Department of Human Services and Behavioral Health Administration

FY 2026-27 Joint Budget Committee Hearing Agenda

Tuesday, December 16

9:00 am – 5:00 pm

9:00 – 9:45 Behavioral Health Administration

Main Presenter: Dannette R. Smith, Commissioner

Supporting Presenters:

- Monique Maurice, Chief Financial Officer
- Kelly Causey, Deputy Commissioner of Programs
- Aisha Rousseau, Chief Strategy Officer

9:45 – 10:15 Behavioral Health Ombudsman

Main Presenters:

- Rebecca Swanson, Office of Behavioral Health, Co-Ombudsman
- Sarah Davidon, Office of Behavioral Health, Co-Ombudsman

10:15 – 10:25 Break

10:25 – 10:35 Department of Human Services, Introductions and Opening Comments

Presenter: Michelle Barnes, Executive Director

10:35 – 10:50 Administration and Finance

Main Presenter: Michelle Barnes, Executive Director

Supporting Presenters:

- Jonathan Sibray, Sr. IT Director, Office of Information Technology (OIT)
- Nina Mak, Head of Product, Colorado Benefits Management System (CBMS)

Topics:

- R-09 CDHS General Administration Reduction: Slide 9
- Payments to OIT: Page 5, Question 3 in the packet, Slides 10-11
- CBMS: Page 6, Question 4 in the packet, Slides 12-13

10:50 – 11:05 Office of Adults, Aging, and Disability Services

Main Presenters:

- Erin Wester, Office Director

Topics:

- R-10 Reduction of the Division of Regional Center Electronic Health Record System Reappropriation Line: Slide 28

11:05 – 12:00 Office of Civil and Forensic Mental Health

Main Presenters:

- Leora Joseph, Office Director

Topics:

- R-04, S-01, Leg-02 Adjustments to Mental Health Funding Sources to Increase Restoration Beds: Page 16, Question 16 in the packet, Slide 57
- R-11 Peer Support Contract Reduction: Slide 58
- R-15 Forensic Community Based Services Operating Reduction: Slide 59

12:00 – 1:30 Lunch

1:30 – 3:15 Office of Economic Security

Main Presenters:

- Shelley Banker, Office Director

Topics:

- R-03 Addressing H.R. 1 Changes to SNAP Administration: Slide 75
- R-05/Leg-03 Reducing Financial Pressure on the Colorado Works Program: Page 31, Question 37 in the packet, Slide 89
- R-06 Supporting the County Block Grant Support Fund: Slide 90
- R-07 Reducing the Home Care Allowance Case Management Agency Appropriation: Slide 92
- R-08/Leg-04 Reducing the Cadence of the County Administration Funding Models: Slide 92
- R-17 Reduce Summer Food Benefits Administration: Slide 92
- R-18 SNAP Outreach Funding Reduction: Page 18, Question 19 in the packet, Slide 92

3:15 – 3:30 Break

3:30 – 5:00 Office of Children, Youth, and Families

Main Presenters:

- Robert “Tres” Newport, Acting Office Director

Supporting Presenters:

- Dr. Megan Stidd, Director, Division of Community Programs
- Alex Stojsavljevic, Director, Division of Youth Services
- Joseph Homlar, Director, Division of Child Welfare

Topics:

- R-13 Collaborative Management Program: Page 59, Questions 62-63 in the packet, Slide 102
- R-12 Tony Grampsas Youth Services Reduction: Page 61, Question 64 in the packet, Slide 103
- R-01 Division of Youth Services Through Technology: Page 43, Question 44 in the packet, Slide 117
- R-02, Leg-01 ABA and Day Treatment: Page 57, Questions 56-61 in the packet, Slide 129
- R-14 Foster and Adoptive Parent Recruitment Training and Support Reduction: Page 61, Question 65 in the packet, Slide 131
- R-16 Hotline for Child Abuse and Neglect Reduction: Page 61, Questions 66-67 in the packet, Slide 132

Behavioral Health Administration

FY 2026-27 Joint Budget Committee Hearing

Tuesday, December 19, 2025

Safety Net System

1. Sen. Kirkmeyer: What is the BHA doing to coordinate at the provider level? Providers may receive funding from multiple state agencies. How is the BHA coordinating with HCPF and other state agencies to ensure there are not duplicative costs?

Providers receive funding from multiple state agencies to:

- Serve different populations. Ex. Providers are reimbursed by the Regional Accountable Entities (RAEs) for inpatient and outpatient behavioral health services provided to a Medicaid member, providers receive capacity funding from the Behavioral Health Administrative Service Organizations (BHASOs) to provide services to uninsured individuals.
- Provide services that are not covered by another payer. Ex. Recovery residence costs cannot be covered by Medicaid, therefore providers can seek stipends to cover these costs for low income individuals from BHASOs, regardless of whether the individual is a Medicaid member or not. Medicaid members are only eligible because this is NOT a Medicaid reimbursable service. It is never appropriate for the Behavioral Health Administration (BHA) to pay for a Medicaid covered service for a Medicaid member.

To maximize state resources, draw down federal match whenever possible, and ensure that providers participate in the full ecosystem of publicly funded services, any provider contracted with the BHASOs to provide a service that Medicaid reimburses must be enrolled with the RAE for that service. In addition to maximizing fiscal resources, this also provides better access to care, as individuals seeking services do not have to bounce between different providers depending on insurance status.

To prevent a duplication of funding, the Department of Health Care Policy and Financing (HCPF) and BHA also collaborated to create the opportunity for BHASOs to participate in the Medicaid claims ecosystem. BHASOs are able to submit behavioral health encounter data to HCPF, which allows for the BHA and HCPF to audit for duplication of payments, and to view data across payers to understand utilization of

services across the state. This repository of behavioral health encounters is scheduled to be available for reporting purposes at the beginning of fiscal year FY 2026-27.

Beyond coordinating funding to avoid duplication, BHA is charged with leading and developing the state's vision and strategy for behavioral health in Colorado. Every state agency that administers a behavioral health program is required to collaborate with BHA to achieve the goals and objectives established by the BHA. In addition to formal written agreements, BHA's Commissioner chairs an Interagency Council, made up of 12 executive directors of state agencies that administer behavioral health programs, where BHA coordinates multiple initiatives across state agencies.

With HCPF being the largest payer of behavioral health services in the state, BHA partners closely with HCPF, as well as with local communities, safety net providers, advocates, individuals and families, to guide the design and implementation of policies to assure a coordinated, cohesive, and effective behavioral health system in Colorado. To promote efficient and unduplicated services, BHA and HCPF engage in daily communication, collaboration, and coordination from individual contributors to senior leadership. HCPF and BHA coordinate through integrated planning, data sharing, joint stakeholder engagement, and aligned policies to ensure efficient service delivery, address gaps, and prevent duplication in behavioral health care. BHA provider regulations and standards are the foundational basis used for service delivery determination and inform codes uses for reimbursements and rate setting for services, so the licensing and regulation partnerships are particularly important. HCPF and BHA don't just share the intention of collaboration, but have multiple policies and programs that demonstrate that alignment. Examples include:

- Safety Net Reform: HCPF and the BHA have worked closely to ensure that reforms and the implementation of Colorado's Safety Net system are cohesive. The BHA defines and regulates safety net services and providers, then HCPF relies on those definitions and licenses to enroll behavioral health providers in Medicaid. BHA and HCPF worked closely through the regulatory review process to ensure Medicaid regulations and infrastructure were considered throughout the new rule structure and the behavioral health service definitions did not include any services that could not be covered by Medicaid. This close collaboration then informed HCPFs reform efforts related to creating pathways to enroll, identify, and reimburse safety net providers, and has led to a significant increase in licensed safety net providers enrolled in Medicaid. Through co-facilitated stakeholder engagement, coordinated responses to providers, and jointly developed FAQs, the new Safety Net system went live in July 2024.
- Substance Use Disorder (SUD) Benefit: In response to expanded and discrete regulatory definitions in BHA rules, HCPF expanded Medicaid provider enrollment options to allow for the full continuum of SUD services based on the levels of care outlined in American Society of Addiction Medicine (ASAM)

criteria, which also aligned with HCPF's SUD residential waiver. This SUD continuum now includes multiple levels of outpatient, high intensity outpatient, residential and inpatient enrollment categories. BHA sends HCPF a monthly report of all licensed SUD providers at every level which allows HCPF to monitor member access to SUD providers statewide. In preparation for the transition from ASAM 3rd Edition to ASAM 4th Edition taking effect July 1, 2027, HCPF and BHA contracted with a vendor to develop a robust Provider Ambassador Program, including a toolkit and recorded trainings, as well as facilitated individual and group stakeholder meetings. BHA and HCPF continue to partner in providing support and resources to providers as they prepare to transition by making facility modifications, staffing modifications and practice modifications to come into alignment with ASAM 4th Ed requirements for July of 2027.

- Provider Supports: HCPF supported the BHA in developing and delivering Training and Technical Assistance (TTA) modules aimed at Safety Net and independent providers as part of the behavioral health transformations. HCPF prioritized funding through the American Rescue Plan Act (ARPA) to contract with a vendor ensuring that the trainings were developed in alignment with adult learning styles and to help providers complete BHA training requirements. These training modules remain available across a provider-focused Learning Management System and a Safety Net Provider Training Library website managed by BHA and HCPF, respectively. Topics include administrative functions like contracting and enrollment, licensing standards for BHA and the Colorado Department of Public Health and Environment (CDPHE), evidence-based practices in program design, and financing skills like how to bill Medicaid and BHA or how to complete a cost report.
- Aligning RAEs and BHASOs: HCPF and BHA have worked closely to thoughtfully align program design for the RAEs and BHASOs. This includes:
    - Creating an aligned regional map for RAEs and BHASOs. HCPF and BHA heard from stakeholders about the importance of aligning the RAE and BHASO regions to create simplicity and reduce confusion for those that may interact with both entities, such as members and providers. HCPF and BHA jointly hosted stakeholder meetings and reviewed statewide population data to determine the optimal region map and other considerations as both ACC Phase III and the BHASOs went live on July 1, 2025.

    - Developing joint care coordination expectations. We heard from stakeholders about the importance of aligning care coordination standards between the RAEs and BHASOs, especially as more Coloradans have cycled off of Medicaid after the public health emergency. HCPF and BHA worked together to align the RAE and BHASO scopes of work around

care coordination to ensure that members transitioning between systems do not experience duplication of efforts nor gaps in care, including:

- Collaborative agreements between RAEs and BHASOs that establish standards, processes and workflows for cross-agency communication and coordination; defined roles and responsibilities; data sharing; and a process for escalating member concerns when necessary.
- A standardized tiering system (Tier 1 Care Navigation, Tier 2 Care Coordination, Tier 3 Care Management) to ensure Coloradans transitioning between RAEs and BHASOs due to changes in Medicaid status will continue to receive the same level of care coordination support in both systems.
- Warm handoffs between care coordinators when a member is transitioning from a RAE to a BHASO and vice versa, as well as the sharing of care coordination documentation, such as care plans and needs assessments, to prevent duplication of effort and gaps in care.

2. Sen. Amabile: Has more comprehensive providers resulted in more people receiving more or better services?

Table 1 below provides data indicating that existing providers served an additional 2,268 individuals in FY 2025-26 compared to FY 2024-25, reflecting a 30% increase. Although HCPF collects information on Medicaid members served by CSNPs, there are gaps in our current data submission that we are working to address. Without this additional data, we cannot confidently conclude whether the increase in recently designated CSNPs has resulted in more people receiving services across all payor sources. These gaps exist because:

1. The two new CSNPs have not started to submit encounter data since gaining their CSNP approval, so we cannot answer the question of 'has the addition of the new CSNPs increased service volume - we would still only be measuring the original providers.

2. For the other providers, the data we have accurately reflects how many CCARs are submitted, but not how many services are provided. Data compliance is low/inconsistent as of implementation of new Provider Rule in 2023.

By July 1, 2026, BHA will have implemented the Unified Data Model, a new model that replaces previous provider data submissions. All BHASO providers, including CSNPs, will submit uniform data that will improve the BHA's ability to measure and compare service delivery over different behavioral health service types in coming years.

Table 1: Mental Health Clients by CSNP with Year over Year Change

CSNP	FY24Q1	FY25Q1	FY26Q1	% change FY24-FY25	% change FY25-FY26
AllHealth Network	979	961	1,156	-1.84%	20.29%
Aurora Mental Health & Recovery	710	669	389	-5.77%	-41.85%
Axis Health System	757	399	*	-47.29%	-100.00%
Centennial Mental Health Center	219	222	199	1.37%	-10.36%
Clinica Campesina/Family Health Services	486	519	*	6.79%	-100.00%
Community Reach Center	785	148	959	-81.15%	547.97%
Diversus Health	785	777	584	-1.02%	-24.84%
Eagle Valley Behavioral Health	163	158	*	-3.07%	-100.00%
Health Solutions	944	621	578	-34.22%	-6.92%
Health Solutions West (Mind Springs Health)	1,311	139	*	-89.40%	-100.00%
Jefferson Center for Mental Health	1,089	927	666	-14.88%	-28.16%

North Range Behavioral Health	1,418	1,131	1,039	-20.24%	-8.13%
San Luis Valley Behavioral Health	324	166	242	-48.77%	45.78%
Solvista Health	208	124	358	-40.38%	188.71%
Summitstone Health Partners	766	*	3,157	-100.00%	-
Valley-Wide Health System	137	149	121	8.76%	-18.79%
WellPower	1,285	1,183	1,113	-7.94%	-5.92%
Total	**12,366**	**8,293**	**10,561**	**-32.93%**	**27.35%**

3. Sen. Amabile: Funding for community services has decreased in the last ten fiscal years after adjusting for inflation while criminal justice programs have increased. Could increasing funding for community mental health and crisis services reduce the need for criminal justice services?

Improved diversion and deflection programs, along with more robust crisis services and capacity, possess the potential to reduce the number of individuals living with severe behavioral health needs who are arrested and incarcerated. Of note, the relationship between community mental health services and criminal justice involvement is complex and influenced by multiple variables and external factors.

Reducing criminal justice involvement requires coordinated cross-system strategies. Research shows that a reduction in incarceration and judicial utilization requires formal diversion programs, co-responder programs, specialized behavioral health courts, strong partnerships between law enforcement and behavioral health agencies, and linkage to community resources. Investment in community mental health services alone typically does not produce significant reductions in criminal justice system use.

The legislature has invested funding to address services that are designed to support the needs of individuals with behavioral health concerns interacting with the criminal justice system. Colorado's behavioral health system uses diversion programs and crisis systems services to divert and deflect individuals to the community-based behavioral health system. Additionally, the legislature has invested funding to support behavioral

health services to individuals while in a carceral setting, such as the jail based behavioral health services (JBBS). These support the individual and immediate needs of people to support their behavioral health needs during and leading up to release back into the community. These programs are also demonstrated to reduce recidivism.

4. Sen. Amabile: How do we know if comprehensive providers are actually serving priority populations as required in statute? Please provide any data the BHA receives to describe how comprehensive providers serve people with severe and persistent mental illness, including but not limited to the number of people served and amount of funding used for this purpose.

Legislation that established the safety net forms the foundation upon which BHA and the BHASOs hold providers accountable to serve priority populations. HB 22-1278 implemented new Safety Net provider types with new emphasis and requirements for these providers to serve priority populations and implement no refusal requirements. The priority populations for Safety Net providers include individuals who are:

1. Uninsured, underinsured, Medicaid-eligible, publicly insured, or whose income is below thresholds established by the BHA; AND
2. 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. (C.R.S. 27-50-101(17)).

Comprehensive Safety Net Providers (CSNPs), per statute and rule, are required to serve all priority population individuals unless the individual requires a level of care the provider does not provide, or the provider does not have the capacity to serve the individual within an appropriate time frame. In those cases, the CSNP will coordinate care for the individual to have their needs met by another provider.

Monitoring of CSNPs' compliance with serving priority populations occurs at two levels: first, the BHA Quality and Standards team issues the CSNP approval and verifies ongoing compliance with no eject/reject requirements. Second, the BHASOs oversee the CSNPs' service to priority populations through contract monitoring.

The BHA Quality and Standards Division (Q+S) tracks all refusals of care in real time and also conducts monthly reviews to determine if appropriate refusal reports are

made by CSNPs. The Q+S Division also accepts complaints for refusal and conducts investigations for each and issues adverse licensing action when required.

BHA funds CSNPs to deliver safety net services to uninsured/underinsured individuals with SMI (and other diagnoses) by contracting state and federal dollars to BHASOs, who in turn contract with the CSNPs and other treatment providers in Colorado. The expectations for which Safety Net Services must be available through the BHASO model are listed in statute, including:

- (I) Emergency or crisis behavioral health services;
- (II) Mental health and substance use outpatient services;
- (III) Behavioral health high-intensity outpatient services;
- (IV) Behavioral health residential services;
- (V) Withdrawal management services;
- (VI) Behavioral health inpatient services;
- (VII) Mental health and substance use recovery supports;
- (VIII) Integrated care services;
- (IX) Care management;
- (X) Outreach, education, and engagement services;
- (XI) Outpatient competency restoration;
- (XII) Care coordination;
- (XIII) Hospital alternatives;
- (XIV) Screening, assessment, and diagnosis, including risk assessment, crisis planning, and monitoring to key health indicators; and
- (XV) Additional services that the BHA determines are necessary in a region or throughout the state. (C.R.S. § 27-50-301(3)(a)).

The BHASOs are responsible to ensure that all Safety Net Services are available in each region, and will purchase those services from CSNPs and other providers. The BHASO-CSNP contracts detail which services will be provided and sets client count goals which the BHASO will monitor throughout the year. If a contracted service is not on track to serve anticipated volume of priority population individuals, the BHASOs will engage the CSNPs in active contract management, beginning with collaborative problem solving and potentially leading to adverse action on the contract if issues within the CSNPs' control are not resolved.

SMI Data

The tables below present some contextual data for how individuals with serious mental illness receive care at CSNPs, from client count goals, to common discharge reasons, to common diagnoses.

Table 2: Adults with Serious Mental Illness or Serious Persistent Mental Illness by CSNP Served in FY26 Q1

CSNP	FY24Q1	FY25Q1	FY26Q1	% change FY24-FY25	% change FY25-FY26
AllHealth Network	586	593	701	1.19%	18.21%
Aurora Mental Health & Recovery	265	253	175	-4.53%	-30.83%
Axis Health System	459	223	*	-51.42%	-100.00%
Centennial Mental Health Center	103	119	104	15.53%	-12.61%
Clinica Campesina/Family Health Services	261	241	*	-7.66%	-100.00%
Community Reach Center	446	85	349	-80.94%	310.59%
Diversus Health	467	472	336	1.07%	-28.81%
Eagle Valley Behavioral Health	70	43	*	-38.57%	-100.00%
Health Solutions	*	343	368		7.29%
Health Solutions West (Mind Springs Health)	534	62	*	-88.39%	-100.00%
Jefferson Center for Mental Health	370	314	225	-15.14%	-28.34%
North Range Behavioral Health	687	576	483	-16.16%	-16.15%
San Luis Valley Behavioral Health	95	39	53	-58.95%	35.90%
Solvista Health	55	34	114	-38.18%	235.29%
Summitstone Health Partners	380	*	1,639	-100.00%	

Valley-Wide Health System	87	79	*	-9.20%	-89.87%
WellPower	866	774	782	-10.62%	1.03%
Total	**5,731**	**4,250**	**5,329**	**-25.84%**	**25.39%**

The percent change columns indicate the percent increase or decrease in the number of unique clients who utilized Mental Health services at a Comprehensive Safety Net provider from the previous year and quarter. Please note some CSNPs may submit CCAR data every six month period rather than every three month period. Mile High Behavioral Health and Paragon are new CSNPs in FY26 and were excluded from analysis. From FY 24 to FY 25, BHA stopped requiring data submission as part of the requirement of licensing. Asterisk represents data suppression for counts less than 30.

Table 3: Top 5 Discharge Reason for Adults treated for SMI/SPMI for FY24-FY26

Discharge Reason	FY2024 Q1 Frequency	FY2025 Q1 Frequency	FY2026 Q1 Frequency
Client stopped coming and contact efforts failed	69.57%	68.36%	65.97%
Client Decision	12.33%	14.73%	15.69%
Attendance	8.03%	6.80%	6.87%
Moved	4.47%	4.27%	4.82%
Died	1.77%	1.95%	0%
Financial/Payments	0%	0%	2.25%

Across all years, the number one reason that individuals with SMI who were discharged in the reporting period was because the client stopped coming and contact efforts failed.

Table 4: Primary Diagnosis for Adults treated for SMI/SPMI

Diagnosis	Percentage of Individuals FY24Q1	Percentage of Individuals FY25Q1	Percentage of Individuals FY26Q1
Post-traumatic stress disorder,	13.39%	15.32%	14.05%

unspecified			
Major depressive disorder, recurrent, moderate	13.73%	13.63%	12.59%
Major depressive disorder, recurrent severe without psychotic features	7.44%	6.98%	6.83%
Major depressive disorder, recurrent, unspecified	NULL	4.60%	5.93%
Major depressive disorder, single episode, unspecified	6.50%	NULL	NULL
Bipolar disorder, unspecified	6.69%	5.50%	5.78%

Funding

Individuals with SMI may require many different types of Safety Net Services to meet their needs with whole-person care, so a person with SMI could be served in any modality, including substance use focused programs. That said, to provide a snapshot of the services that are most focused on the SMI population, the following Table 5 summarizes the funding that BHASOs provide to fund intensive services that prioritize individuals with SMI. Note that the table excludes funding for mental health outpatient, crisis, or substance use care in order to provide this SMI-focused view. The full network budget is approximately $210 million across all Safety Net Services and Care Coordination, so intensive services for individuals with SMI make up approximately 15% of the statewide Safety Net budget in the Colorado LIFTS network.

Table 5: FY26 BHASO Funding to SMI Services

Safety Net Service	Modality	General Funds	Cash Funds	Federal Funds	Total Provider Funds
Behavioral Health High Intensity Outpatient and Hospital Alternative	BH High Intensity Outpatient and Hospital Alternatives	$9,742,741.69	-	$355,000.00	$9,586,341.69
	Assertive Community	$3,629,199.00	-	$708,000.00	$4,337,199.00

	Treatment (ACT)				
	ASCENT (First Episode Psychosis FEP)	$430,000.00	-	$2,130,029.63	$2,560,029.63
Total		$13,801,940.69	-	$3,193,029.63	$16,483,570.32
Behavioral Health Residential Treatment	Mental Health Residential Services	$5,400,000.00	-	$200,000.00	$5,600,000.00
	Community Based Circle Program	$673,141.12	$7,470,950.88	-	$8,144,092.00
Total		$6,073,141.12	$7,470,950.88	$200,000.00	$13,744,092.00
Mental Health & SUD Recovery Supports	Individualized Placement and Support (IPS)	$583,257.00	$340,000.00	-	$923,257.00
Total		$583,257.00	$340,000.00	-	$923,257.00
Total		**$20,458,338.81**	**$7,810,950.88**	**$3,393,029.63**	**$31,150,919.32**

5. Sen. Kirkmeyer: What has the BHA done to create a comprehensive system of behavioral health care across the state and ensure there is not duplication of services across state agencies? Can the BHA identify programs that they have determined to be duplicative, or gaps in service that have been addressed as a result of coordination across state agencies?

BHASO Model

BHA's implementation of BHASOs demonstrates the coordination efforts across state agencies, and especially HCPF, to implement a comprehensive behavioral health safety

net system. Prior to the implementation of the BHASO model in July 2025, the behavioral health system consisted of a crisis network, a separate substance use treatment network, and more than a dozen community mental health centers. Each of these entities had unique contracts, access points, and care standards. In the BHASO model, these three discrete networks have been consolidated into one network—the Colorado LIFTS network. The BHASOs oversee the network and are responsible for coordinating services within the network. This enhanced care coordination includes one centralized point of contact for individuals who need help understanding, locating, or enrolling in services that will address their or their family member's needs.

- If the individual is in an active crisis, the BHASO Care Navigator will provide a warm transfer to 988.
- If the individual is a Medicaid member, the BHASO Care Navigator will provide a warm transfer to their RAE's (Regional Accountability Entity) care navigation team.
- All other individuals, regardless of insurance status, can be assisted by a BHASO's team. This assistance can range from a 'light touch'(recommendation/connection to service provider) to more involved intervention (care plan of wrap-around services provided by a team).

BHA has partnered closely with HCPF, the largest payer of behavioral health services in the state, to inform and design the BHASO model. All Colorado LIFTS providers must be enrolled in Medicaid or pursuing Medicaid enrollment if their service is Medicaid-covered. Per the BHASO contract, providers shall verify if an individual is Medicaid eligible. If the individual is found to be Medicaid eligible and not enrolled, the provider shall offer to assist the individual in enrolling in Medicaid. BHASO Network providers may not use BHA funds to pay for Medicaid-covered services for Medicaid-enrolled individuals. Billing Medicaid (or other third-party payors) as a primary payor ensures BHA funding is used to reimburse providers as the payor of last resort.

The BHASOs and RAEs coordinate care for individuals moving on/off Medicaid or for those who are receiving services from both systems (such as a Medicaid member whose residential substance use treatment costs are covered by Medicaid, but whose room and board costs are covered by the BHASO). BHASOs and RAEs have created policies and procedures to ensure continuity of care for all individuals transitioning into or out of Medicaid enrollment. This prevents an individual from experiencing a delay in accessing services or a disruption in service provision.

For an in-depth discussion on how BHA and HCPF prevent duplication and encourage cooperation in the BHASO/RAE system, also see responses to question 1 on page 1 and question 6 on page 16.

In addition to building and overseeing the provider network, BHASOs are charged with assessing the health of the network. This task is aided by the establishment of Regional Councils, who assist in determining what services are needed to establish a full continuum of care and what barriers exist for individuals seeking quality and timely care within the Safety Net. Per statute, membership of the Regional Councils must include: individual(s) with lived experience, Safety Net Provider(s), a county commissioner, a K-12 educator, and an individual with the Criminal Justice system. This ensures a full spectrum of voice and experience contribute to the success of the model. BHASOs also must complete quarterly Network Adequacy reports in which they provide statistics on the availability of each Safety Net Service in its region, identify gaps, analyze current adequacy of funding (and estimate the resources that would be necessary to improve service availability), and identify reported issues related to access to care challenges.

Colorado System of Care (CO-SOC)
Since late 2023, BHA and HCPF have collaborated on establishing one comprehensive system of care in Colorado for high-acuity youth, the Colorado System of Care (CO-SOC), in alignment with G.A. et al v. Bimestefer (1:21-cv02381) settlement agreement. In *Colorado System of Care (CO-SOC): A Behavioral Health Model for Children and Youth in Medicaid Implementation Plan Version 1.0*, HCPF notes that an evidence-based system of care requires a well-trained workforce that maintains fidelity to the interventions of the model. To ensure there is a statewide workforce for the providers needed to meet the behavioral health needs of children and youth in CO-SOC, BHA is working closely with HCPF to build capacity. There are two different mechanisms through which training is delivered. First, through the inception of a Workforce Capacity Center (WCC) at Colorado State University (CSU), created as a result of JBC sponsored SB25-292. And, second, through BHA's learning management system, Own Path. The WCC centralizes the training and credentialing of all providers participating in CO-SOC, while also monitoring fidelity to the practice models and providing coaching and technical assistance at no cost to providers. In addition, BHA's learning management system, Own Path, houses the training for the Enhanced Standardized Assessment (ESA), at no charge to providers. Together, these promote standardized training and credentialing and access to high-quality behavioral health interventions and services.

BHA and HCPF have also identified the need for BHASOs and RAEs to collaborate on building a unified provider network for both Medicaid and non-Medicaid youth; this ensures that providers are able to meet supervision and capacity standards for practice models while also becoming financially sustainable. BHA's Substance Abuse and Mental Health Services Administration (SAMHSA) grant funding strategically supports behavioral health agencies working toward financial viability; particularly those in rural and underserved areas. These investments serve a dual purpose: first, to build local service capacity; and second, to establish a dependable, statewide referral network that ensures BHA, HCPF, and community partners can consistently connect young Coloradans to the right care at the right time.

Each provider funded with SAMHSA dollars is expected to achieve Medicaid billing capability, ensuring long-term financial sustainability once these initial federal funds are no longer available. Our partnership-driven approach—with alignment through the BHASOs, RAEs, and the Workforce Capacity Center—addresses regional gaps, prevents both provider 'deserts' and oversaturation, and strengthens the stability and efficiency of Colorado's behavioral health system of care for children and youth. The work of CO-SOC is in alignment with the G.A. et al v. Bimestefer (1:21-cv-02381) settlement agreement and is a phased approach over the next 6 years. BHA and HCPF intend to collaborate on this system of care for its duration to eliminate duplicated efforts and services, to align service standards regardless of payor source, and to create one sustainable CO-SOC provider network across Colorado. There are still elements of a full system of care, such as statewide youth crisis, expanding intensive home based treatment, behavioral consult services, and expanded family supports that will need support in future years. These elements of the program are secondary to the focus of years 1-3 and building out the workforce, assessment process, and referral programs for high fidelity wraparound and intensive outpatient services.

As part of this work, BHA, HCPF, and CDHS have expanded the use of the Enhanced Standardized Assessment (ESA) to help determine the necessary behavioral health services for a child or youth. Implementing a single assessment process across multiple state agencies has helped streamline access to funding and services, while decreasing duplicative programmatic requirements, which can be overly burdensome on families. Furthermore, BHA staff have unified and streamlined quality assurance monitoring efforts across BHA Children, Youth, and Families programs that require an Enhanced Standardized Assessment for funding determinations. This simultaneously ensures assessment quality while reducing the duplication of efforts.

Children and Youth Behavioral Health Implementation Plan (CYBHIP)
CYBHIP was designed explicitly to initiate statewide efforts to reduce fragmentation, eliminate duplicative services across state agencies, and establish a coordinated approach to service delivery. It provides a statewide blueprint that brings together key partners including BHA, HCPF, CDHS, CDE, CDEC, CDPHE, DOLA, and DORA, under a shared strategy for improving access, quality, and outcomes for young people. CYBHIP established a cross-agency collaboration structure, including regular interagency meetings, shared work plans, and shared decision distribution that reduce overlap and ensure coordinated implementation across systems.

6. Rep. Brown: How has the BHA approached their role of coordinating care across state agencies without the authority to move or remove programs that may be duplicative in other agencies? What progress can you demonstrate and how could the system be improved?

As Colorado's designated behavioral health authority, the BHA is responsible for the leadership and development of the state's overarching vision and strategy for behavioral health. Each state agency that administers a behavioral health program is mandated to collaborate with the BHA to achieve its established goals and objectives. Beyond formal written agreements, the executive directors of the twelve state agencies that administer behavioral health programs participate in an interagency council, which is chaired by the BHA Commissioner. This Interagency Council serves as the forum where the BHA guides strategic decision-making, emphasizing the prioritization of the safety net system over individualized, boutique-style behavioral health programs. To promote efficient service delivery and avoid duplication, the BHA and state agencies with multiple behavioral health programs (HCPF, CDHS, and DPS) also maintain consistent communication, collaboration, and coordination, ranging from individual contributors to senior leadership, engaging at least on a weekly basis.

Additional detail and examples of this coordination can be found in the above answers to question 1 on page 1, and question 5 on page 12.

To ensure that Colorado's behavioral health programs, which are distributed across various state agencies, are not redundant and that provider services are coordinated through those state agency contracts, the Behavioral Health Administration's (BHA) approach to system transformation is founded upon three core elements:

1. **Authority:** Utilize the BHA's mandate to design and guide the statewide behavioral health system, thereby driving change through measurable

outcomes to propel systemic improvements.

2. **Consolidation:** Combine programs and funding currently dispersed across state agencies to ensure operational flexibility and consistently address the behavioral health needs of Coloradans.
3. **Alignment:** Ensure that programs and investments share common goals and outcomes by establishing a consolidated budget that promotes accountability and coordinated community improvements.

Two potential avenues for immediate system improvement involve elevating the funding flexibility granted to the Behavioral Health Administration (BHA) while simultaneously upholding system transparency. This approach is detailed in Request for Information (RFI) #15. Enhanced funding flexibility will empower the BHA to allocate resources toward high-priority areas demanding immediate intervention, all the while maintaining fidelity to the legislative mandates that the BHA is committed to fulfilling. Furthermore, to effectively operationalize the authority vested in the BHA, alignment in goals and outcomes must be established across all behavioral health programs and investments. Cross-agency behavioral health initiatives must address the behavioral health needs of Colorado's populace in accordance with the BHA's overarching vision and strategy. State agencies responsible for administering behavioral health safety net service programs should be mandated to prioritize the utilization of BHA-approved safety net service providers. The use of BHA-approved providers ensures that services are of high quality, non-duplicative, and compliant with statutorily-driven "no refusal" requirements. Should programs fail to meet these criteria, a determination must be made to reprioritize the corresponding program investments. BHA is working to better leverage formal agreements with state agencies (FADs) and universal contracting provisions (UCPs) to accomplish this moving forward.

Budget Requests

R3 Reduce Substance Use Treatment

7. Sen. Amabile: The request eliminates a substance use capacity grant to use funding for substance use services. How will this impact access to services in the long term?

This request would reduce investments available for future SUD service expansions, while preserving funding to providers for current programming and service provision.

Eliminating this grant program provides an opportunity to reduce duplicative, administratively burdensome funding processes while protecting the sustainability of programs and services that people currently rely on. As such, BHA does not anticipate any reduction in access in the near term. Additionally, in recent years, ARPA provided an unprecedented funding for one-time, capacity building investments across the state's behavioral health system. Many providers expanded services with these funds and carefully crafted sustainability plans to ensure those investments would be able to increase access to services long-term. Those sustainability plans rely upon ongoing service funding such as grants for public programs that help to cover costs that are not otherwise reimbursable by public or private insurance. Given the many challenges facing our state's safety net and behavioral health providers, it is critical that mature programs that provide ongoing service funding are safeguarded. There are also other sources of funding that our BHASOs have to invest in substance use services expansion. Additionally, communities may be able to expand access to substance use services through opioid settlement funds managed by Regional Opioid Abatement Councils (ROACs). These alternate sources aimed at expanding access to substance use services should have a long term impact.

R4 Reduce Care Coordination

8. Sen. Amabile: The request reduces funding for civil commitment care coordination based on caseload in the first year. How did the BHA evaluate future caseload trends, particularly given the recent IMDchange to increase M1 holds from 15 days to 60 days. Does the request account for potential increases to civil commitment?

Yes, the request contemplates the recent IMD change and BHA anticipates a similar caseload for the upcoming year.

The funds provided for the civil commitment care coordination (Terminated Certification Program) are specifically used after an individual has been placed on an involuntary mental health certification and the certification has expired, transferred to another provider, or closed. These funds provide voluntary wraparound services after a person has been discharged from an inpatient mental health hospital. As the involuntary mental health certification is a step after an M1 hold, the IMD waiver does not impact the potential number of people requesting ongoing care coordination when the commitment is expired, transferred, or closed because people may receive this voluntary service regardless of length of stay. Perhaps, over time as awareness

increases, the utilization may increase, but we do not anticipate an increase beyond the current capacity supported by this request.

Additional information: The IMD waiver is paid for through Medicaid while the person is in a mental health hospital. The Terminated Certification Program is paid for through state funds as an additional voluntary service after someone has discharged. The program does not pay for beds or services while the person is in an inpatient mental health hospital.

BHASOs

9. Sen. Bridges: Tell us how the BHASO implementation is going. How does the BHA evaluate what is working and what isn't in the statewide behavioral health system? Is there data to determine if access to services and patient outcomes have improved?

BHASO implementation has gone smoothly. Providers are delivering services, the call lines are active, the regional councils have begun.

For the first time, we are moving beyond administrative process measures to track outcomes and access to care. We are currently in a validation phase with our BHASO partners' inaugural (FY26 Q1) data submissions. The focus today on the definition and intent of these metrics. We look forward to presenting impact data over the course of the next year as these measures stabilize.

- Regional Population to Active Clinics
    - What it Measures: The ratio of providers who are actually delivering services versus the service area population.
    - Impact: Measures geographic availability of services.
    - Why it Matters: This metric ensures BHASOs are delivering the benefits promised by providing reasonable access to active, in-network providers
- Time to Therapeutic Intervention: Crisis Events
    - What it Measures: The average number of days between a crisis event and the first therapeutic follow-up appointment.
    - Impact: Measures timeliness of service delivery
    - Why it Matters: This metric is to ensure the system captures individuals at their most vulnerable moment.
- Time to Therapeutic Intervention: Non-Crisis Events

    - What it Measures: The average number of days between a standard request for services (intake/assessment) and the first clinical treatment.
    - Impact: Measures appropriate access based on client need.
    - Why it Matters: Speed at which an individual receives care can affect an individual's engagement with the BH system of care.
- Client Transition from Withdrawal Management into Residential or Outpatient within 7 Days
    - What it Measures: The percentage of clients who connect with outpatient or residential treatment within 7 days of discharge from a withdrawal management program.
    - Impact: Measures care coordination and whole person care.
    - Why it Matters: This metric tracks continuity of care. Failing to transition a client quickly often results in relapse, making the initial intervention less effective.
- Client Transition from Residential into a Lower ASAM Residential or Outpatient within 7 Days
    - What it Measures: The percentage of clients who connect with a lower level of care within 7 days of discharge from a residential program.
    - Impact: Measures care coordination and identifies gaps in the continuum of care.
    - Why it Matters: Stepping down from residential care is a vital period for clients. Ensuring a "warm handoff" to outpatient care is essential to maintain the progress made during residential treatment.
- LIFTS Behavioral Health Follow-up Service Penetration Among Individuals with Behavioral Health Diagnosis
    - What it measures: Percentage of clients with a MH/SUD at admissions to services who receive at least one therapeutic service after their initial appointment.
    - Impact: Measures client engagement and care coordination
    - Why it Matters: Client engagement and ability to access services can affect an individual's treatment outcome.

<u>System Rule and Network Adequacy Reports</u>

BHA is currently developing System Rules that explain the Colorado behavioral health service continuum, establish service accessibility requirements through network adequacy standards, and promote service alignment across systems and other state agency programs. The System Rules will establish and codify maximum wait time

standards by service type, geographic access requirements (e.g. % of population within a set number of miles of a provider type location), provider-to-population ratios by service category, and new explicit targets for service availability for children, including a focus on ages 0-5 early childhood providers. These rules will be the benchmark by which the BHASOs judge Network Adequacy. BHA will release System Rules for public comment in Spring 2026, with community canvassing occurring in late Spring/early Summer 2026.

Pending the release of network adequacy standards in System Rule, the BHASOs were still able to provide robust network adequacy reports to BHA at the close of their first quarter in operation. BHA posts these reports on its website for public review. The BHASOs identified the following key gap areas where demand outstrips service availability:

- Children and youth services at all levels, but particularly acute in substance use intensive outpatient, partial hospitalization, or residential care. This shortage is even more severe for tribal youth.
- Veteran-focused services in Region 3, containing El Paso County
- Assertive Community Treatment in Adams and Denver counties
- Competency restoration
- Rural and frontier access, especially for services that are less effective by telehealth
- Workforce recruitment and retention
- Mental health residential care
- Secure transportation
- Recovery support services
- Crisis services, particularly mobile response

Both Rocky Mountain Health Plans and Signal Behavioral Health Network are devoting resources to evaluating the current capabilities of the new Colorado LIFTS network, including provider capacity, utilization trends, waitlist data, bed availability, and other metrics. This deep understanding of the capacity and shortfalls of the current network enables the BHASO to deploy any available capacity-expanding resources to maximum effect to close the most severe gaps in access.

To the extent that BHA receives any additional funding in the next several years, it will be directed to fill the well-studied gaps that the BHASOs have identified.

Enhanced Oversight, Accountability, and Fiscal Efficiency: BHA is strategically expanding its analytical infrastructure by developing comprehensive dashboards and regional scorecards. This initiative will provide essential, real-time data transparency,

crucial for ongoing policy oversight and public accountability of the BHASO model. Concurrently, BHA is refining the foundational governance of BHASOs by standardizing deliverables and review processes and systematically reducing administrative redundancies. This refinement effort is directly targeted at achieving operational efficiencies and sustaining a rigorous, data-driven approach to performance management.

Data Transparency and Completeness: Following a successful launch, the primary goal of year one of the BHASO model is to collect starting point data that will allow BHA and the BHASOs to set smart goals to promote gains in the quality and efficiency of Colorado LIFTS services. Baseline data will allow BHA and the BHASOs to set minimum client count and volume benchmarks for key services in SFY27 and beyond. Additionally, BHA will use initial performance on the Performance Hub metrics to set target goals for SFY27. As the system matures, BHA's goal is to increase transparency of system performance through increased public reporting on Performance Hub, and by expanding data reporting capabilities for metrics with less visibility in the current state, including:

- utilization rates by Safety Net service type;
- wait times for first available appointment;
- provider network adequacy per system rule;
- approximate cost per individual served;
- individuals served who were previously unserved;
- continuity of care metrics, such as movement through tiers of care coordination or stepping up and down through levels of care

BHA data collection will be further modernized by the launch of the Unified Data Model (UDM) on July 1, 2026. This updated model is designed to decrease the administrative burden that data reporting places on providers by combining multiple data sets, eliminating redundancies, and adhering to widely-utilized data standards.

10. Rep. Brown/Sen. Bridges: Please describe whether the functions of BHASOs and RAEs are duplicative in detail. How do BHASOs and RAEs divide their responsibilities? How can the state be sure that we aren't paying for the same population, service, or administrative requirement twice? Provide specifics on the following:

- ***BHASO contract terms.***
- ***Administrative roles of the BHA compared to the administrative role of the BHASOs.***
- ***How the BHA coordinates with HCPF to reduce duplication.***
- ***How the BHA evaluates BHASOs and outcomes***
- ***How the BHA ensures money is distributed to most effectively impact the provision of services.***
- ***How the BHA evaluates if the BHASOs improve access to care.***

Please use the response provided by the Department of Public Health and Environment about the state lab as an example for the level of thoroughness expected for the response.

BHASOs and RAEs are similar in that they are both payors of behavioral health services. However, the functions of BHASOs and RAEs are coordinated, but not duplicative. They serve different populations pursuant to different eligibility protocols. BHASOs provide services primarily to uninsured and underinsured individuals, and are able in some cases to cover costs that are not reimbursable by medicaid. RAEs only serve Health First Colorado members and receive risk-based capitation funding. Responsive to both state and federal law and regulation, RAEs and BHASOs have different roles and responsibilities, and those differences are the main cost drivers for BHASOs and RAES, and importantly, combining these two entities would not bring significant savings to the state. More detail about the different roles and responsibilities of BHASOs and RAEs, is addressed in question 12 on page 35.

BHASO contract terms

BHASO contract terms mandate collaboration with the RAEs in a number of ways to ensure that distinct roles are effectively fulfilled, including appropriately directing individuals to the correct entity for care. The terms include requirements for:

- Policies and procedures to ensure continuity of care for all individuals transitioning into or out of Medicaid enrollment, preventing disruption or delay to an individual's services.
- Signed data sharing agreements and privacy policies for individuals transitioning onto or off of Medicaid, as well as those who are receiving coverage from both BHASOs and RAEs simultaneously.
- Definition Care Coordination roles to reduce duplication across BHASO and RAE functions
- Methods to leverage resources within Medicaid and BHA to optimize funding for needed services.
- Procedures to monitor equity and outcomes within regions and share data with one another.
- Procedures to report and share quality information relevant to monitoring provider networks.
- Methods to support provider quality improvement through shared or coordinated training, grievances, and technical assistance.

The BHASOs are also required to coordinate with their regions' RAEs to leverage the statewide Social Health Information Exchange (SHIE) infrastructure, when available, to securely share physical, behavioral, and social health information between providers involved in whole-person care. The BHASOs and RAEs are also required to train their providers in the differences between the RAE and BHASO roles and on how to use the aligned processes that the two systems share in order to reduce provider burden. Further, the BHASOs and RAEs are exploring the best ways to mutually engage in BHASO and RAE regional and statewide advisory councils. One example is that the two groups are a focus of the monthly HRC2B2 (HCPF, RAEs, Child Welfare, Counties, BHA, and BHASOs) Collaborative Forum, which is designed to improve coordination and alignment of policies and practices across the various parties to ensure timely service delivery to child welfare involved children and their families.

BHA and HCPF leadership have actively supported and monitored the success of the relationships and process alignment between the BHASOs and RAEs. Executive leadership met with BHASO and RAE CEOs in the first quarter of FY25-26, after the launch of ACC Phase III and the BHASO model, and both BHASOs and RAEs shared that they have established positive, collaborative relationships to promote a unified system. Open channels of communication between the state and our behavioral health partners have established a culture of active partnership, problem solving, and planning.

Administrative roles of the BHA compared to the administrative role of the BHASOs

In the BHASO model, the BHA and the BHASOs share administrative oversight of the behavioral health Safety Net in Colorado, with clear division of roles and responsibilities.

The BHA is responsible to:

- Provide structure, standards, and guidance to BHASOs as they build their regional networks.
- Drive coordination and collaboration between state agencies and BHASOs to address the behavioral health needs of all people in Colorado.
- Coordinate standards of care, set access and quality metrics, and address any system-level roadblocks.
- Budget state and federal dollars to BHASO regions in a way that is responsive to community need and furthers public health priorities, like children and youth service expansion and support for the competency restoration process. Monitor spending to evaluate whether funding is having the intended impact on goals.
- Support and respond to community voice and needs alongside the BHASOs.

The BHASOs are responsible to:

- Help individuals and families connect to behavioral health care and ensure timely access to service.
- Establish and maintain a continuum of behavioral health safety net services and care coordination that meets established standards for access and network adequacy.
- Negotiate and monitor contracts with each provider to ensure compliance with state terms and best practices.
- Conduct financial administration tasks with the providers to pay them for mental health, substance use, and crisis services delivered under their BHASO contracts, including budgeting, invoicing, cost verification, reconciliations, and audits to ensure compliance with state and federal fiscal standards.
- Measure quality in the provider network and undertake quality improvement initiatives both on the individual provider level and on the regional level.
- Interface and align with the RAEs that manage services and provide care coordination for Medicaid members.

How the BHA coordinates with HCPF to reduce duplication

Between 2023 and 2025, as HCPF prepared for ACC Phase III and BHA designed the BHASO model, the two agencies' development teams met at least every other week to discuss policy developments, align requirements and objectives of the two systems, and maintain consistent stakeholder engagement and communications about the implementation of each. For example, this group worked with external consultants to study population data and patterns in how people travel to receive care, ultimately developing the new aligned region map for ACC Phase III and the BHASOs. This was informed by data from BHA and HCPF programs allowing for statewide decisions that considered the needs of both insured and uninsured individuals.

Duplication is further prevented/reduced by the difference in payment strategies for RAEs and BHASOs. The BHASO contracts with providers on a fee-for-service basis for a small number of programs, but the majority of BHASO agreements with providers are funded with a "capacity-based" budget which supports facilities and programs that are funded from a variety of funding sources including Medicaid, Medicare, local funding, private insurance, State, and other sources of funding. 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 generally accepted accounting principles. The BHASO contract covers the unfunded remainder of the costs (or a portion of that remainder) to maintain service capacity. The unfunded costs covered by the BHASOs are limited to the not-to-exceed amount of the contract(s). Capacity funding may cover a variety of factors and conditions such as: expenses incurred for clients that do not have a payer source; emergency/crisis response; service components that are not client specific but are a necessary component of "best practice" service delivery; and necessary behavioral health infrastructure to serve local communities. Because Medicaid revenue is applied to the incurred costs of a program before the BHASO is billed, double-billing for a given expense is prevented.

