. Competency restoration services are individualized services meant to address the unique barriers to competency, gaps in understanding of the court system, the ability to participate in one's defense, and the facilitating of behavioral health and community-based services that promote long-term stability and prevent further engagement in the criminal justice system. Such services may include, but are not exclusive to:

- Behavioral health treatment
- Treatment specific to Individuals with an intellectual or developmental disability
- Medication evaluation and management
- Peer support
- Case management/coordination
- Psychoeducation focuses on legal knowledge, rational decision-making skills, and strategies to consult with his or her attorney
- Brain injury resources
- Housing resources
- Employment Resources
- Long Term Support Services

3.4.2 Statutory / Rule Citation

a. OCR shall be performed in accordance with C.R.S §16-8.5-111, 2(a) and C.R.S §19-2-1303.
b. OCR shall be performed in accordance with Part 12.5.9 of 2 CCR 502-1.

3.4.3 Target Population / Eligibility

a. OCR shall serve juvenile (ages 10-17) and adult Individuals referred by the courts who have been ordered to engage in community-based restoration services. These services should be provided to Individuals who are on bond and not in jail, prison, or other detention facility. This includes court orders that order outpatient services while the juvenile is still in custody.
    i. If a juvenile becomes an adult before their case is resolved, the case is treated as a juvenile case.
b. There are no children- and youth-specific statements of work under this Chapter, though all treatment modalities in this Chapter shall serve children and youth unless the modality is contraindicated for children and youth.

3.4.4 Activities and Services

a. The BHASO is only responsible for contracting with the BHASO Network for this service. All monitoring and oversight of the OCR BHASO Network is conducted by OCFMH.
    i. OCFMH will alert the BHASO if any action needs to be taken with the BHASO Network provider contract, including but not limited to a corrective action or termination.
    ii. OCFMH is responsible to direct the BHASO to take any action on a BHASO Network provider contract and will inform the BHASO of the implementation, oversight, progress, and completion of that action.
b. Referrals and engagement
    i. The BHASO Network shall receive Individual referrals from OCR. OCR shall provide the BHASO Network referral packet for each referral which shall include the court order, competency evaluation, police reports/probable cause affidavit, and Individual contact information. The BHASO Network shall abide by the timeliness set forth by any Court Order.
        1. For the purposes of this section, the day after receipt of the referral is considered Day 1.
    ii. The BHASO Network shall have documented outreach efforts with each Individual within three (3) business days of receiving an Individual referral from OCR. This

documentation should appear within the BHASO Network monthly reporting delivered to OCR.

iii. The BHASO Network shall perform scheduling of an initial intake with each Individual within ten (10) days of receiving the referral from OCR. The BHASO Network shall inform OCR via email immediately if it is unable to book an appointment for an Individual within the ten (10) business daytime period and provide OCR with written records of efforts made in the body of that email, as OCR is responsible for complying with the court orders to provide restoration services and ongoing updates regarding progress towards restoration.

1. The initial intake appointment with the Individual shall occur within fourteen (14) days of the BHASO Network provider receiving the referral.

iv. The BHASO Network shall inform OCR immediately via email throughout their assignment if the Individual is not attending scheduled sessions.

1. The BHASO Network shall notify OCR if an Individual is at imminent risk of discharge due to non-engagement or any other factor and provide immediate notification to OCR.
2. An Individual shall not be discharged from services without the approval of OCR.

v. The BHASO Network shall not cease competency restoration services with the Individual until advised by OCR to do so.

The BHASO Network shall bill Medicaid for Medicaid-covered competency restoration services.

All competency Individuals must be served regardless of payer source or lack thereof.

c. Transportation

i. The BHASO Network agrees to provide transportation for staff as necessary to treat the Individual in the Individual's community.

d. Competency Restoration Services

i. The BHASO Network shall provide culturally competent and developmentally appropriate competency restoration services tailored to each Individual's unique needs.

ii. The BHASO Network shall provide competency restoration services for each Individual in an outpatient setting within or near the community in which the Individual resides. The BHASO Network shall provide the physical address(es) of

established offices where services shall be performed and indicate specific communities where they are willing to travel to provide restoration education services (if applicable).

iii. Competency restoration services shall occur through face-to-face encounters.
    1. Telehealth may be used where appropriate, including public health emergencies or specific needs of the Individual. If telehealth is utilized, reasoning must be included in the monthly report during the timeframe it is initiated.

iv. The BHASO Network is responsible for scheduling appointments with Individuals served.

v. The BHASO Network shall meet with the Individual individually and/or in a group setting (when appropriate) a minimum of two (2) times per week and a minimum of one (1) hour per meeting. If the BHASO Network does not meet this minimum, changes must receive prior approval from OCR and must be documented in the monthly report.

vi. Within the psychoeducational area of competency restoration services, the BHASO Network shall provide multiple learning formats (including, but not limited to discussion, reading, video, flashcards, games, and experimental methods of instruction, such as role-playing or mock trial) to accommodate different learning styles.

vii. In addition to the multitude of learning materials and resources provided by OCR via its provider portal, the BHASO Network shall use the competency restoration program curriculum provided by OCFMH as a guide to ensure the Individual demonstrates sufficient knowledge of the court system, their ability to participate in their own defense and that the identified barrier(s) to competency have been addressed and are not inhibiting their competency including the following elements:
    1. Rational decision-making skills
    2. Appreciation of criminal charges, the severity of charges, sentencing, and pleas
    3. Roles of the courtroom personnel
    4. Constitutional Amendment Rights
    5. Understanding the relationship between Individuals and their defense attorney

6. Ability to state the alleged facts
7. Strategy for defense including decision-making skills
8. Social skills that support appropriate courtroom behavior
9. Trial process
10. All while ensuring that barriers to competency are not impeding understanding

e. Subcontracted restoration services

i. Outpatient Competency Restoration Services

1. The BHASO Network may subcontract for the provision of any area of Outpatient Competency Restoration Services with another entity. OCFMH OCR Program Staff and the BHASO shall be notified in writing of the subcontract arrangements. The subcontractor must meet all requirements in the Competency Restoration Services Minimum Program Requirements. The BHASO Network is responsible for managing all coordination of subcontracted services and reporting requirements. BHA/OCFMH reserves the right to require the BHASO Network to renegotiate subcontracts where necessary to adhere to the terms of this Contract

f. Assessments and Documentation

i. The BHASO Network shall submit a monthly status report regarding the restoration services for each Individual and corresponding progress notes directly to OCR monthly. The BHASO Network shall send all reports and corresponding progress notes directly to OCR.

1. DELIVERABLE: OCR Monthly Status Report
2. DUE DATE: Monthly, on the third business day after the end of the reported month
3. DESTINATION: encrypted email to cdhs_outptrestoration@state.co.us
4. FILE NAME: BHASO Region[X] - [BHASO] - FY[XX][Month] - Provider List by County

ii. Continuing Services. The closing of a competency case does not imply the closing of all services to an Individual. If a competency case is closed, the provider will reassess the Individual's treatment needs and provide services for assessed needs and/or connect the Individual to a provider that is able to meet the assessed needs of the Individual.

iii. Critical Incidents

1. The BHASO Network shall share the following information directly with OCR via the critical incident form located on the provider portal. This form shall be filled out and submitted within 24 hours of the time the incident occurs.
    a. Name of Individual involved,
    b. Date and time of incident,
    c. Location of the incident,
    d. The nature of the incident,
    e. How the incident was resolved,
    f. Name(s) of staff present/involved, and
    g. Whether the incident resulted in any physical harm to the Individual or any staff.

3.4.5 Network Adequacy

a. The BHASO Network shall not decline to serve an OCR referral unless the provider cannot provide services within an appropriate time frame per the Individual's needs and the agency's capacity. If a provider asserts that they lack the capacity to serve the Individual:
    i. The provider shall instead provide care coordination to support the Individual in accessing alternate services within the statutory timeframe for service delivery.
    ii. The provider must provide documentation demonstrating the lack of capacity.
    iii. If the provider is a Comprehensive Community Behavioral Health Provider, repeated assertions that the provider lacks the capacity to provide Outpatient Competency Restoration services may result in adverse consequences for the provider's approval status as a Comprehensive Community Behavioral Health Provider.
b. The BHASO Network must provide OCR services in an outpatient setting to adult and juvenile Individuals who are involved with the criminal justice system and deemed incompetent to proceed.
c. The BHASO Network shall deliver the OCR program as described in Part 3, Chapter 4 of this statement of work to fidelity. Actual Individuals referred and served shall be monitored and reported. The BHASO Network shall build the capacity to provide OCR

services to a minimum number of Individuals within the Contract Year based on historical data.

3.4.6 Licensing Requirements

a. The BHASO Network shall maintain all business licensing necessary to conduct the related services. The BHASO Network's provider staff shall have a minimum of a bachelor's degree in a related field and attend OCR training to provide OCR services. Proof of such licenses, certifications, approvals, and insurance shall be provided upon OCR's request. Any revocation, withdrawal, or nonrenewal of necessary license, certification, approval, or insurance required to perform OCR services properly, shall be grounds for removal of a staff person from these OCR services or termination of these OCR services by OCR
b. The BHASO Network's provider staff who are not licensed in counseling, social work, or psychology shall have established and consistent supervision by a licensed supervisor.
c. The BHASO Network's provider staff who participate in the OCR program shall complete and submit a background check with the Colorado Bureau of Investigation in accordance with C.R.S. §27-90-111. No contact with Individuals shall take place until the background check is completed and passed.

3.4.7 Staff Credentials and Training

a. The BHASO Network providers and any of its staff who provide OCR services shall participate in training provided by OCR staff. The BHASO Network provider and any of its staff who provide OCR services shall use OCR-approved Competency Restoration Curricula as the basis for their psychoeducation while utilizing additional instructional resources located on the provider portal to meet the needs of various learning styles. The BHASO Network agrees to implement this curriculum and services to fidelity using the Outpatient Competency Restoration Best Practice Manual located on the provider portal.
b. MEETING: The BHASO Network and the BHASO must participate in quarterly conference calls designed to disseminate information, provide education, and resource support, and provide a forum for the BHASO Network to share information, concerns, and suggestions to OCR Program Staff. The BHASO Network is responsible for communicating this information to all staff that provide competency restoration services.

c. All trained BHASO Network provider staff shall be given access to the OCR Provider Portal. This portal is a repository for information and should serve as the primary source of information, frequently asked questions, tools, and resources for supervisors, leads, and staff providing competency restoration services.

3.4.8 Performance Outcome Measures

a. The BHASO Network shall participate in programmatic audits on a schedule determined by OCR. The measures that audits are based on are on the OCR Audit Template provided by OCR. The audit schedule consists of:
    i. Full audits occurring on odd years.
    ii. Follow up audits as required to resolve any findings issuing from the full audits.
    iii. Ad hoc audits in response to problems observed by or reported to the BHASO or OCR.
b. Individual - Specific Measures
    i. The BHASO Network shall document the date of receipt of a referral and have documented outreach to the Individual within three (3) business days of the referral receipt.
    ii. The BHASO Network shall have intake scheduled within ten (10) business days of referral
    iii. The BHASO Network shall complete the intake within fourteen (14) days of referral.
    iv. The BHASO Network shall perform and document outreach to all points of contact to initiate and facilitate Individual engagement in services.
    v. The BHASO network shall ensure the setting of services is appropriate to address the Individual's needs which may include, but is not limited to:
        1. Individual therapy
        2. Group therapy
        3. Telehealth services
        4. In-person Services
        5. Ensure services are not with Individuals out of state
        6. Ensure services are not with Individuals in a locked facility
    vi. The BHASO Network shall contact the Individual at an appropriate frequency and provide documentation and justification regarding the frequency of contact.

vii. The BHASO Network shall use the OCR curriculum and include all education elements in OCR.

viii. The BHASO Network shall utilize the Provider Portal for all curricula and additional tools to use during education sessions.

ix. The BHASO Network shall provide individualized, culturally competent services, and present OCR in a variety of formats to be tailored to the Individual's individual needs.

x. The BHASO Network shall address all barriers to competency documented in the competency evaluation and those identified by the BHASO Network.

xi. The BHASO Network shall make referrals to community services and supports that may assist the Individual in meeting their needs and maintaining stability.

3.4.9 Payment

a. OCR services are paid on a fixed payment basis based on projected capacity level. Rates for OCR providers are found in Exhibit B, Rate Schedule, Section 4.1 and 4.2.

b. BHASO Network providers will be paid the monthly amount identified in Exhibit B, Rate Schedule, Section 4.2, as long as terms and conditions in the Contract are met. OCFMH will monitor the BHASO Network provider's progress towards its projected capacity level on a routine basis. OCFMH may direct the BHASO to reduce the monthly payment if the BHASO Network provider's interim forecasts indicate an impaired ability to meet at least seventy-five percent (75%) of the projected capacity level or if service quality is found to be unsatisfactory.

Chapter 5
Behavioral Health High-Intensity Outpatient Services and Hospital Alternatives

Article 1 - Behavioral Health High-Intensity Outpatient Services and Hospital Alternatives - General Safety Net Service Terms
Article 2 - Assertive Community Treatment - BHA Program
Article 3 - Ascent (First Episode Psychosis) - BHA Program
Article 4 - Forensic Community-Based Services (FCBS) - BHA Program
Article 5 – Crisis Resolution Teams (CRT) for Children, Youth, and Families – BHA Program

Article 1 - Behavioral Health High-Intensity Outpatient Services and Hospital Alternatives - General Safety Net Service Terms

3.5.1.1 Program Description and Objectives

a. Behavioral health high-intensity outpatient services are services provided to an Individual in accordance with their service plan on a regular basis in a non-overnight setting as an alternative to inpatient and residential treatment services which include, but are not limited to, transitional care following an inpatient stay in lieu of continued hospitalization, coordination of outpatient certifications, step-down services, intensive treatment services, case management, rehabilitation, and housing services and supports.

3.5.1.2 Target Population and Eligibility

a. High-Intensity Outpatient Services are intended to serve individuals with high behavioral health needs with intensive services that cannot be sufficiently addressed with standard levels of outpatient services but does not require inpatient or residential levels of care.
a. Behavioral Health High-Intensity Outpatient Services shall be available to adults, children, and youth in the BHASO Region.

b. All treatment modalities in this Chapter shall serve children and youth unless the modality is contraindicated for children and youth.
    i. Article 2 - Assertive Community Treatment serves adults only (ages 18 and up)
c. The children and youth-specific statements of work under this Chapter are:
    i. Article 3 - Ascent (First Episode Psychosis)
    ii. Article 5 - Crisis Resolution Teams for Children, Youth, and Families

3.5.1.3 Rule Citation

a. Behavioral Health High-Intensity Outpatient Services shall be performed in accordance with Chapter 4 of 2 CCR 502-1.
b. Partial Hospitalization Program service shall be performed in accordance with Part 4.7 of 2 CCR 502-1.
c. Enhanced Outpatient Services shall be performed in accordance with Part 10.2 of 2 CCR 502-1.
d. Intensive Outpatient Services shall be performed in accordance with Part 10.3 of 2 CCR 502-1.

3.5.1.4 Activities and Services

a. Programs allowable for adults under this Chapter include, but are not limited to:
    i. Partial hospitalization (pursuant Part 4.7 of 2 CCR 502-1),
    ii. Enhanced Outpatient: requires advance written permission from BHA to evaluate appropriateness under the circumstances (pursuant Part 10.2 of 2 CCR 502-1)
    iii. Assertive Community Treatment,
    iv. Community Dual Disorders Treatment Teams (CDDT),
    v. Day treatment,
    vi. Forensic Assertive Community Treatment,
    vii. Homeless prevention services,
    viii. Intensive case management services (e.g., rapid response treatment teams),
    ix. Intensive Outpatient (IOP) (pursuant Part 10.3 of 2 CCR 502-1),
    x. Hospital alternative services,
    xi. Supportive treatment services (e.g., workforce/vocational services, psychosocial services, step down residential services, coordination of outpatient certifications, respite, tenancy supports, hospital care transitions), and

xii. Other evidence-based or best-practices programs and services approved by BHA.

b. Types of programs allowable for children under this section:
   i. Ascent (First Episode Psychosis (FEP),
   ii. High fidelity wraparound service,
   iii. Intensive services provided for children with high behavioral health needs,
   iv. Systems of care involved youth requiring high fidelity wraparound services,
   v. Trauma systems therapy services, and
   vi. Other evidence-based programs or best-practices and services approved by BHA.
c. Allowable Activities
   i. Assessment,
   ii. Court ordered evaluations,
   iii. Psychological testing,
   iv. Family, group and individual psychotherapy,
   v. Medical and nursing support,
   vi. Care coordination,
   vii. Treatment and/or service planning,
   viii. Medication management,
   ix. Family support,
   x. Skill development,
   xi. Expressive and activity therapies,
   xii. Psychosocial education and training,
   xiii. Wraparound services,
   xiv. Telehealth capacity,
   xv. Supportive and or transitional services,
   xvi. Residential step-down care or support,
   xvii. Transitions of care support,
   xviii. Telehealth support,
   xix. Urgent psychiatric evaluation and/or stabilization,
   xx. Supported employment, and
   xxi. Other evidence-based or best/promising practice activities approved by BHA.
d. Assessments and Documentation
   i. The BHASO Network shall perform assessments and documentation in accordance with the chosen model.

3.5.1.5 Standards and Requirements

a. BHA does not approve the use of the Colorado ACT Model. ACT services must adhere to the Dartmouth ACT Model.

3.5.1.6 Level of Care, Licensing, and Staff Credential Requirements

a. High-intensity outpatient SUD Services include ASAM Criteria Level 2.0 type services and require a Behavioral Health Entity (BHE) license with an endorsement for the corresponding ASAM Level of Care.
b. For all other services in this Chapter 5, level of care and licensing requirements and staff credentials may vary based on program needs. All services must be provided in accordance with the model described.

3.5.1.7 Data Submission

a. 837 Encounter data shall be delivered in accordance with the terms of Exhibit D, as may be amended, Article 2.
b. The BHASO Network shall complete a CCAR/DACODS record or Treatment Episode Report Unified Data Model submission (the successor to former CCAR/DACODS submissions) for each applicable Individual per the technical specification guidelines provided by BHA to BHASOs.

3.5.1.8 Payment

a. This service may be paid on a fee for service and/or capacity basis.
    i. If this service is paid on a fee for service basis, this service reconciles to rates found in Exhibit B, Rate Schedule, Section 3.1.
    ii. The BHASO shall negotiate and record an annual capacity-based budget with each BHASO Network provider utilizing a capacity-based payment methodology. The BHASO shall keep the capacity-based budgets up-to-date with BHASO Network providers as required, and all budgets shall be available to BHA upon request.

Article 2 - Assertive Community Treatment - BHA Program

3.5.2.1 Program Description and Objectives

a. The goals of this program are to provide intensive, community-based treatment and to reduce the need for higher levels of care for adults diagnosed with Severe Mental Illness (SMI) and co-occurring SMI and Substance Use Disorders (SUD).

3.5.2.2 Target Population

a. The ACT program shall target adults diagnosed with Severe Mental Illness (SMI) and/or SMI with co-occurring SUD who have experienced multiple psychiatric hospitalizations or other higher levels of care, incarcerations, or substantial homelessness and to assist those individuals to live successfully in their communities.

3.5.2.3 Activities and Services

a. Services
    i. The BHASO shall establish and maintain a network of evidence-based Assertive Community Treatment (ACT) programs in its Region.
    ii. The BHASO Network shall deliver ACT services in accordance with the Dartmouth Assertive Community Treatment Scale ("DACTS") provided by BHA.
    iii. The BHASO Network shall prioritize ACT referrals from these populations in order:
        1. The Momentum program,
        2. State hospital discharges,
        3. Ascent/First Episode Psychosis (FEP) teams,
        4. The forensic population discharging from state hospitals, and
        5. Individuals with more than one psychiatric inpatient stay in the past year.
    iv. The BHASO Network shall perform the following functions:
        1. Managing the ACT program,
        2. Monitoring admissions and discharges according to DACTS model,
        3. Maintaining appropriate caseloads, and
        4. Adhering to the frequency, duration, and type of contacts required under the DACTS model.
    v. The BHASO Network shall provide assistance with the following types of services:
        1. Activities of daily living

2. Basic needs
3. Benefits acquisition and management
4. Continuity of care
5. Counseling/Therapy
6. Crisis management
7. Employment
8. Family/social life
9. Health care
10. Housing
11. Medication management
12. Nursing
13. Peer support
14. Substance use

vi. When selecting providers for ACT, the BHASO shall take into account providers' scores on fidelity reviews conducted by BHA, among other considerations around participation in ACT services under the BHASO.

vii. If an ACT Team must dissolve for any reason, the BHASO shall inform its BHA BHASO Regional Manager and establish a plan to form a new ACT team to replace it.

1. DELIVERABLE: ACT Team Transition Plan
2. DUE DATE: Within 30 days of BHASO's knowledge of termination of an ACT team in its network.
3. DESTINATION: BHA BHASO Regional Manager email

viii. MEETING: BHA shall facilitate monthly virtual ACT learning Collaborative meetings with all in-network ACT providers. The BHASO Network shall have at least one individual from each ACT team attend each of those meetings and/or a regional meeting to be scheduled. BHA ACT Program Manager shall coordinate the meeting schedule with the ACT teams and the BHASO.

b. Assessments and Documentation

i. See DACTS Fidelity Model.

3.5.2.4 Standards and Requirements

a. Dartmouth Fidelity Reviews
    i. BHA shall provide the current Dartmouth Assertive Community Treatment Scale (DACTS) to the BHASO for distribution to the BHASO Network.
    ii. The BHASO Network shall meet fidelity requirements of the Dartmouth Assertive Community Treatment Scale (DACTS). BHA expects BHASOs to participate in monitoring their subcontractors that are not in compliance and withhold payment if action plans are not met in a manner defined. The BHASOs are to ensure that each ACT participates in scheduled Monthly Learning Collaborative Meetings and all fidelity reviews.
    iii. The BHASO and BHA shall coordinate to schedule fidelity reviews with the BHASO Network. BHA then completes the fidelity reviews using the Dartmouth Assertive Community Treatment Scale (DACTS).
    iv. Good fidelity on the DACTS is defined as an average item score of at least four (4), for a total score of at least one hundred twelve (112).
        1. Programs that do not maintain good fidelity to the DACTS model shall ensure adequate staff training, technical assistance, and program development to attain good fidelity within six (6) months after the previous fidelity review.
        2. If good fidelity is not attained within six (6) months of the initial review, the BHASO shall place the program on corrective action. The BHASO shall coordinate with the BHASO and the BHA to establish goals, timelines, and consequences for the corrective action.
b. The BHASO shall not contract for ACT programs using the Colorado ACT model. Only the DACTS SAMSHA Model is approved for use in the BHASO Network.

3.5.2.5 Staff Credentials and Training

a. The BHASO Network shall form community-based and multidisciplinary teams with staff who are licensed or credentialed (as appropriate pursuant to DACTS) with experience in the following areas:
    i. Psychiatry,
    ii. Psychology,
    iii. Nursing,

iv. Social work,
v. Counseling,
vi. Rehabilitation,
vii. Substance use treatment,
viii. Peer support,
ix. Case management,
x. Housing,
xi. Employment, and
xii. Benefits.

3.5.2.6 Data Submission

a. 837 Encounter data shall be delivered in accordance with the terms of Exhibit D, as may be amended, Article 2.
b. The BHASO Network shall complete a CCAR record or Treatment Episode Report Unified Data Model submission (the successor to former CCAR/DACODS submissions) for each applicable Individual upon admission and discharge from the ACT program. The records must be updated biannually.
    a. The BHASO Network shall assign the special studies code "ACT" to CPT/HCPCS procedural level service encounter data in accordance with the most recent versions of the Behavioral Health Administration Finance and Data Protocols.
c. The BHASO Network shall submit the ACT data to the BHASO using the BHA-provided collection instrument. The BHASO shall provide the compiled data to BHA quarterly. via a secure format. Please reference Data Dictionary described in Exhibit D, Appendix 1, as may be amended, to verify most up-to-date format and requirements.
    a. DELIVERABLE: ACT Data
    b. DUE DATE: last day of the month following the end of the quarter.
    c. DESTINATION: Secure electronic delivery.

3.5.2.7 Payment

a. This service may be paid on a fee for service and/or capacity basis.
    i. If this service is paid on a fee for service basis, this service reconciles to rates found in Exhibit B, Rate Schedule, Section X.

ii. The BHASO shall negotiate and record an annual capacity-based budget with each BHASO Network provider utilizing a capacity-based payment methodology. The BHASO shall keep the capacity-based budgets up-to-date with BHASO Network providers as required, and all budgets shall be available to BHA upon request.

Article 3 - ASCENT (First Episode Psychosis) - BHA Program

3.5.3.1 Program Description and Objectives

a. ASCENT Colorado is a holistic, community-based program that implements the Coordinated Specialty Care model for First Episode Psychosis (FEP) to provide intensive outpatient treatment and support. The objective of ASCENT is to improve outcomes for youth and young adults experiencing their first episode psychosis. The program offers up to three (3) years of specialized services (community outreach and education, individual therapy, family education and support, Care Management, specialized education and employment services, nursing and wellness Support, psychiatry, and peer support) to guide Individuals and their families toward stability and independence. Ascent is funded by a ten percent (10%) set aside for FEP required by the SAMHSA Mental Health Block Grant, though the BHASO may opt to fund FEP above this level.

3.5.3.2 Target Population and Eligibility

a. Each ASCENT Program shall target no more than thirty-five (35) youth and young adults ages fifteen to twenty-nine (15-29) (upon intake to the ASCENT Program) experiencing FEP. FEP is defined as a psychotic episode that occurs for the first time.
b. Individuals served by the ASCENT Program shall have a recent diagnosis of a psychotic disorder, with the onset of symptoms occurring within the last twenty-four (24) months. Psychotic disorders identified in the DSM-5-TR include psychosis within the listed categories of symptoms such as schizophrenia, schizoaffective disorder, schizophreniform disorder, brief psychotic disorder, and unspecified psychotic disorder.
c. Individuals can be served by the ASCENT Program for up to three (3) years with the goal of stepping down to a lower level of care between two to three (2-3) years.
d. Exclusion criteria for admission to the ASCENT Program include psychotic symptoms secondary to the following:
    i. A pervasive developmental disorder,

ii. A physical health or neurological disorder,
iii. Alcohol or substance induced psychosis,
iv. Bipolar disorder with psychotic features,
v. Depressive disorder with psychotic features,
vi. Individuals outside the age range of fifteen to twenty-nine (15-29) years upon admission, or
vii. Individuals who experienced an onset of psychotic disorder more than twenty-four (24) months ago.

3.5.3.3 Activities and Services

a. The BHASO Network shall deliver FEP services in accordance with SAMHSA guidelines and shall follow the Coordinated Specialty Care (CSC) model fidelity scale provided by BHA that provides culturally and linguistically sensitive services consistent with the needs of transition-aged youth. CSC promotes shared decision making and utilizes a team of specialists who work with the Individual to create a personalized treatment plan.
b. In accordance with the CSC model, the BHASO Network shall offer psychotherapy, medication management, family education and support, peer support services, case management, and employment and/or education support, depending on the individual's needs and preferences. The BHASO shall ensure that the Individual and team work together to make treatment decisions, involving family members as much as possible.
c. Utilizing BHA provided ASCENT marketing materials when available, the BHASO Network shall provide community education and assertive outreach to identify and engage Individuals and families as quickly as possible when psychosis first begins.
d. The BHASO Network shall comply with utilizing all ASCENT branding and marketing materials for the ASCENT program.
e. The BHASO Network shall provide ASCENT services in the home, community, clinic, and telehealth settings.
f. Administration
    i. The BHASO shall participate with BHA in state-level development planning.
    ii. The BHASO and BHASO Network shall participate in ongoing collaboration with other systems and agencies to ensure that services are coordinated and, when necessary, integrated.

iii. BHA and the BHASO shall facilitate monthly ASCENT program meetings, and a conference call option shall be provided. The BHASO Network shall have agency representation at those meetings each month.

3.5.3.4 Standards and Requirements

a. Fidelity Scale and Reviews
   i. The BHASO and BHA shall coordinate to schedule fidelity reviews with the BHASO Network.
   ii. BHA shall conduct fidelity reviews of the ASCENT Program on a biannual (every two (2) years) basis using a scale as determined by BHA. The team shall then integrate feedback into ongoing quality improvement. BHA shall provide the CSC Model Fidelity Scale results to the BHASO and the BHASO Network provider evaluated within 30 days of completion of the review.
   iii. Programs that receive fidelity scored items indicated as "foundational" on the CSC model shall ensure adequate staff training from BHA or the ASCENT TTA provider and program development to bring all items to "progressing" or "established." Items indicated as "foundational" shall be reviewed by BHA every six (6) months until they are indicated as "progressing." The BHASO Network shall coordinate with the BHA to schedule additional technical assistance and complete follow-up reviews to ensure that good fidelity has been attained.

3.5.3.5 Staff Credentials and Training

a. ASCENT teams shall be community-based and multidisciplinary, and staff members shall have relative experience to their position and receive additional training when needed. The BHASO Network shall establish and maintain a team consisting of the following ASCENT roles required to provide services to fidelity:
   i. Team lead
   ii. Psychotherapist
   iii. Case manager
   iv. Family education support
   v. Supported Employment and Education Specialist (SEES)
   vi. Pharmacotherapy and primary care coordination
   vii. Peer support specialist

b. In some situations, these positions can be combined with other programs (such as Assertive Community Treatment (ACT)) when appropriate and approved by BHA. Additional training and technical assistance may be required.
c. The BHASO Network shall ensure that all team members participate in required training and supervision.
d. The BHASO shall notify the BHA of the BHASO Network team lead staff names, contact information, and licensure status.
e. The team lead shall participate in all aspects of training and technical assistance on CSC, including receiving technical assistance with EASA CSC contracted trainer/consultants.

3.5.3.6 Data Submission

a. Evaluation/Outcomes Measures - The BHASO Network shall submit the ASCENT data submitting tool each quarter for all individuals receiving Ascent Services. Sections (i) and (ii) both use the same reporting tool. The BHASO shall submit the ASCENT Data Tool to BHA quarterly.
    i. For everyone served, demographic information will be submitted. These fields include Date of Admission, Date of Birth, Date of Onset of FEP, Education/Occupational Status, Housing Status, Risk Identification, and Medication Status.
    ii. The following Outcome Measures materials shall be collected at intake, every six (6) months while enrolled in ASCENT services, and again upon discharge from ASCENT services.
        i. Global Functioning: Social Scale
        ii. Global Functioning: Role Scale
        iii. Lehman's Quality of Life - One Question
        iv. Modified Colorado Symptom Index
    iii. DELIVERABLE: ASCENT Data Reporting Tool
    iv. DUE DATE: last day of the month following the end of each Quarter
    v. DESTINATION: BHA's SFTP Platform (MOVEit) or alternative as indicated by BHA
b. 837 Encounter data shall be delivered in accordance with the terms of Exhibit D, as may be amended, Article 2.
c. The BHASO Network shall complete a CCAR/DACODS record or Treatment Episode Report Unified Data Model submission (the successor to former CCAR/DACODS submissions) for

each applicable Individual per the technical specification's guidelines provided by BHA to BHASOs.

3.5.3.7 Payment

a. This service reconciles to a capacity reimbursement model. The BHASO shall negotiate and record an annual capacity-based budget with each provider utilizing a capacity-based payment methodology. The BHASO shall keep budget up-to-date with providers, and budgets shall be available to BHA upon request.

Article 4 - Forensic Community-Based Services (FCBS) - BHA Program

3.5.4.1 Program Description and Objectives

a. Forensic Community Based Services (FCBS) is the program at the Office of Civic and Forensic Mental Health (OCFMH), partnering with BHA, responsible for oversight of persons found Not Guilty by Reason of Insanity (NGRI) who are placed in the community while still under the authority of the State of Colorado, Department of Human Services. The program proactively works with the BHASO Network to facilitate community reintegration using comprehensive and evidence-based services in the least restrictive environment, while meeting the need for public safety.

3.5.4.2 Statutory and Rule Citation

a. FCBS shall be performed in accordance with C.R.S. § 16-8-115.

3.5.4.3 Target Population and Eligibility

a. All referrals to FCBS are generated by the Colorado Mental Health Hospital (CMHH) inpatient treatment team or Forensic Community Based Services. FCBS Individuals have been adjudicated NGRI and have progressed to the status of Community Placement or Conditional Release, allowing for follow-up treatment in the community.

3.5.4.4 Services

a. The BHASO shall ensure that all its contracted Comprehensive Community Behavioral Health Safety Net Providers participate in the FCBS program.
b. The BHASO shall continually work collaboratively with the FCBS team, while utilizing the Risk Need Responsivity model to facilitate the Individual's ongoing recovery and

criminogenic risk reduction, thereby preventing recidivism and rehospitalization.

c. Treatment services shall account for and align with all requirements for community placement, or all conditions outlined in the conditional release order, as well as all criminogenic risk factors identified in the formal risk assessment conducted at the CMHIP and prioritized by FCBS. FCBS-involved Individuals shall be assigned to Assertive Community Treatment, unless a clinical justification is made by the BHASO and agreed upon by both the BHASO and the FCBS Director/designee.

d. FCBS Process

   i. When serving Individuals who are conditionally released or on community placement from the CMHH at Pueblo and Fort Logan or directly by court order, each BHASO Network Provider shall comply with the most current version of the "Procedures for Community Treatment for Persons Adjudicated Not Guilty by Reason of Insanity and Followed by Forensic Community-Based Services (FCBS)," which is made a part of this Contract by reference.

   ii. When an Individual is approved for community placement, or advances to conditional release from the CMHH, the Individual shall be referred by the CMHH and/or FCBS to a BHASO Network serving the area to which the Individual is discharged.

   iii. The BHASO Network shall initiate the primary contact with the appropriate CMHH or FCBS to request necessary Individual information within ten business days of the initial Individual referral.

   iv. BHA and the BHASO acknowledge and agree that the CMHHs must supply the BHASO Network with necessary Individual information, related to the procedures herein.

   v. In the event the Individual is already residing in the community, the BHASO Network shall initiate the primary contact with the FCBS regional conditional release coordinator to request necessary Individual information within ten (10) business days of the initial Individual referral.

   vi. If the primary contact does not result in the receipt of said information within ten (10) business days, the BHASO Network may contact the BHA FCBS manager or designee for assistance. The BHA FCBS manager or designee shall contact the appropriate CMHH to assist in expediting the receipt of necessary Individual information.

   vii. Reasonable efforts by the BHASO Network to obtain necessary Individual

information shall constitute compliance with the requirements set forth above related to this contract. Reasonable efforts include written or electronic requests, or documented telephone communication requesting said necessary Individual information.

e. FCBS will include the BHASO entity in the client's release of information. FCBS will copy a designated representative from the BHASO on the referral/intake communication. OCFMH will notify the BHASOs if there is a critical change of status of an Individual or escalated event that requires rehospitalization of an Individual receiving services from the BHASO's Network providers.

f. Upon the BHASO Network's acceptance of community placement or conditional release of a FCBS Individual, the BHASO Network shall coordinate with the OCFMH FCBS manager or designee to obtain required programmatic information, to include the most current procedure manuals.

g. The BHASO Network shall collaborate with FCBS when the Individual or FCBS initiates a request for change in CJI legal status. If the BHASO Network supports an evaluation by a qualified professional, not affiliated with the BHASO Network, the BHASO Network shall provide in writing, a statement of their support of the evaluation. The BHASO Network shall provide all treatment records requested by FCBS, or the evaluator, as legally permitted, for their performance of an evaluation of the Individual's eligibility for change in legal status. A guide for the BHASO Network is provided in Appendix C of the current FCBS Procedure Manual.

h. BHA shall provide site based and webinar training and technical assistance to the BHASO Network's forensic coordinators, clinicians, and case managers who interact directly with FCBS-involved Individuals or oversee FCBS-related treatment, monitoring, and reporting activities at the BHASO Network. The BHASO Network shall ensure that newly assigned forensic coordinators shall view the BHA overview webinar in the first thirty (30) days. The BHASO Network shall further ensure that staff working with FCBS Individuals have documented training attendance in the first ninety (90) days of employment or taking on this caseload. The training shall include, at a minimum, the topics of FCBS overview, forensic service planning, and quarterly reporting.

i. OCFMH will conduct fidelity reviews using the current version of the FCBS procedure manual, C.R.S. § 16-8-115, 2 CCR 502-1 Behavioral Health Rules, and applicable Federal regulations. FCBS will inform the BHASOs of the incoming audit scheduling and of the audit results for providers in its network.

j. Each BHASO Network Comprehensive provider shall appoint one person as its forensic coordinator to ensure adherence to Title 16, Article 8, of the C.R.S. Sanity Statutes, as well as the most current version of the FCBS Community Procedure Manual, titled "Procedures for Community Treatment for Persons Adjudicated Not Guilty by Reason of Insanity and Followed by Forensic Community-Based Services (FCBS)." The BHASO Network may obtain a copy from the FCBS director/designee.

k. The BHASO Network shall provide immediate written notification to the FCBS Director/designee and BHA Manager of FCBS Programs of any changes in assignment of the Forensic Coordinator, including changes to duties, address, or telephone numbers and shall promptly update a list of staff assigned as primary therapist or case manager of an FCBS-involved Individual.

l. When a critical incident qualifying event occurs in relation to an Individual on Community Placement or Conditional Release, the BHASO Network Comprehensive provider shall immediately notify the Program Director of FCBS and the BHASO. If the qualifying event occurs after normal operating hours, the Program Director of FCBS shall immediately notify the Director of Forensic Services for all incidents and CMHH Pueblo Administrator on Call (AoC). If the qualifying event occurs during normal operating hours of FCBS, the case manager shall complete a form 1300 (critical incident report). For qualifying events occurring after normal operating hours the AoC shall complete an electronic critical incident report (i-notify). Critical incidents include escape, any arrest, physical/sexual assault, suicide attempts requiring medical attention, death that is unexpected, or any incident deemed critical by the program, agency, or the executive director of the facility.

m. The BHASO Network shall make all reasonable efforts to prevent rehospitalization of FCBS Individuals experiencing psychiatric decline through the utilization of Acute Treatment Units, crisis response and ACT teams or other alternatives to rehospitalization.

n. The BHASO Network is responsible for submitting quarterly reports on the Individual's progress to the FCBS Director/designee, the BHA Manager of FCBS Programs, and the BHASO. These reports shall be completed according to the required format (see Appendix B of the FCBS Procedure Manual).

    i. DELIVERABLE: Quarterly Individual Progress Reports

    ii. DUE DATE: the tenth (10th) business day of the month following the previous quarter (e.g., January, April, July, and October).

iii. DESTINATION: OCFMH FCBS Director/designee by encrypted email.

iv. FILE NAME: BHASO Region[X] - [BHASO] - [Provider] FY[XX] Q[X] - Proof of Insurance

o. Data and Documentation

i. The BHASO Network shall assign the special studies code "FCBS" to procedural level service encounter data in accordance with the most recent versions of the Behavioral Health Administration Finance and Data Protocols.

Article 5 – Crisis Resolution Teams (CRT) for Children, Youth, and Families – BHA Program

3.5.5.1 Program Description and Objectives

a. The BHASO Network shall provide specialized in-home services to children, youth, and families in crisis in Colorado. Young people and families experience improved outcomes when stabilized in the home and reduces the burden on the bed-based behavioral health system. This program is designed to prevent at-risk children from being placed in residential or out-of-home treatment options.as well as prevent referral to higher level of care.

3.5.5.2 Target Population and Dispatch

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

b. Emergency and crisis services shall be available to any individual who is experiencing a behavioral health crisis, regardless of whether the individual is a priority population.

3.5.5.3 Activities and Services

a. The BHASO Network shall provide intensive in-home services to children, youth, and their families referred following a crisis episode. Services offered shall include, as clinically appropriate:

i. Consultation with the BHASO for high-acuity Individual and/or their family to ensure adherence with the goal of reducing referrals to higher levels of care.

1. The BHASO shall be available for case consultation and referral determination.

ii. Intake and needs assessment shall be administered at initial contact with each Individual and the BHASO Network shall accept the family into the CRT program.

iii. The Columbia Suicide Severity Rating Scale (C-SSRS) shall be administered for each Individual at service initiation and again at program discharge

iv. Service and Treatment planning

1. Case management and care coordination shall be provided by the BHASO Network for the family of the Individual
    a. Connection to community-specific support services
    b. The BHASO Network shall utilize the resources in BHA-created CYF Toolkit provided to the BHASO.
2. Connection to and coordination of benefits, which may include but is not limited to Medicaid and other social benefits.
3. Care Coordination which may include, but is not limited to, other providers, agencies, or organizations that are involved with the Individual's and/or family's continuum of care.

v. Crisis management

1. The BHASO Network shall provide support and guidance to an individual experiencing crisis during a crisis episode.
2. Peer support shall be provided throughout the duration of the program for the young person and their family
3. Family skill building, which may include but is not limited to;
    a. improve communication,
    b. behavior management,
    c. problem solving,
    d. conflict resolution
    e. relationship building
    f. coaching
4. Individual and family therapy
5. Group therapy
6. Community connection
7. Psychiatry and medication management
8. Discharge planning and referrals to ongoing support

a. Discharge shall occur once the individual/family is able to demonstrate and maintain improvements in the goals outlined in their treatment/service plan.
b. Referrals to the continuum of care which may include but is not limited to, High-Fidelity Wraparound; The Children and Youth Mental Health Treatment Act (CYMHTA); outpatient therapy and psychiatry; group therapy; and support groups
c. The BHASO Network shall perform a Seven- (7) day post-program discharge follow-up to ensure ongoing stabilization, adequate coping with transition of care, and adherence to ongoing services. An additional fourteen- (14) day follow up shall be required for non-responsive discharge clients.

3.5.5.4 Standards and Requirements

a. Referrals shall be accepted from hospital emergency departments, and the Colorado Crisis Services continuum. Eligibility criteria shall include:
    i. Individuals served shall be children, youth, and families who present to the crisis system and/or emergency departments with high acuity needs, who have received a crisis evaluation and are determined to be safe to remain in the home or community to receive intensive, short-term stabilization interventions. These Individuals shall be prioritized. If the local CRT team is not at capacity, then the team may serve children or youth who present with high-acuity behavioral health needs referred from other agencies (i.e. schools, pediatricians, etc.). The program is not intended as a step-down from higher levels of care.
    ii. Emergency Departments. A child or youth who has sought services at and has been determined to not need a higher level of care, based on the assessment of the program provider.
    iii. CCS Walk-in Centers and Mobile Crisis Response - A child or youth who has sought services and has been determined to not need a higher level of care, based on the assessment of the program provider.
        1. Other referrals may be accepted based upon Crisis Resolution Team availability at the discretion of the BHASO.
b. BHASO Role.

i. The BHASO shall build the teams based on regional needs and staffing availability.
ii. The BHASO shall be responsible for data reporting
iii. The BHASO shall be responsible for coordination with other child, youth, and family programs throughout the state.
iv. The BHASO may use funds not allocated to the clinical team or care coordinator to add positions at the BHASO for the purposes of program management, additional care coordination, and/or program coordination, subject to BHA approval.
    1. If the FTE for Care Coordination is also going to be leveraged to provide direct CYMHTA Clinical Care Coordination, all credentials and responsibilities outlined in Chapter 13, Article 1 are applicable. The three hundred dollars ($300) per member per month for the CYMHTA Individuals shall be billed to CYMHTA and deducted from the monthly salary invoices.

3.5.5.5 Service Hours

a. Frequency of the services shall be offered at a minimum of three (3) days per week, up to a variety of services multiple times daily depending on clinical need.
b. Duration of services shall be offered for a minimum of four (4) weeks, up to six (6) weeks depending on clinical need.

3.5.5.6 Service Targets

a. The BHASO Network shall serve no more than ten (10) families per CRT at any given time.

3.5.5.7 Staff Credentials and Training

a. The program shall employ a multidisciplinary, team-based approach. The teams shall employ a variety of staff, with corresponding supervision based on the level of experience and expertise of the team composition. The team composition may be flexible if the roles and requirements outlined in Activities and Services are met and must be approved by the BHASO and BHA, and include:
    i. Master’s level/licensed clinician,
    ii. Bachelor’s level clinician/case manager,

iii. Peer specialist,
iv. Prescriber,
v. Family skills coach/advocate,
vi. Behavioral coach/analyst

b. The prescriber role is required and may offer telemedicine visits, with approval from BHA and the BHASO, for enrolled individuals within the BHASO Network.

3.5.5.8 Data Submissions

a. 837 Encounter data shall be delivered in accordance with the terms of Exhibit D, as may be amended, Article 2. Encounter data shall be delivered to BHA for each modality of the Crisis System: Crisis Stabilization Unit, Walk-in Crisis, Crisis Respite, or Mobile Crisis Services.
b. The BHASO Network shall complete DACODS or a Treatment Episode Report Unified Data Model submission for each applicable Individual per the technical specification guidelines provided by BHA to BHASOs.
c. Quarterly Data Reporting, which shall include Individual demographic information, number of families served, and services provided. Please reference the Data Dictionary described in Exhibit D, Appendix 1, as may be amended, to verify the most up-to-date format and requirements.
    i. DELIVERABLE: CRT data including unique families served, services delivered, and client data.
    ii. DUE DATE: Quarterly submissions by the 15th of the month following the end of the quarter.
    iii. DESTINATION: Encrypted email to Crisis Program Manager
    iv. FILE NAME: BHASO Region[X] - [BHASO] - FY[XX][QX] - CRT Data

3.5.5.9 Payment

a. This service reconciles to a capacity reimbursement model. The BHASO shall negotiate and record an annual capacity-based budget with each BHASO Network provider utilizing a capacity-based payment methodology. The BHASO shall keep the capacity-based budgets up-to-date with BHASO Network providers as required, and all budgets shall be available to BHA upon request

Chapter 6

Behavioral Health Residential Treatment

Article 1 - Substance Use Disorder and Co-occurring Residential Services - General Safety Net Service Terms
Article 2 - Mental Health Residential Services - General Safety Net Service Terms
Article 3 - Youth Substance Use Disorder Residential Services - BHA Program
Article 4 - Special Connections and Women's Treatment Services - BHA Program
Article 5 - Community-Based Circle Program - BHA Program
Article 6 - Room and Board at Qualified Residential Treatment Programs for Children and Youth

Article 1 - Substance Use Disorder and Co-occurring Residential Services - General Safety5 Net Service Terms

3.6.1.1 Program Description and Objectives

a. The purpose of this Article is to provide residential treatment to Individuals for co-occurring substance use and mental health disorders. A residential treatment unit's primary function is to stabilize Individuals to a point where a less restrictive level of care is appropriate for the Individual's continuum of care.
b. The BHASO shall assure availability of and pay for the cost of residential treatment services for SUDs and co-occurring SUD and mental health disorders for Individuals receiving treatment in their Region who are uninsured/underinsured and who require American Society of Addiction Medicine (ASAM) residential level of care, or admissions which are court-ordered, is determined to be necessary. Residential treatment for SUD is intended to help Individuals decrease substance use and mental health symptoms in a structured environment while developing a community-based individual recovery plan

that shall increase school or work functioning, and family functioning. Effective services should reduce the individual and societal consequences of SUD so that Individuals can return to functioning as productive and healthy members of society.

