Health District
OF NORTHERN LARIMER COUNTY

02/20/2024

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POLICY ANALYSIS

SB24-059: CHILDREN'S BEHAVIORAL HEALTH STATEWIDE SYSTEM OF CARE

Concerning establishing a children's behavioral health statewide system of care.

Details

Bill Sponsors:	House – *Rep. Duran (D), Rep. Pugliese (R)*, Rep. Bradley (R), Rep. Evans (D), Rep. Froelich (R), Rep. Joseph (D), Rep. Young (D) Senate – *Sen. Kirkmeyer (R), Sen. Michaelson-Jenet (D)*, Sen. Fields (D), Sen. Pelton (R), Sen. Zenzinger (D)
Committee:	Senate Health & Human Services
Bill History:	01/17/24- Introduced in the Senate
Next Action:	02/22/24- Hearing in Senate Health & Human Services
Fiscal Note:	2/14/24

Bill Summary

The bill establishes the Office of the Children's Behavioral Health Statewide System of Care (the Office) in the Behavioral Health Administration (BHA) to develop and maintain a comprehensive children's behavioral health system of care. The system would allow children and youth up to 21 years of age to have a single point of access to behavioral health care regardless of payer, insurance, and income. The bill outlines what the system must include at minimum and sets timelines for the office in developing the system of care.

Additionally, the bill mandates the Office to establish a data and quality team to monitor and report annually on important child welfare indicators. It requires the office to create a website and conduct outreach to inform the public about the system's implementation. A grievance policy must also be developed. The bill also requires the Department of Health Care Policy and Financing (HCPF) to set a standard statewide fee schedule or rate structure for Medicaid-covered behavioral health services for children and youth.

Issue Summary

Youth Mental Health Overview

Mental health is a crucial component of a child's overall health and shapes both physical and social well-being.[1] The Centers for Disease Control and Prevention (CDC) categorizes mentally healthy children as youth who learn appropriate social skills and coping mechanisms to approach difficulties, as well as those who attain emotional and developmental milestones.[2] Children who are mentally healthy have a favorable quality of life and function well at home, in school, and in their communities.[2]

Many children experience anxiety or display disruptive behaviors.[2] However, if these symptoms are persistent, severe or disrupt play, academic or home activities, the youth may be diagnosed with a mental disorder.[2] Up to 1 out of 5 children experience a mental health disorder each year, incurring an estimated $247 billion per year in costs to individuals, families and communities.[2] Half of all mental health conditions begin by age 14 and, if left untreated, can be detrimental to quality of life into adulthood and possibly lead

[1] American Psychological Association (APA) (May 2022). *Children's Mental Health*. Retrieved from https://www.apa.org/pi/families/children-mental-health

[2] Centers for Disease Control and Prevention (CDC), (June 3, 2022) Children's Mental Health. Retrieved from https://www.cdc.gov/childrensmentalhealth/basics.html

to suicide.[3] According to the Robert Wood Johnson Foundation, delayed treatment is associated with incomplete and prolonged recovery.[4] Increasingly, experts are recognizing the importance of identifying behavioral health concerns among youth as early as possible. Lack of treatment can also be fatal: suicide was the 2nd leading cause of death for youth ages 10-24 in 2019, account for 19.7% of youth deaths during that year.[5] The rate of teen suicide has nearly doubled since 2011 in Colorado (2011: 12.3 per 100,000; 2020: 21.6 per 100,000).[6] From 2013 to 2017, there were 320 suicide deaths of Colorado youth ages 10 to 18.[7] In 2021, 7.4% of high schoolers in Larimer County had attempted suicide one or more times in the previous 12 months.[8] Nearly double that (14.4%) reported making a plan about how they would attempt suicide in the previous 12 months. Rates vary widely between demographics, with 9% of males, 16% of females and 40% of gender queer/nonbinary students reporting making such plans.