How the BHA evaluates BHASOs and outcomes

BHA monitors the success of BHASOs and ensures accountability through a robust and well-drafted contract, which contains many levers for compliance. BHA oversees BHASO partners in six key areas:

- Contractual compliance

    - Objective: The existing contract deliverables and BHA tracking tools, taken together, build out a full picture of the BHASO entity functionality and performance in a region.
    - Impact: Reduce inefficiencies and administrative burden by capitalizing on existing BHA & BHASO resources.
    - Example contract deliverables evaluated by BHA:
        - Regional work plans that describe each BHASO's approach to delivering each service listed in the statement of work, with quarterly updates reporting progress on client count goals, quality improvement, or addressing any challenges faced in the region.
        - Care coordination policies and procedures.
        - Subcontractor Desk Review Checklists to verify that BHASOs are appropriately monitoring the financial and organizational health of providers receiving federal funds.
    - Expected Outcome: Create visibility into system gaps; develop more efficient processes and resources.
- Service validation and quantification
    - Objective: To validate that contracted services are being delivered, learn the number of clients served/services provided per Safety Net service, and understand the cost of services per individual.
    - Impact: Quantify community impact of Colorado LIFTS (Linking Individuals and Families To Services) services, validate reported costs of service delivery.
    - Example contract deliverables:
        - Providers' 837 submissions that report individual client encounters
        - Providers' CCAR and DACODS submissions and compliance with timelines and benchmarks to prepare for transition to the Unified Data Model
        - Service diversion reports and response process
        - Monthly Actual Expenditure submission from BHASOs with a supporting spreadsheet identifying providers, scopes of work, and fund source
    - Expected Outcome: Clear picture of system volume and costs, which can communicate BHA success and inform/defend future funding requests
- Quality and Performance Measures monitoring

    - Objective: To ensure not only that services are available and accessible, but also that they are of the highest quality and trusted by the community.
    - Impact: BHASOs and Colorado LIFTS Network Providers are driven by clear expectations and ambitious goals that increase service quality and system efficiency.
    - Example contract deliverables:
        - Annual quality assurance work plan describing the BHASOs' plan to monitor clinical quality and patient outcomes in the Colorado LIFTS network
        - Performance Measures data reporting
        - Report of the completeness, accuracy, and timeliness of providers' data submissions
    - Expected Outcome: Colorado LIFTS Safety Net services have the reputation of being high value, high quality, and people-centered.
- Access-to-Care compliance per system rule
    - Objective: To monitor Colorado LIFTS network adequacy per system rules developed by BHA to establish and routinely assess minimum access and availability standards
    - Impact: Colorado LIFTS network will be the key contributor to service capacity in Colorado and will provide BHA with the data needed to demonstrate our compliance and identify and close access gaps
    - Example contract deliverables:
        - Network drafts
        - System Rule volume
        - Network Adequacy Reports
    - Expected Outcome: Safety Net services are available and accessible when people in Colorado need them the most.
- Fiscal compliance / spending monitoring
    - Objective: To monitor spending of state and federal resources and ensure services are provided at great value to the taxpayer and client.
    - Impact: Clear and effective financial management will enable BHA to report to legislature and other funders what the actual costs of service delivery are, enabling us to demonstrate value and make better funding requests backed with transparent data.
    - Example contract deliverables:
        - Monthly Actual Expenditure reports

        - Desk audits
        - Quarterly reconciliations
    - Expected Outcome: Safety Net services are affordable and public funds are maximized to cover services for those most in need.
- Discretionary grant monitoring
    - Objective: To monitor programmatic requirements, fiscal tracking, and federal compliance for BHASO discretionary grant contracts for the Stimulant and Opioid Response Grant (SOR) and Colorado's Trauma Informed System of Care (COACT).
    - Impact: Discretionary grants can be revoked or not renewed by the Federal government if outcomes are not meeting standards or are under-reported, so clear and accessible reporting is even more essential for effective grant management.
    - Example contract deliverables:
        - Government Performance and Results Act (GPRA) submissions (SOR)
        - Child and Adolescent Needs and Strengths (CANS) submissions (COACT)
        - Tailored invoice and reconciliation templates for SOR and COACT
    - Expected Outcome: Colorado and BHA earn a status as an attractive grant recipient and a magnet for federal dollars in the future.

The BHASO model has also established a routinized structure for data-driven performance monitoring. BHA executive leadership will meet with BHASO leadership regularly for Quarterly Performance Reviews. The first meetings will take place in early January 2026. In the first year of the BHASO model, leadership will review expenditures against the budget by region and service category, progress towards the six core access Performance Measures, and will discuss reported gaps in network adequacy. Review of these success measures with BHASO and BHA leadership will provide visibility into Colorado’s approximately $208 million investment into the Colorado LIFTS network of Safety Net services. In state fiscal year (SFY) 2027 and beyond, BHA will expand the scope of review topics to performance measured against minimums and target goals set based on SFY26 data. These include measures specific to children, youth and family-centered goals identified in the Children and Youth Behavioral Health Implementation Plan.

How the BHA ensures money is distributed to most effectively impact the provision of services.

With BHASOs in place, distributing funding to effectively impact the provision of services begins with thoughtful, data-informed allocation to each region. This allocation was driven by two main principles. The first principle was to leverage this fresh opportunity to recognize and address unmet population needs and to adjust resource allocations accordingly based on population health, utilization, and socioeconomic data for each region. The second principle was to avoid sudden, sharp changes in funding to existing providers to reduce disruption in provider stability and subsequent access to care for people receiving care in a given region. The resulting funding allocations by region recognized the needs and opportunities in each region, creating a cohesive Safety Net for Colorado.

Table 6: BHASO Funding by Region and Service Category

BHASO Region	Vendor	Category	Amount ($)
1	Rocky Mountain HMO	Crisis	$11,764,030
		Mental Health	$14,693,177
		Substance Use	$24,673,274
2	Signal Behavioral Health Network	Crisis	$9,788,447
		Mental Health	$9,629,524
		Substance Use	$14,396,825
3	Signal Behavioral Health Network	Crisis	$12,868,122
		Mental Health	$11,247,120
		Substance Use	$19,916,741
4	Signal Behavioral Health Network	Crisis	$12,188,891
		Mental Health	$22,169,554
		Substance Use	$31,996,046
GAE	CYMHTA	Mental Health	$7,977,114

BHASO Region	Vendor	Category	Amount ($)
	FFPSA	Mental Health	$927,671
	IC	Substance Use	$840,509
	QRTP	Mental Health	$3,022,437
	Transportation	Mental Health	$594,572
Grand Total			208,694,054

As a part of this transition, BHA and the BHASOs built new parallel financial systems that have allowed for greater visibility and accountability for funding than ever. Under the new structure, BHA can report the amount of annual funding dedicated to each Safety Net service in BHASO contracts with providers. This system-level view provides important insights into where resources are currently dedicated in Colorado's Safety Net, which services are most resource-intensive, and where gaps may exist.

Financial Monitoring and Stewardship

The BHASO model institutes a new, robust framework for budget structuring, payment, and reconciliation, fundamentally strengthening fiscal governance. BHASO budgets are now consolidated to provide the necessary agility for swift, strategic adjustments to provider contracts. This flexibility is governed by clear guidance on allowable fund applications, validated via a funding allocation matrix that enables BHA staff to confirm that provider budgets-per-service align with utilization directives.

The payment system is anchored by a quarterly prepayment structure, which is subject to rigorous validation through monthly submissions of actual expenditures. Critically, these submissions are tied directly to defined identifiers, including the appropriation, accounting line, and statement of work numbering, ensuring auditable traceability and proper fund utilization. This process also mandates the distinct reporting of administrative costs, which creates unprecedented visibility and clarity into the operational cost of the Colorado LIFTS Safety Net system.

To further elevate fiscal oversight, BHA has implemented key mechanisms, including a structured desk audit component and a monthly statewide cost dashboard. The dashboard reports on actual expenditure costs of each BHASO in each region. Additional work is necessary to capture “fiscal need” within this system; however, a transparent dashboard of actual costs against BHASO budgets is a major step forward. This foundational structural change has significantly enhanced accountability, transparency, and alignment with state expectations. Moving forward, this framework will be indispensable for ensuring the accuracy of reviews, supporting data-driven decision-making, and facilitating proactive, informed conversations with BHASOs regarding network adequacy, service gaps, and quantifiable fiscal needs.

Strategic deployment of funding also puts an emphasis on building a network that is robust and stable at all levels, not just in the most expensive high-acuity services. Network stabilization is a critical investment focused on mitigating system-wide costs by strengthening the fundamental capacity of our behavioral health ecosystem. This is achieved through the BHASOs by strategically expanding and reinforcing the availability of both outpatient and community-based services. By actively growing this upstream provider capacity, BHA is fundamentally shifting the system’s reliance away from costly, high-acuity interventions such as emergency department visits and inpatient care. This proactive strategy ensures that individuals receive timely,

appropriate care in the least restrictive setting, directly translating to system-wide cost-avoidance, improved fiscal efficiency, and a more sustainable use of state resources over the long term.

How the BHA evaluates if the BHASOs improve access to care

Please see the answer to Sen. Bridges' question regarding BHASO implementation, in the last section of the response entitled "How the BHA evaluates BHASOs and outcomes" (Page 26).

11. Sen. Amabile: How does funding from the Mental Health Community Programs line item ($30.0 million General Fund) compare to or interact with funding comprehensive providers receive from RAEs?

The behavioral health safety net requires, by design, coordination between BHA and HCPF. The behavioral health safety net exists to ensure that "priority populations" defined in 27-50-101, C.R.S. as people who are uninsured, underinsured, Medicaid-eligible, publicly insured, or whose income is below thresholds established by the BHA; and 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, are able to access the behavioral health care that they need. A comprehensive funding model that leverages all available funding sources is necessary to ensure the viability of the safety net system. This funding model is expected to use state funds to complement and not supplant other funding sources including Medicaid, federal Substance Abuse Prevention and Treatment Block Grants (SABG), and federal Mental Health Services Block Grants (MHBG). Ultimately, BHA and HCPF together want to prioritize opportunities to support the safety net with federal match funds that can be drawn down.

Detailed funding breakdowns for Comprehensive Providers can be found in Request For Information #14[1] which shows BHA funding to Comprehensive Providers for the past three fiscal years, as well as projected FY 26 amounts. The General Funds appropriated for this purpose are, along with cash and federal funds, contracted to providers through the BHASOs. This funding is typically referred to as capacity

[1] Request For Information #14

funding, and provides funding to providers for the services they provide to uninsured and underinsured populations, as well as services they fund that cannot be reimbursed by Medicaid. The types of services funded by this line item in the BHASO network include:

- crisis walk-in
- crisis mobile response
- crisis stabilization units
- outpatient mental health services
- high-intensity outpatient mental health services including but not limited to Assertive Community Treatment
- mental health recovery services
- individualized Placement and Support employment services
- outreach, engagement and education
- school-based mental health specialist programs.

Medicaid reimburses Comprehensive Providers for the services they provide to Medicaid members using a cost-based prospective payment system (PPS). HCPF cost-based rates are an incentive to participate in the safety net system. The higher standards that safety net providers must comply with also require higher reimbursement. Medicaid reimbursements are key to safety net provider's revenue and stability, and HCPF and BHA together have a shared interest in ensuring that safety net providers achieve financial stability, keeping their doors open to provide critical services to uninsured, underinsured, and Medicaid covered individuals. Cost based rates are the best way to do that.

Coordination between HCPF and BHA, as well as RAEs and BHASOs, ensures that funding from BHA and HCPF do not overlap.

BHA distributes funding to providers in a lump sum based on the volume of services they provide (this is reported to BHA and measurements of service volume are verified). Providers also receive funding from RAEs after claims are submitted for behavioral health services. RAEs directly pay providers for Medicaid behavioral health claims.

HCPF determines the rate for each CSNP based on independently verified cost reports, in accordance with C.R.S. 25.5-4-403. The annual cost reports submitted by each of the Comprehensive Providers detail the revenues incurred during the reporting period. This reporting is reviewed against audited financials and is described within the

Auditing and Accounting guidelines. Funds received from BHA or the BHASOs would be explicitly outlined in the Revenue section of the submitted cost reports, and then excluded from the Medicaid rate calculation to ensure there is no duplication of funding from BHA and HCPF.

BHA and HCPF work together based on provider reporting to each agency to determine which services have been paid, and to create fiscal accountability. To streamline this process, BHA and HCPF have partnered on the Behavioral Health Claims and Eligibility project (BHC&E) which brings all state funded behavioral health encounters into the Medicaid Management Information System (MMIS) system, creating one repository that can be used for:

- Fiscal accountability - ensuring encounters are not paid by both Medicaid and BHA funding
- Mandatory reporting to SAMHSA and other state and federal stakeholders
- Assessment over the entire ecosystem such as Wildly Important Goals, Performance Hub, and others

12. Sen. Amabile: What is the benefit to the state, providers, and people served from having BHASOs and RAEs? Why would we need both?

Though there are similarities, the RAEs and BHASOs have different roles and responsibilities, which are summarized below. These differences are the main cost drivers for BHASOs and RAES, and therefore combining these two entities would not bring significant cost or workload savings to the state.

BHASOs manage non-Medicaid state and federal behavioral health funds while RAEs manage Medicaid funds for Colorado. RAEs, managed by HCPF, are responsible for managing a network of primary care providers and behavioral health providers to ensure access to appropriate physical health and behavioral health care for Medicaid members, in line with the Centers for Medicare and Medicaid (CMS) requirements. This includes paying behavioral health claims to providers, submitting those claims through the Medicaid Enterprise System, negotiating standard and specialty rates for all providers, maintaining and reporting on network adequacy standards, providing care navigation, maintaining member and provider call centers, paying physical and behavioral health providers for whole person care coordination services, submitting all federally required Medicaid data for outcomes and encounters, determining and documenting medical necessity for all services (also known as utilization management), providing practice transformation and technical assistance for providers, contracting with out-of-state providers for clients that cannot be served in Colorado, analyzing and aggregating provider performance and quality data, managing level one grievances and appeals in accordance with state and federal Medicaid laws,

and meeting all federal Managed Care Entity regulations as a health plan. The RAE budgets are determined based on actuarially sound rates, and all provider payment from the RAE to providers are governed by federal Medicaid laws and regulations.

BHASOs coordinate behavioral health services, not physical health services. RAEs fund and reimburse for behavioral health services and coordinate both physical and behavioral health services. Though often providing services to different groups of individuals, BHASOs and RAEs must collaborate to ensure alignment in behavioral health system strategies and in requirements for providers and individuals seeking care. Additionally, BHASOs must maintain close connections to RAEs, as BHASOs are expected to support individuals to enroll in Medicaid, coordinate warm handoffs for Medicaid-enrolled individuals seeking physical health or covered behavioral health services, and support other connections to the RAE's care coordination team for ongoing support.

BHASOs not only support the cost of care for uninsured and underinsured people, they also use funding to build and maintain critical service capacity that will support all people in Colorado regardless of payer. BHASOs have significant flexibility beyond RAEs, who must comply with CMS managed care regulations; for instance unlike Medicaid or a RAE, a BHASO can pay for room and board for residential treatment for Medicaid members. BHASOs will support a number of supportive services that are not covered by Medicaid, but can enhance outcomes for all Coloradans, including those who have Medicaid coverage. These services include recovery housing and other recovery support services. Allowing regional BHASO partners to build a rich network of providers to support both treatment and recovery for the people in their regions helps extend and expand the ways people get the help they need when they need it, and allows for more seamless step up and step down in care.

BHASOs and RAEs also differ in patient population and eligibility protocols: RAEs only serve Health First Colorado members whereas BHASOs primarily serve individuals that are underinsured or uninsured. The financing mechanisms are also very different, with RAEs receiving risk-based capitation funding and BHASOs having non-risk based funding allocations. BHASOs are similar to RAEs in the sense that BHASOs will be payors of behavioral health services and supports delivered to Coloradans pursuant to the terms of their contract.

To maximize alignment and efficiency, and deliver improved quality of service to individuals, HCPF and BHA have made intentional decisions as the agencies have collaborated on the launch of ACC Phase III and BHASOs. The four BHASO and RAE regions have aligned to promote greater whole system alignment, and the BHASOs have entered into formal agreements with RAEs to establish coordination and cooperation between BHASOs and RAEs. These agreements include:

- policies and procedures to ensure continuity of care for all Individuals transitioning into or out of Medicaid enrollment, preventing disruption or delay to an individual's services;

- data sharing and privacy policies for individuals transitioning onto or off of Medicaid, as well as those who are receiving coverage from both BHASOs and RAEs simultaneously;
- definitions of roles in Care Coordination to reduce duplication;
- methods to leverage resources within Medicaid and BHA to optimize funding for needed services;
- procedures to monitor equity and outcomes within their regions and share data with one another;
- procedures to report and share quality information relevant to monitoring the provider network; and
- methods to support provider quality improvement through shared or coordinated training, grievances, and technical assistance.

ARPA Programs

13. Sen. Amabile: How much of ARPA appropriations supported capital projects? Please provide amounts by bill and project.

The below tables provide a breakout, by bill and project, of funding awarded for capital projects through BHA's ARPA investments.

While some of these funds have been refinanced to general fund, of the original $280.97 million[2] in total ARPA State and Local Fiscal Recovery Funds (SLFRF) appropriated to BHA in 2021 and 2022, $62.01[3] million is classified as capital expenditures. Capital expenditures included in this calculation include expenditures to acquire or make additions, improvements, modifications, replacements, rearrangements, reinstallations, renovations, or alterations to capital assets that materially increase their value or useful life. Capital assets include:

- Equipment (items costing $5,000 or more per unit)
- Buildings
- Land
- Software/IT Infrastructure

[2] This figure does not include reductions BHA offered throughout the 2024 and 2025 budget cycles and that were subsequently recaptured, or reversions that occurred prior to 2024.
[3]As noted below table 7 below, some projects have not yet closed out and figures included for those projects represent tentative estimates. This total capital expenditures amount is inclusive of final amounts for closed out projects, and estimates for projects that are ongoing.

While not all of the funding was devoted to capital expenditures, it is important to note that almost all ARPA funds granted out through BHA were directed to one-time, capacity building investments with demonstrated sustainability plans. Investments that were not classified here as capital expenditures were typically one time program start-up or expansion costs.

Table 7: Capital Expenditures by ARPA Project

Bill	Project ID: Name	Capital Amount
SB 21-137	PHI050: High-Risk Families Cash Fund	$1,746,176.00*
SB 21-137	PHI040: Managed Service Organization: Substance Abuse	$899,453.00
SB 21-137	PHI080: Crisis System for Colorado Residents	$55,635.00
SB 21-137	PHI060: Jail Based Behavioral Health Services	$2,034,288.42
SB 21-137	RRI150: Behavioral Health Workforce Development Program	$1,074,754.00
SB 21-137	NEI030: Behavioral Health Workforce Development Program: Capacity Grants	$118,480.00
SB 21-137	PHI110: Behavioral health statewide care coordination infrastructure	$12,578,885.16
SB 21-137	PHI120: County-Based Behavioral Grant Program	$1,610,048.51
SB 21-137	RRI160: San Miguel County-Based Behavioral Grant Program	$793,649.35
HB22-1281 CYF	PHI340: Children, Youth, and Family Behavioral Health Services Grants	$9,000,000.00*
HB22-1281 CIG	PHI310:Behavioral Health Continuum Gap Community Investment Grants	$9,000,000.00*

Bill	Project ID: Name	Capital Amount
HB22-1283	PHI330: Residential Substance Use Treatment Beds for Youth	$2,100,000.00*
HB22-148	PHI390/ PHI39R: Colorado Land-Based Tribe Behavioral Health Services Grant	$5,000,000.00*
SB22-177	PHI350: Round 2: Care Coordination Infrastructure	$7,000,000.00*
SB22-196	PHI300: Criminal Justice Intervention, Detection & Redirection Grant Program	$9,000,000*

*These projects that have not yet closed out and these figures represent tentative estimates as final figures will not be available until close out. Capital estimates are and will continue to be updated in our documentation as additional information is available.

14. Sen. Amabile: Please provide the grant awards for the Children, Youth, and Family grant from H.B. 22-1281 (Behavioral Health Continuum Gap Grant). What is the impact of this funding? How many children, youth, and families were served? What will happen to children, youth, and families when the funding goes away? How do we sustain the good of these programs when funding goes away?

HB 22-1281 appropriated $40 million dollars to Children Youth and Family Behavioral Health Services Grants. These funds were awarded to nonprofits and local governments to expand behavioral health services for children, youth and families and address acute, complex or severe behavioral health problems. Brief descriptions of each project can be found below. These awards were one-time, capacity building investments focused on expanding access to treatment across the state. All awardees provided detailed sustainability plans to demonstrate how these investments would be sustained beyond the one time ARPA investments ranging from enrolling as Medicaid providers to capture ongoing revenue, to utilizing the one time investments to enhance the care experience, such as creating welcoming service environments .

As of September 2025, 17,724 unique individuals have been served by 33 new or expanded programs funded by these grants.

Project overviews and locations:

1. Advocates for Children CASA: **Douglas County**; Establishing or expanding children oriented, youth oriented, & family oriented behavioral health care navigation and coordination services; Collaborative Management Project - improve care access, navigation, and coordination with family advocates.

2. All American Families dba Families Plus: **Delta**; Expanding evidence-based or evidence-informed behavioral health care treatment, including substance use disorder treatment, for children, youth and families; new EHR and BH service expansion.

3. Blue Channel Therapy: **Jefferson County**; Expanding evidence-based or evidence-informed behavioral health care treatment, including substance use disorder (SUD) treatment, for children, youth, and families; BH services for CY and non-English speakers, including early childhood, trauma, and EBPs.

4. Boulder Pride dba Out Boulder County: **Boulder**; Establishing or expanding children oriented, youth oriented, & family oriented behavioral health care navigation and coordination services; increased LGBTQ+ therapy services and connections with providers, management support, support groups, geographic expansion, basic needs support, secondary prevention programming, parent and family services, and an EHR.

5. Child and Family Therapy Center of Denver, LLC: **Jefferson County**; Establishing or expanding intensive outpatient services, including high fidelity wraparound, youth mobile response and expanded caregiver interventions; expand play and expressive therapies, ABA, MEM, SUD, and HFW.

6. Children's Hospital Colorado: **Arapahoe County**; Capital expenditures related to opening a new 8-bed unit that better serves youth who arrive at the Emergency Department (ED) presenting with mental health concerns by providing the space for a multi-disciplinary care team to implement a clinical model that improves the safety, efficiency and experience of patients and families.; Emergency Department Redesign and Transformation.

7. Children's Hospital Colorado: **Arapahoe County**; Establishing or expanding children oriented, youth oriented, & family oriented behavioral health care navigation and coordination services; Clinical Care Transitions for High Acuity Mental health Patients.

8. Conifer Counseling and Therapy Services, Inc.: **Jefferson County/Conifer**; Expanding evidence-based or evidence-informed behavioral health care treatment, including substance use disorder (SUD) treatment, for children, youth, and families; community prevention program with EBP BH services including groups and events.

9. Denver Health and Hospital Authority: **Denver**; Expanding evidence-based or evidence-informed behavioral health care treatment, including substance use disorder (SUD) treatment, for children, youth, and families; three LCSWs will provide EBP in-home family therapy, case management, and psychiatric consultation program serving about 135 youth per year in perpetuity.

10. **Douglas County:** Expanding evidence-based or evidence-informed behavioral health care treatment, including substance use disorder (SUD) treatment, for children, youth, and families; AFFIRM training through Community Response Team and parent support groups.

11. **Douglas County:** Establishing or expanding children oriented, youth oriented, & family oriented behavioral health care navigation and coordination services; develop youth care compact to provide multi-agency care coordination.

12. Eagle Valley Behavioral Health: **Eagle County**; Establishing or expanding children oriented, youth oriented, & family oriented behavioral health care navigation and coordination services; community youth center staffing and operations, care navigation and coordination, peer support for LGBTQ+ youth, EBP services, and a 28-bed (14 youth/14 adults) inpatient psychiatric facility.

13. FullCircle Program, Inc. dba Colorado FullCircle: **Denver**; Establishing or expanding children oriented, youth oriented, & family oriented behavioral health care navigation and coordination services; becoming a Medicaid RCCO, expanded office space, same day access appointments, peer and family specialists, and SUD treatment.

14. **Gunnison County**: Establishing or expanding children oriented, youth oriented, & family oriented behavioral health care navigation and coordination services; expand navigation services for BH for non-English speakers and low-income and non-Medicaid, and Newcomers and expand caregiver interventions through Parents and Teachers home-visitation program, psychoeducation, and Blue House renovations.

15. Health Solutions: **Pueblo**; Establishing and operating a children oriented, youth oriented, & family oriented care access point that is physically connected to a family resource center, or a facility that provides behavioral health care treatment;rehabilitate two buildings to create The Family Center.

16. Illuminate Colorado: **Denver**; Establishing and operating a children oriented, youth oriented, & family oriented care access point that is physically connected to a family resource center, or a facility that provides behavioral health care treatment; Circle of Parents, family support and navigation, illuminating child care, and youth thrive.

17. Jefferson Center for Mental Health: **Jefferson County**; Establishing or expanding children oriented, youth oriented, & family oriented behavioral health care navigation and coordination services; Jefferson Hills CSU and day treatment EHR, program expansion and enhancement, and staff incentives.

18. Kingdom Builders Family Life Center: **El Paso County**; Establishing and operating a children oriented, youth oriented, & family oriented care access point that is physically connected to a family resource center, or a facility that provides behavioral health care treatment; My Brother's/Sister's Keeper DV program, Project Right Direction for high-risk youth, including 24/7/365 crisis hotline, care management, groups, referrals, benefits assistance, and an educational program.

19. **Kit Carson County** Department of Public Health and Environment: Burlington; Expanding evidence-based or evidence-informed behavioral health care treatment, including substance use disorder (SUD) treatment, for children, youth, and families; expand community based BH program, mobile unit, groups.

20. Mental Health Center of Boulder County, Inc. dba Mental Health Partners: **Boulder County**; Establishing or expanding children oriented, youth oriented, & family oriented behavioral health care navigation and coordination services; youth IOP, intensive home-based therapy and navigation, and community based prevention.

21. Metro Community Provider Network dba STRIDE Community Health Center: **Denver**; Expanding evidence-based or evidence-informed behavioral health

care treatment, including substance use disorder (SUD) treatment, for children, youth, and families; psychiatric provider consultant and telehealth.

22. Mile High Council on Alcoholism and Drug Abuse dba Mile High Behavioral Healthcare: **Arapahoe County**; Establishing or expanding children oriented, youth oriented, & family oriented behavioral health care navigation and coordination services; expand SUD and co-occurring MH services at Family Resource Center including various therapy modalities, space renovation, and SBIRT and ASAM.

23. Pediatric Care Network - Children's Hospital, LLC: **Arapahoe County**; Establishing or expanding children oriented, youth oriented, & family oriented behavioral health care navigation and coordination services; care navigation supported by clinical services as needed, resources and referrals.

24. Raise the Future (formerly The Adoption Exchange): **Denver**; Expanding evidence-based or evidence-informed behavioral health care treatment, including substance use disorder (SUD) treatment, for children, youth, and families; Trust-Based Relational Intervention - expand family support services, staffing, training, and becoming a Medicaid biller.

25. Resilience 1220, Inc.: **Jefferson County**, Evergreen; Establishing or expanding children oriented, youth oriented, & family oriented behavioral health care navigation and coordination services; up to 5-10 EBP-based individual therapy sessions for youth with psychiatric or psychological consulting and other resources as needed.

26. Telluride School District: **San Miguel County**, Telluride; Establishing or expanding children oriented, youth oriented, & family oriented behavioral health care navigation and coordination services; behavior techs and clinicians including bilingual services.

27. Tepeyac Community Health Center (La Clinica): **Denver**; Expanding evidence-based or evidence-informed behavioral health care treatment, including substance use disorder (SUD) treatment, for children, youth, and families; build capacity of behavioral health team in an integrated setting to include screening, therapy, care coordination, navigation, and resources.

28. The Aspen Effect: **Douglas County**; Establishing or expanding intensive outpatient services, including high fidelity wraparound, youth mobile response and expanded caregiver interventions; increase youth mentoring programs centered around animals.

29. Thriving Families: **Denver**; Capital expenditures related to providing the treatment and services described above; improve maternal and infant MH outcomes with three existing EBP programs focused on BIPOC with in-person and telehealth services including peers, providers, and office expansion.

30. University of Colorado dba Addiction Research and Treatment Services: **Denver**; Expanding evidence-based or evidence-informed behavioral health care treatment, including substance use disorder (SUD) treatment, for children, youth, and families; expand ARTS Synergy SUD services for youth using MST-SA, CM, DBT, SS, and other EBPs.

31. University of Colorado Health: **Aurora**; Expanding evidence-based or evidence-informed behavioral health care treatment, including substance use disorder (SUD) treatment, for children, youth, and families; expand youth and family-oriented BH care services for acute, complex, or severe BH conditions, including IOP, telehealth, caregiver support, DBT, CBT, etc.

32. **Weld County** Department of Human Services: Greeley; Establishing or expanding intensive outpatient services, including high fidelity wraparound, youth mobile response and expanded caregiver interventions; wraparound.

33. Youth Seen: **Denver**; Expanding evidence-based or evidence-informed behavioral health care treatment, including substance use disorder (SUD) treatment, for children, youth, and families; LGBTQ+ BIPOC youth MH services.

15. Sen. Amabile: How has the BHA evaluated the impact of ARPA funding? Has the BHA developed criteria to evaluate the impact and success of programs? If there is an evaluation, please provide the evaluation by bill and program as a written response.

ARPA funding appropriated to BHA through 2021 and 2022 legislation has funded more than 100 discrete projects across the state. Legislation mandated the uses of these funds for a variety of purposes, but did not specify or fund evaluation of these programs. BHA established criteria to measure impacts for each program, which

generally focused on measuring improvements in access to care by the number of persons served. While formal evaluations are not available, BHA has provided a description of ARPA grant projects and their measured impacts below.

While evaluation of the I Matter Program was not mandated or funded by ARPA, when the program was extended by HB24-001, an evaluation requirement was added. This is the only ARPA program that was formally evaluated.

Two annual evaluations are available:

I Matter Program Evaluation July 2024[4]

I Matter Program Evaluation May 2025[5]

These evaluations provide evidence that participation in the I Matter Program yields meaningful improvements in youth well-being, as well as strong positive feedback from youth and families.The program is evaluated using survey responses that gather feedback on participants' experiences with the program and to measure participants' general level of well-being (personally, with family and friends, and with school and activities) since enrolling in I Matter. The survey also included a question about whether they are doing better than when they started I Matter (perception of change), and whether they would recommend I Matter. The survey is distributed to youth, parents, guardians, and other caring adults through the I Matter telehealth platform after participants' third session. The survey is aligned with evidence-based survey research practices.

Findings from the May 2025 evaluation highlights several key outcomes. Youth surveyed consistently reported feeling "about the same" or "better" after each of their first three sessions, with many demonstrating clear improvement by the third session. Across all three time points, 90–100% of youth agreed that their provider listened to them, understood their concerns, focused on topics important to the youth, and was helpful in addressing their needs. Importantly, these positive outcomes were observed regardless of demographic characteristics or initial levels of financial, emotional, or behavioral need. Families also reported positive experiences and noticeable improvements in their children's well-being, and the evaluations show

[4] I Matter Program Evaluation July 2024

[5] I Matter Program Evaluation May 2025

sustained youth positivity about the program. Together, these findings indicate that the I Matter Program is not only accessible but effective in supporting youth mental health.

ARPA Impacts:

HB 22-1281 Behavioral Health Continuum Gap Community Investment Grants ($35.00M)

This project provides grants to local governments, community based organizations and non-profit organizations from programs and services along the behavioral health continuum in areas of highest need. This includes services spanning prevention, treatment, crisis services, recovery, harm reduction, care coordination, trauma recovery, trauma-informed training, transitional, supportive, and recovery housing and more. The expansion of these community based services fills critical gaps, and helps to decrease the distance or wait times experienced by Coloradans attempting to access behavioral health services.

Impact: As of June 2025, 31 initiatives were funded by these investments, and 21,273 individuals were served through these program expansion initiatives.

HB 22-1281: Children Youth and Family Behavioral Health Services Grants ($40M)

Provides grants to nonprofits and local governments to expand behavioral health services for children, youth and families and address acute, complex or severe behavioral health problems. Uses includes establishing and operating CYF-oriented care “access points” located within a two-hour drive of every community co-located with behavioral health treatment facilities or family resource centers, establishing navigation and coordination services, expanding evidence-based/informed behavioral health treatment (including SUD treatment, intensive outpatient services with wraparound care, and caregiver interventions), and capital expenditures for treatment services.

Impact: As of September 2025, 17,724 unique individuals have been served by 32 new or expanded programs funded by these grants.

HB 22-1281 Substance Use Workforce Stability Grant Program ($15M)

Grants were awarded to support direct care staff who spend 50 percent of more of their time working with clients. Support may include temporary salary increases,

recruitment and retention bonuses, and other strategies that support staff. The program is appropriated $15 million from the Behavioral and Mental Health Cash Fund.

Impact: 686 providers were supported through temporary pay increases or retention bonuses or other workforce support strategies , and approximately 95% of employees who benefited remained in their role for at least six months after receiving the support.

House Bill 22-1283 funded youth substance use disorder and crisis service expansions, including $5 million for increasing capacity related to additional residential substance use treatment beds for youth. Beds have been contracted with Denver Health for Substance Use Disorder treatment services and high acuity, short-term withdrawal management services, with a capacity of 21 beds. Funding also supported a project at Jefferson Center for Mental Health. This project faced staffing challenges when hiring necessary positions that continues to delay the opening of additional beds and has continued to pose a challenge to its operations. Signal has been working directly with them to provide support and find solutions for implementation success. The unit is reopened in a limited capacity with 6 beds and will continue to expand the bed capacity.

Impact: As of June 2025, 99 youth have been served through the residential and withdrawal management programs funded by these projects.

Crisis System Services. $2.5M

HB 22-1283 extended work started by SB21-137 to enhance crisis access for children, youth, and families by and provided funding for Crisis Resolution Teams (CRT). This funding has allowed BHA to operate a crisis resolution team pilot in 21 counties and the city of Colorado Springs since 2022.

Impact: BHA collected data on outcomes to evaluate this program, and over 90% of youth served successfully by CRT move on to lower levels of care, meaning they avoided hospitalization and were able to safely remain in their home and communities. 39% of youth involved in CRT have some sort of suicidal ideation, while 8.6% have self-harm related treatment needs. These are high acuity youth in situations where their next step will be some form of out-of-home residential treatment. No children involved in CRT have died from suicide, showing an incredible impact the program has for youth and their families.

House Bill 22-1326 supported BHA in providing technical assistance to county jails that participate in Colorado's Jail Based Behavioral Health Services (JBBS) Program with development and implementation of medication-assisted substance use treatment (MAT). Funds supported costs directly related to delivering MAT, including medication, staff time related to services for assessment, administering medications, and follow-up.

Impact: Under this project, 19,960 unique individuals received MAT services while incarcerated. 9,563 individuals who have engaged in Jail MAT services under the JBBS umbrella transitioned to a provider for further treatment/ongoing evaluation for MAT services upon transitioning to community-based or DOC settings.

Senate Bill 22-196 established the early intervention, deflection, and redirection from the criminal justice system grant program to provide grants to local governments, federally recognized Indian tribes, health-care providers, community-based organizations, and nonprofit organizations to fund programs and strategies that prevent people with behavioral health needs from becoming involved with the criminal justice system or that redirect individuals in the criminal justice system with behavioral health needs to appropriate services.

Some of the services that have been funded through these projects include:

- School-Based Programs for At-Risk Youth
- Multisystemic Family Therapy for Rural Youth
- Vocational Training
- First Responder Co-Responder Services
- Law Enforcement Assisted Diversion (LEAD)
- Rural Recovery Residence Expansion
- Pre-Release Reentry Planning and Support for Adults and Youth
- Housing Support

Impact; As of September 2025, 16,225 individuals have been served through expansion of early intervention, deflection and/or redirection across 29 initiatives.

16. Rep. Taggart: What has the BHA done to communicate with providers and people receiving services that ARPA grant funding is coming to an end? Are providers and people receiving services expecting programs to continue?

ARPA funds granted out through BHA were almost exclusively one-time, capacity building investments. As part of the application process for all grants, applicants submitted sustainability plans to demonstrate how these investments would be maintained after grant funds were expended. BHA has communicated regularly with ARPA recipients since before initial awards were made about the one time nature of these funds.

Because these were one time funds, BHA, in line with statutory directives, prioritized investments that would not result in programs starting up and then not being able to continue once funds were expended. This included:

- One time program start-up or expansion costs
- Capital investments including construction, renovations, and one time purchases such as furnishings
- Technology development (IT Capital)
- Workforce investments (i.e. developing publicly accessible training materials, one-time costs associated with developing establishing new credentials or education pathways)

Recently Created Programs

17. Sen. Amabile: Please describe the regulation of recovery residences. Can a residence receive Medicaid reimbursement or other public funding without certification? What is the difference between licensing and certification?

Per C.R.S. 27-80-129, BHA delegates regulatory oversight of recovery residences to an approved certifying body, currently Ohio Recovery Housing - Colorado (ORHC). In the process of selecting and approving a certifying body, BHA reviews the agency's standards for certifying recovery residences to ensure those standards of care are aligned with industry best practice, BHA regulations, and relevant statute. The certifying body monitors certified residences to those standards, issues plans of correction when needed, and may issue cease and desist orders and consider revoking certification for substantial and repeated noncompliance.

A license is issued by a government entity as a condition for a business to legally operate. A certification is a credential from a private organization or professional body verifying competency or expertise. In Colorado, a recovery residence must be certified, except in rare circumstances outlined in statute, in order to operate and to receive public funding.

Medicaid may cover the substance use disorder (SUD) or behavioral health treatment of individuals living in sober living homes only when those services are provided by a licensed Behavioral Health Entity or Recovery Support Services Organization, but Medicaid cannot fund housing-related costs. Recovery residences are not licensed to provide SUD or other behavioral health treatment and are not reimbursed for such services under a Recovery Residence certification.

A certified Recovery Residence may receive other public funding. The Housing Assistance funding authorized through SB 21-137 that BHASOs manage supports a scholarship for people to live in a certified recovery residence. Additionally, BHA also uses other federal dollars to support people to stay in certified recovery residences. BHA is also aware that other state agencies and some problem solving courts also provide funding for their clients to live in certified recovery residences. In all of these instances, funding is only available for certified Recovery Residences.

BHA is pursuing legislation to reform BHA's oversight of Recovery Residences, including through state licensing. This will have no impact on reimbursement opportunities. However, it will ensure Recovery Residences adhere to licensing standards aligned with national best practices and improve state oversight and enforcement authority, in accordance with the Administrative Procedures Act. The goal of these changes are to ensure the safety and wellbeing of individuals residing in Recovery Residences, and promote access to high quality recovery housing as part of the Substance Use Disorder treatment continuum.

I Matter

18. Rep. Brown: Please provide detailed data on the annual utilization of the IMatter program, including the number of youth served, locations served, and how youth access the program.

Table 8: Unique Youth Receiving Services Through I Matter

Time frame	FY 2021-22	FY 2022-23	FY 2023-24	FY 2024-25	FY 2025-26 (through Oct)	Total
Youth served	3,330`	5,498	4,110	4,032	1,084	18,054

Youth in every Colorado county have accessed I Matter since the programs inception. Detailed breakdowns are shown in table 9 below. An asterix (*) denotes 1-15 youth served. Data is suppressed in these instances for privacy considerations.

Table 9: Youth Served by County of Residence from Program Start through Oct 2025

Client County of Residence	# Youth Served
1. Adams County	1,901
2. Alamosa County	22
3. Arapahoe County	2,183
4. Archuleta County	*
5. Baca County	31
6. Bent County	*
7. Boulder County	882
8. Broomfield County	362
9. Chaffee County	52
10. Cheyenne County	*
11. Clear Creek County	22
12. Conejos County	*

Client County of Residence	# Youth Served
13. Costilla County	*
14. Crowley County	*
15. Custer County	*
16. Delta County	28
17. Denver County	2,375
18. Dolores County	*
19. Douglas County	1,217
20. Eagle County	653
21. El Paso County	2,208
22. Elbert County	78
23. Fremont County	78
24. Garfield County	185
25. Gilpin County	*
26. Grand County	50
27. Gunnison County	36
28. Hinsdale County	*
29. Huerfano County	*
30. Jackson County	*
31. Jefferson County	1,826
32. Kiowa County	*
33. Kit Carson County	*
34. La Plata County	225
35. Lake County	*
36. Larimer County	1,091
37. Las Animas County	27
38. Lincoln County	*
39. Logan County	39
40. Mesa County	426
41. Mineral County	*

Client County of Residence	# Youth Served
42. Moffat County	19
43. Montezuma County	48
44. Montrose County	26
45. Morgan County	85
46. Otero County	37
47. Ouray County	*
48. Park County	21
49. Phillips County	29
50. Pitkin County	22
51. Prowers County	17
52. Pueblo County	287
53. Rio Blanco County	*
54. Rio Grande County	*
55. Routt County	58
56. Saguache County	*
57. San Juan County	*
58. San Miguel County	*
59. Sedgwick County	24
60. Summit County	236
61. Teller County	45
62. Washington County	*
63. Weld County	848
64. Yuma County	32

Youth are able to access therapy sessions in person or through telehealth, based on the youth or family's selection.

Table 10: Method of Accessing Services

Method	# of sessions (Oct 2021-Oct 2025)	Percentage of total sessions
In Person	25,871	34.3%
Telehealth	49,643	65.7%
Total	75,514	100%

19. Sen. Bridges: Please provide data on the outcomes for the I Matter program. How does the BHA evaluate high utilization of the program results in better outcomes for youth?

SB 24-001 required the I Matter Program to conduct a formal evaluation assessing the program's effectiveness and its ability to meet the mental health needs of participating youth. The program initiated this evaluation process prior to the statutory deadline of July 1, 2024, completing its initial program evaluation in FY 2024 and publishing the first I Matter Program Evaluation in July 2024[6]. A second evaluation was subsequently completed and published in May 2025[7]. These evaluations provide evidence that participation in the I Matter Program yields meaningful improvements in youth well-being, as well as strong positive feedback from youth and families.

The program is evaluated using survey responses that gather feedback on participants' experiences with the program and to measure participants' general level of well-being (personally, with family and friends, and with school and activities) since enrolling in I Matter. The survey also included a question about whether they are doing better than when they started I Matter (perception of change), and whether they would recommend I Matter. The survey is distributed to youth, parents, guardians, and other caring adults through the I Matter telehealth platform after participants' first and third session. The survey is aligned with evidence-based survey research practices.

[6] I Matter Program Evaluation in July 2024

[7] I Matter Program Evaluation May 2025

Findings from the May 2025 evaluation highlights several key outcomes. Youth surveyed consistently reported feeling "about the same" or "better" after each of their first three sessions, with many demonstrating clear improvement by the third session. Across all three time points, 90–100% of youth agreed that their provider listened to them, understood their concerns, focused on topics important to the youth, and was helpful in addressing their needs. Importantly, these positive outcomes were observed regardless of demographic characteristics or initial levels of financial, emotional, or behavioral need. Families also reported positive experiences and noticeable improvements in their children's well-being, and the evaluations show sustained youth positivity about the program. Together, these findings indicate that the I Matter Program is not only accessible but effective in supporting youth mental health.

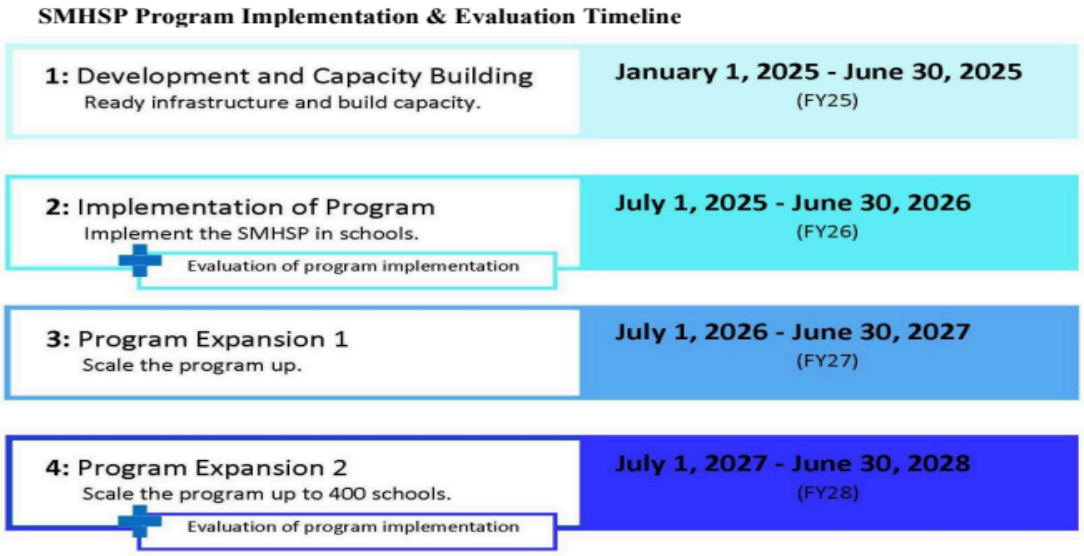
20. Rep. Brown: Please quantify the impact of a $250,000 reduction for I Matter. How would the BHA or the service provider change access to services if funding was reduced?

I Matter funding was reduced from $6,000,000 to $5,000,000 in FY 2024-2025, and ongoing with a BHA initiated budget request submitted during the FY 2025-26 figure setting process. This reduction occurred concurrently with expanded program requirements under SB 24-001, which mandated comprehensive program evaluations and the administration of surveys to youth, guardians, and providers. Any further decrease in funding would directly diminish the resources available for reimbursing therapeutic services for Colorado youth, resulting in fewer sessions delivered and reduced access to care statewide.

I Matter launched in October 2021 and since December 2021, I Matter has consistently offered up to six free therapy sessions to youth across Colorado. A reduction in funding would necessitate lowering the number of sessions available. Currently, the program delivers an average of 4.2 sessions per participant, and feedback from both youth and guardian surveys consistently includes requests to increase the number of available sessions. Continued funding at sustainable levels is therefore essential to maintain service availability and meet the mental health needs identified by Colorado families. Depending on the session type a reduction in $250,000 would lead to an approximate reduction of between 1360-1900 sessions available for youth across Colorado annually.

21. Rep. Sirota: Please address the following questions about the School-based Mental Health program funded on a one-time basis by H.B. 24-1406.

What does the rollout of HB 24-1406 currently look like? More specifically, please share the timeline established by BHA that the external provider must follow in order to implement the program.



Program Expansion Plan 1: Contractor shall submit a detailed expansion plan outlining activities for scaling the program up for the 2026-27 school year.