3.6.1.2 Statutory / Rule Citation

a. Chapter 5 of 2 CCR 502-1.

3.6.1.3 Target Population / Eligibility

a. Uninsured or underinsured Individuals with a substance use disorder, who meets medical necessity for the level of care as determined by ASAM or who are referred by a standardized offender assessment provided by the referring criminal justice agency for those involved in the criminal justice system for that service and who ~~is~~ meets the contractual definition of indigent and for whom there is no insurance coverage for the service.
b. Priority admission for residential treatment by BHASO network providers should be given, regardless of payer sources in the following order:
    i. Pregnant women who use drugs by injection
    ii. Pregnant women
    iii. Individuals who use drugs by injection
    iv. Individuals who are involuntarily committed in accordance with C.R.S. 27-81-112
c. Pregnant Individual Admission: Admission to residential care for pregnant Individuals shall take place within forty-eight (48) hours of first contact. If the BHASO Network provider lacks capacity to provide treatment services to the pregnant woman, the BHASO Network must refer the pregnant woman to the BHASO, who will work to match the pregnant woman with a treatment facility that has the capacity to treat the woman. If no treatment facility has the capacity to admit the pregnant woman, the BHASO network must make available interim services in compliance with 2 CCR 502-1, 9.1.5.D until the woman is admitted into treatment.
d. All treatment modalities in this Chapter shall also serve children and youth unless the modality is contraindicated for children and youth. The children and youth-specific statements of work under this Chapter are:
    i. Article 2 - Youth Substance Use Disorder Residential Services

3.6.1.4 Activities and Services

a. The BHASO Network shall provide evidence-based individual, group and family therapy, recovery skills development, case management, relapse prevention for Individuals experiencing a SUD or co-occurring mental health disorder.
b. The BHASO Network providers shall be enrolled with Medicaid and have contracts with multiple if not all RAEs to serve the Medicaid population.
c. The BHASO Network shall have a variable length of stay dictated by clinical need, but an average Length of Stay (LOS) of fourteen (14) days is anticipated.
d. Facilities with appropriate nursing staff shall coordinate care for Individuals who are currently receiving MAT to assure continuity of care with that Individual's community treatment provider. MAT/MOUD is an allowable expense under this Chapter.

   The BHASO shall employ a retrospective quality review sampling process using ASAM criteria to assure only clinically necessary services are provided. Documentation that an Individual meets ASAM criteria for the level of care where the Individual is placed or in accordance with the standardized offender assessment provided by the referring criminal justice agency for those involved in the criminal justice system, both at admission and throughout their stay shall be documented in the Individual's record no less than every 30 days. If a BHASO Network provider is found to have instances and/or a pattern of non-adherence to criteria for admission, the BHASO may impose consequences on the provider including but not limited to pre-review, corrective actions, payment modifications and termination of contracts.

3.6.1.5 Standards and Requirements

a. Pursuant to C.R.S. Title 27, Articles 80-82, all programs must maintain appropriate BHA treatment facility licenses. The BHASO shall subcontract only with treatment providers who are licensed as a Behavioral Health Entity (BHE) to provide SUD treatment services as specified in 2 CCR 502-1. Services may be delivered by agencies licensed by BHA for any of the following levels of care:
   i. ASAM Level 3.1 (Clinically Managed Low-Intensity Residential Services)
   ii. ASAM Level 3.3 (Clinically Managed Population Specific High Intensity Residential Services)
   iii. ASAM Level 3.5 (Clinically Managed High-Intensity Residential Services)

iv. ASAM Level 3.7 (Medically Monitored Intensive Inpatient Services)

b. The BHASO shall not be required to pay room and board for hospital-based services.
c. The BHASO Network shall serve Individuals of all genders and gender identities. Services for pregnant and parenting women/individuals should be offered by a facility licensed and endorsed by BHA to provide Women's and Maternal Behavioral Health Treatment services in accordance with Chapter 9 of 2 CCR 502-1. If this specialized program is not available, the BHASO or BHASO Network shall refer the Individual to an alternative and clinically appropriate residential treatment facility.

3.6.1.6 Service Hours

a. Residential treatment programs operate 24 hours a day, 7 days a week
b. Clinical intervention hours should align with the facility license standards

3.6.1.7 Service Targets / Network Adequacy

a. The BHASO shall form a network to provide residential SUD services to Colorado residents meeting clinical and financial eligibility.
b. The BHASO shall track waitlists for all providers within its Region using the BHA-approved bed tracking system, weekly at minimum.
c. Average wait time for this level of service may not exceed two (2) weeks.
    i. BHASOs are required to offer referrals to providers outside their regions when waitlists for regional providers exceed two weeks.

3.6.1.8 Level of Care / Licensing Requirements

a. SUD inpatient facilities must:
    i. Maintain a BHA license as a Behavioral Health Entity
    ii. Have a Substance Use Disorder endorsement from BHA for ASAM 3.1, 3.3, 3.5, or 3.7 level of care

3.6.1.9 Performance Outcome Measures

a. Ninety-five percent (95%) of Individuals discharging from residential care shall have an initial appointment for follow up care at a lower level of care within five (5) days of discharge (monitored via DACODS/Unified Data Model/837 submissions).

i. Seventy percent (70%) of those patients shall have at least six (6) services within the ninety (90) days following discharge.

b. The BHASO shall monitor the following performance indicators:
   i. Percent of patients with readmissions within ninety (90) days of discharge (monitored via DACODS/Unified Data Model / 837 submissions).
   ii. Waitlist by provider within the BHASO Network (monitored via provider waitlists).
   iii. Occupancy rates by provider within the BHASO Network (monitored via Waitlist Tracker submissions).

3.6.1.10 Data Submissions

a. The BHASO Network shall complete a CCAR/DACODS record (as applicable for the type of treatment) or Treatment Episode Report Unified Data Model submission (the successor to former CCAR/DACODS submissions) for each applicable Individual per the technical specification guidelines provided by BHA to BHASOs.
b. 837 Encounter data shall be delivered in accordance with the terms of Exhibit D, as may be amended, Article 2.

3.6.1.11 Payment

a. This service reconciles to fee-for-service at the rates found in Exhibit B - Rate Schedule Section 6.1.
b. The BHASO may allow BHASO Network provider agencies to, at the BHASO Network provider's discretion, require non-Medicaid-covered Individuals to pay a daily co-pay of up to $10 per day. However, if a BHASO Network provider agency elects to require an Individual's co-pay, it must follow the method described below.

Federal Poverty Level (FPL)	Daily Co-Pay
Up to 133% FPL	No co-pay
134-200% FPL	Up to $5/day
201-300%	Up to $10/day
Above 300%	N/A (Not eligible for BHA funding)

c. Additionally, BHASO must require BHASO Network provider agencies to waive the copay for Individuals who meet the priority population criteria for involuntary commitments, pregnant women, women with dependent children, and injecting drug users, regardless of Federal Poverty Level (FPL). Lastly, BHASO shall require BHASO Network provider agencies to have a waiver process for all levels of FPL.

Article 2 - Mental Health Residential Services – General Safety Net Service Terms

3.6.2.1 Program Description and Objectives

a. The purpose of this Article is to provide residential treatment to Individuals with mental health disorders with the capability to provide Acute Treatment Unit level of care, and optionally, lower levels of care such as an Assisted Living Residence or Mental Health Transitional Residence.
b. The BHASO shall assure availability of and pay for the cost of residential treatment services for Individuals receiving mental health treatment in their Region who are uninsured/underinsured and who require residential level of care. Residential treatment for mental health is intended to help Individuals decrease mental health symptoms in a structured environment while developing a community-based individual recovery plan that shall increase school or work functioning, and family functioning. Effective services should reduce the individual mental health symptoms so that Individuals can return to functioning as productive and healthy members of society.

3.6.2.2 Statutory / Rule Citation

a. Part 2.26 of 2 CCR 502-1.
b. Chapter 5 of 2 CCR 502-1.
c. Chapter 6 of 2 CCR 502-1.

3.6.2.3 Target Population / Eligibility

a. Individuals with severe mental illnesses who require a 24-hour care setting to provide stabilization services.

3.6.2.4 Activities and Services

a. The BHASO Network shall provide evidence-based individual, group and family therapy, recovery skills development, and case management for Individuals experiencing a mental health disorder.
b. The BHASO Network providers shall be enrolled with Medicaid and have contracts with multiple if not all RAEs to serve the Medicaid population.
c. The BHASO Network shall have a variable length of stay dictated by clinical need.

3.6.2.5 Standards and Requirements

a. The BHASO Network shall be capable of serving Individuals and providing gender- and culturally-inclusive care.

3.6.2.6 Service Hours

a. Residential treatment programs operate 24 hours a day, 7 days a week.
b. BHASO Network providers should post on its website the days of the week when admissions shall occur.
c. Clinical intervention hours should align with the facility license standards.

3.6.2.7 Service Targets / Network Adequacy

a. The BHASO shall have contracts with providers located within their Region to provide services to Colorado residents meeting clinical and financial eligibility.
b. The BHASO shall track waitlists for all providers within its Region using the BHA-approved bed tracking system.
c. Average wait time for this level of service may not exceed two (2) weeks.
    ii. BHASOs are required to support referrals to providers outside their Regions when waitlists for regional providers exceed two weeks.

3.6.2.8 Level of Care / Licensing Requirements

a. BHASO Network providers shall be licensed either by BHA as an Acute Treatment Unit or by CDPHE as an Assisted Living Facility or Mental Health Transitional Living.

3.6.2.9 Data Submission

a. The BHASO Network shall complete a CCAR/DACODS record or Treatment Episode Report Unified Data Model submission (the successor to former CCAR/DACODS submissions) for each applicable Individual per the technical specification guidelines provided by BHA to BHASOs.
b. 837 Encounter data shall be delivered in accordance with the terms of Exhibit D, as may be amended, Article 2.

3.6.2.10 Payment

a. This service reconciles to a fee-for service or capacity reimbursement model.
    a. If using a fee-for service model, this service reconciles to cost report rates.
    b. If using a capacity model, the BHASO shall negotiate and record an annual capacity-based budget with each provider utilizing a capacity-based payment methodology. The BHASO shall keep budget up-to-date with providers, and budgets shall be available to BHA upon request.

Article 3 - Youth Substance Use Disorder Residential Services

3.6.3.1 Program Description and Objectives

a. The purpose of youth Substance Use Disorder (SUD) residential services is to provide access to evidence-based treatment for behavioral health services, including SUD residential treatment beds for youth, as well as ensuring both mental health and SUD treatment services are available for children, youth and their families.

3.6.3.2 Rule Citation

a. Youth behavioral health residential services shall be performed in accordance with Chapter 2, Chapter 5, and Chapter 8 of 2 CCR 502-1 Behavioral Health Rules.

3.6.3.3 Target Population

a. Behavioral health residential services shall serve youth with SUD, ensuring that young people can access the SUD treatment they need and do not need to be sent out of state for residential treatment.

3.6.3.4 Activities and Services

a. The BHASO Network shall provide evidence-based individual, group and family therapy, MAT, recovery skills development, case management, relapse prevention and emotional coping strategies for children and youth experiencing a SUD or co-occurring SUD and mental health disorder.
b. The BHASO shall report quarterly to BHA on expansion efforts of youth behavioral health residential services
    i. DELIVERABLE: Quarterly Youth SUD Residential Report
    ii. DUE DATE: Quarterly, on the 15th day of each month following the reported quarter.
    iii. DESTINATION: cdhs_bhaso_deliverables@state.co.us
    iv. FILE NAME: BHASO Region[X] - [BHASO] - FY [Prior year FY] - Quarterly Youth SUD Residential Report
c. The BHASO Network shall have a variable length of stay dictated by clinical need.

3.6.3.5 Standards and Requirements

a. The BHASO shall ensure the following requirements are met:
    i. The BHASO Network shall offer at least ASAM 3.5 and/or ASAM 3.7.
    ii. Youth SUD Residential programs in any BHASO region must be available to anyone in Colorado.

3.6.3.6 Data Submissions

c. The BHASO Network shall complete a CCAR/DACODS record or Treatment Episode Report Unified Data Model submission (the successor to former CCAR/DACODS submissions) for each applicable Individual per the technical specification guidelines provided by BHA to BHASOs.
d. 837 Encounter data shall be delivered in accordance with the terms of Exhibit D, as may be amended, Article 2.

3.6.3.7 Payment

a. This service reconciles to a capacity reimbursement model. The BHASO shall negotiate and record an annual capacity-based budget with each provider utilizing a capacity-

based payment methodology. The BHASO shall keep budget up-to-date with providers, and budgets shall be available to BHA upon request.

Article 4 - Special Connections and Women's Treatment Services – BHA Program

3.6.4.1 Program Description and Objectives

a. The goal of Women's Treatment Services and the Special Connections Program is to provide gender-specific substance use and co-occurring treatment for pregnant women and women with dependent children to maximize the chance of positive maternal and child health outcomes, to prevent child maltreatment, and to effectively meet the treatment needs of women.

3.6.4.2 Rule Citation

a. Women's Treatment Services and Special Connections Programs for substance use disorder services and treatment shall be performed in accordance with Chapter, 2, Chapter 5, and Chapter 9 of 2 CCR 502-1, and 45 CFR § 96.120 through 96.137.
b. For Special Connections provider eligibility and Medicaid reimbursable services, see HCPF Rule 10 CCR 2505-10 8.745.

3.6.4.3 Target Population

a. The BHASO Network shall serve all pregnant and parenting women who request treatment from, and meet ASAM criteria, for Women's Treatment Services, including Individuals who may be:
    i. Medicaid eligible,
    ii. Uninsured and/or underinsured, and
    iii. Individuals under three hundred percent (300%) of the Federal Poverty Line.
b. The BHASO Network shall determine Individual eligibility for Special Connections by ensuring:
    i. Prospective Individuals referred to the Special Connections program are assessed for appropriate level of care using ASAM.
    ii. Individuals enrolled in the Special Connections program are pregnant at admission or no more than one year postpartum.

iii. Individuals enrolled in the Special Connections program are participating in the program voluntarily (unless court-ordered or an Involuntary Commitment client) and if pregnant, are willing to receive prenatal care during the pregnancy.

3.6.4.4 Activities and Services

a. In order to respond to the specific needs of pregnant and parenting women seeking treatment, the BHASO Network shall treat the family as a unit and admit both women and their children into treatment services, if appropriate, and at minimum, provide or arrange for the provision of the following services:
    i. Primary medical care, including prenatal care, for women who are receiving substance use services.
    ii. Childcare while the women are receiving services.
    iii. Primary pediatric care for the women's children, including immunizations.
b. Gender-specific substance use treatment and other therapeutic interventions for women that may address issues of relationships, sexual abuse, physical abuse, and parenting.
c. Therapeutic interventions for children in custody of women in treatment which may, among other things, address the children's developmental needs and their issues of sexual abuse, physical abuse, and neglect.
d. Sufficient case management and transportation services to ensure that the women and their children have access to the services provided by (a.) through (c.) above.
e. In addition to a-d, the following services are required to be provided by BHASO Network Special Connections programs at the client level: Gender-specific and evidence-based substance use disorder treatment including individual, group and family therapy, recovery skills development, medication-assisted treatment, peer support, case management/care coordination, relapse prevention and emotional coping strategies.
f. The BHASO Network shall allow infants and young children to remain with their parent in residential treatment wherever possible and provide or coordinate provision of childcare while Individuals are engaging in therapeutic and/or medical care.
    i. Therapeutic interventions for children in custody of the women in treatment may address, among other things:
        1. Children's development needs and presenting concerns, including, but not limited to infant and early childhood mental health assessments

and interventions that strengthen the parent-child relationship and mitigate the impacts of trauma.

2. The BHASO Network shall assess Individuals for perinatal mood and anxiety disorders and coordinate treatment, as necessary. The BHASO Network shall provide health education groups that are didactic in nature and cover such topics as prevention of communicable diseases, child development, parenting skills, reproductive healthcare, healthy relationships, and other health concerns.

ii. The BHASO shall report, and keep updated, The Special Connections program details, including age of children allowed, if it is a co-occurring program, childcare offerings, and other unique program factors such that BHA and BHASO have a detailed understanding of the different program offerings that would be relevant for the purpose of program replication and/or making quality referrals to the program.

1. DELIVERABLE: Special Connections Program Model Details Work Plan (template provided by BHA)
2. DUE: 30 days after contract execution
3. DESTINATION: cdhs_BHASO_deliverables@state.co.us
4. FILE NAME: BHASO Region[X] - [BHASO] - FY[XX] - Special Connections Program Model Details Work Plan

3.6.4.5 Standards and Requirements

a. Services shall be provided in an environment that emphasizes physical and emotional safety, where safety of the mother/child dyad takes precedence over all other considerations in treatment.
b. Families are treated as a unit, with the Individual's self-identified family included in treatment wherever possible and not contraindicated.
c. Treatment is provided in a women-only therapeutic environment.
d. Program services shall address trauma issues currently manifesting in the Individual's life, either through direct service provision or by referral.
e. Naloxone is dispensed to pregnant or postpartum Individuals at intake and discharge and is paired with education about how to use it.
f. Priority admission to treatment must be given to all pregnant Individuals who contact or are referred to the BHASO network. In the event that the BHASO Network has

insufficient capacity to provide treatment services within 48 hours of first contact to any pregnant woman who seeks the services of the BHASO Network, the BHASO Network shall:

i. Notify the BHASO's Care Coordination team for assistance with placement and treatment.

ii. Maintain a continually updated system to identify treatment capacity and match pregnant women with a facility that has capacity, including treatment facilities outside of the BHASO's region.

iii. If no facility has capacity to admit the pregnant woman within 48 hours, the BHASO Network must make available interim services in compliance with 2 CCR 502-1, 9.1.5.D and 45 CFR 96.131(d) until the woman is admitted into treatment.

1. Interim services include the following, at minimum:

A. Referral for prenatal/postpartum care;

B. Information on the effects of alcohol and drug use on the fetus and perinatal individual;

C. Daily phone contact with the individual for those seeking residential care; and,

D. Education regarding the transmission and prevention of communicable diseases such as HIV/AIDS, Tuberculosis, Syphilis, and Hepatitis A, B and C.

g. The BHASO shall develop effective strategies for monitoring BHASO and BHASO Network compliance with Article 3.6.3.5 f and shall report on the specific strategies used to identify compliance problems and corrective actions taken to address those problems.

i. DELIVERABLE: Women's Treatment Services: Priority Population Admissions Work Plan (template provided by BHA)

ii. DUE: 30 days after contract execution

iii. DESTINATION: cdhs_bhaso_deliverables@state.co.us

iv. FILE NAME: BHASO Region[X] - [BHASO] - FY[XX] - Women's Treatment Services Priority Population Admissions Work Plan

h. Referrals shall be accepted from community members and community agencies and systems having regular contact with pregnant Individuals, as well as self-referrals from the Individuals themselves.

i. The BHASO Network providers shall be enrolled with Medicaid and have contracts with multiple if not all RAEs to serve the Medicaid population.

j. The BHASO Network shall assure continuity of care for each Individual across all involved Network providers through the entire course of treatment. This shall be accomplished by providing case management services which include service planning and utilization review, referral, and establishing linkages with other community resources.
k. Every effort shall be made to admit and retain eligible pregnant and parenting women in treatment. If a pregnant or parenting woman is not able to enter or remain in treatment due to clinical or other issues, the participating BHASO Network must make every effort to coordinate admission in the most appropriate treatment setting The participating BHASO Network may not discharge program participants solely for failure to abstain from substance use.
l. BHASO and the BHASO Network shall:
    i. Collaborate on BHASO's Outreach campaign for women-specific services to raise awareness and utilization of Women's Treatment Services.
    ii. Make every effort to attend bi-annual Special Connections provider meetings, facilitated by the BHA and HCPF.

3.6.4.6 Level of Care

a. ASAM Level 3.1, clinically managed low-intensity residential services
b. ASAM Level 3.5, clinically managed high intensity residential treatment
c. ASAM Level 3.7, medically managed high intensity residential treatment
d. ASAM Level 1, outpatient treatment
e. And ASAM Level 2.1, intensive outpatient treatment
f. These levels of care may be combined with Medicaid approved MAT that is reimbursed outside of the Special Connections program.

3.6.4.7 Staff Credentials and Training

a. Provider agencies must have a BHE license for SUD treatment, with endorsements for residential and/or outpatient levels of care and Women's and Maternal Behavioral Health modalities. Practitioners and counselors must have Certified Addiction Technician (CAT), Certified Addiction Specialist (CAS) or Licensed Addiction Counselor (LAC) certification and training/experience in providing women-specific services to individuals who are pregnant and parenting.

3.6.4.8 Data Submissions

a. The BHASO Network shall complete a CCAR/DACODS record or Treatment Episode Report Unified Data Model submission (the successor to former CCAR/DACODS submissions) for each applicable Individual per the technical specification guidelines provided by BHA to BHASOs.
    i. This should include a "Pregnancy/Postpartum Risk Assessment" on each Special Connections client. This data submission is for compliance with BHA's interagency agreement with HCPF.
b. 837 Encounter data shall be delivered in accordance with the terms of Exhibit D, as may be amended, Article 2.

3.6.4.9 Payment

a. Medicaid Services
    i. Payment of Medicaid funds for approved services for eligible pregnant and postpartum Individuals shall be billed electronically as required by the Department of Health Care Policy and Financing and following the guidance found in the Uniform Standards Coding Standards Manual, (including codes, modifiers, and service units), which may be via submission to the Individual's Regional Accountable Entity (RAE).
        1. Medicaid rates for treatment are negotiated between the BHASO Network and the Regional Accountable Entity (RAE) with whom they are contracting.
        2. Services as of date of execution of this Contract are defined in and subject to changes per Health Care Policy and Financing's Uniform Service Coding Standards Manual.

b. BHA Services
    i. The BHASO Network must bill the BHASO for room and board per the BHASO's regular procedures.
    ii. The BHASO may fund Special Connections residential treatment when an Individual is uninsured/underinsured.
    iii. The BHASO may fund Special Connections residential treatment when an Individual's Medicaid Special Connections eligibility expires, but the

Individual is determined to have clinical need to continue in the same enhanced treatment program.

1. This service reconciles to fee-for-service at the rates found in Exhibit B - Rate Schedule Section 6.1 for room and board and Women's and Maternal Behavioral Health, family-centered residential enhancement, utilizing women's treatment funding or other appropriate sources.

iv. The BHASO shall provide a summary of actual and reconciled costs incurred for the Special Connections program during the previous fiscal year by October 1st

1. DELIVERABLE: Special Connections Costs Summary
2. DUE: October 1st
3. DESTINATION: cdhs_BHASO_deliverables@state.co.us
4. FILE NAME: BHASO Region[X] - [BHASO] - FY[XX] - Special Connections Costs Summary
5.

Article 5 - Community Based Circle Program - BHA Program

3.6.5.1 Program Description and Objectives

a. The purpose of this Article is to provide comprehensive residential treatment to Individuals with co-occurring substance use and mental health disorders with the capability to provide ASAM 3.7 level of care facility, and optionally, lower levels of care.
b. A residential treatment unit's primary function is to stabilize Individuals to a point where a less restrictive level of care is appropriate to provide the balance of needed treatment.

3.6.5.2 Statutory/Rule Citation

a. Chapter 5 of 2 CCR 502-1.

3.6.5.3 Target Population

a. Community-Based Circle Programs shall serve Individuals with co-occurring substance use and mental health disorders and meet the ASAM criteria for placement within an ASAM 3.7 level of care, optionally lower levels of residential care if offered by the BHASO Network.

b. The BHASO Network shall follow priority admission requirements in this order:
    i. Individuals who use intravenous drugs and are pregnant,
    ii. Individuals who are pregnant,
    iii. Individuals who use intravenous drugs,
    iv. Women with dependent children, and
    v. Individuals involuntarily committed through the BHA's SUD Involuntary Commitment rules, Chapter 7 of 2 CCR 502-1.

3.6.5.4 Activities and Services

a. The BHASO shall work with the BHASO Network to operate an ASAM 3.7 residential treatment program within its region that provides comprehensive services to adults with co-occurring substance use and mental health disorders.
    i. Psychiatric services including medication management, and where appropriate, medication assisted treatment for SUDs are required components of care for Individuals served at this program.
b. The BHASO Network shall provide case management and coordination with referral systems to support continuation of care for Individuals upon return to their home communities.
c. The BHASO Network must be capable of and approved to prescribe buprenorphine for opioid use disorders or have relationships with other providers who can.

3.6.5.5 Service Hours

a. The Circle Program shall be open 24 hours a day, 365/366 days per year.

3.6.5.6 Network Adequacy

a. The BHASO Network will have a goal to maintain a ninety (90%) percent occupancy rate from the date of opening.

3.6.5.7 Licensing Requirements

a. The BHASO Network shall be licensed as a Behavioral Health Entity (BHE) with an endorsement for ASAM Level 3.7 Substance Use Disorder Service.

3.6.5.8 Staff Credentials and Training

a. Medical and behavioral health staff must be appropriately licensed by DORA.

3.6.5.9 Performance Outcome Measures.

a. Individuals are expected to receive continuation services within seven (7) days of discharge from this program. The transition plan should include prescribed medications to be maintained by a receiving continuing care provider. The BHASO shall ensure the BHASO Network makes reasonable efforts to ensure continuation of care in the Individual's local community upon discharge.

3.6.5.10 Data Submission

e. The BHASO Network shall complete a CCAR/DACODS record or Treatment Episode Report Unified Data Model submission (the successor to former CCAR/DACODS submissions) for each applicable Individual per the technical specification guidelines provided by BHA to BHASOs.
f. 837 Encounter data shall be delivered in accordance with the terms of Exhibit D, as may be amended, Article 2.

3.6.5.11 Payment

a. This service reconciles to a fee-for service or capacity reimbursement model.
    i. If using a fee-for service model, this service reconciles to rates found in Exhibit B - Rate Schedule, Section 6.1.
    ii. If using a capacity model, the BHASO shall negotiate and record an annual capacity-based budget with each provider utilizing a capacity-based payment methodology. The BHASO shall keep budget up-to-date with providers, and budgets shall be available to BHA upon request.
b. Co-pays
    i. The BHASO shall allow the BHASO Network to, at the BHASO Network Provider's discretion, require non-Medicaid-covered Individuals to pay a daily co-pay of up to ten dollars ($10) per day. However, if the BHASO Network requires an Individual co-pay, it must follow the method described below.

Federal Poverty Line	Daily Co-Pay
Up to 133% FPL	No co-pay
134-200% FPL	Up to $5/day
201-300%	Up to $10/day
Above 300%	N/A (Not eligible for BHA funding)

1. Additionally, the BHASO shall require the BHASO Network to waive the copay for Individuals who meet the priority population criteria for involuntary commitments, pregnant Individuals, and injecting drug users, regardless of Federal Poverty Line.
2. The BHASO shall require the BHASO Network to have a waiver process for all levels of the Federal Poverty Line.

c. Capital costs are allowable expenses under this Article 4.

Article 6 - Room and Board at Qualified Residential Treatment Programs for Children and Youth

3.6.6.1 Background, Purpose, and Target Population 3.6.6.1.1 Background and Purpose

Colorado would like to expand its ability to provide room and board costs for youth entering residential treatment. House Bill 24-1038 seeks to fill the gap seen in youth access to residential treatment by providing for room and board costs. These funds will allow for children and youth eligible for Medicaid to have their room and board paid for by the Behavioral Health Administration (BHA).

3.6.6.1.2 Target Population

Children and youth under the age of twenty-one (21) who are eligible for Medicaid entering a Qualified Residential Treatment Program for medically necessary services and are not in the legal custody of a county child welfare agency or Division of Youth Services.

3.6.6.2 Definitions and Acronyms

3.6.6.2.1 PSU: The Division of Child Welfare- Provider Services Unit (PSU), provides regulatory oversight by enforcing Volume 7 regulations and related statutes.

3.6.6.2.2 VPA: Voluntary Placement Agreement. A voluntary agreement between a parent(s)/guardian(s) and a county department of human or social services (DHS) that allows DHS to provide placement and care of a child/youth for up to 90 days while the parent or guardian retains custody and legal authority. Youth receiving services in a QRTP under a VPA are only eligible for room and board funding if QRTP services are authorized through the RAE or HCPF and DHS is not responsible for paying room and board costs

3.6.6.3 Activities and Services

3.6.6.3.1 The Contractor shall offer a subcontract to all licensed QRTP providers located in the Contractor's region to offer room and board costs to enrolled Medicaid members not in the custody of a county child welfare agency or Division of Youth Services residing in the facility and receiving QRTP services authorized through the RAE or HCPF.

3.6.6.3.2 For as long as funds are available from the State, the Contractor shall offer a subcontract within sixty (60) days of BHA notifying the Contractor of a new QRTP provider being licensed by the Colorado Department of Human Services (CDHS)/Division of Child Welfare Provider Services Unit (PSU) and enrolled as a QRTP (provider type 68) with the Colorado Department of Health Care Policy and Financing (HCPF). BHA shall send the Contractor an updated list of all eligible QRTPs every quarter.

3.6.6.3.2.1 The Contractor shall notify BHA of any fiscal concerns related to offering a subcontract to a newly licensed QRTP provider before determining whether a subcontract will not be offered.

3.6.6.3.3 The Contractor shall notify BHA's Program Manager for Momentum/TSP and RMHS fifteen (15) business days of when the Contractor begins funding ~~the~~ QRTP room and board costs for a youth that is Momentum or TSP involved.

3.6.6.3.4 When the youth is involved with Momentum or TSP, the Contractor shall maintain ongoing communication with the youth's Momentum or TSP team. As needed, the Contractor shall enter a Business Associate Agreement or a Data Sharing Agreement with Rocky Mountain Human Services.

3.6.6.3.5 If a child or youth temporarily leaves the QRTP, the Contractor shall pay room and board costs for up to two (2) calendar days to hold the bed.

3.6.6.3.5.1 If the QRTP requests to hold the bed past two (2) calendar days, the Contractor shall request an extension from BHA to pay for additional room and board costs to hold the bed. BHA will respond to the request by the end of the next business day, and all extensions must be approved by BHA. The following information must be included in the request:

3.6.6.3.5.1.1 Youth's name and Medicaid Number,

3.6.6.3.5.1.2 Facility Name,

3.6.6.3.5.1.3 Date of request,

3.6.6.3.5.1.4 Date bed hold began,

3.6.6.3.5.1.5 End date for bed hold

3.6.6.3.5.1.5.1 A maximum of fourteen (14) calendar days will be approved unless there are extenuating circumstances justifying the request for continued funding, AND

3.6.6.3.5.1.6 Reason for bed hold request and justification for why the number of days requested is required to support the youth's treatment

3.6.6.3.6 Once a youth no longer meets medical necessity for QRTP level of care, the Contractor shall continue paying room and board costs for up to five (5) calendar days if needed to support the youth's transition from a QRTP level of care. If the fifth calendar day falls on a weekend or holiday, the Contractor shall continue paying room and board costs until the next business day.

3.6.6.3.6.1 If the QRTP requests to extend room and board funding past five (5) calendar days, the Contractor shall request an extension from BHA to pay for additional room and board costs to support the youth's transition from a QRTP level of care. BHA will respond to the request by the end of the next business day, and all extensions must be approved by BHA. The following information must be included in the request:

3.6.6.3.6.1.1 Youth's name and Medicaid Number

3.6.6.3.6.1.2 Facility Name

3.6.6.3.6.1.3 Date of Request

3.6.6.3.6.1.4 First non-covered day by Medicaid

3.6.6.3.6.1.5 End date of requested funding

3.6.6.3.6.1.5.1 A maximum of fourteen (14) calendar days will be approved unless there are extenuating circumstances justifying the request for continued funding.

3.6.6.3.6.1.6 Reason additional funding is requested and justification for why the number of days requested is required to support the youth's transition

3.6.6.3.6.1.7 Plan to transition the youth from QRTP

3.6.6.3.6.2 If any of the following parties request a meeting to discuss a room and board extension request, the Contractor shall work with the QRTP provider to convene and facilitate a staffing. The following parties, if relevant to the case, shall be included in the staffing:

3.6.6.3.6.2.1 Youth

3.6.6.3.6.2.2 Youth's parent(s) or primary caregiver(s)

3.6.6.3.6.2.3 QRTP provider

3.6.6.3.6.2.4 BHA

3.6.6.3.6.2.5 RAE (for RAE authorized admissions)

3.6.6.3.6.2.6 HCPF

3.6.6.3.6.2.7 Rocky Mountain Human Services (for youth in services with Momentum or TSP)

3.6.6.3.6.2.8 A county Department of Human or Social Services (if working with the family)

3.6.6.3.6.2.9 The Contractor

3.6.6.3.6.3 The Contractor is not responsible for creating the transition plan or supporting the transition of the youth from QRTP.

3.6.6.3.7 BHA shall notify the Contractor at a minimum every quarter of the total funds available in the GAE.

3.6.6.3.7.1 When the Contractor is notified the total funds available in the GAE is equal to or less than five hundred thousand dollars ($500,000), the Contractor shall notify BHA when the Contractor is notified by a QRTP of a new admission needing room and board funding.

3.6.6.3.7.2 If funding is not available, BHA shall work with the Contractor to identify and refer the QRTP provider to alternative funding sources.

3.6.6.3.7.3 BHA shall work with the Contractor to provide additional updates on the total funds available in the GAE when requested.

3.6.6.4 Minimum Qualifications

3.6.6.4.1 Qualified Residential Treatment Programs shall have a childcare license with a QRTP service type issued by CDHS / PSU.

3.6.6.4.2 Qualified Residential Treatment Programs shall be enrolled in Health First Colorado as a QRTP (provider type 68) with HCPF.

3.6.6.4.3 Qualified Residential Treatment Programs shall be contracted with and credentialed by the RAE when the RAE is responsible for authorizing and reimbursing QRTP services under the capitated behavioral health benefit.

3.6.6.5 Deliverables Table

Timeline	Activity	Party Responsible
60 days after the contract or amendment execution	Subcontracts with QRTPs to provide room and board executed	BHASO and subcontractors to execute. Executed subcontracts due to: cdhs_bhaso_deliverables@state.co.us
60 days after the BHA notifies the Contractor that a new QRTP is licensed by CDHS/PSU	Subcontract with QRTP to provide room and board executed	BHASO and subcontractors to execute. Executed subcontracts due to: cdhs_bhaso_deliverables@state.co.us
Monthly, 20th day following prior month	Monthly Data Reporting	The Contractor submits data on provided invoice template to: cdhs_bhaso_deliverables@state.co.us
*Deadlines may be altered administratively	Intentionally left blank	Intentionally left blank

3.6.6.6 Data Collection and Reporting

3.6.6.6.1 The Contractor shall collect and submit monthly data for this program through the BHA-provided invoice template to cdhs_bhaso_deliverables@state.co.us no later than the 30th of the following month, in accordance with BHA's billing process

3.6.6.7 Treatment Providers

3.6.6.7.1 The Contractor shall use the Colorado Department of Human Services (CDHS) Room & Board daily rate for treatment occurring in a QRTP setting.

3.6.6.7.2 When HCPF authorizes clinical treatment, the Contractor may ask the QRTP to attest that the youth has received an Independent Assessment and QRTP level of care is recommended. The Contractor does not need to seek additional confirmation or authorization from HCPF or BHA.

3.6.6.7.3 When clinical treatment is authorized by the RAE, the Contractor may ask the QRTP for proof that the RAE authorized QRTP services. The Contractor does not need to seek additional confirmation or authorization from HCPF or BHA.

3.6.6.8 Residential Rates

Service	Description	Rate	Unit
Room and Board	QRTP room and board includes all costs associated with lodging and food	$425.00	Date

3.6.6.9 Payment

3.6.6.9.1 **Invoicing**. Contractors shall invoice for QRTP room and board rates on a separate invoice from the general BHASO invoice. BHA will provide an invoice template upon contract execution. Contractor shall submit monthly invoices for room and board rates to QRTP providers to cdhs_BHApayment@state.co.us no later than the 20th of the following month, in accordance with BHA's billing process.

3.6.6.9.2 **Indirect -** The Contractor shall earn a five percent (5%) administrative rate on top of the room and board costs for indirect costs to their organization. This cost will not be reflected in the above rate table for room and board.

3.6.6.9.3 **General Accounting Encumbrance** - Payment to the Contractor is made from available funds encumbered and shared across multiple contractors. The State may increase or decrease the total funds encumbered at its sole discretion and without formal notice to the Contractor. No minimum payment is guaranteed to the Contractor. The liability of the State for such payments is limited to the encumbered amount remaining of such funds.

Chapter 7
Behavioral Health Inpatient Services - General Safety Net Service

3.7.1 Program Description and Objectives

a. Behavioral health inpatient services shall be provided for Individuals with mental health disorders and co-occurring mental health substance use disorders. Inpatient treatment is an essential part of the continuum of treatment for these disorders.

3.7.2 Rule Citation

a. Behavioral health inpatient services shall be performed in accordance with applicable CDPHE and BHA standards.
b. Involuntary inpatient mental health services provided by 27-65 designated facilities must be performed in accordance with Chapter 11 of 2 CCR 502-1.

3.7.3 Target Population

a. The BHASO Network shall provide Care Coordination to Individuals who meet medical necessity criteria for the appropriate behavioral health inpatient services.
b. There are no children- and youth-specific statements of work under this Chapter, though all treatment modalities in this Chapter shall serve children and youth unless the modality is contraindicated for children and youth.

3.7.4 Activities and Services

a. The BHASO shall be responsible for providing Care Coordination to Individuals who require an inpatient level of care. The BHASO does not directly pay or manage mental health inpatient services, however the BHASO must facilitate access to inpatient services via agreement with other providers for Individuals in its Region requiring this service.
b. The BHASO shall only form referral agreements with providers that do not discriminate against any Individual based on age, race, gender, gender identity, sexual orientation, or disability.

c. Momentum and Transition Specialist Programs. The BHASO Network shall make referrals to the Momentum Program or Transitional Specialist Program operated by BHA and the Momentum and Transition Specialist Programs provider, where clinically appropriate, if an Individual leaving inpatient care has a history of co-occurring mental health issues and could benefit from wrap-around services to help integrate in the community. Direct consultation referrals can be made to the Momentum and Transition Specialist Programs provider to see if the Individual meets criteria.

3.7.5 Service Hours

a. All inpatient facilities must be open twenty-four (24) hours a day, seven (7) days a week.
b. Facilities may have intake and discharge scheduling during business hours, Monday-Friday, but must make these known to prospective Individuals and referral sources.

3.7.6 Level of Care and Licensing Requirements

a. Psychiatric Hospitals must be;
    i. Licensed by the Colorado Department of Public Health and Environment as a hospital
    ii. Be designated to treat Individuals on an involuntary basis under 27-65 designation by BHA.

3.7.7 Payment

a. Inpatient mental health treatment is not funded by BHA via this Contract. This service must be funded by other appropriate payors such as Medicaid, commercial insurance, or self-pay.
b. BHASO administrative costs shall be covered by the BHASO's Administrative Fee.

Chapter 8
Integrated Care Services

3.8.1 Program Description and Objectives

a. The purpose of integrated care is to provide a range of evidence-based practices and services for behavioral health needs that include mental health and substance use disorders, health behaviors from chronic medical conditions, physical and life stressors and crises that occur within outpatient primary care settings.
b. Integrated Care is a high level of collaboration between providers to deliver person-and family-centered services driven by the needs and preferences of Individuals receiving services for their families.
c. The BHASO will encourage the provision of integrated care in its Region's network and connect providers to known organizations who provide practice transformation for integrated care, such as Practice Transformation Organizations.

3.8.2 Statutory Citation

a. The BHASO Network shall ensure integrated care services are available as a Safety Net Service on a community, regional, and statewide basis pursuant to C.R.S. §27-50-301(3)(a)(VIII).
b. The BHASO Network shall include, but shall not be limited to, Essential Safety Net Providers approved to provide integrated care services pursuant to C.R.S. §27-50-101(13).

3.8.3 Activities and Services

a. Integrated Practice Assessment. In Year One of the BHASO contract, the BHASO shall identify providers in the BHASO Network to who are interested in engaging, developing or evolving integrated care and determine the level of collaboration/integration defined by tools such as the 1302/ BHI Building Blocks of Behavioral Health Integration Assessment (BBA). https://www.thenationalcouncil.org/resources/integration-practice-assessment-tool-ipat/
b. As a part of the determination of readiness for engaging in integrated care, the BHASO shall give the BHASO Network the opportunity to indicate whether they

are interested in receiving support in increasing integration of their practice and connect providers to organizations who support practice transformation and integrated care.

c. The BHASO shall report to the BHA which providers are interested in increasing integration of their practice.
    1. DELIVERABLE: Integrated Care Assessment Report
    2. DUE DATE: January 15, 2026
    3. DESTINATION: cdhs_BHASO_deliverables@state.co.us
    4. FILE NAME: BHASO Region[X] - [BHASO] - Integrated Care Assessment Report
d. The BHASO shall write a plan to support the development of integrated care practices in its Region in years 2-5 of the BHASO Contract. Examples of supports include connection to practice transformation organizations.
    1. DELIVERABLE: Integrated Care Support Plan
    2. DUE DATE: June 1, 2026
    3. DESTINATION: cdhs_BHASO_deliverables@state.co.us
    4. FILE NAME: BHASO Region[X] - [BHASO] - Integrated Care Support Plan

3.8.4 Payment

a. This deliverable shall be funded by the BHASO's Administrative Fee.

Chapter 9

Mental Health and Substance Use Disorder Recovery Supports

Article 1 - Mental Health and Substance Use Disorder Recovery Supports - General Safety Net Service
Article 2 - Recovery Community Organizations - BHA Program
Article 3 - Recovery Residences - BHA Program
Article 4 - Individualized Placement and Support - BHA Program
Article 5 - Recovery Coach Doula - BHA Program

Article 1 - Mental Health and Substance Use Disorder Recovery Supports - General Safety Net Service

3.9.1.1 Program Description and Objectives

a. Mental Health and Substance Use Disorder Recovery Supports services include a variety of recovery-focused services and supports for Individuals with a behavioral health disorder and/or who are in recovery from a behavioral health disorder.
b. Mental Health and Substance Use Disorder Recovery Supports services may be rendered by certified Peer Support Professionals.
c. Mental Health and Substance Use Disorder Recovery Supports services must include engaging Individuals in peer-to-peer relationships that support healing, personal growth, life skills development, self-care, and crisis strategy development to help achieve recovery, wellness, and life goals.

3.9.1.2 Target Population

a. The BHASO Network will provide services for people in recovery, their family, friends, and recovery allies.

b. The BHASO shall provide peer navigator services for Individuals receiving Involuntary Commitment services, pregnant and parenting Individuals, and other high acuity Individuals.
c. There are no children- and youth-specific statements of work under this Chapter, though all treatment modalities in this Chapter may serve children and youth unless the modality is contraindicated for children and youth.

3.9.1.3 Statutory/Rule Citation

a. Mental health and substance use disorder recovery supports shall be performed pursuant to Chapter 3 of 2 CCR 502-1.

3.9.1.4 Activities and Services

a. Allowable programs for Individuals under this Article to help achieve recovery include:
    i. Peer support professional-run drop-in centers,
    ii. Recovery and wellness centers,
    iii. Employment services,
    iv. Prevention and early intervention activities,
    v. Peer support professional mentoring for children and youth,
    vi. Warm line, as defined in Chapter 1 of 2 CCR 502-1,
    vii. Advocacy services,
    viii. Recovery coaching,
    ix. Peer support professional-led support groups,
    x. Navigation of community resources,
    xi. Recovery planning services, and
    xii. Other activities supporting the recovery experience of an Individual.
b. A peer support professional may provide services in a variety of settings, if permitted access, that may include but are not limited to:
    i. Court-affiliated settings, such as the Department of Corrections, county jails, or community correctional placements,
    ii. Physical health settings, such as primary care physician offices,
    iii. Emergency departments,
    iv. Audio-visual or audio-only telehealth,
    v. Agencies serving Individuals who are unhoused,

vi. Peer respite homes,
vii. School-based health centers,
viii. Home and community-based settings, and
ix. Brick and mortar recovery community organizations, including faith-based organizations.

c. The BHASO will offer peer navigator(s) for Individuals entering the Involuntary Commitment (IC) program, after the Individual's designated court date and throughout the IC, e.g., Withdrawal Management, residential, and outpatient treatment.
d. The BHASO shall offer peer navigator(s) for pregnant or parenting Individuals upon arrival on a treatment facility bed waitlist as a guide through early stages of the recovery process. The BHASO shall ensure Individuals who are discharged from the treatment facility, for any reason, are offered a connection with a peer navigator for assistance connecting with physical health, behavioral health and social supports outside of the residential setting for themselves and their children.
e. Peer navigators for pregnant Individuals and parenting women shall coordinate with the Tough as a Mother campaign to offer Individuals information for the weekly support group, Tougher Together.
f. Activities that are outside of the scope of a peer support professional included, but are not limited to:
    i. Performing clinical/diagnostic assessments, service planning, or treatment, and
    ii. Drug and/or alcohol testing, monitoring, and/or collection of toxicology samples.