Mental disorders commonly diagnosed in youth are anxiety, depression, post-traumatic stress disorder (PTSD) attention-deficit/hyperactivity disorder (ADHD), and behavior disorders such as oppositional defiant disorder (ODD), conduct disorder (CD), Tourette syndrome, and obsessive-compulsive disorder (OCD). [2] Some children with a mental disorder may never be diagnosed, while others can be diagnosed at in early childhood or later in the teenage years.[2] In fact, 1 in 6 U.S. children aged 2–8 years (17.4%) had a diagnosed mental, behavioral, or developmental disorder.[9] The symptoms of mental disorders fluctuate as the child grows; consequently, early diagnosis and engagement of applicable services is key to maximizing treatment benefit for youth and their families.[2] Treatment rates vary among different mental disorders for youth. For children aged 3-17 with depression, 78.1% received treatment; however, for children with anxiety only 59.3% received treatment and 53.5% with behavior disorders received treatment.[9]

Impact of the COVID-19 Pandemic on Youth Mental Health[10]

The COVID-19 pandemic has exacerbated youth mental health conditions. Public health policies over the course of the public health emergency have required social distance to minimize spread of the virus. However, social distancing and other requirements to minimize community spread frequently prevented social contact outside of the home. Schools closed and required children to learn from virtual classes and childcare centers closed. Children were thus largely disconnected from social support systems and networks outside of their home and missed typical milestones – birthday parties, graduations, proms, etc., while also not being able to visit with family and loved ones. This social isolation and disruption caused youth significant emotional distress. Parents also faced a variety of challenges including being transitioned to work from home, subjected to higher risk of catching the virus as an essential worker, or lost their jobs due to the ensuing economic down-turn. The resulting caregiver stress, paired in some cases with the added loss of economic security and change in routine, compounded in some youth their anxiety, depression, and mental distress. Additionally, some youth may have been more exposed to child abuse and neglect, sexual violence and intimate partner violence at home. In fact, more than half (55%) of high school students in the United States reported in a 2021 survey that they had experienced emotional abuse by a parent or other adult in

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[3] The World Health Organization (WHO) (2022) *Improving the mental and brain health of children and adolescents.* Retrieved from https://www.who.int/activities/Improving-the-mental-and-brain-health-of-children-and-adolescents

[4] Robert Wood Johnson Foundation (April 1, 2012). *Early Intervention in Psychosis.* Retrieved from https://www.rwjf.org/en/library/research/2012/04/early-intervention-in-psychosis.html

[5] Heron, M. (July 26, 2021). Deaths: Leading Causes for 2019. *National Vital Statistics Reports. (70)*9. CDC: Division of Vital Statistics. Retrieved from https://www.cdc.gov/nchs/data/nvsr/nvsr70/nvsr70-09-508.pdf

[6] Kids Count Data Center, "Teen Suicides" 2021. https://datacenter.kidscount.org/data/tables/9851-teen-suicides-rate-per-100000?loc=7&loct=2#detailed/2/any/false/1729,37,871,870,573,869,36,868,867,133/any/19168,19169

[7] Mintz, S., Heilmann, L., Hoagland, K., & Jamison, E. (n.d.) *Suicide Among Youth in Colorado, 2013-2017: Ages 10-18.* Colorado Department of Public Health & Environment. Retrieved from https://drive.google.com/file/d/1fPpGOpl3Rcje0hFHVz1m7lkRrvu1pt3a/view

[8]Colorado Department of Health & Environment [CDPHE] (2022). Healthy Kids Colorado Survey Dashboard. Retrieved from https://cdphe.colorado.gov/healthy-kids-colorado-survey-dashboard

[9] CDC (June 3, 2022). *Data and Statistics on Children's Mental Health.* Retrieved from https://www.cdc.gov/childrensmentalhealth/data.html

[10] CDC (March 31, 2022). *New CDC data illuminate youth mental health threats during the COVID-19 pandemic*. Retrieved from https://www.cdc.gov/media/releases/2022/p0331-youth-mental-health-covid-19.html

the home, including swearing at, insulting, or putting down the student. And 11% experienced physical abuse by a parent or other adult in the home, including hitting, beating, kicking, or physically hurting the student.