Year 2 (FY 2026) DELIVERABLES - Expansion Plan 1: Contractor due to submit the following items for BHA approval by January 1, 2026;

- Detailed plan for the School Mental Health Support Program (SMHSP) rollout and implementation in schools for the 2026-27 school year.
- Plan for outreaching Rural and Underserved Schools.
- Updated Logic Model outlining inputs, activities, outputs, outcomes, and impact.
- Budget FY 2027: Finalized budget that outlines program costs for the 2026-27 school year.
- Budget FY 2028: Updated forecast of costs to scale the program up to 400 schools by the 2027-28 school year.
- Budget FY 2029: Forecast the program's operational costs for the 2028-29

school year.
- Timeline of activities that align with BHA timeline and Logic Model.
- Partner Commitment Documentation
- Collaborate with BHA to develop an updated SOW for FY 2027, including activities and deliverables for the post-launch period.

Program Expansion Plan 2: Contractor shall provide a detailed plan outlining schools, trainings, and steps for SMHSP rollout and implementation in at least 400 schools by the 2027-28 school year.

Contract Year 3 (FY 2027) DELIVERABLES - Expansion Plan 2: Submit the following items for BHA approval by January 1, 2027;

- Updated Logic Model outlining the inputs, activities, outputs, outcomes, and impact.
- Budget FY 2028: Finalized budget outlining the 2026-27 school year program costs.
- Budget FY 2029: Forecast the program's operational costs for the 2028-29 school year.
- Provide an updated forecast of the costs for scaling the program to 400 schools by the 2027-28 school year.
- Collaborate with BHA to update the FY 2028 SOW.

22. How are schools or districts being recruited? How are you ensuring that the program reaches schools in rural areas and schools with students who do not have equitable access to mental health care?

The Kempe Center and the Butler Institute focused on strengthening relationships with potential partners at the state and community levels to advance SMHSP efforts. A collaborative kickoff meeting launched the SMHSP collaboration efforts, and extensive outreach with stakeholders, districts and agencies. They have leveraged existing collaboration with the Boards of Cooperative Educational Services (BOCES), community mental health and medical providers to target schools in need of services in rural communities. The following partners are also engaged as part of ongoing outreach efforts to target rural schools and students who do not have equitable access to mental health care:

- Colorado Behavioral Health Administration (BHA)
- Colorado Department of Education (CDE)
- Colorado Office of School Safety (OSS)
- Finding Hope Counseling and Consulting

- Hispanic/Latino Behavioral Health Center of Excellence
- Mental Health Colorado
- National Center for School Mental Health
- Pediatric Mental Health Institute at Children's Hospital Colorado
- Project AWARE (BHA and CDE)

23. What does the program offer schools? How are schools and educators trained, and how do they obtain ongoing access to program materials?

SMHSP created a comprehensive Menu of Services to clearly outline available offerings for all current and potential partners. This Menu defines three levels of engagement, allowing schools to select the type of support that best fits their needs and readiness for implementation. For more information on the program offerings see SMHSP Program Offerings[8]

Level 1: Flexible Learning Opportunities that focus on building foundational knowledge and enhancing practical skills that promote student mental health, staff well-being, trauma-informed practices, and positive school climate.

- Multiple virtual statewide trainings are offered each month.
- Participants receive topic-specific resources, which will be added to the online LMS resource bank for ongoing access.

Level 2: Targeted Skill Development. Designed with more focused professional growth.

- Participants engage in specialized training and coaching aligned with the areas of focus identified through the needs assessment process.
- Emphasizes collaborative learning and application of new strategies within a school or organizational context.

Level 3: Intensive Implementation Support. Provides individualized, comprehensive assistance to partners implementing systemic and sustainable practice changes. Builds on the skills developed in Level 2 with tailored coaching, consultation, and technical support.

- Focuses on integrating trauma-informed and mental health supports into everyday systems and culture to create lasting impact.

[8] SMHSP Program Offerings

24. How many schools are implementing the program this school year ('25-'26)? Where are the schools located?

The Kempe Center secured 51 commitments[9] from schools in rural and underserved communities to begin August 2025. Outreach efforts are ongoing, with a goal to contract with 120 schools for school year 25-26.

25. Can you please share more about the training and resources offered to schools? Additionally, what are the specific mental wellness and resiliency skills being offered to students?

Curriculum development is evidence-based, adult learning principle-focused, and includes foundational and advanced trainings. These are web-based and synchronous trainings for knowledge delivery, and offer group facilitation and coaching for application of knowledge and integration into school's Social Emotional Learning (SEL) programming, Multi-Tiered System of Supports (MTSS) tiers, and Positive Behavioral Interventions and Supports (PBIS) initiatives.

Current training, resources and activities offered:

- Mental Health and Well Being
- Self Regulation and resilience Skills
- Culturally Responsive Environments
- Mindfulness Skills
- Cognitive-Behavioral Techniques (CBT)
- Educator Wellness and Resiliency
- Trauma-informed Practices
- Individualized Mental Health Plans
- Suicide Risk

For a more comprehensive list of Training and Resource offerings utilizing the MTSS model see Trainings and Resources[10].

[9] Participating Schools

[10] Trainings and Resources

26. What are the resources and training being offered to students to manage suicide risk and how is the external provider coordinating care among families, schools and health care providers for youth at risk of suicide?

SMHSP is a capacity-building, training, and implementation support program that strengthens schools' ability to deliver evidence-based, trauma-responsive mental health supports across all three tiers of MTSS. Teachers, counselors, and school staff are receiving mental health training and resources to support students who are struggling with underlying mental health issues that maybe at higher risk for suicide.

Key components include:

- Suicide risk management strategies implemented in collaboration with the Colorado Office of School Safety (OSS).
- Support interested schools in development of referral pathways between schools and external mental health providers.
- Joint meetings between school staff and community mental health providers to improve collaboration and continuity of care.
- Support for schools to strengthen coordination with external providers, especially for students with intensive mental health needs.
- Understanding the referral networks to new providers where service gaps exist.
- Sharing suicide prevention training and culturally responsive resources from partners through the LMS.
- Support for cross-system collaboration between educators and mental health providers.
- Coordination meetings between schools and external providers.
- Alignment with OSS, Colorado Department of Education (CDE), on suicide risk management strategies.
- Access to evidence-based suicide prevention resources through the LMS.
- Ongoing technical assistance to school teams on coordination, referral processes, and family engagement.
- Data-informed tracking of training access and resource utilization through the LMS.
- Continued coordination support for the expansion of external provider referral networks.
- Additional family-facing suicide prevention and education resources.
- Ongoing growth of the LMS library of high-quality, evidence-based suicide prevention and mental health resources.

27. Can you please share what evidence-based mental health practices the external provider is using?

- Trauma-Informed Care frameworks (SAMHSA; NCTSN)
- Cognitive Behavioral Therapy (CBT)–informed skill development
- Mindfulness and self-regulation strategies
- Social-Emotional Learning (SEL) and resilience-building practices
- Trauma-responsive Positive Behavioral Interventions and Supports
- High-Fidelity Wraparound (HFW) principles
- Suicide prevention and postvention best practices
- Staff wellness and secondary traumatic stress prevention

28. What is the strategy the external provider has designed to build future partnerships with community or hospital-based providers to assist schools in implementing the program?

The external provider holds regular meetings in collaboration with existing partners (shown below), to build and strengthen partnerships with providers.

- Colorado Behavioral Health Administration (BHA)
- Colorado Department of Education (CDE)
- Colorado Office of School Safety (OSS)
- Finding Hope Counseling and Consulting
- Hispanic/Latino Behavioral Health Center of Excellence
- Mental Health Colorado
- National Center for School Mental Health
- Pediatric Mental Health Institute at Children's Hospital Colorado
- Project AWARE (BHA and CDE)

The SMHSP's monthly newsletter is currently being sent out to professionals, partners, schools, districts, BOCES, hospitals and agencies to promote the program. MHSP also hosts tables at several conferences to publicize the program and recruit new school, district, BOCES, and agency partners. See SMHSP Collaborative Model[11]

BHA is also supporting the external provider in coordinating with the CO LIFTS network to ensure robust connection to community providers.

[11] SMHSP Collaborative Model

29. What is the determined cost of implementing the program in at least four hundred schools by the start of the 2027-28 school year?

This determination is under way. Kempe began implementation in schools this fall, and BHA and Kempe are working together to determine a FY 2026-27 budget. Notably, the legislative declaration indicates the general assembly's intention to scale the SMHSP to support 400 schools, and the proponents of HB24-1406 had indicated that they would pursue additional funding to enable this scaling. With the budget challenges facing Colorado, BHA has worked with Kempe to maximize impact within the current one time appropriation. As we finalize the FY 27 budget in light of these recommendations, BHA will work with the contractor to determine costs to reach the 400 schools, and will provide updates to JBC on how many schools the program expects to reach within the current appropriation. For the program to be implemented in a minimum of four hundred schools, BHA and Kempe have collaborated and determined the following would be necessary:

- Expanded outreach: This will include developing and implementing a statewide, targeted outreach strategy that includes clear messaging, tailored materials, region-specific engagement events, partnering with BOCES, district leaders, and other agencies.
- Increased program staffing: Regionally based Implementation Specialists will tailor supports to schools' needs. Schools engaging at Levels 2 and 3 require individualized, ongoing support to integrate efforts with existing initiatives, meet requirements, and plan thoughtfully for implementation and sustainability.
- Curriculum expansion: Expanding flexible, accessible curriculum, including self-paced learning modules, geared especially towards paraprofessionals and staff providing intensive student support in rural areas
- Learning Management System (LMS) development: Will support the tracking and facilitation of learning sessions; manage registration, monitor participation and completion, and provide on-demand, virtual and hybrid learning options. An LMS will also allow the program to scale efficiently while maintaining high-quality data and consistent access to resources and training.

30. How does BHA plan to evaluate the efficacy of the program across school types and student populations.

The BHA is partnering with an external evaluator to design and provide a comprehensive evaluation of the SMHSP. The contract with an external evaluator began July 1, 2025. Following the 2025-26 school year implementation of this program, a mid-year evaluation will be scheduled to evaluate the initial implementation of the program. Following the implementation of the 2027-28 school year, a larger comprehensive external program evaluation will be conducted to assess the SMHSP Contractor and program efficacy across different school types and student populations. The external evaluator will assess the program, recommend improvements, and collect data on its efficacy. This final report will be due June 30, 2028. The evaluation will provide objective insights into the SMHSP's impact, helping BHA continuously improve and adapt its support services, identifying barriers and disparities to improve mental health outcomes in rural and underserved populations. The findings will guide future efforts to strengthen mental health support for educators and students.

The program evaluation will focus on three primary objectives:

1. **Evaluate Program Efficacy:**
   Assess the effectiveness of the School Mental Health Support Program in supporting educators and improving student mental health outcomes, with a focus on underserved communities.
2. **Identify Opportunities for Improvement:**
   Recommend actionable strategies to enhance the SMHSP's overall effectiveness and impact.
3. **Evaluate Partnership Effectiveness:**
   Assess the strength and effectiveness of partnerships between the SMHSP contractor, schools, partner organizations, and relevant support resources.

22. Sen. Amabile: Please provide data on utilization of the youth room and board payments created by H.B. 24-1038 (High Acuity Youth). How many youth have been served by the funding each year? Is there a waitlist for services? What would be the impact of reducing the appropriation?

FY25 Room and Board Data:

- 58 unique youth served with an average length of stay of 101 days.

- BHA began funding QRTP room and board October 2024 through the ASOs. A total of 8 QRTPs accepted contracts with the ASOs to receive reimbursement for room and board in FY25.

FY26 Room and Board Data:

- 42 unique youth served during the 1st quarter of FY26 (July 1, 2025 - September 30, 2025).
- 14 QRTPs were contracted with the BHASOs to receive reimbursement for room and board during the 1st quarter of FY26
    - 18 licensed QRTPs were eligible to receive room and board funding during the 1st quarter of FY26. Of the 4 QRTPs who do not have contracts to receive room and board reimbursement:
        - 2 only accept placements through county child welfare departments and/or DYS so they declined the BHASO contracts
        - 2 stopped responding to BHASO outreach attempts.
        - BHASOs are contractually required to continue engaging these QRTPs to offer them contracts when requested. We've also continued to outreach them at the state level (CHDS / BHA).

Total Unique Youth Served (October 1, 2024 - September 30, 2025)- 75

There is no waitlist for QRTP room and board funding.

Reducing this appropriation will recreate a disparity in funding for youth who are not in the custody of a child welfare agency but who require treatment in a QRTP, which HB24-1038 was enacted to address. Before HB24-1038, there was no guaranteed funding for room and board costs in a QRTP for a Medicaid member. As such, families were frequently referred to county child welfare departments, not due to abuse or neglect, but solely so counties could cover room and board for youth who require higher levels of behavioral health treatment. Counties would often have to take temporary custody of the youth to cover these costs. If these funds are no longer available through BHA, the responsibility for serving these families will likely shift back to county child welfare departments.

Ag Behavioral Health

23. Rep. Sirota: How many people are being served by the Rural Behavioral Health program?

The Rural Behavioral health voucher program provides $50,000 annually to fund the Colorado Agricultural and Addiction Mental Health Program (CAAMHP). CAAMHP provided 280 hours of no-cost, culturally tailored therapy to 56 Coloradans in rural and agricultural communities during state fiscal year 2025. Since its establishment in 2021, 1,167 hours of therapy have been funded for farmers, ranchers, agriculture workers and their families.

24. Sen. Amabile: Please describe how Rural Behavioral Health vouchers created by S.B. 21-137 do or do not overlap with resources in other areas, including BHASOs, RAEs, funding in the Department of Agriculture from S.B. 24-055, and the AgrAbility Project in CSU.

The funds for Rural Behavioral Health vouchers created by SB 21-137 are complementary, not duplicative, of other resources mentioned. BHA's $50,000 appropriation for rural behavioral health vouchers provides vouchers for up to six mental health sessions for a qualifying individual through the Colorado Agricultural Addiction and Mental Health Program (CAAMHP). CAAMHP supports farmers and ranchers facing anxiety, depression, substance use disorders, and other behavioral health concerns that are worsened by day to day challenges facing farmers and ranchers. CAAMHP is co-administered by CSU AgrAbility, which is a broader program that provides education, and services to farmers, ranchers, agricultural workers and their families with disabilities. Funding for AgrAbility is additive, not duplicative of BHA's funding for CAAMHP.

Individuals eligible for these vouchers may be eligible for therapy services through their BHASO, if uninsured or underinsured, or through the RAE, if eligible for Medicaid. However, even when individuals may be able to access these services through BHASOs or RAEs, individuals report that stigma and other barriers prevent them from seeking behavioral health care through those avenues. At the same time, these individuals may be willing to seek lifesaving care through CAAMHP.

SB 24-055 created the Agricultural and Rural Program housed within the BHA, to equip licensed behavioral health providers with the practical skills and knowledge needed to

provide culturally informed care to agricultural-based clients. The BHA partnered with the LandLogic Model Training, Colorado Department of Agriculture, and Colorado State University to develop and implement this training.

Additionally, while the statute does maintain a grant program in CDA established by SB25-055, there is currently no funding appropriated for this purpose. Behavioral health funding in CDA funds .5 FTE, costs for facilitating the monthly Agricultural Behavioral Health Community of Practice Work Group, and convening an annual summit facilitated by BHA and CDA to bring behavioral health organizations and agricultural organizations together to discuss the behavioral and mental health challenges that rural and agricultural communities face and work to meet those needs.

Common question For Department Hearings (Written-only Response)

(PLEASE RETAIN THE NUMBERING IN ORDER TO MAINTAIN CONSISTENT LABELING ACROSS DEPARTMENTS.)

1. Please provide a breakdown of your department's total advertising budget for the current and prior fiscal year. Specifically:

a. What is the total amount budgeted and expended on advertising and media placement type?

Lift The Label & Recovery Cards Project

- FY25: The paid media space budget of $738,000 was split up by the following percentages:
    - Out of Home, 8%
    - Paid Search, 1%
    - Terrestrial Radio,17%
    - CTV, 19%
    - Rich Media, 10%
    - Digital Video, 18%
    - Paid Social, 12%
    - Streaming Audio, 7%
    - Native, 5%
    - Display, 3%

- FY26: The paid media space budget of $448,000 is split up by the following percentages:
    - Connected TV/Over the Top TV, 19%
    - YouTube/Online Video, 11%
    - Streaming Audio, 7%
    - Paid Social, 31%
    - Off Social Stories, 9%
    - Rich Media, 7%
    - Paid Search, 12%
    - Spanish Media Outlet Space (in addition to Spanish-language placements in other tactics), 4%

I Matter

- FY25: The paid media space budget of $440,000 was split up by the following percentages:
    - In-App Gaming, 18%
    - Digital Video, 11%
    - Paid Social, 21%
    - Streaming Audio, 23%
    - Paid Search, 5%
    - Rich Media, 22%
- FY26: The paid media space budget of $395,000 is split up by the following percentages:
    - Digital & Rewarded Video: 30%
    - Rich Media: 21%
    - Paid Social: 14%
    - Off-Social Stories: 10%
    - Print: 3%
    - OOH: 2%
    - Streaming Audio: 14%
    - Paid Search: 6%

Crisis

- FY25: The paid media space budget of $159,073.69 (all MHBG funding) was split up by the following percentages:
    - Out of Home, 79%

    - Paid Search, 21%
- FY26: We are still in media planning for the full $176,075 (all MHBG funding) budget and do not yet have recommended media percentage splits.

988 Colorado

- FY25: The TOTAL paid media space budget of $1,435,000 (Board Budget[12]: $450,000 , COHORT III[13]: $985,000) was split up by the following percentages:
    - Out of Home, 39%
    - Paid Search, 4%
    - Terrestrial Radio,11%
    - CTV, 8%
    - Digital Video, 21%
    - Paid Social, 9%
    - Streaming Audio, 8%
- FY26: The TOTAL paid media space budget of $1,090,000 (Board Budget: $215,000, COHORT III: $875,000) was split up into two separate media buys.
    - $75,000 was taken from just the board funding to complete a short bridge campaign the percentages of which were split up as follows:
        - Paid Search, 26%
        - Digital Video, 64%
        - Paid Social, 10%
    - We are still in media planning for the remaining $1,015,000 and do not yet have recommended media percentage splits.

b. How are those advertising dollars allocated across different media types (e.g., television (national/local/cable), radio (terrestrial vs streaming), SEM, digital (display, YouTube), connected TV, social media, print, outdoor, etc.)?

Answer applies to all campaigns, for both fiscal years: Media strategy is first defined by audience profiles, and who should be reached with the message. Then, based on these audience profiles balanced with the priorities of the campaign overall (e.g., also keeping in mind anything such as geographical focuses), media consumption data is pulled and analyzed to select media tactics to reach the audience effectively.

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[12] Board budget refers to 988 Enterprise Revenue
[13]COHORT III refers to SAMHSA Awarded Federal 988 Grants

Essentially, looking at how particular groups of people are taking in media—are they watching a lot of streaming services, are they on Facebook a lot, are they reading the local newspaper, etc. This is also balanced with the consideration of what media tactics are most efficient to reach the intended audience in terms of awareness and education (e.g., outdoor, print, radio, etc.), and a balance of this with additional tactics that are more efficient and hyper-targeted traffic drivers (e.g., paid social, digital, SEM, etc.). All of these considerations are taken into account in the allocation of advertising dollars across different media types.

c. How much of that spending is directed to Colorado-based or local media outlets? How is the media currently purchased?

Lift The Label & Recovery Cards Project: It is important to note that all of the media placements that are purchased are geo-fenced to Colorado, meaning that even if Lift The Label advertisements are served by national media outlets, the content of the ads is not served outside of Colorado. The placements purchased are Colorado-specific. Media placements are purchased directly through vendor portals following negotiations.

- FY25:
    - Out of Home, 6% of overall media budget via National Outlet (Basis digital OOH), 1% of overall media budget via Colorado based outlet (Colorado Delivers)
    - Paid Search, 1% of overall media budget via National Outlet (Google)
    - Terrestrial Radio, 17% of overall media budget via Colorado radio stations, although primarily owned by national companies
    - CTV, 19% of overall media budget via National Outlets (Basis)
    - Rich Media,10% of overall media budget via National Outlets (GumGum)
    - Digital Video, 18% of overall media budget via National Outlet (Google, Basis)
    - Paid Social, 12% of overall media budget via National Outlets (Reddit, Snapchat, Meta, TikTok, Nextdoor)
    - Streaming Audio, 7% of overall media budget via National Outlets (Spotify, Pandora)
    - Native, 5% of overall media budget via National Outlets (Basis)
    - Display, 3% of overall media budget via National Outlets (Basis)
- FY26:

- Connected TV/Over the Top TV, 19% of overall media budget via National Outlet (Q1 Media)
- YouTube/Online Video, 11% of overall media budget via National Outlet (Google)
- Streaming Audio, 7% of overall media budget via National Outlet (Spotify, iHeart Radio, Megaphone)
- Paid Social, 31% of overall media budget via National Outlet (Meta, Reddit, TikTok)
- Off Social Stories, 9% of overall media budget via National Outlet (Equativ, Q1 Media)
- Rich Media, 7% of overall media budget via National Outlet (Equativ)
- Paid Search,12% of overall media budget via National Outlet (Google)
- Spanish Media Outlet Space (in addition to Spanish-language placements in other tactics), 4% of overall media budget via Colorado locally based outlets

I Matter: It is important to note that all of the media placements that are purchased are geo-fenced to Colorado, meaning that even if I Matter advertisements are served by national media outlets, the content of the ads is not served outside of Colorado. The placements purchased are Colorado-specific. Media placements are purchased directly through vendor portals following negotiations.

- FY25:
  - In-App Gaming, 18% of overall media budget via National Outlet (Basis, Unity)
  - Digital Video, 11% of overall media budget via National Outlets (SuperAwesome, YouTube)
  - Paid Social, 21% of overall media budget via National Outlets (TikTok, Pinterest, Snapchat)
  - Streaming Audio, 23% of overall media budget via National Outlet (Basis)
  - Paid Search, 5% of overall media budget via National Outlet (Google)
  - Rich Media, 22% (Undertone, AdChat)
- FY26:
  - Digital & Rewarded Video: 30% of overall media budget via National Outlets (Equativ, YouTube, Q1 Media)
  - Rich Media: 21% of overall media budget via National Outlet (Q1 Media)
  - Paid Social: 14% of overall media budget via National Outlets (Meta, TikTok)

- Off-Social Stories: 10% of overall media budget via National Outlet (Equativ)
- Print: 3% of overall media budget via via a Colorado-based outlet (Colorado Parent Magazine)
- OOH: 2% of overall media budget via a Colorado-based distribution company (Colorado Delivers)
- Streaming Audio: 14% of of overall media budget via National Outlet (Equativ)
- Paid Search: 6% of overall media budget via National Outlet (Google)

Crisis: It is important to note that all of the media placements that are purchased are geo-fenced to Colorado, meaning that even if CCS/Crisis Marketing's advertisements are served by national media outlets, the content of the ads is not served outside of Colorado. The placements purchased are Colorado-specific. Media placements are purchased directly through vendor portals following negotiations.

- FY25:
  - Out of Home, 79% of overall media budget via National Outlet (Basis digital OOH, OUTFRONT) as well as local OOH (Lamar and Mile High)
  - Paid Search, 21% of overall media budget via National Outlet (Google)
- FY26: N/A

988 Colorado: It is important to note that all of the media placements that are purchased are geo-fenced to Colorado, meaning that even if 988 Colorado advertisements are served by national media outlets, the content of the ads is not served outside of Colorado. The placements purchased are Colorado-specific. Media placements are purchased directly through vendor portals following negotiations.

- FY25:
  - Out of Home, 39% of overall media budget via National Outlet (Basis digital OOH, placebased, Outfront) as well as Colorado based like (Lamar and Mile High OOH)
  - Paid Search, 4% of overall media budget via National Outlet (Google)
  - Terrestrial Radio, 11% of overall media budget via Colorado radio stations, although primarily owned by national companies
  - CTV, 8% of overall media budget via National Outlets (Basis, Amazon)
  - Digital Video, 21% of overall media budget via National Outlet (YouTube, Basis, SuperAwesome)

    - Paid Social, 9% of overall media budget via National Outlets (Reddit, Snapchat, Meta)
    - Streaming Audio, 8% of overall media budget via National Outlets (Amazon Music, Basis Audio)
- FY26:
    - Digital & Rewarded Video: 64% of overall media budget via National Outlets (Basis, YouTube)
    - Paid Social: 10% of overall media budget via National Outlets (Meta)
    - Paid Search: 26% of overall media budget via National Outlet (Google)

d. What performance metrics or evaluation tools does the department use to measure the effectiveness of these advertising campaigns? What are the goals of the campaigns, and what key performance indicators are measured for success?

Lift The Label & Recovery Cards Project

- FY25 & FY26: Paid media campaigns are evaluated via pre-determined key performance indicators (KPIs) ahead of each campaign. These are strategically aligned with the goals of the campaign–Lift The Label's goals are to increase awareness and education of substance use disorder while also driving individuals to treatment resources shared on its website. These KPIs are defined with benchmark goals based on each individual campaign tactic, and are tracked by platform and via marketing tracking softwares. Benchmark goals are based in past performance and current industry standards. These types of KPIs include things like click-through rate, impressions, reach, engagement rate, and video completion rate.

I Matter

- FY25 & FY26: Paid media campaigns are evaluated via pre-determined key performance indicators (KPIs) ahead of each campaign. These are strategically aligned with the goals of the campaign–I Matter's goals are to increase awareness and use of free youth therapy services. These KPIs are defined with benchmark goals based on each individual campaign tactic, and are tracked by platform and via marketing tracking softwares. Benchmark goals are based on past performance and current industry standards. These types of KPIs include things like click-through rate, impressions, reach, engagement rate, and video completion rate.

Crisis

- FY25 & FY26: Paid media campaigns are evaluated via pre-determined key performance indicators (KPIs) ahead of each campaign. These are strategically aligned with the goals of the campaign–CCS/Crisis Marketing's goals currently are to increase awareness of 988 as the primary mental health line in Colorado and to encourage use of the service. These KPIs are defined with benchmark goals based on each individual campaign tactic, and are tracked by platform and via marketing tracking softwares. Benchmark goals are based on past performance and current industry standards. These types of KPIs include things like click-through rate, impressions, reach, engagement rate, and video completion rate.

988 Colorado

- FY25 & FY26: Paid media campaigns are evaluated via pre-determined key performance indicators (KPIs) ahead of each campaign. These are strategically aligned with the goals of the campaign – 988 Colorado's goals are to increase awareness of 988 Colorado Mental Health Line and to encourage use of the services provided. These KPIs are defined with benchmark goals based on each individual campaign tactic, and are tracked by platform and via marketing tracking softwares. Benchmark goals are based on past performance and current industry standards. These types of KPIs include things like click-through rate, impressions, reach, engagement rate, and video completion rate.

e. If any portion of advertising is managed through third-party vendors (or 'partners';) or media buying firms, please provide any available data or reporting from those companies on campaign performance and spending. How often do the departments discuss media placements with these vendors?

For all campaigns: All advertising is managed through a communications agency. Media placements are discussed regularly. At the beginning of each fiscal year, a media brief outlines strategy for all parties to align on, and that is used by the communications agency to develop a full media plan with specific placements scheduled through the fiscal year. The BHA team reviews and approves this plan. When media is placed and in-market, the communications agency is continuously managing and optimizing performance. Mid-campaign reporting check-ins are shared with learnings and recommendations for the remainder of the year, but there are unscheduled check-ins as needed with recommendations that don't align with the

mid-campaign report. The BHA is in daily contact with the communications agency about each campaign.

Lift The Label & Recovery Cards Project

- FY25: FY25 reports are available here.
- FY26: Reports are not yet available for this fiscal year, because the paid media campaign is not yet in market.

I Matter

- FY25: FY25 reports are available here.
- FY26: Reports are not yet available for this fiscal year, because the paid media campaign has not had enough time in market to report on.

Crisis

- FY25: FY25 reports are available here.
- FY26: Reports are not yet available for this fiscal year, because the paid media campaign is still in the planning phase and has not had enough time in market to report on.

988 Colorado

- FY25: FY25 reports are available here.
- FY26: The Bridge Plan post campaign report is available here. Reports are not yet available for the grater fiscal year, because the paid media campaign is still in the planning phase and has not had enough time in market to report on.

Monthly or quarterly reporting - how is reporting delivered?

Lift The Label & Recovery Cards Project: Mid-campaign and post-campaign reports are delivered for paid media placements.

I Matter: Mid-campaign and post-campaign reports are delivered for paid media placements.

Crisis: Mid-campaign and post-campaign reports are delivered for paid media placements.

988 Colorado: Mid-campaign and post-campaign reports are delivered for paid media placements longer than 8 weeks.

COMMON QUESTION FROM CDPHE BRIEFING FOR CDPHE/CDHS/BHA/ CDEC/HCPF

2. How many contracts does the BHA have with the Kempe Center? What are the purpose and amount of the contracts? Is there duplication across the contracts?

BHA has one current contract with Kempe Center, the School Based Mental Health Support Program established by HB 24-1406 and addressed in detail in question 21 on pages 56-63.

FY 2025-26 (26 IBEH 197343): $745,667.15

Human Services

FY 2026-27 Joint Budget Committee Hearing

Tuesday, December 16

9:00 am – 5:00 pm

Common question For Department Hearings (Written-only Response)

1. Please provide a breakdown of your department's total advertising budget for the current and prior fiscal year. Specifically:

    i. What is the total amount budgeted and expended on advertising and media placement type?

    Marketing and advertising of CDHS programs are key components to ensure services reach their intended users. CDHS focuses on a social marketing approach, utilizing commercial marketing strategies to promote social programs. As part of our social marketing efforts, advertising accompanies outreach, stakeholdering, public relations and other tactics to create a network of touchpoints that promote services or help audiences internalize key messages. CDHS advertising efforts have helped Coloradans access a multitude of services and benefits, from accessing nutritious food through the Healthy Incentives Pilot program (eHip); obtaining help heating their homes with the Low-Income Energy Assistance Program (LEAP); feeding youth with Summer Electronic Benefits Transfer Program (S-EBT) to safeguarding the safety and wellbeing of children with the Child Abuse and Neglect Hotline. The total budgeted and expended on advertising across the department was:

    - FY 2024-25: $1.220,277.27
    - FY 2025-26: $1,088,221.00 (budgeted)

    The vast majority of these funds support the public awareness campaign for the Colorado Child Abuse and Neglect Hotline and the recruitment and retention of foster parents. For FY 2025-26, these account for $347,414 and $129,411 respectively. The remaining amounts support the promotion of such benefits and programs such as: the Veterans Community Living Centers, eHip, LEAP, S-EBT and the Supplemental Nutrition Assistance Program Education (SNAP-Ed), among others.

ii. How are those advertising dollars allocated across different media types (e.g., television (national/local/cable), radio (terrestrial vs streaming), SEM, digital (display, YouTube), connected TV, social media, print, outdoor, etc.)?

Advertising dollars are allocated through social marketing, evidence-based targeting strategies that reach the intended audience to influence their behavior. Audience segmentation is used to delineate geographic, demographic and psychographic breakdowns, allowing CDHS to refine audience targeting, and therefore, maximize the media spend. We use a variety of outlets including digital ad placements, social media (Meta and Snapchat), paid search (Google), billboards, streaming (both radio, YouTube and local TV) and in-app advertising targeting mandatory reporters and parents through LInkedIn and Peachjar. Additionally, some of the advertising spend is used to develop outreach materials like fliers and posters that are distributed to schools and community-based organizations.

iii. How much of that spending is directed to Colorado-based or local media outlets? How is the media currently purchased?

CDHS programs and services are only advertised in-state, with the vast majority of our media spending going directly to Colorado-based agencies. In unavoidable instances, there is a need to purchase ads on non-Colorado owned platforms for example, social media site companies based outside of the state.

The current media buys are done through CDHS marketing or advertising agency partners with a small portion done directly in-house on outlets like LinkedIn and Meta platforms.

iv. What performance metrics or evaluation tools does the department use to measure the effectiveness of these advertising campaigns? What are the goals of the campaigns, and what key performance indicators are measured for success?

Perhaps the best measure of campaign performance is uptake of, and participation in, programs and services. To that end, CDHS works with agency partners to measure the impact of its marketing and advertising campaigns by identifying, monitoring and optimizing media placements throughout the campaign lifespan. CDHS campaigns typically have one or a combination of three goals: awareness, education or engagement. During the media planning process of each campaign, key performance indicators are determined in line with campaign objectives. For CDHS' awareness and education campaigns,

including the Child Abuse and Prevention Hotline awareness campaign, SNAP-Ed, LEAP, eHIP and SEBT, we maximize for metrics that highlight the reach of ads among the target audience. These campaigns track impressions, reach, views and ad recall. Engagement campaigns, like those implemented for foster parent recruitment and retention, focus on measuring audience actions tracking click-through-rates, view-through-rates and related actions on given landing pages, for example, clicks on the foster parent interest form.

v. If any portion of advertising is managed through third-party vendors (or 'partners';) or media buying firms, please provide any available data or reporting from those companies on campaign performance and spending. How often do the departments discuss media placements with these vendors?

For larger campaigns that exceed the Department's resource capacities, marketing or advertising agency partners are utilized to help plan, develop and implement marketing campaigns. It is CDHS policy that every scope of work for marketing campaigns include media planning and account management to ensure that the media plan is adequately discussed prior to its placement and, consequently, tracked and evaluated as the advertising flights are in place. When budgets allow, our vendors report media placement performance through media performance dashboards that are updated either bi-weekly or monthly depending on the length of the flight. Smaller campaigns' performance are reported through weekly meetings between the department and the vendor. This cadence allows CDHS to closely track media spend and key performance indicators, while providing flexibility to divert resources to the highest performance outlets when needed.

vi. Monthly or quarterly reporting - how is reporting delivered?

Results from media placements are reported to the relevant CDHS contract manager either on a bi-weekly or monthly basis.

COMMON QUESTION FROM CDPHE BRIEFING FOR CDPHE/CDHS/CDEC/HCPF

2. How many contracts does the Department have with the Kempe Center? What are the purpose and amount of the contracts? Is there duplication across the contracts?

   The Department has nine contracts with the Kempe Center. There is no duplication across the contracts. The purpose and total amount of each contract are as follows:

Table 1: CDHS Kempe Center Contracts

Original CMS #	Summary of Scope	Contract $ Amount
22 IHFA 1172474	Data Sharing Agreement	N/A
23 IHFA 181043	Fostering Healthy Futures – Preteen (FHF-P) Program Intermediary for the State of Colorado	$93,843.78
23 IHFA 181125	Multisystemic Therapy (MST) Program Intermediary for State of Colorado	$93,843.78
24 IHFA 185564	To establish procedure for Kempe Center to help train CDHS Staff.	$12,868,066.00
24 IHFA 189916	The Kids PLUS program goal is to identify and develop appropriate Kin supports for permanent placements and/or relationships and enhance connectedness to communities and cultures.	$512,281.58
25 IBEH 195430	School Mental Health Support program for Colorado public schools. Provide comprehensive training and resources for educators to effectively support student well-being Enhance student access to mental health resources and services.	$1,117,755.23
25 IHFA 193520	Implement and grow Program Intermediaries: Multisystemic Therapy (MST) in Colorado.	$782,513.49
25 IHFA 193527	Implement and Grow Program Intermediaries: Fostering Healthy Futures (FHF) in Colorado.	$869,768.00
26 IHFA 201669	Continued services for Parent Child Interaction Therapy (PCIT) Program Intermediary for State of Colorado.	$16,683.36

Administration and Finance/IT

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3. *Rep. Brown:* What is driving increasing OIT costs for the Department? Is it driven by any specific system like CBMS? Describe how the Department is working with OIT to control costs. **(Slide 11)**

   The increase in the Department's OIT costs is primarily driven by external economic factors, rather than a specific system like CBMS. The Department is actively engaging with OIT to gain a better understanding of these costs and identify opportunities for reduction.

   OIT faces the same challenges as all state departments regarding inflation and rising labor costs. Perhaps more so as digital technology platforms have changed how technology services are delivered, such as the ubiquity of the Software as a Service (SaaS) model. These technology shifts drive marked increases in the specialized skills required to support and maintain modern technology infrastructure, and thus are more susceptible to economic drivers such as inflation and rising labor costs, which has significant impacts to the overall OIT budget. It is important to note that CBMS is not the primary driver of these increased costs.

   While the current dynamic involves OIT fulfilling requested services and departments simply requesting requirements, achieving long-term efficiencies necessitates a different approach. The Department's strategy for cost control focuses on several key areas. First, it is essential to establish true cost and tracking by fully understanding and meticulously tracking the true required cost of all investments. Second, there is a need to improve subject matter expertise (SMEs) within the Department—possessing SMEs capable of accurately translating program needs to OIT is critical for bridging the knowledge gap. Third, a thorough review of contracts and services is underway, covering both contracted state services utilized and the services directly tied to OIT Full-Time Equivalents (FTE). Finally, the Department is adjusting requests by working with OIT to gain a better understanding of services and associated costs. This collaboration allows the Department to request adjustments when contracts are due for renewal, modify requests for services when costs driven by FTE exceed the necessity of the application, and investigate less expensive "out of the box" solutions as viable alternatives.

4. *Sen. Bridges:* What is the latest update with CBMS? How is the Department collaborating with HCPF to implement required federal changes? *Note from JBC/Emily: I'm assuming that more questions will come up about CBMS in Tom's briefing, so we can eliminate this if it becomes duplicative of other questions later.* **(Slide 13)**

   In the past year, CBMS performance and reliability issues have been improved. There are fewer incidents and down time and defects are being resolved more quickly, though much more work is needed. The CBMS product team has also conducted user research with counties to better understand needs and pain points, worked with independent third parties to conduct technical assessments of the system to determine root causes of issues and level of effort needed for remediation, and collaborated with program and county stakeholders to develop a vision for the future of CBMS.

   Among the more than 100,000 hours of enhancements completed on CBMS this year, the Adult Financial and Colorado Works programs have piloted a new single-page eligibility interface to replace the dozens of screens eligibility technicians need to enter data on, reducing application processing time for these cases by 1/3. The SNAP team has begun implementing changes to address sources of error and drive down the SNAP Payment Error Rate (PER). Several enhancements were made to improve workflows for Medical Assistance Long Term Care. PEAK continues to be enhanced to improve the user experience applying for and maintaining benefits and decrease county workload.

   CDHS and HCPF are also investing significant effort into planning for and implementing many federal changes per H.R. 1. Areas of collaboration include:

   - CDHS has approached implementation of H.R. 1-mandated work requirements for SNAP to maximize the ability for SNAP verification of work requirements to meet new Medicaid work requirements that are effective as of January 1, 2027 for dually-enrolled participants. Through a strong foundation in SNAP data, many Medicaid participants will not need to independently verify work activities for Medicaid. HCPF has also involved SNAP program experts in developing the initial system changes needed to comply with Medicaid work requirements.
   - Representatives from HCPF are involved in the SNAP Payment Error Rate (PER) workstream structure to identify common root causes of error across the programs and ensure that PER solutions also help reduce PERM issues in Medicaid.

The experience trying to implement system changes to comply with rapidly changing federal requirements, combined with the findings from our user research and technical assessments, have made it clear that major changes are needed to our systems to adequately meet State or user needs, and we can no longer afford to delay addressing these challenges. CDHS and HCPF are therefore collaborating through a Planning Sprint to develop a strategy for urgently modernizing the CBMS ecosystem. The goals of this effort are to outline a plan, timeline, estimated costs, federal approval strategy, and user engagement strategy to:

i. Implement a more holistic, integrated solution that better meets user needs and drives efficiencies
ii. Enable programs to adapt to new challenges more nimbly and cost-effectively

The request for funding to pursue this reimaging of CBMS was submitted to the JTC on December 10, 2025, and will be discussed at our JTC hearing on December 17, 2025.

5. *Rep. Taggart:* Why is there an $865,378 General Fund increase for annual depreciation lease equivalent payments if the lease market is softening?

   The increase reflects new assets placed in service and updated department depreciation calculations, rather than changes in the external lease market. We would expect to see increases year-over-year as more capital is placed into service.

   The $865,378 increase in Annual Depreciation Lease Equivalent (ADLE) payments isn't related to current lease market conditions. ADLE is calculated based on the State's depreciation schedules, capital asset values, and accounting requirements, not commercial lease rates.

6. *Sen. Kirkmeyer:* Please provide an update on the Trails system. What were the most recent updates? Are there outstanding updates? **(Slide 125)**

   Trails Modernization is approximately 85 percent complete, and as of today, the vast majority of caseworkers complete their work in a single modernized application. OCYF anticipates full modernization by the end of the current fiscal year. The summary below highlights key accomplishments from recent releases and outlines the planned milestones that will bring Colorado's modernization effort to completion.

   Assessment Mod - July 2024

   This release fully modernized the child welfare intake process, allowing all intake workers to operate exclusively in Trails Modernization. It streamlined the intake

workflow, increased efficiency, and strengthened support for staff performing critical front-end functions.

Traditional Case Mod - July 2025

As the first and largest phase of case modernization, this release updated the full scope of work for most general ongoing caseworkers. It significantly improved usability, consistency, and overall workflow efficiency. Notably, this transition occurred without the need for any rollbacks.

Program Area 3 (PA3)/Prevention - October 2025

This release enhanced coordination of prevention services by integrating screened-out records and improving visibility across service areas. It provided a more unified experience for staff supporting families prior to formal child welfare involvement.

Interstate Compact on the Placement of Children (ICPC)/National Electronic Interstate Compact Enterprise (NEICE) - February 2026 (Planned)

This planned release will satisfy multiple federal and state requirements and will streamline the placement of children and youth across state borders. It will also improve coordination between agencies and strengthen compliance with interstate placement processes.

Remaining Case Mod - May 2026 (Planned)

The final release will include all remaining case functionality, including adoption, relative guardianship, independent living, and Chafee services, and will complete the modernization of all caseworker functions within Trails.

Colorado anticipates sunsetting Trails Legacy by the end of June 2026, marking the full transition to the modernized system.

Office of Adults, Aging, and Disability Services (OAADS)

Regional Centers

7. *Sen. Amabile:* Are there waitlists for placement at the Regional Centers? If so, which Centers have a waitlist and how long is it? **(Slide 27)**

   There are no waitlists for placement at the Division of Regional Centers, (DRCs, Regional Centers) for individuals who meet admission criteria.

   Admission criteria includes:

   - The individual must be at least 18 years of age;
   - A completed process for Imposition of Legal Disability (ILD)
   - The individual must be a Colorado resident or a person receiving out-of state services that are funded by the State of Colorado;
   - The individual must be eligible for:
     - Intellectual/developmental disability (IDD) services through a case management agency;
     - Federal Medicaid and Supplemental Security Income (SSI) or Social Security Disability benefits.

   Further admission criteria at the Regional Centers requires that the individual needs access to supports and services 24 hours a day, that the individual is unable to maintain safety and stabilization in the community and that alternative community options necessary to best serve the individual's needs have been explored and are not viable.

   As a reminder, admission requirements at our group homes differ from eligibility requirements for the Home and Community Based Services (HCBS) waiver program under the Department of Health Care Policy and Financing (HCPF) which is the Medicaid program that pays for these services.

8. *Rep. Taggart:* Please provide a status update for the disposition of the state property that is the former campus of the Grand Junction Regional Center.

   The Department, our tribal partners, and other stakeholders have completed several consultations regarding the disposition of the former campus of the Grand Junction Regional Center property. The Department of Military and Veterans Affairs (DMVA), owns a portion of the land adjacent to the former Grand Junction Regional Center. After consulting with tribal leaders, DMVA has agreed to conduct a geophysical search for remains on their land if funding is available.

DMVA has applied for grant funds through History Colorado to cover research costs. DMVA is expecting a final decision from History Colorado by the end of December 2025. Ute Mountain Ute and Southern Ute tribal councils are awaiting final geophysical reports prior to finalizing the memorization plan; therefore no final decisions have been made about the final disposition of the property.

There will likely be substantial remediation costs on the CDHS property. The Department currently estimates that remediation costs for the twenty-eight buildings on the property could be $12 million. To offset some of these costs, the Department is seeking funds through a Brownsfield grant, an Environmental Protection Agency (EPA) program that provides grants and technical assistance to communities, states, tribes and others to assess, safely clean up and sustainably reuse properties. Grant awards will be announced in June 2026.

Currently, the costs for maintaining the former campus property include utility and maintenance and staff costs. The annual utility costs are for electricity and water only, with an average cost of $74,000 per year. The electricity and water costs include:

- Active fire alarms in 8 buildings
- Minimal lighting for security purposes
- Irrigation system
- Water to for fire hydrants

Maintenance and staff costs on the property for the calendar year 2025 include:

- Approximately 1113 hours of technician time at the campus
- 8-16 hours per month in administrative costs
- $3500 to purchase large stock plywood for boarding up broken windows
- Operating costs for January - July 2025 $1484
- Operating costs August 2025 to date $641

Office of Civil and Forensic Mental Health (OCFMH)

Competency Caseload

9. *Sen. Amabile:* OCFMH reported 3,596 competency evaluations in FY 2024-25. Does this include re-evaluations? How many individual people received evaluations in FY 2024-25? **(Slide 46)**

   3,596 represents the number of court orders the Department received from criminal courts for initial evaluations to determine a defendant's competency in FY 2024-25. Accounting for multiple or simultaneous orders, these orders represent 3,517 individual defendants. This number does not include orders for competency evaluation from juvenile courts or for defendants committed to the Department of Corrections at the time of the order, nor does it include any other type of evaluation ordered or performed by the Department in FY 2024-25, including restoration evaluations, mental condition evaluations, or sanity evaluations.

   In addition to these initial evaluation orders, the Department received 3,097 orders, representing 2,847 individuals, to evaluate whether an incompetent defendant had been restored to competency, and 186 orders, representing 178 individuals, for sanity and/or mental condition evaluations.

   The Department conducted 3,087 total initial competency evaluations in FY 2024-25. The difference between this number and the number of orders above indicates the number of cases in which orders were vacated by the courts for various reasons, including but not limited to cases that were dismissed, cases in which competency was dropped, and cases in which the defendant was engaged in a diversion program. Beyond these initial competency evaluations, CDHS conducted an additional 2,530 restoration to competency evaluations and 102 sanity and/or mental condition evaluations.

   Of the 3,087 initial competency evaluations completed by the Department, 152 individuals were reported to have two or more initial competency evaluations in FY 2024-25 due to either competency raised in a separate matter or new concern about competency in a case in which a defendant had already been restored. Since 2019, 31.8 percent of individuals who have been ordered to competency restoration have subsequently been found incompetent again.

10. *Rep. Brown:*

    a. Why are the investments in OCFMH not decreasing the waitlist for inpatient competency restoration? What is driving the growth in the waitlist? **(Slide 50)**

    Despite investments in the Office of Civil and Forensic Mental Health (OCFMH), Colorado's inpatient competency restoration waitlist continues to grow because hospital bed capacity can't keep up with court-ordered admissions and the increasing complexity of high-acuity cases. Rising demand for competency evaluations further strains the system. As investments into the competency system increased, waitlist numbers decreased significantly between 2022 and 2024. However, increases in orders for competency evaluations and inpatient restoration treatment have caused waitlist numbers to increase again over the past year.

    b. What solutions are available within and outside of the Department?