3.9.1.5 Standards and Requirements

a. Peer support professionals must be supervised on at least a monthly basis for at least an hour by a licensee in good standing with their credentialing body and/or an experienced peer support professional who meets the criteria set forth in Part 3.3 of 2 CCR 502-1. Supervisors shall document supervision date, time, duration, and topics discussed.
b. Supervisors of peer support professionals must demonstrate upon request from BHA or BHASO that they have received training in:
    i. The provision of peer support services
    ii. The supervision of peer support professionals
    iii. The role of peer support professionals

c. Supervision of a peer support professional may include co-reflective supervision strategies in which supervisors and supervisees engage in a relationship of mutual learning.
d. Peer support professionals with a certification credential must be in good standing with their certifying body, including compliance with the certifying body's code of ethics.

3.9.1.6 Staff Credential Requirements

a. Peer support professionals providing peer recovery support services must hold a professional peer support certification credential or have successfully completed formal training that covers all content areas outlined in "Core Competencies for Peer Workers in Behavioral Health Services - 2018" (December 13, 2018), established by United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), which is incorporated herein by reference and does not include any later amendments or editions.
b. Training or proof of certification must be documented in personnel files.
c. For peer support professionals with a certification credential, the certification credential must include the following requirements:
    i. At least sixty (60) hours of training, including training covering all content areas in "core competencies for peer workers in behavioral health services – 2018" established by United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), incorporated by reference in subsection A, above.
    ii. At least two hundred (200) hours of experience as a peer support professional.
    iii. Passing a certification exam.

3.9.1.7 Payment

a. This service reconciles to a capacity reimbursement model. The BHASO shall negotiate and record an annual capacity-based budget with each provider utilizing a capacity-based payment methodology. The BHASO shall keep budget up-to-date with providers, and budgets shall be available to BHA upon request.

Article 2 - Recovery Community Organizations (RCOs) - BHA Program

3.9.2.1 Program Description and Objectives

a. The purpose of Recovery Community Organizations is to provide peer delivered recovery support services to individuals living with a SUD or co-occurring disorders.

3.9.2.2 Statutory and Rule Citation

a. Recovery Community Organizations shall provide services pursuant to C.R.S. §27-80-126.
b. Recovery Community Organizations shall provide services pursuant to Chapter 3 of 2 CCR 502-1.

3.9.2.3 Target Population

a. Recovery Community Organizations shall support Coloradans living with SUD and co-occurring disorders.

3.9.2.4 Activities and Services

a. Services
    i. The BHASO Network shall engage Individuals in peer-to-peer relationships that support healing, personal growth, life skills development, self-care, and crisis strategy development to help achieve recovery, wellness, and life goals.
    ii. The BHASO shall increase capacity and access to peer support providers or coaches that shall provide culturally appropriate outreach and/or outpatient, re-entry, or other level of care services to community members that are at increased risk of SUD and co-occurring disorders.
    iii. The BHASO Network shall provide activities for Individuals suffering from SUD and co-occurring disorders to enhance their wellness within the dimensions of recovery, health, home, purpose and community.
    iv. The BHASO Network shall provide guidance and support services to family members and support systems as well as Individuals suffering from mental health diagnosis, substance use disorder, and co-occurring disorders, on navigating treatment, social services, and recovery support systems.
    v. The RCO programs shall be peer governed.
    vi. The programs shall establish and sustain an environment that promotes and supports a social and physical environment of recovery.
    vii. The program shall provide local and state recovery resources to participants and their support system.

viii. The BHASO Network shall provide Peer Support Professionals or Coaches with supervision and support.

ix. The BHASO shall ensure Peer Support Professionals or Coaches in the BHASO Network certified as a Colorado Peer and Family Specialist through the Colorado Providers' Association, or that are trained in culturally appropriate peer support programming or given additional culturally relevant training within one year of hire.

b. Assessments and Documentation

i. Performance outcome measures include tracking of unique individuals served with peer delivered recovery support services. The type and duration of services provided should also be tracked and reported monthly.

1. DELIVERABLE: RCO Individuals Served Report
2. DUE DATE: Monthly, on the 15th day of each month following the reported month.
3. DESTINATION: cdhs_bhaso_deliverables@state.co.us
4. FILE NAME: BHASO Region[X] - [BHASO] - FY[XX][Month] - RCO Individuals Served

ii. The BHASO Network shall complete a GPRA at required intervals for every Individual served using SOR funding.

3.9.2.5 Standards and Requirements

a. The BHASO Network provider shall be registered as a non-profit, 501(c)(3).

3.9.2.6 Staff Credentials and Training

a. Peer support providers or coaches are defined to include those certified as a Colorado peer and family specialist through the Colorado Providers' Association or eligible within one year of hire, and that are trained in culturally appropriate peer support programming or given additional culturally relevant training. Training consists of sixty (60) total hours of training within each of the domains:

i. Ten (10) hours of Advocacy

ii. Ten (10) hours of Mentoring and Education

iii. Ten (10) hours of Recovery and Wellness Support

iv. Sixteen (16) hours of Ethics

v. Fourteen (14) hours of additional training

3.9.2.7 Payment

a. This service reconciles to a capacity reimbursement model. The BHASO shall negotiate and record an annual capacity-based budget with each provider utilizing a capacity-based payment methodology. The BHASO shall keep budget up-to-date with providers, and budgets shall be available to BHA upon request.

Article 3 - Recovery Residences - BHA Program

3.9.3.1 Program Description and Objectives

a. The purpose of recovery residences is to provide housing stability for individuals in recovery from a substance use disorder who are temporarily unable to afford the costs associated with living in a recovery residence.

3.9.3.2 Statutory Citation

a. Recovery Residences shall be certified by the recovery residence certifying body pursuant to Sections 25-1.5-108.5(4), C.R.S. and 27-80-122(4), C.R.S. and endorsed pursuant to Chapter 3 of 2 CCR 502-1 as applicable.

3.9.3.3 Activities and Services

a. Services

i. The BHASO shall contract with Oxford House or CARR certified recovery residences to offer funding to stay at a recovery residence.

1. The BHASO shall develop a process with recovery residences for determining financial need within the first two months of contract execution. Each BHASO-contracted recovery residence must have a written policy for financial need at time of contracting with the BHASO. The BHASO shall make each recovery residence's financial need policy available to BHA upon request.

ii. The BHASO shall work with the BHASO Network to ensure the scholarship is paid in full on a monthly basis.

1. In the event scholarship is not paid in a timely manner, BHA and the BHASO shall expedite a meeting to remediate the issue.

iii. The BHASO shall select to establish these residences and shall complete and maintain a web-based listing for the BHASO Network's pre-existing and new recovery homes in Colorado, including the organization name, county, and telephone number. Optionally, email address and website for each location.

b. The BHASO Network shall teach residents the evidence-based standards for operations of recovery residences to effectively operate the houses throughout the state.

3.9.3.4 Level of Care

a. These funds are intended to support costs at recovery residences that fit within the NARR definitions for level 1 (peer run), level 2 (monitored) or in some cases, level 3 (supervised), or level 4 (service provider). Oxford Houses meet the definition of NARR level 1.
b. The BHASO Network shall only pay for a recovery residence that is either a chartered Oxford House or a CARR (or its successor organization) certified recovery residence.

3.9.3.5 Payment

a. This service reconciles to a fee-for-service reimbursement model, reconciling to rates found in Exhibit B - Rate Schedule, Section 9.1 for Individuals who are unable to afford the cost to stay.

Article 4 - Individual Placement and Support - BHA Program

3.9.4.1 Program Description and Objectives

a. The purpose of IPS is to increase competitive employment for individuals diagnosed with Serious Mental Illness (SMI) and/or co-occurring SMI and Substance Use Disorder (SUD) and to assist those individuals to live successfully in their communities.

3.9.4.2 Target Population

a. The IPS program shall target adults and may include transition-age youth (ages 15-26), with SMI who are in need of intensive support obtaining and/or maintaining competitive employment.

3.9.4.3 Activities and Services

a. The BHASO Network shall establish and maintain an evidence-based supported employment program based on the Individual Placement and Support (IPS) model described below.
b. The BHASO Network shall ensure IPS staff members whose salaries are reimbursed under this contract shall be experienced in helping individuals with SMI and/or co-occurring SMI and SUD obtain and maintain competitive employment. Minimum education of bachelor's degree is required for Medicaid billing.
c. The BHASO Network shall operate the IPS teams according to the following evidence-based practice principles of IPS:
    i. Focus on competitive employment: agencies providing IPS services are committed to competitive employment as an attainable goal for individuals with SMI and or co-occurring SMI and SUD who are seeking employment.
    ii. Eligibility based on individual choice: Individuals are not excluded on the basis of job readiness, diagnoses, symptoms, substance use history, psychiatric hospitalizations, level of disability, or legal system involvement.
    iii. Integration of rehabilitation and mental health services: IPS programs are closely integrated with mental health treatment teams.
    iv. Attention to individual preferences: services are based on individuals' preferences and choices, rather than providers' judgments.
    v. Personalized benefits counseling: employment specialists help individuals obtain personalized, understandable, and accurate information about their Social Security, Medicaid, and other government entitlements.
    vi. Rapid job search: IPS programs use a rapid job search approach to help individuals obtain jobs directly, rather than providing lengthy pre-employment assessment, training, and counseling.
    vii. Systematic job development: employment specialists build an employer network based on individuals' interests, developing relationships with local employers by making systematic contacts.
    viii. Time-unlimited and individualized support: follow-along supports are individualized and continued for as long as the individual wants and needs the support.

d. BHA shall coordinate with the Department of Labor and Employment, Division of Vocational Rehabilitation (DVR) to assist IPS Individuals who need DVR services and support as needed.
e. BHA shall facilitate quarterly IPS program meetings, and a conference call option shall be provided. The BHASO Network shall have provider representation at each of those meetings.
f. After initial network development, if the BHASO Network is forming new IPS programs funded by this Contract, the new program shall be formed within three (3) months of Contract execution.
    i. The BHASO shall maintain existing IPS programs from year one to year two of the Contract.
g. The BHASO shall notify BHA immediately if any IPS program stops providing services or has loss of staffing impacting capacity.
h. Assessments and Documentation
    i. The BHASO Network shall submit IPS data using the International IPS Employment Center online reporting portal.
        1. DELIVERABLE: IPS Data
        2. DUE DATE: Quarterly, on the 15th day of each month following the reported quarter.
        3. DESTINATION: http://reporting.ipsworks.org (State's secure portal.)

3.9.4.4 Standards and Requirements

a. In collaboration with the BHASO Network, BHA shall provide technical assistance and shall provide or coordinate with the DVR or BHASOs to provide virtual and site-based training to the IPS program until good fidelity is obtained. This training and technical assistance shall be provided to IPS supervisors, employment specialists, clinicians, administrators, and DVR staff who interact directly with the IPS program.
    i. The BHASO and BHA shall coordinate to schedule fidelity reviews with the BHASO Network. BHA then completes the fidelity reviews using the IPS supported employment fidelity scale.
    ii. Good fidelity on the IPS fidelity scale is defined as an average item score between 4 and 4.4 (for a total minimum score of 100), and good fidelity shall be the minimum expectation for IPS programs.

iii. Programs that do not maintain good fidelity to the IPS model shall ensure adequate staff training, technical assistance, and program development to attain good fidelity before their next annual review. The BHASO Network shall coordinate with BHA to schedule and implement training and TA support for IPS supervisors, employment specialists, clinicians, administrators, and DVR staff who interact directly with the IPS program.

3.9.4.5 Service Hours

a. The BHASO Network shall provide IPS services during standard business hours, Monday - Friday, 8:00am-5:00pm.

3.9.4.6 Staff Credentials and Training

a. The BHASO Network shall require individuals providing IPS services to have a bachelor's degree.

3.9.4.7 Performance Outcome Measures

a. The BHASO Network shall continually work toward attaining an annual mean of forty-five percent (45%) employment rate for individuals who have been served by their IPS program.
    i. The BHASO Network shall provide the mean employment rate for Individuals served by their IPS program during annual fidelity reviews with BHA.
b. The BHASO shall continually work toward attaining good fidelity on the IPS fidelity scale, defined as an average item score between 4 and 4.4 (for a total minimum score of 100).

3.9.4.8 Payment

a. This service shall be reconciled to a capacity-based budget. The BHASO shall negotiate and record an annual capacity-based budget with each provider utilizing a capacity-based payment methodology. The BHASO shall keep budget up-to-date with providers, and budgets shall be available to BHA upon request.

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Article 5 - Recovery Coach Doula – BHA Program

3.9.5.1 Purpose

a. The purpose of this Article is to expand evidence-based recovery coach doula services for pregnant and postpartum women (up to 12mo postpartum) with substance use disorder (SUD) who are under- and uninsured. This project will support the employment of two recovery coach doulas from the University of Colorado College of Nursing Recovery Coach Doulas ("RCD") Program who will provide care to the target population. The RCD program will also fund recovery coach doulas to attend regional conferences to teach people about SUD in the peripartum period, the role of Recovery Coach Doulas in providing support, and further develop professional and community knowledge in peer services and childbirth education.

3.9.5.2 Target Population

This program supports Individuals with SUD during pregnancy and through 12 months postpartum and the RCDs who care for them.

3.9.5.3 Activities/Services

a. The BHASO shall fund at least two full time RCDs who will provide RCD care for Individuals with substance use disorder (SUD) during pregnancy and through 12 months postpartum
b. RCDs will attend regional conferences about SUD in the peripartum period and the role of RCDs in providing support. RCDs will further develop their knowledge in peer services and childbirth.
c. The BHASO shall submit data quarterly that includes the number of pregnant Individuals with SUD who were referred to RCD and how many of those Individuals received RCD care. The report shall track the number of pregnant Individuals with SUD who were referred to RCD services and how many of those Individuals who received RCD services
    1. DELIVERABLE: Quarterly RCD Report
    2. DUE DATE: Quarterly, on the 15th day following the end of each quarter
    3. DESTINATION: cdhs_BHASO_deliverables@state.co.us

3.9.5.4 Budget/Payment

The BHASO shall negotiate and record an annual capacity-based budget with each provider utilizing a capacity-based payment methodology. The BHASO shall keep budget up-to-date with providers, and budgets shall be available to BHA upon request.

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Chapter 10
Outreach, Education, and Engagement Services

Article 1 - Outreach, Education, and Engagement Requirements – General Safety Net Service
Article 2 - School Based Mental Health Specialist (SBMHS) – BHA Program

Article 1 - Outreach, Education, and Engagement Requirements

3.10.1.1 Outreach, Education, and Engagement Services are services by an agency that have identified target populations and service needs in the area the agency serves that require higher levels of active engagement by the agency to produce positive behavioral health outcomes.

3.10.1.2 Target Populations

a. Outreach, Education, and Engagement activities may be provided to any population.
b. The children and youth-specific statements of work under this Chapter are:
    i. Article 2 - School Based Mental Health Specialist (SBMHS)

3.10.1.3 The BHASO shall develop a strategic plan to provide Outreach, Education, and Engagement services. The strategic plan shall include the following:

a. Identified target population(s) and/or treatment needs,
b. Plans for outreach, education, and engagement services in the community to meet the SUPTRS and MHBG requirements for outreach to priority populations. Plans must include:
    i. How outreach, education, and engagement services will support efforts toward screening, early intervention, treatment, and recovery supports,
    ii. Community events and intentional engagement with Priority Populations, that may involve, but are not limited to:
        1. Community partners that address social determinants of health in serving priority populations in assessed areas,
        2. Local law enforcement,

3. Local public health organizations, and
4. Cultural centers or community-based organizations.

iii. The BHASO may develop and propose outreach campaigns that shall be approved by the BHA.
   1. The BHASO must obtain BHA approval before discontinuing existing outreach campaigns prior to the discontinuation of the service.

iv. How planned outreach, education, and engagement services can improve behavioral health outcomes, and

v. How data will be gathered and analyzed to measure outreach, education, and engagement service outcomes.

c. The outreach, education, and engagement services strategic plan shall be delivered to the BHASO and BHA using the following:
   i. DELIVERABLE: Outreach, Education & Engagement strategic plan
   ii. DUE DATE: Within 30 Days of Contract Execution

   DESTINATION: cdhs_bhaso_deliverables@state.co.us

   FILE NAME: BHASO Region [X] - [BHASO] - FY[XX] - Outreach, Education & Engagement strategic plan

3.10.1.4 The BHASO Network must engage in outreach, education, and engagement services according to the strategic plan.

3.10.1.5 Payment

a. This service reconciles to actual expenses.

Article 2 - School Based Mental Health Specialist (SBMHS)

3.10.2.1 Program Description and Objectives

a. The goal of the School-Based Mental Health Specialist (SBMHS) program is to provide high-quality behavioral health outreach, linkage, consultation, and collaboration between BHASO Network Providers and school districts. The SBMHS can work broadly on systemic issues within schools and school districts that offer essential support for addressing educator efficacy and reduce burnout, mental health wellness for youth and, provide resources to manage suicide risk and coordinate care for at-risk youth. as well as work closely with internal and external stakeholders.

3.10.2.2 Target Population

a. The SBMHS program targets school-aged children and adolescents within the BHASO Network's Region.

3.10.2.3 Activities and Services

a. The SBMHS will provide consultation, training, and support to enhance the multi-tiered systems of mental health support (MTSS) framework. MTSS is a comprehensive framework that integrates academic, social, emotional, and behavioral needs to support all student's mental health along a continuum of services. This position provides school personnel with training, consultation, and implementation planning to promote mental health and well-being for school aged children and adolescents across the BHASO region.
    i. The SBMHS shall identify schools who are seeking intensive training and technical assistance regarding cultural and procedural change to increase the school's nurturing environment, increase mental health wellness, increase school safety, and increase academic achievement.
    ii. The BHASO Network shall develop a Memorandum of Understanding (MOU) with each school district with whom the SBMHS will provide consultative services. Within the MOU, the BHASO Network shall include an agreement to follow-up and to cooperate in all program evaluation activities, including the collection of data relevant to measuring achievement of the program through the completion of the Quarterly Retrospective Report.
    iii. Based on need, the SBMHS will provide direct guidance to schools through implementing specific interventions, as determined by BHA.
    iv. Use the MTSS framework to partner with school personnel to enhance mental health prevention, education, and consultation support.
    v. Complete needs assessments to identify opportunities in programming and to determine school-based interventions to meet the identified area of need.
    vi. Provide training, assistance, and consultation to schools to assist with implementation of mental health initiatives based on data from needs assessment and MTSS framework.
    vii. Provide consultation and support to schools and districts around the School Based Mental Health Consultation Tiered Resource Guide determined by BHA.

viii. Train school staff on mental health interventions.
ix. Provide consultation as needed and refer to community resources as appropriate.
x. Coordinate the delivery of mental health trainings and train school staff to deliver these training on an ongoing basis.
xi. Complete all required reporting and documentation including monthly and quarterly reports.

b. SBMHS and SBMHS Supervisors, and including representative(s) of the BHASO, shall attend a monthly school-based mental health supervision meeting facilitated by the BHA.
c. The BHASO Network's SBMHS provider(s) will complete a Monthly Deliverables Report using BHA template.
d. The BHASO will submit to BHA per the following:
    i. DELIVERABLE: SBMHS Monthly Deliverables Report
    ii. DUE DATE: by the fifteenth day (15th) of the month following the month end. DESTINATION: cdhs_bhaso_deliverables@state.co.us
    iii. FILE NAME: BHASO Region [X] - [BHASO] - FY[XX] - SBMHS Monthly Deliverables Report
e. The BHASO shall complete a Quarterly Retrospective Report using BHA template, compiled from data provided from individual SBMHS and delivered per the following:
    i. DELIVERABLE: SBMHS Quarterly Retrospective Report
    ii. DUE DATE: by the fifteenth day (15th) of the month following the reported quarter
    iii. DESTINATION: cdhs_bhaso_deliverables@state.co.us
    iv. FILE NAME: BHASO Region [X] - [BHASO] - FY[XX] - SBMHS Quarterly Retrospective Report

3.10.2.4 Standards and Requirements

a. The BHASO Network may choose to dedicate no more than two (2) staff in place of one (1) FTE. The FTEs shall act as direct liaisons between schools, school districts, school-based health centers, and the BHASO region.
b. The BHASO Network shall notify the BHASO of the SBMHS staff's name, contact information, and professional degree. Any staff changes shall be reported by the BHASO Network to the BHASO within ten (10) business days. The BHASO will provide BHA notice of the SBMHS staff upon written request by BHA, within ten (10) business days.

c. The SBMHS shall not provide direct clinical services under this program and will provide a referral for direct clinical services that fall outside the scope of work.
d. The BHASO Network shall not bill Medicaid or any other funding for FTE reimbursed by the BHASO for SBMHS.

3.10.2.5 Service Hours

a. The BHASO Network shall provide SBMHS throughout the calendar year.
    i. During school months the BHASO Network shall provide SBMHS and shall:
        1. Require the SBMHS and SBMHS Supervisors attend monthly supervision meetings facilitated by the BHA (with participation from BHASO).
        2. Ensure SBMHS supervisors attend a quarterly supervisors meeting.
    ii. During summer months the SBMHS shall:
        1. Provide consultative services to schools who operate on a full calendar year,
        2. Ensure the SBMHS attends monthly supervision meetings facilitated by the BHASO to prepare deliverables for the upcoming school year, and
        3. Ensure SBMHS supervisors attend a quarterly supervisors meeting.

3.10.2.6 Service Targets

a. The BHASO Network shall provide a goal of schools to be served within thirty (30) days of execution with the BHASO and are required to be approved by the BHASO and BHA. The number of schools served may be impacted by:
    i. Services
    ii. Population
    iii. Capacity
    iv. FTE
    v. The Annual Goals shall be delivered to the BHASO and BHA according to the following:
        1. DELIVERABLE: Annual Goal
        2. DUE DATE: Within thirty (30) days of contract execution
        3. DESTINATION: cdhs_bhaso_deliverables@state.co.us
        4. FILE NAME: BHASO Region [X] - [BHASO] - FY[XX] - SBMHS Annual Goal

3.10.2.7 Staff Credentials and Training

a. The SBMHS shall have:
    i. at least a Bachelor's degree but preferably a Master's degree in psychology, social work, counseling, school counseling or related field.
    ii. A minimum of one year of experience in a school setting.
b. A non-licensed SBMHS is required to be supervised by a licensed clinician.
c. The SBMHS will participate in all training offered through BHA to obtain the knowledge and skills necessary to provide support, training, and consultation.
d. The SBMHS will provide services and support to the district or school(s) at least one (1) time per week through the school calendar year.

3.10.2.8 Performance Outcome Measures Quarterly Retrospective Report

(See Section 3.10.2.3(e) Activities and Services)

a. Total Number of schools and/or school district that were served,
b. List all trainings provided to the schools and/or school district,
c. List the consultative services provided,
d. List prevention activities provided,
e. Community/School Reception of Specialists (any identified relationship/partnership challenges),
f. Barriers (any barriers identified that limit the effectiveness of the specialist),
g. Identified gaps (identified areas that are not currently being served by the specialist),
h. Ongoing school and /or school district needs,
i. Summer work summary (what outreach and preparation was done during summer months),
j. Quarterly Outcomes Summary, and
k. Success Stories

3.10.2.9 Payment

a. This service reconciles to cost-reimbursement based on FTE:
    i. The BHASO Network will provide invoices with hours billable based on FTE. The costs for employee compensation and the employer portion of fringe benefits are allowable costs.

Chapter 11

Screening, Assessment, and Diagnosis

Article 1 - Screening, Assessment, and Diagnosis Overview
Article 2 - Enhanced Standardized Assessment for Children and Youth
Article 3 -Enhanced Standardized Assessments for County Departments of Human Services and the Division of Youth Services

Article 1 - Screening, Assessment, and Diagnosis Overview

3.11.1.1 Description and Objectives

a. The BHASO Network shall complete screening, assessment(s), and diagnosis that focuses on person-centered care, which must be completed by a licensed or license-eligible behavioral health clinician and reviewed and approved by a licensed behavioral health clinician.

3.11.1.2 Rule Citation

a. Screening, Assessment, and Diagnosis shall be performed in accordance with Chapter 2, Part 12 of 2 CCR 502-1.

3.11.1.3 Target Population

a. Screening tools and approaches shall be culturally- and linguistically-appropriate to the Individual's needs. Tools and approaches shall be trauma-informed and shall accommodate an Individual's disability/disabilities based on Individual needs and as required by law.
b. All treatment modalities in this Chapter shall serve children and youth unless the modality is contraindicated for children and youth. The children- and youth-specific statements of work under this Chapter are:
    i. Article 2 - Enhanced Standardized Assessment for Children, Youth and Families
    ii. Article 3 - Enhanced Standardized Assessments for County Departments of Human Services and the Division of Youth Services

3.11.1.4 Screening

a. Activities
    i. Screenings shall collect at least the following information from Individuals seeking services:
        1. Identifying information
        2. Primary complaint or reason for seeking services
        3. Current behavioral health symptoms, including severity, duration, mental status, and changes or impairments in functioning of symptoms
        4. Chronic behavioral health concerns
        5. Screen for substance use
        6. Acute or chronic physical health concerns, including, but not limited to, pregnancy and postpartum status
            A. The screening and screening staff must directly state that the Individual may decline to answer regarding pregnancy and postpartum status.
        7. Evaluation of imminent risk, including, but not limited to,
            A. Suicide risk using the Columbia Suicide Severity Rating Scale (CSSRS)
            B. Danger to self or to others; assess for thoughts, plan, intent, recent aggression or agitation, as well as imminence (versus chronicity)
            C. Grave disability
            D. Urgent or critical physical health conditions, including withdrawal or overdose risk
            E. Other immediate risks, including threats from another person
        8. Preliminary determination of level of care needed
b. Standards and Requirements
    i. Requirements for the credentials of staff performing screenings and screening formats may be specified by BHA or specific program, statutory, or regulatory requirements.

ii. Individuals found to be at imminent risk as detailed in this Article shall be screened by the BHASO Network every time an Individual presents for treatment to the BHASO Network.

1. Where additional screening may be redundant, the BHASO Network may provide supporting documentation that a screening tool was administered within the past six (6) months and shall be incorporated into an Individual's record in place of the similar screening requirements.

iii. Screenings that identify an imminent risk as detailed in this Article that may require the Individual to be placed on a mental health hold shall be reviewed and approved by a behavioral health licensee, licensed addiction counselor (LAC), a certified addiction specialist (CAS), or a licensure candidate performing within the scope of their practice. A determination of imminent risk may result in the need for referral to more intensive services.

3.11.1.5 Assessment

a. When an initial screening is performed, an Individual's screening tool may indicate the Individual is in need of more intensive services. If an Individual's initial screen warrants more intensive services, the Individual will be referred for an assessment.

i. If the initial screening does not warrant referral for an assessment, the BHASO Network shall coordinate care or refer to other care as indicated in the screening.

b. Activities

i. Initial Assessments

1. The initial assessment, including information gathered as part of the preliminary screening and risk assessment shall include, but is not limited to:

a. Provisional diagnosis
b. The source of referral
c. The reasons for seeking care, as stated by the Individual or other referral source(s)
d. Identification of the Individual's immediate clinical care needs related to the diagnosis for Mental Health Conditions and Substance Use Disorders

e. A list of current prescriptions and prescribing provider, over-the-counter medications, and any other substances the Individual may be taking, including doses and frequency
f. After Individual has screened positive for suicide risk or ideation, or harm to others, assess level of risk to determine next steps to support suicidal Individual
g. An assessment of whether the Individual has other concerns for their own safety
h. Assessment of the need for physical health care
    i. With referral to services and any follow-up as required
i. A determination of whether the Individual presently is or has even been a member of the United States armed forces
j. Current healthcare providers
k. Current pregnancy status or desire to become pregnant within the next year.

2. Individual must be informed that they may decline to answer any question and that this will not impact their eligibility to receive services.

ii. Comprehensive Assessments

1. Information gathered as part of screening or the initial assessment may be incorporated into the comprehensive assessment.
2. Individual must be informed that they may decline to answer any question and that this will not impact their eligibility to receive services.
3. Ongoing comprehensive assessments shall be documented in the Individual's record and shall include as available, but is not limited to:
    a. Identification and demographic information
    b. Primary complaint/reason for seeking services
        i. Including onset of symptoms and severity of symptoms
    c. Mental health history, including but not limited to:
        i. Suicidal risk or ideation per the Columbia assessment
        ii. Homicidal ideation
    d. Substance use and substance use withdrawal history
    e. Physical health issues, including chronic infections, acute concerns, and treatment history.

f. A diagnosis with sufficient supporting criteria
    i. Any subsequent changes in diagnosis
g. A mental health examination(s) for Individuals who receive a diagnosis
    i. Personnel shall consider other diagnoses or disabilities that may impact motor and speech activity

4. History of involuntary treatment

a. Advance directives, including physical health and behavioral health
b. Activities of Daily Living (ADL)
c. Cultural factors that may impact treatment which may include, but is not limited to:
    i. Age
    ii. Ethnicity
    iii. Linguistic/communication needs
    iv. Gender
    v. Gender identity
    vi. Sexual orientation
    vii. Relational roles
    viii. Spiritual beliefs
    ix. Socio-economic status
    x. Personal values
    xi. Level of acculturation and/or assimilation
    xii. Coping strategies
d. Education, vocational training, and military service
e. Geographic location (frontier, urban, rural, mountain)
f. Family and/or social relationships
g. Trauma and trauma history
h. Physical and/or sexual abuse or perpetration and current risk
i. Legal issues that may impact behavioral health outcomes
j. Disability status
k. Issues specific to older adults, including but not limited to:
    i. Hearing loss
    ii. Vision loss

iii. Physical strength
iv. Mobility
v. Other aging issues

l. Issues specific to children, including but not limited to:
i. Growth and development
ii. Daily activities
iii. Legal guardians
iv. Need for family involvement and engagement in the child's treatment
v. Strengths, abilities, and interests
vi. Barriers to treatment

c. Standards and Requirements
i. The BHASO Network shall conduct assessments throughout the course of treatment, review previous assessments, update assessments, and update the Individual's treatment or care plan whenever there is a change in the person's level of care or functioning.
ii. All methods and procedures used by the BHASO Network to assess and evaluate an Individual shall be developmental and age-appropriate, include competencies for culture, language and disabilities, and are trauma-informed.
iii. All methods and procedures used to assess and evaluate an Individual shall be able to be provided in the preferred language or communication method.
iv. For the BHASO Network providers that have or are seeking a SUD sub-endorsement for any level of care, the assessment shall:
1. Use the ASAM criteria 3rd edition as a guide for assessing and placing Individuals into the appropriate level of care.
2. Document information gathered on the six (6) dimensions outlined in the ASAM criteria for assessments
3. Utilize the decisional flow process as outlined in the ASAM criteria to determine and document the assessed level of care.
v. Assessments shall apprise adult Individuals, as applicable, of risk factors associated with acquiring and transmitting HIV/AIDS, TB, Hepatitis A, B, C, and other infectious diseases. Appropriate testing and pre- and post-test counseling shall be offered on-site or through referral.
vi. Additional assessment requirements may be required for specific endorsements.

d. Staff Credentials and Training
    i. Assessments shall be conducted by or reviewed and approved by a behavioral health licensee, licensed addiction counselor (LAC), a certified addiction specialist (CAS), or a licensure candidate performing within the scope of their practice.
    ii. Notwithstanding the above term, requirements for screening staff credentials and formats may be otherwise specified by BHA or specific program, statutory, or regulatory requirements.

3.11.1.6 Diagnosis

a. Diagnosis shall be reviewed and approved by a behavioral health licensee, licensed addiction counselor (LAC), a certified addiction specialist (CAS), or a licensure candidate performing within the scope of their practice. If a licensure candidate gives a diagnosis, the diagnosis must be approved by a licensee.

3.11.1.7 Payment

a. See associated statement of work for the service where the screening, assessment, or diagnosis takes place to determine payment methodology.

Article 2 - Enhanced Standardized Screener and Assessment for Children and Youth

3.11.2.1 Program Description & Objectives

a. The screener is a tool approved by Behavioral Health Administration and the Department of Health Care Policy and Financing that is designed specifically for identifying children and youth who meet the criteria for an Enhanced Standardized Assessment (ESA). The BHA-designated screener will be used to identify children and youth at risk of out-of-home placement due to behavioral health conditions and/or multisystem involvement, including but not limited to children and youth requiring or receiving mental health residential care.
b. The Enhanced Standardized Assessment (ESA) is a comprehensive, clinical assessment process completed by a mental health professional to assist in making recommendations about the level of care and treatment/service planning for children, youth, and their families.

3.11.2.2 Statutory / Rule Citation

a. The Enhanced Standardized Assessment (ESA) shall be performed in accordance with Chapter 3 and 4 of 2 CCR 506.

3.11.2.3 Target Population

a. Children and youth under the age of 21 who need behavioral health services in the home, community, residential, or inpatient setting.

3.11.2.4 Activities and Services

a. The BHASO shall have a direct phone line and email address or secure online platform system that allows users to electronically send and receive referrals for receiving ESA referrals/requests, which is publicly available on their website, and shall notify BHA and all referring agencies of the phone number, email address, and a direct contact person.
b. The BHASO shall receive agency referrals for ESA through calls, emails, or a secure link which are directly initiated by a Regional Accountable Entity (RAE), county Department of Human Services (DHS), and the Division of Youth Services (DYS). The BHASO shall accept all referrals that contain all of the following, unless otherwise specified by BHA:
    i. Enhanced Standardized Assessment face sheet,
    ii. BHA-designated screener, and
    iii. Parent and/or legal guardian's or referring party's contact information
c. The BHASO shall receive caregiver- and self-referrals (from youth 12 years and older) for non-crisis children, youth, and family mental health services through calls and emails or secure link, which are directly initiated by the youth, parent, or legal guardian.
    i. If a youth or family resides outside of the BHASO's region, the BHASO shall connect the youth or family with the appropriate BHASO, unless otherwise specified by BHA or specific program, statutory, or regulatory requirements.
d. The BHASO shall assign the ESA referral to an assessor within one (1) business day of the referral being accepted, unless otherwise specified by BHA or specific program, statutory, or regulatory requirements.
e. The BHASO shall notify and furnish contact information for the assigned assessor to the requesting party (e.g. parent/guardian, caseworker, client manager) within one (1) business day of assignment.

f. The BHASO shall securely submit assessment materials to the referring as indicated below:
    i. DELIVERABLE:
        1. Counties/DYS: assessment summary report and CO CANS
        2. ESA narrative, ESA summary report, CO CANS, and CO CANS Decision Support Matrix
        3. RAEs: the completed ESA narrative, CO CANS, and CO CANS Decision Support Matrix
    ii. DUE DATE: within ten business days of the date the initial assessment referral was accepted, unless otherwise specified by BHA or specific program, statutory, or regulatory requirements.
    iii. DESTINATION: secure method
g. The BHASO shall ensure all ESAs utilize and address all components of the following:
    i. BHA-designated Enhanced Standardized Assessment narrative.
    ii. BHA-designated Colorado Child and Adolescent Needs and Strengths (CO CANS) assessment tool
    iii. BHA-designated CO CANS Decision Support Matrix.
h. The BHASO shall ensure all ESAs address the following components and meet the following standards:
    i. ESAs shall meet the requirements for screening and assessing children outlined in 2 CCR 502-1-8.4.
    ii. ESAs shall meet the BHA's Quality Assurance Standards (QAS)
    iii. The ESA assessor shall complete a suicide and homicide risk assessment for the child.
    iv. The ESA assessor shall complete a mental status exam for the child or youth, unless otherwise specified by BHA or specific program, statutory, or regulatory requirements.
    v. The assessor shall provide a diagnosis for the child or youth as defined in the DSM-5-TR or the ICD-10-CM, unless otherwise specified by BHA or specific program, statutory, or regulatory requirements.
    vi. The ESA assessor shall incorporate input from appropriate third parties listed in 3.11.2.4.j.ii below into the CO-CANS, along with the ESA assessor's clinical interpretation to determine the appropriate level of care, clinical recommendations, and supportive services for the child or youth, as required by

BHA.

1. The ESA assessor shall provide clinical justification as to why the recommended level of care and each treatment recommendation represents the least restrictive treatment options required to treat, correct, or ameliorate the behavioral health conditions identified by the Enhanced Standardized Assessment.
2. If the ESA assessor recommends a different level of care than identified by the CO-CANS Decision Support Matrix, the BHASO assessor shall provide additional explanation as to why the recommended level of care will treat, correct, or ameliorate the conditions better than the level identified by the Decision Support Matrix.

vii. ESA assessors shall make recommendations for short and long-term clinical goals for each service identified on the individualized treatment plan.

i. The BHASO shall ensure that ESA assessors gather information according to the following:

i. ESA assessors shall conduct a face-to-face clinical interview with the child or youth.

1. If it is clinically indicated or requested by the child/youth or family, the ESA assessor shall conduct an in-person clinical interview.
2. For in-person ESAs, the BHASO assessor shall meet the child/youth and family where the child/youth and family are located, with no expectations that the child/youth or family travel to a location chosen by the BHASO or BHASO assessor.
3. If an in-person interview is not clinically indicated or requested by the child/youth or family, ESA assessors may use a HIPAA-compliant audio-visual telehealth platform to conduct the face-to-face clinical interview with the child/youth, unless otherwise specified by BHA or by specific program, statutory, or regulatory requirements.

ii. ESA assessors shall make a reasonable effort to interview the following individuals, if these individuals are part of the child/youth and family's treatment team, and integrate the obtained information into the assessment:

1. Parents/caregivers,
2. County Department of Human Services caseworker,
3. DYS client manager,
4. RAE care coordinator,

5. Relevant school staff and/or IEP team,
6. Primary behavioral health treatment provider, and
7. Psychiatrist or person authorized to prescribe medications.
8. Previous behavioral health treatment providers,
9. Other natural supports and/or family members identified by the child/youth and family,
10. Mentors/behavioral coaches,
11. Guardian ad litem (GAL),
12. Counsel for Youth (CYF),
13. Probation officers
14. Court Appointed Special Advocate (CASA),
15. Any recent (past twelve (12) months) foster parents or guardians, and
16. Other collateral information as relevant to the case.

iii. The assessor shall make reasonable efforts to obtain and review supporting documentation from the family and treatment team as applicable, including but not limited to:

1. Educational records, including Individualized Education Program (IEP) documents and 504 plans
2. Applicable child welfare case notes and court orders,
3. Behavioral health screens, assessments and treatment notes,
4. Division of Youth Services assessment reports and documents,
5. RAE records,
6. Team meeting notes,
7. Any hospitalization records from the last year, and
8. Probable cause statements and other judicial assessments that were completed within the last year.

iv. All methods and procedures used to assess and evaluate the child/youth and family shall be provided in the preferred language or communication method (i.e. ASL).

j. The BHASO shall ensure the assessment and corresponding activities are documented in a central record database.

k. For agency referrals, the BHASO shall submit the finalized ESA to the referring party and BHA within ten (10) business days of accepting the ESA referral, unless otherwise specified by BHA or specific program, statutory, or regulatory requirements.

3.11.2.5 Standards and Requirements

a. The BHASO shall comply with the ESA Quality Assurance Process (QAP) and incorporate BHA feedback and requested changes into their quality assurance monitoring procedures, as determined by BHA.
b. BHA retains the right to update or change the Quality Assurance Process (QAP) but must give 90 days' notice to the BHASO.
a. The BHASO shall conduct quality assurance monitoring for Enhanced Standardized Assessments and assessors by developing and following a BHA-approved Quality Assurance Monitoring Plan (QAMP). The BHASO shall provide evidence of quality and process improvements during the annual BHA review, as outlined by the ESA Quality Assurance Process.
c. The BHASO shall ensure all ESA Quality Assurance Monitoring Plans (QAMP) meet the minimum criteria outlined in the ESA Quality Assurance Process.
d. The BHASO shall submit a QAMP once a year, at a minimum, for review and approval by the BHA.
    i. DELIVERABLE: ESA Quality Assurance Monitoring Plan section in QA Work Plan
    ii. DUE DATE: June 30, 2025, for FY26, and March 31 annually in years thereafter for the upcoming fiscal year
    iii. DESTINATION: cdhs_BHASO_deliverables@state.co.us
    iv. FILE NAME: BHASO Region[X] - [BHASO] - FY[XX] - QA Work Plan
e. BHA retains the right to review all Enhanced Standardized Assessments and corresponding clinical recommendations completed by BHASO assessors and other parties as identified by BHA, unless otherwise waived by BHA.

3.11.2.6 Service Hours

a. Assessments shall occur during the BHASO's business hours. Business hours shall be posted on the BHASO's website, and BHA and all referring parties of the ESA shall be notified of all changes to routine business hours thirty (30) days prior to any changes.

3.11.2.7 Network Adequacy

a. The BHASO shall maintain a network of licensed or licensure candidate mental health professionals, defined in 2 CCR 502-1 8.3.1(b), who are credentialed to complete the

ESA, who can respond to all geographical areas within the BHASO's region, and who can complete the ESA within the outlined timeframe, unless otherwise specified by BHA or specific program, statutory, or regulatory requirements.

3.11.2.8 Staff Credentials and Training

a. The BHASO shall ensure all ESA assessors adhere to all ethical and legal requirements regarding duty to warn, duty to protect, and duty to report suspected abuse or neglect during the course of the assessment process.
b. The BHASO shall utilize mental health professionals, as defined in 2 CCR 502-1 8.3.1(b), as ESA assessors and maintain evidence of current licensure on file, unless otherwise specified by BHA or specific program, statutory, or regulatory requirements.
c. The BHASO shall ensure ESA assessors maintain a CANS certification, and the BHASO shall maintain evidence of current certification on file, and the BHASO shall maintain evidence of training completion on file.
d. The BHASO shall ensure ESA assessors complete the BHA-designated ESA trainings, and the BHASO shall maintain evidence of completion of these trainings and learning collaboratives

Article 3 - Enhanced Standardized Assessments for County Departments of Human Services and the Division of Youth Services

3.11.3.1 Program Description and Objectives

a. The Enhanced Standardized Assessment (ESA) is a comprehensive, clinical assessment process completed by a mental health professional to assist in determining appropriate level of care and treatment/service planning for children, youth, and their families.
b. The Family First Prevention Services Act (Family First) recognizes children and youth should grow up in a safe, stable and secure family that supports their long-term well-being. Family First aims to prevent children from entering foster care by allowing federal reimbursement for mental health services, substance use treatment, and in-home parenting skill training. It also seeks to improve the well-being of children in out-of-home placement by incentivizing states to reduce the placement of children in

congregate care through:

i. Creating a new type of residential service for children and youth called Qualified Residential Treatment Programs (QRTPs)
ii. Requiring a comprehensive, clinical assessment completed by a Qualified Individual (QI) to determine the appropriateness of a child or youth's placement and services.

3.11.3.2 Target Population

a. Family First shall serve all children and youth under the age twenty-one (21) and under, referred by a county Department of Human Services (County) or Division of Youth Services (DYS) who are requesting QRTP or Psychiatric Residential Treatment Facilities (PRTF) level of care.

3.11.3.3 Activities and Services

a. The BHASO shall have a direct phone line and email address or secure online platform system that allows users to electronically send and receive referrals, for receiving County and DYS ESA referrals, which is publicly available on their website, and provided to BHA and all referring parties.
b. The BHASO shall provide BHA and all referring parties with the name(s) and contact information of the staff member(s) responsible for overseeing the BHASO's County/DYS ESA process.
c. The BHASO shall receive referrals for County/DYS ESAs directly from the County or DYS regional office located within the BHASO's geographical region. The BHASO shall accept all referrals that contain the following information:
    i. Enhanced Standardized Assessment face sheet or the Universal Referral form,
    ii. Referring party contact information, and
    iii. Consent to treatment
d. The BHASO shall work with the County and DYS to obtain signed consent to treatment and release of information forms for the purpose of completing the ESA.
e. The BHASO shall assign the County/DYS ESA referral to a Qualified Individual (QI) as defined in Chapter 2 of this contract.
    i. County/DYS ESA referrals accepted by the BHASO before 1:00 pm shall be assigned to a QI on the same business day.
    ii. County/DYS ESA referrals accepted by the BHASO after 1:00 pm may be assigned

to a QI the next business day.

f. The BHASO shall have the assigned QI review, agree, and return the BHA provided Independent Assessor Affidavit to the BHASO before the QI starts work on the County/DYS ESA referral. The BHASO shall maintain the signed Independent Assessment Affidavit on file.
    i. If the QI is unable to agree to the Independent Assessor Affidavit, they will notify the BHASO and the BHASO shall reassign the County/DYS ESA referral to another QI in the BHASO's network.
g. The BHASO shall notify and furnish the assigned QI's contact information to the referring agency within one (1) business days of the assignment.
h. The BHASO shall ensure all County/DYS ESAs utilize and address all components of the following:
    i. BHA-designated Enhanced Standardized Assessment narrative template,
    ii. BHA-designated Summary Report template,
    iii. BHA-designated Colorado Child and Adolescent Needs and Strengths (CO CANS) assessment tool, and
    iv. BHA-designated CO CANS Decision Support Matrix.
i. The BHASO shall ensure all County/DYS ESAs address the following components and meet the following standards:
    i. County/DYS ESAs shall meet the requirements for assessing children outlined in 2 CCR 502-1-8.4.
    ii. County/DYS ESAs shall meet the BHA's Quality Assurance Standards (QAS)
    iii. If an interview with the child or youth occurs, the QI shall complete a suicide and homicide risk assessment for the child.
    iv. If a face-to-face interview with the child or youth occurs, the QI shall complete a mental status exam for the child or youth.
    v. If a face-to-face interview with the child or youth occurs, the QI may provide a diagnosis for the child or youth as defined in the DSM-5-TR or the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM).
    vi. The QI shall utilize the CO-CANS and CO-CANS Decision Support Matrix along with their clinical interpretation to recommend the appropriate level of care, clinical recommendations, and supportive services for the child or youth, as required by BHA.
        1. The QI shall provide clinical justification as to why the recommended

level of care and each treatment recommendation represents the least restrictive treatment options required to treat, correct, or ameliorate the behavioral health conditions identified by the County/DYS ESA.

a. If QRTP is the recommended level of care, the QI shall specify why the needs of the child/youth cannot be met in a less restrictive environment and how it is the most effective and appropriate level of care consistent with short and long-term goals as specified in the permanency plan. A shortage of foster family homes or other community placements are not an acceptable reason for QRTP approval.