Collaboration Among State Departments

Effective collaboration among various state departments is crucial for providing coordinated care to children, youth, and families in need. Without such collaboration, there is a risk of family members assuming the role of primary medical managers.[11] The complex array of services and supports from multiple entities can lead to duplicative efforts or unnecessary service utilization.[12] Drawing from literature on community-based processes, it is evident that interagency collaboration is key to developing an effective system of care.[13, 14]

Interorganizational distrust and conflict often arise when there is a lack of mutual trust or confidence between different organizations collaborating on a shared goal or project.[15] Government plays a critical role in shaping the development of systems of care for children and adolescents with behavioral health needs. Collaboration among agencies, driven by supportive policies from government leaders, can lead to better-integrated and more comprehensive services. However, without strong backing for interagency collaboration, care for youth may become disjointed, duplicative, inefficient, and less effective, resulting in fragmented services and compromised outcomes.[16]

Single Point of Access

A "single point of entry" program serves as a comprehensive hub where individuals seeking or requiring long-term care can access essential services and support.[17] Research suggests that such single-entry models (SEMs) are effective in reducing the time from primary care referral to consultation, thereby enhancing access to a range of health services.[18] Clients benefit from simplified processes, improved access, reduced wait times, and enhanced quality of care.[19, 20] Service providers also experience advantages such as more comprehensive assessments, time savings, and improved team collaboration.[21]

System of Care

Originally defined as a comprehensive spectrum of mental health and other necessary services organized into a coordinated network to address the diverse and evolving needs of children and their families the

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[11] Berry, J. G., Hall, M., Neff, J., Goodman, D., Cohen, E., Agrawal, R., Kuo, D., & Feudtner, C. (2014). Children with medical complexity and Medicaid: spending and cost savings. Health affairs (Project Hope), 33(12), 2199–2206. https://doi.org/10.1377/hlthaff.2014.0828

[12] Oregon Health Authority, Oregon Department of Human Services. (2018). Oregon's Child, Youth & Family Continuum of Care: A System in Crisis – Proposed Systemic Solutions

[13] Beckley, T.M., Martz, D., Nadeau, S., Wall, E., Reimer, B. (2008). Multiple capacities, multiple outcomes: delving deeper into the meaning of community capacity. Journal of Rural and Community Development, 3, 56–75

[14] Bryson, J.M.; Crosby, B.C., & Middleton Stone, M. (2006). The design and implementation of cross-sector collaborations: Propositions from the literature. Public Adm. Rev., 66, 44–55.

[15] Gonçalves de Almeida, J. M., Gohr, C. F., & Santos, L. C. (2020). Assessing collaborative capabilities for sustainability in interorganizational networks. *Sustainability*, *12*(22), 9763.

[16] Zachik, A. A., Heffron, W. M., Junek, W., Pumariega, A., & Russell, T. (2003). Relationships between systems of care and federal, state, and local governments. In A. J. Pumariega & N. C. Winters (Eds.), The handbook of child and adolescent systems of care: The new community psychiatry (pp. 353–379). Jossey-Bass/Wiley.

[17] Title: Single point of entry Definition | Law Insider URL: https://www.lawinsider.com/dictionary/single-point-of-entry

[18] Milakovic, M., Corrado, A. M., Tadrous, M., Nguyen, M. E., Vuong, S., & Ivers, N. M. (2021). Effects of a single-entry intake system on access to outpatient visits to specialist physicians and allied health professionals: a systematic review. *Canadian Medical Association Open Access Journal*, *9*(2), E413-E423.

[19] Sawyer, D. A., & Moreines, S. F. (1995). A model for rural children's mental health services. *Administration and Policy in Mental Health and Mental Health Services Research*, *22*(6), 597-605.

[20] Melathopolous, K., & Cawthorpe, D. (2019). Impact of central intake development and system change on per capita child and adolescent mental health discharges from 2002 to 2017: Implications for optimizing system design by shaping demand. *The Permanente Journal*, *23*.

[21] Isaacs, A. N., Sutton, K., Dalziel, K., & Maybery, D. (2017). Outcomes of a care coordinated service model for persons with severe and persistent mental illness: a qualitative study. *International Journal of Social Psychiatry*, *63*(1), 40-47

system of care approach continues to adapt to advancements in research and service delivery.[22] Embracing core values of community-based, family-driven, youth-guided, and culturally and linguistically competent services, it emphasizes the provision of effective, individualized care while promoting coordination across child-serving systems.[7] Since its inception, systems of care have been conceptualized as multifaceted interventions rooted in a shared philosophy and set of principles, offering adaptability to diverse local contexts and evolving needs.