    Department efforts to continue to push back against the growing waitlist focus on revamping jail-based restoration programs; expanding outpatient restoration services and exploring new approaches to outpatient competency restoration for defendants with moderate- to high-acuity mental health; developing diversion programs for individuals with Intellectual Disability Disorders (IDD), dementia, and neurocognitive conditions; and intensifying the efforts of Forensic Navigators to coordinate care and move clients off the waitlist. Additional strategies related to court processes include streamlining the process of moving competency clients into the civil mental health system and prioritizing placement of individuals who can safely be diverted out of the competency system. Outside the Department, strategies would involve partnering with community providers, working to ensure connection to the right level of care for individuals with IDD and dementia, increasing private hospital capacity, and implementing policy reforms to divert low-acuity individuals to community-based care or out of the competency system.

11. *Sen. Amabile:* What would be the impact of reducing contracted private hospital inpatient competency restoration beds on the waitlist? **(Slide 51)**

    OCFMH's contracted private hospital beds serve about three patients per year, at a cost of $1,200 per day on average, so each private bed closure would increase the waitlist by about three individuals each year. If OCFMH had to close all 84 private hospital beds, for example, 252 individuals would have to wait longer for admission.

12. *Sen. Amabile:*

a. How many people are being served annually through jail-based competency restoration? **(Slide 53)**

In FY 2024-25, 235 individuals were served in jail-based restoration (JBR) settings. Arapahoe Restoring Individuals Safely and Effectively (RISE) served 184 and Denver Restoration Treatment Unit (DRTU) served 51.

b. How do outcomes compare to outpatient and inpatient hospital services?

Because of the security provided by the jail setting, JBR programs are able to treat defendants with the highest criminal charges on the waitlist, which many hospital settings cannot accommodate. In contrast, JBR does not treat defendants with the highest levels of mental health acuity, as these patients generally receive care in a hospital setting. Nonetheless, JBR offers all of the same services and therapies as a hospital setting.

Because JBR treats defendants who are less acute than hospital settings, the average length of stay in JBR settings tends to be shorter than the average length of stay in hospital settings, allowing the programs to treat hundreds of patients each year who may otherwise experience long waits for inpatient hospital beds because of their low acuity. JBR also takes transferred patients from the inpatient hospitals, patients who were initially too high acuity to be treated in a JBR setting but have now stabilized and can complete treatment in a JBR setting, freeing up hospital beds for more acute patients. In FY 2024-25, 24 individuals moved from inpatient hospitals to jail-based restoration, and eight transferred from jail-based programs to hospitals. Fluid transfers between jail-based and hospital-level programs allowed patients to receive the appropriate level of care, reducing length of stay and increasing admissions.

c. What are the barriers to using outpatient services for this population?

JBR patients do sometimes discharge to outpatient restoration if their mental health has stabilized or if a satisfactory discharge plan, including connection to housing and services as well as outpatient restoration treatment, has become available. However, many JBR patients are not able to participate in outpatient restoration because their high level charges preclude them from being granted bond by the courts, making outpatient services an unlikely alternative to JBR in many cases.

ARPA Programs

H.B. 22-1283 Youth Psychiatric Residential Treatment Facility at Fort Logan

13. *Sen. Amabile:* Please provide additional detail on construction of the youth PRTF at Fort Logan. What is the expected construction timeline? Please describe how the facility will operate with a contractor providing services. **(Slides 39, 40)**

    The Youth Psychiatric Residential Treatment Facility (PRTF) is currently under construction with anticipated completion in early 2027. Payment of the construction contractor is predominantly contingent upon how the contractor meets performance goals and milestones. Given the 14-month construction timeline, the majority of the expenditures are projected to occur within the next year.

    PRTF has the goal of accepting patients no later than March, 2027. The Department has completed an Invitation to Negotiate (ITN), and following negotiations, a contract provider to operate the facility has been selected and awarded to Griffith Centers, Inc. The Department now has a defined period to finalize the contract with the operator, along with adequate ramp-up time to allow the contractor to hire and onboard staff in the latter part of 2026. Full operations and patient treatment are anticipated to begin no later than March 2027. OCFMH will oversee the contractor's performance, ensuring compliance with programmatic and budgetary expectations, maintaining fiscal accountability, and aligning PRTF operations with Colorado's broader adolescent behavioral health system. OCFMH will also oversee admissions to the facility, and the contracted provider will be required to accept and treat all youth selected by the OCFMH admissions team, without exclusion based on acuity or clinical history. This oversight ensures the PRTF fulfills the State's objective of serving children and youth with the most acute and complex behavioral health needs in Colorado.

14. *Sen. Amabile:* Expenditure reports from September 2025 show that only $8.9 million of $39.4 million appropriated for the project is expended. Please provide the expected expenditure timeline. Does the Department expect funds to be fully expended by December 2027? What will happen to the project if construction delays prevent full expenditure before spending authority ends? **(Slide 40)**

    The Department is still planning to fully spend these funds by the deadline. Unfortunately, the project is experiencing some time and financial delays related to testing and addressing unbeknownst hazardous materials in the soil. In the event that these delays create a risk that the funds will not be fully expended on time, the Department will develop a contingency plan to ensure the funds are fully spent by

the deadline if possible and ensure the project will have sufficient funding to be seen through to completion.

H.B. 22-1303 Residential Behavioral Health

15. *Sen. Amabile:* Expenditure reports from September 2025 show the following amounts by project.

H.B. 22-1303 ARPA Expenditures by Project

Project	Allocation	Reverted	Expended	Encumbered	Unencumbered
Contract beds	$11,185,761	$233,426	$7,155,871	$3,277,779	$518,685
Fort Logan Gwing	7,355,715	0	6,264,391	602,525	488,799
Transitional homes	6,615,935	104	4,711,488	437,548	1,466,794
Total	$25,157,411	$233,531	$18,131,750	$4,317,852	$2,474,278

Why are there still amounts that are unexpended if the projects are complete? Please provide the expected timeline for expenditure. Can unencumbered amounts be used to provide more contract beds? **(Slides 41, 42)**

The H.B. 22-1303 projects identified in the expenditure reports originated as American Rescue Plan Act (ARPA) appropriations and include expenditures related to both the construction and renovation of G-Wing at the Colorado Mental Health Hospital in Fort Logan (CMHHIFL) and the Mental Health Transitional Living (MHTL) Homes as well as operational expenditures for these two facilities. The operational expenditures consist of contract beds in MHTL Homes run by private providers, administrative and oversight FTE for the MHTL Homes, and facilities management FTE for the MHTL Homes and G-Wing. Funding in H.B. 22-1303 still remains unspent because the timeframe for this bill was extended in H.B. 24-1465 to December 31, 2025. Although the September 2025 expenditure reports show that CDHS has a total of $2,474,278 in unexpended funding, the Department expects that this amount will be significantly smaller by the end of the spending time frame on December 31, 2025. The Department is continuing to spend funds until then. At this time, it is hard to be certain how much will remain unspent in the end, but any funds that are reverted, both SLFRF and refinanced General Fund, will be tracked and reported to JBC using the normal processes run by OSPB.

Unencumbered funds cannot be used to provide more contract beds because funds cannot be used for purposes other than what they were appropriated to be used for. Unspent operating funding from H.B. 22-1303 is designated for administrative and facilities management FTE and operating expenses for the MHTL Homes and G-Wing and cannot be repurposed. The Department would not repurpose these funds for beds, as they are still being spent for the appropriated purpose. Similarly, the Department also cannot repurpose capital funding for the MHTL Homes and G-Wing to pay for the operating expenses of these programs or for any other purpose.

Executive Order Budget Adjustments

16. *Sen. Amabile:* Please discuss the $1.7M refinance in the hospitals and whether that change will have any impact on the hospitals and their patients. **(Slide 57)**

    The Mental Health Hospitals (MHHs) have experienced recent increases in earned revenue due to opening two new units and re-opening two existing units, which has resulted in a higher average daily census. Additionally, earned revenue is higher due to increases in daily Medicare, Medicaid, and private insurance rates.

    The $1.7 million refinance is included in the FY 2025-26 General Fund (GF) reduction for the hospitals proposed in the Department's FY 2026-27 R-04, S-01, Leg-02 decision item. The request proposes reducing GF and offsetting it with increased spending authority for revenue earned by the hospitals as cash funds (CF) and reappropriated funds (RF).

    If the Department's FY 2026-27 R-04, S-01, Leg-02 is not approved, GF for the hospitals will decrease by $1.7 million and the Department will not have the increase in spending authority needed to supplant this GF decrease with earned revenue. In that case, OCFMH anticipates needing to either reduce the number of private hospital beds by ten and transfer this money to the hospitals to cover their expenses or close a unit at the hospitals. Either action would reduce the number of patients served by approximately 30 each year and increase the waitlist by 30 individuals per year.

Office of Economic Security (OES)

General Factors

Community Food Providers Assistance Grant Program

17. *Rep. Sirota:* Please provide a detailed update on the status and use of the $7.0 million of the October interim supplemental that has been expended. Are there any plans to expend the remaining $3.0 million that was authorized. **(Slide 69)**

    $7.0 million of the 1331 Emergency Supplemental that was approved on October 31 was contracted to Trailhead Institute through an amendment to the existing Community Food Assistance Grant Program contract. Those funds were all distributed to Feeding Colorado, the umbrella organization for Colorado's five large food banks that cover the entire State, including approximately 1,300 community food partners serving communities in all 64 counties. Specifically, the emergency supplemental funds were distributed based on SNAP data, provided by the Department, to target areas with the highest level of need per the SNAP benefits disruption.

    The full $7.0 million was directed to purchasing food, utilizing the volume purchasing leverage among Feeding Colorado's food bank partners. Specific reporting from the Food Banks will be available at the end of December.

    The remaining $3.0 million is in process of being reduced from the contract. Per the contractual agreement, the entire $7.0 million was to be committed for food purchases. The spending authority for the funds has been restricted and any uncommitted funds are to be returned to the State by December 30, 2025.

Summary of Requests

R18 Reduce SNAP Outreach

18. *Sen. Amabile:* With the passage of Proposition MM, can Health School Meals for All revenue be used for SNAP outreach purposes? **(Slide 74)**

    Yes. The text of the ballot measure made funds available for "supporting the Supplemental Nutrition Assistance Program (SNAP) that helps low-income Colorado families afford groceries." The enabling statute (S.B. 25B-003) designates that beginning in July 2026, resources can be used for implementing the SNAP as well as for providing outreach related to SNAP.

19. *Rep. Brown:* What metrics does the Department use to evaluate the effects of SNAP outreach? Please provide a discussion on these metrics and what that data show. **(Slide 92)**

The federal Food and Nutrition Service (FNS) states that the purpose of SNAP Outreach is to conduct program informational activities (i.e. outreach) to inform low-income households about the availability, eligibility requirements, application procedures, and the benefits of SNAP. Additionally, SNAP outreach can correct myths and misperceptions about SNAP and enable potentially eligible people to make an informed decision about applying. The Department submits an annual Outreach Report to the Food and Nutrition Service at the end of each December. The report provides data on the State's primary uses of SNAP Outreach and associated performance. In Colorado, SNAP outreach is focused on helping individuals apply for or renew SNAP benefits. Corresponding metrics are regarding the numbers of applications and redeterminations submitted by outreach partners. Table 2 shows the number of applications and recertifications submitted by SNAP Outreach Partners in the last four years.

Table 2: SNAP Outreach Applications

Federal Fiscal Year	Goal	Actual Submittal
FFY 2022	30,316	37,964
FFY 2023	33,628	38,835
FFY 2024	29,193	27,294
FFY 2025	24,495	37,964

In Federal Fiscal Year 2023, the Department completed a new Request for Proposals (RFP) process. Subsequently, one out-of-state nonprofit partner was no longer eligible as a Colorado Outreach provider due to its inability to provide in-person support for SNAP applicants. This resulted in a decrease in the number of applications submitted in FFY 2024. As the data demonstrates, with the exception of FFY 2024, the number of applications submitted has surpassed the outreach partners' goals.

Budget Reduction Options

20. *Sen. Kirkmeyer:* With respect to Transitional Jobs Program, has there been any discussion of potential duplication with the other workforce programs across the state? Is this duplicative with other programs that the state is supporting? **(Slide 66)**

    The Department works closely with the Colorado Department of Labor and Employment (CDLE) and the Colorado Workforce Development Council (CWDC) to avoid duplication of employment and training programs through annual statewide workforce planning. Additionally, the Department utilizes internal safeguards to ensure that its workforce programs, such as the Colorado Works Subsidized Training and Employment Program (CW STEP) and ReHire Colorado, serve distinct populations of Coloradans. In 2024, CDHS and CDLE jointly reviewed ReHire Colorado, CW STEP, the Workforce Innovation and Opportunity Act programming, and other CDLE workforce programs. The analysis confirmed that each program offers distinct services that complement one another. As such, ReHire Colorado is statutorily designated to serve low-income populations who typically would not qualify for TANF or CW STEP which requires TANF eligibility.

    Specifically, ReHire Colorado and other mainstream workforce programs in Colorado cater to distinct populations and provide tailored services to meet the varying needs of Coloradans:

    - *ReHire Colorado* prioritizes serving low-income veterans, individuals aged 50 and older, and non-custodial parents who owe child support with significant barriers to and/or gaps in employment. It provides intensive case management and paid work experience opportunities with local employers to help participants establish a work history and transition into stable jobs. ReHire's unique services demonstrate exceptionally high evidence-based outcomes.
    - *Workforce Innovation and Opportunity Act (WIOA) program* offers short-term, skills-focused training and career services to low-income individuals who are eager to re-enter the workforce quickly. Programming focuses on education and credential development.
    - *CW STEP* provides paid work-experience opportunities for TANF Basic Cash Assistance recipients who have been assessed by their TANF case manager as ready to work. The program helps participants acquire practical job skills and transition toward long-term employment.

Impact of Federal Changes to SNAP

21. *Rep. Brown:* Please provide county-level data regarding timeliness of eligibility determinations. **(Slide 68)**

    Colorado's Application Processing Timeliness (APT) data by county indicates that in November 2025, the statewide timeliness rate is 98 percent: 56 counties' APT is at least 95 percent; 36 counties have 100 percent timeliness.

22. *Rep. Brown:* With regard to Payment Error Rates:

    a. What is the variation amongst counties in their Payment Error Rate? **(Slide 76)**

       Payment Error Rate (PER) data from the first nine months of FFY 2025 shows wide variation among Colorado counties' error rates. This data is specific to the federally-determined sample which does not include cases from all counties. It is important to note that the statistically valid sample is designed to generate a statewide PER estimate; some counties are sampled rarely, if at all. Thus, the sampling methodology may not provide reliable county-level PER estimates, despite providing an accurate estimate of PER across the State, as a whole.

    b. How does Colorado, as a state, compare to other states? **(Slide 78)**

       The most recent national PER data available is for FFY 2024. Colorado's PER was 9.97 percent, below the national average of 10.93 percent. As this data displays, states' PER rates range from 3.28 percent to 24.66 percent. Four states (Alaska, District of Columbia, Florida, and Georgia) had PER rates above 15 percent. Nine states and territories (Idaho, Nebraska, Nevada, South Dakota, Utah, Vermont, Virgin Islands, Wisconsin, and Wyoming) had PER rates below 6 percent.

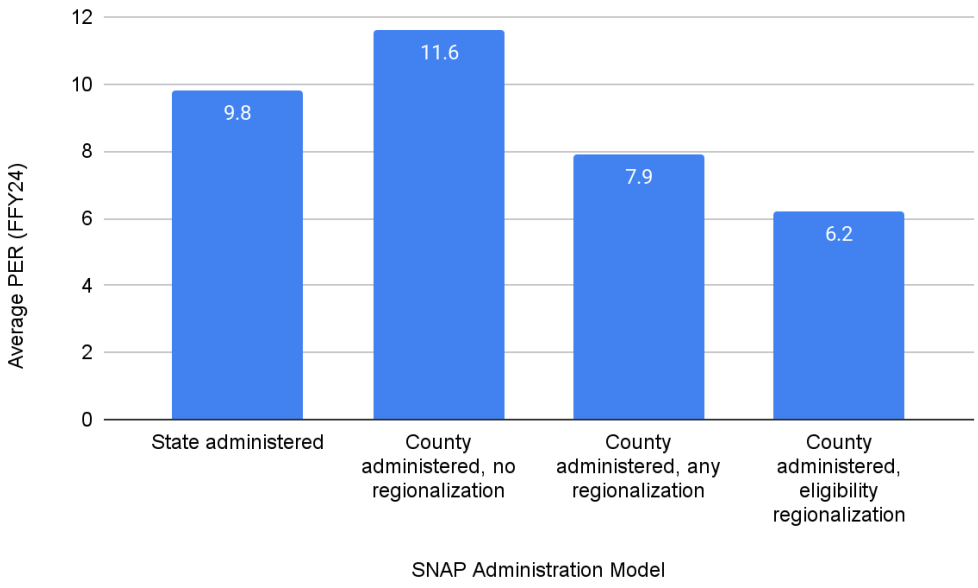
       FNS has provided partial FFY 2025 data for states for October 2024 through June 2025. However, this data is incomplete, pending official FNS review; PER could change significantly before the data is finalized at the end of the PER review period in June 2026. This partial data indicates that Colorado's state-reported PER is 8.71 percent, below the national average of 10.28. This partial data indicates similar variation, with three states' partial state-reported PER above 15 percent (Alaska, District of Columbia, and New Mexico) and seven states' partial PER below 6 percent (Idaho, Iowa, Kentucky, Nebraska, South Dakota, Vermont, and Wyoming).

c. What are the administration models that have the best and worst Payment Error Rates? **(Slide 78)**

There are 43 states and territories who administer SNAP at the state level. In FFY 2024, these 43 states/territories had an average PER of 9.8 percent. The remaining ten states are county administered. Six of these county-administered states, including Colorado, are wholly operated by counties; these six states had an average PER of 11.6 percent in FFY 2024. The four county-administered states who are regionalized had an average PER of 7.9 percent in FFY 2024. The two county-administered states with the highest degree of regionalization (i.e. pooling eligibility resources and services versus just state-level shared services such as a call center), had an average PER of 6.2 percent.

Figure 1 presents states PER rates, by administrative configuration.

Figure 1: PER Rates by Administrative Model



23. *Sen. Kirkmeyer:* Does the Department have county-level data that is in the same format and analyzed in the same way as the State's Payment Error Rate that is sent to the federal Food and Nutrition Service? **(Slide 76)**

Yes. State-reported PER data through June 2025 has been released to the federal Food and Nutrition Service (FNS), which is determined by the State Quality Control (QC) team following protocol from the FNS Handbook 310. Per federal regulation,

Colorado may not release data until after it has been reported to FNS. The full scope of data, including FFY 2025 PER, to date, for all sampled counties is attached.

24. *Rep. Brown:* Please discuss the sustainability for using General Fund to support SNAP administration. What is the long-term plan to minimize the impact of federal policy changes on the State's General Fund? **(Slide 77)**

    Any future budget requests that include SNAP funds will request the new federal match ratio. The Department will need to be judicious in its requests for any additional SNAP resources, balancing the need to ensure eligible Coloradans receive timely and accurate benefits with the other demands on the State General Fund. In order to minimize the potential General Fund impact to operate the SNAP program, the Department is investing significant resources and focus to reduce the PER to limit the potential future financial obligations for the State share of SNAP benefits.

25. *Rep. Sirota/Sen. Kirkmeyer:* In what programs should the General Assembly invest to realize significant immediate improvements in the state SNAP payment error rates? **(Slide 77)**

    The Department, in conjunction with counties, has created a comprehensive PER workstream structure to focus on lowering the State's PER as quickly and effectively as possible. This work would continue alongside the federally mandated quality control system that requires extensive processes that take approximately four months to complete and the ultimate results can often be for a period of time than can be a year or more in the past. The workstreams focus on a number of issue areas which the Department has identified as foundational to immediate and lasting PER improvement. These areas have been informed both by USDA guidance and extensive conversations with other states. Specifically, these areas have been identified as those whereby dedicated resources will have the most impact on reducing PER and sustaining a lowered PER.

    - Data infrastructure: Facilitate monitoring the array of factors that contribute to PER and quickly evaluating implemented interventions. This approach can provide actionable insight into errors without the constraints of the federally prescribed process that entails detailed review, including client interviews.This federally mandated review process, which requires multiple levels of review, takes an average of three months (and as long as six months to research unresponsive cases) to complete.
    - County support and training: Ensure county eligibility staff are using consistently correct policy and processes.

- State-level coordination: Focusing on aligning policies and practices and increasing efficiency across all eligibility programs, including SNAP, TANF, Medicaid, and Adult Financial programs. This area could also include moving eligibility processing to a regionalized system, for instance modeling Wisconsin's pooled eligibility model which has facilitated consistency and accuracy across the state.
- Technology: Facilitate accurate and consistent processes. This approach could include improvements to the existing Colorado Benefits Management System (CBMS) or movement towards a more efficient and streamlined benefits eligibility system. An updated system could allow for more rapid and responsive updates and refinements that require less staff time and cost to implement.
- Experienced SNAP Staff: In its "SNAP Keys to Payment Accuracy" guidance, the federal Food and Nutrition Service (FNS) recommends that states utilize experienced Supplemental Nutrition Assistance Program (SNAP) staff, separate from the official QC team, to "examine case information to identify whether workers and the eligibility system processed cases correctly." These recommended reviews do not include any client contact, which is one of the factors that takes the most time in the QC reviews, and are not part of the official QC process. At least eight states (California, Kansas, Missouri, North Dakota, Nebraska, Pennsylvania, South Dakota, and Virginia) credit this process as a source of PER improvement. (Because FNS recommends this approach, additional other states likely use it; Colorado is specifically aware of these eight states through targeted conversations).

26. *Sens. Amabile and Kirkmeyer:* How many of the states doing well are state supervised? How many state-supervised, county-administered state with regional offices that are county administration? **(Slides 78, 80)**

    On average, state-administered and regionalized states have lower PER rates than county-administered states. Specifically, nine of the ten states with the best PER rates (all with PER rates below 6.06) are state administered and one is regionalized. The 43 state-administered states and territories had an average PER of 9.8 in FFY 2024. The six fully state supervised, county-administered states (i.e. with no regionalization), including Colorado, had an average PER of 11.6 in FFY 2024. The four county-administered states with regionalization had an average PER of 7.9 in FFY 2024. Among those four county-administered states with regionalized services, the two states with the highest degree of regionalization (including pooled resources and eligibility determination services versus consolidated shared services such as a call center) had an average PER of 6.2 in FFY 2024.

27. *Rep. Brown:* Has the State ever considered the use of performance-based contracting for county administration? Please provide a detailed description the purposes for which counties use county administration appropriations. **(Slide 79)**

Performance-based Contracting: The Department has researched performance-based contracting (PBC) as a tool to incentivize quality and efficiency and encourage data-informed decision-making for administering public assistance programs. Evidence from other states' human service programs (e.g. Indiana, Oklahoma, and Wisconsin) suggests that PBC can shorten wait times, improve client outcomes, and control costs. In fact, Wisconsin utilized PBC as a core feature of its move from a fully county-administered model to one operated via ten regional consortia. However, it's worth noting that there is insufficient evidence regarding PBC for SNAP administration in wholly county-administered states.

County Administration Appropriations: The Department's County Administration appropriation provides resources for counties' share of allocable costs to process SNAP, Adult Financial (Aid to the Needy Disabled and Home Care Allowance cases), Low-income Energy Assistance (LEAP), and Child Support cases. Approximately 91 percent of the County Admin appropriation is used by counties to administer the SNAP program. Based on recent Settlement reports, the other spending in the line was used for Child Support (5 percent), Adult Financial (4 percent), and LEAP (0.01 percent). It is important to note that the County Administration appropriation in the Long Bill [Section (4)(F)] is *only* used to cover costs for these programs. Counties use their TANF County Block Grant appropriation [Section (4)(C)(2) in the Long Bill] to cover TANF's share of administrative costs. Similarly, the Old Age Pension (OAP) County Administration appropriation [Section (4)(C)(A) in the Long Bill] covers OAP's share of the costs.

Administrative funds (including those in the County Administration appropriation, TANF county block grant, and Old Age Pension appropriation) primarily support counties' costs for direct program staff, common supportive staff, and general administration, including operating, travel, contractual services, capital outlay, and leased space. Counties are responsible for ensuring that all administrative expenses are in compliance with 2 CFR 200 – Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards. Per federal guidance, all expenses must be necessary, reasonable, and allocable.

R5 TANF State Policy Changes

28. *Rep. Brown*: Please provide a short history of TANF contingency funds. What are the primary factors that influence this extra distribution? **(Slide 82)**

    The TANF Contingency Fund is a federal resource that can provide additional dollars to qualifying states. Specifically, states must either demonstrate an increasing SNAP caseload or high unemployment to qualify. Additionally, states must exceed their maintenance-of-effort requirement (to qualify, Colorado is required to demonstrate approximately $126 million in MOE, $38 million more than our $88 million MOE obligation per the TANF Block Grant, based on the annual block grant and additional contingency funds received). States must apply for contingency funds annually; Colorado annually applies for these funds in the late summer/early fall upon our demonstration that we qualify per the criteria listed above. Resources are available on a first-come, first-served basis. Contingency Funds can be used for any allowable TANF usages. The dollars are not separately distributed to counties; instead, they are added into the total pool of resources that can be appropriated for TANF purposes, including the County Block Grant.

    Colorado first became eligible for contingency funds in the fall of 2008 and has remained consistently eligible. Colorado is eligible to receive up to $27.2 million (20 percent of our TANF Block Grant); however, it is highly unlikely any state would receive its maximum amount given the number of states who compete for the limited pool of funding. In recent years, Colorado has received about $15 million in contingency funds. However, there have been years when Colorado has received much less. It is possible that Colorado could not receive contingency funds, despite being eligible, if more states meet the criteria and apply for funds.

29. *Sen. Kirkmeyer:* How will this request affect the state Workforce Participation Rate? Who will be the responsible party? **(Slide 82)**

    This proposal will not affect the Work Participation Rate (WPR). The State will maintain its responsibility for maintaining compliance with the WPR. However, counties will continue to be expected to meet their individual WPR performance levels. To meet this requirement, counties will continue to receive the same level of resources for case management and supportive services that will ensure that clients are able to comply with work activities, participate in workforce training, and secure gainful employment in order to successfully transition off the BCA caseload.

30. *Rep. Brown:* Do the counties use any portion of their TANF funds allocation for administration? If so, how much by county? **(Slide 84)**

    Yes. Counties spend a portion of their TANF allocation on program administration, including eligibility determination, case management, overhead, and indirects. Over the last six years, counties have spent an average of 27 percent of their TANF block grant on program administration. Total TANF administrative spending increased $11 million between FY 2019-20 ($35,292,725) and FY 2024-25 ($46,324,333) as detailed in the attached document which presents county-by-county TANF administrative spending in the last six years.

31. *Rep. Brown:* Please provide a detailed description of the types of activities that qualify as supportive services. How do other states manage these other services? How do other states manage the reserves? **(Slide 84)**

    Supportive services include the array of extra support provided to clients receiving Basic Cash Assistance (BCA) for things like transportation (e.g. bus passes or gas vouchers), housing/utility supports, job training (e.g. soft or hard skills training), work readiness expenses (e.g. eyeglasses or work boots), and child care assistance. Additionally, counties can choose to direct TANF resources for services provided by external partners, such as domestic violence interventions, household budgeting, parenting education, after-school care, and a host of other activities that meet one of the four federal purposes of TANF [1. Provide assistance to needy families so children can be cared for in their own Help need families so children can be cared for in their own homes; 2. Promote job preparation, work, and marriage; 3. Prevent and reduce the incidence of out-of-wedlock pregnancies; and 4. Encourage the formation and maintenance of two-parent families.] These services and support help families stabilize their situation, pursue employment, secure housing, and move towards self-sufficiency without TANF cash assistance. Most other states manage the array of TANF services centrally; even county administered states follow state guidance regarding supportive services usage. Colorado is an outlier in its approach whereby individual counties set local policies regarding supportive services.

    Colorado is the only state among the state-supervised, county-administered states that allows counties to maintain local TANF reserves.

32. *Rep. Sirota:* What are the supportive services that each county is offering? What is the variation and commonalities among counties? Is this system equitable for individuals across the state receiving TANF basic cash assistance and supportive services? **(Slide 84)**

    Counties have discretion to provide additional support to households, including both cash support via supportive service payments to BCA clients and contracted services with community providers for targeted services that support a wide array of needs among both BCA clients and the broader TANF-eligible community. County supportive services payment practices vary significantly per individual county policies and availability of funds. Meanwhile, Basic Cash Assistance (BCA) is uniformly and equitably provided to clients in all counties.

    A 2024 survey of Colorado counties' use of TANF funds for contracted supportive services found that the most common services include youth enrichment and child care, parenting education and services, housing and basic needs support, domestic violence intervention, and Family Resource Centers. While some of these services are targeted to clients receiving BCA, they are generally available to the broader TANF-eligible population, defined as households with income up to $75,000, a significantly higher income eligibility threshold than BCA. H.B. 25-1279 requires the State to develop both a standardized process for reporting on external services funded with TANF funds and recommendations for a menu of standardized outcome measures in order to better understand the use and utility of TANF-funded contracts for services. The Department and counties have collaborated significantly to ensure the fiscal data reported by counties can provide granular information regarding the types of services being provided with TANF. That data will begin to be available on the Department's website beginning in January 2026.

33. *Sen. Kirkmeyer:* Please provide an in-depth discussion about state management of basic cash assistance payments. **(Slides 85, 86)**

    a. How does shifting the management of basic cash assistance payments to the state save and preserve state funding?

       Shifting management of BCA to the State ensures equitable benefits for Coloradans, statewide and avoids risks of needing additional General Fund resources to pay BCA benefits in future years.

       In the current approach, each county's allocation is to be used for BCA, administration, supportive services, and contracts. Counties must balance those resources against their caseload projections and other community needs. However, if caseload spikes in County A, that county will need to make choices

regarding how they will use their funds, which could impact clients in those communities. Meanwhile, if County B has a decreased caseload, it will be able to make different choices regarding serving clients. Moving the BCA allocation to the State level avoids these scenarios. Clients in both County A and B would have equitable access to BCA benefits. Meanwhile, the counties would continue to have the rest of their County Block Grant available for supportive services, administration, and contracts.

Furthermore, if BCA continues to be paid by individual counties, it could accelerate the depletion of both county and State TANF reserves to provide BCA amid growing caseloads and application of a Cost of Living Adjustment (COLA). To comply with statute changes per H.B. 22-1259, General Fund or other State fund sources would be required to meet the need. However, creating a BCA appropriation at the State level enables state policy makers to set an amount for BCA benefits that cannot be exceeded, thereby eliminating the risk of spending beyond the funding made available. With the variation among caseloads and resources available in counties, it would be impractical to implement this strategy through the County Block Grant. Thus, this strategy limits the need for General Fund contributions for BCA, unless the General Assembly chooses to appropriate the funds.

b. What is the impact on counties?

The Department is cognizant of the increasing financial strain on counties as their TANF funds are stretched thin. Shifting BCA to the State allows counties to focus on providing services to their clients. Counties will continue to receive their individual County Block Grant allocation, through the formula agreed by the Works Allocation Committee; that allocation will contain counties' funds for program administration, supportive services, and contracts. The only difference is that the dollars that would have been designated for BCA benefits will not be included in that allocation.

However, if any counties' BCA caseload/expenditures are below the projection, those counties would lose the flexibility to redirect those dollars to other purposes, including administration, supportive services, or their TANF reserves.

c. How would reducing TANF funds management impact counties?

Currently, counties must balance their anticipated costs for BCA benefits against other costs for program administration, supportive services, and contracts. At its core, this budgeting process is unpredictable; for instance, an unexpected spike in BCA could create fiscal risk to counties, especially if their allocation is already

committed to contracts or other purposes. Managing funds for BCA benefits at the State level eliminates this risk to counties; it provides more budgeting predictability, as they would only be responsible for expenditures for which they have direct control. Furthermore, counties would not be responsible for covering future COLA increases for BCA from their individual allocations.

34. *Sen. Kirkmeyer:* Please provide, by county, the county reserve balances and amounts transferred to the CCDF (child care) and Title XX (child welfare) block grants since 2021. **(Slide 87)**

    County-by-county reserve balances and transfer amounts are presented in the following tables. Transfers to CCDF (child care) and Title XX (child welfare) have been historically low: counties have collectively transferred less than 1 percent of the federal TANF block grant annually.

    Historical County Closeout and Transfers to CCDF and Title XX

35. *Sen. Kirkmeyer:* Please provide a detailed discussion about the implementation of the proposal for state-level management of transfers to the CCDF and Title XX block grants. **(Slide 87)**

    a. What is the reasoning behind the request for state management of transfers for CC and Title XX? Is state management better?

       Federal law allows states to transfer up to 30 percent of its annual TANF Block Grant to the Child Care Development Fund (CCDF) and/or Title XX programming. Colorado has neither a budget nor statewide process to guide these transfers. Instead, the decision is mostly up to counties to transfer funds. However, there are some State-level transfers that have been authorized by the General Assembly (e.g. annual Foster Care Transportation program and the Kinship Foster Care Homes in FY 2024-25 and FY 2025-26). The total scope/costs of county transfers are not known until the closeout process at the end of the state fiscal year. This process precludes the State or counties from balancing the costs of these potential, yet unknown, transfers with other needs that could be supported with TANF in any given year. For instance, federal changes to CCDF programming could increase the need for more TANF transfers to child care. Moreover, it creates substantial risk for exceeding the transfer limit and/or overspending the block grant.

       Planning for and executing transfers to CCDF and/or Title XX at the beginning of each fiscal year, combined with setting an appropriation for BCA benefits each fiscal year, enables the General Assembly to make deliberate policy choices on

what TANF should fund and by how much. These fiscal guardrails will avoid spending beyond the available resources in future years, amid the changing federal and State policy landscapes.

b. How will state-level management impact state funds?

This proposal protects State funds because the TANF budget for CCDF and Title XX would be determined in advance of each fiscal year, specific to Legislative action. TANF spending on these programs could not exceed the appropriated amount from the TANF block grant.

36. *Rep. Amabile:* What is the most important thing for families: BCA, child care, other services and supports? Is putting all of this money into BCA an effective policy choice that will lead to positive outcomes? Which category of support will have the biggest impact on these families? **(Slide 88)**

The Department's efforts to re-envision the TANF program is grounded in extensive research. Research indicates that cash assistance produces the most positive immediate impact on low-income families.[1][2][3] When paired with supportive services, outcomes improve further. These positive outcomes include reduced child maltreatment and child welfare engagement, increased employment, and improved food and housing security. BCA is universally and consistently available statewide, while supportive services vary by county and are distributed based on county policies, resources availability, and county-specific practices. Thus, BCA is an effective policy choice deriving significant positive impacts to households. Additionally, on January 1, 2026 the Department will submit an evaluation of H.B. 22-1259 that was conducted by Colorado State University. This report will provide some insight into the most effective support strategies for low-income households.

[1] Cusick, G.; Gaul-Stout, J.; Kakuyama-Villaber, R.; Wilks, O.;Grewal-Kök, Y.; Anderson, C. A. (2024). Systematic Review of Economic and Concrete Support to Prevent Child Maltreatment. Societies 2024, 14, 173. https://drive.google.com/drive/folders/1-7VXxXr-VXN4ScOR4gW_kgDEi-WuBHQA
[2] Freedman, M., & Kim, Y. (2022). Quasi-Experimental Evidence on the Effects of Expanding Cash Welfare. Journal of Policy Analysis & Management, 41(3), 859–890. https://drive.google.com/file/d/1otBYJL6KqIBS8-38gYh7JrMoBOjmk-fM/view?usp=sharing
[3] Cancian, M; Yang, M.; Slack, K.S.; (2013). The Effect of Additional Child Support Income on the Risk of Child Maltreatment. Social Service Review. https://drive.google.com/file/d/1gkawJVjNXd5ecksZdyCCgjjROEsCGw5K/view?usp=sharing

37. *Sen. Kirkmeyer:* Please provide a review of the county engagement process in assessing the fiscal impact of H.B. 22-1259. **(Slide 89)**

The Department worked closely and extensively with counties to assess the fiscal impacts of H.B. 22-1259. Engagement strategies encompassed multiple statewide forums, including the TANF Collective Vision process, Colorado Human Services Directors Association (CHSDA), the Works Allocation Committee (WAC), the WAC Finance Working Group, the Economic Security and Finance SubPACs, the Financial Officer Group (FOG), the TANF Coding Workgroup, the Family Voice Council, and the Joint Alignment Committee (JAC).

For example, in partnership with CHSDA, the Department surveyed counties early in 2025 to gauge their projected year-end reserves and expected transfers and held follow-up meetings to review assumptions, validate fiscal impacts, and understand county-level pressures. Additionally, the Department and counties collaborated on an in-depth review of TANF coding guidance and expenditure reporting, ensuring alignment with statutory expectations and H.B. 25-1279 requirements. County participants in the H.B. 25-1279 evaluation process were designated by the voting membership of the WAC based on their knowledge and expertise in program evaluation. The county representatives directly informed the scope of work with Colorado State University that performed the evaluation of H.B. 22-1259.

On September 1, 2025 the Department submitted Multi-Department RFI #6 on concerning the impact of state funding and local decision-making on Colorado's Child Care Assistance (CCCAP), Temporary Assistance for Needy Families (TANF), and Child Welfare programs. Specifically, the request required that counties actively collaborate with the State and other stakeholders to evaluate state and local expenditures to administer the programs, analyze budget practices, and recommend strategies per funds management and cost containment. That process was completed through the Joint Alignment Committee (JAC). For TANF, that review and recommendations were specifically related to the fiscal situation that has emerged per H.B. 22-1259. Counties provided data, reviewed fiscal models, and shaped recommendations per long-term TANF sustainability, including BCA, COLA, reserve levels, and transfers. While counties did not agree with every proposal, their feedback and perspectives were integral to the development of the Department's final recommendations.

Finally, the engagement process extended beyond counties to include perspectives from the Family Voice Council and other stakeholder groups to understand both operational and client-level impacts of the program changes implemented per H.B. 22-1259. Meanwhile, the Department is committed to continuing to work with

counties (CHSDA, WAC, JAC), clients, and other stakeholders to address program needs, beyond the R-05/Leg-03 request, which is focused on program budget stability. While stabilizing the budget is the immediate goal, fundamental shifts in policy and practice will be required to ensure delivery of high-quality services within fiscal constraints and shifting federal priorities. The Colorado Evaluation and Action Lab is engaged in this process to lead TANF stakeholders through an in-depth process to identify evidence-based changes to the TANF program to promote education, upskilling, sustainable wages, and long-term economic stability for families.

Office of Children, Youth and Families (OCYF)

Division of Youth Services (DYS)

Caseload

38. *Sen. Kirkmeyer:* Please provide data about DYS community providers for the last ten fiscal years, including but not limited to: **(Slide 108)**
    i. The number of facilities and provider locations.
    ii. The total number of beds available.
    iii. The total number of youth in community placements for detention.
    iv. The total number of youth in community placements for commitment.

Detention: Private, contract detention placements are not utilized. These placements most recently occurred 7 years ago in FY 2018-2019, with an average of 2.4 youth on the average day (Average Detention Population - ADP) held in privately operated detention programs. From FY 2019-2020 to FY 1025-2026, no community placements for detention were utilized. Contract placements for detention, by fiscal year, for the last ten years, are listed as follows:

- FY 2016: 5.3 ADP (Brown Center 1.1 ADP; Robert DeNier 2.3 ADP; Youthtrack Alamosa - San Luis Valley 1.9 ADP)
- FY 2017: 5.1 ADP (Brown Center 0.4 ADP; Robert DeNier 2.8 ADP; Youthtrack Alamosa - San Luis Valley 1.8 ADP)
- FY 2018: 6.8 ADP (Robert DeNier 4.9 ADP; Sage Detention 1.9 ADP)
- FY 2019: 2.4 ADP (Robert DeNier 0.3 ADP; Sage Detention 2.1 ADP)
- FY 2020: 0.0 ADP
- FY 2021: 0.0 ADP
- FY 2022: 0.0 ADP
- FY 2023: 0.0 ADP
- FY 2024: 0.0 ADP
- FY 2025: 0.0 ADP
- FY 2026: 0.0 ADP (current/partial FY)

Importantly, while operated by private vendors, these three “community provider” detention placements were secure placements. Provider names and locations:

- Brown Center (Montrose): last detainees held in FY 2017
- Robert DeNier (Durango): closure of DeNier was August 23, 2018
- Youthtrack San Luis Valley (Alamosa): this program changed to Sage Detention in FY 2017-18

Commitment: Provider names and locations of all community placements for committed youth that have been used over the past 10 years, both currently open and closed, are listed below. Providers with which the Division of Youth Services (DYS) has placed youth this fiscal year are denoted with an asterisk. Beds available to DYS at these provider programs are not guaranteed and largely determined on a referral basis.

State-Owned Facility, Privately Operated/Contracted Program:

- Rite Of Passage - Betty K. Marler (Denver)
- Rite Of Passage - Robert E. DeNier (Durango)
- Rite Of Passage - Ridge View (Watkins)

Private Owned, Private Operated:

- *Alternative Homes for Youth (Greeley)
- *Ariel Clinical Services
- Dale House (Colorado Springs)
- Denver Area Youth Services - DAYS (Denver)
- Devereux Cleo Wallace (Westminster)
- Gateway CPA (Commonworks)
- *Gateway Residential Program - (Commonworks) (Delta)
- Griffith Centers for Children (Colorado Springs)
- Griffith Centers for Children, CHINS UP (Colorado Springs)
- Hand Up Homes for Youth (Whitewater, near Grand Junction)
- Haven Corporation
- Hilltop Residential Youth Services (Grand Junction)
- Hilltop Robert A. Brown Center (Montrose)
- Jefferson Hills (Aurora)
- Job Corps (Collbran)
- Kids Crossing
- Maple Star
- Mesa County Community Corrections & Work Release
- Southern Peaks (Canyon City)
- Reflections for Youth
- *Rite of Passage - Mt. Evans Qualifying House or Q-House (Idaho Springs)
- Savio (Denver)
- Synergy (Denver)
- *Third Way - Lincoln (Denver)
- *Third Way - Lowry (Denver)

- *Third Way - Pontiac (Denver)
- Third Way - Bannock (Denver)
- *Third Way - York (Denver)
- Turning Point - Mathews (Ft. Collins)
- Turning Point - Prospect (Ft. Collins)
- Whimspire CPA
- Youthtrack - Work & Learn
- Youthtrack - San Luis Valley (Alamosa)

DYS contract placements for commitment, by fiscal year, for the last ten years, are listed as follows:

- FY 2016: 358.3 ADP
- FY 2017: 311.0 ADP
- FY 2018: 299.0 ADP
- FY 2019: 212.8 ADP
- FY 2020: 147.4 ADP
- FY 2021: 83.3 ADP
- FY 2022: 37.1 ADP
- FY 2023: 30.8 ADP
- FY 2024: 29.8 ADP
- FY 2025: 33.7 ADP
- FY 2026: 31.2 ADP (current/partial FY)

39. *Sen. Amabile:* House Bill 25-1146 required DYS to report on available placements for juveniles awaiting services and barriers to placement by July 2027. Does the Department have any information to report from preliminary surveys? **(Slide 110)**

    A Request for Proposals (RFP) has been submitted to select a private vendor to complete the Juvenile Placement Survey and Cost Analysis. Once the vendor is selected, we will be able to discuss a timeline for providing the report on or before July 1, 2027, per H. B. 24-1146.

40. *Sen. Amabile:* Please describe why funding for the Institutional Programs subdivision in DYS has increased over the last ten fiscal years even though caseload has dropped significantly. **(Slide 113)**

    Over the last ten fiscal years, funding for the institutional program's subdivision has increased even as overall caseloads declined, reflecting the significant increase in treatment and programming for youth in custody. Although fewer youth are being committed, the population that remains in DYS youth centers has higher and more complex behavioral, educational, and clinical needs. As community provider capacity

has decreased, primarily from program closures, DYS has assumed responsibility for services that were previously delivered in community placements. This has required expanding and enhancing youth center-based programming and treatment, including career and technical education, employment and education support, housing assistance, behavioral health and medical care, and community reintegration services.

Additionally, while the overall commitment population remained relatively steady from FY 2020-2021 to FY 2024-2025, with an Average Daily Population (ADP) of 262.2 in FY 2024-25, DYS has invested in evidence-based programming and a staffing model that supports smaller caseloads and more intensive services. This model has contributed to a reduction in recidivism rates from 30.9 percent reported in 2015 to 20.2 percent in 2025. Additionally, DYS has seen a decline in the number of juvenile arrests, youth detained, detention screens and admissions. However, even with this decline, we have seen an increase in detained youth with violent charges and longer stays in detention.

41. *Sen. Amabile:* Please provide an update on the utilization of DYS provider incentives from H.B. 23-1307. How are the incentives used? How many youth have been placed using the incentives each fiscal year? What are the daily rates with and without incentives? **(Slide 127)**

    Incentive funds in FY 2024-25 were approved for 17 youth across 8 counties. A total of $399,203.93 was approved as funding to remove barriers to placement and/or provide incentives to providers which were used in services shown in Table 2 below. The remainder of the $1.7 million in appropriated funds was used to cover the costs for youth identified as eligible which subsequently offset the cost to counties and to secure beds that served the same purpose and to establish capacity for the placement of youth in detention due to a lack of providers willing/able to take them. These programs, operated by Brad's House and by Shiloh House in partnership with Savio House, have served 61 clients in the last 12 months.

    Daily rates without incentives are below.

    Foster care daily rates:

    - 9-13 years $54.65
    - 14 and up $66.44

Qualified Residential Treatment Program:

- $425/day

The daily rate with incentive varies based on the needs of the youth and specific provider requests to remove barriers. Incentive funding provided to providers for individual youth covered a range of purposes but was primarily used to fund additional staffing, educational costs, and additional case management and therapeutic services for youth. Services and incentives requested for FY 2024-25 are included in the table below:

Table 3: Requested Services and Incentives for FY 2024-25

Reason for funds requested	Number of times each service was requested (each youth may have more than one type of service indicated)
Cover the cost of private treatment	1
Cover the difference in the requested rate from the base anchor rate (incentive payments)	10
Cover Educational Costs	2
Additional Supervision	4
Paying for other services (misc after-school activities, additional case management from Child Placement Agencies-CPAs, etc)	6
Mentoring	1

The program at Brad's House, subcontracted through El Paso County as fiscal agent, supports four beds. This program is funded with an additional $250/day incentive for 1:1 mentoring services and higher staffing ratios. This is in addition to the $425 QRTP base rate paid by the placing authority.

The program at Shiloh House is funded in a 50/50 split with the placing authority. CDHS, via Arapahoe County as fiscal agent, pays $363.79 incentive to Shiloh House for additional staffing, mentoring supports, and community connections. CDHS, via Arapahoe County as fiscal agent, also pays Savio House $12,511 per month for assessment and case coordination services designed to support the youth's timely return to the community with supports to help them succeed in their

home environment. The typical rate for a Residential Child Care Facility (RCCF) is $326.34/day. The assessment and case coordination efforts would vary in cost based on the specific battery and service array per client.