2. If the QI recommends a different level of care than identified by the CO-CANS Decision Support Matrix, the QI shall provide additional explanation as to why the recommended level of care will treat, correct, or ameliorate the conditions better than the level identified by the Decision Support Matrix.

vii. The QI shall make recommendations for short and long-term clinical goals for each service identified on the individualized treatment plan.

viii. The QI shall attend a Family and Permanency Team Meeting (FPTM) or Multidisciplinary Team Meeting (MDT) to present the County/DYS ESA outcomes and recommendations.

1. For County referrals, a FPTM must be coordinated by the county and occur within the 10 business day timeframe;
2. For DYS referrals, an MDT must be coordinated by DYS and occur within the 30 calendar day timeframe;

ix. The QI shall integrate the Family and Permanency Team's or Multidisciplinary Team's input and feedback into the County/DYS ESA.

x. The QI shall include documentation of any objections to the assessment recommendations that were not resolved during the Family and Permanency meeting or MDT meeting.

j. The BHASO shall ensure that the QI gathers and incorporates information for the County/DYS ESA according to the following:

i. The QI shall make reasonable efforts to conduct a face-to-face clinical interview with the child or youth. If a face-to-face interview cannot occur, the QI may

conduct a phone interview. If the QI cannot interview the youth, the County/DYS ESA shall be completed through a records review and collateral interviews.

1. If it is clinically indicated or requested by the child/youth or family, the QI shall conduct an in-person clinical interview.
2. For in-person ESAs, the QI shall meet the child/youth and family where the child/youth and family are located, with no expectations that the child/youth or family travel to a location chosen by the BHASO or BHASO assessor.
3. If an in-person interview is not clinically indicated or requested by the child/youth or family, the QI may use a HIPAA-compliant audio-visual telehealth platform to conduct the face-to-face clinical interview with the child/youth, unless otherwise specified by BHA or by specific program, statutory, or regulatory requirements.

ii. The QI shall make a reasonable effort to interview the following individuals, if these individuals are part of the child/youth and family's treatment team, and integrate the obtained information into the assessment:

1. Parents/caregivers,
2. County Department of Human Services caseworker,
3. DYS client manager,
4. RAE care coordinator,
5. Relevant school staff and/or IEP team,
6. Primary behavioral health treatment provider, and
7. Psychiatrist or person authorized to prescribe medications.
8. Previous behavioral health treatment providers,
9. Other natural supports and/or family members identified by the child/youth and family,
10. Mentors/behavioral coaches,
11. Guardian ad litem (GAL),
12. Counsel for Youth (CYF),
13. Probation officers
14. Court Appointed Special Advocate (CASA),
15. Any recent (past twelve (12) months) foster parents or guardians, and
16. Other collateral information as relevant to the case.

iii. The QI shall make reasonable efforts to obtain and review supporting

documentation from the family and treatment team as applicable, including but not limited to:

1. Educational records, including Individualized Education Program (IEP) documents and 504 plans
2. Applicable child welfare case notes and court orders,
3. Behavioral health screens, assessments and treatment notes,
4. Division of Youth Services assessment reports and documents,
5. RAE records,
6. Team meeting notes,
7. Any hospitalization records from the last year, and
8. Probable cause statements and other judicial assessments that were completed within the last year.

iv. All methods and procedures used to assess and evaluate the child/youth and family shall be provided in the preferred language or communication method (i.e. ASL).

k. For County referrals, the BHASO shall securely submit the finalized ESA Summary Report and CO CANS to the referring party and the ESA Narrative, Summary Report, CO CANS, and CO CANS Decision Support Matrix to BHA and the assigned RAE within ten (10) business days of accepting the ESA referral.

l. For DYS referrals, the BHASO shall securely submit the finalized ESA Summary Report and CO CANS to the referring party and the ESA Narrative, Summary Report, CO CANS, and CO CANS Decision Support Matrix to BHA and the assigned RAE within thirty (30) calendar days of accepting the ESA referral or within thirty (30) days of the youth entering a QRTP, whichever comes first.

m. The BHASO shall accept requests from Counties or Division of Youth Services to transfer an ESA completed through the RAE to a County/DYS ESA if the original ESA was completed within (30) thirty calendar days. The BHASO shall utilize the following transfer process:

i. The BHASO will contact the original ESA assessor to determine if the ESA assessor is available to complete the ESA transfer within ten (10) business days.

1. If the original ESA assessor is unable to complete the transfer within ten (10) business days, the BHASO may request an extension of up to thirty (30) calendar days from the County or DYS for the transfer to be completed.

2. If the original ESA assessor cannot complete the transfer within the timeframes specified above, the BHASO shall notify the referring agency that the transfer is cancelled and a new County/DYS ESA will be conducted in accordance with the process outlined above.

ii. The referring party shall coordinate a Family and Permanency Team meeting (FPTM) or Multidisciplinary Team Meeting (MDT) with the QI to occur within the ten (10) business day timeframe.

1. If an extension for the transferred assessment is agreed upon by the Contractor and County Department of Human Services, the FPTM must occur within the thirty (30) calendar day timeframe.

iii. The QI shall integrate the Family and Permanency Team's or Multidisciplinary Team's input and feedback into the Independent Assessment Summary Report

iv. The QI shall complete the BHA-designated Summary Report

v. The BHASO shall securely submit the finalized ESA Summary Report and CO CANS to the referring party and the ESA Narrative, Summary Report, CO CANS, and CO CANS Decision Support Matrix to BHA within the ten (10) business day timeframe, or thirty (30) calendar day timeframe if an extension was agreed upon.

n. A RAE may request the BHASO transfer a County/DYS ESA to the RAE if the original assessment was completed within (30) thirty calendar days. The contractor will send the original finalized Assessment Narrative, Summary Report, CO CANS, and CO CANS Decision Support Matrix within ten (10) calendar days of the request to the RAE.

o. The BHASO shall ensure the assessment and corresponding activities are documented in a central record database.

3.11.3.4 Standards and Requirements

a. The BHASO shall comply with all standards and requirements outlined in the Enhanced Standardized Assessment for Children and Youth section (Exhibit A, Part Three, Chapter 11, Article 2) of this contract.

3.11.3.5 Service Hours

a. Assessments shall occur during the BHASO's business hours. Business hours shall be posted on the BHASO's website and BHA shall be notified of all changes to routine business hours thirty (30) days prior to any changes.

3.11.3.6 Network Adequacy

a. The BHASO shall maintain a network of licensed or licensure candidate mental health providers, defined in 2 CCR 502-1 8.3.1(b), (Qualified Individuals) who can respond to all geographical areas within the BHASO's region and complete the required assessment within the outlined timeframe.

3.11.3.7 Staff Credentials and Training

a. The BHASO shall utilize mental health professionals, as defined in 2 CCR 502-1 8.3.1(b), as QIs and maintain evidence of current licensure on file.
b. The BHASO shall ensure QIs are not an employee of the Title IV-E agency and are not connected to, or affiliated with, the primary funding source or any placement/treatment setting in which children are placed by the Title IV-E agency to complete independent assessments.
c. The BHASO shall ensure QIs maintain a CANS certification, and the BHASO shall maintain evidence of current certification on file.
d. The BHASO shall ensure QIs complete the BHA-designated onboarding trainings for ESAs and Family First and the BHASO shall maintain evidence of training completion on file.
e. Qualified Individuals shall participate in at least four (4) hours of BHA-sponsored Independent Assessment learning collaborative and/or CO-CANS Community of Practice annually.
f. BHASOs that also function as Regional Accountable Entities can maintain internally hired Qualified Individuals. The BHASO shall demonstrate to BHA that no conflict of interest exists with each Qualified Individual and receive BHA approval. If BHA approval is not received, the internally hired Qualified Individuals shall only complete assessments for other BHASOs.

3.11.3.8 Payment

a. ESA rates can be found in Exhibit B - Rate Schedule, Sections 11.1-11.5.
b. General Accounting Encumbrances.
    i. Payment to BHASO is made from available funds encumbered and shared across multiple BHASOs. The State may increase or decrease the total funds

encumbered at its sole discretion and without formal notice to BHASO. No minimum payment is guaranteed to BHASO. The liability of the State for such payments is limited to the encumbered amount remaining of such funds.

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Chapter 12
Additional Services

Article 1 - Transportation for Behavioral Health Service

3.12.1.1 Program Description and Objectives

a. The purpose of this encumbrance is to provide funding for both secure and non-secure transportation for individuals across the behavioral health treatment spectrum and to inpatient hospital care.

3.12.1.2 Target Population and Eligibility

a. Transportation may be provided to any Individual fitting the criteria in Activities and Services below.
b. Only licensed Behavioral Health Secure Transport (BHST) Providers may transport Individuals in crisis.

3.12.1.3 Activities and Services

a. Transportation provided by this funding can be utilized for transport between different levels of care, up to higher levels of care, for higher level of care discharge return to community, or the first outpatient discharge appointment.
    i. Between different levels of care means across, not within the same level of care. For example, across would imply transporting an individual from a WIC to a CSU or hospital or upon discharge from the hospital back home or to an appointment. Within would refer to transporting an individual who is in outpatient care from home to an appointment or group or back home. Transport within levels of care is not an allowable expense under this section.
b. Secure Transportation means vehicles are equipped with the following:
    i. Safety locks,
    ii. Safety mechanism that ensures vehicle driver(s) and passenger safety, and
    iii. Transparent safety partitions, if utilized.
c. Secure transportation should be used for Individuals on a mental health hold who require a transport to a higher level of care.
    i. This level of transportation also requires training for the driver and attendant

including de-escalation and trauma-informed care.

d. Non-secure transportation does not require vehicles to be retrofitted with safety mechanisms and can be used for Individuals requiring transportation not on a mental health hold.
    i. These transports can be utilized for across levels of care, up to higher levels of care, and for higher level of care discharge return to community or the first outpatient discharge appointment.
e. Transportation under this section must be one of the following forms:
    i. Third-party Secure Transportation,
    ii. Third-party non-secure transportation
    iii. In-house Secure or non-Secure Transportation
f. The BHASO shall collaborate with community partners to develop strategy about access to Behavioral Health Secure Transportation and communication across involved entities.

3.12.1.4 Data Collection and Reporting.

a. The BHASO Network shall record the number, distance, and expense of each transport billed to this Article and compile into a quarterly report.
    i. DELIVERABLE: Quarterly Transportation Report
    ii. DUE DATE: Quarterly, on the 15th of the month following the reported month.
    iii. DESTINATION: cdhs_bhaso_deliverables@state.co.us
    iv. FILE NAME: BHASO Region[X] - [BHASO] - FY[XX] Q[X] - [BHASO Name] Transportation Quarterly Report

3.12.1.5 Payment - General Accounting Encumbrance

a. This service is paid on a fee-for-service reimbursement model in accordance with the rates in Exhibit B – Rate Schedule, Section 12.1.
b. Payment to the BHASO is made from available funds encumbered and shared across multiple contractors. The State may increase or decrease the total funds encumbered at its sole discretion and without formal notice to the BHASO. No minimum payment is guaranteed to the BHASO. The liability of the State for such payments is limited to the encumbered amount remaining of such funds.
c. The BHASO Network may be initially limited to a soft budget cap for the State Fiscal

Year, established prior to contract renewal. Budgets in excess of the soft cap must be approved in advance in writing by BHA.

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Chapter 13

Multimodality Programs

Article 1 - Children and Youth Mental Health Treatment Act - BHA Program
Article 2 - Additional Family Services - BHA Program
Article 3 - Strategic Individualized Remediation Treatment (STIRT) - BHA Program
Article 4 - Ridge View Supportive Residential Community Substance Use Continuum Services
Article 5 - Involuntary Commitment Services (SUD) - BHA Program

Article 1 - Children and Youth Mental Health Treatment Act - BHA Program

3.13.1.1 Program Description and Objectives

a. The Children and Youth Mental Health Treatment Act (CYMHTA) is a program that provides access to mental health treatment to children and youth who are at risk of out-of-home placement, to prevent unwarranted child welfare involvement. Parents experience challenging circumstances when their children have significant mental health needs, which can result in a behavioral health crisis, putting children at risk of out-of-home placement.

3.13.1.2 Statutory and Rule Citation

a. CYMHTA shall be performed in accordance with C.R.S. §27-67-101 et. seq.
    i. Notifications shall contain all information outlined in 2 CCR 502-1, 21.200.43.I and 21.200.45
    ii. The BHASO shall comply with all aspects of C.R.S. §27-67-101 et. seq. and 2 CCR 502-1, 21.200.4

3.13.1.3 Target Population and Eligibility

a. Target Population
    i. CYMHTA shall serve children and youth, ages zero to eighteen (0-18), who are at risk of out of home placement.
b. Eligibility
    i. The Responsible Persons requesting services through CYMHTA shall have custody (medical decision-making rights).
    ii. At the time of the CYMHTA Enhanced Standardized Assessment request, the child or youth shall be under the age of eighteen (18).
    iii. If receiving CYMHTA funding for services at the time the youth turns eighteen (18) years old, the youth may continue to receive funding for clinically appropriate services up until age twenty-one (21).
    iv. The child or youth's immediate family may not have an open dependency and neglect action through child welfare. If there is a pending dependency and neglect action through child welfare, the outcome of the investigation/assessment shall be determined as a prerequisite to CYMHTA funding.
    v. The child or youth shall have a Mental Health Diagnosis, as defined in Section 27-65-102(22), C.R.S., a Mental Health Diagnosis and a co-occurring Intellectual or Development Disability (IDD) Diagnosis, or a Mental Health Diagnosis and a co-occurring Autism Spectrum Disorder (ASD) Diagnosis. A child or youth's diagnoses may be unknown at the time of the CYMHTA Enhanced Standardized Assessment request, as the CYMHTA Enhanced Standardized Assessment can provide a Mental Health Diagnosis as clinically appropriate.
    vi. CYMHTA Enhanced Standardized Assessments and funding are not available to the Medicaid or categorically eligible Medicaid population.
    vii. The child or youth shall have private/commercial insurance or have no insurance.
        1. For a child or youth with private insurance, and multisystem involvement, CYMHTA funding shall be the most appropriate funding stream for the clinically recommended services from the CYMHTA assessment.
    viii. The child or youth shall be at risk of out of home placement, as defined in 2 CCR 502-1 21.200.41. The clinical services from the CYMHTA Enhanced Standardized Assessment shall be indicated to reduce the risk of out of home placement.

ix. There is nothing in statute or rule that precludes a child or youth who is undocumented from accessing CYMHTA provided all other eligibility criteria are met.

3.13.1.4 Activities and Services

a. Services

i. The BHASO shall ensure CYMHTA services for the Region by providing Enhanced Standardized Assessments in accordance with Chapter 11 Article 2 of this document as well as clinical care coordination and care/case management to coordinate community-based services, residential treatment services, and non-residential mental health transition services for children and youth who meet the criterion to receive funding under CYMHTA.

ii. CYMHTA Requests.

1. The BHASO shall receive requests for CYMHTA Enhanced Standardized Assessments and services through its published contact point(s) (one or more of the following: website, phone, email). The requests shall be initiated by the parent or legal guardian (responsible person) of the child or youth. The BHASO's contact point(s) for the team overseeing assessments will also serve as the primary point of contact for community partners, stakeholders, and BHA program staff.

iii. Clinical Care Coordination and Care/Case Management.

1. The BHASO shall arrange for continuity of care and coordination of the array of services necessary for appropriately treating a child or youth as recommended by the Enhanced Standardized Assessment, including but not limited to:

a. Communicating with responsible persons, the family systems navigator, and funded providers at least every thirty (30) calendar days to assure services are being delivered as planned and adequate progress is being made;

i. HIPAA-compliant video conference services may be used for care coordination activities unless the family requests in-person services. If a responsible person requests in person services, the BHASO shall make every effort to accommodate the request.

b. Discharge planning and development; and
c. Rescinding authorization for any treatment services with proper notice.

2. The BHASO shall provide CYMHTA funded services based on the recommendations of the CYMHTA Enhanced Standardized Assessment, system navigation, and ongoing clinical care coordination. Such services shall include:
    a. Ongoing clinical care coordination and clinical case management,
    b. Ongoing assessment of services,
    c. Clinical recommendations,
    d. Clinical care coordination of services,
    e. Systems navigation in circumstances where the CYMHTA family systems navigator is unable to be involved, and
    f. Notifications of any increase, decrease, termination or denial of, CYMHTA funded services to the family within five (5) business days of implementation, and system navigation support.

iv. The BHASO shall also provide as part of clinical care coordination:
1. The monitoring and oversight of the CYMHTA clinical treatment providers (including review of treatment plans and safety plans) to ensure services are being provided in accordance with the child or youth's Services and Financial Agreement (SFA) pursuant to 2 CCR 502-1, 21.200.481.D and 2 CCR 502-1, 21.200.481.H, as well as in accordance with Chapter 8 of 2 CCR 502-1;
2. Coordination of treatment services;
3. Determination of the fee for the responsible person(s)
4. Completion of CYMHTA ongoing paperwork (notification letters, SFA's, plans of care/fee agreements, status forms, Colorado Child and Adolescent Needs and Strengths (CO CANS) assessment tool);
5. Ongoing assessment of services, including the need to increase, decrease, terminate or deny services, along with the clinical justification/rationale for such assessment;
6. Ongoing assessment of the continued need of CYMHTA funded services by providing a clinical justification and/or rationale;

7. Determination of whether CYMHTA is the most appropriate funding stream for clinically recommended services; and
8. Completion of the CO CANS during the Enhanced Standardized Assessment, every six months while a child or youth is in CYMHTA, and at discharge, unless otherwise specified by BHA.

v. Record-keeping.

1. The BHASO shall maintain a comprehensive clinical record for all children and youth receiving services under CYMHTA, which shall include the monitoring and oversight of the delivery of third-party providers and clinical service plan(s). In accordance with 2 CCR 502-1, 21.200.481.H, as part of the comprehensive Individual clinical records, the following process shall be followed:
    a. In quarter 1 of FY26, all Services and Financial Agreements (SFA) shall be approved by BHA and completed with the appropriate signatures from the BHASO, responsible person, and the Individual as appropriate.
    b. Beginning in quarter 2 of FY26, all SFAs shall be submitted to BHA within 1 business day of completion with appropriate signatures of the responsible person, and the Individual, as appropriate.
        i. Deliverable
            1. DELIVERABLE: Signed SFAs
            2. DUE DATE: within one (1) business day of final signature.
            3. DESTINATION: BHA CYMHTA Program Manager by encrypted email.
    c. The BHASOs shall collaborate to provide a unified statewide projection of the CYMHTA GAE spend rate and balance to BHA on a quarterly basis.
        i. DELIVERABLE: CYMHTA GAE Projections
        ii. DUE DATE: 15 days following the end of the quarter
        iii. DESTINATION: CYMHTA Program Manager and cdhs_BHASO_deliverables@state.co.us
        iv. FILE NAME: BHASO - [BHASO] - FYXX Q[x] CYMHTA GAE Projections

d. If BHA or the BHASO identify through projections that the CYMHTA GAE fund balance is at risk of overspend, BHA or the BHASO will notify the other parties and BHA will make the determination of whether funds can be added to the GAE or if CYMHTA needs to enact a waitlist for services.
e. If the BHASO approves services that are unallowable under CYMHTA, BHA will not reimburse the service and the BHASO will be financially accountable for the service. The BHASO shall provide to BHA a mitigation plan to correct the error identified.
f. BHA will not approve invoices for services that do not have a corresponding SFA.
g. The BHASO shall provide a list of provider rates for approved CYMHTA services to BHA annually at minimum annually for review, with updates as required. The BHASO will seek BHA approval for any rate that has not previously been included in this reporting.
    i. DELIVERABLE: CYMHTA Provider Rates
    ii. DUE DATE: June 1 annually for the upcoming year and as required
    iii. DESTINATION: cdhs_BHASO_deliverables@state.co.us
    iv. FILE NAME: BHASO Region [X] - [BHASO] - FYXX CYMHTA Provider Rates
h. The approved/signed Services and Financial Agreement forms are distributed to families, providers, and any other parties as appropriate and made available to BHA upon request.

vi. Fees.

1. The BHASO shall provide the determination, monitoring, and fiscal oversight of administrative fees, parental fees, and third-party provider fees.

vii. Appeal Process.

1. The BHASO shall complete the internal appeals process, which shall be completed within two (2) business days of a responsible person's request for an appeal due to a denial, termination, increase or decrease of CYMHTA funded services or a recommendation of a child's discharge from funded services, pursuant to 2 CCR 502-1, 21.200.45. If the BHASO

requires additional time to complete the internal review, and the responsible person is in agreement, the BHASO may take up to 5 days to complete the appeal. The internal appeal cannot be subcontracted out and shall be provided internally through the BHASO as part of the administrative overhead and oversight of the program.

viii. Deliverables

1. The BHASO shall submit all deliverables outlined in C.R.S. § 27-67-101, 2 CCR 502-1, 21.200.4, and the CYMHTA mental health agency handbook and procedure manual to BHA according to the instructions below, unless otherwise specified by BHA CYMHTA program manager. This includes annual encounter data submitted covering the previous fiscal year.
    a. DELIVERABLE: CYMHTA Tracking and Monitoring Document
    b. DUE DATE: prior to September 1st of each year
    c. DESTINATION: cdhs_bhaso_deliverables@state.co.us, cdhs_cymhta@state.co.us
    d. FILE NAME: BHASO Region[X] - [BHASO] - FY[XX][Month] - CYMHTA Tracking and Monitoring Document
2. For children and youth seeking CYMHTA funding, the BHASO shall submit all required BHA documentation as outlined in C.R.S. §27-67-105 et. seq., 2 CCR 502-1, 21.200.4, and the mental health agency handbook and procedure manual.

b. Assessments and Documentation

i. For all CYMHTA Enhanced Standardized Assessments that do not result in ongoing treatment services funded through CYMHTA, the BHASO shall submit a CYMHTA status form to ensure funding of the CYMHTA Enhanced Standardized Assessment and corresponding Clinical Care Coordination/case management. The BHASO shall provide BHA with the CYMHTA status form prior to the BHASO's submission of an invoice to BHA using a BHA-approved template.
    1. DELIVERABLE: CYMHTA status form
    2. DUE DATE: prior to invoice submission
    3. DESTINATION: encrypted email to cdhs_cymhta@state.co.us
    4. FILE NAME: BHASO Region[X] - [BHASO] - FY[XX][Month] - CYMHTA Status Form

ii. CYMHTA Enhanced Standardized Assessments

1. BHASO CYMHTA assessors shall be licensed mental health professionals, defined in 2 CCR 502-1 8.3.1(b), who are credentialed to complete Enhanced Standardized Assessments.
2. The CYMHTA Enhanced Standardized Assessment shall be completed in accordance with Exhibit A Part Three - Chapter 11 Article 2 and within three (3) business days of a request (or within twenty-four (24) hours of receipt of an urgent situation request pursuant to 2 CCR 502-1, 21.200.432.G.1.).
3. If the responsible person for the child or youth agrees, then the BHASO may take up to, but no more than fourteen (14) calendar days as outlined in 2 CCR 502-1, 21.200.43.G.3.
4. The BHASO shall conduct quality assurance monitoring for CYMHTA Enhanced Standardized Assessments and comply with the Quality Assurance Process (QAP) outlined in Exhibit A Part Three - Chapter 11 Article 2, unless otherwise specified by BHA.
    a. DELIVERABLE: CYMHTA Quality Assurance Monitoring Plan (QAMP) section in QA Work Plan
    b. DUE DATE: June 30, 2025, for FY26, and March 31 annually in years thereafter for the upcoming fiscal year
    c. DESTINATION: cdhs_bhaso_deliverables@state.co.us
    d. FILE NAME: BHASO Region[X] - [BHASO] - FY[XX][Month] - QA Work Plan
5. The BHASO shall complete an Enhanced Standardized Assessment and notify the responsible person of the clinical recommendations within the time frame orally and in writing following criteria outlined in 2 CCR 502-1, 21.200.43.
6. The BHASO shall ensure that notifications contain all information outlined in 2 CCR 502-1, 21.200.43.I and 21.200.45. The BHASO shall develop and maintain a network of providers for CYMHTA Enhanced Standardized Assessments, ongoing clinical care coordination, and treatment providers.
7. BHA has the right to review all CYMHTA Enhanced Standardized Assessments and corresponding clinical recommendations completed by the BHASO Network.

3.13.1.5 Standards and Requirements

a. The BHASO shall enter into written agreements with the BHASO Network to provide all services outlined in C.R.S. §27-67-101, 2 CCR 502-1, 21.200.4, and the CYMHTA mental health agency handbook and procedure manual.
b. In providing CYMHTA residential services, the BHASO shall use a Qualified Residential Treatment Program, as defined in 26-5.4-102(2), C.R.S. or a Psychiatric Residential Treatment Facility, as defined in 25.5-4-103(19.5), C.R.S.
c. If CYMHTA funded services include a schooling component, the BHASO shall ensure that the youth's school district is notified of the child or youth's service plan. BHA shall not pay for the educational costs.
d. The BHASO shall use the most recent version of the Diagnostic and Statistical Manual of Mental Disorders and the Uniform Service Coding Standards Manual from The Department of Health Care Policy and Financing and the Behavioral Health Administration as applicable, based on services provided.
e. The BHASO shall use the most recent edition of the CYMHTA mental health agency handbook and procedure manual, as well as the most recent documentation and templates from BHA.

3.13.1.6 Service Hours

a. The BHASO shall respond to requests for a CYMHTA Enhanced Standardized Assessment during standard working hours, Monday through Friday.

3.13.1.7 Network Adequacy

a. The BHASO shall establish, grow, and maintain an adequate network of quality providers to meet the needs of the children, youth, and their families, as indicated by the Enhanced Standardized Assessment:
    i. Awareness to expand access.
        1. The BHASO shall work to ensure a network of stakeholders, community partners, and providers, in order to continually increase awareness of the CYMHTA program, benefits, eligibility, and knowledge of how to assist a family in accessing CYMHTA.
    ii. Quality management.

1. The BHASO shall develop and implement a quality assurance monitoring process for their providers.

b. Expansion in the breadth and variety of the BHASO Network shall take into account the pre-existing primary provider network, and the degree of coverage or participation of those providers across an array of commercial insurance plans, to identify and work towards resolving gaps.
c. The BHASO shall provide and grow an adequate network for all services to ensure statewide access for children and youth, securing contracts with direct service providers of children and youth.
d. Establishing referral sources.
    i. The BHASO shall develop and implement an engagement strategy for CYMHTA regionally to support the growth of the CYMHTA program statewide, increase access and knowledge of the CYMHTA program for children, youth, families, and promote the CYMHTA program, in order to establish referral sources.
e. The BHASO is responsible for maintaining a provider list that is available upon request from a responsible person and community stakeholder/partner. Updated versions of this list should be submitted to the BHA quarterly, unless otherwise specified by BHA.
    1. DELIVERABLE: CYMHTA Current Provider List
    2. DUE DATE: Prior to the first days of February, May, August, and November of each year
    3. DESTINATION: cdhs_cymhta@state.co.us
    4. FILE NAME: BHASO Region[X] - [BHASO] - FY[XX][Month] - CYMHTA Current Provider List

3.13.1.8 Staff Credentials and Training

a. Staff Credentials
    i. The BHASO shall ensure, at minimum, that an unlicensed master's level clinician provides the ongoing clinical care coordination/case management services for children and youth receiving CYMHTA services. An unlicensed master's degree provider has a master's degree in a mental health field (including, but not restricted to, counseling, family therapy, social work, psychology, etc.) from an accredited college or university. LSW and unlicensed psychotherapist fall in the unlicensed master's level category. This provider shall be supervised in the

provision of services by a licensed mental health professional, defined in 2 CCR 502-1 8.3.1(b).

ii. The BHASO shall ensure its employees and the employees of its providers who complete CYMHTA Enhanced Standardized Assessments and/or provide ongoing clinical care coordination are certified in the CO CANS and maintain CO CANS certification while providing such CYMHTA services.

b. Training

i. The BHASO shall provide all CYMHTA staff with training in accordance with the BHASO training plan, as well as any other topics BHA finds critical in operating CYMHTA services.

ii. The BHASO shall attend all scheduled CYMHTA liaison meetings hosted by BHA.

iii. The BHASO shall complete any other training or certifications that BHA requires, including, but not limited to, high fidelity wraparound facilitator training.

c. Staffing

i. The BHASO shall ensure a licensed mental health professional as outlined in 2 CCR 502-1, 200.4, completes each CYMHTA Enhanced Standardized Assessment.

ii. The BHASO shall ensure within its own organization and that of its providers, that the same Individual who is providing ongoing Clinical Care Coordination and/or CYMHTA Enhanced Standardized Assessments, does not also provide clinical treatment services or otherwise receive CYMHTA funding for other services.

3.13.1.9 Performance Outcome Measures

a. The BHASO shall maintain records and submit data on all CYMHTA service recipients according to C.R.S. §27-67-105. Data reporting on CYMHTA recipients shall include, but is not limited to the number of children and youth who are at risk of out-of-home placement and whose parent or legal guardian requested residential or community-based care pursuant to section C.R.S. §27-67-104 to whom the following services were provided:

i. An assessment pursuant to section C.R.S. §27-67-104 (1)(a),

ii. Community-based care,

iii. Residential treatment, or

iv. Post-residential follow-up services.

b. The number of children and youth who are at risk of out-of-home placement and for whom a child abuse and neglect referral was made to the county department.

c. The number of children and youth for whom either:
    i. An assessment was requested by not performed, and the reason the assessment was not performed, or
    ii. An assessment was performed but the BHASO Network did not provide services pursuant to C.R.S. §27-67-101 and the reasons that services were not performed, including whether the family refused the services offered.
d. The costs associated with the provision of mental health treatment services described in C.R.S. §27-67-104 (1)(a).
e. The demographic information of the children, youth, and families served.
f. The outcomes of treatment for the children and youth served, as determined by BHA in consultation with mental health agencies, comprehensive and/or essential safety net providers, and families.
g. The length of stay and funding totals for residential services and community-based care.
h. The aggregate number of third-party reviews completed by the state department for children service pursuant to C.R.S. §27-67-101, delineated by children who are and are not categorically eligible for Medicaid.

3.13.1.10 Data Submissions

a. The BHASO shall deliver any 837 Encounter data received for CYMHTA services in accordance with the terms of Exhibit D, as may be amended, Article 2.
b. When CYMHTA funds provision of applicable services, the BHASO Network shall complete a Treatment Episode Report Unified Data Model submission (the successor to former CCAR/DACODS submissions) for each applicable Individual per the technical specification guidelines provided by BHA to BHASOs.

3.13.1.11 Payment

a. The BHASO shall use the Colorado Department of Human Services (CDHS) daily rate for treatment occurring in a Qualified Residential Treatment Program (QRTP) and the HCPF all-inclusive daily rate for treatment occurring in a Psychiatric Residential Treatment Facility (PRTF).
    i. For the behavioral health treatment services provided in a QRTP setting, the residential treatment's Medicaid rate is used.
b. The BHASO shall contract with providers using the following rates:

i. Comprehensive and Essential Safety Net Providers: BHA Essential Provider Fee Schedule in Exhibit B – Rate Schedule, Section 3.1. Comprehensive Providers' PPS does not apply for CYMHTA services.

ii. Non-Safety Net Providers: The BHASO shall negotiate rates for services rendered by providers who are not Safety Net Providers.

c. Treatment provider rates may be determined on an individual basis if there is no other treatment provider available or the service being provided is highly specialized and needed to prevent a child or youth from entering the child welfare system and reduce the risk of out of home placement. The BHASO shall obtain approval directly from BHA when these situations arise.

d. CYMHTA may fund the CYMHTA assessment recommendations with a variety of funding sources, including but not limited to, private insurance, Department of Human Services (DHS) funding, Colorado Youth Detention Continuum (CYDC), and Supplemental Security Income (SSI) and Medicaid affiliated with SSI approval (specific to PRTF/QRTP only).

e. There is a parental fee component for the treatment services being funded by CYMHTA. There is no parental fee affiliated with the CYMHTA assessment, clinical care coordination/case management or interpretation and translation services. The BHASO shall ensure the BHASO Network for the treatment services is collecting the parental fee directly from the responsible person. The BHASO shall not invoice BHA for the parental fee.

f. Invoicing.

i. The BHASO shall invoice for services under CYMHTA (assessment services, clinical care coordination/case management, and reimbursement for treatment providers) on a separate invoice from the general crisis services invoice. BHA shall provide a CYMHTA invoice template upon contract execution. The BHASO shall submit CYMHTA monthly invoices for clinical care coordination, assessments, and treatment providers to cdhs_BHApayment@state.co.us no later than the 20th of the following month, in accordance with BHA's CYMHTA billing process.

ii. The BHASO can bill for interpretation services for Individuals/families receiving CYMHTA funding for the treatment services and CYMHTA clinical care coordination, as well as the translation of Individual specific CYMHTA documents (SFAs, plans of care/fee agreements, and notification letters). The interpretation and/or translation services need to be included on the SFA. If only

the assessment and clinical care coordination is provided, include these services on the CYMHTA status form. There is no parental fee affiliated with translation or interpretation services.

1. CYMHTA assessment rates – See Appendix 1 to Exhibit B, Rate Schedule, Section 13.1.

iii. General Accounting Encumbrances. Payment to BHASO is made from available funds encumbered and shared across multiple BHASOs. The State may increase or decrease the total funds encumbered at its sole discretion and without formal notice to BHASO. No minimum payment is guaranteed to BHASO. The liability of the State for such payments is limited to the encumbered amount remaining of such funds.

Article 2 - Additional Family Services - BHA Program

3.13.2.1 Program Description and Objectives

a. The BHASO shall use Additional Family Services (AFS) funds to provide behavioral health services to Individuals and/or families who are at risk of becoming involved in the child welfare system or who are involved in the child welfare system.

3.13.2.2 Target Population / Eligibility

a. Individuals and/or families with SUD and or mental health diagnosis who are at risk of becoming involved in the child welfare system or who are already involved in the child welfare system.

3.13.2.3 Activities and Services

a. Allowable expenses include, but are not limited to:
   i. Assessment Staff. The BHASO Network shall include SUD and/or mental health providers licensed and trained to assess referred Individuals for the appropriate care needed.
   ii. SUD Residential Room and Board. The BHASO offers funding support for room and board for uninsured/underinsured
   iii. SUD and mental health services. The BHASO makes funds available for the continuum of SUD and mental health treatment services.

iv. Support for Pregnant and Parenting Women. The BHASO Network supports continued SUD residential stays for pregnant and parenting women beyond Medicaid-determined medical necessity, focusing on ongoing clinical necessity. The BHASO also supports investments in specialized supportive services for pregnant and parenting women that could include childcare, vocational support, peer/mentor supports, etc.

v. SUD Recovery Living Home Support. Individuals requiring SUD treatment may gain access to recovery living as a step-down service.

vi. Case Management. Case Management services may be purchased from Providers or may be performed as a service of the BHASO. Case Management definition is in the General Provisions of this Contract under "Intensive Case Management".

3.13.2.4 Deliverables & Data Submissions

a. The Contractor shall submit quarterly reports that include how many individuals and families were served who are involved in child welfare and how many individuals and families were served who were at risk of child welfare involvement.

   i. DELIVERABLE: AFS Quarterly reports
   ii. DUE DATE: Fifteen days after the end of each quarter
   iii. DESTINATION: cdhs_BHASO_deliverables@state.co.us

b. 837 Encounter data as required shall be delivered in accordance with the terms of Exhibit D, as may be amended, Article 2.

c. The BHASO Network shall complete a Treatment Episode Report Unified Data Model submission (the successor to former CCAR/DACODS submissions) for each applicable Individual per the technical specification guidelines provided by BHA to BHASOs.

3.13.2.5 Payment

a. Depending on the service type, the appropriate reimbursement model shall be used by the parties for required repayment of funds analysis.

   i. For capacity reimbursement, the BHASO shall negotiate and record an annual capacity-based budget with each provider utilizing a capacity-based payment methodology. The BHASO shall keep budget up-to-date with providers, and budgets shall be available to BHA upon request.

ii. For fee-for-service reimbursement, see Exhibit B – Rate Schedule for the corresponding service.

Article 3 - Strategic Individualized Remediation Treatment (STIRT) - BHA Program

3.13.3.1 Program Description and Objectives

a. The Strategic Individualized Remediation Treatment (STIRT) program is a continuum of care designed to provide adult Individuals with a history of criminal justice involvement with safe, structured, drug and alcohol-free environments in which to define and examine their relapse and recidivism risk factors, learn alternatives to risky behaviors, implement behavior changes, and increase treatment involvement and compliance with criminal justice supervision requirements.
b. STIRT's primary goal is reducing substance use and re-incarceration rates by applying the Risk Needs Responsivity principles (RNR), and engaging participants in clinical services intended to identify and address substance use disorders, mental health disorders, and criminogenic behaviors. STIRT is a corrections diversion alternative to immediate incarceration for those Individuals struggling to meet compliance with the conditions of release for probation or parole, or participation in problem-solving courts.

3.13.3.2 Target Population and Eligibility

a. Individuals, aged eighteen (18) years or older, who are involved in the criminal justice system, and whose struggle with substance use disorders, criminogenic behaviors, and/or co-occurring mental health disorders puts them at risk of re-incarceration or further penetration into the criminal justice system.
b. STIRT services are provided to adult individuals who are involved in the criminal justice system and are struggling with substance use disorders, criminogenic behaviors, and/or co-occurring mental health disorders that threaten successful recovery and community transition. To be eligible to participate in the STIRT programs, Individuals must:
    i. Be an adult aged eighteen (18) years or older,
    ii. Have a drug and/or alcohol related offense,

iii. Have one or more current or deferred felony or misdemeanor(s) convictions with no pending or new felony charges, except for pretrial navigation referrals,

iv. Have been sentenced to problem solving court or are currently in community corrections, on parole, or on probation,

v. Have a minimum Level of Supervision Inventory (LSI) score of 25, or a minimum Ohio Risk Assessment System's (ORAS) Community Supervision Tool (CST) score of 23 for men or 21 for women, and/or

vi. Have a minimum SOA-R recommended treatment level of 4A, B, or C.

3.13.3.3 Activities and Services

a. STIRT Residential Program Activities and Services.

i. The first phase of the STIRT continuum of care consists of a twenty-one (21) day intensive residential program (ASAM Level 3.5 and/or 3.7) intended to intervene and stabilize Individuals and provide them with the opportunity to start or regain their recovery and transitional footing. The residential program provides highly structured residential services to adults with substance use and/or mental health issues who face imminent incarceration without treatment.

ii. Individuals shall be engaged in a minimum of sixty (60) hours of treatment services (e.g. individual, group, family treatment) and an additional twelve (12) hours of ancillary recovery services (e.g., peer support, AA/NA, other support groups, case management, etc.), over a twenty-one (21) day length of stay (twenty-four (24) hours per week).

1. Each Individual is expected to be engaged in services on a daily basis for the duration of their stay.

iii. Treatment in STIRT Residential shall include a mix of developmental classes, therapeutic/clinical groups, and individual therapy, and/or other services as deemed necessary by the treating agency.

iv. Referrals to the STIRT residential program may come from the following sources:

1. the criminal justice system including but not limited to probation, parole, Problem Solving Courts, or Community Corrections.
2. Treatment providers may initiate a referral to STIRT in collaboration with the criminal justice supervising agency.

3. Where necessary, an Individual may self-refer and enter the residential program component immediately following a successful Withdrawal Management stay.

v. Providers shall utilize evidence-based curricula approved by the STIRT Advisory Committee.
   1. All counselors shall be trained on the evidence-based curricula being used.

vi. Providers shall follow Risk Need Responsivity (RNR) principles when providing treatment.

vii. A STIRT Advisory Committee consisting of treatment providers, referral agencies, and BHA shall be maintained to provide treatment and program guidance.

b. STIRT Withdrawal Management
   i. Withdrawal Management services are offered for Individuals referred to and approved to enter STIRT residential programs but are in need of or are in the process of withdrawal management.

c. STIRT Continuing Care Activities and Services
   i. The second phase of the STIRT continuum is STIRT Continuing Care outpatient programming (STIRT CC) intended for STIRT residential program graduates. An individual can engage in STIRT CC services, including group and individual therapy, psychoeducation, peer support services, and ongoing care management for up to nine months, with possible extensions as needed on an individualized basis.
   ii. STIRT CC service providers must have a BHA license, ASAM Level 1, ASAM Level 2.1, or ASAM 2.5, in good standing, to provide services to Persons Involved in the Criminal Justice System.
   iii. Individuals are expected to engage in the STIRT CC program within two weeks (fourteen (14) calendar days) of successful discharge of the residential program. If an Individual requests enrollment into the STIRT CC program beyond the two-week period when they were successfully discharged from a STIRT residential program, the Continuing Care provider shall first screen the Individual to determine if this level of care is still appropriate to address their needs.

iv. STIRT CC services are intended to be a step-down in the continuum of care and may be provided in intensive outpatient (ASAM Level 2.1), enhanced outpatient, and traditional outpatient (ASAM Level 1) settings.

v. Individuals' initial service plans shall include appropriate sobriety monitoring services, e.g. Breathalyzers, UAs, SCRAM, etc., to help stabilize Individuals in the community setting.

vi. Providers should utilize evidence-based curricula approved by the STIRT Advisory Committee.

1. All counselors shall be trained on the evidence-based curricula being used.
2. Providers may also petition the committee for the addition of curricula or treatment methods appropriate to this population.

vii. STIRT Continuing Care funds may be used to purchase clinically-appropriate primary recovery services and pro-social community re-entry activities.

viii. Case Manager Salary (Capacity);

1. STIRT providers may submit a proposal to their BHASO for funding to implement and support case manager services.

ix. Up to three months' rent at an Oxford House chartered or CARR-certified Recovery Residence (Capacity)

1. Maximum monthly costs paid to any recovery residence shall be reimbursed per the Exhibit B-2 Rate Schedule Section VII for the recovery living community.

x. STIRT Continuing Care funds may be allotted to contracted provider agencies to allow maintenance of appropriate staffing to provide STIRT Continuing Care services. (Actual Expenses)

1. Allowable expenses for Continuing Care personnel include staff salaries, printing/postage, rent, staff development (must be related to clinical services), staff phone, and indirect costs, allocated in proportion to the benefit to the program.
2. Funding for personnel expenses is only available to BHASO-contracted providers

xi. Non-Personnel STIRT Continuing Care service funds are available to all service providers with the appropriate BHA licensing to provide services to persons involved in the criminal justice system, regardless of BHASO-contracted status.

d. STIRT Prescription Medication Assistance Activities and Services

i. The STIRT Prescription Medication Assistance (Rx) funds are allocated to provide assessments and medications for Individuals in treatment with co-occurring mental health disorders who have no other resources to obtain mental health services and/or medication.

ii. STIRT Rx funds provide psychiatric evaluations, psychotropic medications, staff time, and other services associated with co-occurring treatment.

iii. These funds are available to Individuals participating in STIRT Residential (ASAM Level 3.5 and/or 3.7) and/or STIRT Continuing Care (ASAM Level 1 and ASAM Level 2.1), regardless of BHASO-contracted status of the Provider.

iv. STIRT Rx funds are available to all service providers with the appropriate BHA license to provide STIRT CC services, regardless of BHASO-contracted status of the provider

e. STIRT Transportation Activities and Services

i. Transportation services may be purchased to transport individuals who have verified transportation barriers to access treatment.

ii. Allowable expenses are bus tickets, taxis or car services, and mileage for provider vehicles at the IRS rate. In rural locations that do not have access to transportation services including a bus system or taxi cabs, special arrangements can be made to eliminate transportation barriers.

iii. These funds are available to Individuals participating in STIRT Residential (ASAM Level 3.5 and/or 3.7) and/or STIRT Continuing Care (ASAM Level 1 and ASAM Level 2.1).

iv. Transportation funds are available to all service providers with the appropriate BHA license to provide STIRT CC services, regardless of BHASO-contracted status of the Provider.

f. Training

i. Training funds are available to help develop STIRT staff skills and keep them knowledgeable of the latest research and advancements for working with the criminal justice populations.

ii. The BHASO shall work with STIRT providers to identify staff training needed to obtain and maintain quality care across the continuum.

iii. Training paid for with STIRT funding shall be made available to STIRT residential and Continuing Care programs and staff, both contracted and non-contracted.

iv. When training is developed by a provider and training capacity cannot be met by that provider, the program shall make every effort to fill available training slots with participants from other STIRT residential or Continuing Care program staff before requesting the training.

v. The BHASO shall submit requests for training to the BHA STIRT Program Manager before costs are incurred. Only approved training shall be reimbursable under this section. Requests should include the following information:

1. The training requested,
2. The name, position, and credentials of the individual submitting the training request,
3. Indication as to whether this training requires an approved trainer;
4. The name of the trainer and cost for the training,
5. Capacity of the training for number of participants,
6. Length of training (days and time),
7. Indication as to whether other STIRT programs coordinated the training event with the requesting provider,
8. Participants' names, credentials, positions, and programs,
9. Location of training, and
10. Additional costs.

vi. Funds cannot be used to rent a facility/location, pay for staff transportation or lodging, or provide refreshments.

3.13.3.4 Standards and Requirements

a. The funds for the STIRT program originated as a JBC allocation from the Correctional Treatment Fund (formerly Drug Offender Surcharge (DOS) fund) and were partially matched with block grant funds.

b. BHA manages the STIRT program, in coordination with the BHASO, and with input from stakeholders who make up the STIRT Steering Committee. BHA shall not directly

communicate or manage performance with STIRT providers. BHA shall meet with the BHASO monthly to oversee the management of STIRT programs.

3.13.3.5 Level of Care and Licensing Requirements

a. BHA Substance Use Disorder Treatment agencies providing STIRT intensive residential services must be BHA licensed to provide services to persons Involved in the Criminal Justice System at an ASAM Level 3.5
b. Agencies providing STIRT Continuing Care services must be BHA licensed to provide services to persons Involved in the Criminal Justice System at ASAM Level 1 and/or ASAM Level 2.1 outpatient settings.
c. Agencies providing Withdrawal Management services must be BHA licensed at 3.2 WM (Clinically Managed Residential Withdrawal Management) or 3.7 WM (Medically Monitored Inpatient Withdrawal Management).