Medical Necessity Criteria

There are instances where insurers may deny claims, implement coverage restrictions, and explore alternative approaches to navigate compliance with the law. One approach frequently utilized is the consideration of "medical necessity," which insurers and public insurance programs often reference when making decisions regarding treatment approval or rejection.[23] In clinical settings, medical necessity serves as a rationale for approving certain medications or surgeries deemed essential for a patient's well-being.[24] However, the definition of "medically necessary" can be ambiguous, as it relies on delineating what is deemed necessary for health care, medical care, health-related well-being, or disease treatment, often leaving room for interpretation. “Medically necessary” is often interpreted as care that is "generally accepted in the medical community." [25] Such broad definitions have provided insurers with significant flexibility in making coverage determinations, potentially prioritizing financial considerations over person-centered care.[26]

This Legislation

The bill mandates collaboration among several state agencies, including the Behavioral Health Administration (BHA) partnering with the Office of Children, Youth, and Families in the Department of Human Services (DHS); the Department of Health Care Policy and Financing (HCPF); the Division of Insurance (DOI) in the Department of Regulatory Agencies; and the Department of Public Health and Environment (CDPHE), to develop, establish, and maintain a comprehensive Children's Behavioral Health Statewide System of Care (system of care) in Colorado. This system will serve as the centralized, single point of access to address the behavioral health needs of children and youth in the state, regardless of payer, insurance, and income.

The system of care will cater to children and youth up to twenty-one years old who are dealing with mental health disorders, substance use disorders, co-occurring behavioral health disorders, or intellectual and developmental disabilities.

Key components of the system of care will include, at a minimum, a statewide behavioral health standardized screening and assessment tool, a trauma-informed mobile crisis response and stabilization services for children and youth, tiered care coordination for moderate and intensive levels of need, parent and youth peer support, intensive in-home and community-based services, out-of-home treatment services, and respite services.

The bill establishes the Office of the Children's Behavioral Health Statewide System of Care (Office) within the BHA. This Office will be the primary governance entity responsible for coordinating all relevant state agencies involved in the system of care, including, but not limited to, the DHS Office of Children, Youth, and

[22] Stroul, B. A., & Friedman, R. M. (2011). Effective strategies for expanding the system of care approach. A report on the study of strategies for expanding systems of care. Atlanta, GA: ICF Macro.
[23] Godwin, S., & Earp, B. D. (2023). The paradox of medical necessity. *Clinical Ethics*, *18*(3), 281-284.
[24] Gilmore, E. J. (2020). Continuous Electroencephalogram—Necessity or Luxury? *JAMA neurology*, *77*(10), 1211-1212.
[25] Sabin, J. E., & Daniels, N. (1994). Determining" medical necessity" in mental health practice. *The Hastings Center Report*, *24*(6), 5-13.
[26] Monahan, A. B., & Schwarcz, D. (2021). Rules of Medical Necessity. *IowA L. REv.*, *107*, 423.

Families, the Division of Child Welfare, and the Division of Youth Services; HCPF; the DOI; and CDPHE. The Office will be directed by the Deputy Commissioner of the Office.

The bill requires the Office to create and convene, on or before November 1, 2024, a Leadership Team responsible for decision-making and oversight. The Leadership Team is required to provide a report to the House Public and Behavioral Health and Human Services Committee (now known as the Health and Human Services Committee) and the Senate Health and Human Services Committee, or their successor committees, on or before July 1, 2027. In addition, by the July 2027 deadline, the Leadership Team must determine whether to recommend if HCPF or the BHA should pursue procurement of a single statewide managed care entity (MCE) to oversee the system of care.