Incident Reports

42. *Sen. Amabile:* Why was the Lookout Mountain Youth Services facility closed over the summer? Were there issues with staff treatment of youth in the facility? How will facility operations change now that it has reopened? What practices are in place to make sure there will not be problems in the future? **(Slide 116)**

    In August, the Lookout Mountain Youth Services Center (LMYSC) temporarily transferred all youth and a majority of its staff to other DYS facilities. This was due to a combination of factors, including an increasingly complex youth population at LMYSC and industry-wide staffing instabilities. These factors impacted our ability to maintain an environment of safety for everyone at the facility.

    Over the past several years, the youth center has undergone substantial operational and organizational changes, including reductions in census, restructuring into four smaller units and later consolidating back into one facility. Additionally, we have experienced numerous transitions in leadership, adjustments in staffing, and ongoing building and infrastructure improvement with the goal of improving stability and effective programming. Even with these efforts, the youth center continued to experience similar challenges, resulting in the need to temporarily transfer youth and staff from the facility.

    The facility did not close, but operations were limited for a short period of time. LMYSC has since operationalized its assessment unit, housing up to 13 youth, in early November and its transition unit will operationalize in mid-December, housing up to 24 youth. The assessment unit at LMYSC is the initial step for committed youth entering DYS, where they receive comprehensive assessments to identify their individual risk and needs. The transition unit acts as a step-down program for committed DYS youth by increasing opportunities for job readiness, community engagement and practicing skills in a natural environment. Staff have additionally returned with increased training to provide care for these youth.

    While there were no specific issues related to staff treatment of youth at LMYSC, the facility experienced an increase in critical incidents, due to the low staffing and a population of youth with high acuity needs.

    As stated, LMYSC has since operationalized an assessment unit in November and will operationalize a transition unit in December. To ensure continuity of operations

and the care of our youth, all staff received additional training. DYS is examining the populations that return to LMYSC and will continue to ensure staff have the training and experience necessary to adequately manage and treat our youth.

43. *Sen. Amabile:* Please provide information to summarize DYS incident reports, including but not limited to: **(Slide 116)**
    i. The total number of reports for each of the last five fiscal years.
    ii. A categorization for the severity of reports, and the total number of reports by category.
    iii. Details about the most severe category of reports.

DYS incident reports fall into three categories: Informational Reports (IRs), Major Rule Violations (MRVs), and Critical Incident Reports (CIRs). Each category is comprised of incident types, and under each type are multiple incident choices. See the table that follows.

Table 4: DYS Incident Categories

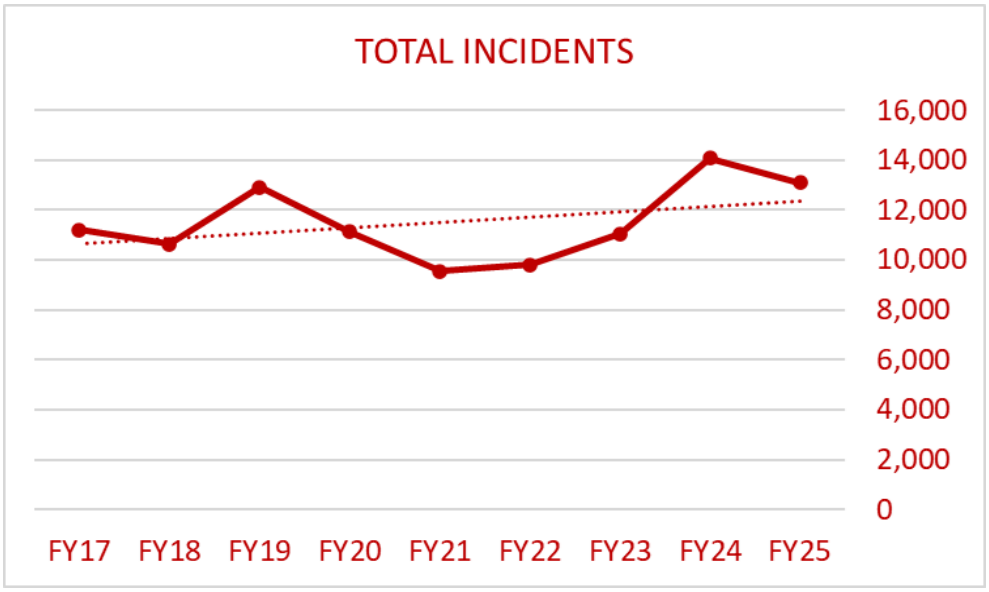
3 Incident Categories		
(1) Informational Report (IR)	(2) Major Rule Violation (MRV)	(3) Critical Incident Report (CIR)*
3rd Party Abuse Allegation	Assault/Fight	While there are no breakdown of incident types under this category, as all would be categorized as “CIR”, DYS policy mandates the following activities be entered as a CIR: • Death of staff/youth • Suicide or Self Injurius Behaviors Requiring Outside Medical Attention • Life threatening injuries • Medication Errors • Healthcare-associated Infections • Missing Persons • Mistreatment,

3 Incident Categories		
		Abuse, Neglector Exploitation Allegations • Criminal Activity
Informational Facility (To include information related to facility management that does not rise to the level of an MRV or CIR but should be documented. E.g., a pipe is dripping in a dorm that is impacting youth programming)	Behavior Management	
Informational Youth	Escape	
Prision Rape Elimination Act (PREA) (alleged)	PREA	

*Most severe incident category.

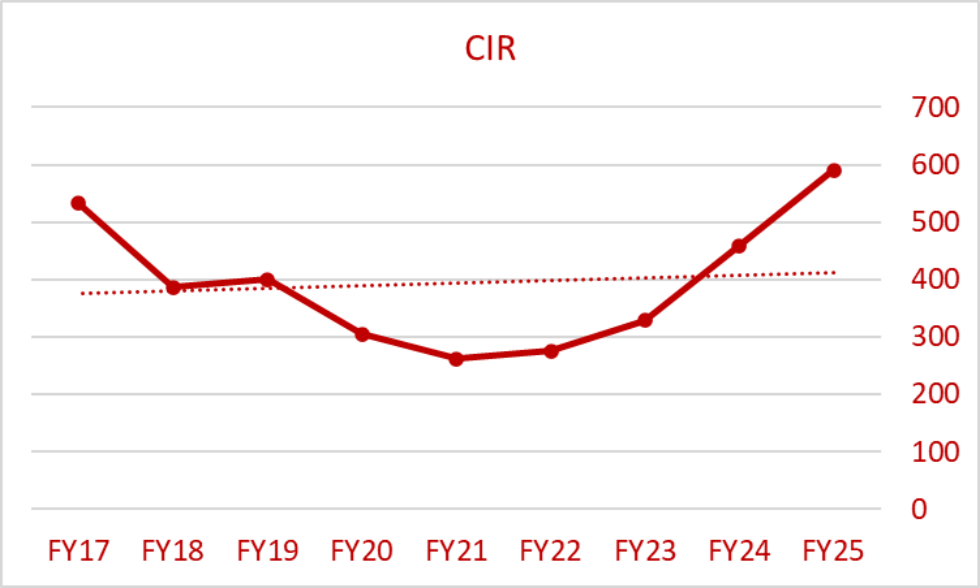
Total incident reports across DYS youth centers for the past five fiscal years, which includes all three major categories, is as follows:

- FY 2017: 11,208
- FY 2018: 10,647
- FY 2019: 12,908
- FY 2020: 11,132
- FY 2021: 9,552
- FY 2022: 9,797
- FY 2023: 11,057
- FY 2024: 14,066
- FY 2025: 13,107

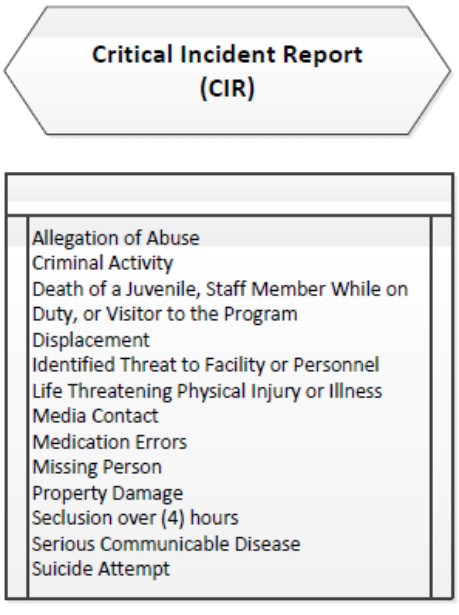


The most severe category of incident report is the Critical Incident Report (CIR). Divisionwide, across the DYS secure youth centers, the number of CIRs is as follows:

- FY 2017: 533 (4.8 percent of all incidents)
- FY 2018: 387 (3.6 percent of all incidents)
- FY 2019: 400 (3.1 percent of all incidents)
- FY 2020: 305 (2.7 percent of all incidents)
- FY 2021: 262 (2.7 percent of all incidents)
- FY 2022: 276 (2.8 percent of all incidents)
- FY 2023: 329 (3.0 percent of all incidents)
- FY 2024: 459 (3.3 percent of all incidents)
- FY 2025: 590 (4.5 percent of all incidents)



On average, across the five fiscal years, the majority of incident reports were from the Major Rule Violation category (73 percent), followed by Informational Reports (23 percent), and 3 percent that fall within the most serious/severe incident category of Critical Incident Report. Refer to the following visual for the choices that fall within the DYS Critical Incident Report category. A more comprehensive visual can be found here.



R1 DYS Radios

44. *Sen. Kirkmeyer and Rep. Taggart:* Please describe the radio system used in DYS. Are they Motorola radios used within the facility? Are they part of the digital trunked radio system? Has the Department explored more cost effective options, including but not limited to an internal phone system? **(Slide 117)**

    DYS utilizes two-way communication equipment with designated employees who are responsible for the supervision and/or safety of youth in its care. The primary function of the two-way communication equipment is to efficiently communicate with other Division of Youth Services employees to manage the routine shift operations, address safety, security, and emergency incidents and concerns (codes), and provide for a fail-safe immediate communication in a correctional environment.

    DYS radios are programmed and operate on the digital trunk radio system as this system allows for better radio functionality within the youth center. DYS is not using the digital trunk radio system in communications outside the specific youth center or with other agencies. For secure transports, DYS will either use facility radios or cell phones to communicate.

    DYS has reviewed other manufacturers but found Motorola to be the most effective radio for our needs and cost. Utilizing Motorola radios enables DYS to continue using current radios and replace radios on a rotation moving forward, as our current radios will be able to interface with the new Motorola radios.

    The use of an internal phone system to address imminent or immediate safety, security, or emergency situations is not an appropriate use in a correctional setting. Each staff member must be able to immediately alert others to ensure the highest quality of safety and security in a secure residential setting. In addition, an internal phone system could become inoperable and eliminate required communication in safety, security, and emergency situations, which could lead to significant harm to a youth, a staff, or the community. Comparatively, DYS has never experienced an incident where all radios have become inoperable, which ensures constant communication for safety, security, and emergency situations.

Division of Child Welfare

Adoption

45. *Sen. Amabile:* What are adoption and relative guardianship payments supporting? Are the payments ongoing or one-time? How is the amount of the payment determined? Are the payments adequate to support families who have children with high medical needs? **(Slide 123)**

    The Adoption and Relative Guardianship Assistance Program (RGAP) is an entitlement program that provides financial assistance to adoptive parents, relative guardians, non-relative guardians, and legal custodians for a child or youth's needs in order to best support permanency. This program provides financial assistance to adoptive parent(s) and legal guardianship parent(s) with an adoption assistance or relative guardianship assistance agreement in specific, defined, and limited ways to provide for the needs of an eligible child/youth.

    Adoption/RGAP assistance is intended to help or remove financial barriers to Colorado children and youth with needs identified in Section 26-7-102, C.R.S., that would otherwise prevent or hinder a path to permanency through adoption or Allocation of Parental Responsibility.

    The adoption assistance/relative guardianship agreement may include a monthly financial assistance payment that cannot be higher than the rate the child/youth received while in foster care (per Social Security Act 473), non-recurring adoption expenses which are limited to a one-time reimbursement of up to $2,000 per child/youth (per Social Security Act 473 and §1356.41), case services which are to provide support to the family with services that are not covered via Medicaid or another public resource, and Medicaid (per Social Security Act 473). Per Colorado's Title IV-E plan, we also exercise the option at section 475(8)(B) of the Social Security Act to extend Title IV-E foster care, guardianship assistance, and adoption assistance to eligible children up to age 21. Colorado allows for youth to claim Title IV-E funds for youth 18 years of age through the month of the twenty-first birthday when one of the following criteria is met per CCR 7.306.54.

    In the summer of 2021, following an Office of the Colorado Child Protection Ombudsman investigation into adoption practices in Colorado, a workgroup was formed to establish a methodology for determining adoption assistance and to define the child/youth's and family's needs within that methodology, using foster care rates as a basis. The worksheet is not currently required for RGAP assistance negotiations, but many counties do use it. The Adoption Assistance Negotiation

Worksheet created consistency statewide by providing a standardized tool that still allows for discussion of individual needs, while clearly defining parameters to assist in rate determination. This was also studied by Colorado State University, which showed that family circumstances and child/youth needs were consistently being negotiated across Colorado. The worksheet was also updated in May 2025 with minor adjustments and is generally reported to be a helpful and efficient tool by county departments and parents.

If a child/youth has significant medical or other documented needs while in foster care, they may receive an individualized negotiated rate. That individual rate would still be the maximum the child/youth could receive and would be used as the rate in their adoption assistance negotiation. Per eligibility requirements, these children and youth may be able to receive Supplemental Security Income (SSI) or services through various Colorado waiver programs.

46. *Sen. Amabile:* What is driving increased costs for adoption subsidies? What are the challenges to projecting caseload and expenditures? **(Slide 123)**

Adoption assistance in Colorado has steadily increased both due to the creation of the Adoption Assistance Negotiation Worksheet, as this has provided a guide for payments as well as the foster care daily rate increasing steadily over the last few fiscal years. Prior to the worksheet, county departments offered a variety of agreements, including Medicaid-only or minimal payments regardless of the child/youth's needs or the family's circumstances, which was a barrier and not in alignment with federal guidelines. The adoption assistance payment is determined through discussion and negotiation between the adoptive parents and the county, based on the child/youth's needs and the family's circumstances. The agreed-upon payment should be combined with the parents' resources to cover the child/youth's ordinary and special needs, as projected and anticipated needs, e.g., child care. Anticipation and discussion of these needs are part of negotiating the amount of the adoption assistance payment.

The challenges of projecting adoption caseloads are that caseloads are inherently unpredictable, and can at any time be renegotiated based on the child/youth’s needs and or family circumstances. The Department also sees a spike in annual adoptions each November due to National Adoption Month as many counties hold local celebrations and finalize adoptions during this time. This seasonal increase makes it difficult to provide an accurate projection prior to the November 1 budget submission. These renegotiated rates are based on the current foster care rates rather than the foster care rate at the time the adoption was finalized, and the ability to renegotiate at the current foster care rates is allowed in federal program

instructions. Children and youth are more likely to achieve and maintain permanency when families can access adoption assistance or the Relative Guardianship Assistance Program (RGAP) for support.

47. *Sen. Kirkmeyer:* What are the options for reducing RGAP expenditures? Describe any work the Department has done to work with counties to reduce costs, including potential regulatory or legislative changes that could reduce future costs. **(Slide 123)**

    One recommendation, given that Colorado has sought consistency in adoption/RGAP assistance, is a standardized case service regulation across all 64 counties. This would allow a capped reimbursement rate (per year/month) while still supporting barriers. While case services are included in the standardized tool , counties can determine these reimbursements at their discretion, within their individual county budgets. This recommendation would limit the amount of expenditure.

    Case services are time-limited reimbursement services that support a case plan for children/youth as part of an adoption/RGAP assistance agreement. Case services may be provided to meet a child/youth's needs when the child/youth's adoption is finalized, and which are not covered by adoption/RGAP assistance or Medicaid. Currently, adoptive/guardianship families may request reimbursement, all or in part, for non-Medicaid-covered services to support the health and well-being of the child/youth, considering the family's circumstances.

    Case services must be agreed upon and documented in the adoption/RGAP assistance agreement before reimbursement is requested. Case services are not included in the monthly adoption/RGAP payment and are reimbursed to the family. The intent is that these services are only being utilized at the time of need of the service (Ex: daycare), and would not be included to be paid for the entirety of the adoption/RGAP agreement. County departments have provided feedback that they may authorize case service amounts through the negotiation process and have also reported a significant increase in case service payments over the past few years.

    Fully eliminating case service reimbursement would likely not be in the best interest of children, youth and families and could ultimately increase adoption/RGAP agreement rates to compensate for the loss of case services.

    Another option to mitigate RGAP expenditures may be to limit what services may be reimbursed. Currently, in regulation, it states that these requested services may include child care, tutoring coordinated with school services to achieve age-appropriate grade-level academic competency, or therapies, such as animal-assisted therapy, or therapeutically recommended prosocial or recreational

activities. These services must be documented and recommended or prescribed by a medical, dental, mental health, and/or educational professional, or other qualified professional based upon education, professional experience, certification, or licensure.

The Department has worked diligently with counties to achieve consistency in the negotiated rates for adoption/RGAP, addressing the previous inconsistencies that resulted in families receiving different services and negotiations based on county practice, rather than on the needs of the child/youth and family circumstances, as required by federal and state law.

Another recommendation proposed by JBC staff during the Briefing for OCFY is to lower the reimbursement rate to counties from 90 percent to 80 percent, requiring legislation change. This change would place additional strain on county budgets.

48. *Rep. Sirota:* Cash fund reports and RFI responses show that the Department expended $115,128 for Adoption Savings when there was a cash fund balance of $3.7 million in FY 2024-25. Why is this funding under-utilized? What are the Department's plans to utilize the funding in the current and future years? **(Slide 123)**

    Federal law (Section 473(a)(8) of the Social Security Act) requires Title IV-E agencies to reinvest any savings generated from applying the revised eligibility criteria for "applicable children" into child welfare service activities permitted under Titles IV-B or IV-E. These "adoption savings" must supplement, rather than replace adoption assistance, and may be only used for certain allowable permanency and adoption service activities. These allowable activities include post-legal adoption services for families who have adopted children with special needs, such as day treatment and respite care, and efforts to increase the adoption of older youth from foster care, including child-specific recruitment strategies.

    The Department currently spends approximately $500,000 annually on post-permanency support for families and on a pilot program serving high-needs youth who remain in the system but require permanency. Historically, the cash fund has been under utilized. Part of this under-expenditure stems from the limited scope of allowable federal activities and the discontinuation of prior contracts after an evaluation by Colorado State University found the contracted service model ineffective for the target population. As a result, fewer activities could be charged to the fund until new, effective programming was established. The Department is now expanding the use of this cash fund to support statewide post-permanency services and specialized clinical supports delivered through community partners to better serve high-needs children and youth.

In addition, last fiscal year expenditures were lower because the Department shifted approximately $373,000 in eligible costs from this cash fund to an expiring federal Adoption Incentives Grant to fully maximize federal dollars before they lapsed. This temporary shift resulted in lower spending in the cash fund despite typical program needs remaining consistent. The $115,000 spent this fiscal year, along with the $373,000 shifted to other funding sources, aligns with prior year spending patterns.

Moving forward, the Department will continue to work closely with counties and community partners to fully utilize this cash fund, ensure alignment with federal allowable activities, and support permanency outcomes for Colorado's children and youth.

Recent Legislation

49. *Sen. Amabile:* Is there an evaluation of the foster youth housing voucher program created in S.B. 23-082? Please provide information about how $1.4 million General Fund for case management from the bill is utilized. **(Slide 126)**

The program has only been issuing vouchers for 18 months, so we do not yet have an in-depth evaluation available. However, our program team will begin studying its efficacy and impact on the youth we serve as they exit the program using existing administrative data sources and resources once we have had sufficient turn over in the vouchers to collect meaningful and representative data. This will begin in 2027 at the earliest. In the first 18 months, the program has issued 84 vouchers that were 'leased'. A 'leased voucher' is a voucher that was not only issued to a youth, but is currently being used by a youth who has entered into an approved lease with a housing vendor. There have been zero evictions in the 18 months the program has been issuing vouchers. The 0 percent eviction rate demonstrated by this program is a considerable improvement over the 7.8 percent national average for evictions (for the general public) reported by Princeton University's Eviction Lab.

Half of the case management programs are using the Pathways to Success intervention as their case management model. This program is currently undergoing a rigorous evaluation in Colorado, conducted by the Center for Policy Research and Mathematica. That evaluation will conclude in April of 2026, and an evaluation report is expected in 2028 or 2029. However, this model was previously evaluated using a less rigorous pre/post evaluation that demonstrated significantly improved outcomes that included a reduction in homelessness and an increase in educational/employment outcomes. Those findings can be found here.

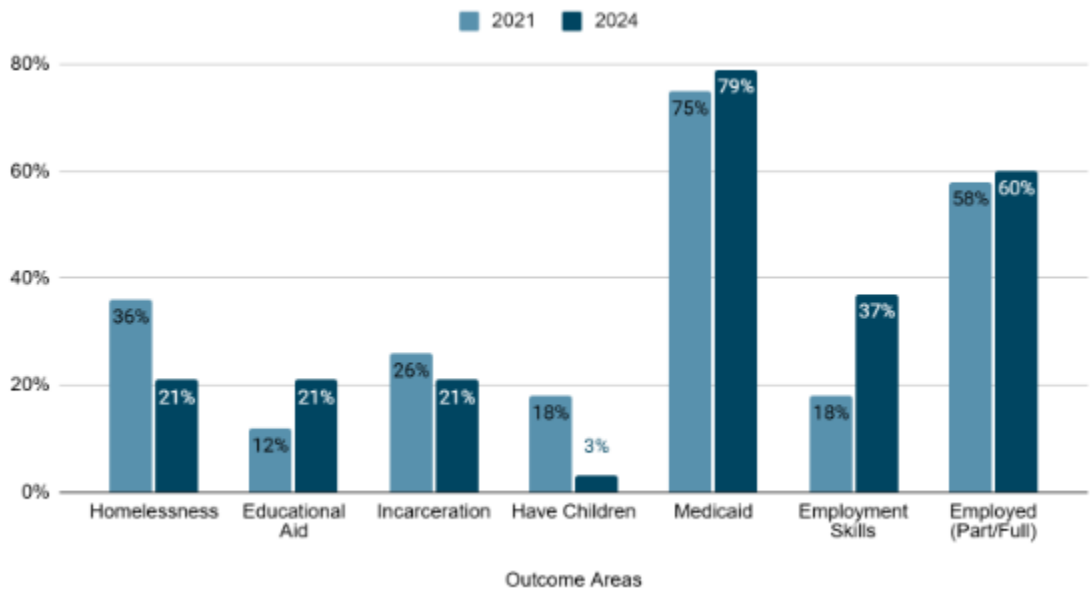
The combination of case management and housing assistance have been incredibly successful in mitigating evictions and have resulted in positive relationships with landlords. This is a direct result of supportive case management and immediate resources to address concerns, providing support to voucher participants. This ensures that they learn skills related to reading and interpreting leases, reporting repairs and problems in their units, properly maintaining their apartments, and scheduling utility service and budgeting to pay monthly bills. Approximately 75 percent of the $1.4 million in case management funding has been used to hire the county and non-profit program staff who provide direct case management services to youth in these vouchers. The remainder of the case management funding covers move-in expenses, providing emergency housing, funding for landlord incentives, flexible funding to support you in obtaining employment, the cost of group activities, connecting youth with any mental health or substance use treatment they may need, and ensuring staff have the training required to implement the Pathways case management model, called Engaging Youth in a Coach Like Way.

CDHS, Division of Child Welfare (DCW) Transition Services Specialists are currently processing annual recertification for voucher participants and gathering direct feedback and data via the recertification application, updated Homelessness Risk Assessments, and income verification.

Assessment of the feedback data has indicated that program participants have consistently reported positive outcomes related to employment and educational goals, improved safety and stability, a significant decrease in Homelessness Risk criteria, and general independent living skills. Suggested improvements noted in the feedback were related to payment challenges often experienced by voucher recipients.

Colorado's National Youth in Transition Database (NYTD) outcomes for youth transitioning to Colorado have also shown significant improvement, attributable to improvements in the supports offered to youth transitioning to adulthood from foster care in Colorado, including S.B. 23-082, H.B. 21-1094, and S.B. 22-008. Those outcomes can be seen in the figure below and include a 15 percent reduction in homelessness during a time when the general population in Colorado was experiencing an increase in homelessness:

Figure 2: NYTD Outcomes of 21 Year Olds



50. *Rep. Taggart/Sen. Amabile:* Please provide an update on the implementation of H.B. 24-1038 (High Acuity Youth). Please provide data on the utilization of provider incentives for each fiscal year, including but not limited to: **(Slide 128)**
    i. The number of facilities and provider locations that have received incentives.
    ii. The total number of high acuity beds available.
    iii. The total number of youth in residential placements supported by incentives.
    iv. The daily rates without incentive payments, and the daily rate with incentives.

    The implementation of provider incentives pursuant to House Bill 24-1038 has been executed successfully. Through various methods that began during COVID, the Division of Child Welfare contracts for 58 beds of varying type and level and works with counties to place children or youth in these beds when all other referrals to out of home care providers have failed. This program was previously established under Senate Bill 21-137 and House Bill 22-1283 were sustained through the maximization of primary funding sources (including Medicaid and county block funding), supplemented by the incentive funding authorized by this committee. The Department has entered into additional contracts for the provision of beds, as part of ongoing efforts to appropriately scale the service array for children and youth exhibiting high acuity needs.

    - The Department currently contracts with six vendors utilizing funds allocated under H.B. 24-1038, accounting for 38 beds:

i. Psychiatric Residential Treatment Facilities (PRTF): Southern Peaks (12 beds) and Third Way Centers (3 beds)
ii. Qualified Residential Treatment Program (QRTP): Shiloh House (5 beds), Griffith Centers (5 beds), and Third Way Centers (3 beds)
iii. Specialized foster care: Specialized Alternatives for Families and Youth (SAFY) (6 beds), Envoi Associates (4 beds)

- These 38 beds, in combination with beds contracted for the Intellectual Developmental Disability (IDD) Program created by S.B. 18-254 and with beds contracted for services by H.B. 23-1307, total 58 beds across nine providers. These beds provide an array of services at multiple levels of care and for several populations of children and youth with unmet complex needs.
- In the last 12 calendar months (November 2024 - October 2025), the beds funded through H.B. 24-1038 served 79 youth. The 58 combined beds contracted with CDHS through H.B. 24-1038, H.B. 23-1307, and S.B. 18-254 served 140 youth.
- Current rate schedules by level of care at base rate and with contract incentives are included below.

Table 5: Current Rate Schedules

	Base	**With incentive**
PRTF	$803.71	$1241.71 - $1713.71
QRTP	$558.96	$777.96 - 1108.96
RCCF	$326.34 (county) $569.54 - $691.90+ (CHRP)	$770 (no active Children's Habilitation Residential Program-CHRP) $1125.57+ (CHRP)
TREATMENT FOSTER	$247.53 (county) $89.71 - $330.54+ (CHRP)	$467.53 (no active CHRP) $745.23+ (CHRP)

County Child Welfare Expenditures

51. *Sen. Kirkmeyer:* Please provide the estimated county expenditures for certified and non-certified kinship foster care in FY 2025-26. What conversations has the Department had with counties to ensure that the state share of county expenditures are covered? What are the options for containing costs? **(Slide 121)**

    The current projection for non-certified kinship costs in FY 2025-26 is $6.1 million, and the projected spend for certified kinship foster care is $21 million. It is important to note that certified kinship foster care has always been paid at the full foster care rate when a kinship provider chose to certify at the family foster home level. However, prior to the implementation of S.B. 24-008, the Department did not consistently track certified kinship homes separately, making it difficult to determine which currently certified homes would have previously been certified under the family foster home pathway.

    In FY 2022-23, FY 2023-24, and FY 2024-25, the Department paid $73.3 million, $76.9 million, and $76.7 million respectively for all foster home-level placements, including kinship foster care. As implementation of the bill continues, the Department is closely monitoring shifts in total out-of-home care costs. The projected total for FY 2025-26 for all foster home-level placements is $83.5 million, an increase of $6.7 million compared to FY 2023-24 and FY 2024-25.

    The Department received $4.2 million in General Fund and $4.5 million in TANF Long-Term Works Reserve funding for FY 2025-26 to support implementation of S.B. 24-008. In alignment with the Administration for Children and Families' (ACF) request to reduce barriers to kinship certification, and with the corresponding allowance for these new certification types to draw down Title IV-E, the Department can access additional Title IV-E revenue for eligible homes and clients, helping to offset provider payment costs.

    The Department has emphasized the importance of certification as a strategy to maximize federal funds. If expenditures exceed the appropriation due to insufficient certifications with Title IV-E eligibility, remaining costs would need to be reconciled through the block. To date, the Department has not engaged counties in any discussions regarding cost-containment strategies related to this legislation, but as indicated in the JBC staff briefing, there are options to reduce reimbursement. Counties have concerns about these options and they would require statute change.

52. *Rep. Sirota:* What transparency does the Department have into county expenditures from the capped allocations? How much money from the child welfare capped allocations are used for county administrative costs? What are the significant categories and amounts of county expenditures from the capped allocations? **(Slide 122)**

    The Department receives child welfare expenditure data through two primary sources within the Colorado Financial Management System (CFMS):

    1. Client and Case-Related Expenditures (Trails to CFMS): Counties enter client- and case-specific expenditures into the Trails system, which then feed directly into CFMS. These costs reflect services and support provided to children, youth, and families.
    2. County Administrative Expenditures (Directly Entered into CFMS): Counties also enter administrative expenditures directly into CFMS through administrative cost pools or direct administrative charges. These costs can include salaries; health, dental, and life insurance; long-term disability; Medicare and Social Security taxes; retirement contributions; workers' compensation; personnel services allocations; vehicle leases; meeting and training rentals; travel; office supplies; and other operating expenses.

    Since State Fiscal Year (SFY) 2019-20, Child Welfare Block funding has increased by more than $64 million. Over the same period, however, county administrative spending has grown by $79 million, outpacing available funding and contributing significantly to the counties exceeding the appropriation in Child Welfare. These administrative costs encompass more than operational expenses, they also include case management staffing costs. These positions frequently provide direct support to children, youth and families and salaries for these workers are categorized as administrative costs even though these staff deliver essential, client-facing work.

    On average, child welfare administrative costs account for 72.65 percent of the counties' capped allocation, including $26.9 million in 100 percent state-funded dollars. The remaining amount is funded at an 80/20 state-county split, which totaled $263 million, $281 million, and $294 million over the last three fiscal years.

    Other major categories of county spending, also funded at the 80/20 split, include out-of-home placements, case services, and child welfare-related child care. These collectively represent the core service costs required to support children and families in Colorado.

53. *Rep. Brown:* What processes are in place to ensure that county expenditures from the child welfare capped allocations are appropriate? Please provide data to describe recent caseload and expenditure changes. Are expenditure increases driven by a particular caseload change? **(Slide 122)**

    Colorado's county-administered child welfare system operates under multiple layers of fiscal oversight to ensure that expenditures within the capped allocation are appropriate, allowable, and compliant with state and federal requirements. Counties are subject to federal audit requirements under 2 CFR Part 200, with results reviewed by the State's Internal Audit team. When findings relate to child welfare grants, program staff evaluate them to verify appropriate use of funds and required corrective actions.

    Counties also undergo continuous monitoring through state management evaluation reviews and audits. Public transparency is further supported through county child welfare contracts, which are available upon request.

    At the state level, fiscal oversight is reinforced through ongoing review of total monthly expenditures and the reconciliation processes that apply federal claiming rules. Together, these functions ensure that spending is allowable within the capped allocation and aligned with federal requirements.

    Despite declining case counts in recent years, overall child welfare expenditures, particularly in out-of-home placements and administrative staffing, have increased markedly. Both the Child Welfare Allocation Committee (CWAC) and Joint Alignment Committee (JAC) have consistently acknowledged this misalignment between caseload trends and spending patterns.

    Placement costs have risen two to three times over the past five years, even as the number of children in care has decreased. Cost per case has also grown significantly, driven by higher-acuity needs and inflationary pressures, including workforce costs, cost of living, and rates for contracted services. Counties have also increased staffing expenditures as they filled long-vacant positions and raised wages to remain competitive in a tight labor market. Overall administrative costs have expanded as well, further contributing to expenditure growth.

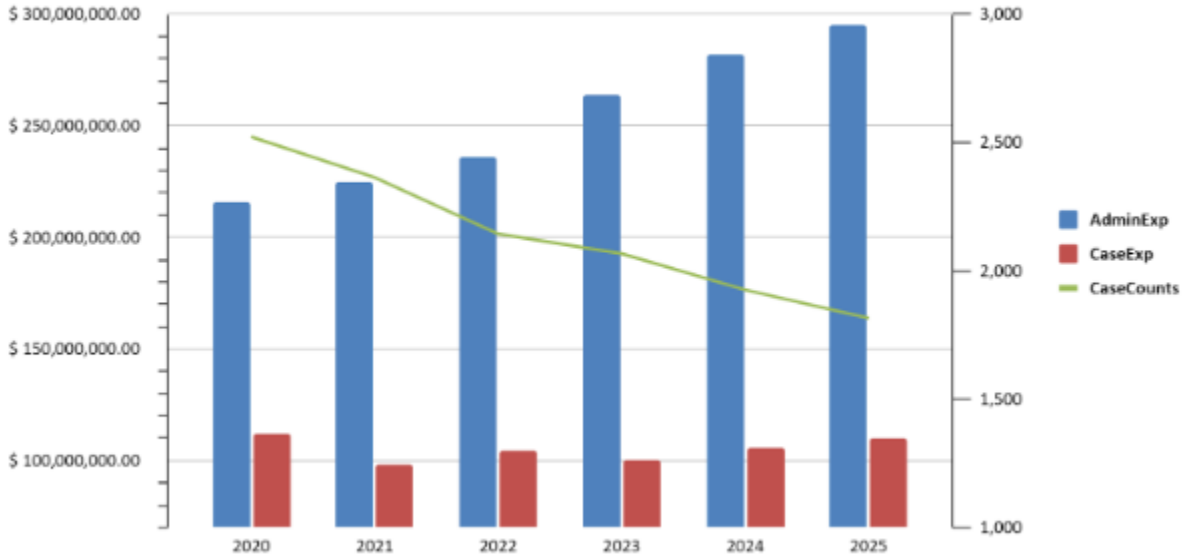
    The State and counties consistently report that higher expenditures are not the result of increased caseloads; in fact, caseloads continue to decline. Instead, spending growth is driven by rising per-case costs, including:

    - Youth with higher-acuity behavioral/mental health needs requiring specialized and costly placements;

- Labor market conditions reflecting increases in salaries, benefits, and administrative expenses;
- Market shortages of treatment-level foster homes and residential beds, which elevate rates;
- Increased use of services necessary to safely maintain children with their families.

Overall, expenditure increases are cost-driven rather than volume-driven.

Figure 3: Admin & Case Expenditures with Case Counts



54. *Rep. Sirota/Sen. Amabile:* Please discuss the child welfare cost containment strategies included in the September TANF/CCCAP/Child Welfare RFI. Why are the cost containment strategies not reflected in the request? How is the Department collaborating with counties to contain costs? **(Slide 122)**

    In addition to detail that is contained in the RFI itself, there were three major projects that received the most support from both county department and CDHS leadership and are being tracked by the Joint Alignment Committee (JAC), which was established last year as an enterprise approach across three state programs (Colorado Child Care Assistance Program, Temporary Assistance to Needy Families, and Child Welfare) in order to consider and commit to projects or practices that support their stability.

    1. The first effort, known as the “Strikethrough Crew” consisted of over 50 state and county volunteers who pored through various sections of regulation for departments and caseworkers to see if there were rules that

could be cut or changed if they did not benefit families and were not required by law. While the effort did not uncover a major opportunity for reform, such as what we had in changing Review, Evaluate, and Direct (RED Team), there were some rules that are being reviewed and considered by various working groups hosted by the Child Welfare Sub Policy Advisory Committee.

2. The second effort encouraged several large counties to report staffing patterns, salaries, and funding/spending information to the Office of Children, Youth & Families for analysis and recommendations. All counties involved reported this to be a worthwhile exercise, and all committed to sharing their own information more broadly and across other county departments for their awareness and input.
3. The third effort involves evaluating case-to-staff ratios to support workforce balance. This effort is being led by county representatives, who will bring in OCYF staff at a time in the near future to evaluate and advise on its work. The intent is not to impose a rigid benchmark, but to create awareness and offer guidance.

In addition to these efforts, others have been implemented, such as reviewing existing child welfare and child care rules and sharing program guidance to ensure that counties are aware of opportunities to invest in child care differently when a child in an open child welfare case requires child care to ensure safety. There is also ongoing work to analyse various mandates that have driven costs without increases in funding. Finally, projects involving prevention services, such as drawdown and primary and secondary prevention programs that counties created several years ago, are being evaluated for their cost-to-impact ratio. At this time, evaluating and adjusting prevention programming is largely county-by-county, although the Office of Children, Youth & Families remains committed to providing support or convening a larger endeavor.

At this time, these cost containment ideas were not included in the Department's Decision Items because the state and counties have not agreed upon solutions or next steps that would require formal or legislative action. All of these projects can be managed through existing staff, and their willingness to partner with one another to see if these cost containment ideas can bear any fruit.

55. *Sen. Kirkmeyer/Rep. Sirota:* How does the Department account for county caseload impacts to the capped allocations for the fiscal note process? **(Slide 126)**

When analyzing the fiscal impact of legislation, the Departments takes into account increases in caseload or expenditures that affect capped allocations, analyzing the

data and information available and creating a cost analysis to add to the information submitted to Legislative Council.

R2 ABA Facility Licensing

56. *Rep. Brown:* Describe how the landscape of ABA services has changed over the last five years, and when and how the Department began to receive complaints about ABA facilities. **(Slide 129)**

    The Department was first alerted in March 2024 to a specific Applied Behavior Analysis (ABA) provider serving children and youth at three locations without a license, based on several complaints of physical restraints occurring in the facilities. Upon issuing cease-and-desist notices to this provider, they began identifying numerous other facilities around the state that were providing services in a manner consistent with the previously identified provider. In March 2024, the Department learned from a related membership organization of a statewide network of ABA providers, some of which were/are licensed as day treatment providers, while the vast majority were/are not. Prior to this complaint and the discovery of a vast number of ABA providers, the Department licensed and continues to oversee over a dozen day treatment facilities providing ABA therapy. The Department assumes that after the passing of S.B. 09-244, requiring that all health insurance plans cover assessment, diagnosis, and treatment of Autism Spectrum Disorder (ASD) not subject to any dollar limits, there was a significant growth of ABA providers in Colorado. HCPF may have more specific reimbursement data on this to show the actual growth over the last 5 years based on data of reimbursed services.

57. *Rep. Taggart/Rep. Brown:* Has the Department collaborated with the Department of Regulatory Agencies to consider if professional licensing for ABA would address the concerns identified in the Department's request? **(Slide 129)**

    A sunrise request was submitted to the Department of Regulatory Agencies (DORA) seeking consideration of professional licensure of ABA providers in 2020, at which time the sunrise report did not recommend licensure.. Given that the Department does not oversee professional licensure, such a determination is outside of our scope. Professional licensure of individuals and staff does not negate the need for facility licensure and oversight to ensure the safety of children and youth served in such programs. If DORA decided to grant a subsequent sunrise request to license Board Certified Behavior Analysts (BCBAs) and Registered Behavior Technicians (RBTs), the need to regulate the physical operations of a facility serving vulnerable children and youth does not fall under professional licensure. There are operational requirements, such as the use of restraint and seclusion, medication administration,

fire safety, and many other considerations for building operations that would necessitate oversight that would fall under CDHS.

58. *Rep. Brown:* How is the Department being alerted to concerns with ABA facilities? **(Slide 129)**

    The Department has received notification of concerns within ABA facilities both through complaints filed with various entities, including CDPHE, CDEC, CDE, BHA, HCPF, and CDHS, and through notification of legal action taken against them as a result of allegations of abuse and neglect. Other ABA providers and licensed facilities, parents of children receiving services, ABA membership organizations, the Governor's Office, and members of the public have also alerted the Department to concerns about practices in unlicensed ABA centers.

59. *Rep. Brown:* How does the Department anticipate that licensing caseload will continue to grow regardless of whether the request is approved if the Department continues to identify and pursue legal action against facilities that do fall under the day treatment definition? **(Slide 129)**

    The Department is investigating and discussing licensure with a limited number of ABA providers at this time and prioritizing based on complaints, legal action, concerns for child safety, and reports of physical management. When it is determined that a provider meets the definition of day treatment and should thus be licensed, the current licensing team, when necessary, absorbs those providers into their caseloads. The absorption of potentially hundreds of new providers is not possible within current capacity and would more than double current caseloads, leading to poorer quality of services, missed opportunities for intervention, increased cases of child abuse and neglect, and staff burnout.

60. *Rep. Brown:* The request indicates that the Department estimates that there are 263 ABA facilities statewide. How many facilities does the Department estimate fall under the current day treatment definition? **(Slide 129)**

    Without the staffing to fully investigate all identified ABA providers currently in operation, the Department does not have the capacity to make accurate determinations about the number of providers that meet the statutory definition of day treatment at this time. As of December 10, 2025, the Department believes there to be at least 305 unlicensed providers based on preliminary research with the number of unlicensed entities growing each day. Further, without applications from providers, the Department lacks any statutory authority to oversee operations or determine whether the facility meets the statutory definition of day treatment.

Instead, the Department relies on provider transparency and conversation to determine if programming meets statutory requirements for licensure.

61. *Sen. Bridges:* Why is the Department pursuing action against facilities rather than individuals providing ABA therapy who may be bad actors? What is preventing an individual therapist from moving to a different facility if they are a bad actor even if facilities are licensed? **(Slide 129)**

    The licensing of facilities and the licensing of individuals providing ABA Therapy are two separate processes identified under the respective statutes. CDHS is responsible for licensing facilities and agencies under § 26-6-903, also known as the Foster Care, Kinship Foster Care, Residential, Day Treatment, and Child Placement Agency Licensing and Certification Act. Additionally, it was determined that CDHS does, in fact, have the authority to license and supervise these programs under the noted statutes (§ 26-6-903), as determined by the Denver District Court on March 11, 2025. The oversight of these facilities will also allow CDHS to manage the staff members working within these facilities, and to ensure there are no “bad actors” that are employed by these facilities. This is one of the main reasons why it is important for these entities to become licensed, as the laws and regulations require background checks for all person employed in these faclities and allows the Department to ensure the removal of any individuals with criminal backgrounds or founded cases of child abuse and/or neglect from working with these vulnerable children through open Colorado Burearu of Investigation (CBI) flags on the staff in every licensed location.

Requested Reductions

62. *Rep. Sirota:* The R13 CMP reduction utilizes unspent General Fund transferred to a cash fund intended to incentivize counties to start CMP programs. Why didn’t more counties join the program? Were there timeline, capacity, or other constraints? **(Slide 102)**

    There are several reasons a county might choose not to participate in the Collaborative Management Program (CMP). One common reason counties choose not to participate is the program's statutorily required data collection and reporting. Some counties believe the funds they would receive through the CMP allocation would not be sufficient to cover the required workload.

    In 2023, there was also a tight timeline for counties that did not already participate in CMP to complete the required activities to become a new CMP. H.B. 23-1249 passed on May 8, 2023, and the Governor signed it on June 1. CMP Memorandum

of Understanding (MOU) Drafts are due to CDHS by May 1, and the MOU with signatures is due June 30.

63. *Rep. Taggart:* Why are there ongoing costs for Collaborative Management Programs (CMPs)? It makes sense to have incentive funds to set up collaboration, but then the collaboration should be established and not require ongoing state funding. Please describe how ongoing CMP funding is utilized by counties, and the potential service impact of the requested decrease. **(Slide 102)**

    After the passage of H.B. 23-1249, CMP no longer uses “incentive funds”. The bill, Reduce Justice Involvement for Young Children, removed all mentions of performance-based incentives from the CMP statute. Previously, the CMP funding formula was based on CMP sites achieving performance and process measures. CMP funding is now distributed based on need rather than performance.

    CMP funding is utilized by counties to support the implementation of the program at the local level. Every CMP site is required to have an Interagency Oversight Group (IOG), which facilitates system-level collaboration, and an Individualized Service and Support Team (ISST), which facilitates direct service-level collaboration.

    Each CMP site employs a CMP Coordinator to facilitate the collaboration at the system and direct service level. These Coordinators are also responsible for completing the annual CMP Memorandum of Understanding (MOU) as well as state-required data collection and reporting. In FY 2024-25, on average, counties spent $69,181 on program personnel.

    CMP sites also use CMP funding to provide services and hard goods for families. In FY 2024-25, CMP sites spent an average of $27,506 on services for families and an average of $8,050 on hard goods (food, clothes, beds, etc.). CMP sites can also use CMP funds for the administration of the program (average of $4,900) and indirect costs (average of $4,829).

    Collaboration requires ongoing coordination and facilitation to ensure the processes are successful. Without the annual allocation of CMP funds, most, if not all, CMP sites would have to discontinue the program.

64. *Sen. Kirkmeyer:* The R9 Tony Grampsas reduction partially offsets a $400,000 General Fund decrease with an increase of $200,000 from the Marijuana Tax Cash Fund. Is an increase of $200,000 from the Marijuana Tax Cash Fund feasible under the forecast? What would be the programmatic impact if the General Fund reduction was taken without the cash fund increase? **(Slide 103)**

    The Tony Grampsas Youth Services (TGYS) program currently serves over 73,000 children, youth, and community partners annually. The OSPB forecast is projecting that, including budget reductions and increases reflected in the Marijuana Tax Cash Fund (MTCF) budget package for FY 2026-27, the $200,000 increase for TGYS is feasible. The budget package maintains the balance above the required reserve while preserving critical investments and taking budget balancing actions with minimal programming impact. Additional information can be found here in Statewide Request S-01/R-07 MTCF Balancing.

    If the General Fund reduction were taken without the cash fund increase, TGYS would reduce the number of grants or the amounts awarded to three-year TGYS grantees, in addition to terminating the annual Youth and Community Partnerships grant. This would reduce the number of children, youth, and community partners served by TGYS programming. Based on current TGYS three-year grantees, it is estimated that a $400k reduction would eliminate programming for 2,100 children, youth, and community members.

65. *Rep. Brown:* R14 is a $150,000 reduction for foster youth training and recruitment. Where did this funding originate? Was it from a recent bill or budget request? **(Slide 131)**

    The foster home recruitment and retention line originated over 10 years ago, in a budget request from the Department to fund 2.0 FTE and support counties and child placement agencies in recruiting and retaining foster parents at the state level. This includes media campaigns, two contracts supporting community agencies serving foster parents and kinship providers, training, and a statewide inquiry form.

66. *Sen. Kirkmeyer:* What is the anticipated cost per call to the child abuse and neglect hotline for counties in FY 2026-27? Is the Department asking for a decrease in funding for the child abuse and neglect hotline while also increasing the cost per call to counties? **(Slide 132)**

    This request includes a reduction of $629,000 General Fund to the Hotline for Child Abuse and Neglect program in FY 2026-27 and ongoing. This reduction is available due to a system upgrade completed in Fall 2024, which transitioned the Hotline to a cloud-based technical platform, allowing the Department to significantly lower

operational costs. The Hotline's 24/7 operations will remain fully supported without disruption. The proposed reduction does not negatively impact child and youth safety, as it applies to unencumbered funds in the hotline budget, not to any funds used to directly support the hotline system. However, it should be noted that any unspent General Fund dollars in this line have line item transfer authority to the Child Welfare Block, which could impact the ability to use these funds for this purpose in the future.