3.13.3.6 Data Submissions

a. 837 Encounter data shall be delivered in accordance with the terms of Exhibit D, as may be amended, Article 2.
b. The BHASO Network shall complete a Treatment Episode Report Unified Data Model submission (the successor to former CCAR/DACODS submissions) for each applicable Individual per the technical specification guidelines provided by BHA to BHASOs.

3.13.3.7 Payment

a. The BHASO shall negotiate and record an annual capacity-based budget with each provider utilizing a capacity-based payment methodology. The BHASO shall keep budget up-to-date with providers, and budgets shall be available to BHA upon request.
b. STIRT Withdrawal Management and Continuing Care reconcile to fee for service based on Exhibit B - Rate Schedule, Section 13.2.
c. Co-pays for STIRT Continuing Care may not be more than five dollars ($5.00) per person per session.
d. BHA shall not pay for vacant Full Time Equivalent/positions for STIRT Continuing Care Personnel.

e. Criteria governing payment for continued service in STIRT residential settings when authorization for medical necessity expires are found in the Medicaid Residential Treatment Continuing Stay Criteria, incorporated by reference, as may be amended.

Article 4 - Ridge View Supportive Residential Community (Substance Use Continuum Services)

3.13.4.1 Program Description and Objectives

a. The Supportive Residential Community (SRC), is a community where residents can recover from homelessness, find long-term housing stability, and reintegrate into their community of choice. The SRC shall provide a continuum of care informed by American Society of Addiction Medicine Standards (ASAM), which shall be available to people coming from the transitional housing program and to the general public deemed to be in medical need of care.
b. The Colorado Department of Local Affairs Division of Housing (DOH) contracts the funding for this project to the Colorado Department of Human Services, Behavioral Health Administration (BHA) to contract with a Behavioral Health Administrative Services Organization (BHASO) for purposes of providing withdrawal management and substance use disorder services on the Supportive Residential Community (SRC) Campus located at 28101 East Quincy Avenue, Watkins, CO 80137.
c. The BHASO shall procure a licensed vendor or vendors to provide services for ASAM level 3.2WM or 3.7WM, withdrawal management, ASAM 3.7 medically-monitored residential treatment, ASAM level 3.5, clinically managed high-intensity residential treatment, ASAM 2.1 intensive outpatient substance use disorder (SUD) services, and ASAM 1.0 outpatient SUD services. Additionally, the BHASO shall procure a vendor to offer recovery support services.
d. Withdrawal management services should be offered onsite preferably but could be offered through coordination with offsite facilities that includes transportation and active transfer by staff of the offsite facility or the SRC.
e. Services shall begin to be operational no later than September 1, 2025.

3.13.4.2 Statutory Rule and Citation

a. Withdrawal Management Services shall be performed in accordance with requirements set forth in Part 5.6 (ASAM Level 3.2-WM) and/or 5.10 (ASAM Level 3.7-WM) as well as all applicable regulations in Chapter 2 and Chapter 5 of 2 CCR 502-1.
b. BH Residential services shall be performed in accordance with requirements set forth in Chapter 5 of 2 CCR 502-1.

3.13.4.3 Target Population and Eligibility

a. Program Eligibility
    i. Participants receiving services funded through this SOW, must be 18 years or older and be experiencing homelessness or at imminent risk of experiencing homelessness.
    ii. Participants shall have a history or diagnosis of substance use disorder.
    iii. Services will be voluntary and driven by individual choice. Recognizing that individuals may initially or periodically refuse assistance or services, SUD provider(s) will assertively and creatively engage Participants including outreaching on campus Participants multiple times to maximize participation in treatment services.

3.13.4.4 Activities and Services

a. Activities
    i. BHA shall have the authority in administering the SUD contract with Region 4 BHASO as described herein.
    ii. BHA is responsible for directing and overseeing the terms of this Statement of Work (SOW) and the requirements established for the BHASO to procure a provider for this specific work at the SRC.
        1. The BHASO shall provide technical assistance and subject matter expertise to DOH and BHA in support of activities funded under this Statement of Work.
        2. The BHASO shall oversee the selection process for subrecipient(s) funded to provide SUD services as described in this SOW and ensure inclusion of DOH.

3. The BHASO shall provide training, technical assistance, and monitoring of subrecipient(s).
4. The BHASO shall monitor overall progress and quality of the SUD services, both the methods used to develop it and the end deliverables.
5. The BHASO shall manage monitoring and evaluation through the monitoring and evaluation process.
6. The BHASO shall resolve conflicts and remove obstacles to progress.
7. BHA in collaboration with the BHASO shall represent the Project in interagency meetings.
8. BHA in collaboration with the BHASO shall provide regular updates regarding progress and outcomes to DOH.
9. The BHASO shall author and submit a quarterly and annual report regarding progress and outcomes to BHA and DOH leadership.
10. The BHASO shall coordinate services with other onsite vendors as needed including health clinic, transitional housing provider, and facilities manager.
11. The residential treatment and withdrawal management subrecipient(s) will partner with campus food vendor to provide appropriate food services to participants.

iii. The responsibilities of DOH include:

1. Collaborate with the BHASO to review and approve applications from treatment organizations to provide services described herein, and review resulting contracts.
2. Review deliverables and collaborate with BHA on all aspects of this Agreement.
3. Oversee project to ensure fiscal and contractual requirements are met.
4. Approve any deviations from the outlined work plan.
5. Monitor services funding and outcomes analysis and services funding model process and outcomes in coordination with BHA.
6. Assist BHA with resolving conflicts and removing obstacles to progress.
7. Review the BHASOs annual report.

b. Services
    i. The onsite Substance Use Treatment at the SRC is as defined by ASAM Care Continuum for Addiction Treatment, as shown in Figure 1. The operational costs assume the following levels of treatment and recovery services:
        1. Level 3 Residential:
            a. Level 3.7 is Medically Managed Residential.
            b. Level 3.5 is Clinically Managed High-Intensity Residential.
        2. Level 2 Intensive Outpatient:
            a. Level 2.1 is IOP services consisting of at least 9 and no more than 20 hours per week of treatment.
        3. Level 1 Outpatient:
            a. Level 1 outpatient treatment consists of treatment for substance use that is less than 9 hours a week. Level 1 is appropriate for people with less severe disorders, or as a step down from more intensive services.
        4. Withdrawal Management
            a. Level 3.7 WM is Medically Monitored Inpatient Withdrawal Management
            b. Level 3.2WM is Clinical-Managed Residential Withdrawal Management
        5. Controlled Substance License from BHA.
        6. Recovery Support Services.
c. Treatment Volume and Service Model
    i. Anticipated treatment volume is as follows:
        1. SUD Residential Treatment (ASAM 3.5 and 3.7)
            a. Two patients per room or 12 per pod
            b. 24 in ASAM 3.5 and 12 in ASAM 3.7
        2. Intensive Outpatient (ASAM 2.1)
            a. 50 people staying 6 weeks in the on campus Transitional Housing component.
        3. Outpatient Treatment (ASAM 1.0)
            a. 100 people per full time equivalent (FTE)

ii. Service Model:

1. Substance Use Treatment services staff shall provide services using current best practice models, such as Housing First, Medication Assisted Treatment, Harm Reduction, Motivational Interviewing, and Trauma-Informed Care. Other services and treatment models, such as Assertive Community Treatment (ACT), modified ACT, or Intensive Case Management, may be coordinated with or incorporated into the services programming based on the Participants served. The delivery of all services will be guided by the principles of cultural competence, recovery and resiliency, with an emphasis on building Participants strengths and resources in the community with family, and with Participant peer/social network.

d. Evaluation

i. DOH and BHA will agree upon scope of program monitoring and evaluation of the implementation, outcomes, impacts and/or cost benefits/avoidances of the SUD treatment program, in collaboration with the Region 4 BHASO.

ii. DOH will manage, and if needed, procure services for program monitoring and evaluation to examine implementation, outcomes, impacts, and/or cost benefits/avoidances in accordance with Colorado State Procurement Code to eligible applicants as applicable.

iii. Services funded through these sources shall be provided during the timeframe of this Agreement (between DOH and BHA, and subsequently between BHA and Region 4 BHASO) and be renewed based upon performance and funding availability.

3.13.4.5 Service Hours

a. Withdrawal Management and Residential Services shall be open 24 hours a day, 7 days a week.

i. Admissions to Withdrawal Management should be available 24 hours a day, 7 days a week.

ii. Admission to residential treatment modalities may be scheduled at regular intervals, Monday-Friday, but may be more often.

b. IOP and OP services should minimally be available Monday-Friday

3.13.4.6 Data / Deliverables

a. Data Submissions
    i. 837 Encounter data shall be delivered in accordance with the terms of Exhibit D, as may be amended, Article 2.
    ii. The BHASO Network shall complete a Treatment Episode Report Unified Data Model submission (the successor to former CCAR/DACODS submissions) for each applicable Individual per the technical specification guidelines provided by BHA to BHASOs.

b. Annual Report.
    i. Programmatic documentation will be required through submission of an annual report that includes, but is not limited to:
        1. Demographic information
        2. Program Admission and Discharge dates
        3. Housing Status
        4. Connection to Healthcare and/or public benefits
    ii. Annual report is due from Region 4 BHASO to BHA, no later than October 31st. Report should include progress and outcome information and the required data points.
        1. DELIVERABLE: Annual Report
        2. DUE DATE: October 31st annually
        3. DESTINATION: cdhs_bhaso_deliverables@state.co.us
        4. FILE NAME: BHASO Region[X] - [BHASO] - FY [Prior year FY] - SRC Annual Report

3.13.4.7 Payment

a. This service may be paid on a fee for service and/or capacity basis.
    i. If this service is paid on a fee for service basis, this service reconciles to rates found in Exhibit B, Rate Schedule, Section 13.3.
    ii. The BHASO shall negotiate and record an annual capacity-based budget with each provider utilizing a capacity-based payment methodology. The BHASO shall keep budget up-to-date with providers, and budgets shall be available to BHA upon request.

Article 5 - Involuntary Commitment Services (SUD) - BHA Program

3.13.5.1 Program Description and Objectives

a. The purpose is to expedite placement of involuntarily committed Individuals into treatment, reduce the wait time for Individuals in Withdrawal Management facilities, and improve the outcomes for Individuals treated under Involuntary Commitment (IC) processes.

3.13.5.2 Statutory and Rule Citation

a. Involuntary Commitment Services shall be performed in accordance with C.R.S. 27-81-111, §27-81-112 and BHA Rule Chapter 7 of 2 CCR 502-1.

3.13.5.3 Target Population and Dispatch

a. Individuals under an Involuntary Commitment order pursuant to C.R.S. §27-81-112.
    i. Notwithstanding any other provision of this section to the contrary, Emergency and Crisis Services must be available to any Individual who is experiencing a behavioral health crisis, regardless of whether the Individual is a Priority Population.

3.13.5.4 Activities and Services

a. The BHASO shall work collaboratively with BHA to ensure placement at the ASAM level approved by the BHA IC Team in order to facilitate timely treatment admission, service provision, and continuity of care by utilizing facilities offering the appropriate level of care for each Individual.
b. The BHASO shall ensure that all funded Withdrawal Management facilities:
    i. Follow IC guidelines created by BHA IC Team to ensure legislative mandates and applicable rules are followed regarding Emergency Commitment (EC) holds and IC processes.
    ii. Have access to a physician licensed to practice medicine in the State of Colorado for assessments and physician certificates as well as medication evaluations.
    iii. Submit a biopsychosocial assessment and an ASAM assessment and attend a meeting with BHA and BHASO to review assessments of Individuals at least four business days prior to the court date.

1. Once an assessment is received from the BHASO Network, and the meeting to review the assessments has occurred, BHA shall give recommendations of placement/stipulation for the proper ASAM level of care.

iv. Coordinate and provide clinically appropriate transportation to ensure continuity of care, (e.g. into care, between levels of care, to medically necessary appointments, and to court dates related to the commitment/re-commitment hearings) as required.

v. Provide Individuals with medication and psychiatric evaluations where clinically indicated. Prior written approval from BHA is required if ancillary funds are being utilized for these services.

c. The BHASO shall ensure that all subcontractors providing IC Individuals Substance Use Treatment and services:

i. Follow IC guidelines created by BHA IC Team to ensure adherence to legislative mandates and applicable rule regarding EC holds and IC processes.

ii. Coordinate and provide clinically appropriate transportation to ensure continuity of care, (e.g. into care, between levels of care, to medically necessary appointments, and to court dates related to the commitment/re-commitment hearings) as required.

iii. Provide Individuals with medication and psychiatric evaluations where clinically necessary with written approval from BHA.

d. The BHASO shall adhere to the following when working with IC Individuals:

i. Collaborate with BHA IC team, and direct their subcontractors providing Withdrawal Management, EC holds, substance use treatment, and other related services to follow applicable guidelines created by BHA IC team to ensure timely and appropriate care that is in alignment with current legislation and rule.

ii. Provide placement of Individuals in a licensed facility at the appropriate level of care within five business days of the stipulated order or committed order being received, except for reasons of delay outside of the BHASO's direct control.

iii. Coordinate treatment admissions and transfers between treatment programs at every level of care throughout the IC.

iv. Ensure admission updates and status of treatment admission be communicated to the BHA IC Team at least one business day prior to the IC petition court date.

v. Coordinate with BHA for the IC recommitment process by obtaining a physician certification and appropriate assessments from providers within 21 days of the current commitment order expiring.

vi. Assess providers within its network and outside of its network to determine the most appropriate treatment provider for the needs of the Individual within the required ASAM level of care.

vii. Induct Individuals into Medication Assisted Treatment with consent of the Individual and as clinically appropriate, per the terms of Section V.C. Medication Assisted Treatment and overdose prevention programs below.

viii. The BHASO shall contract with agencies to provide adjunct supplementary services that align with court orders, such as monitored sobriety.

ix. The BHASO shall refer Individuals to a high-acuity peer prior to initial admission.

x. The BHASO shall coordinate care with the Medicaid RAE care coordinator for all Individuals with Medicaid benefits.

xi. In the event of a Critical Incident, the BHASO shall ensure they and the BHASO Network follow all required processes to report the incident within twenty-four (24) hours of the incident by submitting a Critical Incident report and notifying BHA IC team.

xii. The BHASO shall meet weekly with BHA IC Team to review IC cases.

xiii. Review the number of Individuals and the associated costs on a quarterly basis with BHA IC team to monitor funding and expenditures.

1. BHA shall issue care coordination payments to the BHASO to cover costs associated with managing an IC treatment.
2. BHA shall reimburse medications and monitored sobriety methods at cost for Individuals without insurance or the ability to pay. Other ancillary fees to be approved by BHA using the ancillary approval form on a case-by-case basis.

2. Assessments and Documentation

a. The BHASO Network shall complete ASAM level of care assessments with all Individuals at the time of initial IC filing, at readmission to WM, and updated monthly during treatment and during the recommitment process if the ASAM in the monthly report was completed more than ten (10) days prior.

b. The BHASO Network shall complete a biopsychosocial assessment with all Individuals at the time of initial IC filing.
c. The BHASO shall submit or provide access to BHA IC Team a monthly report of ICs filed, using the template mutually agreed upon by BHA, BHASO, and the BHASO Network, indicating:
    i. the number of IC petitions filed in its region,
    ii. by provider/county/primary substance, number of Individuals that readmit to WM,
    iii. length of time Individuals wait for their next treatment following a readmit to WM,
    iv. number of elopements from treatment,
    v. distribution of Individuals by level of care,
    vi. number of high acuity peer contacts,
    vii. number of Individuals inducted on MAT,
    viii. number of Individuals in a recovery residence,
    ix. length of time from stipulation/commitment to initial placement, number of clinical hours each Individual receives;
    x. Individuals with a co-occurring diagnosis,
    xi. those accepting of medication management,
    xii. and receiving treatment for co-occurring diagnoses,
        1. DELIVERABLE: IC Monthly Report
        2. DUE DATE: the 20th of the following month
        3. DESTINATION: secure electronic format to cdhs_bha_ic@state.co.us
        4. FILE NAME: BHASO Region[X] - BHASO - FY[XX][Month] - [NAME OF DELIVERABLE]

3.13.5.5 Standards and Requirements

a. The BHASO shall require and verify the BHASO Network's compliance with the requirement that an Individual who is involuntarily committed to treatment may not be charged a fee as a condition of admission to the program.
b. The BHASO shall identify an IC coordinator team for each IC to act as a care coordinator for Individuals, to facilitate communication with the BHA IC team and to problem-solve challenging cases.

c. The BHASO shall submit quarterly reports to the BHA IC team on re-admittance or attendance rates of Individuals whose IC has been dismissed within the past ninety (90) days to the following services: withdrawal management centers and treatment programs. Reports are due quarterly on the twentieth (20th) day of the month following the end of the quarter. Please reference Data Dictionary described in Exhibit D, Appendix 1, as may be amended, to verify most up-to-date format and requirements.
   i. DELIVERABLE: IC Quarterly Report
   ii. DUE DATE: the 20th of the following month
   iii. DESTINATION: secure electronic format to cdhs_bha_ic@state.co.us
   iv. FILE NAME: BHASO Region[X] - BHASO - FY[XX][Month] - IC Quarterly Report
d. MEETING: The BHASO shall meet quarterly with the BHA IC team to discuss budgets, best practices, and review process improvements.
e. Monitor compliance of the entities within the BHASO Network who provide services for IC Individuals with those portions of BHA Rules pertaining to IC Individuals (Chapter 7 of 2 CCR 502-1) and with the expectations outlined in BHA IC provider guides.
f. Monitor compliance by the BHASO Network who provide Withdrawal Management services with those portions of the BHA Substance Use Disorder treatment rules pertaining to the emergency commitment of Individuals appropriate for this procedure (Part 7.2 of 2 CCR 502-1).
g. In the event that Withdrawal Management services are discontinued at a funded facility in its region, the BHASO shall follow the standards set forth in part 2.25 of 2 CCR 502-1.

3.13.5.6 Service Hours

a. Withdrawal Management and residential substance use disorder treatment programs shall be open and provide services twenty-four (24) hours per day, seven (7) days per week, 365 days per year.

3.13.5.7 Licensing Requirements

a. Agencies within the BHASO Network shall obtain a BHE license with appropriate substance use disorder endorsements, including an endorsement to serve emergency and involuntary commitment Individuals.

3.13.5.8 Staff Credentials and Training

a. Staff credentials shall follow standards set forth in BHA Rule Part 5.2.2 of 2 CCR 502-1.
b. The BHASO shall ensure that all funded withdrawal management sites have identified staff who are trained in the EC/IC process and act as facilitators with the BHA IC Team for Individuals awaiting hearing or awaiting new placement.

3.13.5.9 Data Submissions

a. 837 Encounter data shall be delivered in accordance with the terms of Exhibit D, as may be amended, Article 2.
b. The BHASO Network shall complete DACODS or a Treatment Episode Report Unified Data Model submission for each applicable Individual per the technical specification guidelines provided by BHA to BHASOs.

3.13.5.10 Payment

a. This service reconciles to fee-for-service at the rates found in Exhibit B - Rate Schedule Section 13.4 and13.5.
b. This section is included in the Involuntary Commitments GAE.
    i. Payment to BHASO is made from available funds encumbered and shared across multiple BHASOs. The State may increase or decrease the total funds encumbered at its sole discretion and without formal notice to BHASO. No minimum payment is guaranteed to BHASO. The liability of the State for such payments is limited to the encumbered amount remaining of such funds.
c. Payment to the BHASO for IC Services provided by providers performing IC petition filings, authorized transports, authorized physician certificates and evaluations, and engagement of Individuals after the IC as described in this contract shall be made as earned, in whole or in part, from the available funds encumbered for the Involuntary Commitment Services program. At any time, the liability of the State for such payment shall be limited to the encumbered amount remaining of such funds.
d. The New IC Filing Care Coordination Case Rate payment shall be distributed to the BHASO originating each new IC petition via the Contract's standard invoicing procedure. Once an IC petition is filed in a county, the BHA shall count that Individual as an IC Individual for purposes of receiving the care coordination payment.

e. The BHASO originating the IC petition shall receive the Withdrawal Management, Outpatient, or Residential contract payments for the treatment of the Individual.
f. If the Individual is placed outside of the BHASO originating the IC petition, that BHASO shall reimburse the region providing the treatment services the applicable rate identified in the receiving BHASO's contract.
g. An additional Post-IC Engagement Care Coordination payment shall be distributed to the BHASO via the Contract's standard invoicing procedure for each Individual that receives at least four treatment (non-withdrawal management) services within forty-five (45) days after the IC court order has been dismissed.

Chapter 14

Capacity Support and Expansion Funding Streams

Article 1 - Senate Bill 16-202 - Increasing Access to Effective Substance Use Disorder Services Act

Article 2 - Building Substance Use Disorder Treatment Capacity in Rural and Frontier Colorado Grant Program (HB 19-1287)

Article 1 - Senate Bill 16-202 - Increasing Access to Effective Substance Use Disorder Services Act

3.14.1.1 Program Description and Objectives

a. It is the intent of the general assembly that each BHASO use money allocated to it from the marijuana tax cash fund to cover expenditures for substance use disorder services that are not otherwise covered by public or private insurance. Each BHASO may use its allocation from the marijuana tax cash fund to implement its community action plan, including expenditures for substance use disorder services and for any start-up costs or other expenses necessary to increase capacity to provide such services.
b. Annually the BHA completes a SMART Act (State Measurement for Accountable, Responsible, and Transparent Government Act) report to the Joint Budget Committee based on the annual reports provided by the BHASOs. Areas of work highlighted in this report and requested that BHASOs provide specific reporting on are Medication Assisted Treatment and MAT Expansion; Recovery Support Services; Withdrawal Management and Treatment Sustainability, Prevention and Early Intervention, and Care Coordination/Care Navigation.

3.14.1.2 Statutory Citation

a. Increasing access to effective SUD services shall be performed in accordance with C.R.S. §27-60-107.5

3.14.1.3 Target Population / Eligibility

a. The BHASO shall use funds appropriated under this Article 1 to cover expenditures for substance use disorder services that are not otherwise covered by public or private insurance.

3.14.1.4 Activities and Services

a. The BHASO shall use money allocated to it from the marijuana tax cash fund pursuant to this Article 1 to cover expenditures for and increase access to substance use disorder services that are not otherwise covered by public or private insurance. The services shall fall within the continuum of substance use disorder services, including prevention, treatment, and recovery support services.
    i. The BHASO shall submit an annual report to BHA concerning the amount and purpose of actual expenditures under this contract in the prior fiscal year. The report must contain a description of the impact of the expenditures on addressing the needs that were identified in the initial and any subsequent community assessments and action plans developed by the BHASO.
        1. DELIVERABLE: SB-202 Annual Report
        2. DESTINATION: cdhs_BHASO_deliverables@state.co.us
        3. DUE DATE: September 1 annually
        4. FILE NAME: BHASO Region[X] - [BHASO] - FY[XX] - SB-202 Annual Report

3.14.1.5 Payment

a. In consideration of the provision of services and reporting as set forth herein and subject to all payment and price provisions herein and further subject to verification by BHA of full and satisfactory compliance with the terms of this Contract, BHA shall cause to be paid to the BHASO a sum not to exceed the applicable amount listed in Exhibit B, Budget.
b. For each state fiscal year beginning July 1, BHA shall disburse one hundred percent (100%) of the SB202 funds for the then current state fiscal year.
c. On or after July 30th annually, BHA shall review the BHASO's final report of actual expenditures and conduct a reconciliation between disbursements and actual expenditures. BHASOs shall track their expenditures and other revenue sources utilizing the appropriate reimbursement model described in letter e below.

d. Any carryover funds disbursed from BHA to the BHASO for substance use disorder services hereunder, without corresponding expenses incurred in the previous two contract years, shall be considered unearned by the BHASO and shall require a repayment of funds from the BHASO to BHA no later than September 15th of the following state fiscal year.
e. Depending on the service type, the appropriate reimbursement model shall be used by the parties for required repayment of funds analysis.
    i. For capacity reimbursement, the BHASO shall negotiate and record an annual capacity-based budget with each provider utilizing a capacity-based payment methodology. The BHASO shall keep budget up-to-date with providers, and budgets shall be available to BHA upon request.
    ii. For fee-for-service reimbursement, see Exhibit B – Rate Schedule for the corresponding service.
        1. Fee-for-service reimbursement requests shall use the BHA Special Studies Code “SB202”.
    iii. For services modeled with a case rate, the parties shall develop a case rate methodology, with supporting service data.
f. Funding should be expensed in compliance with the first in first out (FIFO) method. Funding that has been designated “carry-over” from a prior year, with approved State spending authority, must be spent first. Current year funding must be spent only after the approved carry-over funding has been spent, unless otherwise designated or with prior BHA approval. Carryover must be booked in the BHASO’s accounting system as restricted reserves. The BHASO must report these reserves to BHA as part of its yearly financial audit.
g. Both parties agree that BHA has the right to offset against funds otherwise payable pursuant to this contract based on discovery of overpayment or improper use of funds pursuant to any contracts between the parties. “Overpayment or improper use of funds” is interpreted to apply to specific terms of prior year contracts and includes without limitation requirements of BHA’s Accounting and Auditing Guidelines, Generally Accepted Accounting Principles issued by the American Institute of Certified Public Accountants, and applicable sections of the Colorado Revised Statutes.
h. The BHASO is eligible for any Cost-of-Living Adjustment (COLA) increases as appropriated by the Colorado General Assembly and approved by BHA.
i. Capital costs are allowable expenses under this Article 1.

Article 2 - Building Substance Use Disorder Treatment Capacity in Rural and Frontier Colorado Grant Program (HB 19-1287)

3.14.2.1 Program Description and Objectives

a. HB19-1287 created a grant program to fund treatment capacity in rural and frontier communities. The funds are appropriated to the BHA through this House Bill and extended through SB21-137.
b. Each Region that consists of at least fifty percent (50%) rural or frontier counties shall receive an equal portion of the annual grant program funds to disburse through local grants. The grants must be used to increase access to a continuum of substance use disorder treatment and recovery services, including medical or clinical detoxification, residential treatment, recovery support services, and intensive outpatient treatment. Applicants may include capital costs in their funding requests.
c. The BHASO shall run the grant application process herein described and subcontract with local governments, municipalities, counties, schools, law enforcement agencies, and primary care or substance use disorder treatment providers within or outside of the BHASO's network of providers to receive grant funds to increase substance use disorder treatment services and capacity.

3.14.2.2 Statutory Citation

a. Building SUD treatment capacity in rural and frontier Colorado shall be performed in accordance with C.R.S. §27-80-120.

3.14.2.3 Activities and Services

a. BHASOs shall honor the second year of the two-year grants made by the Managed Service Organizations in Fiscal Year 2026.
b. BHA shall work with the BHASO to draft a statewide grant application template to distribute to interested parties in qualifying Regions.
c. The BHASO shall post the grant application for public response for a length of time designated in the grant application.
d. The BHASO shall convene a grant committee to review grant applications and, if approved, award local grants.
    i. The grant committee shall include two members appointed by the county commissioners in the relevant Regions, two representatives from the BHASO,

and two members representing BHA and appointed by the BHA Commissioner or their delegate.

ii. The award of a local grant must be approved by a majority of the members of the grant committee.

iii. In approving a local grant, the grant committee shall prioritize geographic areas that are unserved or underserved.

iv. After local grants are approved for each Region, the BHASO shall enter subcontracts with selected grantees for the approved services. The BHASO shall be responsible for the delivery of all services set forth in the approved grant applications.

e. After local grants are approved for each Region, BHA shall disburse grant program money to the BHASO for distribution to local grant recipients.

f. If the BHASO and a grantee are unable to reach agreement in a contract within sixty (60) days after the initial outreach to winning grantees, the BHASO may cancel the award and reallocate funds to other grantees selected by the selection committee herein described.

g. The BHASO may reallocate funds that are identified to be underspent to other grantees selected by the selection committee herein described.

h. The BHASO shall use local grants to ensure that local communities increase access to a continuum of substance use disorder treatment services, including medical or clinical detoxification, residential treatment, recovery support services, and intensive outpatient treatment, including the capital costs associated with the grant proposals.

i. Local governments, municipalities, counties, schools, law enforcement agencies, and primary care or substance use disorder treatment providers whether previously or not a subcontractor of the BHASO's network of providers may apply for a local grant to provide services.

j. The BHASO shall include local grantees in Quality Assurance site visits and reporting described in Exhibit A, Part One, Chapter 8, Article 1.

k. The BHASO shall manage all fiscal and administrative aspects of the area-wide system, including but not limited to sub-contracting and efficient, timely and accurate billing and payment procedures affecting all network providers; receive and disburse the funds from this Contract. All subcontractors shall receive payment within 45 days of their date of billing the BHASO, unless otherwise agreed by all affected parties, subject to receipt of payment from BHA.

3.14.2.4 Standards and Requirements

a. To be eligible to receive grant funds under this program, a Region must consist of at least fifty percent rural or frontier counties out of total counties in the Region.
b. Any treatment providers selected by the grant program must be licensed to provide substance use disorder treatment services as specified in 2 CCR 502-1 Behavioral Health Rules.
c. BHASO shall provide the State with information about actual expenditures of the grant awards quarterly in the HB-1287 Expenditures Report template provided by BHA.
    i. DELIVERABLE: HB-1287 Expenditures Report
    ii. DESTINATION: cdhs_BHASO_deliverables@state.co.us
    iii. DUE DATE: Last working day of the month following the end of the quarter (i.e. the last day of October, January, and April)
    iv. FILE NAME: BHASO Region[X] - [BHASO] - FY[XX] - HB-1287 Expenditures Report.

3.14.2.5 Payment

a. Money appropriated to BHA for the grant program that remains unexpended and unencumbered at the end of the fiscal year is further appropriated to BHA for the pilot program in the next fiscal year.
b. At the time that a grant application is approved, the BHASO shall invoice BHA for one hundred percent (100%) of the selected application's budgeted maximum amount.
c. The BHASO may retain five percent (5%) of the Region's total fiscal year grant budget as an administrative fee for expenses in managing the grant application process and subcontract management activities.
d. On or after July 30th annually, BHA shall review the BHASO's final report of actual expenditures and conduct a reconciliation between disbursements and actual expenditures in accordance with Article 3.14.2.5.f below.
e. Any carryover funds disbursed from BHA to the BHASO for grants awarded hereunder, without corresponding expenses incurred in the previous two contract years, shall be considered unearned by the BHASO and shall require a repayment of funds from the BHASO to BHA no later than September 15th of the following state fiscal year.
f. Depending on the service type, the appropriate reimbursement model shall be used by the parties for required repayment of funds analysis.

i. For capacity reimbursement, the BHASO shall negotiate and record an annual capacity-based budget with each provider utilizing a capacity-based payment methodology. The BHASO shall keep budget current with providers, and budgets shall be available to BHA upon request.

ii. For fee-for-service reimbursement, the BHASO shall submit 837 Encounters for reimbursement.

iii. For services modeled with a case rate, the parties shall develop a case rate methodology, with supporting service data.

iv. For cost reimbursement items, the parties shall use an invoice methodology for reimbursement.

g. Funding should be expensed in compliance with the first in first out (FIFO) method. Funding that has been designated "carry-over" from a prior year, with approved State spending authority, must be spent first. Current year funding must be spent only after the approved carry-over funding has been spent, unless otherwise designated or with prior BHA approval. Carry-over must be booked in the BHASO's accounting system as restricted reserves. The BHASO must report these reserves to BHA as part of its yearly financial audit.

h. Both parties agree that BHA has the right to offset against funds otherwise payable pursuant to this contract based on discovery of overpayment or improper use of funds pursuant to any contracts between the parties. "Overpayment or improper use of funds" is interpreted to apply to specific terms of prior year contracts and includes without limitation requirements of BHA's Accounting and Auditing Guidelines, Generally Accepted Accounting Principles issued by the American Institute of Certified Public Accountants, and applicable sections of the Colorado Revised Statutes.

i. The BHASO is eligible for any Cost-of-Living Adjustment (COLA) increases as appropriated by the Colorado General Assembly and approved by BHA.

j. Capital costs are allowable expenses under this Article 2.

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COLORADO
Behavioral Health Administration

Exhibit B-1
Part 1: FY26 Annual Budget

Signal Behavioral Health Network Region: 3 Administrative Fee 6.7%

Category	Budget Group	Appropriation	Fund	General	Cash	Federal	Total
Crisis	Crisis Resolution Teams Pilot	IGABG0805	1000	$295,550.00			$295,550.00
	General Crisis Services	ICABG0805	15RS		$1,682,614.93		$1,682,614.93
		IFJJB0170	1000			$313,605.00	$313,605.00
		IGABG0805	1000	$7,869,837.00			$7,869,837.00
		IGJJB0170	1000	$2,207,135.00			$2,207,135.00
	Total			**$10,372,522.00**	**$1,682,614.93**	**$313,605.00**	**$12,368,741.93**
Mental Health	Competency Restoration	IGASZ0F33	1000	$452,470.00			$452,470.00
	First Episode Psychosis (FEP)	IFJJB0170	1000			$607,639.00	$607,639.00
	Offender Services	ICLGS0711	15RS		$953,335.00		$953,335.00
	Safety Net Services	IFJJB0170	1000			$83,570.00	$83,570.00
		IGJJB0170	1000	$5,719,581.00			$5,719,581.00
	Safety Net Services High Acuity (175)	IGJJC0175	1000	$2,981,632.00			$2,981,632.00
	School-Based Programs	IGJJB0170	1000	$233,893.00			$233,893.00
	Total			**$9,387,576.00**	**$953,335.00**	**$691,209.00**	**$11,032,120.00**
Substance Use Disorder	Capacity Expansion 202	ICLAV0523	15RS		$4,598,360.00		$4,598,360.00
	General Substance Use Disorder Treatment	ICLAT0545	15RS		$513,983.00		$513,983.00
		IFLAW0522	1000			$5,646,818.00	$5,646,818.00
		IGLAW0522	1000	$1,246,222.00			$1,246,222.00
	Housing/Residential	IGMGN0525	1000	$1,321,390.98			$1,321,390.98
	Offender Services	IGLAS0524	1000	$810,230.00			$810,230.00
	Recovery Support Services	IFLAW0522	1000			$958,849.00	$958,849.00
		IGMGO0809	1000	$375,222.41			$375,222.41
	Total			**$3,753,065.39**	**$5,112,343.00**	**$6,605,667.00**	**$15,471,075.39**
Grand Total				**$23,513,163.39**	**$7,748,292.93**	**$7,610,481.00**	**$38,871,937.32**

GAE	Children and Youth Mental Health Treatment Act	ICKBE0179	15RS		$453,698.00		$453,698.00
		IGKBE0179	1000	$7,385,735.62			$7,385,735.62
		IRKBE0179	1000				$137,680.00
	Independent Assessor - FFPSA	IGGKK0068	1000	$264,418.00			$264,418.00
		IGKBF0176	1000	$663,253.00			$663,253.00
	Involuntary Commitment Incentives	IFLAW0522	1000			$739,509.10	$739,509.10
		IGLAW0522	1000	$101,000.00			$101,000.00
	QRTP Room and Board	IGABG0805	1000	$3,022,436.89			$3,022,436.89
	Secure Transportation	ICAFB0802	15RS		$594,572.00		$594,572.00
Grand Total				**$11,436,843.51**	**$1,048,270.00**	**$739,509.10**	**$13,362,302.61**

GAE = General Accounting Encumbrance. Payment to Contractor is made from available funds encumbered and shared across multiple contractors. The Sate may increase or decrease the total funds encumbered at its sole discretion and without formal notice to Contractor. No minimum payment is guaranteed to Contractor. The liability of the State for such payments is limited to the encumbered amount remaining of such funds.

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Exhibit B-1

Part 1: FY26 Annual Budget

The BHASO shall participate in all programs indicated with a checkmark

Signal Behavioral Health Network		Region 3
Part 1: General Provisions		
	General Provisions	☒
Part 2: Care Coordination		
Article 1	Care Navigation, Care Coordination, and Care Management	☒
Article 2	SUD Pre-Release Case Management	☐
Part 3: Safety Net Services		
Chapter One: Emergency and Crisis Services		
Article 1	Emergency or Crisis Behavioral Health Services	☒
Article 2	Mobile Crisis Services	☒
Article 3	Walk-In Crisis Services	☒
Article 4	Crisis Stabilization Units	☒
Article 5	Crisis Respite Services	☒
Chapter Two: Withdrawal Management		
	Withdrawal Management	☒
Chapter Three: Mental Health and Substance Use Outpatient Services		
Article 1	Outpatient Behavioral Health Services	☒
Article 2	Medication for Opioid Use Disorder (SOR Funded, may use, if SOR Funding runs out)	☐
Article 3	Overdose Prevention (e.g. Naloxone) (SOR Funded, may use, if SOR Funding runs out)	☐
Article 4	Contingency Management	☒
Article 5	Child First Model Implementation	☐
Chapter Four: Outpatient Competency Restoration		
	Outpatient Competency Restoration	☒

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Chapter Five: Behavioral Health High Intensity Outpatient Services and Hospital Alternatives		
Article 1	Behavioral Health High-Intensity Outpatient Services and Hospital Alternatives	☒
Article 2	Assertive Community Treatment	☒
Article 3	ASCENT (First Episode Psychosis) *This is not statutory but is required for BHA to meet the required MHBG set aside.	☒
Article 4	Forensic Community Based Services	☒
Article 5	Crisis Resolution Teams for Children Youth and Family	☒
Chapter Six: Behavioral Health Residential Treatment		
Article 1	Substance Use Disorder and Co-Occurring Residential Services - General Safety Net Services Terms	☒
Article 2	Mental Health Residential Services - General Safety Net Service Terms	☒
Article 3	Youth Substance Use Disorder Residential Services	☒
Article 4	Special Connections and Women's Treatment Services	☒
Article 5	Community Based Circle Program	☐
Article 6	Room and Board at QRTPs for Children and Youth	☒
Chapter Seven: Behavioral Health Inpatient Services		
	Behavioral Health Inpatient Services	☒
Chapter Eight: Integrated Care		
	Integrated Care	☒
Chapter Nine: Mental Health and Substance Use Disorder Recovery Supports		
Article 1	Mental Health and Substance Use Disorder Recovery Supports Overview	☒
Article 2	Recovery Community Organizations (RCOs)	☒
Article 3	Recovery Residences	☒
Article 4	Individualized Placement and Support (IPS)	☒
Article 5	Recovery Coach Doula	☐

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Chapter Ten: Outreach, Education, and Engagement Services		
Article 1	Outreach, Education, and Engagement Requirements	☒
Article 2	School Based Mental Health Specialist (SBMHS)	☒
Chapter Eleven: Screening, Assessment, and Diagnosis		
Article 1	Overview of Screening, Assessment, and Diagnosis	☒
Article 2	Enhanced Standardized Assessments for Children and Youth	☒
Article 3	Enhanced Standardized Assessments for County Departments of Human Services and the Division of Youth Services	☒
Chapter Twelve: Additional Services		
	Secure Transportation	☒
Chapter Thirteen: Multimodality Programs		
Article 1	Children, Youth, Family Mental Health Treatment Act (CYMHTA) - BHA Program	☒
Article 2	Additional Family Services - BHA Program	☒
Article 3	Strategic Individualized Remediation Treatment (STIRT) - BHA Program	☒
Article 4	RidgeView Supportive Residential Community	☐
Article 5	Involuntary Commitment Services (SUD)	☒
Chapter Fourteen: Capacity Support and Expansion Funding Streams		
Article 1	Substance Use Disorder Network and Capacity Expansion (SB16-202 - Increasing Access to Effective Substance Use Disorder Services Act)	☒
Article 2	Building Substance Use Disorder Treatment Capacity in Rural and Frontier Colorado Grant Program (HB19-1287)	☐

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Exhibit B-1

Part 2: Behavioral Health Administrative Service Organization Rate Schedule

The BHASO Administrative Fee is recognized based on utilization.

This list of rates is not exhaustive.

BHA may consider rates up to 10% above the maximum rates pending justification from the BHASO and written pre-approval by BHA.

Chapter 1

Emergency & Crisis Services Rates

1.1 Exhibit A, Part 3, Chapter 1, Crisis Stabilization Units. The BHASO will pay either the provider's Comprehensive Provider Calculated Rate - CSU/ATU per diem rate set annually by HCPF, or the provider's cost-based rate, if the provider does not have a Comprehensive Provider Calculated Rates rate set by HCPF.

Chapter 2

Withdrawal Management

2.1 Exhibit A, Part 3, Chapter 2, Withdrawal Management (where FFS is elected by BHASO) Rates

Method	3.2 WM	3.7 WM
R&B Per Diem	$70.04-$105.06	$70.04-$105.06
Uninsured/Underinsured WM Per Diem	$103-$309	$515-$927

Chapter 3

Mental Health and Substance Use Outpatient Services

3.1 Exhibit A, Part 3, Chapter 3, Article 1 - Mental Health Outpatient Treatment Rates

The BHASO may negotiate rates within 100%-125% of the ranges below for Mental Health Outpatient Treatment services

Code	Mod	Description	BHA Price
00104		Anesthesia, Electroconvulsive Therapy	21.11
90785		INTERACTIVE COMPLEXITY (LIST SEPARATELY IN ADDITION TO THE CODE FOR PRIMARY PROCEDURE)	4.54

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90791		PSYCHIATRIC DIAGNOSTIC EVALUATION	159.67
90791	GT	PSYCHIATRIC DIAGNOSTIC EVALUATION	164.92
90792		PSYCHIATRIC DIAGNOSTIC EVALUATION WITH MEDICAL SERVICES	178.4
90832	GT	Psychotherapy, 30 minutes with patient	72.75
90832		Psychotherapy, 30 minutes with patient	68.76
90833	GT	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service, add on	67.93
90833		Psychotherapy, 30 minutes with patient when performed with an evaluation and management service, add on	62.93
90834		Psychotherapy, 45 minutes with patient	91.09
90834	GT	Psychotherapy, 45 minutes with patient	96.09
90836		Psychotherapy, 45 minutes with patient when performed with an evaluation and management service, add on	79.63
90836	GT	Psychotherapy, 45 minutes with patient when performed with an evaluation and management service, add on	84.63
90837	GT	Psychotherapy, 60 minutes with patient	139.51
90837		Psychotherapy, 60 minutes with patient	134.51
90838		Psychotherapy, 60 minutes with patient when performed with an evaluation and management service, add on	105.41
90838	GT	Psychotherapy, 60 minutes with patient when performed with an evaluation and management service, add on	110.41
90839		PSYCHOTHERAPY FOR CRISIS; FIRST 60 MINUTES	128.01
90840		PSYCHOTHERAPY FOR CRISIS; EACH ADDITIONAL 30 MINUTES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY SERVICE)	60.69
90846		Family psychotherapy (without the patient present), 50 minutes	87.01
90846	GT	Family psychotherapy (without the patient present), 50 minutes	92.01
90847	GT	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes	95.09
90847		Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes	90.09
90849		Multiple-Family Group Psychotherapy	31.44

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90853		Group Psychotherapy (Other Than, Multiple-Family Group)	24.36
90870		Electroconvulsive Therapy (W/Monitoring); Single Seizure	89.64
90875		Individual Psychophysiological Therapy W/Biofeedback Training; Approximately 20-30 Min	53.86
90876		Individual Psychophysiological Therapy W/Biofeedback Training; Approximately 45-50 Min	92.33
90887		Interpretation/Explanation Results, Psychiatric/Medical Exam/Proc W/Family	149.37
96116	GT	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [eg, acquired knowledge, attention, language, memory, planning and problem solving)	103.46
96116		Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [eg, acquired knowledge, attention, language, memory, planning and problem solving)	98.46
96121		Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [eg, acquired knowledge, attention, language, memory, planning and problem solving)	78.29
96130		Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test	132.41
96131		Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test	104.87
96132		Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test	134.51
96133		Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test	102.58

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96136		Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes	68.1
96137		Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method each additional 30 minutes	49.84
96138		Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes	32.41
96139		Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; each additional 30 minutes	19.25
96146		Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only	9.82
96372		Therapeutic, Prophylactic, or Diagnostic Injection (Specify Substance or Drug); Subcutaneous or Intramuscular	14.89
97535		Self Care/Home Management Training, Direct Contact, Each 15 Min	28.77
97537		Community/Work Reintegration Training, Direct Contact, Each 15 Min	27.82
98966		Telephone assessment and management service provided by a nonphysician qualified health care professional to an established patient, parent, or guardian (5-10 min)	13.68
98967		Telephone assessment and management service provided by a nonphysician qualified health care professional to an established patient, parent, or guardian (11-20 min)	24.82
98968		Telephone assessment and management service provided by a nonphysician qualified health care professional to an established patient, parent, or guardian (21-30 min)	34.59
99202	GT	Office or other outpatient visit for the evaluation and management of a new patient (15 min)	54.39

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99202		Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision-making (15 min)	49.39
99203		Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision-making (30 min)	102.87
99203	GT	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision-making	107.87
99204	GT	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision-making	141.94
99204		Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision-making	136.94
99205		Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision-making	186.02
99205	GT	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision-making	191.02
99211		Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care provider	19.74
99211	GT	Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care provider	24.84
99212		Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision-making	47.49

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99212	GT	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision-making	52.59
99213	GT	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision-making	80.5
99213		Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision-making	75.5
99214	GT	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision-making	111.67
99214		Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision-making	106.67
99215		Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision-making	149.29
99215	GT	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision-making	154.29
99245		Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and high level of medical decision-making	190.88
99341		Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision-making	54.24
99342		Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision-making	74.88

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99344		Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision-making	148.21
99345		Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision-making	167.06
99347		Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision-making	49.11
99348		Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision-making	73.84
99349		Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision-making	105.23
99350		Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision-making	153.47
G0176		Opps/Php;Activity Therapy	35%*
G0177		Opps/Php; Train & Educ Serv	97.27
H0002		Behavioral health screening to determine eligibility for admission to treatment program	11.5
H0004		Behavioral health counseling and therapy, per 15 minutes	26.57
H0023		Behavioral health outreach service (planned approach to reach a targeted population)	8.94
H0025		Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude and/or behavior)	62.68
H0032		Mental Health Service Plan Development By Non-Physician	92.33
H0033		Oral Medication Administration, Direct Observation	18.23
H0035		Mental Health Partial Hospitalization, Treatment, Less Than 24 Hours	325.45

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H0036		Community Psychiatric Supportive Treatment, Face-To-Face, Per 15 Min	43.68
H0037		Community Psychiatric Supportive Treatment Program, Per Diem	1048.02
H0038		Self-Help/Peer Services, Per 15 Minutes	7.71
H2011		Crisis intervention service, per 15 minutes	13.05
H2012		Behavioral health day treatment, per hour	130.09
H2014		Skills training and development, per 15 minutes	13.08
H2015		Comprehensive community support services, per 15 minutes	34.96
H2016		Comprehensive community support services, per diem	318.73
H2017		Psychosocial rehabilitation services, per 15 minutes	20.21
H2021		Community-based wrap-around services, per 15 minutes	17.89
H2022		Community-based wrap-around services, per diem	263.73
H2033		Multisystemic therapy for juveniles, per 15 minutes	45.58
S5150		Unskilled Respite Care, Not Hospice, Per 15 Minutes	35%*
S5151		Unskilled Respite Care, Not Hospice, Per Diem	35%*
S9445		Patient education, not otherwise classified, non-physician provider, individual, per session	50.44
S9480		Intensive outpatient psychiatric (IOP) services, per diem	185
T1005		Respite care services, up to 15 minutes	35%*
T1017	UB	Targeted Case Management, Each 15 Minutes	27.29
T1017		Targeted Case Management, Each 15 Minutes	17.85
T1017	TL	Targeted Case Management, Each 15 Minutes	17.85

GT = Telehealth

HD = Special Connections

TL = Targeted case management for a child enrolled in early intervention

U1 = ASAM 3.1

U3 = ASAM 3.3

U5 = ASAM 3.5

U7 = ASAM 3.7

UB = Targeted case management with transition coordination

* = Percentage of billed charges

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3.2 Exhibit A, Part 3, Chapter 3, Article 1- Substance Use Outpatient Rates

Service	Rate
Uninsured/Underinsured Case Rate - Outpatient	$1,846.79/client / year
Uninsured/Underinsured Case Rate – Partial Hospitalization (ASAM 2.5) – H0016	$358 - $408 Per Day
Uninsured/Underinsured Case Rate – Intensive Outpatient Treatment (ASAM 2.1) – H0015	$185 - $235 Per Day

3.3 Exhibit A, Part 3, Chapter 3, Articles 2 & Article 3 - MOUD and Overdose Prevention Reimbursement Rates for Opioid Treatment Programs (OTPs)

Medication	Brand name	Monthly OTP Rate
Naltrexone (oral)		$457.32
Depot-naltrexone (injectable)	Vivitrol	$1,284.41
Buprenorphine (buprenorphine/naloxone contraindicated)	Suboxone & generics	$472.77
Buprenorphine/naloxone	Suboxone & generics	$472.77
Methadone		$420.24

a. OTP Rate is per client per month, inclusive of all related services.