Additionally, the Office is required to create and convene, on or before January 15, 2025, an implementation team tasked with creating an implementation plan for the system of care. The bill further mandates the establishment, by January 15, 2025, of an Advisory Council composed of various stakeholders to provide guidance and input on the development and implementation of the system of care. By January 15, 2030, the Deputy Commissioner of the Office, the BHA Commissioner, and Advisory Council must review the implementation team's duties and functions to determine if it continues or if it is disbanded.
This implementation plan, developed by January 15, 2026, must include the following components:

- A plan for strategic communications, outreach, information, referral, training and workforce development, implementing and monitoring evidence informed and promising practices, achieving mental health equity, and creating a timeline for implementing the full continuum of services.
- Ways to expand screening in primary care and school settings.
- Means of identifying which assessment tools to utilize in various circumstances.
- Plans for identifying and credentialing individuals who administer assessment tools.
- Ways to expand crisis resolution teams statewide.
- Ways to expand intensive and moderate care coordination using high-fidelity wraparound services.
- Ways to revise the definition and qualifications of parent and youth support to be used in conjunction with other services.
- Means of identifying what intensive in-home and community-based services, in addition to multisystemic therapy and functional family therapy, should be included in the services offered.
- Means of identifying what out of home services, in addition to psychiatric residential treatment facilities, should be included in the services offered.
- Ways to address expanding access to trauma-specific services and substance use disorder services
- Ways to expand respite services statewide.
- Ways to remove cumbersome prior authorization and service location requirements, as well as other service limitations that hamper access to services.
- Ways to work with the DOI to implement a policy that requires commercial insurance plans to offer the same child behavioral health services as are provided under Medicaid.
- Ways to expand funding for school-based behavioral health services and ensure they maximize the use of Medicaid.
- Ways to reimburse or provide funding options to continue payment for services provided to families when a child becomes ineligible for Medicaid due to hospitalization or detention.
- Status and recommendations on ways to improve access to Medicaid waivers.
- Making recommendations for full-time employees needed for the Office.
- And recommendations concerning the expansion of funding for the new capacity- building center.

The capacity-building center must receive an annual appropriation of at least $10 million. The implementation plan will have specific requirements related to the center, including a student loan

forgiveness program, paid internships and clinical rotations, revisions to graduate medical education programs in Colorado, a financial aid program for youth transitioning out of foster care, and an expansion of current BHA efforts related to workforce support.

The BHA must develop a state-level process to monitor, report on, and promptly resolve complaints, grievances, and appeals available to all partners within the system of care, including providers and clients.

In addition, the Office must begin or contract for a cost and utilization analysis of the populations of child and youth who are included in the system of care by January 1, 2025, and report on the analysis by July 1, 2025.

HCPF must establish medical necessity criteria for all services in the system of care and by August 30, 2028, the BHA and DOI must determine whether they recommend that private insurers be required to adopt the same medical necessity criteria.

Further, HCPF must set standard rate and utilization floors for all services across all regional accountable entities (RAEs) by July 1, 2025. By that same deadline, HCPF and the BHA must establish a statewide fee schedule or rate frame for Medicaid and non-Medicaid behavioral health services for children and youth.

Each RAE and Behavioral Health Administrative Services Organization (BHASO) must contract with an adequate number of providers within accessible distances to serve all who are eligible for the system of care, including ensure in-person services are available and accessible. There also must be an annual review of whether additional provider specializations should be included in the contracts for the RAEs and BHASOs. RAEs and BHASOs are required to establish agreements with every qualified residential treatment facility or psychiatric treatment facility licensed in Colorado. Contracts with RAEs and BHASOs must also include that services are available to all children or youth who are eligible, such as child welfare or juvenile justice.

The Office must establish a data and quality team to identify key indicators of quality, identify requirements that create duplication or ineffectual reports, identify barriers to data sharing and solutions to the barriers, and determine how the data system will support meaningful data collection and sharing to facilitate the system's implementation.

The BHA will develop a website to provide regularly updated information regarding the goals, activities, progress, and timelines for the system of care. This must include a key performance indicators dashboard. The capacity-building center must work on an education campaign to further education providers, partners, youth, families, and others about the system of care implementation. Also, the Office and the BHA must provide funding to state and local family and youth-run organizations to support awareness campaigns and engage families and youth in planning and participation in the system of care.

Fiscal Note

For state fiscal year (SFY) 2024-25, $3.8 million to multiple state agencies. The bill increases state expenditures by $568 million in SFY 2025-26, and $1.1 billion per year in SFY 2026-27 and future years. These costs are primarily paid from the state's General Fund supplemented in part by state cash funds and federal funds.