This budget is to stand up and run a statewide, coordinated 24/7 hotline that can triage and route calls accordingly, and can serve as a backstop if counties are unexpectedly busy. Over the years, many counties have contracted directly with the Hotline County Connection Center (HCCC) based in Prowers County for them to take their county's after-hours calls or all calls. This allows counties to reduce or eliminate their own hotline staff and/or operations, and to save block dollars on their own staff and overhead, but this is above and beyond what CDHS contracts with the HCCC for. If you were to call the hotline right now, you would get an automated message to say the name of the county where the child you have concerns about lives. If this is seamless, the caller is routed straight to that county. If there are questions or confusion about anything, or if that county contracts with the HCCC to take its referrals, the caller gets routed to an HCCC hotline operator and not a county. The report rate is set by the HCCC to account for additional staff and administrative costs to provide full-time or after-hours call coverage services for both Child Protection and Adult Protection abuse/neglect reports, not through this budget. From 2016-2025, the per-call rate increased slightly, from $22 to $25. The latest increase, which will be implemented in the new MOUs between the HCCC and counties, is to $32 per call, and was due to cost of living and scaling to need. Notably, a call (referral) takes about 45 minutes to complete with the concerned party. This, in addition to tying up the referral information, sending it to the county, totals about an hour per event, not including overhead, ancillary duties (answering email reports and other inquiries), and staff benefits.

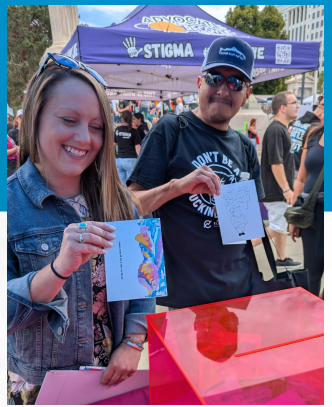
For most counties, the annual cost for HCCC call coverage services is less than 1 FTE. The HCCC currently does 24/7 full-time call coverage for 47 counties and after-hours call coverage for 11 additional counties. Because of the quality and benefit to the many counties, the number of those the HCCC serves continues to grow.

Through this same funding stream, the state increased the HCCC budget for SFY 25-26 to account for 1 additional call taker, 1 additional supervisor, and increased administrative costs. Through the hotline budget for the state, we pay for 14.4 FTE call takers, 1 manager, and 3 supervisors at the HCCC. All additional HCCC staff

(approximately 10 call takers) are paid through the county MOUs for their requested call coverage. Of the Big 11 Counties, Weld uses the HCCC full-time, while Pueblo, Larimer, El Paso, Douglas, and Mesa use it after hours.

67. *Sen. Kirkmeyer/Rep. Sirota:* What is the anticipated service impact to reducing funding for the child abuse and neglect hotline if funding that is unutilized from the hotline can be transferred to the Child Welfare Block, and the General Fund appropriation to the Block is not sufficient to cover 80.0 percent of county expenditures? **(Slide 132)**

    Unspent General Fund dollars in the hotline line item may be transferred to the Child Welfare Block at the end of each state fiscal year. A reduction to this line would therefore leave fewer unspent dollars available to help cover any portion of county allocations that exceed the annual appropriation. However, these transfers have not been sufficient to fully cover overspending in recent years, two counties exceeded their allocations in FY 2023-24, three counties in FY 2024-25, and current projections indicate the transfer will not cover spending that exceeds the appropriation this year. The amount associated with this reduction request represents 4 percent of the total overspend in FY 2023-24 and 3.7 percent of the total overspend in FY 2024-25.



Behavioral Health Administration

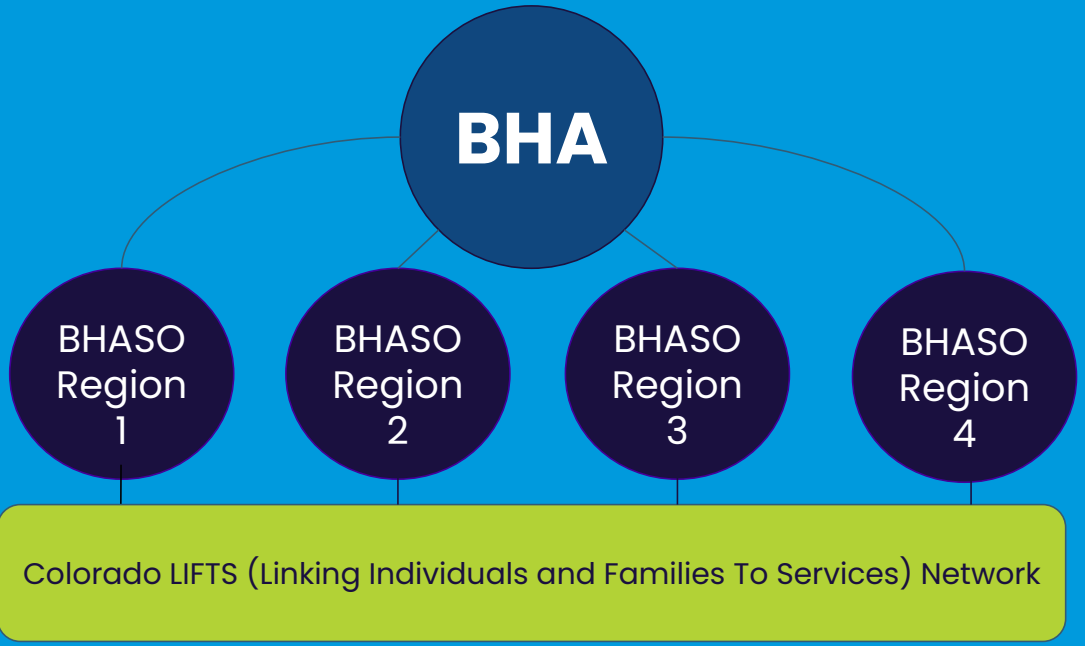
Joint Budget Committee Presentation, Dec. 2025

Dannette R. Smith, Commissioner
Monique Maurice, Chief Financial Officer
Kelly Causey, Deputy Commissioner of Programs
Aisha Rousseau, Chief Strategy Officer

COLORADO
Behavioral Health Administration

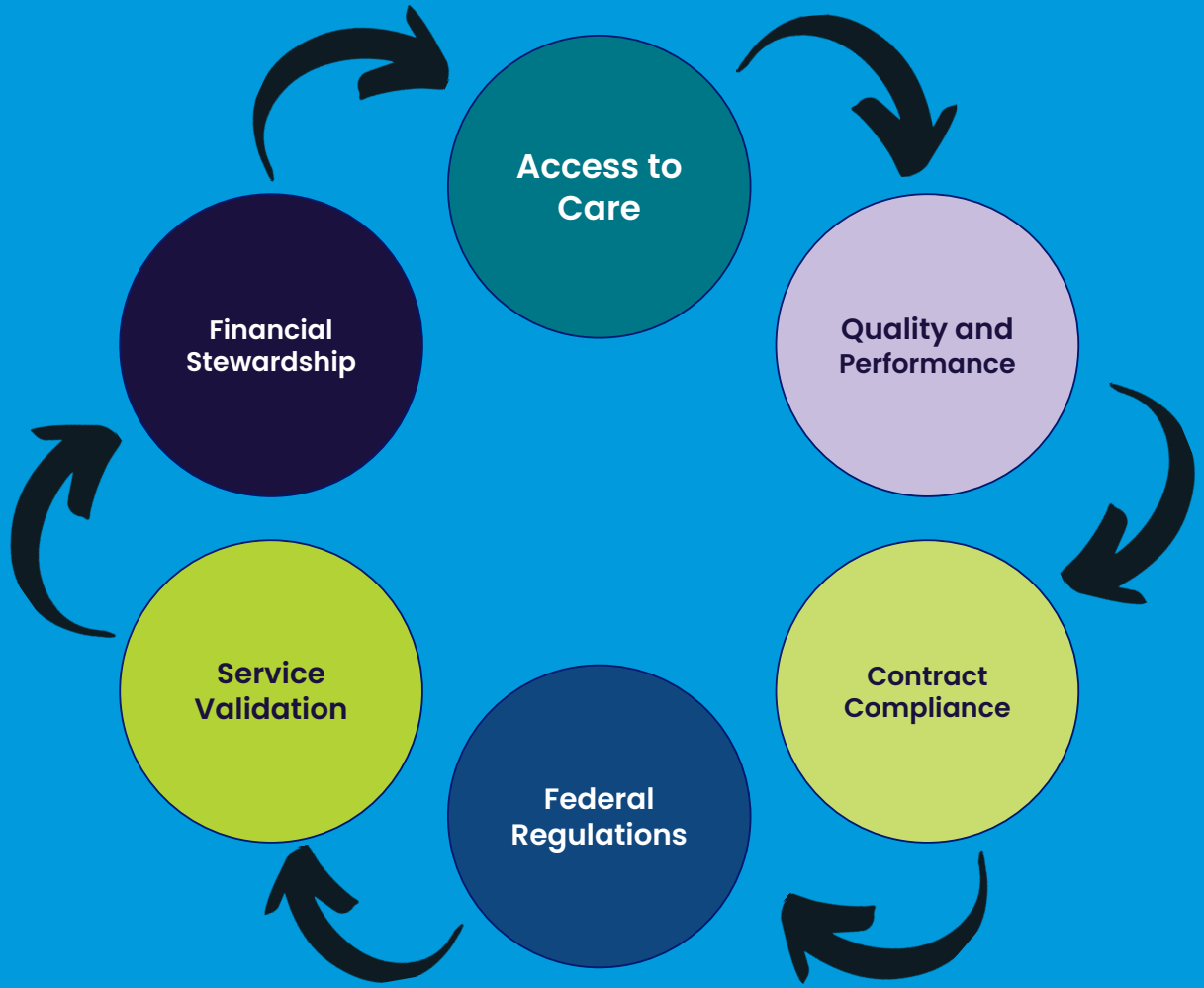
Dannette Smith,
BHA Commissioner

BHASO Model



Q1 p.1-4

BHA Oversight: Increasing service access and outcomes, including priority populations and criminal justice services



Q2-4 p. 4-12

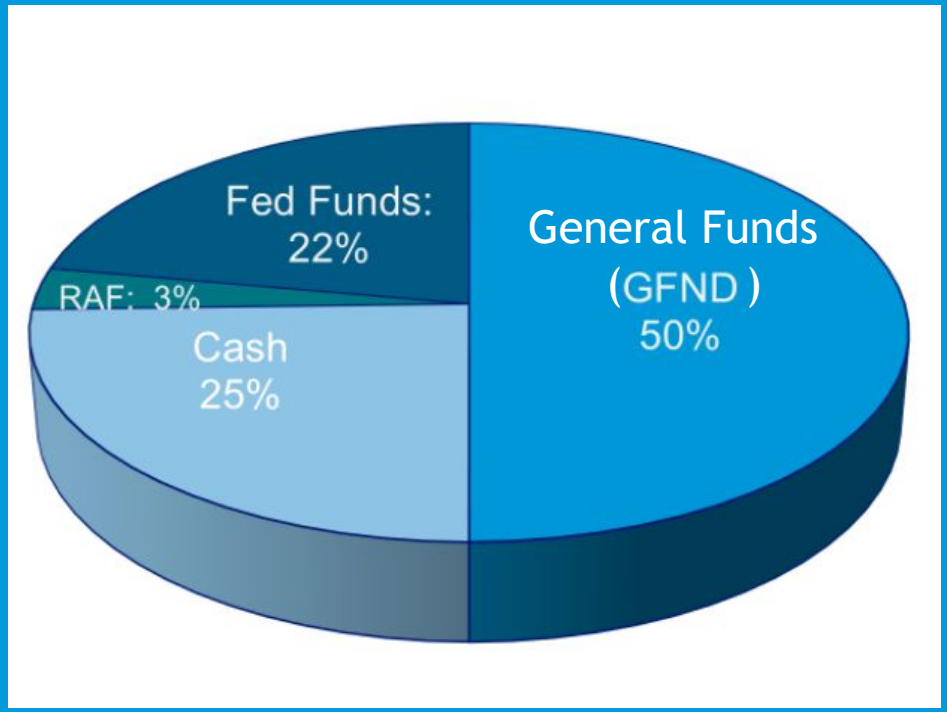
Coordination of Services & Duplicative Efforts

- Consistent communication, collaboration, and coordination with each state agency that administers behavioral health programs for efficient delivery of services
- Ensuring programs and investments share the same goals

Q5-6 p. 12 - 17

Monique Maurice,
Chief Financial Officer

Total Funds by Funding Type



BHA FY 2027 Budget Request At a Glance

R1	*-4.0 FTE Administrative Reduction*	**-$550K**
R2	*Repeal of Safety Net Technical Assistance Program*	**-$500K**
R3	*SUD Treatment Capacity Building Grant Program*	**-$3M**
R4	*Reduction to Support Certified Individuals*	**-$250K**
R6	*Recovery Support Services Grant Program 'Recycled Statewide Reduction'*	**-$1.6M**

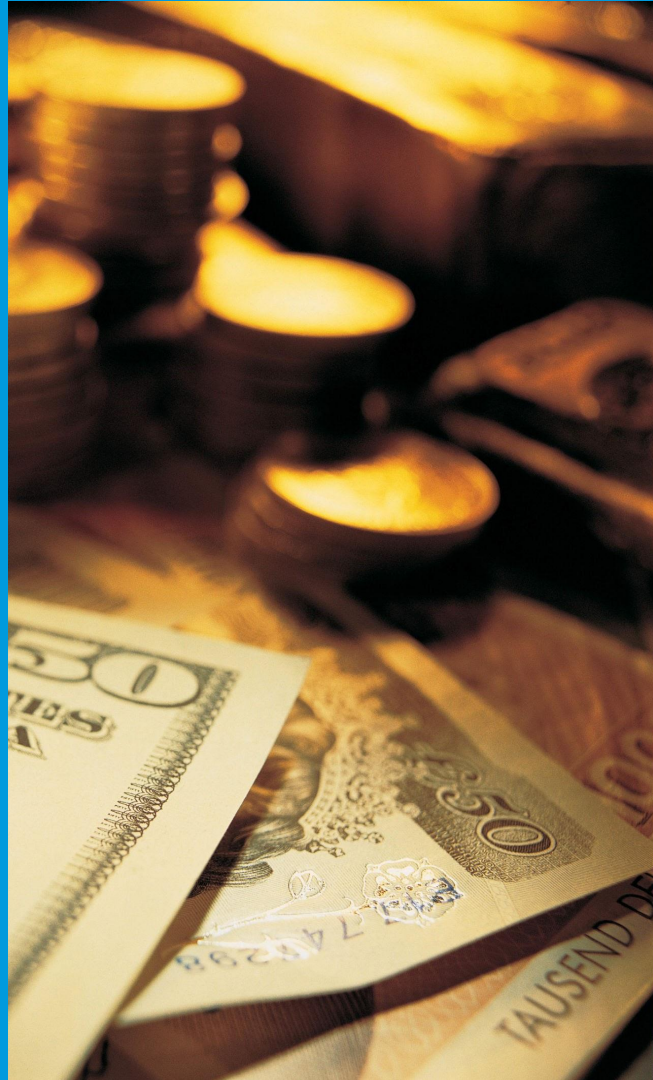
Total $5.9 Million

Budget Request 3

SUD Treatment Capacity Building Grant Program

- NO reduction in access to services
- Ensures that service funding for active programming is maintained
- Focus on sustaining ongoing services for existing programming through a refinance of funds

Q7 p 17-18



Budget Request 3 - Refinance

Repeal SUD Treatment Capacity Grant Program
HB19-1287

-$3M, Cash Fund

SUD Grant for Public Programs
SB10-175

+$3M, Cash Fund
-$3M, General Fund

Q7 p.17-18

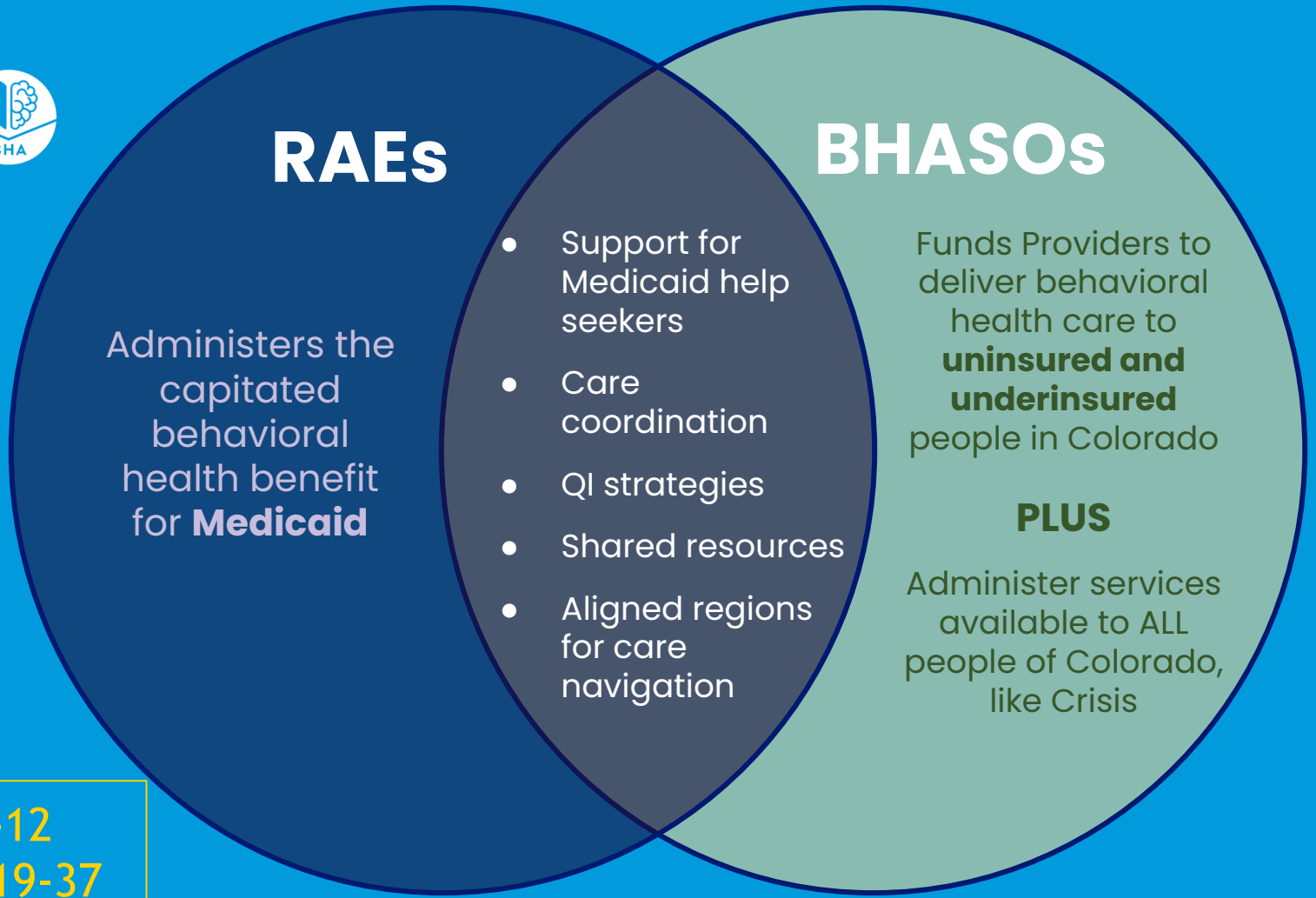
Budget Request 4

Reduction to Support Certified Individuals

- Request reduces funding for civil commitment care coordination based on caseload
- The IMD waiver increase will NOT have an impact on the caseload for this program
- Support services are voluntary, many individuals choose not to engage

Q8 p.18-19

Dr. Kelly Causey,
Deputy Commissioner of Programs


RAEs
Administers the capitated behavioral health benefit for **Medicaid**
Support for Medicaid help seekers
Care coordination
QI strategies
Shared resources
Aligned regions for care navigation
BHASOs
Funds Providers to deliver behavioral health care to **uninsured and underinsured** people in Colorado
PLUS
Administer services available to ALL people of Colorado, like Crisis

Q9-12
p. 19-37

ARPA

- $62M invested in capital projects through ARPA funds
- Ribbon cutting of Clinica's Crisis Walk-in and Addiction Services Center

Q13-16 p. 37-49

Regulation of Recovery Residences

- Third Party Certifications
- Recovery Residence Reimbursements
- State Oversight - Legislative Agenda Item

Q17 p. 49-50

I Matter

- 18,375 individual youth served in all 64 counties
- Over 76,000 total sessions
- Any reductions could mean…
  - Less access to therapy
  - Fewer providers, fewer appointments
  - Potential for waitlists

Q18-20 p.51-55

School-Based Mental Health

August 2025
51 Commitments in Rural and Underserved Communities

School Year: 2025/2026
120 Schools Under Contract and Participating

Q21 p. 56

HB 24-1038

Concerning addressing the high-acuity crisis for children and youth in need of residential care

- 75 youth served
- No current waitlist
- No need to involve Child Welfare

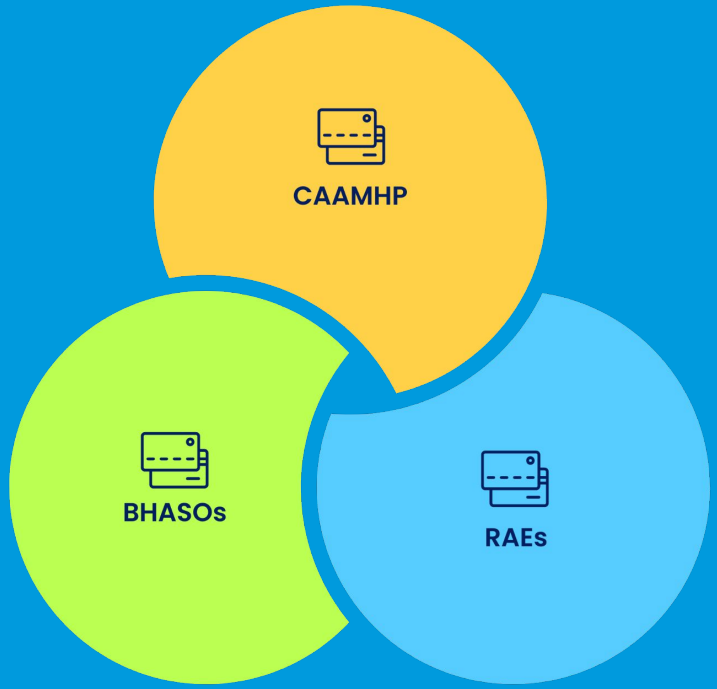
Q22 p. 63-64

Dr. Aisha Rousseau,
Chief Strategy Officer

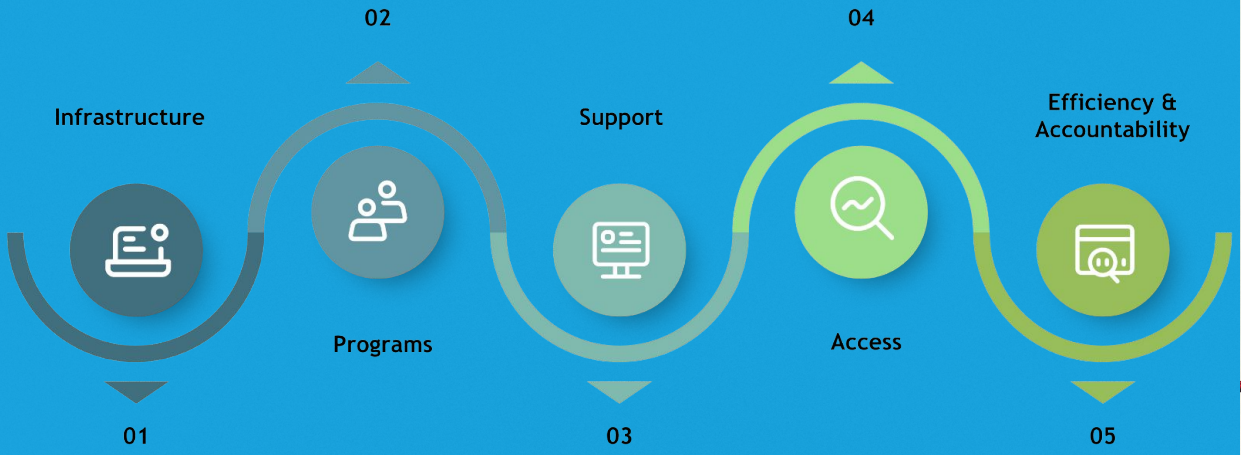
Rural Behavioral Health

Q23-24 p. 65-66

- Vouchers administered through the Colorado Agricultural and Addiction Mental Health Program (CAAMHP)
- Vouchers covered 280 hours of therapy in FY 25 for 56 individuals
- Additive, not duplicative, of BHASO and RAE services



In Closing


01
Infrastructure
02
Programs
03
Support
04
Access
05
Efficiency & Accountability

Thank You

bha.colorado.gov
@BHAConnect

COLORADO
Behavioral Health
Administration

The Ombudsman for Behavioral Health Access to Care (BHOCO) Presentation to the Joint Budget Committee 12/16/2025

Presented by:
Sarah Davidon, Ed.D., Co-Ombudsman
Rebecca Swanson, MPP, Co-Ombudsman

Behavioral Health Ombudsman of Colorado

BHOCO At a Glance

Notable Issues FY 2024-25

Questions?

Behavioral Health Ombudsman of Colorado (BHOCO) At a Glance

Established by Colorado HB18-1357 and HB19-1269

Neutral party to help navigate and resolve issues and ensure compliance regarding consumer access to behavioral health care, including care for mental health conditions and substance use disorders.

In 2025
BHOCO received
and responded to
more than **350**
new cases

BHOCO neither provides nor funds direct behavioral health care services.

Not limited in scope by type of funding source, geographical location, facility or service type, or connection to any other state or local system.

BHOCO Notable Issues 2024-25

ISSUE 1: Lack of clear facility oversight

Lack of clarity regarding who oversees some entities.

In some cases, there was no appropriate agency to file a complaint with, and therefore no investigation or resolution for a complaint.

.

ISSUE 2: Long-term care facility evictions and discharge to inappropriate care levels

Denial of re-entry to a long-term care facility - sometimes after months or years of residence.

Subsequent discharge from acute care to homeless shelters or to homes of family members who expressed that they were not capable of providing the level of care that was needed.

Perpetuates a cycle of emergency rooms and mismatched care solutions for those who have already been approved for long-term supports.

ISSUE 3: Persistent gaps in behavioral health services for children with high intensity support and service needs

Emergency departments as de facto holding spaces, sometimes for weeks, straining healthcare resources

Children discharged with no safe placement

Limited availability of residential treatment for youth and robust, accessible in-home and community-based alternatives

Long-Term Planning Goals

1. Collaboration with local, state and federal entities
2. Robust data management and case management
3. Mental health parity and access follow-up

Staff

Aubrey Boggs - Appointed Ombudsman
(Specialties: complex case management, criminal justice and housing systems, peer counseling and lived experience expertise)

Jane Davis - Intake Specialist
(Specialties: first point of contact, safe and warm intakes, initial assessments of needs, daily office management)

Sarah Davidon - Co-Ombudsman
(Specialties: complex case management - youth and children, case tracking systems, policy/strategy/budgeting)

Rebecca Swanson - Co-Ombudsman
(Specialties: complex case management - adults, mental health parity and access laws, policy/strategy/budgeting)

Sarah Younggren - Consultant
(Specialties: complex case management - youth and children, expertise as practicing provider)

Questions?

Contact information:
Website: www.bhoco.org
Email: ombuds@bhoco.org

COLORADO
Department of Human Services

We are the people who help people

Fiscal Year 2026 - 2027

Joint Budget Committee Hearing
December 16, 2025

Agenda

10:30-12:00

- Department Overview
- Administration & Finance
- Adult, Aging and Disability Services
- Civic and Forensic Mental Health

1:30 - 5:00

- Economic Security
- Children, Youth and Families

OUR MISSION

Together, we empower Coloradans to thrive.

OUR VISION

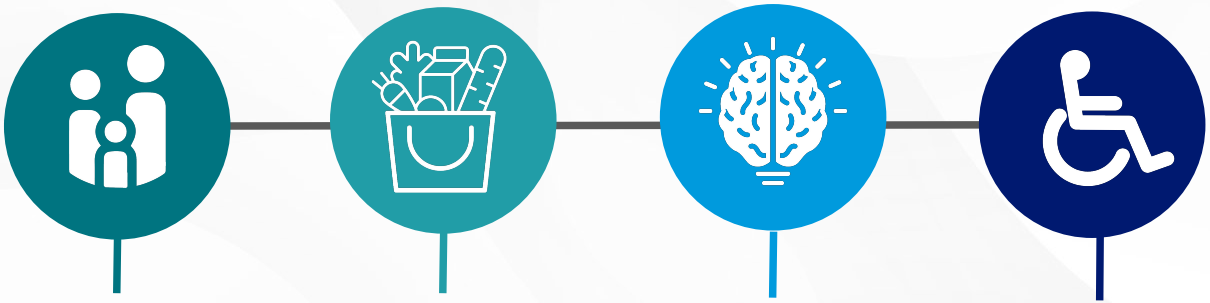
To serve Coloradans through bold and innovative health and human services.

OUR VALUES

- A people-first approach
- We are ethical
- Collaboration helps us rise together
- Transparency matters
- Balance creates quality of life
- We hold ourselves accountable

CDHS Overview

Through four distinct programmatic offices, **our work supports people and families at every stage of their journey through life** - from childhood to adult and aging services.



People and Places

We serve 1 in 8 Coloradans across the State

We have over 5,000 employees, with over 70% serving in direct care

Two lanes of service

Direct Care

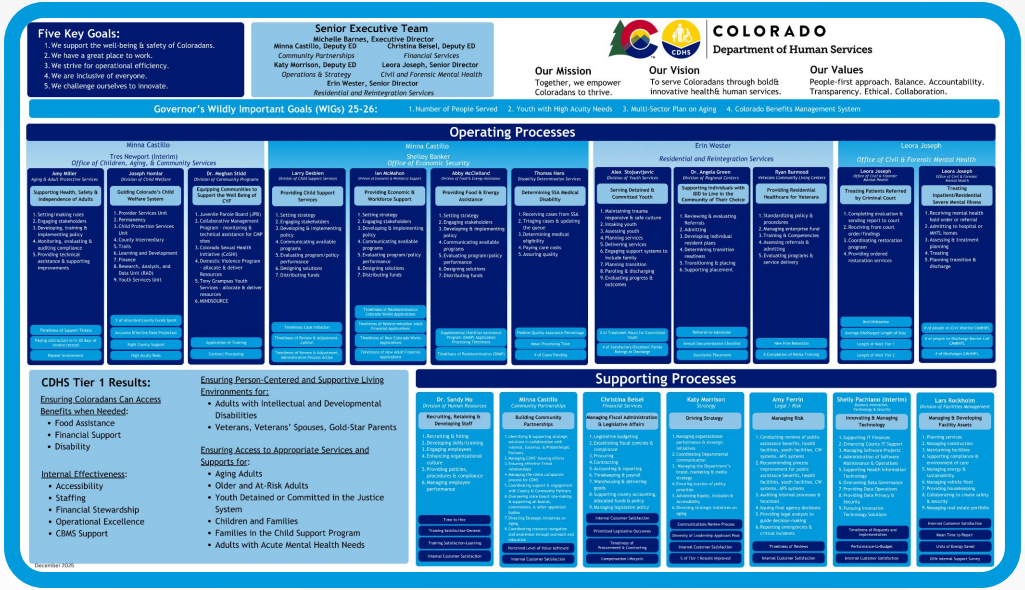
- Mental Health Hospitals
- Regional Centers
- Youth Services Centers
- Veterans Community Living Centers

County & Community

- Food, housing and energy assistance
- Child and family services
- Older adult services
- Disability services

Keeping ourselves accountable to Coloradans

A focus on process prioritization, project management, and accountability is a commitment CDHS has made to strengthen how we run the organization in order to fulfill our vision.



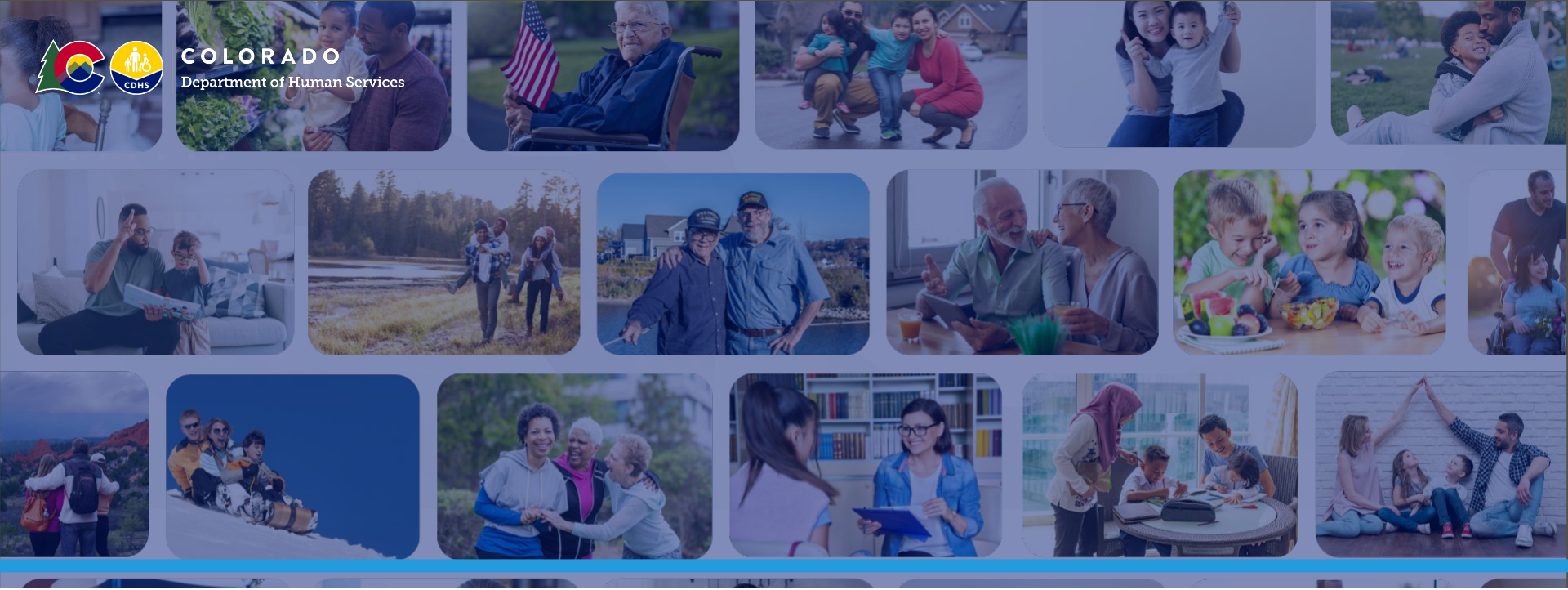
Our focus is on preserving the most critical services for our clients

We need to pivot with urgency to continue to provide basic social safety net services.







Executive Director's Office/Administration & Finance

R-09 General Administrative Reduction

Reducing **administrative costs** frees up resources to **invest in other critical areas that support Coloradans.**

Our goal is to preserve the most critical services for the people we serve. We are strategically looking at our priorities to **ensure this commitment is met.**

Technology that puts Coloradans first

Our systems are designed around the people who use them, we work to ensure they are modern, easy to use and client-focused.

Technology strengthens our support for Coloradans by:

Broadening Our Reach

Digital, accessible tools help services reach more Coloradans, including those in rural areas and people with disabilities.

Ensuring Quality Care

Our technology systems, like our electronic health records systems, help staff manage health information and keep patients safe and well.

Promoting Evidence-Based Decision-Making

Data analytics help us understand what's working, identify gaps and target resources effectively.

Payments to the Governor's Office of Information Technology (OIT): Performance to Budget (Q3, pg5)

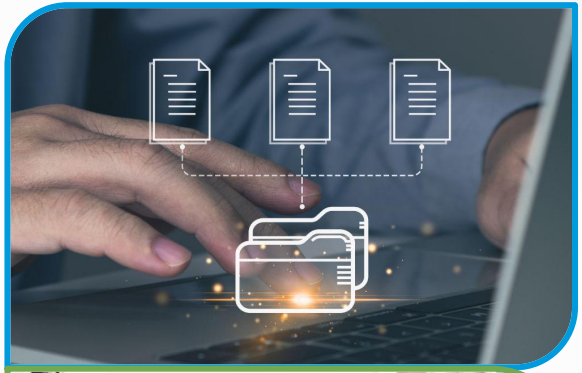
In coordination with OIT, a joint **Performance to Budget** initiative aims to improve accuracy in tracking IT investments, more effectively translate program needs to OIT, and conduct thorough reviews of OIT contracts to ensure appropriate billing.

Colorado Benefits Management System (CBMS)

- Serves as the central technology platform for processing applications and determining eligibility for Colorado's public assistance programs

  Supports eligibility and enrollment for: Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), Medicaid, Colorado Children's Health Plan and Adult Financial Assistance

- Utilized by state and county human service employees for case processing and management



CBMS Update (Q4, pg6)

CDHS and HCPF collaborating to implement H.R. 1 changes:

- Maximizing the use of SNAP work requirements verifications to meet new Medicaid community engagement requirements for dually-enrolled
- Addressing common root causes of errors that impact PER (SNAP) and PERM (Medicaid)

Looking ahead: CDHS and HCPF collaborating to develop a plan to modernize the CBMS ecosystem to:

- Implement a more holistic and integrated solution to better meet user needs and drive efficiencies
- Enable programs to be able to adapt to challenges more nimbly

Thank you!
Questions?

COLORADO
Department of Human Services

Office of Adult, Aging & Disability Services

Fiscal Year 2026 - 2027

Agenda

- OAADS divisions
- Aging and Adult Protective Services
  - State Unit on Aging
  - Adult Protective Services
- Division of Regional Centers
- Veterans Community Living Centers

Aging and Adult Protective Services

Division of Regional Centers

Veterans Community Living Centers

Disability Determination Services

Office of Adult, Aging and Disability Services

Aging and Adult Protective Services (AAPS)

COLORADO
Department of Human Services

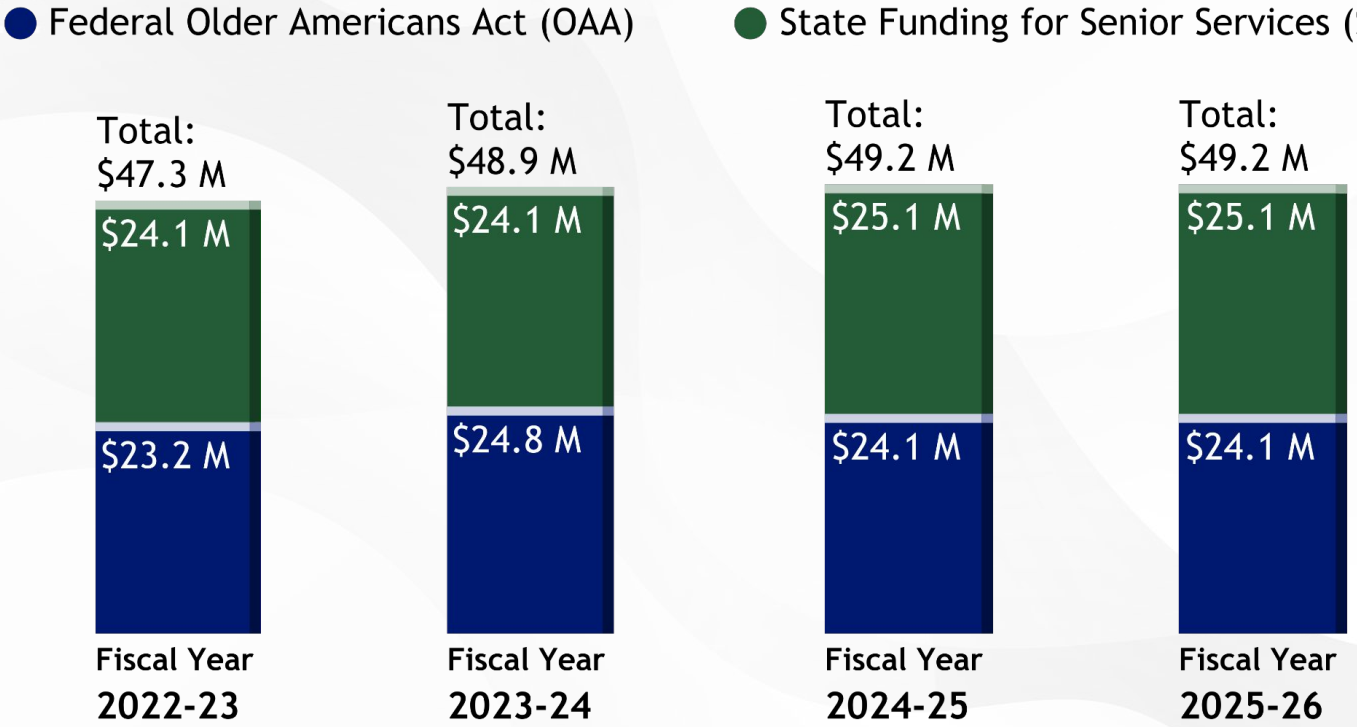
State Unit on Aging (SUA)

Supports older Coloradans to **age-in-place** in their communities.

Delivers services to those 60+ and caregivers through **16 regional Area Agencies on Aging (AAAs)** and local provider agencies.

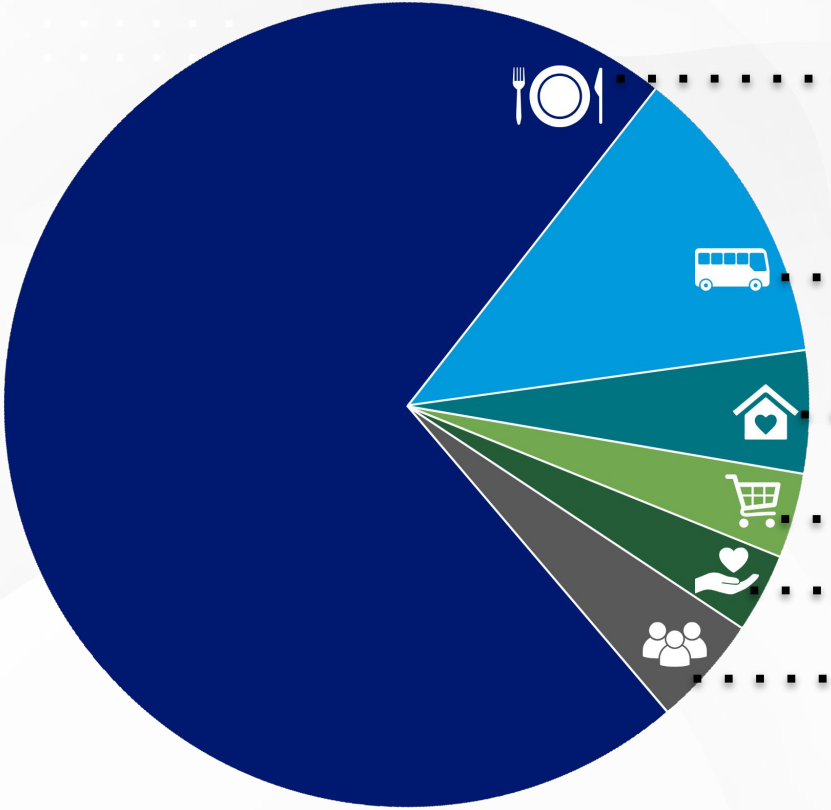
Served over **45,000 older Coloradans** last year.

Federal, State & Total Funding for Senior Services by Fiscal Year



*Does not include one time funding from the American Rescue Plan Act (ARPA) or the Homestead Act.

Area Agency on Aging Services Provided in Fiscal Year 2024-25

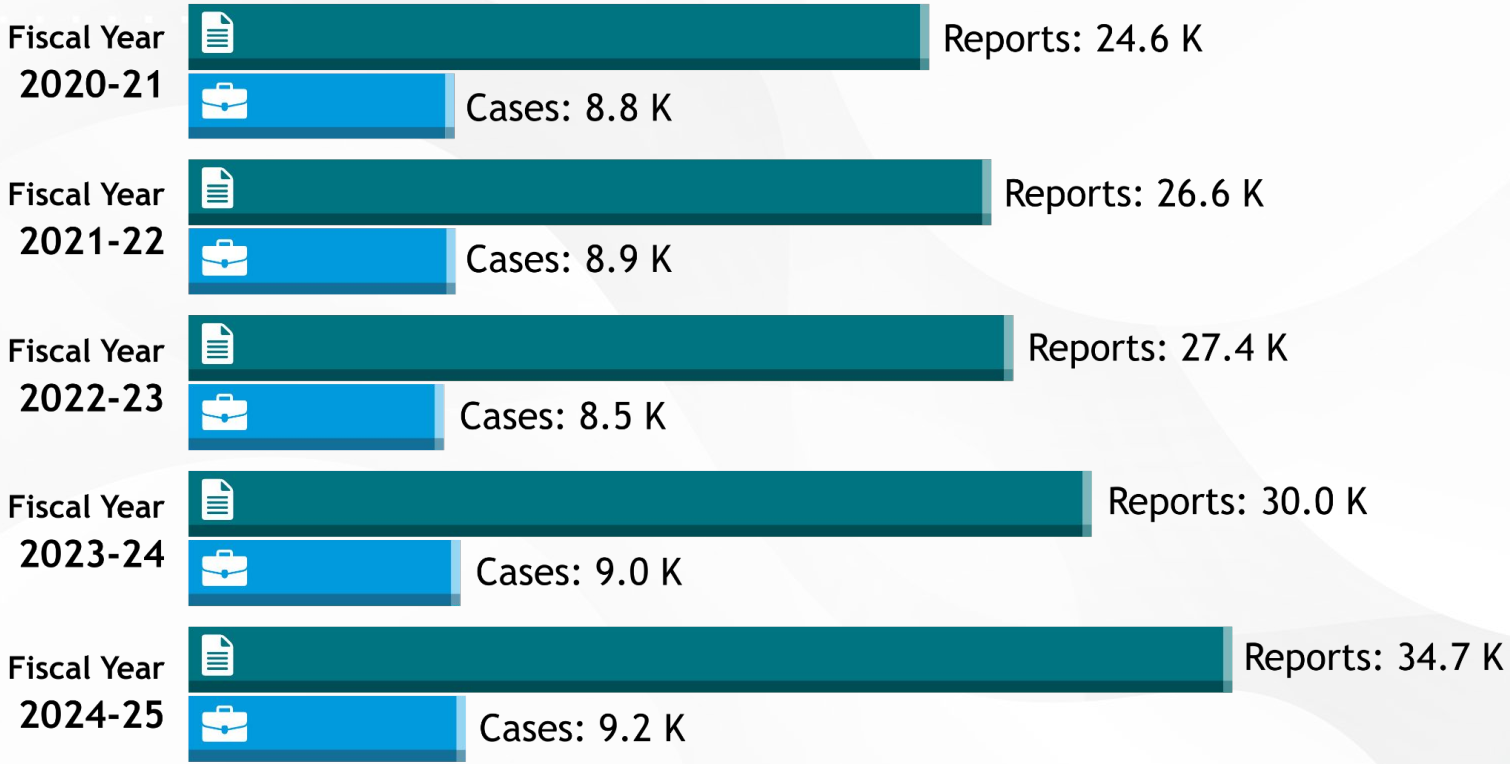


- Meals — 71.7%
  - Home delivered: 68%
  - Congregate: 32%
- Transportation — 12.1%
- In-Home & Adult Day — 5.0%
- Material Aid — 3.4%
- Caregiver Support — 3.2%
- Other — 4.5%

Adult Protective Services (APS)

APS is a state-supervised, county-administered program that investigates allegations of mistreatment and self-neglect involving at-risk adults and provides protective services to increase safety and reduce risk.