3.4 Exhibit A, Part 3, Chapter 3, Articles 2 & Article 3 - MOUD and Overdose Prevention Reimbursement Rates for Non-OTPs

Medication	Brand name	Monthly Prescriber/ Administration Rate	Monthly Tx & Case Mgmt. Rate
Naltrexone (oral)		$190.55	$210.12
Depot-naltrexone (injectable)	Vivitrol	$253.38	$210.12
Buprenorphine (buprenorphine/naloxone contraindicated)	Suboxone & generics	$380.07	$210.12

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Buprenorphine/naloxone sublingual film	Suboxone & generics	$380.07	$210.12
Buprenorphine (extended release)	Sublocade	$380.07	$210.12

3.5 Exhibit A, Part 3, Chapter 3, Articles 2 & Article 3 - MOUD and Overdose Prevention Reimbursement Rates for Opioid Treatment Programs (Non-OTPs)

a. MOUD Medication Costs Only

Medication	Brand name	Monthly Medication Rate
Naltrexone (oral)		$103
Depot-naltrexone (injectable)	Vivitrol	$1,303.98
Buprenorphine (buprenorphine/naloxone contraindicated) (2 mg dose)	Suboxone & generics	$38.11
Buprenorphine (buprenorphine/naloxone contraindicated) (4 mg dose)	Suboxone & generics	$49.44
Buprenorphine/naloxone sublingual film (2 mg/0.5mg dose)	Suboxone & generics	$84.46
Buprenorphine/naloxone sublingual film (4mg/1mg dose)	Suboxone & generics	$147.29
Buprenorphine/naloxone sublingual film (8mg/2mg dose)	Suboxone & generics	$147.29
Buprenorphine/naloxone sublingual film (12mg/3mg dose)	Suboxone & generics	$289.43
Buprenorphine (extended release)	Sublocade	$1,891.08

Chapter 4

Outpatient Competency Restoration

4.1 OCR services are paid on a fixed payment basis based on projected capacity level. $22,966 base rate for each provider, then a per-person rate of $1366 for each client that is allotted to the provider; this amount constitutes the annual contract amount.

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BHASO Network providers will be paid the monthly amount identified as long as terms and conditions in the Contract are met.

4.2 Outpatient Competency Restoration Rates

Agency/Organization	FY26 Contract Capacity Level	FY26 Contract Amount w/ Provider Rate	Monthly Contract Amount
AllHealth Network	50	$91,266	$7,605
AspenPointe/Diversus	160	$241,526	$20,127
Aurora Mental Health	80	$132,246	$11,020
Axis Behavioral Health	35	$70,776	$5,898
Centennial Mental Health Center	25	$57,116	$4,760
Community Reach Center	45	$84,436	$7,036
Eagle Valley Behavioral Health	5	$29,796	$2,483
Health Solutions (MHC)	55	$98,096	$8,175
Jefferson Center for Mental Health	55	$98,096	$8,175
Mental Health Partners	45	$84,436	$7,036
Mind Springs Health	53	$95,364	$7,947
North Range Behavioral Health	80	$132,246	$11,020
San Luis Valley Behavioral Health	15	$43,456	$3,621
Solvista Health	23	$54,384	$4,532
Southeast Health Group	15	$43,456	$3,621
SummitStone Health	80	$132,246	$11,020
WellPower	160	$241,526	$20,127
Paragon Health	18	$47,554	$3,963
Mile High Behavioral Healthcare	15	$43,456	$3,621
TOTAL	1014	$1,821,478	$151,787

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Chapter 5

Behavioral Health High Intensity Outpatient Services – Hospital Alternatives

5.1 No Rates to Report

Chapter 6

Behavioral Health Residential Treatment

6.1 Exhibit A, Part 3, Chapter 6, Article 1,Substance Use Disorder and Co-Occurring Residential Services

a. Exhibit A, Part 3, Chapter 6, Article 2 - Mental Health Residential Services
b. Exhibit A, Part 3, Chapter 6, Article 4 - Special Connections BHA Program and Women's Treatment Services
c. Exhibit A, Part 3, Chapter 6, Article 5 - Community Based Circle Program Rates

Service	Code	Description	Rate Range	Unit
Room & Board	S9976	Residential room and board includes all costs associated with lodging and food.	$70.04 - $105.00	Day
ASAM 3.1 Treatment	H2036:U1	Substance use residential treatment delivered at the ASAM 3.1 level of care (excluding room and board)	$94.76- $173.04	Day
ASAM 3.5 Treatment	H2036:U5	Substance use residential treatment delivered at the ASAM 3.5 level of care (excluding room and board)	$57.59 – $283.25	Day
ASAM 3.7 Treatment	H2036:U7	Substance use residential treatment delivered at the ASAM 3.7 level of care (excluding room and board)	$367.71 – $577.83	Day
Adolescent Treatment	H2036:U*n*	Substance use residential treatment for adolescents, delivered at the ASAM 3.*n* level of care (excluding room and board)	$262.65- $525.30	Day
Women's gender-responsive, family-centered	H2022	Residential program providing gender-responsive substance use disorder treatment and services for co-occurring mental illness to women with children using a safety-first philosophy. Must provide case management to assure	$220.42	Day

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residential enhancement		availability of childcare, intensive parenting services and supports, prenatal care coordination (as appropriate) developmentally appropriate prevention and treatment services for children, therapeutic supervised visitation, peer support, assistance with employment and housing and transportation to off-site medical services.		

6.2 Exhibit A, Part 3, Chapter 6, Article 6 - Room and Board Rates at Qualified Residential Treatment Programs for Children and Youth

Service	Description	Rate	Unit
Room and Board	QRTP room and board includes all costs associated with lodging and food	$425.00	Day

a. Exhibit A, Part 3, Chapter 6, Article 6 - Professional Fees for Qualified Residential Treatment Programs for Children and Youth

Procedure Code	Modifier 1	Rate effective July 1, 2024	Unit	Service
H0019	U1	$133.96	Per Diem	Qualified Residential Treatment Program
Note: The QRTP rate is inclusive of medical services provided to the child in the facility-by-facility staff. Medical services provided outside of the facility or by non-facility staff are billed separately as fee-for service.				

Chapter 7
Behavioral Health Inpatient Services

7.1 No Rates to Report

Chapter 8
Integrated Care Services

8.1 No Rates to Report

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Chapter 9

Mental Health and Substance Use Disorder Recovery Supports

9.1 Exhibit A, Part 3, Chapter 9, Article 3 - Recovery Residence Rates

Recovery Residence Monthly Assistance Maximum	Recovery Residence Monthly Admin Maximum
$4000/client/month	$500/client/month

Chapter 10

Outreach, Education, and Engagement

10.1 No Rates to Report

Chapter 11

Screening, Assessment, and Diagnosis

11.1 The BHASO shall invoice BHA one thousand two hundred fifty dollars ($1,250.00) per County/DYS ESAs and pay the provider of the service one thousand two hundred fifty dollars ($1,250.00) per County/DYS ESA.

11.2 The BHASO shall invoice BHA three hundred fifty dollars ($350.00) and pay the provider of the service three hundred fifty dollars ($350.00).

11.3 The BHASO shall earn a ten percent (10%) administrative rate on top of the County/DYS ESA fee (one hundred twenty-five dollars ($125.00) per County/DYS ESA).

11.4 The BHASO shall earn a ten percent (10%) administrative rate on top of the Independent Assessment transfer fee (thirty five dollars ($35.00) per County/DYS ESA transferred from the RAE to the county Department of Human Services or Division of Youth Services).

11.5 Training

a. The BHASO shall invoice BHA for required FFPSA Qualified Individual onboarding training at the rate of fifty dollars ($50) per hour plus affiliated cost(s) of the training, at the discretion and approval of BHA.
b. Qualified Individuals shall invoice the BHASO and be reimbursed at a rate of fifty dollars ($50) an hour by BHA for up to ten (10) hours annually of BHA-sponsored learning collaborative, CANS community of practice, or other relevant training, at the discretion and approval of BHA.
c. The BHASO's administrative fee is not earned on top of this fee.

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Chapter 12

Additional Services

12.1 Transportation for Behavioral Health Service

a. Third-party Secure Transportation allowable fees, up to:
    i. Flat rate not to exceed ninety dollars ($90.00) per hour:
        1. Plus not to exceed six dollars and twenty-eight cents ($6.28) per patient loaded mile, and
        2. Plus lodging fee not to exceed two hundred dollars and forty-four cents ($200.44) if over twelve (12) hour shift and when transport is to or from 250 miles distance to an accepting facility, ($100.22/Individual Travel Lodging per diem and $100.22/Escort travel lodging per diem).
    ii. Third-party non-secure transportation allowable fees, up to:
        1. Flat rate not to exceed seventy-five dollars ($75) per one-way trip,
        2. Plus not to exceed six dollars and twenty-eight cents ($6.28) per patient loaded mile, and
        3. Plus lodging fee not to exceed two-hundred dollars and forty-four cents ($200.44) if over a twelve (12) hour shift and working in rural/frontier areas ($100.22/Individual Travel Lodging and $100.22/Employee travel lodging).
    iii. In-house Secure or non-Secure Transportation per transport:
        1. Employee wage
        2. Vehicle mileage rate at Federal allowable rate (for depreciation or amortized lease payment, fuel, insurance, and maintenance)
            a. The BHASO Network may lease a vehicle to provide services under this section. Purchasing a vehicle is unallowable. Leases must be pre-approved by BHA and are subject to availability of GAE funds.
        3. Employee and Individual meal expenses
        4. Employee lodging expenses if transport extends beyond a twelve (12) hour shift
    iv. Employee and Individual meal expenses

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1. Eighty-seven dollars and ninety-six cents ($87.96) per diem. ($43.98/Individual and $43.98/employee).

v. Non-Emergency Medical Transport (NEMT), allowable fees, not to exceed (if not covered by Medicaid or another payor):
   1. Three hundred ninety dollars ($390) per transport
   2. Plus eight dollars ($8) per loaded patient mile

vi. Cleaning fees are both allowable expenses

vii. Other Expenses may be approved by BHA as appropriate under the circumstance.

Chapter 13
Multimodality Programs

13.1 Exhibit A, Part 3, Chapter 13, Article 1 - Children and Youth Mental Health Treatment Act (CYMHTA)

a. The BHASO shall pay providers a base rate of nine hundred and fifty dollars ($950) per CYMHTA Enhanced Standardized Assessment. The BHASO may optionally add a workforce retention enhancer rate of three hundred dollars ($300) per assessment, paid to the provider.

b. The BHASO shall earn a ten percent (10%) administrative rate on top of the assessment fee (ninety-five dollars ($95.00) or one-hundred and twenty-five dollars ($125) per CYMHTA assessment, if the services are provided outside of the BHASO. The ten percent (10%) administrative fee is not applied to services provided directly by the BHASO.

c. CYMHTA clinical care coordination/case management services. The BHASO shall earn a BHA clinical care coordination/case management fee of three hundred dollars ($300) per Individual per month, which shall not be prorated, in recognition that intake and discharge periods generate additional case management and administrative work. The fee of three hundred dollars ($300) per Individual per month is to be paid to the BHASO. If an Individual who has discharged from CYMHTA funding is approved for SSI the BHASO can bill for one month of clinical care coordination at the rate of three hundred dollars ($300).

d. The BHASO shall contract using the treatment providers' Medicaid rates for services outside of residential treatment.

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e. The BHASO shall earn a ten percent (10%) administrative rate on top of the clinical fee, if the services are provided outside of the BHASO. The ten percent (10%) administrative fee is not applied to services provided directly by the BHASO. The BHASO Administrative Fee in Chapter 1, Article 1.5.3.3 is not applied in addition to this fee.

13.2 Exhibit A, Part 3, Chapter 13, Article 3 - Strategic Individualized Remediation Treatment (STIRT)

Service	Procedure Code	Rate	Unit
Psychiatric Diagnostic Evaluation BioPsychoSocial Assessment (MA only)	90791	$204.12	Encounter
Psychiatric diagnostic evaluation with medical services (psychiatric evaluation)	90792	$489.30	Encounter
Add on Psychotherapy with client 30 min (provided same day as Eval and Mgmt Svc)	90833	$114.80	Encounter
Psychotherapy with client, 60 minutes	90837	$144.93	Encounter
Established Patient Office or Other Outpatient Visit w/ Moderate MDM, typically 30-39 mins	99214	$139.00	Encounter
Alcohol and/or Drug (AOD) Assessment	H0001	$367.50	Encounter
Alcohol and/or drug services; group counseling by a clinician	H0005	$68.25	Per Hour
Clinically managed residential withdrawal management: ASAM Level 3.2WM, per diem	H0010	$210.00	Per Day
Clinically managed residential withdrawal management: ASAM Level 3.7WM, per diem	H0011	$866.25	Per Day
Respite care services, not in the home, per diem	H0045	$75.00	Per Day
Alcohol and/or drug testing; collection and handling only, specimens other than blood – METRO	H0048	$29.40	Encounter
Alcohol and/or drug testing; collection and handling only, specimens other than blood – RURAL	H0048	$48.00	Encounter

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a. Co-pays for STIRT Continuing Care may not be more than five dollars ($5.00) per person per session.

13.3 Exhibit A, Part 3, Chapter 13, Article 4 - Ridge View Supportive Residential Community (Substance Use Continuum) Withdrawal Management Rates

Method	3.2 WM	3.7 WM
R&B Per Diem	$70.04-$105.06	$70.04-$105.06
Uninsured/Underinsured WM Per Diem	$103-$309	$515-$927

a. Exhibit A, Part 3, Chapter 13, Article 4 - Ridge View Supportive Residential Community (Substance Use Continuum) Residential Rates.

Service	Code	Description	Rate Range	Unit
Room & Board	S9976	Residential room and board includes all costs associated with lodging and food.	$70.04 - $105.00	Day
ASAM 3.1 Treatment	H2036:U1	Substance use residential treatment delivered at the ASAM 3.1 level of care (excluding room and board)	$94.76- $173.04	Day
ASAM 3.5 Treatment	H2036:U5	Substance use residential treatment delivered at the ASAM 3.5 level of care (excluding room and board)	$57.59 – $283.25	Day
ASAM 3.7 Treatment	H2036:U7	Substance use residential treatment delivered at the ASAM 3.7 level of care (excluding room and board)	$367.71 – $577.83	Day
Adolescent Treatment	H2036:U*n*	Substance use residential treatment for adolescents, delivered at the ASAM 3.*n* level of care (excluding room and board)	$262.65- $525.30	Day

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13.4 Exhibit A, Part 3, Chapter 13, Article 5 - BHASO Care Coordination Case Rates

Service	Rate	Unit
New IC Filing Care Coordination Case Rate	$1,891.08	Per Case
Re-stipulated IC Care Coordination Case Rate	$945.54	Per Case
Post-IC Engagement Care Coordination Case Rate	$420.24	Per Case

13.5 Exhibit A, Chapter 13, Article 5 - IC Provider Rates

Service	Procedure Code	Rate	Unit
Medication evaluation		$105.06	Encounter
Physician certification			Encounter
Psychiatric diagnostic evaluation with medical services (psychiatric evaluation)	90792	$489.30	Encounter
Alcohol and/or Drug (AOD) Assessment	H0001	$367.50	Encounter
Alcohol and/or drug testing; collection and handling only, specimens other than blood – METRO	H0048	$29.40	Encounter
Alcohol and/or drug testing; collection and handling only, specimens other than blood – RURAL	H0048	$48.00	Encounter
Third Party Secure Transport		$90.00	Per Hour
Third Party Secure Transport patient loaded mile		$9.00	Per Mile
Third Party Secure Transport lodging if over 12-hour shift		$225.00	Per Night
Third Party Non-Secure Transport		$75.00	Per Hour
Third Party Non-Secure Transport patient loaded mile		$7.40	Per Mile
Third Party Non-Secure Transport lodging if over 12-hour shift		$175.00	Per Night
Non-Emergency Medical Transport		$390.00	Per Transport
Non-Emergency Medical Transport patient loaded mile		$8.00	Per Mile

Exhibit B-1

Part 3: Appropriations Guidance

Exhibit B-1 – Part 3

Appropriation	Fund	Long Bill Category	Long Bill Line Item	Bill	Statute	Spending Purpose (Long)	Spending Purpose (Short)	Allowable Uses
ICABG0805	15RS	D-Integrated Behavioral Health Services	Behavioral Health Crisis Response System Services	N/A	39-28.8-501(1)	Utilize marijuana tax revenue to fund efforts needed in response to legalized marijuana, specifically related to crisis response system programs and support. The new retail marijuana tax revenue presents an opportunity to invest in services, support, intervention, and treatment related to marijuana and other drugs. Therefore, the purposes identified in the subsection (2) prioritize appropriations related to legalized marijuana, such as drug use prevention and treatment, protecting the state's youth and ensuring the public peace, health, and safety.	N/A	Chapter 1: Emergency/Crisis, Article 1: Emergency and Crisis Behavioral Health Services Chapter 1: Emergency/Crisis, Article 2: Mobile Crisis Services Chapter 1: Emergency/Crisis, Article 3: Walk-In Crisis Services Chapter 1: Emergency/Crisis, Article 4: Crisis Stabilization Services Chapter 1: Emergency/Crisis, Article 5: Crisis Respite Services
ICAFB0802	15RS	D-Integrated Behavioral Health Services	Behavioral Health Crisis Response System Secure Transportation Pilot Programs	N/A	39-28.8-501(1)	Utilize marijuana tax revenue to fund efforts needed in response to legalized marijuana, specifically related to the crisis response system secure transport pilot program. (Review 27-60-14(7)). The purpose of the pilot is to assess the feasibility of alternative transportation options for individuals on mental health holds and quantify the ability of secure transportation to offset the use of law enforcement and ambulances. In addition, the pilot study will document the experience of individuals transported, the needs of law enforcement, including the volume of law enforcement transports, alternatives to law enforcement transports, and statutory or regulatory areas that could be changed to improve transportation in a crisis situation. The new retail marijuana tax revenue presents an opportunity to invest in services, support, intervention, and treatment related to marijuana and other drugs. Therefore, the purposes identified in this subsection (2) prioritize appropriations related to legalized marijuana, such as drug use prevention and treatment, protecting the state's youth, and ensuring the public peace, health, and safety. Any moneys in the fund not expended for the purposes specified in subsection (2) of this section may be invested by the state treasurer as provided by law. All interest and income derived from the investment and deposit of moneys in the fund shall be credited to the fund.	N/A	Chapter 12: Additional Services, Article 1: Transportation for Behavioral Health Services.

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Appropriation	Fund	Long Bill Category	Long Bill Line Item	Bill	Statute	Spending Purpose (Long)	Spending Purpose (Short)	Allowable Uses
ICKBE0179	15RS	B-Community Based Mental Health Services	Children and Youth Mental Health Treatment Act (CYMHTA)	N/A	39-28.85-501(1)	Utilize marijuana tax revenue to fund efforts needed in response to legalized marijuana, specifically related to crisis response system programs and support. The new retail marijuana tax revenue presents an opportunity to invest in services, support, intervention, and treatment related to marijuana and other drugs. Therefore, the purposes identified in the subsection (2) prioritize appropriations related to legalized marijuana, such as drug use prevention and treatment, protecting the state's youth and ensuring the public peace, health, and safety. (IV) Subject to the limitation in subsection (5) of this section, the general assemble may annually appropriate any money in the fund for the following purposes: (B) to provide services for adolescents and school-aged children in school settings or through community-based organization; (O) For the development of local dually identified crossover youth plans and services as described in section 19-2.5-302; Any moneys in the fund not expended for the purposes specified in subsection (2) of this section may be invested by the state treasurer as provided by law. All interest and income derived from the investment and deposit of moneys in the fund shall be credited to the fund.	N/A	Chapter 13: Multimodality, Article 1: Children, Youth, Family Mental Health Treatment Act (CYMHTA) – BHA Program

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Appropriation	Fund	Long Bill Category	Long Bill Line Item	Bill	Statute	Spending Purpose (Long)	Spending Purpose (Short)	Allowable Uses
ICLAT0545	15RS	C-Substance Use Treatment and Prevention Services	Community Prevention and Treatment Programs	N/A	39-28.8-501	Utilize marijuana tax revenue to fund efforts needed in response to legalized marijuana, specifically related to crisis response system programs and support. The new retail marijuana tax revenue presents an opportunity to invest in services, support, intervention, and treatment related to marijuana and other drugs. Therefore, the purposes identified in the subsection (2) prioritize appropriations related to legalized marijuana, such as drug use prevention and treatment, protecting the state's youth and ensuring the public peace, health, and safety. (IV) Subject to the limitation in subsection (5) of this section, the general assemble may annually appropriate any money in the fund for the following purposes: (A) To educate people about marijuana to prevent its illegal use or legal abuse; (H) To study the use of marijuana and other drugs, their health effects, and other social impacts related to them; (N) For housing, rental assistance, and supportive services, including reentry services, pursuant to section 24-32-721; Any moneys in the fund not expended for the purposes specified in subsection (2) of this section may be invested by the state treasurer as provided by law. All interest and income derived from the investment and deposit of moneys in the fund shall be credited to the fund.	N/A	Chapter 2: Withdrawal Management Chapter 3: Mental Health and Substance Use Disorder Outpatient, Article 1: Outpatient Behavioral Health Services Chapter 3: Mental Health and Substance Use Disorder Outpatient, Article 2: Medications for Opioid Use Disorder Chapter 3: Mental Health and Substance Use Disorder Outpatient, Article 3: Overdose Prevention Chapter 5: High Intensity/Hospital Alternatives, Article 1: Behavioral Health High Intensity Outpatient Services and Hospital Alternatives Chapter 6: Behavioral Health Residential, Article 1: Substance Use Disorder and Co-Occurring Residential Services – General Safety Net Services Terms Chapter 6: Behavioral Health Residential, Article 3: Youth Substance Use Disorder Residential Services – BHA Program Chapter 6: Behavioral Health Residential, Article 5: Community Based Circle Program – BHA Program Chapter 10: Outreach, Article 1: Outreach, Education, and Engagement Requirements
ICLAT0545	24T0	C-Substance Use Treatment and Prevention Services	Community Prevention and Treatment Programs	HB16-1168	CRS 27-80-117	Rural alcohol and substance abuse prevention and treatment program. *Administered by CDPHE as of 7/1/22 (except a small amount of funds maintained within BHA and contracted to BHASOs). These funds are under sunset review, if not renewed, they will expire 9/1/25.	Rural Alcohol and substance abuse prevention and treatment program	Chapter 2: Withdrawal Management

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Appropriation	Fund	Long Bill Category	Long Bill Line Item	Bill	Statute	Spending Purpose (Long)	Spending Purpose (Short)	Allowable Uses
ICLAV0523	15RS	C-Substance Use Treatment and Prevention Services	Increasing Access to Effective Substance Use Disorder Services	SB16-202	27-80-107.5 (2023); 39-28.8-501(2)(b)(IV)(C) (2023)	Utilize marijuana tax revenue to fund efforts needed in response to legalized marijuana, specifically related to efforts that increase access to effective SUD services. This statute provides the funding for substance use disorder services. BHASOs provide treatment services for substance use disorders. It is also required for BHASOs to assess the sufficiency of substance use disorder services in its geographic region, and to prepare a community action plan to address the most critical services gaps. Any moneys in the fund not expended for the purposes specified in subsection (2) of this section may be invested by the state treasurer as provided by law. All interest and income derived from the investment and deposit of moneys in the fund shall be credited to the fund.	N/A	Chapter 14: Capacity Expansion, Article 1: Substance Use Disorder Network and Capacity Expansion (SB16-202 – Increasing access to Effective Substance Use Disorder Services Act).

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Appropriation	Fund	Long Bill Category	Long Bill Line Item	Bill	Statute	Spending Purpose (Long)	Spending Purpose (Short)	Allowable Uses
ICLAW0522	15RS	C-Substance Use Treatment and Prevention Services	Treatment and Detoxification Programs	N/A	39-28.8-501	The new retail marijuana tax revenue presents an opportunity to invest in services, support, intervention, and treatment related to marijuana and other drugs. Therefore, the purposes identified in the subsection (2) prioritize appropriations related to legalized marijuana, such as drug use prevention and treatment, protecting the state's youth and ensuring the public peace, health, and safety. (IV) Subject to the limitation in subsection (5) of this section, the general assemble may annually appropriate any money in the fund for the following purposes: (A) To educate people about marijuana to prevent its illegal use or legal abuse; (H) To study the use of marijuana and other drugs, their health effects, and other social impacts related to them; (N) For housing, rental assistance, and supportive services, including reentry services, pursuant to section 24-32-721; Any moneys in the fund not expended for the purposes specified in subsection (2) of this section may be invested by the state treasurer as provided by law. All interest and income derived from the investment and deposit of moneys in the fund shall be credited to the fund.	N/A	Chapter 2: Withdrawal Management Chapter 3: Mental Health and Substance Use Disorder Outpatient, Article 1: Outpatient Behavioral Health Services Chapter 3: Mental Health and Substance Use Disorder Outpatient, Article 2: Medications for Opioid Use Disorder Chapter 3: Mental Health and Substance Use Disorder Outpatient, Article 3: Overdose Prevention Chapter 5: High Intensity/Hospital Alternatives, Article 1: Behavioral Health High Intensity Outpatient Services and Hospital Alternatives Chapter 6: Behavioral Health Residential, Article 1: Substance Use Disorder and Co-Occurring Residential Services – General Safety Net Services Terms Chapter 6: Behavioral Health Residential, Article 3: Youth Substance Use Disorder Residential Services – BHA Program Chapter 6: Behavioral Health Residential, Article 5: Community Based Circle Program – BHA Program Chapter 10: Outreach, Article 1: Outreach, Education, and Engagement Requirements Chapter 14: Capacity Expansion, Article 2: Building Substance Use Disorder Treatment Capacity in Rural and Frontier Colorado Grant Program (HB19-1287)

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Appropriation	Fund	Long Bill Category	Long Bill Line Item	Bill	Statute	Spending Purpose (Long)	Spending Purpose (Short)	Allowable Uses
ICLAW0522	19Y0	C-Substance Use Treatment and Prevention Services	Treatment and Detoxification Programs	N/A	18-13-122	The general assembly finds and declares that it is necessary for the state of Colorado to educate Colorado youth about the dangers of early use of alcohol and marijuana, to actively promote programs that prevent the illegal use of alcohol and marijuana, and to teach Colorado youth about responsible use and the healthy choices available to an adult once he or she is able to legally consume alcohol or marijuana. MIP post-trial assessment programs: If determined necessary and appropriate, submit to a substance abuse assessment approved by the behavioral health administration in the department of human services and complete any treatment recommended by the assessment. The Behavioral Health Administration is authorized to seek and accept gifts, grants, or donations from provide or public sources for the purposes of this section. All private and public money received through gifts, grants, or donations must be transmitted to the state treasurer, who shall credit the same to the fund. Money in the fund is subject to annual appropriation by the general assemble to the Behavioral Health Administration in the department of human services, established in Article 80 of title 27, for adolescent substance abuse prevention and treatment programs. The surcharge collected pursuant to subsection (4)(e) of this section must be transmitted to the state treasurer, who shall credit the same to the adolescent substance abuse prevention and treatment fund, which is created and referred to in this section as the “fund”.	Adolescent substance abuse prevention and treatment programs	Chapter 2: Withdrawal Management

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Appropriation	Fund	Long Bill Category	Long Bill Line Item	Bill	Statute	Spending Purpose (Long)	Spending Purpose (Short)	Allowable Uses
ICLGS0711	15RS	B – Community Based Mental Health Services	Mental Health Services for Juvenile and Adult Offenders	N/A	27-66-104(4); 39-28.8-501(1)	Utilize marijuana tax revenue to fund efforts needed in response to legalized marijuana, specifically related to juvenile and adult offenders programs and support. The mental health services for juvenile and adult offenders line item was originally funded with tobacco litigation settlement moneys and was created to provide co-responder, case management services, wrap-around services, medications and treatment services for juvenile and adult offenders with mental health and substance use disorders who are involved in the criminal justice system. Mental health services for juvenile and adult offenders were refinanced with marijuana tax cash fund dollars. In FY2017-18 the appropriations were increased to expand services statewide to all safety net providers. Any moneys in the fund not expended for the purposes specified in subsection (2) of this section may be invested by the state treasurer as provided by law. All interest and income derived from the investment and deposit of moneys in the fund shall be credited to the fund.	N/A	Chapter 3: Mental Health and Substance Use Disorder Outpatient, Article 1: Outpatient Behavioral Health Services Chapter 6: Behavioral Health Residential, Article 2: Mental Health Residential Services – General Safety Net Services Terms Chapter 6: Behavioral Health Residential, Article 5: Community Based Circle Program – BHA Program

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Appropriation	Fund	Long Bill Category	Long Bill Line Item	Bill	Statute	Spending Purpose (Long)	Spending Purpose (Short)	Allowable Uses
ICLHN0812	15RS	D-Integrated Behavioral Health Services	Circle Program and other Rural Treatment Programs for people with co-occurring disorders	N/A	39-28.8-501	The new retail marijuana tax revenue presents an opportunity to invest in services, support, intervention, and other treatment related to marijuana and other drugs. Therefore, the purposes identified in this subsection (2) prioritize appropriations related to legalized marijuana, such as drug use prevention and treatment, protecting the state's youth, and ensuring the public peace, health, and safety. (IV) Subject to the limitation in subsection (5) of this section, the general assemble may annually appropriate any money in the fund for the following purposes: (C) To treat and provide related services to people with any type of substance use or mental health disorder, including those with co-occurring disorders, or to evaluate the effectiveness and sufficiency of behavioral health services; (H) To study the use of marijuana and other drugs, their health effects, and other social impacts related to them. Any moneys in the fund not expended for the purposes specified in subsection (2) of this section may be invested by the state treasurer as provided by law. All interest and income derived from the investment and deposit of moneys in the fund shall be credited to the fund.	N/A	Chapter 3: Mental Health and Substance Use Disorder Outpatient, Article 1: Outpatient Behavioral Health Services Chapter 6: Behavioral Health Residential, Article 5: Community Based Circle Program – BHA Program

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Appropriation	Fund	Long Bill Category	Long Bill Line Item	Bill	Statute	Spending Purpose (Long)	Spending Purpose (Short)	Allowable Uses
IFJJB0170	1000	B-Community Based Mental Health Services	Mental Health Community Programs	N/A	27-65-101; 27-66-101	The mental health community programs line item provides funding for the services delivered in the public mental health system (federal grant funding). This line Items includes costs that are funded by the SAMHSA Mental Health Services Grant and the SAMHSA homeless PATH grant. Services include behavioral health planning council expenses, mental health advocacy contracts, mental health engagement and outreach services for the homeless or at risk of homelessness population and other community mental health initiatives and services		Chapter 1: Emergency/Crisis, Article 1: Emergency and Crisis Behavioral Health Services Chapter 1: Emergency/Crisis, Article 2: Mobile Crisis Services Chapter 1: Emergency/Crisis, Article 3: Walk-in Crisis Services Chapter 1: Emergency/Crisis, Article 4: Crisis Stabilization Services Chapter 1: Emergency/Crisis, Article 5: Crisis Respite Services Chapter 3: Mental Health and Substance Use Disorder Outpatient, Article 1: Outpatient Behavioral Health Services Chapter 3: Mental Health and Substance Use Disorder Outpatient, Article 5: Child First Model Implementation Chapter 5: High Intensity/Hospital Alternatives, Article 1: Behavioral Health High-Intensity Outpatient Services and Hospital Alternatives Chapter 5: High Intensity/Hospital Alternatives, Article 2: Assertive Community Treatment Chapter 5: High Intensity/Hospital Alternatives, Article 3: Ascent (First Episode Psychosis) Chapter 5: High Intensity/Hospital Alternatives, Article 5: Crisis Resolution Teams for Children, Youth, and Family Chapter 9: Recovery Supports, Article 1, Mental Health and Substance Use Disorder Recovery Supports Overview Chapter 10: Outreach, Article 1: Outreach, Education, and Engagement Requirements

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IFLAW0522	1000	C-Substance Use Treatment and Prevention Services	Treatment and Detoxification Programs	N/A	N/A	This line item includes costs that are funded by the SAMHSA substance use prevention treatment and recovery grant. Services include behavioral health planning council expenses, mental health advocacy contracts, mental health engagement and outreach services for the homeless or at risk of homelessness population and other community mental health initiatives and services.	N/A	Care Coordination, Article 2: Pre-Release Case Management Chapter 1: Emergency/Crisis, Article 1: Emergency and Crisis Behavioral Health Services Chapter 1: Emergency/Crisis, Article 2: Mobile Crisis Services Chapter 1: Emergency/Crisis, Article 3: Walk-in Crisis Services Chapter 1: Emergency/Crisis, Article 4: Crisis Stabilization Services Chapter 1: Emergency/Crisis, Article 5: Crisis Respite Services Chapter 2: Withdrawal Management Chapter 3: Mental Health and Substance Use Disorder Outpatient, Article 1: Outpatient Behavioral Health Services Chapter 3: Mental Health and Substance Use Disorder Outpatient, Article 2: Medications for Opioid Use Disorder Chapter 3: Mental Health and Substance Use Disorder Outpatient, Article 3: Overdose Prevention Chapter 5: High Intensity/Hospital Alternatives, Article 1: Behavioral Health High-Intensity Outpatient Services and Hospital Alternatives Chapter 6: Behavioral Health Residential, Article 1: Substance Use Disorder and Co-Occurring Residential Services – General Safety Net Services Terms Chapter 6: Behavioral Health Residential, Article 3: Youth Substance Use Disorder Residential Services – BHA Program Chapter 6: Behavioral Health Residential, Article 4: Special Connections – BHA Program Chapter 6: Behavioral Health Residential, Article 5: Community Based Circle Program – BHA Program

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Appropriation	Fund	Long Bill Category	Long Bill Line Item	Bill	Statute	Spending Purpose (Long)	Spending Purpose (Short)	Allowable Uses
								Chapter 9: Recovery Supports, Article 1, Mental Health and Substance Use Disorder Recovery Supports Overview Chapter 9: Recovery Supports, Article 2: Recovery Community Organizations (RCOs) Chapter 9: Recovery Supports, Article 4: Individual Placement and Support (IPS) Chapter 9: Recovery Supports, Article 5: Recovery Coach Doula Chapter 10: Outreach, Article 1: Outreach, Education, and Engagement Requirements Chapter 13: Multimodality, Article 2: Additional Family Services – BHA Program Chapter 13: Multimodality, Article 5: Involuntary Commitment Services

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Appropriation	Fund	Long Bill Category	Long Bill Line Item	Bill	Statute	Spending Purpose (Long)	Spending Purpose (Short)	Allowable Uses
IGABG0805	1000	D-Integrated Behavioral Health Services	Behavioral Health Crisis Response System Services	N/A	27-60-103(1)(b)(ii), (iii) and 27-60-104	This line funds an array of services that provide the foundation for the statewide behavioral health crisis response system. The services are available to individuals regardless of their ability to pay. The specific components of the crisis response system include: walk-in services and stabilization units that have the ability to initiate a response in a timely fashion, and residential and respite crisis services.	Crisis response, including walk-in, stabilization, mobile crisis, residential, and respite	Chapter 1: Emergency/Crisis, Article 1: Emergency and Crisis Behavioral Health Services Chapter 1: Emergency/Crisis, Article 2: Mobile Crisis Services Chapter 1: Emergency/Crisis, Article 3: Walk-in Crisis Services Chapter 1: Emergency/Crisis, Article 4: Crisis Stabilization Services Chapter 1: Emergency/Crisis, Article 5: Crisis Respite Services Chapter 5: High Intensity/Hospital Alternatives, Article 5: Crisis Resolution Teams for Children, Youth, and Family Chapter 6: Behavioral Health Residential, Article 6: Room and Board at QRTPs.
IGASZ0F33	1000	N/A	N/A	N/A	N/A	N/A	N/A	Chapter 4: Outpatient Competency Restoration
IGBDB0110	1000	A-Community Behavioral Health Administration	Program Administration	N/A	26-1-210 27-50-101 27-60-101 27-66-101 27-80-101 27-80-102 27-81-101 27-82-201 39-28.8-501	Provides funding for salaries, benefits, professional and temporary contract services and operating costs for the direct and indirect costs of the BHA	N/A	Chapter 1: Emergency/Crisis, Article 1: Emergency and Crisis Behavioral Health Services Chapter 1: Emergency/Crisis, Article 2: Mobile Crisis Services
IGGKK0068	1000	N/A	N/A	N/A	N/A	N/A	N/A	Chapter 11: Screening, Assessment, and Diagnosis, Article 3: Enhanced Standardized Assessments for County Departments of Human Services and Division of Youth Services

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Appropriation	Fund	Long Bill Category	Long Bill Line Item	Bill	Statute	Spending Purpose (Long)	Spending Purpose (Short)	Allowable Uses
IGJJB0170	1000	B-Community Based Mental Health Services	Mental Health Community Programs	N/A	27-65-101 27-66-101	The mental health community programs line item provides funding for services delivered in the public mental health system (general state funding). The contracts that BHA enters into with approved behavioral health services providers requires the provision of emergency, inpatient, partial hospitalization, outpatient, along with consultative and educational services across age categories. As part of this service array, the approved behavioral health contractors provide a variety of services, which are primarily outpatient services to uninsured/underinsured individuals across the state. As part of the state's behavioral health 'safety net' approved behavioral health contractors also utilize funding from other state funding sources, such as Medicaid payments, made on behalf of individuals enrolled in the Regional Accountable Entities (RAEs). This line item funds vital mental health center services that are not covered by Medicaid, private insurance, vocational rehabilitation, or other funding sources that includes employment related services and costs, housing supports, treatment facility infrastructure, workforce development (staff training, recruitment/retention intitiatives), wrap around services/costs, peer services and other needed services. This line item also supports funding for school-based mental health specialists.	General state mental health funding	Chapter 5: High Intensity/Hospital Alternatives, Article 1: Behavioral Health High Intensity Outpatient Services and Hospital Alternatives Chapter 5: High Intensity/Hospital Alternatives, Article 2: Assertive Community Treatment Chapter 6: Behavioral Health Residential, Article 2: Mental Health Residential Services – General Safety Net Services Terms Chapter 6: Behavioral Health Residential, Article 5: Community Based Circle Program – BHA Program Chapter 9: Recovery Supports, Article 1, Mental Health and Substance Use Disorder Recovery Supports Overview Chapter 10: Outreach, Article 1: Outreach, Education, and Engagement Requirements Chapter 10: Outreach, Article 2: School Bases Mental Health Specialist (SBMHS) Chapter 13: Multimodality, Article 2: Additional Family Services – BHA Program

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Appropriation	Fund	Long Bill Category	Long Bill Line Item	Bill	Statute	Spending Purpose (Long)	Spending Purpose (Short)	Allowable Uses
IGJJC0175	1000	B-Community Based Mental Health Services	Assertive Community Treatment Programs and Other Alternatives to the Mental Health Institutes	N/A	27-65-111 27-66-101	The assertive community treatment programs and other alternatives to the mental health institutes line item supports intensive outpatient case management services for severe and persistent mental health disorders. Assertive Treatment (ACT) is an evidence based service delivery model for providing comprehensive community-based treatment to adults with serious and persistent mental illness through safety net providers. The ACT model includes a community based multidisciplinary team that conducts outreach and engagement with clients with risk factors such as criminal justice involvement, homelessness and serious mental illness. These teams provide the treatment, rehabilitation, and support services that adults with serious mental illnesses need to live successfully in the community. This line also supports alternative placements for people who would otherwise require hospitalization at one of the state's two mental health institutes. Services include, but are not limited to inpatient hospitalization capacity, acute treatment unit capacity, medication, medication administration, intensive therapy/case management, mentoring services, and other services to improve the patient's level of functioning to enhance his or her success in the community. Funding covers services for clients who are not eligible for Medicaid and services that are not covered by Medicaid for Medicaid-eligible clients (i.e. residential room and board expenses).	Assertive Community treatment – outpatient	Chapter 5: High Intensity/Hospital Alternatives, Article 1: Behavioral Health High Intensity Outpatient Services and Hospital Alternatives Chapter 5: High Intensity/Hospital Alternatives, Article 2: Assertive Community Treatment Chapter 5: High Intensity/Hospital Alternatives, Article 5: Crisis Resolution Teams for Children, Youth, and Family Chapter 6: Behavioral Health Residential, Article 2: Mental Health Residential Services – General Safety Net Services Terms Chapter 6: Behavioral Health Residential, Article 5: Community Based Circle Program – BHA Program Chapter 10: Outreach, Article 1: Outreach, Education, and Engagement Requirements Chapter 13: Multimodality, Article 2: Additional Family Services – BHA Program

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Appropriation	Fund	Long Bill Category	Long Bill Line Item	Bill	Statute	Spending Purpose (Long)	Spending Purpose (Short)	Allowable Uses
IGKBE0179	1000	B-Community Based Mental Health Services	Children and Youth Mental Health Treatment Act (CYMHTA)	N/A	39-28.8-501(1) 27-67-101	Children and youth mental health treatment act (CYMHTA) which allows families to access community residential, intensive community-based services that are an alternative to residential treatment, and post residential transitional treatment services for their child without requiring a dependency and neglect action, when there is no child abuse or neglect. The funding covers the cost of treatment that is not paid by private insurance, Medicaid, Supplemental Security Income (SSI) benefits, and a sliding scale parental fee based on Child support guidelines. For community-based treatment services, costs are covered by the Act and a parental fee not to exceed 50% of the residential parental fee.	Children and Youth Mental Health Treatment Act	Chapter 13: Multimodality, Article 1: Children, Youth, Family Mental Health Treatment Act (CYMHTA) – BHA Program
IGKBF0176	1000	N/A	N/A	N/A	N/A	N/A	N/A	Chapter 11: Screening, Assessment, and Diagnosis, Article 3: Enhanced Standardized Assessments for County Departments of Human Services and Division of Youth Services
IGLAS0524	1000	C-Substance Use Treatment and Prevention Services	Offender Services	N/A	16-11.5-102 27-80-101 27-81-101 27-82-101 18-19-103(5) (c) and (d)	Offender services are intended to reduce recidivism among adult offenders, age eighteen years or older, who have been unsuccessful in community treatment for drug and alcohol abuse and continue to commit offenses. Short-term intensive residential remediation and treatment (STIRRT) includes two weeks of intensive residential treatment followed by nine months of outpatient continuing care. The evidence based practice is often implemented as a diversion to incarceration.	Substance use treatment for offenders to reduce recidivism	Chapter 3: Mental Health and Substance Use Disorder Outpatient, Article 1: Outpatient Behavioral Health Services Chapter 6: Behavioral Health Residential, Article 1: Substance Use Disorder and Co-Occurring Residential Services – General Safety Net Services Terms Chapter 6: Behavioral Health Residential, Article 5: Community Based Circle Program – BHA Program Chapter 13: Multimodality, Article 3: Strategic Individualized Remediation Treatment (STIRT) – BHA Program

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Appropriation	Fund	Long Bill Category	Long Bill Line Item	Bill	Statute	Spending Purpose (Long)	Spending Purpose (Short)	Allowable Uses
IGLAW0522	1000	C-Substance Use Treatment and Prevention Services	Treatment and Detoxification Programs	N/A	16-11.5-102 (2023) 27-80-101 (2023) 27-81-101 (2023) 27-82-201 (2023) 18-19-103 (5) (c) and (d) (2023) 39-28.8-501 (2023)	BHA provides detoxification and substance use treatment services via contracts with four BHASOs over four geographical areas across the State. Each of the BHASOs subcontract with local community providers to provide substance use treatment services and non-hospital withdrawal management services necessary to protect the client and public health and safety and ensure that substance use treatment services are available across the state. The intent of the BHA treatment contracts is to purchase coordinated and comprehensive services for specific low-income populations of highest priority to the state and federal governments, as well as for clients outside the specific priority populations. The required basic treatment services in the treatment contracts are withdrawal management, outpatient opioid and synthetic opioid replacement treatment, individual, group, and family outpatient therapy, transitional residential treatment, therapeutic community and intensive residential treatment.	General SUD treatment dollars	Chapter 2: Withdrawal Management Chapter 3: Mental Health and Substance Use Disorder Outpatient, Article 1: Outpatient Behavioral Health Services Chapter 3: Mental Health and Substance Use Disorder Outpatient, Article 2: Medications for Opioid Use Disorder Chapter 3: Mental Health and Substance Use Disorder Outpatient, Article 3: Overdose Prevention Chapter 3: Mental Health and Substance Use Disorder Outpatient, Article 4: Contingency Management Chapter 5: High Intensity/Hospital Alternatives, Article 1: Behavioral Health High Intensity Outpatient Services and Hospital Alternatives Chapter 6: Behavioral Health Residential, Article 1: Substance Use Disorder and Co-Occurring Residential Services – General Safety Net Services Terms Chapter 6: Behavioral Health Residential, Article 3: Youth Substance Use Disorder Residential Services – BHA Program Chapter 6: Behavioral Health Residential, Article 5: Community Based Circle Program – BHA Program Chapter 10: Outreach, Article 1: Outreach, Education, and Engagement Requirements Chapter 13: Multimodality, Article 2: Additional Family Services – BHA Program Chapter 13: Multimodality, Article 5: Involuntary Commitment Services

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IGLHN0812	1000	D-Integrated Behavioral Health Services	Circle Program and other Rural treatment programs for people with co-occurring disorders	N/A	27-66-101 (2023) 27-80-101 (2023) 27-81-101 (2023)	The circle program and other rural treatment programs for people with co-occurring disorders line item provides funding for the circle programs that serves adults who suffer from co-occurring disorders (mental illness and substance abuse). Additionally, this line funds a full continuum of co-occurring behavioral health services in southern Colorado and the Arkansas Valley for the adolescent and adult indigent population	Circle Program	Chapter 6: Behavioral Health Residential, Article 5: Community Based Circle Program – BHA Program
IGMGN0525	1000	C-Substance Use Treatment and Prevention Services	Housing Assistance for Individuals with a substance use disorder	SB21-137	27-80-125	This program line funds the housing assistance program. This program provides temporary financial housing assistance to individuals with substance use disorders (SUD) who have no supportive housing options when the individual is: transitioning out of a residential treatment setting and into recovery or receiving treatment for an individual's SUD. Housing assistance for individuals with a substance use disorder-report-rules-appropriation. Concerning the Behavioral Health Recovery Act of 2021, and in connection therewith, making an appropriation.	Housing assistance for individuals with a substance use disorder	Chapter 9: Recovery Supports, Article 3: Recovery Residences
IGMGO0809	1000	D-Integrated Behavioral Health Services	Recovery Support Services Grant Program	SB21-137	27-80-126	Through SB 21-137 funding the RSS grant program will provide grants to recover community organizations for the purpose of providing recovery-oriented services to individuals with a substance use disorder or co-occurring substance use and mental health disorder.	SUD Recovery Support Services	Chapter 9: Recovery Supports, Article 2: Recovery Community Organizations (RCOs)

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Exhibit B-1 – Part 3

Appropriation	Fund	Long Bill Category	Long Bill Line Item	Bill	Statute	Spending Purpose (Long)	Spending Purpose (Short)	Allowable Uses
IRKBE0179	1000	B-Community Based Mental Health Services	Children and Youth Mental Health Treatment Act (CYMHTA)	N/A	39-28.8-501(1) 27-67-101	Children and youth mental health treatment act (CYMHTA) which allows families to access community residential, intensive community-based services that are an alternative to residential treatment, and post residential transitional treatment services for their child without requiring a dependency and neglect action, when there is no child abuse or neglect. The funding covers the cost of treatment that is not paid by private insurance, Medicaid, Supplemental Security Income (SSI) benefits, and a sliding scale parental fee based on Child support guidelines. For community-based treatment services, costs are covered by the Act and a parental fee not to exceed 50% of the residential parental fee.	Children and Youth Mental Health Treatment Act	Chapter 13: Multimodality, Article 1: Children, Youth, Family Mental Health Treatment Act (CYMHTA) – BHA Program

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Exhibit D

Data and Technology Requirements

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Article 1 - BHA Provider Services Technology - BHASO IT Support and Management

1.1 BHA Provider Services is an ecosystem of technology tools that are designed to meet a variety of provider needs. This ecosystem will intend to achieve a more streamlined provider experience through interoperability and data exchange, though these changes will continue to be iterative over time meaning they will both be changed and improved throughout their lifespan.