Reasons to Support

The bill aims to provide access to a comprehensive behavioral health system for children and youth in Colorado, regardless of their payer, insurance, or income status. This approach is intended to promote equity and ensure that under-resourced populations receive necessary care. This would also alleviate the

patchwork system of care that has been largely left to communities to address with limited funding and capacity.

Additionally, the establishment of the Office of the Children's Behavioral Health Statewide System of Care facilitates centralized governance and coordination among relevant state agencies. This coordinated approach is expected to enhance the efficiency and effectiveness of service delivery, reducing fragmentation and duplication of efforts.

The requirement to establish Leadership and Implementation Teams aims to ensure robust decision-making, oversight, and accountability, enhancing the success and sustainability of the system of care. Another critical component of the system is the capacity building center which would serve to bolster the growth and development of the behavioral health workforce.

Quality assurance measures, such as monitoring and resolving complaints, grievances, and appeals, are included to maintain high standards of service delivery and promote trust among stakeholders. Additionally, the emphasis on transparency through regular reporting and the development of a public website seeks to foster accountability and stakeholder engagement. Transparent communication ensures that all partners are informed about the goals, activities, and progress of the system of care, facilitating trust and collaboration. In addition, data system may allow for more alignment between agencies regarding reporting, which could mean a decreased administrative burden for providers providing different measures to different state entities. The absence of centralized information poses a distinctive challenge within the children's system of care, hindering the ability to identify available services, locate contact details for essential personnel within programs, and access data crucial for making well-informed treatment decisions. Increasing access to this information may increase families' and caregivers' access to timely and appropriate care and support services.

Supporters

- ACLU of Colorado
- Adams County Board of County Commissioners
- American Academy of Pediatrics
- Arapahoe County
- Boulder County
- Colorado League of Charter Schools Action
- COMBINE
- Children's Hospital Colorado
- City and County of Broomfield
- Clayton Early Learning
- Colorado Association of Family and Children's Agencies (CAFCA)
- Colorado Counties Inc. (CCI)
- Colorado Cross Disability Coalition
- Colorado Education Association
- Colorado Hospital Association
- Colorado Society of School Psychologists
- Counties & Commissioners Acting Together (CCAT)
- Denver Health
- Envision: You
- Fostering Colorado
- Jefferson County Human Services
- Oliver Behavioral Consultants
- Raise the Future
- The Arc of Colorado
- Weld County

Reasons to Oppose

Overall, while the bill aims to address critical gaps and improve the behavioral health system for children and youth in Colorado, potential challenges and concerns regarding cost, bureaucracy, standardization, managed care, and data reporting need to be carefully considered and addressed during the legislative process. Some may argue that the bill's implementation represents a significant financial burden on the state budget. Critics raise concerns about the sustainability of funding and potential long-term costs.

The centralized coordination mandated by the bill may lead to bureaucratic complexity and administrative overhead. Critics may argue that the involvement of multiple state agencies and the creation of various teams and councils could result in inefficiencies, delays, and increased bureaucracy. While standardization efforts are emphasized in the bill, critics may raise concerns about the practical challenges of establishing medical necessity criteria, rate structures, and fee schedules for behavioral health services. While enhancing data tracking and reporting is essential for informed decision-making and improving outcomes, critics may raise concerns about the burden that could be placed on providers and agencies to collect, analyze, and report data.

Opponents

- No opposition has been reported.

Other Considerations

The bill requires HCPF to set standard rate and utilization floors for all services across all RAEs by July 1, 2025. The fiscal note does not include impacts for this as HCPF does not currently pay a set fee for service rate for care coordination. The RAEs pay for care coordination services from their per member per month allocation. If HCPF was to set rates for care coordination services, it would represent a major change in the current model and could drive significant fiscal impacts.

About this Analysis

This analysis was prepared by Health District of Northern Larimer County staff. The Health District is a special district of the northern two-thirds of Larimer County, Colorado, supported by local property tax dollars and governed by a publicly elected five-member board. The Health District provides behavioral health, dental care, preventive, and health planning services to the communities it serves. This analysis is accurate to staff knowledge as of date printed. For more information about this analysis or the Health District, please contact David Navas, Policy Analyst, at (970) 530-2736, or e-mail at dnavas@healthdistrict.org.