APS Reports and Case Numbers by Fiscal Year



Office of Adult, Aging and Disability Services

Division of Regional Centers (DRC)

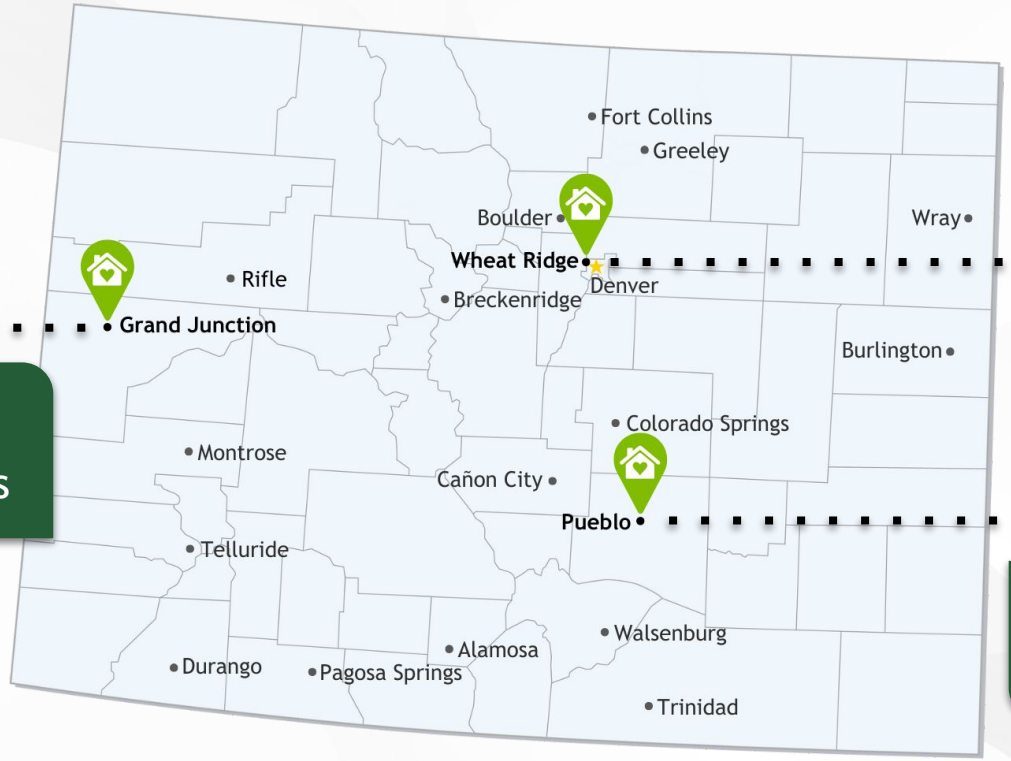
COLORADO
Department of Human Services

What We Do

- 24/7 residential and nursing staff
- Additional supportive services:
  - Behavioral
  - Community transitions
  - Therapies and medical
- Employment First and Supported Employment
- Community integration activities
- Day programs

Daily life for the individuals at CO's Regional Centers.

Division of Regional Centers



Wheat Ridge

19 group homes

Grand Junction

11 group homes

Pueblo

9 group homes

Sen. Amabile — Are there waitlists for placement at the Regional Centers? If so, which Centers have a waitlist and how long is it? (Q7, pg9)

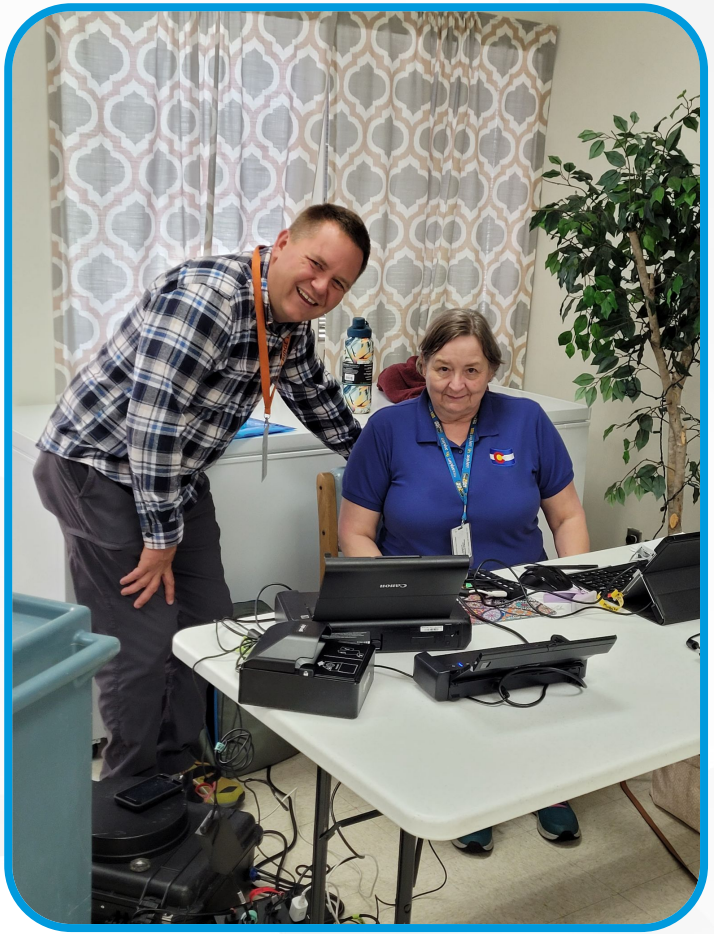
No waitlist for placement in our group homes for individuals who meet admission criteria.

R-10: DRC Electronic Health Records (EHR) System Reduction

Reduction of $290,000 in Fiscal Year 2026-27 and ongoing.

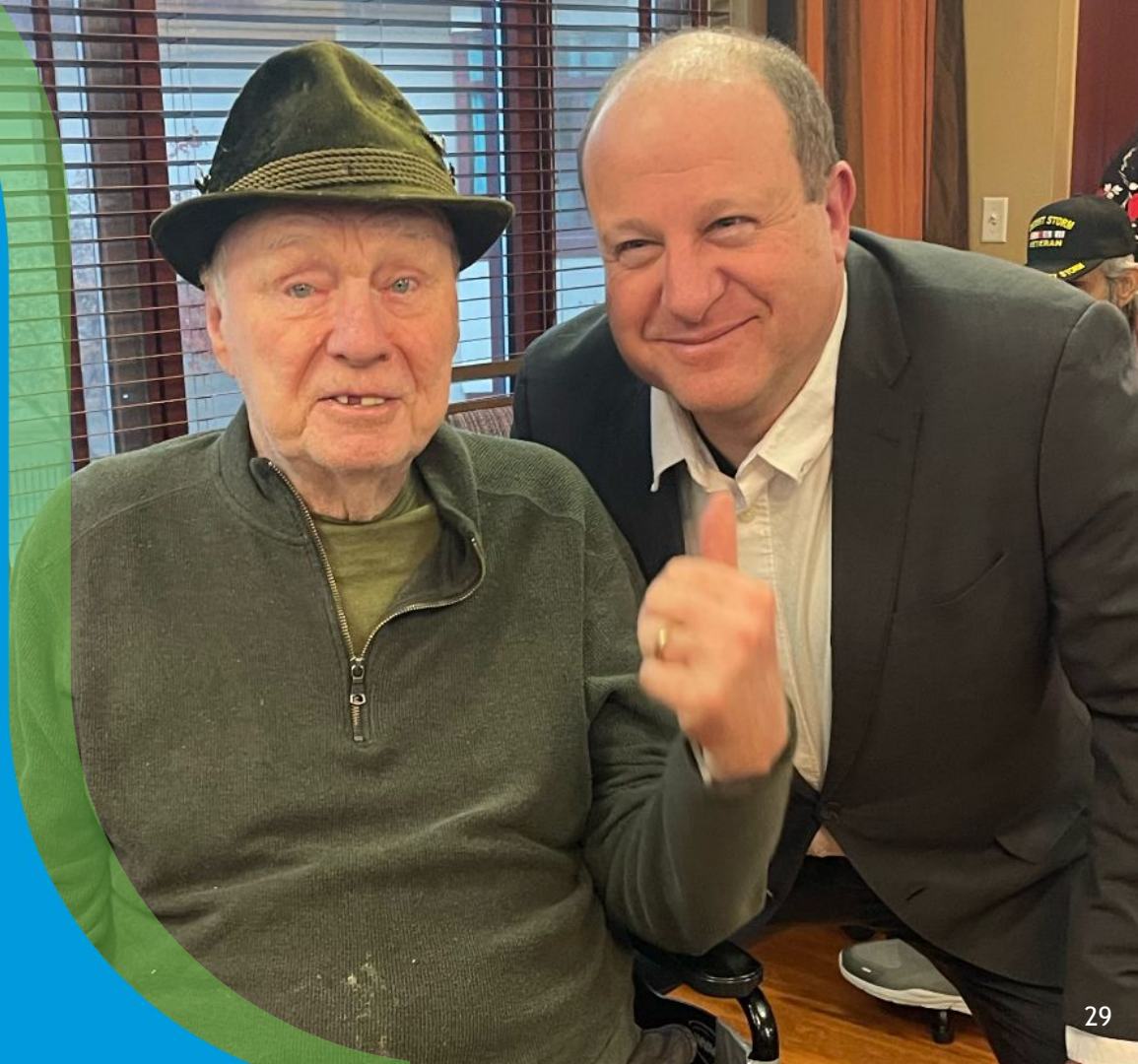
- Project implementation began in 2017-2018 using phased-in project lifecycle.
- In final project phase, which includes:
  - Staffing
  - Subscription costs

Reduction does not impact operations.



Office of Adult, Aging and Disability Services

Veterans Community Living Centers (VCLCs)



Veterans Community Living Centers

VCLC at Fitzsimons in Aurora

VCLC at Rifle

Bruce McCandless VCLC at Florence

VCLC at Homelake

Spanish Peaks VCLC* in Walsenburg

*Spanish Peaks is a public/private partnership.

VCLC Update

Maurice “Mo” Wade, 77

- U.S. Army veteran who served in Vietnam
- Avid rodeo roper
- Received care and rehabilitation at VCLC at Fitzsimons for knee injury
- Fox31 covered his recovery and named him “Serving Those Who Serve” Hero of the Month

Thank you!

Questions?

COLORADO
Department of Human Services

COLORADO
Department of Human Services

Office of Civil and Forensic Mental Health

Fiscal Year 2026 - 2027

Joint Budget Committee Hearing
December 16, 2025

Agenda

- Overview of the Office of Civil and Forensic Mental Health (OCFMH)
  - What we do
  - Who we serve
- Overview of Competency and the Waitlist
- Budget Requests
  - R-04: Adjustments to Mental Health Funding Sources to Increase Restoration Beds
  - R-11: Peer Support Contract Reduction
  - R-15: Forensic Community Based Services Operating Reduction

Overview of Office of Civil and Forensic Mental Health

What we do and who we serve

Office of Civil and Forensic Mental Health

Mental Health Hospitals

Provide inpatient behavioral health services for civil and forensic patients

Forensic Services

Provide evaluation, treatment and case management to the forensic population statewide

Mental Health Transitional Living Homes (MHTL)

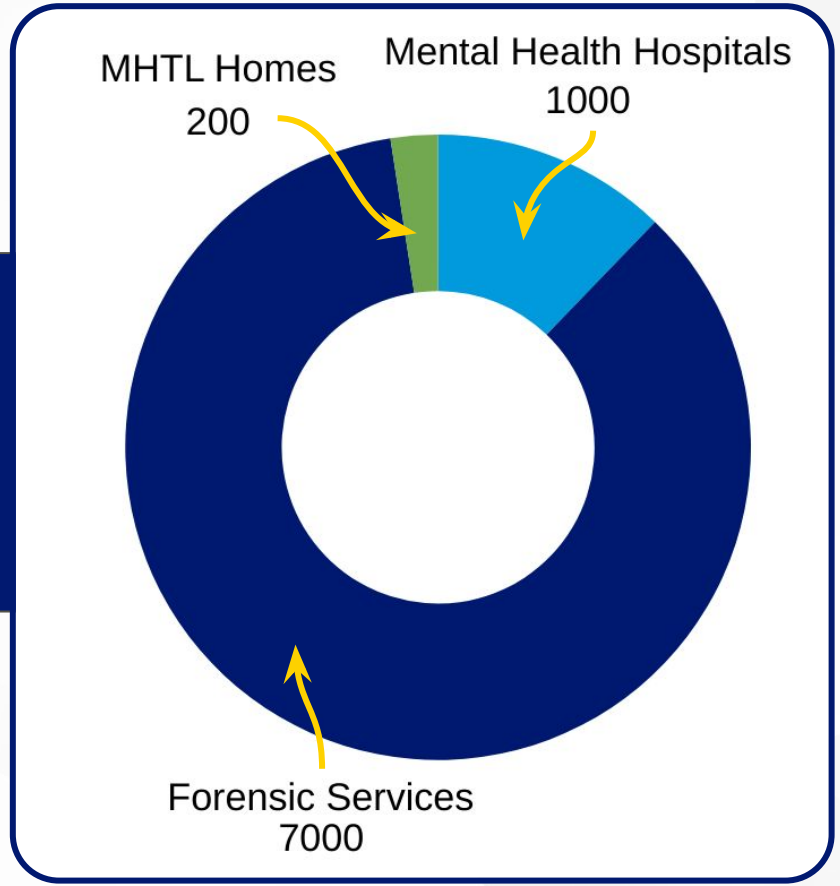
Provide a less restrictive setting for individuals with severe mental health conditions

Psychiatric Residential Treatment Facility (PRTF)

Serving youth with complex diagnoses, the PRTF will act as an access hub for a variety of services, all in one place, designed to help kids heal and thrive.

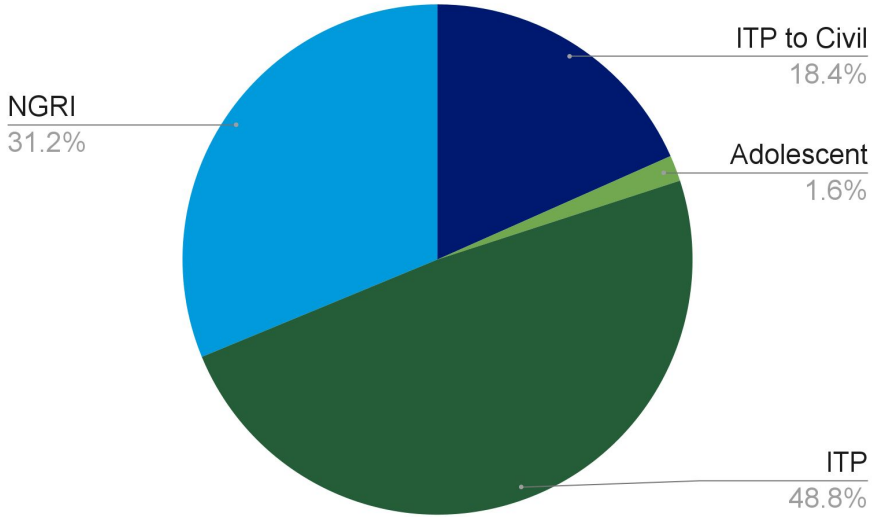
Patients Served Per Year

All OCFMH programs together serve about **8,200** Coloradans per year.

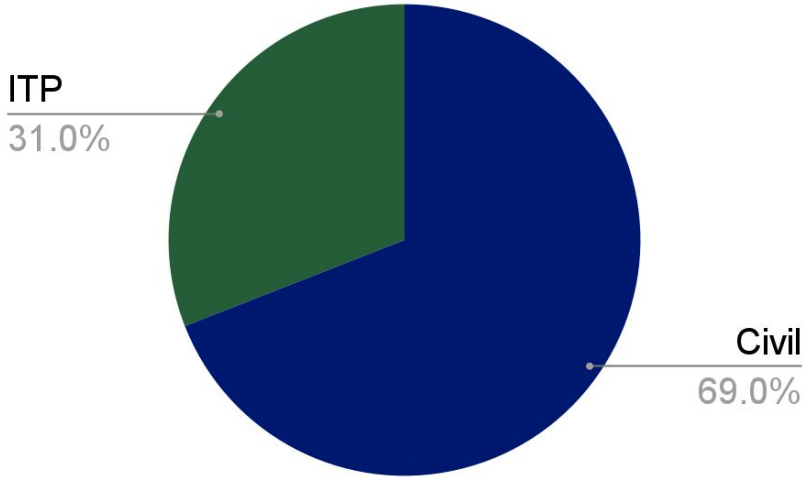


Populations OCFMH Hospitals Serve

Colorado Mental Health Hospital in Pueblo (CMHHIP) Census



Colorado Mental Health Hospital in Fort Logan (CMHHIFL) Census



Psychiatric Residential Treatment Facility (Q13, pg14)

- Funded by HB 22-1283
- Will serve youth with severe mental health needs.
- First state-owned PRTF in Colorado
- Will be operated by a contractor

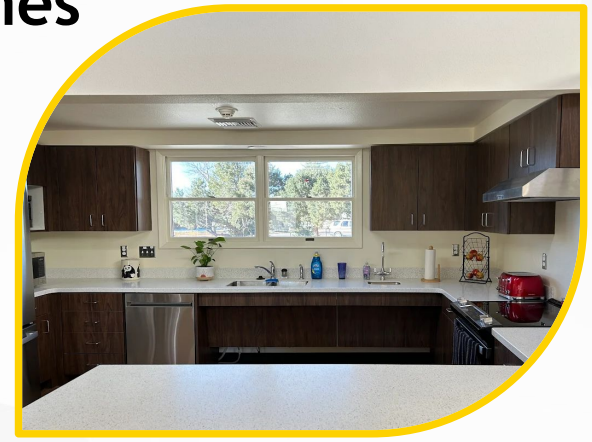
Psychiatric Residential Treatment Facility (Q13, pg14) (Q14, pg14)

- Estimated project completion January 2027
- Estimated patient admissions by March 2027
- **Funds will be fully expended by December 2027**

Mental Health Transitional Living Homes (MHTL) (Q15, pg15)

- Created by HB 22-1303
- Provides home-like environment for patients with mental health conditions
- Originally funded for 125 beds, we opened 164 beds across 16 homes

Mental Health Transitional Living Homes (Q15, pg15)



Overview of Competency

What is competency?

A legal construct that refers to an individual's current capacity to function meaningfully and knowingly in a legal proceeding.

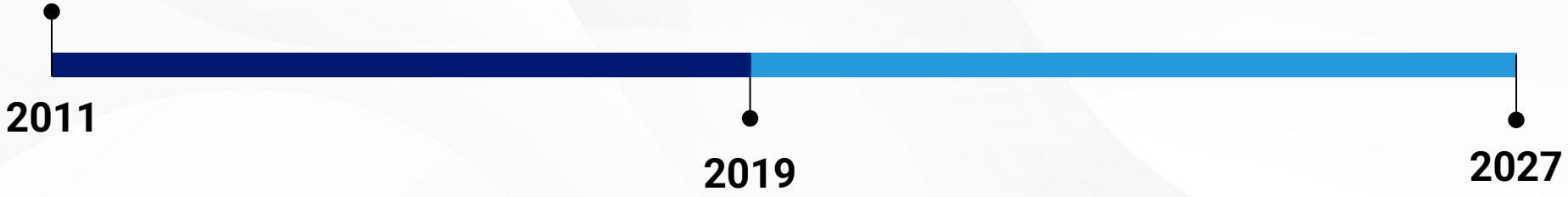
Competency services are about due process in criminal cases, not about holistic mental health treatment.

The Mental Health Hospitals do provide mental health care in tandem with competency restoration services, however, this treatment ends once individuals are restored to competency or they are otherwise discharged from our hospitals.

The Consent Decree Timeline

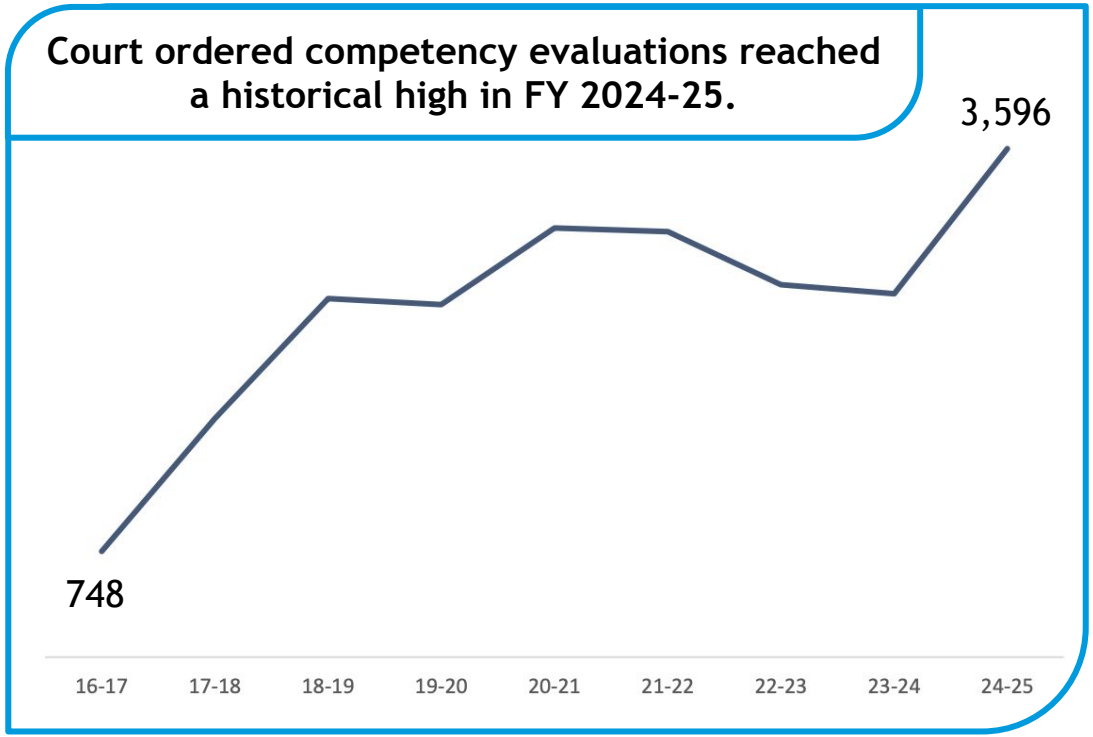
Disability Law Colorado sues Colorado Department of Human Services for failure to provide timely competency evaluations and restoration treatment.

CDHS pays approximately $12 million/year in fees and fines for non-compliance and has paid a total of $51.7M so far.



Parties enter Consent Decree.

Competency Evaluation Numbers (Q9, pg11)



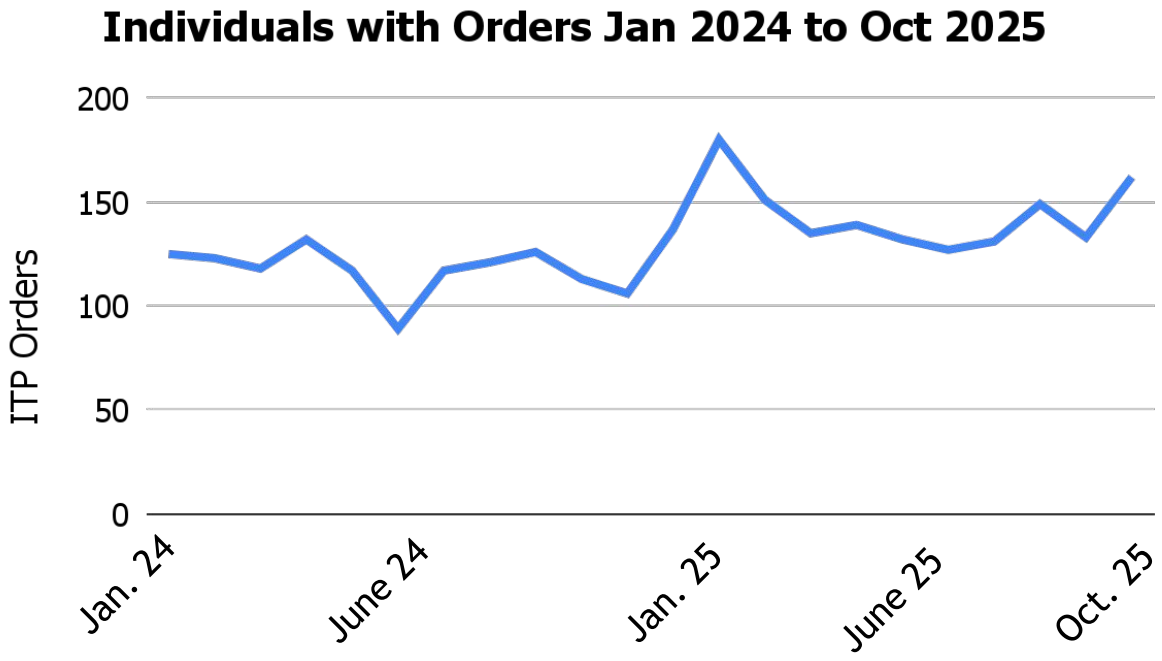
- 3,596 court orders to determine competency
- 3,087 total initial competency evaluations completed
- This is a 384% increase since 2016-17

Individuals Returning to Competency System

31.8% of individuals ordered to competency restoration since 2019 have returned to the competency system.

Increases in Inpatient Restoration Orders Since Jan 2024

- The waitlist grew because ITP orders increased.
- This year there is **a 21% increase in average monthly orders from last year.**

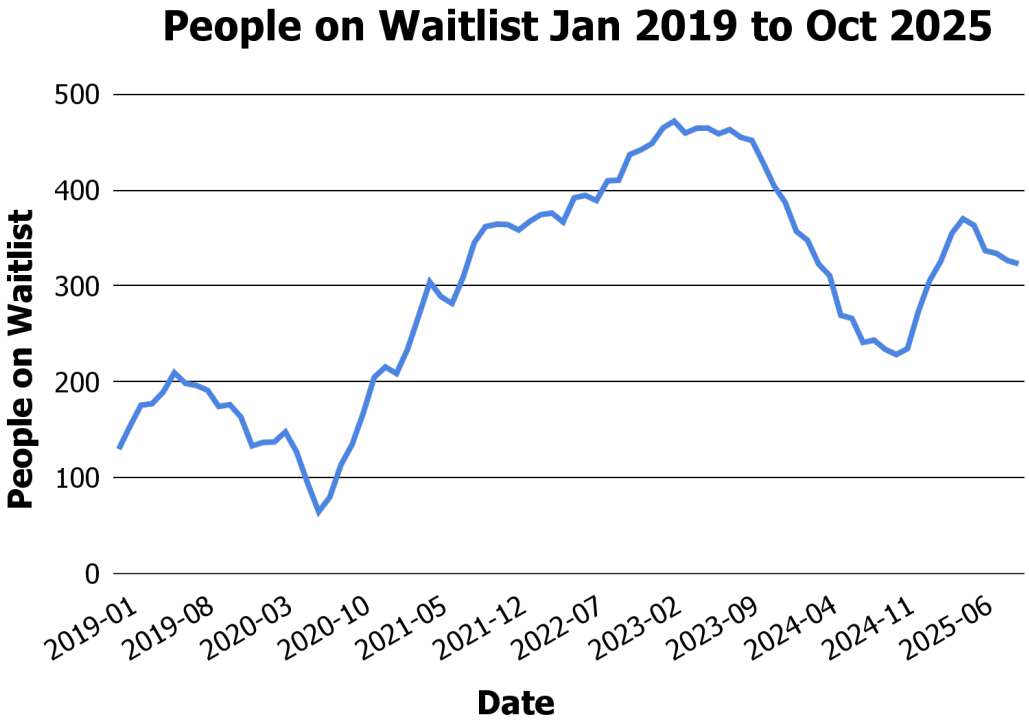


Waitlist Data

There was a considerable decrease in the waitlist in 2024 as new beds were added and staff retention efforts were successful.

The waitlist has grown since this time last year due to **considerable increases in court orders.**

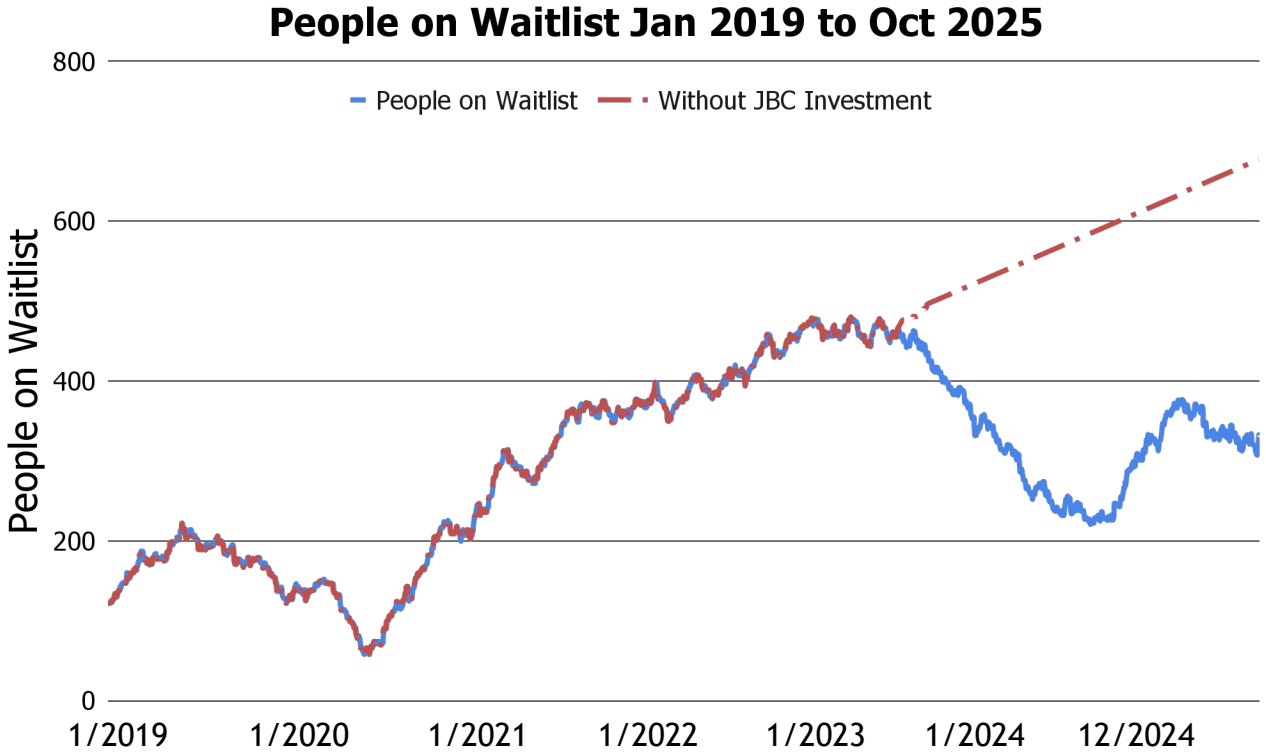
Current waitlist: 339



Forecasted Waitlist without JBC Investments (Q10, pg12)

Current waitlist: **339**

Approximate waitlist without investments: **677**



Private Hospital Beds (Q11, pg12)

Every **1** contracted private hospital bed serves about **3** patients per year

Investments Are Making A Difference

> For at least one year, the Department admitted more than 300 people to inpatient restoration every quarter—the most since the start of the Consent Decree.
>
> - Special Masters' Quarterly Report to the Court, October 2025

Competency Restoration Programs (Q12, pg13)

Location	Mental Health	Charges
Mental Health Hospitals	All needs	Pueblo: all charges Fort Logan: low to moderate charges
Private Hospital Beds	All needs	Low to moderate charges
Jail-based Restoration	Low to moderate needs	All charges
Outpatient Restoration	Low to moderate needs	Low charges

Individuals Unlikely to be Restored

Permanently Incompetent to Proceed (PITP):

Individuals who have been deemed unlikely to be restored to competency in the foreseeable future by competency evaluators.

80 out of 1,852 current ITP patients are PITP, which represents 4.32% of our population.

How is OCFMH Serving PITP Patients Now?

Tracking cases

Individual case management

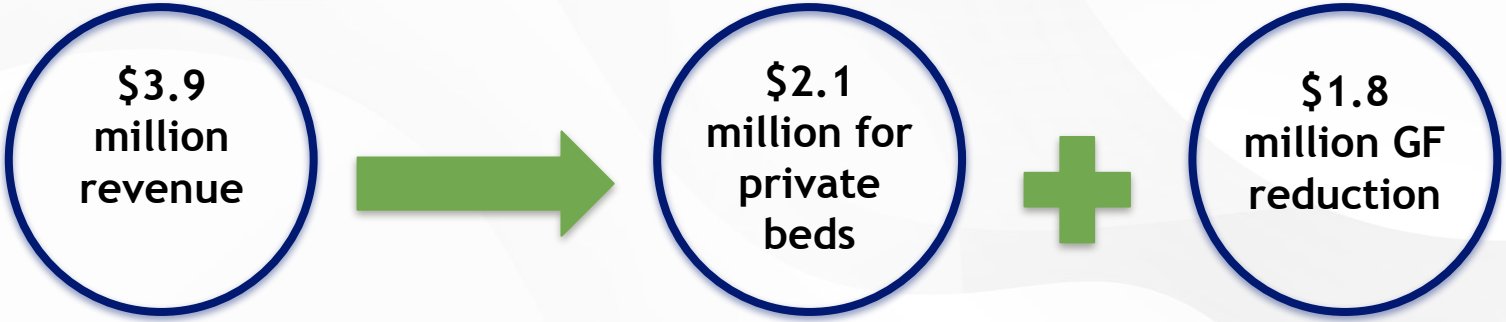
Strategic partnership

Decision Items

R-04, R-11, R-15

R-04: Adjustments to Mental Health Funding Sources to Increase Restoration Beds (Q16, pg16)

- The hospitals earn revenue from insurance, Medicaid/Medicare that exceeds current spending authority.
- This request seeks to balance budgeted funds with earned revenue.



R-11: Peer Support Contract Reduction

- Reduces OCFMH budget by $649,260 as a budget balancing measure
- Eliminates Peer Support services at the Mental Health Hospitals
- Will not affect patient treatment or outcomes

R-15: Forensic Community Based Services Operating Reduction

- Reduces FCBS budget by $300,000 as a budget balancing measure
- Historically, this program has not fully spent its appropriation
- Will not affect client treatment or outcomes

Regarding performance on the Consent Decree, **we continue to see many ways the Department has been genuinely successful**.

-Special Masters' Quarterly Report to the Court, October 2025

Thank you!
Questions?

COLORADO
Department of Human Services

Office of Economic Security

Fiscal Year 2026 - 2027

Agenda

- Overview of the Office of Economic Security
- HR1 Implications & Federal Aftermath
- Temporary Assistance for Needy Families (TANF)
- Final Solutions

Office of Economic Security ~ FY 2026-27 Requests

Funding Requests:

R-03: Addressing H.R. 1 Changes to SNAP Administration

TANF Package:
R-05/Leg-03: Reducing Financial Pressure on the Colorado Works Program

R-06: Supporting the County Block Grant Support Fund

Funding Reductions:

R-07: Reducing the Home Care Allowance Case Management Agency Appropriation

R-08/Leg-04: Reducing the Cadence of the County Administration Funding Model

R-17: Reduce Summer Food Benefits Administration

R-18: SNAP Outreach Funding Reduction

Overview of the Office of Economic Security

Who we are, who we serve and what we do

Office of Economic Security: Serving Coloradans (Q20, pg19)

Income Support

$191M in FY 2024-25

Employment Support

$51M in FY 2024-25

Food & Energy

$1.62B in FY 2024-25

Targeted Support

$60M in 2024-25

Supports for Vulnerable Coloradans

Temporary Assistance for Needy Families (TANF)

Hannah is eligible because her income is under $331. She receives $405 in Basic Cash Assistance (BCA).

Supplemental Nutrition Assistance Program (SNAP)

Hannah is eligible because of her low income and receives $513 a month.

Medicaid

Hannah and Josh also receive Medicaid.

Child Support Services

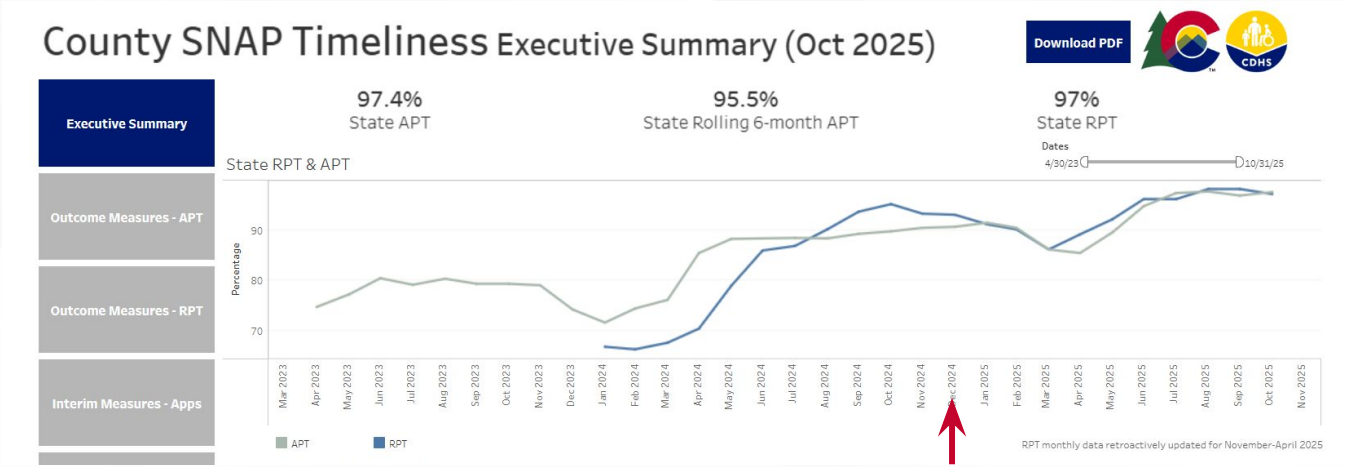
Hannah can apply for child support services to help establish paternity and secure financial support for Josh.

Hannah lives in rural Colorado with her 6 year old son Josh. She struggles to find full-time work due to high local unemployment in her county and earns only $250 a month in part-time work.

SNAP Application Process Timeliness (APT) (Q21, pg20)

In the summer of 2024, Gov. Polis announced a Wildly Important Goal to improve SNAP APT from 88% to 95% by June of 2025.

- Colorado reached 95% in June 2025
- Colorado reached 98% timeliness in November 2025, marking six months with timeliness at or over 95%



Delivering Nov. 2025 SNAP benefits (Q17, pg17)

On Oct. 1, 2025, the federal government shutdown

- On Oct. 10, USDA informed states that it would not fund SNAP benefits during the shutdown
- Colorado worked quickly to mitigate impact to vulnerable citizens

On Oct. 30, the JBC approved $10M to provide funds to food banks. Resources were distributed on Nov. 1

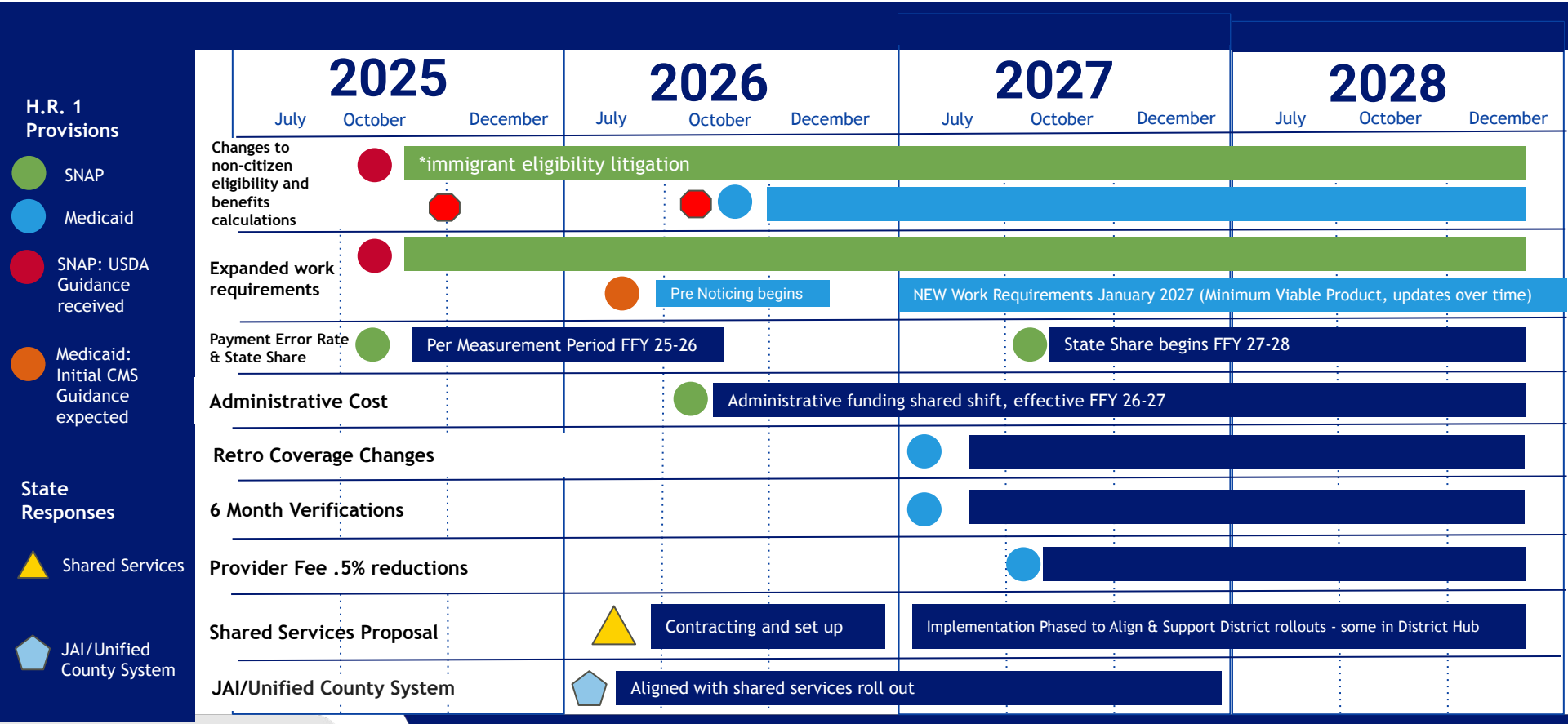
Federal shutdown officially ended the evening of Nov. 12

By the next afternoon, Nov. 13, Colorado delivered 100% of Nov. SNAP benefits to 600k eligible participants

H.R.1 Impacts and Federal Aftermath

Addressing changes to the SNAP Administration

Eligibility Timelines: H.R.1 SNAP/Medicaid Implementation & Responses



COLORADO
Department of Human Services

Updated 12.2025

2025 Government Shutdown disrupting SNAP benefits & 2026 expected SNAP benefits disruption per FNS guidance/warning at end of USDA appropriations

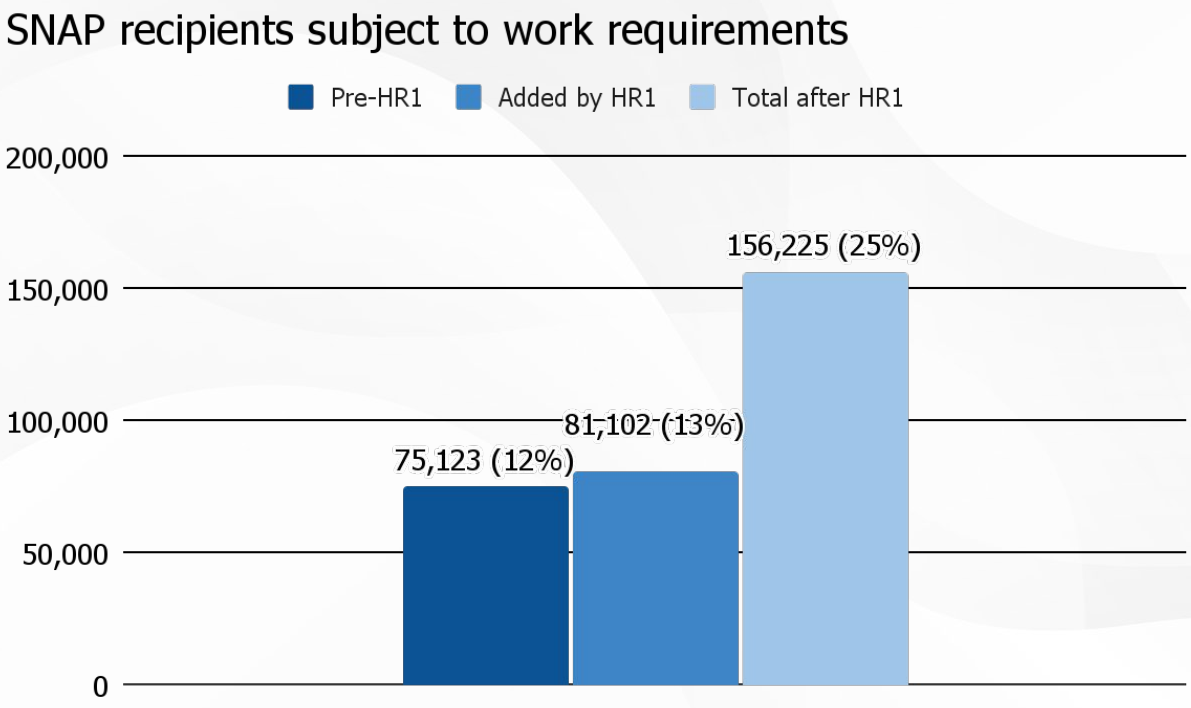
H.R.1: Three substantive components

Key Changes affecting SNAP:

- Immigration status eligibility
- Benefits calculations based on energy program participation
- Expanded ABAWD definitions (work requirements)

These changes were all effective on July 4, 2025. USDA allowances for implementation time expired on November 1, 2025.

Work Requirements Double



Administrative cost sharing (Q18, pg17)

Effective October 1, 2026

- Federal match is reduced from 50% to 25%
- Total budget would reduce by almost $50M* (based on FY 2024-25 spending)
    - County Admin = ~($31M)
    - State Admin (SNAP administration, QA, Fair Hearings) = ~($1.2M)
    - Colorado Benefits Management System CBMS (Operating, contract, pool hours, training) = ~($6.8M)
    - Other spending (Outreach, Indirects) = ~($10M)

* Totals are based on a full state FY - however, the reduction would be approximately $38 M in SFY 26-27 per the mismatch with the federal fiscal year.