1.2 BHA intends to release and improve software in small, frequent steps rather than big, infrequent updates. This allows for quicker adjustments based on feedback and needs. BHASOs will work closely with BHA to help network providers adapt to these frequent software changes, ensuring that providers understand and can effectively use new features as they are introduced. As the BHA's technology offerings evolve, BHASOs shall support network providers for additional technical considerations, including but not

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limited to the following:

a. BHASOs shall support any technology end-of-life or deprecations aligned with SB24-224, including transitioning to new technologies. This support includes, but is not limited to,
   i. supporting data transfers and modifications to provider processes to support continuity of data collection
   ii. training and onboarding providers on replacement technologies or processes
b. 1.2b BHASOs shall be involved with the design and implementation and adoption of cross agency technologies. One example is supporting the rollout of the Social Health Information Exchange (SHIE). This involvement includes, but is not limited to:
   i. Facilitation of BHASO network surveying to understand needs in implementation and adoption of technologies
   ii. Engagement in stakeholdering sessions with state agency networks to advocate for provider needs

1.3 BHASOs shall train providers on the BHA systems and administrative access to help manage their providers within the system. BHASOs will be provided with training and learning materials to support managing their providers.

1.4 BHASOs shall provide Tier 0-1[1] level technical support to providers and escalate them to the provider support inbox cdhs_bha_provider_support@state.co.us to submit requests for technical support as needed.

1.5 BHASOs shall partner with BHA to validate access to BHA systems by members of its

[1] Tier 0 refers to self-service support where users resolve issues independently through readily available resources like FAQs, online knowledge bases, or chatbots, while Tier 1 represents the first level of human interaction with support agents who handle basic troubleshooting and common issues like password resets, making it the initial point of contact for most customer inquiries.

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network providers, maintaining an up-to-date knowledge of those authorized as system administrators per provider for each BHA technology system.

1.6 BHASOs shall designate a member of its staff as the Identity and Access Control Administrator for its network, who will be responsive to BHA requests confirming the identities of trusted administrators at network providers and may be empowered to directly administer access controls within BHA systems.

Article 2 - Gather and Submit Data

2.1 Data Expectations Overview

a. In the BHASO Network, BHA is working to expand options for submitting legislatively and contractually-mandated data. As BHASOs will be required to collect and submit significant amounts of data as defined in this Exhibit D from their provider networks, BHASOs shall join BHA's efforts to understand and accommodate varying levels of provider technical capability and reduce administrative overhead for providers wherever reasonable and possible.
b. Technology adoption timelines. BHA understands that technology implementations may take time and evolve. As such, the following section sets out both current and future-looking expectations. BHASOs will provide a timeline for how data submission requirements will be accomplished within the BHASO technology ecosystem, as well as how the BHASO will continue to update and maintain their technology system over the length of the contract term.
c. BHASOs are responsible for supporting providers in these various levels of data collection and are responsible for ensuring that all methods offered adhere to standards and methods outlined in this section (Exhibit D, Article 2). All methods shall be user centered, and shall not prevent subsets of the provider network from meaningfully participating in the data exchange process
d. Data sets and frequency. BHA will release an Annual Data Requirements Report, included in an online format as Appendix 1 and updated at least annually, which lays out the minimum data sets that BHA expects to receive from BHASO provider networks.
    i. Data is never static, however, and BHA will enter into good faith discussions and co-creation efforts with BHASOs and relevant stakeholders whenever data

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sets can be improved or altered to improve the outcomes for people seeking or providing care in Colorado.

ii. As part of each of these requirements, BHASOs shall adopt recommendations and findings of BHA reports in this area. The findings of these reports include items such as improvements to error handling, updating records, data field changes, etc.

1. BHA will collaborate with BHASOs to implement these findings. BHASOs and BHA will implement technology in an agile manner to enable the findings.

e. Data cleaning requirements. Data shall be submitted in a standardized format and will be assessed against the *Technology Compliance Measures,* detailed and defined in the table in Article 11, for completeness, accuracy, timeliness, and structure. Data which does not meet the below standards will trigger a review of methodologies and implementations by BHA.

i. Accuracy and validity are commonly interchangeably used within the data quality space, and both speak to the reliability and confidence of a given dataset. In the context of this framework, accuracy specifically refers to the percentage of successful records for a given dataset. Rejection rules for each data source can be defined per data source

2.2 BHASO Responsibilities: The BHASOs are responsible for the following tasks:

a. Collecting data from provider networks where required, in a manner which minimizes administrative burden on the providers.

i. BHASO shall offer an agreed upon subset of the following methods of data collection from providers:

1. Individual record submission via GUI web applications as deemed by BHA for the specified purpose(s).
2. Secure batch submission via SFTP, Web interface, “Bulk FHIR” compliant API, or other methodology agreed upon with BHA.
3. FHIR-compliant API-based data exchange between EMRs and BHA; or

A. other real-time data exchange method, using a methodology agreed upon with the BHA; or

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B. other direct or custom data exchange between provider and BHASO systems, using a methodology agreed upon with BHA.

4. Integration via HIE, or HIE-like intermediary/intermediaries that support the same methods outlined in this section (Article 2).

b. Submitting data on behalf of provider networks in a timely and automated manner, which minimizes administrative burden on BHA

i. BHASOs shall provide data to BHA in a timely and automated manner, with an ultimate desire to achieve near-real-time data submission, updating, and feedback loops. BHA will provide, and BHASOs shall integrate with, one or more of the following methods (in order of preference):

A. FHIR-compliant API-based data exchange between EMRs and EHRs; or

i. other real-time data exchange method, using a methodology agreed upon with BHA; or

ii. other direct or custom data exchange between BHA and BHASO systems, using a methodology agreed upon with BHA.

B. Integration via HIE, or HIE-like intermediary/intermediaries that support the same methods outlined in this section (Article 2).

C. Secure batch submission via SFTP, Web interface, “Bulk FHIR” compliant API, or other methodology agreed upon with BHA

c. Monitor and enforce provider reporting compliance, including completeness, quality and timeliness across various programs and provider use cases listed below.

i. BHASOs shall ensure that providers in their network submit various data items directly to BHA in a timely manner. BHA will provide easy to use interfaces where required for data submission and make reports available to BHASOs on current provider compliance. BHASOs shall:

A. Ensure BHA has an up-to-date administrative contact for each provider organization, in a structured format

B. Ensure that provider data has been properly submitted on the required timelines

C. Address any data submission quality issues directly with providers

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D. Alert BHA to any reported usability issues or overly burdensome processes so that we can improve our submission processes.

d. Fund and complete internal technology development to meet the needs of this contract and emergent improvements in a timely manner.
   i. BHA is moving to adopt national standards for behavioral health data and information in order to simplify and normalize data submission and exchange across the Colorado behavioral health ecosystem.
      1. To align with this effort, BHASOs shall work with BHA to identify and adopt national data standards where appropriate, and extend them as necessary in collaboration with BHA, for both data collection and submission.
      2. Where data does not fit the agreed standard, BHASOs shall work with BHA to develop or select an alternative standard. Custom data models will not be permissible for data collection and exchange unless BHA and the BHASO agree that no commonly accepted standard exists.
         A. BHASOs will immediately notify BHA in writing of the inability to adhere to commonly accepted standards
         B. Detailed information about the custom data must be provided regarding the format and structure, including but not limited to:
            i. Clear description of the data elements and their definitions
            ii. The format or encoding used for the data (e.g. XML, JSON)
            iii. Any instructions or requirements for processing or interpreting the data
         C. It is at the discretion of BHA to determine if BHASO will be permitted to use any custom data models
      3. Understanding the technical options and providing guidance and technology adoption support to providers with high, moderate and low technical sophistication in completing data submission requirements.
      4. If alternative data standards and models emerge during the course of this contract, BHA and BHASOs will enter into good faith discussions and co-creation efforts to consider their adoption in addition to, or as a replacement for, previously specified data standards and models. Where

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new data requirements have been set according to state or federal mandates, providers must satisfy the new requirements in an expedient manner (within reasonable cost expectations).

5. BHA periodically releases reports and guidance on reducing administrative burden for providers of varying technical abilities. BHASOs shall participate in and adopt the findings of the reports, updating and modernizing user experience and technology systems as needs evolve and new technologies become the standard, or as new legislation may require it.

2.3 Encounters Detail:

a. Encounters Detail

i. Beginning July 1, 2025, BHASOs are responsible for submitting encounter data for all services for which encounter submission indicated in the Annual Data Requirements Report and BHA Finance & Data Protocols. Submission guidelines are included in subsequent sections.

1. BHA Finance & Data Protocol #1, Special Studies Codes & Program Eligibility, Amendment 8 (or as may be amended)
2. State Behavioral Health Services Billing Manual

ii. BHASOs shall enroll in the Medicaid interChange within 90 days of signing the BHA/BHASO contract.

1. Provider Web Portal Quick Guide - Web Portal Registration | Colorado Department of Health Care Policy & Financing
2. Colorado Provider Portal > Home (gainwelltechnologies.com)

iii. All BHASOs, and all providers in their network, must receive PeakPro access and training.[2]

iv. Encounters must be submitted by the last business day of the following month in which the service was rendered.

[2] PeakPro streamlines Medicaid eligibility verification as well as individual enrollment into Medicaid and BHA funded services and programs. BHASOs are required to ensure that all network providers formally enroll all individuals served, check for Medicaid eligibility and establish a member identification number (StateID) for individuals. This allows BHA the ability to track and monitor services across Medicaid and BHA programs.

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1. Starting July 1, 2025, For the initial reporting periods BHASOs will be permitted to submit encounter files directly to BHA using the CCAR interface to fulfill this requirement.
2. BHASOs will participate in a working group (the "MMIS Work Group") with HCPF and BHA to identify requirements and a comprehensive test plan for direct submission of encounters to the interChange. The working group will also establish a timeline for direct submission of encounters to the interChange by BHASOs.
    a. As of the agreed upon date established in the MMIS work group (mentioned in the previous section), encounters shall be sent in the 837P 5010 format via the interChange.

v. As of the agreed upon date established in the MMIS work group (mentioned in the previous section) encounters, regardless of submission interface, must contain a valid client identifier. Valid client identifiers include:
    1. Medicaid ID
    2. State ID (requested via PEAKPro)
    3. Universal ID (for use only while a client is unwilling or unable to provide their identity, e.g. certain crisis scenarios)

2.4 Provider Use Cases:

a. The BHASO shall be responsible for ensuring data is submitted directly to BHA from providers, including, but not limited to, the following data submission system use cases:
    i. Treatment Episode Report Unified Data Model submission (the successor to former CCAR/DACODS submissions) (to be rolled out ahead of BHASO Operational Start Date) including Special Connections
    ii. Programmatic and assessment-based client data collection (to be updated from secure email submission to modernized data collection system):
        1. Child and Adolescent Needs & Strengths Assessment (CANS)
        2. Assertive Community Treatment (ACT) block grant reporting
        3. First Episode Psychosis (FEP) block grant reporting
        4. Additional use cases as required
    iii. Client Level Data for all Crisis Services, including the following stages:
        1. Crisis Stabilization
        2. Mobile

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3. Respite
4. Walk In

iv. Central Registry (Opioid Clinics only) CommCare data collection system

v. Evidence-Based Practices

vi. Involuntary Commitment/Emergency Commitment Client Level Data

vii. Provider facility and service operations information

1. Providers must ensure that information for individual facilities is maintained and updated on a quarterly basis within BHA systems, including but not limited to:
    a. OwnPath Profile (see Article 6)
    b. LADDERS licensing system (see Article 8)
    c. OwnPath Care Directory

b. BHA is in the midst of several efforts to modernize data collection systems which shall involve a period of transition from legacy systems to new systems. BHASOs shall support providers through these transitions in collaboration with BHA.

2.5 Additional or Urgent Data Requests:

a. BHASO acknowledges that BHA may contact the provider if additional data or information is needed to satisfy grant, state, or legislative reporting requirements. Timely communication, response, and reporting of requested data elements is expected.
b. In the event that BHA receives an urgent data request from the federal or state government or driven by law, or other parties that may have authority to impose a deadline on BHA, BHA may make requests directly of the BHASO Network providers, copying the BHASO. The BHASO shall comply or shall support the BHASO Network providers in complying with the timeline that is provided to BHA by the requestor or in law.

Article 3 - Pull Reporting

3.1 Backend Technology System: Business Intelligence (BI) Tooling and Data Access

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a. BHA will set a process and mechanism to collect data shared by BHASOs and/or providers in their network and share data/insights back with BHASOs and providers in their network.
b. Timeline to share data back to BHASOs and their provider network is to be determined but will be available after July 2025.

3.2 Data Evaluation Responsibilities:

a. BHASOs are responsible for the following tasks:
    i. BHASOs shall evaluate and assess their network's performance using data that the BHASO collects from its providers. Provider and overall network performance data will be submitted to the BHA as required by this Exhibit D.
b. The BHASOs shall be responsible for reviewing metrics and reports delivered by BHA. This includes, but is not limited to, the following use cases:
    i. BHASOs shall review and monitor their provider network's performance based on data submitted by BHASOs and/or providers within their network as defined in the Performance Metrics article below. Data will be aggregated for analytics by BHA.
    ii. Providers shall review their own metrics and performance through aggregate reporting mechanisms.

Article 4 - Search For Care

4.1 Backend Technology System: Client Care Search and Referrals tool, a BHA directory and business process tool that connects behavioral health providers to facilitate client transfers, or BHASO's own tooling, if available.

4.2 BHASO Responsibilities:

a. BHASOs are responsible for the following tasks:
    i. BHASOs leverage Client Care Search and Referrals tool to:
        1. Receive and support case escalations that require care coordination, and
        2. Place people seeking care.
    ii. Ensuring providers issue appropriate and comprehensive referrals and/or transfers as needed to other providers.

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iii. Ensure data and metrics are provided to assess and understand the performance of Client Care Search and Referrals tool within their region of network providers either by using BHA systems or providing data from BHASO supported systems

1. Report referral data as outlined in our referrals data model.

4.3 Provider Use Cases:

a. The BHASO shall be responsible within its Region for promoting the Client Care Search and Referrals tool or their own if available to support referrals amongst the BHASO Network. This includes, but is not limited to, the following use cases:
   i. Share referral intake process information with other providers & care coordination teams,
   ii. Ensure patients are only referred and/or transferred to relevant and appropriate care settings, ensuring quality of those referrals,
   iii. Escalate cases for support from care coordination, and
   iv. Receive and manage transfer requests and manage intake process of new clients.
   v. Ensuring all of the above when required to place referrals outside their BHASO region (e.g. provider referral to another BHASO region provider)
b. BHASOs shall be responsible within their region of network providers for utilizing the BHA provided OwnPath Care Directory search for care tool or their own if available. This includes, but is not limited to, the following use cases:
   i. Find information on DUI education and therapy programs to support clients in next steps.
   ii. Provide OwnPath Care Directory resource as tools for clients who are looking for care options.

Article 5 - Update Capacity

5.1 Backend Technology System: Client Care Search- Bed Capacity Tracking

5.2 BHASO Responsibilities:

a. BHASOs are responsible for the following tasks:

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i. Ensure that contracted inpatient facilities update their bed capacity in Client Care Search bed capacity tracking tool at least once every twenty-four (24) hours and residential facilities update their bed capacity when there is a change.
ii. BHASOs shall be responsible within their region of network providers for ensuring the utilization of the BHA Client Care Search bed capacity tracking tool or submitting data to support the same, for all data as detailed for Bed Capacity Tracking in Article 2 and as mandated in statutory requirements HB19-1278.

5.3 Provider Responsibilities:

i. The BHASO Network shall be responsible for utilizing the BHA bed capacity tracking tool or submitting data to support the same, for all data as detailed for Bed Capacity Tracking in Article 2 and as mandated in statutory requirements HB19-1278.

Article 6 - Update Provider Information

6.1 Backend Technology System: OwnPath Profile

6.2 BHASO Responsibilities:

BHASOs are responsible for the following tasks:

i. Ensure providers keep their provider information up-to-date in OwnPath Profile, including following up with providers who have missed their quarterly OwnPath Profile update,
ii. Remind providers on a quarterly basis to update their profile information on OwnPath Profile,
iii. Opt into displaying their profile on the OwnPath Care Directory, and
iv. Manage OwnPath Profile associated trainings in onboarding for new providers,
v. Provide tier 0 level technical support to providers and direct providers to the BHA OwnPath Profile support inbox to submit requests for technical support
vi. Coordinate and facilitate communications between BHA and providers related to efforts including but not limited to system trainings, data updates, and new features,

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vii. Provide BHA with a list of all network providers on a quarterly basis as outlined in the provider profile data structure,

viii. Ensure all providers have at least one user adequately trained and onboarded to OwnPath Profile, and

ix. Notify the BHASO once a user of OwnPath Profile no longer works at the facility and needs to be decommissioned from OwnPath Profile.

Article 7 - Alert BHA to Grievances, Complaints, and Incidents

7.1 BHASO Responsibilities:

a. BHASOs will be responsible for informing providers of the BHA Grievance System where providers can alert the BHA of major incidents and grievances including:
   i. Report complaints and/or grievances,
   ii. Report any critical incident reports through the Critical Incident Report Form or as designated in the online Annual Data Requirements Report (Appendix I)

7.2 Provider Use Cases:

a. The BHASO Network shall be responsible for:
   i. Submitting critical incidents through the Critical Incident Report Form or any future Critical Incident Process provided by BHA.

Article 8 - Renew Licensing

8.1 Backend Technology System: LADDERS platform

8.2 BHASO Responsibilities:

a. BHASOs are responsible for the following tasks:
   i. Verify provider licenses/endorsements, designations, and/or approvals
   ii. Meet the network adequacy standards
   iii. Ensure that Providers keep their licensing, designation, and/or approval information up to date in LADDERS
b. BHA responsibilities
   i. Provide system access to BHA systems for BHASO personnel to perform the responsibilities listed here (Article 8 – Renew Licensing)

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Article 9 - Get Training

9.1 Frontend Technology System: BHASOs ensure access for providers to training or materials provided by the BHA or via OwnPath Learning Hub public facing website as available.

9.2 Other Technology Systems: Cross agency technology systems that support the BHA ecosystem, including but not limited to Social Health Information Exchange (SHIE), grievances system(s), federal enrollments (e.g. Medicare/Medicaid), and any professional licensing or certification systems.

9.3 BHASO Responsibilities:

a. BHASOs are responsible for the following tasks:
    i. Ensure providers receive training on technical systems including providing support for registration, onboarding and account management and promote provider training and certifications via OwnPath Learning Hub,
    ii. Support for provider uptake of training to ensure consistency in quality and training between providers, and
    iii. Shall ensure that providers are adequately trained and enrolled on PeakPro before July 2025 and on an ongoing basis thereafter as mandated by encounter submission requirements for BHA.

Article 10 - Care Access (Telehealth Video/Telephony/Mobile Access)

10.1 BHASO Responsibilities:

a. BHASOs are responsible for the following tasks:
    i. Ensure that BHASO Network providers' telehealth services are in compliance with the State Digital Equity Plan, and
    ii. Monitor and enforce the appropriate use of telehealth video, telehealth telephony, low connectivity telehealth modalities (e.g. SMS, chat, or similar), and mobile access (e.g. vehicular-based outreach teams, or similar) service provision.

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10.2 Provider Use Cases:

a. The BHASO Network shall be responsible for ensuring comprehensive telehealth services are reasonably available within its Region, with a particular focus on people in rural and underserved communities.
    i. Telehealth technology solutions may be offered by network providers or directly by the BHASO.

Article 11 - Performance Monitoring

11.1 BHASO Performance Monitoring:

a. The BHASO shall meet performance monitoring thresholds as set by BHA to ensure people in Colorado are accessing quality care.
    i. In Year 1 of the contract, BHA will collect data from the BHASO and provide updates to BHASOs on their metric performance at a minimum on a quarterly basis. Year 1 data will be used to set an appropriate baseline for annual goal setting and expected metric performance.
        1. BHA will engage with BHASOs in the goal setting process to assess challenges and opportunities that BHASOs see in overseeing their provider networks.
    ii. In Years 2-5, BHASOs shall meet or surpass expected annual metric performance. In the event the BHASO is unable to meet a given metric goal, the BHASO shall engage with BHA to develop a performance improvement plan to ensure that goal is met in future years. BHA and BHASOs will identify if performance improvement goals may require targeted new investments.
        1. BHASOs will have the ability to monitor key metrics on a quarterly basis through BHA's Performance Hub platform.
b. Performance metrics may be subject to change based on input from BHASOs, which may include, but is not limited to, the following:

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Metric Name	Metric Description	Technical Specification
Compliance Measures	**Intentionally left blank**	**Intentionally left blank**
Technology Compliance Measures	**Intentionally left blank**	**Intentionally left blank**
Data Completeness	Data is >= 90% complete on first submission Completeness is defined as the percent of total records submitted to BHA compared to the expected number of records. Methodology for "expected number of records" may be defined per data set, or use year-over-year comparison, trend line projection, or proxy data set comparison.	N/A
Data Accuracy	Data is >= 90% error free on first submission Accuracy and validity are commonly interchangeably used within the data quality space, and both speak to the reliability and confidence of a given dataset. In the context of this framework, accuracy specifically refers to the percentage of successful	N/A

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	records for a given dataset. Rejection rules for each data source can be defined per data source	
Data Timeliness	Data is submitted >= 95%, based on Data Source requirements For each data source, there is a defined expectation for when data should be submitted to BHA to be considered timely. This calculation therefore is the percentage of records that were submitted to BHA within the defined acceptable range.	N/A
Data Structure	Data is submitted on time >=95%, based on Data Source requirements Data collection at BHA uses highly structured data collection instruments that should not be adjusted or deviated from at time of collection or submission. When these data collection instruments are modified, data may not be able to be loaded into BHA's Data Lakehouse or create errors at time of	N/A

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	loading. This calculation expresses the success rate of loading submitted data as the percentage of files that were able to be loaded successfully.	
System Utilization Compliance	Data adheres to the agreed upon structure and standards	N/A
Contractual and Program Compliance Measures	Intentionally left blank	Intentionally left blank
Quality Measures	Intentionally left blank	Intentionally left blank
Time to Services (I-SERV)	The I-SERV measure calculates the Average time for clients to access three different types of services at Behavioral Health Clinics (BHCs) reporting the measure. The I-SERV measure is comprised of three sub-measures of time until provision of: (1) initial evaluation, (2) initial clinical services, and (3) crisis services.	CCBHC Quality Measures
Depression Remission at Six Months	The DEP-REM-6 measure calculates the percentage of clients (12 years of age or older) with Major Depression or Dysthymia who reach Remission Six Months (+/- 60 days) after an Index Event Date.	CCBHC Quality Measures

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Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	The ASC measure calculates the Percentage of clients aged 18 years and older who were screened for unhealthy alcohol use using a Systematic Screening Method at least once within the last 12 months AND who received brief counseling if identified as an unhealthy alcohol user.	CCBHC Quality Measures
Screening for Social Drivers of Health	The SDOH measure calculates the Percentage of clients 18 years and older screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety.	CCBHC Quality Measures

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Exhibit E

Community Mental Health Services Block Grant Contract Supplement

1. Purpose

This supplement is applicable to services funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) Mental Health Block Grant (MHBG).
The Contractor shall reproduce this exhibit in any subcontracts that expend MHBG funds. This exhibit may not be incorporated into subcontracts by reference but must appear in the subcontract.

2. General Requirements
   a. 42 USC 300x-1.(b)(1)(A)(iii) Coordination of Services, 42 USC 300x-1.(b)(1)(C) Children's Services and § 96.132(c) Additional Agreements
      i. The Contractor must coordinate comprehensive community mental health services provided to adults with a serious mental illness (SMI) with the provision of other appropriate services (including health services, rehabilitation, employment, housing, educational, substance use disorder, legal, law enforcement, social services, child welfare, medical and dental, and other support services) to maximize the efficiency, effectiveness, quality, and cost-effectiveness of services to produce the best possible outcomes.
      ii. The Contractor must coordinate comprehensive community mental health services provided to children with a serious emotional disturbance (SED) with the provision of other appropriate services (including social, educational, child welfare, juvenile justice, law enforcement and substance use disorder services) in order for such children to receive care appropriate for their multiple needs.
   b. 42 USC 300x-5. and 300x-31. Restrictions on Expenditure of Grant
      i. The Contractor must not use block grant funds:
         1. To provide inpatient hospital services
         2. To make cash payments to intended recipients of health services
         3. To purchase or improve land

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4. To purchase, construct, or permanently improve (other than minor remodeling) any building or other facility
5. To purchase major medical equipment
6. To satisfy any requirement for expenditure of non-federal funds as a condition for the receipt of federal funds (such as local matching funds)
7. To provide financial assistance to any entity other than a public or nonprofit private entity

c. 42 USC 300x-53.(a) Additional Requirements and § 96.136

The Contractor agrees to participate, if selected, in the Independent Peer Review conducted by the State. The Contractor agrees to permit and cooperate with federal investigations into the use of the MHBG.

d. 42 USC 300x–56. Prohibitions regarding receipt of funds

i. The Contractor understands the following as conditions regarding receipt of MHBG funds:

1. Persons associated with the Contractor shall not knowingly and willfully make or cause to be made any false statement or representation of a material fact in connection with the furnishing of items or services for which payments may be made from the MHBG.
2. Persons associated with the Contractor with knowledge of the occurrence of any event affecting the initial or continued right of the person to receive any payments from a grant made from the MHBG shall not conceal or fail to disclose any such event with an intent to fraudulently secure such payment either in a greater amount than is due or when no such amount is due.
3. Any person who violates any prohibition established in this section shall for each violation be fined in accordance with federal law or imprisoned for not more than 5 years, or both.

e. 42 USC 300x–57. Nondiscrimination

For the purpose of applying the prohibitions against discrimination on the basis of age under the Age Discrimination Act of 1975 [42 U.S.C. 6101 et seq.], on the basis of handicap under section 504 of the Rehabilitation Act of 1973 [29 U.S.C. 794], on the basis of sex under title IX of the Education Amendments of 1972 [20 U.S.C. 1681 et seq.], or on the basis of race, color, or national origin under title VI of the Civil Rights Act of 1964 [42 U.S.C. 2000d et seq.], providers and activities funded

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in whole or in part with MHBG funds shall be considered to be providers and activities receiving Federal financial assistance.

No person shall on the ground of sex (including, in the case of a woman, on the ground that the woman is pregnant), or on the ground of religion, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any program or activity funded in whole or in part with funds made available through the MHBG.

f. 42 USC 300x-66. Services for Individuals with Co-occurring Disorders

The Contractor may use funds available for treatment under 42 USC 300x and 300x-21. to treat persons with co-occurring substance abuse and mental disorders as long as funds available under such sections are used for the purposes for which they were authorized by law and can be tracked for accounting purposes.

g. 2 CFR 200.501 Single State Audit

   i. The Contractor shall adhere to the following requirements:

      1. If the Contractor expends $750,000 or more in federal financial assistance during the Contractor's fiscal year, an independent financial and compliance audit must be completed by a Certified Public Accounting firm under the auspices of 2 CFR 200 Uniform Administrative Requirements for Federal Awards–Single State Audit. The Contractor must submit one electronic copy of the audit report to cdhs_BHAdeliverables@state.co.us by May 31 annually. The Contractor must also submit a data collection form and reporting package to the Federal Audit Clearinghouse.
      2. If the Contractor is a non-Federal entity that expends less than $750,000 during the Contractor's fiscal year, the Contractor must retain records to support expenditures, and the Contractor will make those records available for review or audit by appropriate officials of the Substance Abuse and Mental Health Services Administration (SAMHSA), the state, and the General Accounting Office.
      3. If the 2 CFR 200 audit report includes findings or questioned costs, the Contractor must develop and implement a corrective action plan that addresses the audit findings and recommendations contained therein. The Contractor must submit the corrective action plan to

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cdhs_BHAdeliverables@state.co.us within 60 days of provider's receipt of the audit findings.

4. The Contractor must retain records to support expenditures and make those records available for review or audit by appropriate officials of SAMHSA, the awarding agency, the General Accounting Office and/or their representatives.

h. Health and Human Services Acquisition Regulations 331.101-70 – Salary Limitation
The Contractor shall not use contract funds to pay the direct salary of an individual at a rate in excess of the Federal Executive Schedule Level II in effect on the date the funding was obligated. As of 1/1/23, the salary limitation for Executive Level II is $212,100.

i. Title 31, United States Code, Section 1352, Prohibition on Using Funds for Lobbying
No funds provided under the attached Notice of Award (NoA) may be used by you or any subrecipient under the grant to support lobbying activities to influence proposed or pending federal or state legislation or appropriations. The prohibition relates to the use of federal grant funds and is not intended to affect your right or that of any other organization, to petition Congress or any other level of government, through the use of other nonfederal resources. Reference 45 CFR § 93.
If the Contractor receives federal funds in excess of $100,000, it must disclose whether and how much it uses any non-federal funds for lobbying.

j. Public Law 103-227 Pro-Children Act of 1994 (Act) – Non-smoking
The Contractor shall demonstrate that it prohibits smoking in any facilities owned, leased, or contracted for the provision of health, day care, early childhood development services, education, or library services to children under the age of 18, if the services are funded by federal providers.

k. 45 CFR 75.213— Suspension and Debarment
Non-federal entities are subject to the non-procurement debarment and suspension regulations implementing Executive Orders 12549 and 12689, 2 CFR parts 180 and 376. These regulations restrict awards, subawards and contracts with certain parties that are debarred, suspended or otherwise excluded from or ineligible for participation in Federal assistance programs or activities.

l. Marijuana Restriction

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SAMHSA grant funds may not be used to purchase, prescribe, or provide marijuana or treatment using marijuana. See, e.g., 45 CFR § 75.300(a) (requiring HHS to ensure that Federal funding is expended in full accordance with U.S. statutory and public policy requirements); 21 U.S.C. §§ 812(c)(10) and 841 (prohibiting the possession, manufacture, sale, purchase or distribution of marijuana).

m. Universal Identified and SAM Requirements

This award is subject to requirements as set forth in 2 CFR § 25 – Universal Identifier and System of Award Management (SAM) Requirements.

i. SAM Requirement

Unless you are exempted from this requirement under 2 CFR § 25.110, you, as the recipient, must review and update your information in SAM to ensure it is current, accurate, and complete until you submit the final financial report required under this award or receive the final payment, whichever is later. You are required to review and update the information at least annually after the initial registration, or more frequently if required by changes in your information or another award term.

ii. Unique Entity Identifier

Requirement for unique entity identifier if you are authorized (reference project description) to make subawards under this award, you:

1. Must notify potential subrecipients that no entity (see definition in paragraph C of this award term) may receive a subaward from you, unless the entity has provided its unique entity identifier to you; and
2. May not make a subaward to an entity, unless the entity has provided its unique entity identifier to you.

iii. Definitions.

For purposes of this award term:

1. System of Award Management (SAM) means the Federal repository into which an entity must provide information required for the conduct of business as a recipient. Additional information on SAM registration procedures may be found at: https://www.sam.gov.
2. Unique entity identifier means the identifier required for SAM registration to uniquely identify business entities.

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3. Entity, as it is used in this award term, means all of the following, as defined at 2 CFR § 25, subpart D:
    a. A governmental organization, which is a state, local government, or Indian Tribe;
    b. A foreign public entity;
    c. A domestic or foreign nonprofit organization;
    d. A domestic or foreign for-profit organization; and
    e. A Federal agency, but only as a subrecipient under an award or subaward to a non-Federal entity.
4. Subaward:
    a. This term means a legal instrument to provide support for the performance of any portion of the substantive project or program for which you received this award and that you as the recipient award to an eligible subrecipient.
    b. The term does not include your procurement of property and services needed to carry out the project or program (for further explanation, see 2 CFR § 200.1 and 2 CFR § 200.331).
    c. A subaward may be provided through any legal agreement, including an agreement that you consider a contract.
5. Subrecipient means an entity that:
    a. Receives a subaward from you under this award; and
    b. Is accountable to you for the use of the Federal funds provided by the subaward.

n. 45 CFR § 75.113 – Mandatory Disclosures

The non-Federal entity or applicant for a Federal award must disclose, in a timely manner, in writing to the HHS awarding agency or pass-through entity all violations of Federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the Federal award. Non-Federal entities that have received a Federal award including the term and condition outlined in Appendix XII are required to report certain civil, criminal, or administrative proceedings to SAM. Failure to make required disclosures can result in any of the remedies described in § 75.371,

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including suspension or debarment. (See also 2 CFR parts 180 and 376, and 31 U.S.C. 3321).

o. The Trafficking Victims Protection Act of 2000 (22 U.S.C. § 7104(G)), as amended, and 2 C.F.R. § 175

The Trafficking Victims Protection Act of 2000 authorizes termination of financial assistance provided to a private entity, without penalty to the Federal government, if the recipient or subrecipient engages in certain activities related to trafficking in persons. SAMHSA may unilaterally terminate this award, without penalty, if a private entity recipient, or a private entity subrecipient, or their employees:

i. Engage in severe forms of trafficking in persons during the period of time that the award is in effect;

ii. Procure a commercial sex act during the period of time that the award is in effect; or,

iii. Use forced labor in the performance of the award or subawards under the award.

p. Drug-Free Workplace Requirements

The Drug-Free Workplace Act of 1988 (41 U.S.C. §§ 701 et seq.) requires that all organizations receiving grants from any Federal agency agree to maintain a drug-free workplace. When the AR signed the application, the AR agreed that the recipient will provide a drug-free workplace and will comply with the requirement to notify SAMHSA if an employee is convicted of violating a criminal drug statute. Failure to comply with these requirements may be cause for debarment. Government wide requirements for Drug-Free Workplace for Financial Assistance are found in 2 CFR § 182; HHS implementing regulations are set forth in 2 CFR § 382.400. All recipients of SAMHSA grant funds must comply with the requirements in Subpart B (or Subpart C if the recipient is an individual) of § 382.

q. Accessibility Provisions

Grant recipients of Federal financial assistance (FFA) from HHS must administer their programs in compliance with Federal civil rights law. This means that recipients of HHS funds must ensure equal access to their programs without regard to a person's race, color, national origin, disability, age, and in some circumstances, sex and religion. This includes ensuring your programs are accessible to persons with limited English proficiency.

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r. Liquidation

Recipients must liquidate and invoice BHA for all obligations incurred under an award no later than forty-five (45) days after the end of the award obligation and expenditure period (i.e., the project period).

s. Annual Reporting Requirements 42 USC 300x-9(b)

The BHASO shall provide BHA with requested expenditure and treatment data that is required for BHA's annual reporting requirements for MHBG funds.

3. MHBG Requirements

a. 42 USC 300x(b)(1) Target Population

The Contractor must use block grant funds solely to support community mental health services for:

i. Adults with serious mental illnesses: Includes persons age 18 and older who have a diagnosable behavioral, mental, or emotional condition as defined by the Psychiatric Association's *Diagnostic and Statistical Manual (DSM) of Mental Disorders*. Their condition substantially interferes with or limits one or more major life activities, such as:

1. Basic daily living (for example, eating or dressing)
2. Instrumental living (for example, taking prescribed medications or getting around the community)
3. Participating in a family, school, or workplace

ii. Children with serious emotional disturbances: Includes persons up to age 18 who have a diagnosable behavioral, mental, or emotional issue (as defined by the DSM). This condition results in a functional impairment that substantially interferes with, or limits, a child's role or functioning in family, school, or community activities.

b. 42 USC 300x-1.(b)(1)(A)(vi) Person-centered Planning

The Contractor must engage adults with SMI and children with SED and their caregivers, where appropriate, in making health care decisions including activities to enhance communication among individuals, families, caregivers, and treatment providers.

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c. 42 USC 300x-1.(b)(1)(A)(v) Case Management Services, 42 USC 300x-1.(b)(1)(D) Rural and Homeless Populations, 42 USC 300x-1.(b)(1)(A)(vii)(I-IV) Additional Activities, 42 USC 300x-1.(b)(1)(C) Children's Services, 42 USC 300x-9.(c)(1) Early Serious Mental Illness

   The Contractor shall provide the following services in accordance with program descriptions in the Statement of Work:

   i. Children with severe emotional disturbance,
   ii. Persons with early serious mental illness,
   iii. Case management services,
   iv. Services for rural/homeless populations,
   v. Activities to reduce hospitalization and hospital stays,
   vi. Activities to reduce incidents of suicide,
   vii. Activities to integrate behavioral health and primary care and/or co-occurring mental health and substance abuse services, and/or
   viii. Activities to provide recovery supports for adults with serious mental illness and children with severe emotional disturbance.

d. 42 USC 300-x-2.(c) Criteria for Mental Health Centers

   Services provided by a community mental health center (CMHC) must be provided as follows:

   i. Principally to individuals residing in a defined geographic area (i.e., a service area or catchment area)
   ii. Within the limits of the capacity of the center to serve anyone residing or employed in the service area without regard to ability to pay
   iii. Made available and accessible promptly, as appropriate
   iv. In a manner which preserves human dignity and assures continuity and high-quality care

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4. Contractor and/or Subcontractor Services

   The contractor and/or subcontractor must provide each of the following services:

   i. Outpatient services including:
      1. Specialized services for children
      2. Specialized services for elderly
      3. Specialized services for individuals with serious mental illness
      4. Specialized services for residents of the service area who have been discharged from inpatient treatment at a mental health facility

   ii. 24-hour-a-day emergency services

   iii. Day treatment or other partial hospitalization services or psychosocial rehabilitation services

   iv. Screening for admission to state mental health facilities to determine the appropriateness of such admission.

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Exhibit F - Substance Use Prevention, Treatment, and Recovery Services Block Grant Contract Supplement

1. Purpose

   This supplement is applicable to services funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRS).

   The Contractor shall reproduce this exhibit in any subcontracts that expend SUPTRS funds. This exhibit may not be incorporated into subcontracts by reference, but must appear in the subcontract.

2. General Requirements

   a. 42 USC 300x-28.(c) and § 96.132(c) Additional Agreements

      The Contractor must coordinate prevention and treatment activities with the provision of other appropriate services (including health, social, correctional and criminal justice, educational, vocational rehabilitation and employment services) to maximize the efficiency, effectiveness, quality, and cost-effectiveness of services to produce the best possible outcomes

   b. 42 USC 300x-5. and 300x-31.(a) Restrictions on Expenditure of Grant

      The Contractor must not use block grant funds:

      i. To provide inpatient hospital services, unless an exemption per 42 USC 300x-21 is granted by BHA

      ii. To make cash payments to intended recipients of health services

      iii. To purchase or improve land

      iv. To purchase, construct, or permanently improve (other than minor remodeling) any building or other facility

      v. To purchase major medical equipment

      vi. To satisfy any requirement for expenditure of non-federal funds as a condition for the receipt of federal funds (such as local matching funds)

      vii. To provide financial assistance to any entity other than a public or nonprofit private entity

   c. 42 USC 300x-53.(a) Additional Requirements and § 96.136

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The Contractor agrees to participate, if selected, in the Independent Peer Review conducted by the State. The Contractor agrees to permit and cooperate with federal investigations into the use of the SUPTRS.

d. 42 USC 300x–56. Prohibitions regarding receipt of funds

The Contractor understands the following as conditions regarding receipt of SUPTRS funds:

i. Persons associated with the Contractor shall not knowingly and willfully make or cause to be made any false statement or representation of a material fact in connection with the furnishing of items or services for which payments may be made from the SUPTRS.

ii. Persons associated with the Contractor with knowledge of the occurrence of any event affecting the initial or continued right of the person to receive any payments from a grant made from the SUPTRS shall not conceal or fail to disclose any such event with an intent to fraudulently secure such payment either in a greater amount than is due or when no such amount is due.

iii. Any person who violates any prohibition established in this section shall for each violation be fined in accordance with federal law or imprisoned for not more than 5 years, or both.

e. 42 USC 300x–57. Nondiscrimination

For the purpose of applying the prohibitions against discrimination on the basis of age under the Age Discrimination Act of 1975 [42 U.S.C. 6101 et seq.], on the basis of handicap under section 504 of the Rehabilitation Act of 1973 [29 U.S.C. 794], on the basis of sex under title IX of the Education Amendments of 1972 [20 U.S.C. 1681 et seq.], or on the basis of race, color, or national origin under title VI of the Civil Rights Act of 1964 [42 U.S.C. 2000d et seq.], Contractors and activities funded in whole or in part with SUPTRS funds shall be considered to be Contractors and activities receiving Federal financial assistance.

No person shall on the ground of sex (including, in the case of a woman, on the ground that the woman is pregnant), or on the ground of religion, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any program or activity funded in whole or in part with funds made available through the SUPTRS.

f. 42 USC 300x-66. Services for Individuals with Co-occurring Disorders

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The Contractor may use funds available for treatment under 42 USC 300x and 300x-21. to treat persons with co-occurring substance abuse and mental disorders as long as funds available under such sections are used for the purposes for which they were authorized by law and can be tracked for accounting purposes.

g. 2 CFR 200.501 Single State Audit

The Contractor shall adhere to the following requirements:

i. If the Contractor expends $750,000 or more in federal financial assistance during the Contractor's fiscal year, an independent financial and compliance audit must be completed by a Certified Public Accounting firm under the auspices of 2 CFR 200 Uniform Administrative Requirements for Federal Awards–Single State Audit. The Contractor must submit one electronic copy of the audit report to cdhs_bhadeliverables@state.co.us by May 31 annually. The Contractor must also submit a data collection form and reporting package to the Federal Audit Clearinghouse.

ii. If the Contractor is a non-Federal entity that expends less than $750,000 during the Contractor's fiscal year, the Contractor must retain records to support expenditures, and the Contractor will make those records available for review or audit by appropriate officials of the Substance Abuse and Mental Health Services Administration (SAMHSA), the state, and the General Accounting Office.

iii. If the 2 CFR 200 audit report includes findings or questioned costs, the Contractor must develop and implement a corrective action plan that addresses the audit findings and recommendations contained therein. The Contractor must submit the corrective action plan to cdhs_bhadeliverables@state.co.us within 60 days of Contractor's receipt of the audit findings.

iv. The Contractor must retain records to support expenditures and make those records available for review or audit by appropriate officials of SAMHSA, the awarding agency, the General Accounting Office and/or their representatives.

h. Health and Human Services Acquisition Regulations 331.101-70 – Salary Limitation

The Contractor shall not use contract funds to pay the direct salary of an individual at a rate in excess of the Federal Executive Schedule Level II in effect on the date the funding was obligated. As of 1/1/23, the salary limitation for Executive Level II is $212,100.

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i. Title 31, United States Code, Section 1352, Prohibition on Using Funds for Lobbying
No funds provided under the attached Notice of Award (NoA) may be used by you or any subrecipient under the grant to support lobbying activities to influence proposed or pending federal or state legislation or appropriations. The prohibition relates to the use of federal grant funds and is not intended to affect your right or that of any other organization, to petition Congress or any other level of government, through the use of other nonfederal resources. Reference 45 CFR § 93.

If the Contractor receives federal funds in excess of $100,000, it must disclose whether and how much it uses any non-federal funds for lobbying.

j. Public Law 103-227 Pro-Children Act of 1994 (Act) – Non-smoking
The Contractor shall demonstrate that it prohibits smoking in any facilities owned, leased, or contracted for the provision of health, day care, early childhood development services, education, or library services to children under the age of 18, if the services are funded by federal providers.

k. 45 CFR 75.213— Suspension and Debarment
Non-federal entities are subject to the non-procurement debarment and suspension regulations implementing Executive Orders 12549 and 12689, 2 CFR parts 180 and 376. These regulations restrict awards, subawards and contracts with certain parties that are debarred, suspended or otherwise excluded from or ineligible for participation in Federal assistance programs or activities.

l. Marijuana Restriction
SAMHSA grant funds may not be used to purchase, prescribe, or provide marijuana or treatment using marijuana. See, e.g., 45 CFR § 75.300(a) (requiring HHS to ensure that Federal funding is expended in full accordance with U.S. statutory and public policy requirements); 21 U.S.C. §§ 812(c)(10) and 841 (prohibiting the possession, manufacture, sale, purchase or distribution of marijuana).

m. Universal Identified and SAM Requirements
This award is subject to requirements as set forth in 2 CFR § 25 – Universal Identifier and System of Award Management (SAM) Requirements.

i. SAM Requirement
Unless you are exempted from this requirement under 2 CFR § 25.110, you, as the recipient, must review and update your information in SAM to ensure it is current, accurate, and complete until you submit the final financial

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report required under this award or receive the final payment, whichever is later. You are required to review and update the information at least annually after the initial registration, or more frequently if required by changes in your information or another award term.

ii. Unique Entity Identified

Requirement for unique entity identifier if you are authorized (reference project description) to make subawards under this award, you:

1. Must notify potential subrecipients that no entity (see definition in paragraph C of this award term) may receive a subaward from you, unless the entity has provided its unique entity identifier to you; and
2. May not make a subaward to an entity, unless the entity has provided its unique entity identifier to you.

iii. Definitions.

For purposes of this award term:

1. System of Award Management (SAM) means the Federal repository into which an entity must provide information required for the conduct of business as a recipient. Additional information on SAM registration procedures may be found at: https://www.sam.gov.
2. Unique entity identifier means the identifier required for SAM registration to uniquely identify business entities.
3. Entity, as it is used in this award term, means all of the following, as defined at 2 CFR § 25, subpart D:
    a. A governmental organization, which is a state, local government, or Indian Tribe;
    b. A foreign public entity;
    c. A domestic or foreign nonprofit organization;
    d. A domestic or foreign for-profit organization; and
    e. A Federal agency, but only as a subrecipient under an award or subaward to a non-Federal entity.
4. Subaward:
    a. This term means a legal instrument to provide support for the performance of any portion of the substantive project or program for which you received this award and that you as the recipient award to an eligible subrecipient.

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b. The term does not include your procurement of property and services needed to carry out the project or program (for further explanation, see 2 CFR § 200.1 and 2 CFR § 200.331).
c. A subaward may be provided through any legal agreement, including an agreement that you consider a contract.

5. Subrecipient means an entity that:
   a. Receives a subaward from you under this award; and
   b. Is accountable to you for the use of the Federal funds provided by the subaward.

n. 45 CFR 75.113– Mandatory Disclosures

The non-Federal entity or applicant for a Federal award must disclose, in a timely manner, in writing to the HHS awarding agency or pass-through entity all violations of Federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the Federal award. Non-Federal entities that have received a Federal award including the term and condition outlined in Appendix XII are required to report certain civil, criminal, or administrative proceedings to SAM. Failure to make required disclosures can result in any of the remedies described in § 75.371, including suspension or debarment. (See also 2 CFR parts 180 and 376, and 31 U.S.C. 3321).

o. The Trafficking Victims Protection Act of 2000 (22 U.S.C. § 7104(G)), as amended, and 2 C.F.R. § 175

The Trafficking Victims Protection Act of 2000 authorizes termination of financial assistance provided to a private entity, without penalty to the Federal government, if the recipient or subrecipient engages in certain activities related to trafficking in persons. SAMHSA may unilaterally terminate this award, without penalty, if a private entity recipient, or a private entity subrecipient, or their employees:

i. Engage in severe forms of trafficking in persons during the period of time that the award is in effect;
j. Procure a commercial sex act during the period of time that the award is in effect; or,
k. Use forced labor in the performance of the award or subawards under the award.

p. Drug-Free Workplace Requirements

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The Drug-Free Workplace Act of 1988 (41 U.S.C. §§ 701 et seq.) requires that all organizations receiving grants from any Federal agency agree to maintain a drug-free workplace. When the AR signed the application, the AR agreed that the recipient will provide a drug-free workplace and will comply with the requirement to notify SAMHSA if an employee is convicted of a violating acriminal drug statute. Failure to comply with these requirements may be cause for debarment. Government wide requirements for Drug-Free Workplace for Financial Assistance are found in 2 CFR § 182; HHS implementing regulations are set forth in 2 CFR § 382.400. All recipients of SAMHSA grant funds must comply with the requirements in Subpart B (or Subpart C if the recipient is an individual) of § 382.

q. Accessibility Provisions

Grant recipients of Federal financial assistance (FFA) from HHS must administer their programs in compliance with Federal civil rights law. This means that recipients of HHS funds must ensure equal access to their programs without regard to a person's race, color, national origin, disability, age, and in some circumstances, sex and religion. This includes ensuring your programs are accessible to persons with limited English proficiency.

r. Liquidation

Recipients must liquidate and invoice BHA for all obligations incurred under an award no later than forty-five (45) days after the end of the award obligation and expenditure period (i.e., the project period).

s. Annual Reporting Requirements 45 CFR 96.122(f)

The BHASO shall provide BHA with requested expenditure and treatment data that is required for BHA's annual reporting requirements for SUPTRS funds.

3. SUPTRS Requirements

a. 42 USC 300x-22.(b)(3) Childcare and Prenatal Care and § 96.124 Certain Allocations:

If the Contractor receives SUPTRS funds for special services for pregnant women and women with dependent children (including women attempting to regain custody of their children), the Contractor must provide or arrange for each of the following:

i. Primary medical care, including prenatal care, for women who are receiving substance abuse services.

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ii. Child care while the women are receiving services.

iii. Primary pediatric care for the women's children, including immunizations.

iv. Gender-specific substance abuse treatment and other therapeutic interventions for women that may address issues of relationships, sexual abuse, physical abuse, and parenting.

v. Therapeutic interventions for children in custody of women in treatment which may, among other things, address the children's developmental needs and their issues of sexual abuse, physical abuse, and neglect.

vi. Sufficient case management and transportation services to ensure that the women and their children have access to the services provided by (1.) through (5.) above.

The Contractor must also treat the family as a unit and, therefore, admit both women and their children into treatment services, if appropriate.

b. 42 USC 300x-23. and § 96.126 Capacity of Treatment for Intravenous Drug Abusers The Contractor must:

i. Within 7 days, notify the State whenever the Contractor has reached 90 percent of its treatment capacity.

ii. Admit each individual who requests and is in need of treatment for intravenous drug abuse up to its capacity:

1. Not later than 14 days after making the request for admission or
2. Within 120 days after the request if no other Contractor has the capacity to admit the individual on the date of request and if the Contractor makes interim services available including referral for prenatal care within 48 hours, and the Contractor offers the interim services until the individual is admitted to a substance abuse treatment Contractor

iii. Offer interim services, when appropriate, that include, at a minimum, the following:

1. Counseling and education about HIV and TB, the risks of needle-sharing, the risks of transmission to sexual partners and infants, and steps that can be taken to ensure that HIV and TB transmission does not occur

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2. Referral for HIV or TB treatment services, if necessary
3. Counseling pregnant women on the effects of alcohol and other drug use on the fetus
4. Referrals for prenatal care for pregnant women

iv. Maintain a waiting list that includes a unique patient identifier for each injecting drug user seeking treatment, including patients receiving interim services while awaiting admission.

v. Maintain a mechanism that enables the Contractor to:
   1. Maintain contact with individuals awaiting admission
   2. Consult with the State's capacity management system to ensure that waiting list clients are admitted or transferred to an appropriate treatment provider within a reasonable geographic area at the earliest possible time

vi. Take clients awaiting treatment for intravenous substance abuse off the waiting list only when such persons:
   1. Cannot be located for admission into treatment *or*
   2. Refuse treatment

vii. Carry out activities to encourage individuals in need of treatment services for intravenous drug abuse to undergo such treatment by using scientifically sound outreach models such as those outlined below or, if no such models are applicable to the local situation, another approach which can reasonably be expected to be an effective outreach method:
   1. The standard intervention model as described in *The NIDA Standard Intervention Model for Injection Drug Users: Intervention Manual,* National AIDS Demonstration Research (NADR) Program, National Institute on Drug Abuse, (Feb. 1992)
   2. The health education model as described in Rhodes, F., Humfleet, G.L. et al., *AIDS Intervention Program for Injection Drug Users: Intervention Manual*, (Feb. 1992)
   3. The indigenous leader model as described in Wiebel, W., Levin, L.B., The Indigenous Leader Model: Intervention Manual, (Feb. 1992)

viii. Ensure that outreach efforts have procedures for:
   1. Selecting, training, and supervising outreach workers

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2. Contacting, communicating, and following up with high-risk substance abusers, their associates, and neighborhood residents within the constraints of federal and state confidentiality requirements
3. Promoting awareness among injecting drug users about the relationship between injecting drug use and communicable diseases such as HIV
4. Recommending steps that can be taken to ensure that HIV transmission does not occur

c. 42 USC 300x-24. and § 96.127 Requirements Regarding Tuberculosis (TB)

i. The Contractor must, directly or through arrangements with other public or nonprofit private entities, routinely make available the following TB services to each individual receiving treatment for substance abuse:
   1. Counseling the individual with respect to TB
   2. Testing to determine whether the individual has contracted TB and to determine the appropriate form of treatment for the individual
   3. Appropriate medical evaluation and treatment for individuals infected by TB

ii. For clients denied admission to the program on the basis of lack of capacity, the program must refer such clients to other providers of TB services.

iii. The Contractor must have infection control procedures that are consistent with those established by the Colorado Department of Public Health and Environment to prevent the transmission of TB and that address the following:
   1. Screening patients and identifying those individuals who are at high risk of becoming infected
   2. Meeting all state reporting requirements while adhering to federal and state confidentiality requirements, including 42 CFR part 2
   3. Case management activities to ensure that individuals receive such services

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iv. The Contractor must report all individuals with active TB to the Colorado Department of Public Health and Environment as required by state law and in accordance with federal and state confidentiality requirements, including 42 CFR part 2.

d. 42 USC 300x-27. and § 96.131 Treatment Services for Pregnant Women and § 96.121 Definitions

i. The Contractor must give preference in admission to pregnant women who seek or are referred for and would benefit from SUPTRS-funded treatment services.

ii. The Contractor publicizes the availability of such services and that pregnant women receive admission preference and by conducting outreach activities and campaigns to encourage awareness of and engagement in services.

iii. If the Contractor receives funds to serve an injecting drug-abusing population, the Contractor gives admission to treatment preference as follows:

1. Pregnant injecting drug users
2. Pregnant substance abusers
3. Injecting drug users
4. All others

iv. The Contractor must refer pregnant women to who in the state agency when the Contractor has insufficient capacity to provide services to any such pregnant women who seek the services of the Contractor.

v. The Contractor must make interim services available within 48 hours to pregnant women who cannot be admitted because of lack of capacity.

vi. If a BHASO Network provider is unable to ensure admission into treatment within 48 hours for women who are pregnant, the BHASO Network provider must immediately notify the BHASO for assistance with placement.

vii. The Contractor must offer interim services, when appropriate, that include, at a minimum, the following:

1. Counseling and education about HIV and TB, the risks of needle-sharing, the risks of transmission to sexual partners and infants,

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and steps that can be taken to ensure that HIV and TB transmission does not occur

2. Referral for HIV or TB treatment services, if necessary
3. Counseling pregnant women on the effects of alcohol and other drug use on the fetus and referrals for prenatal care for pregnant women

e. 42 USC 300x-28.(b) and § 96.132 Additional Requirements

i. The Contractor must offer substance abuse prevention, treatment, and recovery personnel ongoing training in the following:

1. Recent trends in substance use disorders in the state
2. Improved methods and evidence-based practices for providing substance use disorder treatment services
3. Performance-based accountability
4. Data collection and reporting
5. Any other matters that would further improve substance use disorder treatment

ii. The Contractor must have in effect a system to protect patient records from inappropriate disclosure, and the system must:

1. Comply with all applicable State and Federal laws and regulations, including 42 CFR part 2
2. Include provisions for employee education on confidentiality requirements and the fact that disciplinary action may occur upon inappropriate disclosure

f. 42 USC 300x-65.(c) Charitable Choice

i. If the Contractor is part of a religious organization/faith-based provider, the Contractor may:

1. Retain the authority over its internal governance
2. Retain religious terms in its name
3. Select board members on a religious basis
4. Include religious references in the mission statements and other governing documents
5. Use space in its facilities to offer SUPTRS-funded activities without removing religious art, icons, scriptures, or other symbols

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ii. If the Contractor is an SUPTRS-funded Contractor that is part of a faith-based organization, the Contractor may not use SUPTRS funds for inherently religious activities such as the following:
    1. Worship
    2. Religious instruction
    3. Proselytization

iii. The Contractor may only engage in religious activities listed under 2. above if both of the following conditions are met:
    1. The activities are offered separately, in time or location, from SUPTRS-funded activities
    2. Participation in the activities is voluntary

iv. In delivering services, including outreach activities, SUPTRS-funded religious organizations cannot discriminate against current or prospective Contractor participants based on:
    1. Religion
    2. Religious belief
    3. Refusal to hold a religious belief
    4. Refusal to actively participate in a religious practice

v. If an otherwise eligible client objects to the religious character of the Contractor, the Contractor shall refer the client to an alternative provider within a reasonable period of time of the objection.

vi. If the Contractor is a religious organization, the Contractor must:
    1. Use generally accepted auditing and accounting principles to account for SUPTRS funds similar to other nongovernmental organizations.
    2. Segregate federal funds from non-federal funds.
    3. Subject Federal funds to audits by the government.
    4. Apply Charitable Choice requirements to commingled funds when state/local funds are commingled with SUPTRS funds.

g. § 96.137 Payment Schedule

The Contractor must ensure that SUPTRS funds for special services for pregnant women and women with dependent children, TB services, and HIV early intervention services are the “payment of last resort,” and the Contractor must make every reasonable effort, including establishment of systems for eligibility

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determination, billing, and collection, to do the following to pay for these services:

i. Collect reimbursement for the costs of providing such services to persons entitled to insurance benefits under the Social Security Act, including programs under title XVIII and title XIX, any state compensation program, any other public assistance program for medical expenses, any grant program, any private health insurance, or any other benefit program.

ii. Secure payments from patients or clients for services in accordance with their ability to pay.

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Exhibit G - Supplemental Provisions for Federal Awards

For the purposes of this Exhibit only, Contractor is also identified as "Subrecipient." This Contract has been funded, in whole or in part, with an award of Federal funds. In the event of a conflict between the provisions of these Supplemental Provisions for Federal Awards, the Special Provisions, the Contract or any attachments or exhibits incorporated into and made a part of the Contract, the Supplemental Provisions for Federal Awards shall control. In the event of a conflict between the Supplemental Provisions for Federal Awards and the FFATA Supplemental Provisions (if any), and/or exhibit regarding SLFRF Federal Provisions, the terms re FFATA and/or SLFRF shall control. If the source of the funding of the Contract is a grant, these Federal Provisions are subject to the Award as defined in §2 of these Federal Provisions, as may be revised pursuant to ongoing guidance from the relevant Federal or State of Colorado agency or institutions of higher education.

1) Federal Award Identification
   i. Subrecipient: Signal Behavioral Health Network
   ii. Subrecipient Unique Entity ID number: D4ZKSXP3G5D5
   iii. The Federal Award Identification Number (FAIN) is
      a) Mental Health Block Grant: B09SM090320
      b) H24 Substance Use Prevention Treatment Block Grant: B08TI087028
      c) H25 Substance Use Prevention Treatment Block Grant: B08TI088095
   iv. The Federal award date is
      a) Mental Health Block Grant: 12/6/2024
      b) H24 Substance Use Prevention Treatment Block Grant: 2/20/2024
      c) H25 Substance Use Prevention Treatment Block Grant: 2/24/2025
   v. The subaward period of performance start date is July 1st 2025 and end date is June 30th 2026.
   vi. Federal Funds:

Contract or Fiscal Year	Amount of Federal funds obligated by this Contract	Total amount of Federal funds obligated to the Subrecipient	Total amount of the Federal Award committed to Subrecipient by CDHS
MHBG FY26	$1,004,814.00	$1,004,814.00	$1,004,814.00
H24 SABG 7/1/25-9/30/25	$759,404.81	$759,404.81	$759,404.81

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Contract or Fiscal Year	Amount of Federal funds obligated by this Contract	Total amount of Federal funds obligated to the Subrecipient	Total amount of the Federal Award committed to Subrecipient by CDHS
H25 SABG FY26	$5,846,262.19 and $ as earned from pooled encumbrance	$5,846,262.19 and $ as earned from pooled encumbrance	$5,846,262.19 and $ as earned from pooled encumbrance

vii. Federal award project description: Behavioral Health Administrative Services Organizations ("BHASOs") are regionally informed administrative organizations with which BHA contracts to establish, administer, and maintain adequate networks of Behavioral Health Safety Net Services and Care Coordination. (C.R.S. § 27-50-401(1)).

viii. The name of the Federal awarding agency is the Substance Abuse and Mental Health Services Administration (SAMHSA) the name of the pass-through entity is the State of Colorado, Department of Human Services (CDHS); and the contact information for the awarding official is Steven Fry, Division of Grants Management, SAMHSA, 7-1109, 1 Choke Cherry Road, Rockville, MD 20857, 240-276-1422, Steven.Fry@samhsa.hhs.gov.

ix. The Catalog of Federal Domestic Assistance (CFDA) number is 93.958, name is Block Grants for Community Mental Health Services, and dollar amount is $18,627,388.00.

The Catalog of Federal Domestic Assistance (CFDA) number is 93.959, name is H24 Substance Use Prevention Treatment and Recovery Services Block Grant, and dollar amount is $36,230,912.00

The Catalog of Federal Domestic Assistance (CFDA) number is 93.959, name is H25 Substance Use Prevention Treatment and Recovery Services Block Grant, and dollar amount is $36,222,192.00

x. This award is not for research & development

xi. The indirect cost rate for the Federal award (including if the de minimis rate is charged per 2 CFR §200.414 Indirect (F&A) costs) is pre-determined based upon the State of Colorado and CDHS cost allocation plan.

2) All requirements imposed by CDHS on Subrecipient so that the Federal award is used in accordance with Federal statutes, regulations, and the terms and conditions of the Federal award, are stated in Exhibit A, Exhibit B, Exhibit E, Exhibit F, and Exhibit G.
3) Any additional requirements that CDHS imposes on Subrecipient in order for CDHS to meet its own responsibility to the Federal awarding agency, including identification of any required financial and performance reports, are stated in Exhibit C and Exhibit D.
4) Subrecipient's approved indirect cost rate is 6.7%.

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5) Subrecipient must permit CDHS and auditors to have access to Subrecipient's records and financial statements as necessary for CDHS to meet the requirements of 2 CFR §200.332 Requirements for pass-through entities, §§ 200.300 Statutory and National Policy Requirements through §200.309 Period of performance, and Subpart F—Audit Requirements of this Part.
6) The appropriate terms and conditions concerning closeout of the subaward are listed in Section 15 of this Exhibit and may be further specified in the accompanying Scope of Work exhibit.
7) **Performance and Final Status**. Subrecipient shall submit all financial, performance, and other reports to CDHS no later than thirty (30) calendar days after the period of performance end date or sooner termination of this Contract containing an evaluation and review of Subrecipient's performance and the final status of Subrecipient's obligations hereunder.
8) **Matching Funds**.
   i. Subrecipient is not required to provide matching funds.

1. Definitions.

1.1 For the purposes of these Federal Provisions, the following terms shall have the meanings ascribed to them below. For a full list of definitions (as of October 1, 2024) under the Uniform Guidance, see 2 CFR 200.1.

1.1.1 "Award" means an award of Federal financial assistance, and the Contract setting forth the terms and conditions of that financial assistance, that a non-Federal Entity receives or administers.

1.1.1.1 Awards may be in the form of:

1.1.1.1.1 Grants;

1.1.1.1.2 Contracts;

1.1.1.1.3 Cooperative Contracts, which do not include cooperative research and development Contracts (CRDA) pursuant to the Federal Technology Transfer Act of 1986, as amended (15 U.S.C. 3710);

1.1.1.1.4 Loans;

1.1.1.1.5 Loan Guarantees;

1.1.1.1.6 Subsidies;

1.1.1.1.7 Insurance;

1.1.1.1.8 Food commodities;

1.1.1.1.9 Direct appropriations;

1.1.1.1.10 Assessed and voluntary contributions; and

1.1.1.1.11 Other financial assistance transactions that authorize the expenditure of Federal funds by non-Federal Entities.

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1.1.1.1.12 Any other items specified by OMB in policy memoranda available at the OMB website or other source posted by the OMB.

1.1.1.2 Award ***does not*** include:

1.1.1.2.1 Technical assistance, which provides services in lieu of money;

1.1.1.2.2 A transfer of title to Federally-owned property provided in lieu of money; even if the award is called a grant;

1.1.1.2.3 Any award classified for security purposes; or

1.1.1.2.4 Any award funded in whole or in part with Recovery funds, as defined in section 1512 of the American Recovery and Reinvestment Act (ARRA) of 2009 (Public Law 111-5).

1.1.2 "Contract" means the Contract to which these Federal Provisions are attached and includes all Award types in § of this Exhibit.

1.1.3 "Contractor" means the party or parties to a Contract funded, in whole or in part, with Federal financial assistance, other than the Prime Recipient, and includes grantees, subgrantees, Subrecipients, and borrowers. For purposes of Transparency Act reporting, Contractor does not include Vendors.

1.1.4 "Unique Entity ID number" or "UEI" is the universal identifier for federal financial assistance applicants, as well as recipients and their direct subrecipients (first tier subrecipients).

1.1.5 "Entity" means:

1.1.5.1 If the source of the funding is a Grant:

1.1.5.1.1 a Non-Federal Entity; or

1.1.5.1.2 a non-profit organization or for-profit organization.

1.1.5.2 If the source of funding is not a Grant:

1.1.5.2.1 all of the following as defined at 2 CFR part 25, subpart C;

1.1.5.2.2 A governmental organization, which is a State, local government, or Indian Tribe;

1.1.5.2.3 a foreign public entity;

1.1.5.2.4 a domestic or foreign non-profit organization;

1.1.5.2.5 a domestic or foreign for-profit organization; and

1.1.5.2.6 a Federal agency, but only a Subrecipient under an Award or Subaward to a non-Federal entity.

1.1.6 "Executive" means an officer, managing partner or any other employee in a management position.

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1.1.7 If the source of funding is a Grant, "Federal Awarding Agency" means a Federal agency providing a Federal Award to a Recipient as described in 2 CFR 200.1. If the source of funding is not a Grant, "Federal Award Identification Number (FAIN)" means an Award number assigned by a Federal agency to a Prime Recipient.

1.1.8 "FFATA" means the Federal Funding Accountability and Transparency Act of 2006 (Public Law 109-282), as amended by §6202 of Public Law 110-252. FFATA, as amended, also is referred to as the "Transparency Act."

1.1.9 "Federal Provisions" means these Federal Provisions subject to the Transparency Act and Uniform Guidance, as may be revised pursuant to ongoing guidance from the relevant Federal or State of Colorado agency or institutions of higher education.

1.1.10 If the source of funding is a Grant, "Grant" as used herein is the Contract to which these Federal Provisions are attached.

1.1.11 "Grantee" means the party or parties identified as such in the Grant to which these Federal Provisions are attached if the source of funding is a Grant. Grantee also means Subrecipient.

1.1.12 "Non-Federal Entity means a State, local government, Indian tribe, institution of higher education, or nonprofit organization that carries out a Federal Award as a Recipient or a Subrecipient.

1.1.13 "Nonprofit Organization" means any organization that:

1.1.13.1 Is operated primarily for scientific, educational, service, charitable, or similar purposes in the public interest;

1.1.13.2 Is not organized primarily for profit;

1.1.13.3 Uses net proceeds to maintain, improve, or expand the organization's operations; and

1.1.13.4 Is not an IHE.

1.1.14 "OMB" means the Executive Office of the President, Office of Management and Budget.

1.1.15 "Pass-through Entity" means a recipient or subrecipient that provides a Subaward to a Subrecipient (including lower tier subrecipients) to carry out part of a Federal program. The authority of the pass-through entity under this part flows through the Subaward agreements between the pass-through entity and subrecipient.

1.1.16 "Prime Recipient" means a Colorado State agency or institution of higher education that receives an Award, or, of the source of funding is a Grant it is that agency or institution identified as the Grantor in the Grant to which these Federal Provisions are attached.

1.1.17 "Subaward" means an award provided by a pass-through entity to a Subrecipient to contribute to the goals and objectives of the project by

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carrying out part of a Federal award received by the pass-through entity. The term does not include payments to a contractor, beneficiary or participant.

1.1.18 "Subrecipient" or, if the source of funding is a Grant, "Subgrantee" means an entity that receives a subaward from a pass-through entity to carry out part of a Federal award. The term Subrecipient does not include a beneficiary or participant. A Subrecipient may also be a recipient of other Federal awards directly from a Federal agency.

1.1.19 "Subrecipient Parent UEI Number" means the subrecipient parent organization's 12-digit Unique Entity ID System (UEI) number that appears in the subrecipient's System for Award Management (SAM) profile, if applicable.

1.1.20 "System for Award Management (SAM)" means the Federal repository into which an Entity must enter the information required under the Transparency Act, which may be found at http://www.sam.gov.

1.1.21 "Total Compensation" means the cash and noncash dollar value an Executive earns during the entity's preceding fiscal year. This includes all items of compensation as prescribed in 17 CFR 229.402(c)(2).

1.1.22 "Transparency Act" means the Federal Funding Accountability and Transparency Act of 2006 (Public Law 109-282), as amended by §6202 of Public Law 110-252. The Transparency Act may also be referred to as FFATA.

1.1.23 "Uniform Guidance" means the Office of Management and Budget Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards, which, unless the source of funding is a Grant, supersedes requirements from OMB Circulars A-21, A-87, A-110, and A-122, OMB Circulars A-89, A-102, and A-133, and the guidance in Circular A-50 on Single Audit Act follow-up. The terms and conditions of the Uniform Guidance flow down to Awards to Subrecipients unless the Uniform Guidance or the terms and conditions of the Federal Award specifically indicate otherwise.

1.1.24 "Vendor" means a dealer, distributor, merchant or other seller providing property or services required for a project or program funded by an Award. A Vendor is not a Prime Recipient or a Subrecipient and is not subject to the terms and conditions of the Federal award. Program compliance requirements do not pass through to a Vendor.

2. Compliance.

2.1 Contractor/Grantee shall comply with all applicable provisions of the Transparency Act and the regulations issued pursuant thereto, all applicable

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provisions of the Uniform Guidance, including, but not limited to, all applicable Federal Laws and regulations required by this Federal Award. Any revisions to such provisions or regulations shall automatically become a part of these Federal Provisions, without the necessity of either party executing any further instrument. The State of Colorado, at its discretion, may provide written notification to Contractor/Grantee of such revisions, but such notice shall not be a condition precedent to the effectiveness of such revisions.

3. System for Award Management (SAM) and Unique Entity ID System (UEI) Requirements.

3.1 SAM. Contractor/Grantee must obtain a UEI but are not required to fully register in Sam.gov. Contractor/Grantee shall maintain the currency of its information in SAM until the Contractor/Grantee submits the final financial report required under the Award or receives final payment, whichever is later. Contractor/Grantee shall review and update SAM information at least annually after the initial registration, and more frequently if required by changes in its information.

3.2 UEI. Contractor/Grantee shall provide its UEI number to its Prime Recipient, and shall update Contractor's/Grantee's information in www.sam.gov at least annually after the initial registration, and more frequently if required by changes in Contractor's/Grantee's information.

4. Total Compensation.

4.1 Contractor/Grantee shall include Total Compensation in SAM for each of its five most highly compensated Executives for the preceding fiscal year if:

4.1.1 The total Federal funding authorized to date under the Award is $30,000 or more if the source of funding is a Grant, or otherwise $25,000 or more if the source of funding is not a Grant; and

4.1.2 In the preceding fiscal year, Contractor/Grantee received:

4.1.2.1 80% or more of its annual gross revenues from Federal procurement contracts and subcontracts and/or Federal financial assistance Awards or Subawards subject to the Transparency Act; and

4.1.2.2 $25,000,000 or more in annual gross revenues from Federal procurement contracts and subcontracts and/or Federal financial assistance Awards or Subawards subject to the Transparency Act if the source of funding is a Grant or otherwise $25,000,000 or more in annual gross revenues from Federal procurement contracts and subcontracts and/or Federal financial assistance Awards or Subawards subject to the Transparency Act if the source of funding is not a Grant; and

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4.1.2.3 The public does not have access to information about the compensation of such Executives through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C. 78m(a), 78o(d) or § 6104 of the Internal Revenue Code of 1986.

5. Reporting.

5.1 If Contractor/Grantee is a Subrecipient of the Award pursuant to the Transparency Act, Grantee shall report data elements to SAM and to the Prime Recipient as required in this Exhibit. No direct payment shall be made to Grantee for providing any reports required under these Federal Provisions and the cost of producing such reports shall be included in the Contract/Grant price. The reporting requirements in this Exhibit are based on guidance from the US Office of Management and Budget (OMB), and as such are subject to change at any time by OMB. Any such changes shall be automatically incorporated into this Contract/Grant and shall become part of Contractor's/Grantee's obligations under this Contract/Grant.

6. Effective Date and Dollar Threshold for Reporting.

6.1 If the source of funding is a Grant, Reporting requirements in §7 below apply to new Awards as of October 1, 2010, if the initial award is $30,000 or more. If the initial Award is below $30,000 but subsequent Award modifications result in a total Award of $30,000 or more, the Award is subject to the reporting requirements as of the date the Award exceeds $30,000. If the initial Award is $30,000 or more, but funding is subsequently de-obligated such that the total award amount falls below $30,000, the Award shall continue to be subject to the reporting requirements.

6.2 If the source of funding is not a Grant, Reporting requirements in §7 below apply to new Awards as of October 1, 2010, if the initial award is $25,000 or more. If the initial Award is below $25,000 but subsequent Award modifications result in a total Award of $25,000 or more, the Award is subject to the reporting requirements as of the date the Award exceeds $25,000. If the initial Award is $25,000 or more, but funding is subsequently de-obligated such that the total award amount falls below $25,000, the Award shall continue to be subject to the reporting requirements.

6.3 The procurement standards in §8 below are applicable to new Awards made by Prime Recipient as of December 26, 2015. The standards set forth in §11 below are applicable to audits of fiscal years beginning on or after December 26, 2014.

7. Subrecipient Reporting Requirements.

7.1 If Contractor/Grantee is a Subrecipient, Contractor/Grantee shall report as set forth below.

7.2 To SAM. A Subrecipient shall report the following data elements in SAM ***for each*** Federal Award Identification Number (FAIN) assigned by a Federal agency to a

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Prime Recipient no later than the end of the month following the month in which the Subaward was made:

7.2.1 Subrecipient UEI Number;

7.2.2 Subrecipient UEI Number if more than one electronic funds transfer (EFT) account;

7.2.3 Subrecipient parent's organization UEI Number;

7.2.4 Subrecipient's address, including: Street Address, City, State, Country, Zip (+ 4 if source of funding is a Grant or as otherwise directed per SAM directives for proper reporting), and Congressional District;

7.2.5 Subrecipient's top 5 most highly compensated Executives if the criteria in §4 above are met; and

7.2.6 Subrecipient's Total Compensation of top 5 most highly compensated Executives if the criteria in §4 above met.

7.3 To Prime Recipient. A Subrecipient shall report to its Prime Recipient, upon the effective date of the Contract/Grant, the following data elements:

7.3.1 Subrecipient's UEI Number as registered in SAM.

7.3.2 Primary Place of Performance Information, including: Street Address, City, State, Country, Zip code + 4, and Congressional District.

8. Procurement Standards.

8.1 Procurement Procedures. A Subrecipient shall use its own documented procurement procedures which reflect applicable State, local, and Tribal laws and applicable regulations, provided that the procurements conform to applicable Federal law and the standards identified in the Uniform Guidance, including without limitation, 2 CFR 200.318 through 200.327 thereof.

8.2 If the source of funding is a Grant: Domestic preference for procurements (2 CFR 200.322). As appropriate and to the extent consistent with law, the non-Federal entity should, to the greatest extent practicable under a Federal award, provide a preference for the purchase, acquisition, or use of goods, products, or materials produced in the United States (including but not limited to iron, aluminum, steel, cement, and other manufactured products). The requirements of this section must be included in all subawards including all contracts and purchase orders for work or products under this award.

8.3 Procurement of Recovered Materials. If a Subrecipient is a State Agency or an agency of a political subdivision of the State, its contractors must comply with section 6002 of the Solid Waste Disposal Act, as amended by the Resource Conservation and Recovery Act. The requirements of Section 6002 include procuring only items designated in guidelines of the Environmental Protection Agency (EPA) at 40 CFR part 247, that contain the highest percentage of recovered materials practicable, consistent with maintaining a satisfactory level of competition, where the purchase price of the item exceeds $10,000 or the value of

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the quantity acquired during the preceding fiscal year exceeded $10,000; procuring solid waste management services in a manner that maximizes energy and resource recovery; and establishing an affirmative procurement program for procurement of recovered materials identified in the EPA guidelines.

9. Access to Records.

9.1 A Subrecipient shall permit Recipient/Prime Recipient and its auditors to have access to Subrecipient's records and financial statements as necessary for Recipient to meet the requirements of 2 CFR 200.311-200.332 (Requirements for pass-through entities), 2 CFR 200.300 (Statutory and national policy requirements) through 2 CFR 200.309 (Modification to period of performance), 2 CFR 200.337 (Access to Records) and Subpart F-Audit Requirements of the Uniform Guidance.

9.2 A Subrecipient must collect, transmit, and store information related to this Subaward in open and machine-readable formats (2 CFR 200.336).

10. Single Audit Requirements.

10.1 If a Subrecipient expends $1,000,000 or more in Federal Awards during the Subrecipient's fiscal year, the Subrecipient shall procure or arrange for a single or program-specific audit conducted for that year in accordance with the provisions of Subpart F-Audit Requirements of the Uniform Guidance, issued pursuant to the Single Audit Act Amendments of 1996, (31 U.S.C. 7501-7507). 2 CFR 200.501.

10.2 Election. A Subrecipient shall have a single audit conducted in accordance with Uniform Guidance 2 CFR 200.514 (Scope of audit), except when it elects to have a program-specific audit conducted in accordance with 2 CFR 200.507 (Program-specific audits). The Subrecipient may elect to have a program-specific audit if Subrecipient expends Federal Awards under only one Federal program (excluding research and development) and the Federal program's statutes, regulations, or the terms and conditions of the Federal award do not require a financial statement audit of Prime Recipient. A program-specific audit may not be elected for research and development unless all of the Federal Awards expended were received from Recipient and Recipient approves in advance a program-specific audit.

10.3 Exemption. If a Subrecipient expends less than $1,000,000 in Federal Awards during its fiscal year, the Subrecipient shall be exempt from Federal audit requirements for that year, except as noted in 2 CFR 200.503 (Relation to other audit requirements), but records shall be available for review or audit by appropriate officials of the Federal agency, the State, and the Government Accountability Office.

10.4 Subrecipient Compliance Responsibility. A Subrecipient shall procure or otherwise arrange for the audit required by Subpart F of the Uniform Guidance and ensure it is properly performed and submitted when due in accordance with the Uniform Guidance. Subrecipient shall prepare appropriate financial statements, including

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the schedule of expenditures of Federal awards in accordance with 2 CFR 200.510 (Financial statements) and provide the auditor with access to personnel, accounts, books, records, supporting documentation, and other information as needed for the auditor to perform the audit required by Uniform Guidance Subpart F-Audit Requirements.

11. Contract/Grant Provisions for Subrecipient Contracts.

11.1 In addition to other provisions required by the Federal Awarding Agency or the Prime Recipient, Contractors/Grantees that are Subrecipients shall comply with the following provisions. Subrecipients shall include all of the following applicable provisions in all subcontracts entered into by it pursuant to this Contract/Grant.

11.2 {Applicable to federally assisted construction contracts.} Equal Employment Opportunity. Except as otherwise provided under 41 CFR Part 60, all contracts that meet the definition of "federally assisted construction contract" in 41 CFR Part 60-1.3 shall include the equal opportunity clause provided under 41 CFR 60-1.4(b), in accordance with Executive Order 11246, "Equal Employment Opportunity" (30 FR 12319, 12935, 3 CFR Part, 1964-1965 Comp., p. 339), as amended by Executive Order 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and implementing regulations at 41 CFR part 60, Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor.

11.3 {Applicable to on-site employees working on government-funded construction, alteration and repair projects.} Davis-Bacon Act. Davis-Bacon Act, as amended (40 U.S.C. 3141-3148).

11.4 Rights to Inventions Made Under a contract/grant or agreement. If the Federal Award meets the definition of "funding agreement"/ "funding Contract" under 37 CFR 401.2 (a) and the Prime Recipient or Subrecipient wishes to enter into a contract with a small business firm or nonprofit organization regarding the substitution of parties, assignment or performance of experimental, developmental, or research work under that "funding agreement,"/"funding Contract", the Prime Recipient or Subrecipient must comply with the requirements of 37 CFR Part 401, "Rights to Inventions Made by Nonprofit Organizations and Small Business Firms Under Government Grants, Contracts and Cooperative Agreements," and any implementing regulations issued by the Federal Awarding Agency.

11.5 Clean Air Act (42 U.S.C. 7401-7671q.) and the Federal Water Pollution Control Act (33 U.S.C. 1251-1387), as amended. Contracts and subgrants of amounts in excess of $150,000 must contain a provision that requires the non-Federal awardee(s) to agree to comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act (42 U.S.C. 7401-7671q) and the Federal Water Pollution Control Act as amended (33 U.S.C. 1251-1387). Violations must be

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reported to the Federal Awarding Agency and the Regional Office of the Environmental Protection Agency (EPA).

11.6 Debarment and Suspension (Executive Orders 12549 and 12689). A contract award (see 2 CFR 180.220) must not be made to parties listed on the government wide exclusions in the System for Award Management (SAM), in accordance with the OMB guidelines at 2 CFR 180 that implement Executive Orders 12549 (3 CFR part 1986 Comp., p. 189) and 12689 (3 CFR part 1989 Comp., p. 235), "Debarment and Suspension." SAM Exclusions contains the names of parties debarred, suspended, or otherwise excluded by agencies, as well as parties declared ineligible under statutory or regulatory authority other than Executive Order 12549.

11.7 Byrd Anti-Lobbying Amendment (31 U.S.C. 1352). Contractors that apply or bid for an award exceeding $100,000 must file the required certification. Each tier certifies to the tier above that it will not and has not used Federal appropriated funds to pay any person or organization for influencing or attempting to influence an officer or employee of any agency, a member of Congress, officer or employee of Congress, or an employee of a member of Congress in connection with obtaining any Federal contract, grant or any other award covered by 31 U.S.C. 1352. Each tier must also disclose any lobbying with non-Federal funds that takes place in connection with obtaining any Federal award. Such disclosures are forwarded from tier to tier up to the non-Federal award.

11.8 Never contract with the enemy (2 CFR 200.215). Federal awarding agencies and recipients are subject to the regulations implementing "Never contract with the enemy" in 2 CFR part 183. The regulations in 2 CFR part 183 affect covered contracts, grants and cooperative agreements that are expected to exceed $50,000 during the period of performance, are performed outside the United States and its territories, and are in support of a contingency operation in which members of the Armed Forces are actively engaged in hostilities.

11.9 Prohibition on certain telecommunications and video surveillance equipment or services (2 CFR 200.216). Grantee is prohibited from obligating or expending loan or grant funds on certain telecommunications and video surveillance services or equipment pursuant to 2 CFR 200.216.

11.10 Collection of Unallowable Costs (2CFR 200.410). Payments made for costs determined to be unallowable by either the awarding Federal agency, cognizant agency for indirect costs, or pass-through entity must be refunded with interest to the Federal Government. Unless directed by Federal statute or regulation, repayments must be made in accordance with the instructions provided by the Federal agency or pass-through entity that made the allowability determination. See §§ 200.300 through 200.309, and §200.346.

11.11 Whistle Blower Protections. An employee of a subrecipient must not be discharged, demoted, or otherwise discriminated against as a reprisal for disclosing

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to a person or body described in paragraph (a)(2) of 41 U.S.C. 4712 information that the employee reasonably believes is evidence of gross mismanagement of a Federal contract or grant, a gross waste of Federal funds, an abuse of authority relating to a Federal contract or grant, a substantial and specific danger to public health or safety, or a violation of law, rule, or regulation related to a Federal contract (including the competition for or negotiation of a contract) or grant. The subrecipient must inform their employees in writing of employee whistleblower rights and protections under 41 U.S.C. 4712. See statutory requirements for whistleblower protections at 10 U.S.C. 4701, 41 U.S.C. 4712, 41 U.S.C. 4304, and 10 U.S.C. 4310.

12. Certifications.

12.1 Unless prohibited by Federal statutes or regulations, Recipient/Prime Recipient may require Subrecipient to submit certifications and representations required by Federal statutes or regulations on an annual basis. 2 CFR 200.415. Submission may be required more frequently if Subrecipient fails to meet a requirement of the Federal award. Subrecipient shall certify in writing to the State at the end of the Award that the project or activity was completed or the level of effort was expended. If the required level of activity or effort was not carried out, the amount of the Award must be adjusted.

13. Exemptions.

13.1 These Federal Provisions do not apply to an individual who receives an Award as a natural person, unrelated to any business or non-profit organization he or she may own or operate in his or her name.

13.2 A Contractor/Grantee with gross income from all sources of less than $300,000 in the previous tax year is exempt from the requirements to report Subawards and the Total Compensation of its most highly compensated Executives.

14. Event of Default and Termination.

14.1 Failure to comply with these Federal Provisions shall constitute an event of default under the Contract/Grant and the State of Colorado may terminate the Contract/Grant upon 30 days prior written notice if the default remains uncured five calendar days following the termination of the 30-day notice period. This remedy will be in addition to any other remedy available to the State of Colorado under the Contract/Grant, at law or in equity.

14.2 Termination (2 CFR 200.340). The Federal Award may be terminated in whole or in part as follows:

14.2.1 By the Federal Awarding Agency or Pass-through Entity, if a Non-Federal Entity fails to comply with the terms and conditions of a Federal Award;

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14.2.2 By the Federal awarding agency or Pass-through Entity with the consent of the Non-Federal Entity, in which case the two parties must agree upon the termination conditions, including the effective date and, in the case of partial termination, the portion to be terminated;

14.2.3 By the Non-Federal Entity upon sending to the Federal Awarding Agency or Pass-through Entity written notification setting forth the reasons for such termination, the effective date, and, in the case of partial termination, the portion to be terminated. However, if the Federal Awarding Agency or Pass-through Entity determines in the case of partial termination that the reduced or modified portion of the Federal Award or Subaward will not accomplish the purposes for which the Federal Award was made, the Federal Awarding Agency or Pass-through Entity may terminate the Federal Award in its entirety; or

14.2.4 By the Federal Awarding Agency or Pass-through Entity pursuant to termination provisions included in the Federal Award.

15. Additional Terms re Payments to Grantee to Supplement Main Terms in Contract.

15.1 **Federal Recovery**: The closeout of a Federal Award does not affect the right of the Federal Awarding Agency or the State to disallow costs and recover funds on the basis of a later audit or other review. Any cost disallowance recovery is to be made within the Record Retention Period, as defined below.

15.2 **Close-Out**: Grantee shall close out this Award within 45 days after the Fund Expenditure End Date shown on the Signature and Cover Page for this Agreement. To complete closeout, Grantee shall submit to the State all deliverables (including documentation) as defined in this Agreement and Grantee's final reimbursement request or invoice. The State will withhold 5% of allowable costs until all final documentation has been submitted and accepted by the State as substantially complete. If the Federal Awarding Agency has not closed this Federal Award within one year and 90 days after the Fund Expenditure End Date shown on the Signature and Cover Page for this Agreement due to Grantee's failure to submit required documentation, then Grantee may be prohibited from applying for new Federal Awards through the State until such documentation is submitted and accepted.

Exhibit End