R-03: Addressing H.R. 1 Changes to SNAP Administration

Goal: Offset the decrease in **federal SNAP funds** caused by H.R. 1, starting October 2026.

- **Investment:** $36.8 million in **General Fund** (FY 2026-27).
- **Ongoing Investment**: **$46.9 million** (FY 2027-28 and ongoing) to reflect a full year.
- **Purpose: Stabilize funding** and ensure the continuous delivery of **SNAP benefits** and **administrative activities** (State and County).

What is PER (Payment Error Rate)? (Q22a, pg20) (Q23, pg21)

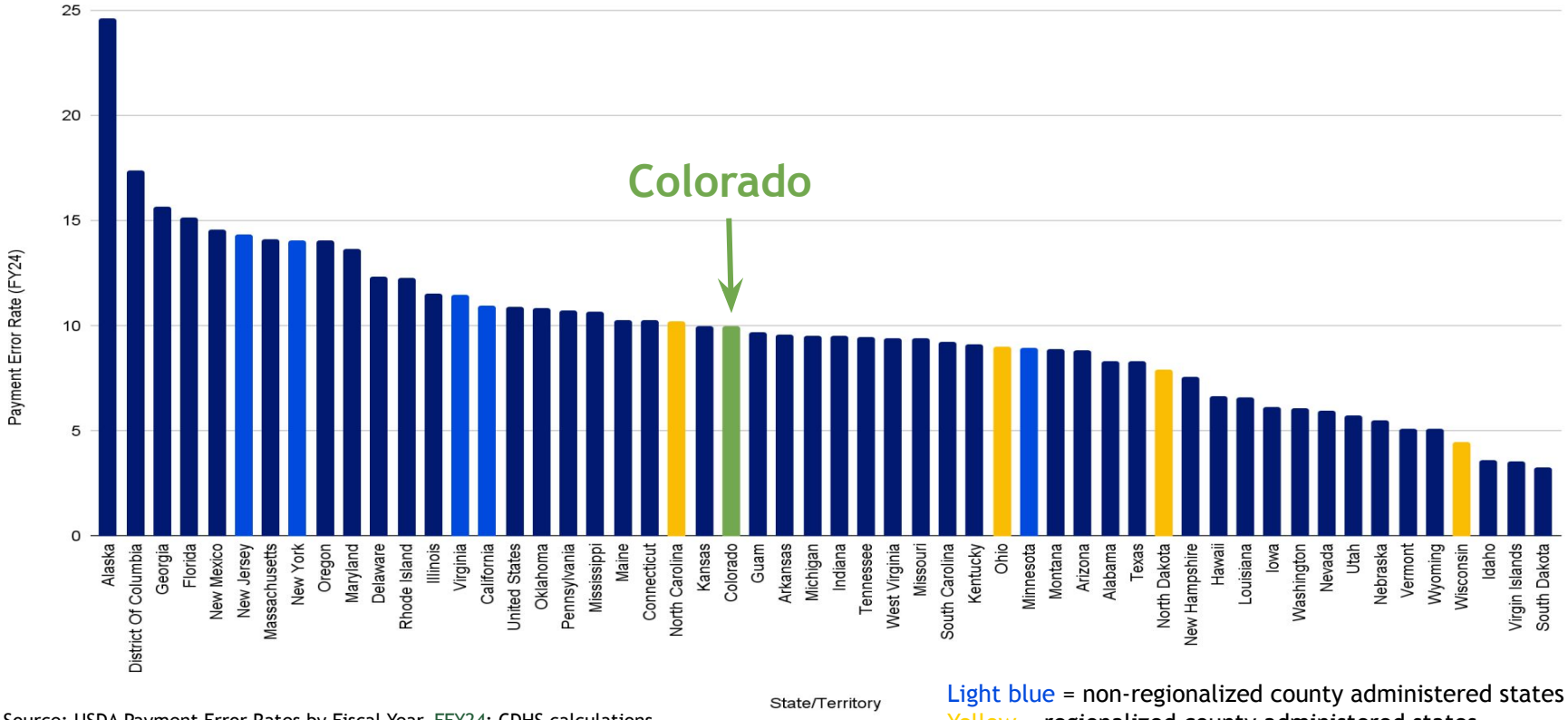
- A measure of SNAP payment accuracy
- Includes both overpayments and underpayments
    - County doesn't process a document in time or misapplies policy
    - Client doesn't submit required documentation
    - System errors
- Calculation is a highly federally regulated process, conducted by the CDHS Quality Assurance team
- Rate is statistically valid on a state level for a year - not enough sampling for more granular rates (by county or by month)

Colorado share (Q24, pg22) (Q25, pg22)

Effective date October 1, 2027

- Based on PER from FFY25 or FFY26
- Colorado's FFY24 rate is 9.97%.
- The state share amount depends on both the state PER and the caseload size

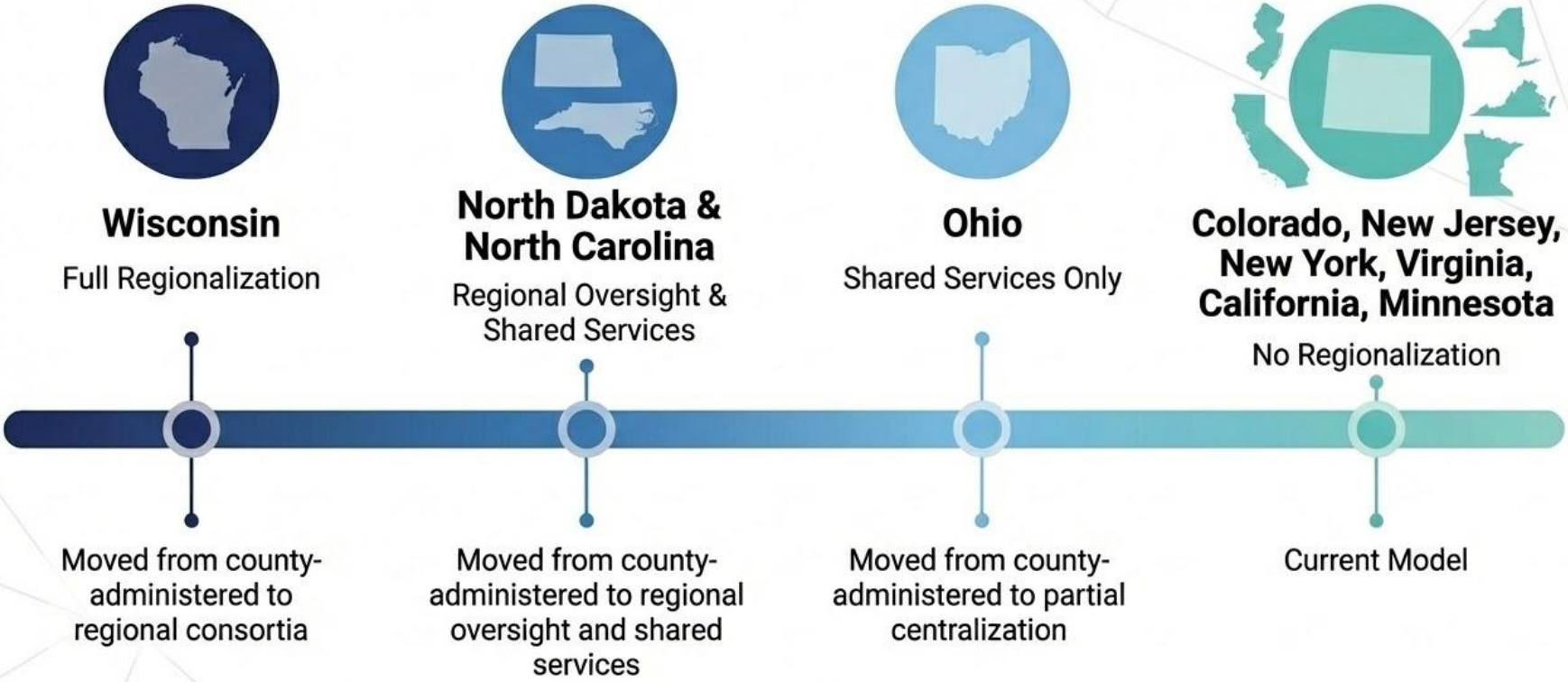
SNAP: PER & State Administrative Structure (Q22b/c, pg20) (Q26, pg23)



Source: USDA Payment Error Rates by Fiscal Year, FFY24; CDHS calculations

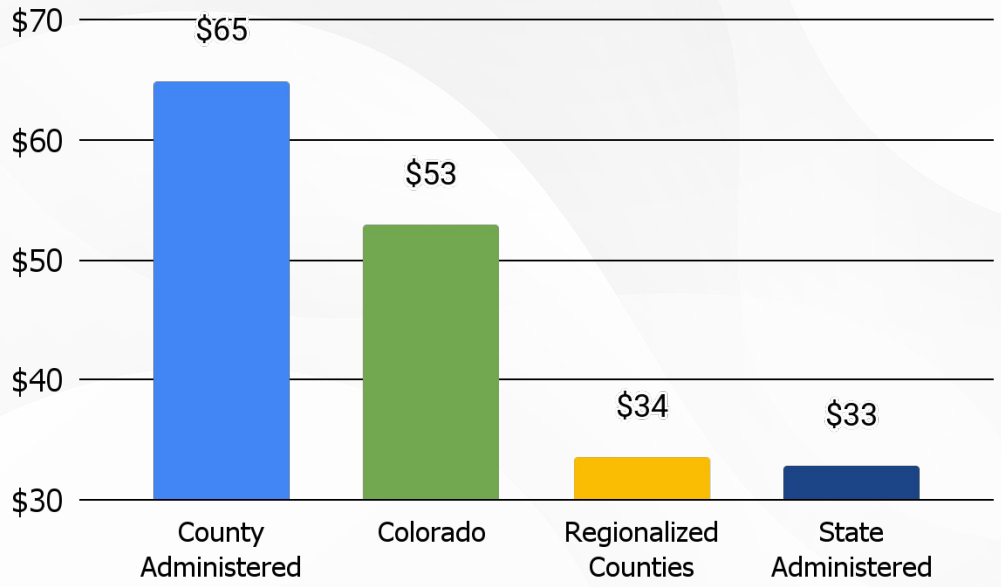
Light blue = non-regionalized county administered states
Yellow = regionalized county administered states

Spectrum of Regionalization (Q27, pg24)



SNAP: Administrative Models Impact Costs (Q26, pg23)

SNAP average monthly administrative cost per case, FY 2023



Why this matters:

States that administer eligibility at a more centralized or regional level spend $19 less per SNAP case than Colorado.

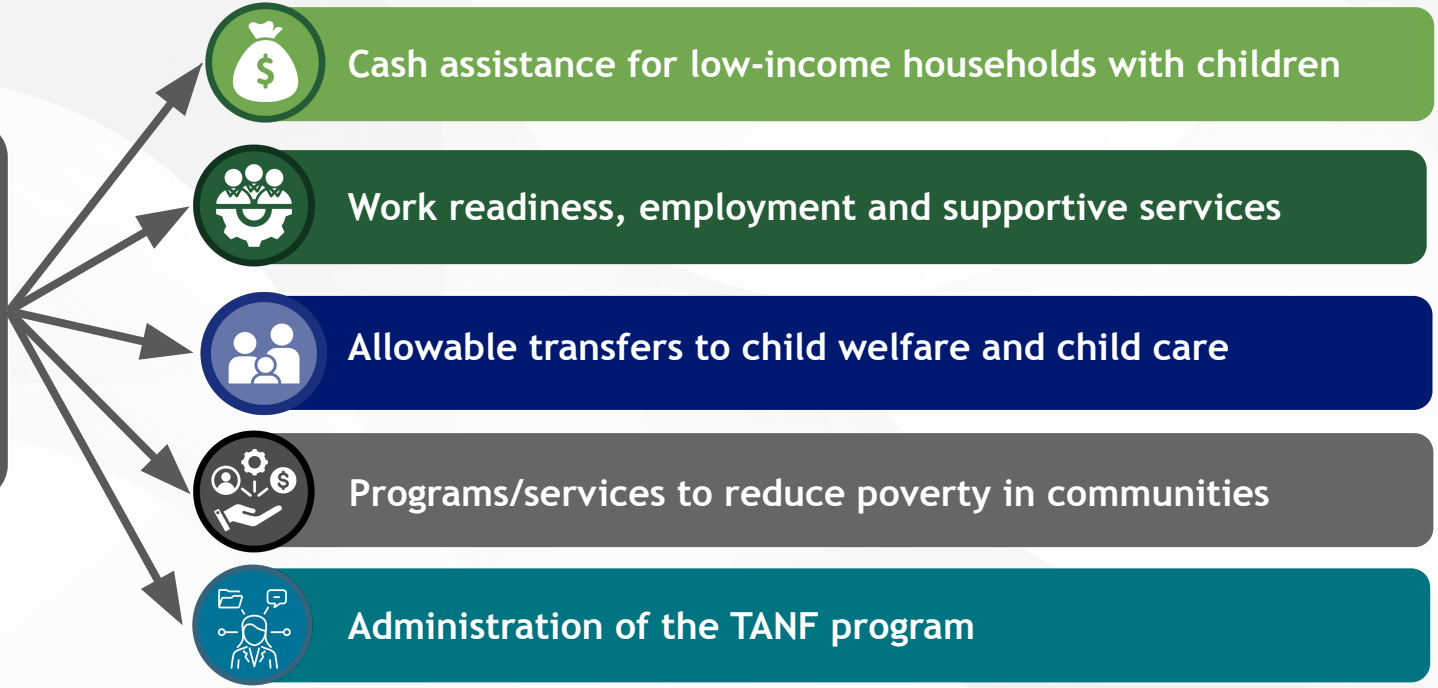
Source: SNAP State Activity Report FY 2023; CDHS calculations.

Colorado Works - TANF

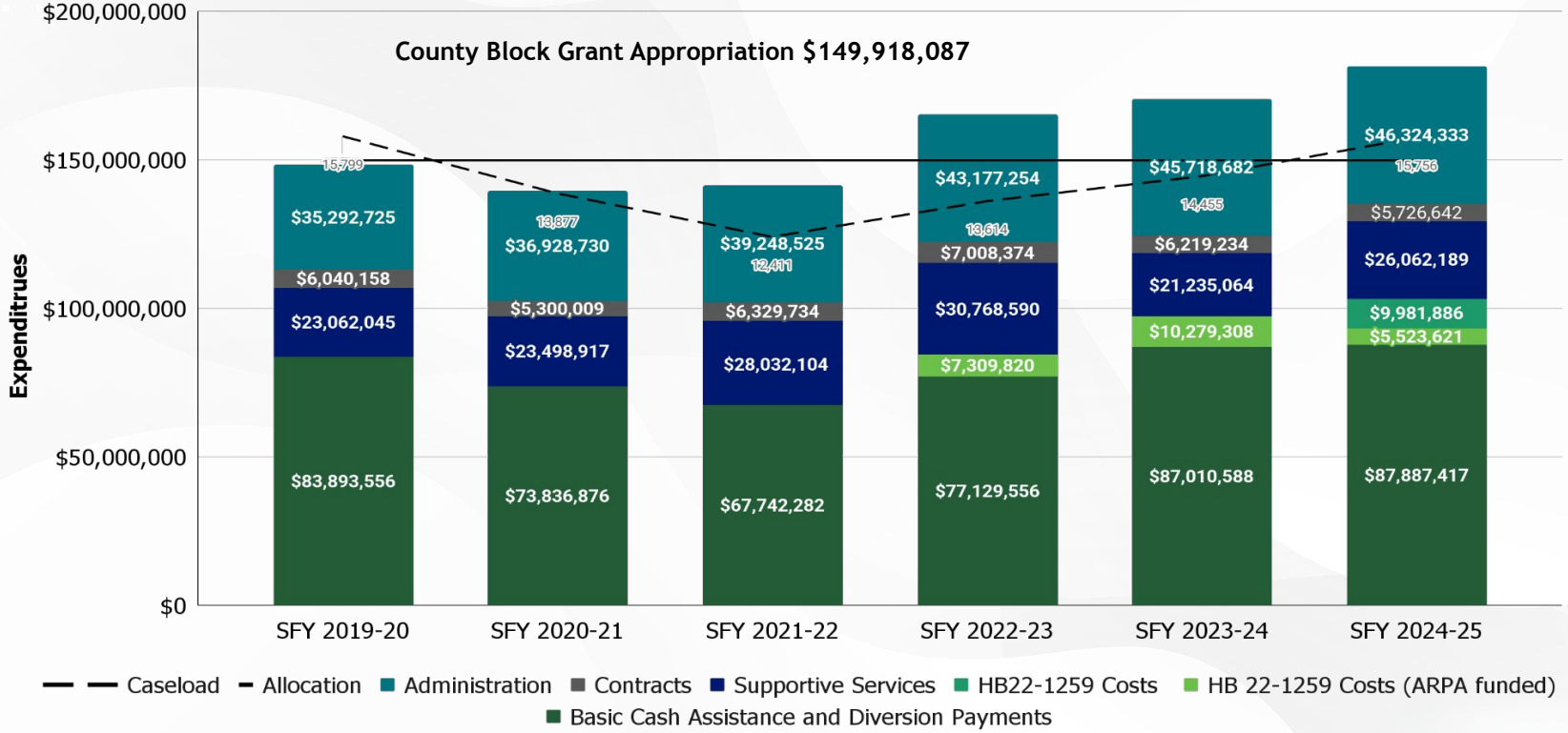
Supporting Coloradans through Income Assistance and Supportive Services

Temporary Assistance for Needy Families (TANF) (Q28, pg25) (Q29, pg25)

Federal Block Grant + Contingency, implemented within federal guidelines



County TANF Block Grant Spending by Category FY 2019/20-2024/25



FY 2024-25 County Block Grant Expenditures (Q30, pg26) (Q31, pg26) (Q32, pg27)

Administration & Case Management

$46M in FY 2024-25

Supportive Services

$27M in FY 2024-25

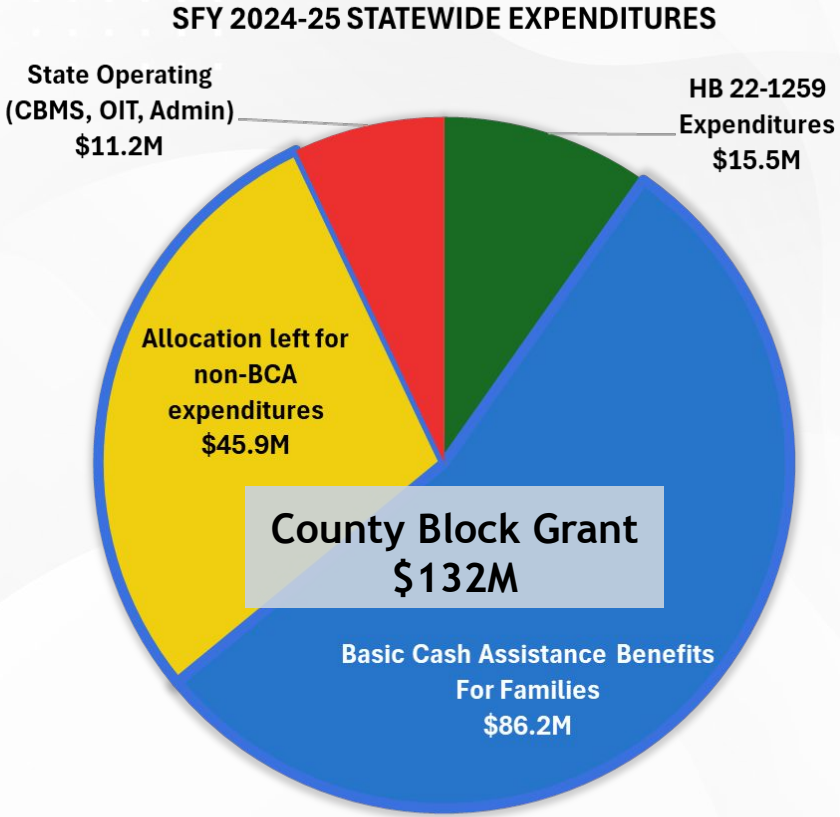
Cash Assistance for Families

$87M in FY 2024-25

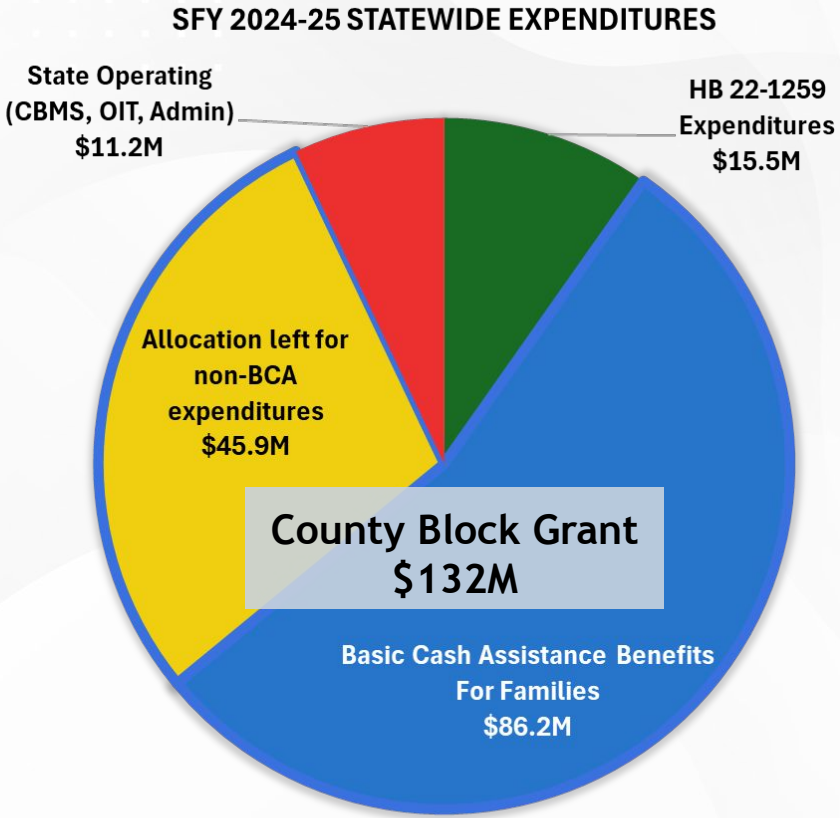
Contracts

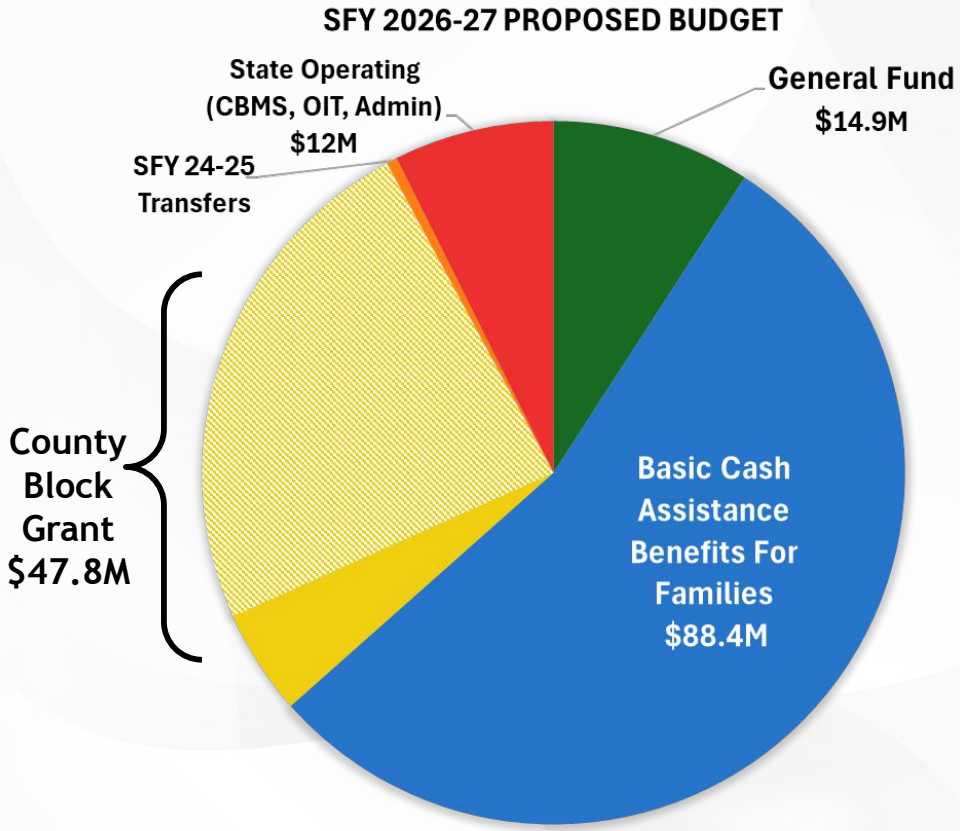
$5.7M in 2024-25

Budgeting Monthly Cash Assistance Benefits for Families Q33, pg27)



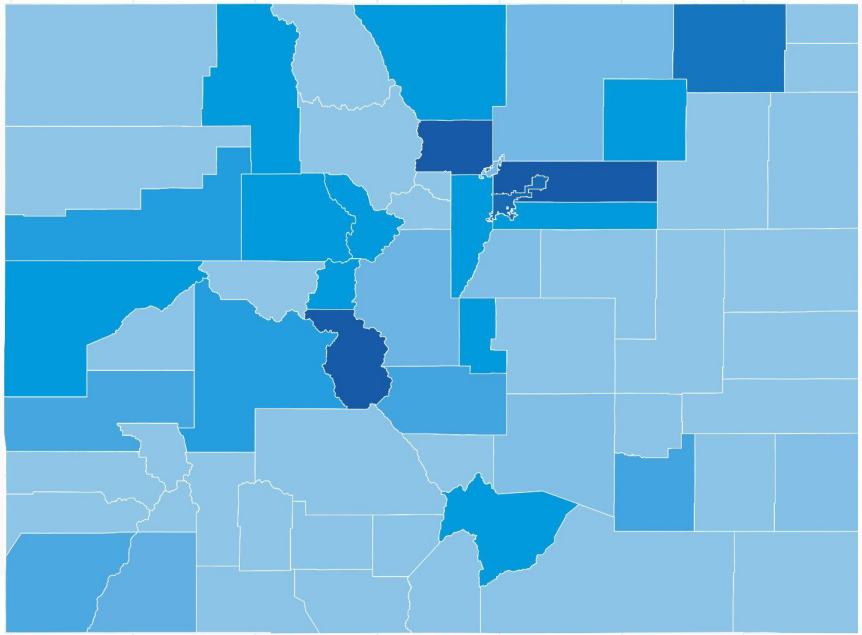
Budgeting Monthly Cash Assistance Benefits for Families Q33, pg27)



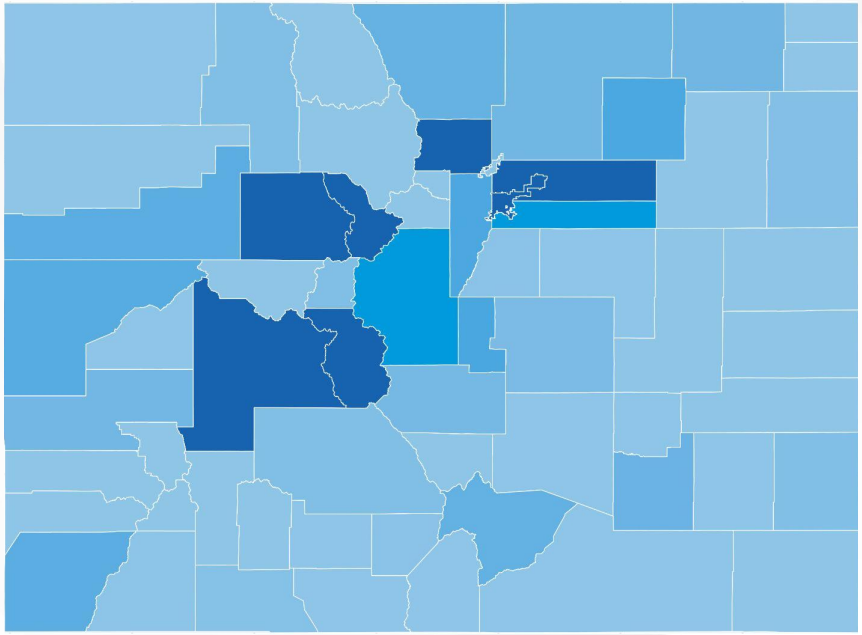


TANF Reserves used by County (Q34, pg29) (Q35, pg29)

SFY 2023-24 Closeout

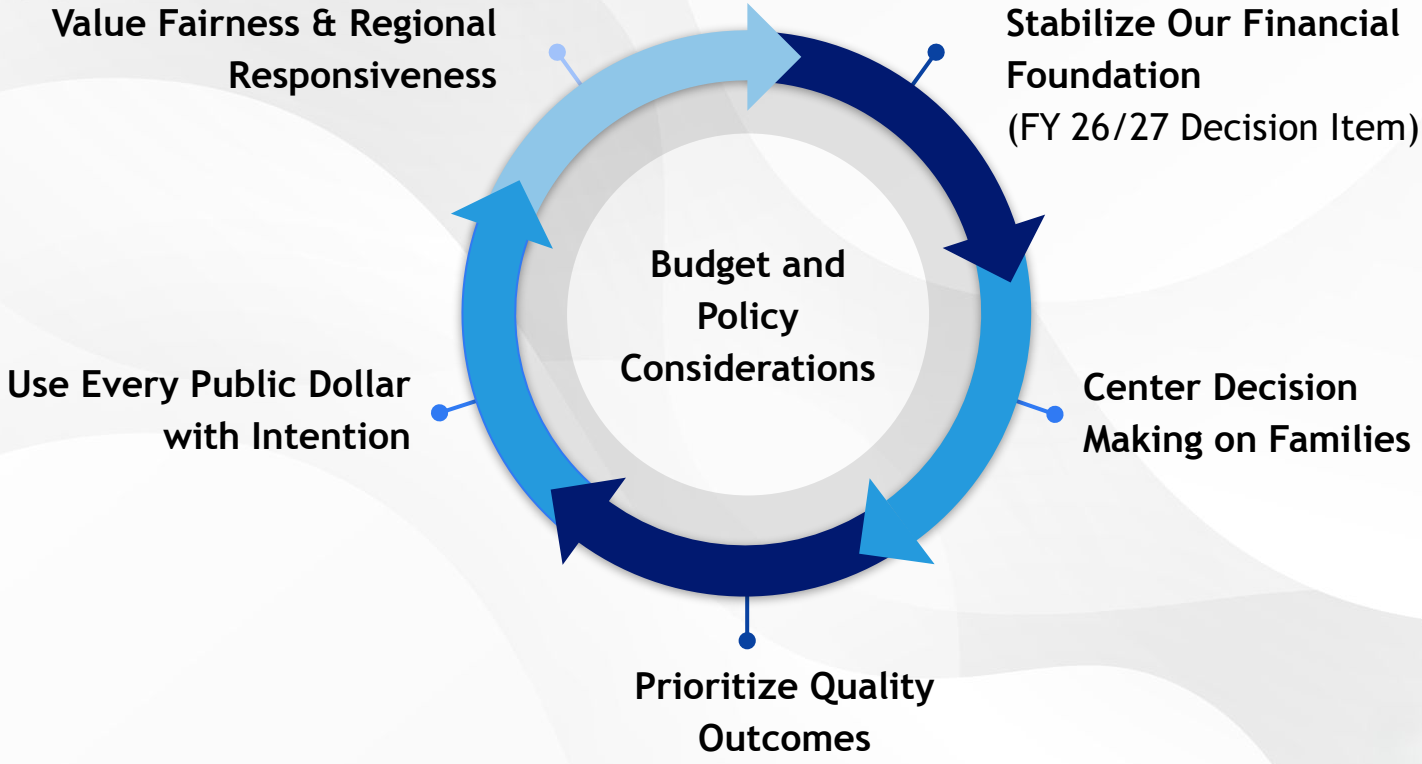


SFY 2024-25 Closeout



In SFY 2025, counties spent $6.8 million in reserves and transferred $794,000 to Child Care Quality Initiatives. Counties also gained $1.9 million in unspent allocation to reserves, resulting in a net reserve spend of $5.8 million. $1 million was reverted to the excess reserve distribution.

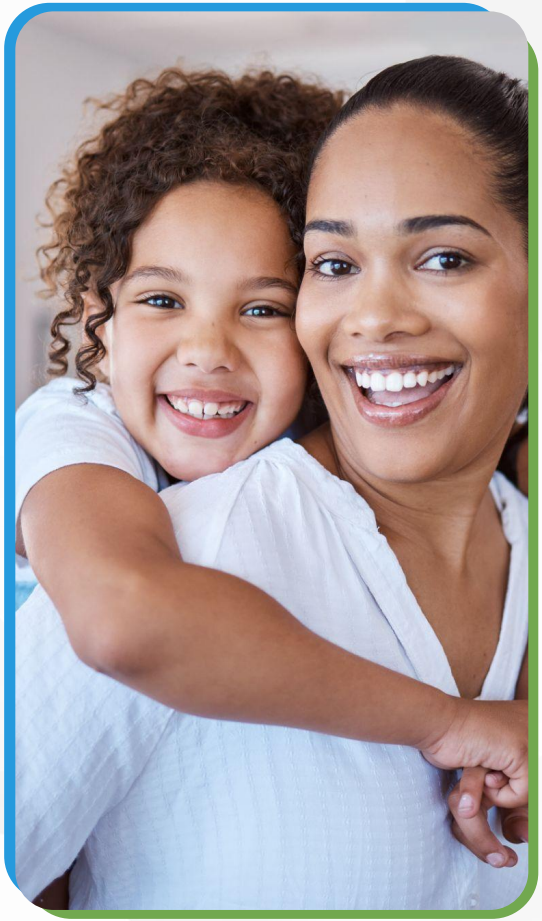
Prioritizing What Is Best for Families (Q36, pg30)



R-05/Leg-03: Proposed Changes to Colorado Works (TANF) Funding (Q37, pg31)

Goal: Reduce **Financial Pressure** on the Colorado Works Program (Total: **$19.2 million** in Cash/County MOE).

- Establish a **State-Managed BCA Fund** (outside County Block Grant).
- **Pause BCA COLA** increases for two years.
- Reduce **County Reserve Cap** from **40% to 20%**.
- **Remove State LTR backfill** requirement for County Reserves.
- Create a **Statewide Approach** for transferring **TANF funds** to **Child Care/Welfare**.



R-06: Ensuring Emergency Funding is Available

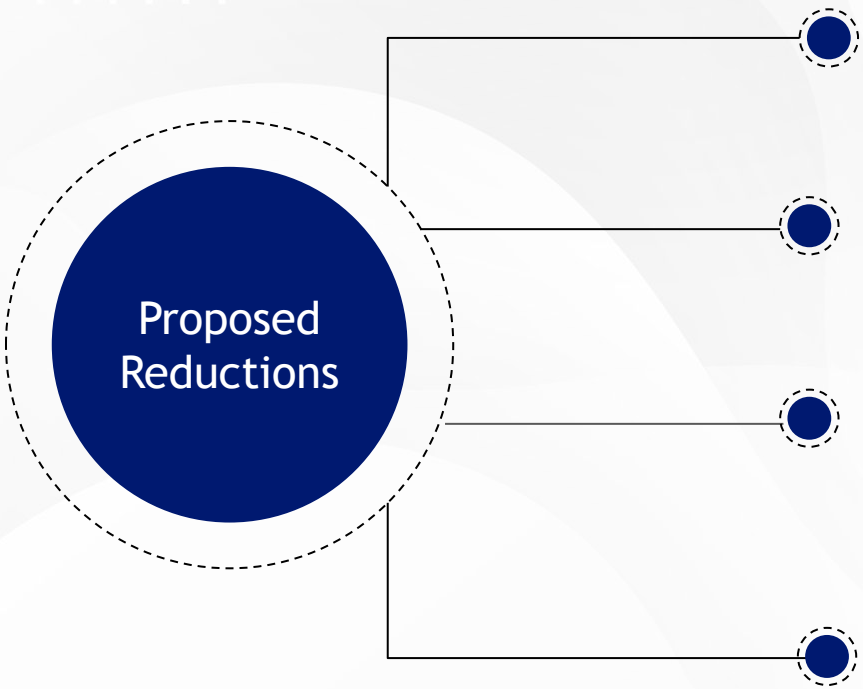
Goal: Support the **County Block Support Fund with a $250,000 Investment**

- **Purpose:** Provide **emergency resources** to counties with **low reserves** facing **natural disasters/emergencies** to ensure continued **TANF services**.
- **Funding Offset: $250,000** in federal **TANF Program Administration** funds will be reduced (5.3% reduction) in FY 2026-27 ongoing.
- **Rollback:** If funds are unused, they revert to the **State Long-term Reserve (LTR)**.

COLORADO
Department of Human Services

Solutions

Proposed Budget Reductions (Q19, pg18)



R-7: Reducing the HCA Case Management Agency Appropriation
($531,629) in FY 20226-27

R-08/Leg-04: Reducing the Cadence of the County Admin Funding Model
($200,000) in FY 2026-27

R-17: Reduce Summer Food Benefits Administration
($360,066) in FY 2026-27

R-18: SNAP Outreach Funding Reduction
($1,250,000) in FY 2026-27

Thank you!
Questions?

COLORADO
Department of Human Services

Office of Children, Youth & Families

Fiscal Year 2026 - 2027

Agenda

- Office Overview
- Division of Community Programs (DCP)
- Division of Youth Services (DYS)
- Division of Child Welfare (DCW)

Office of Children, Youth & Families

Our vision is to ensure children, youth and families across Colorado are safe and thriving. OCYF programs include:

Child Welfare
Approx - **13,000** open involvements

Youth Services
547 youth served daily

Community Programs
Approx - 111,000 Coloradans served annually

Other programs:
Legislative Affairs, Communications, Trails, Medical Team

Office of Children, Youth & Families
FY 2026-27 Requests

Funding:

- R-01 Division of Youth Services Safety through Technology
- R-02/Leg-01 ABA and Day Treatment

Reductions:

- R-12 Tony Grampsas Youth Services
- R-13 Collaborative Management Program
- R-14 Foster and Adoptive Parent Recruitment, Training and Support
- R-16 Hotline for Child Abuse and Neglect
- NP-09 CDHS General Administration Reduction

Office of Children, Youth & Families

Division of Community Programs

COLORADO
Department of Human Services

Division of Community Programs

The Division of Community Programs (DCP) works to create and elevate a community of practice around the work of community facing units within OCYF.

DCP strives to implement, serve and nurture partnerships and family/youth engagement through community facing funding and programming.

- Collaborative Management Program (CMP)
- Colorado Sexual Health Initiative (CoSHI)
- Domestic Violence Program (DVP)
- Juvenile Parole Board (JPB)
- MINDSOURCE Brain Injury Network
- Tony Grampsas Youth Services Program (TGYS)

Collaborative Management Program (CMP)

CMP requires multi-system collaboration

51 participating counties

131 Individual Service and Support Teams (ISSTs) and;

121 prevention programs

11,000+ children/youth served annually

$528.38 average cost per youth

Tony Grampsas Youth Services Program(TGYS)

Statewide Community Grants

- **4** youth prevention areas
- **84** funded organizations
- **51** counties and Southern Ute Tribes served
- **73,000+** children/youth served annually
- **$11.5 M** awarded in SFY 2025-2026

Collaborative Management Program Reduction (R-13) (Q62, pg59) (Q63, pg60)

- Reduces $700,000 General Fund in FY 2026-27 and ongoing.
- Temporarily increases Collaborative Management Cash Fund spending authority in FY 2026-27 and FY 2027-28 to use available balance.
- No short-term service impacts expected.
- Once cash fund balance is depleted (expected FY 2027-28), ongoing reduction will affect county CMP sites.

Tony Grampsas Youth Services Reduction (R-12) (Q64, pg61)

- Reduces $400,000 GF in FY 2026-27, offset by $200,000 Cash Fund/Marijuana Tax Cash Fund to TGYS.
- Eliminates Youth & Community Partnership grants, which are low-dollar, one-year awards, minimizing impact versus cutting three-year grants.
- If three-year grants were reduced instead, about 2,100 children, youth, and caregivers could be impacted.

Office of Children, Youth & Families

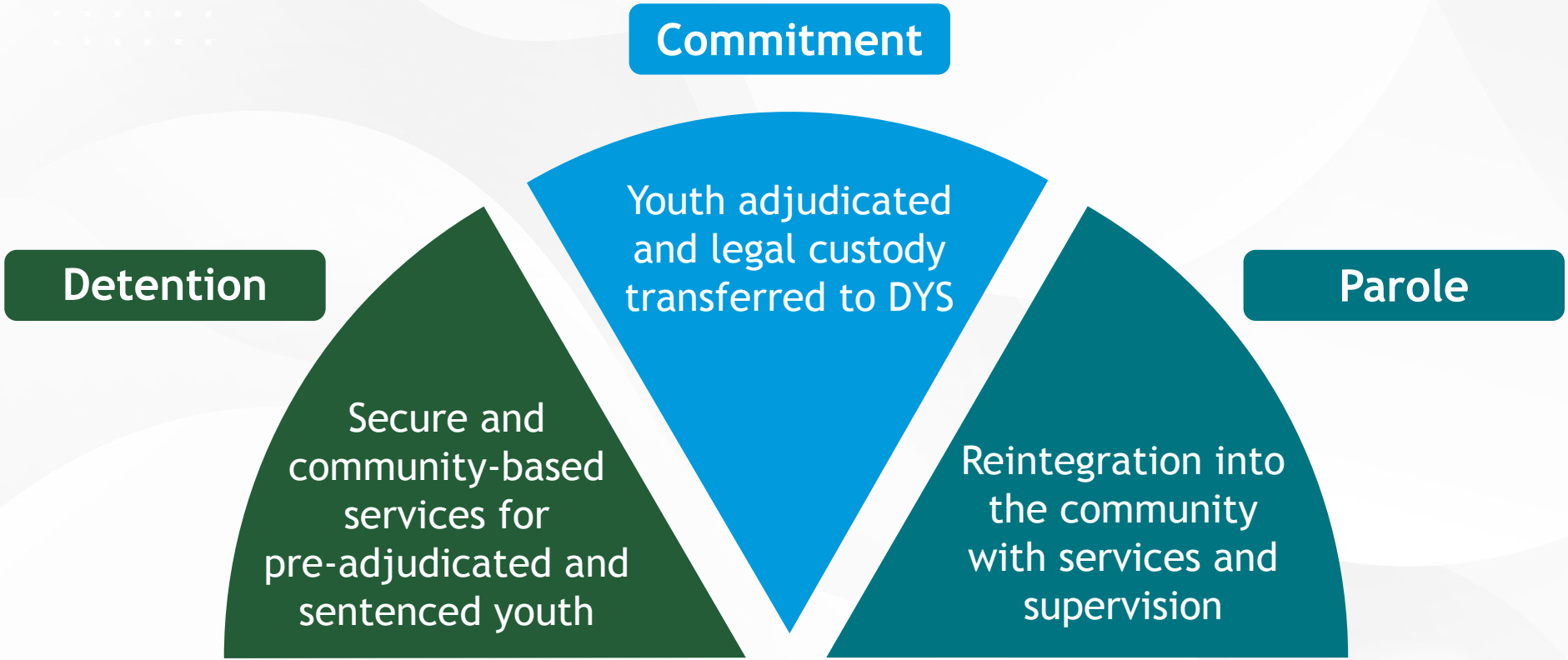
Division of Youth Services (DYS)

COLORADO
Department of Human Services

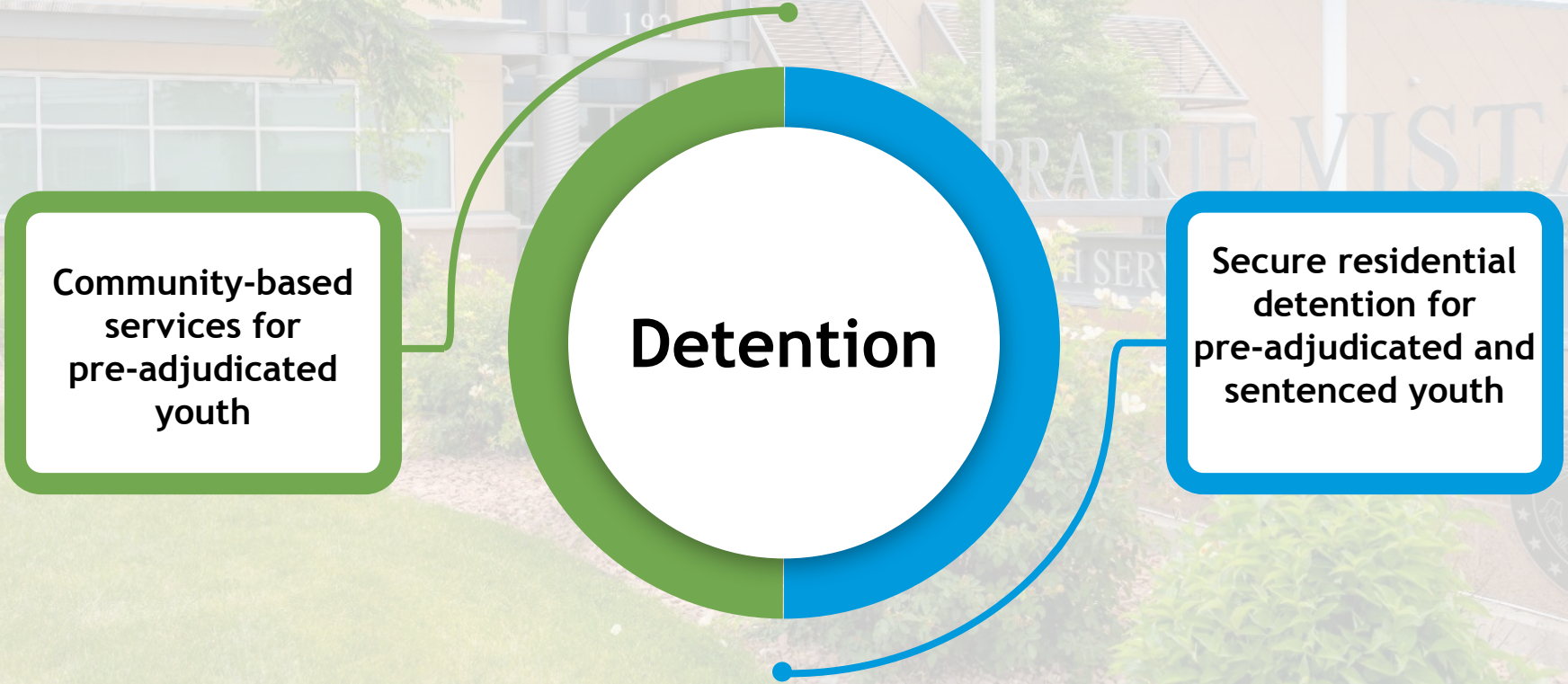
I was able to be successful and grew to be very mature because of the group and supportive staff I had at Grand Mesa Youth Services Center and my team. I am now pursuing my goal of being a pilot, am in flight training and have a job as well.

- Laiken

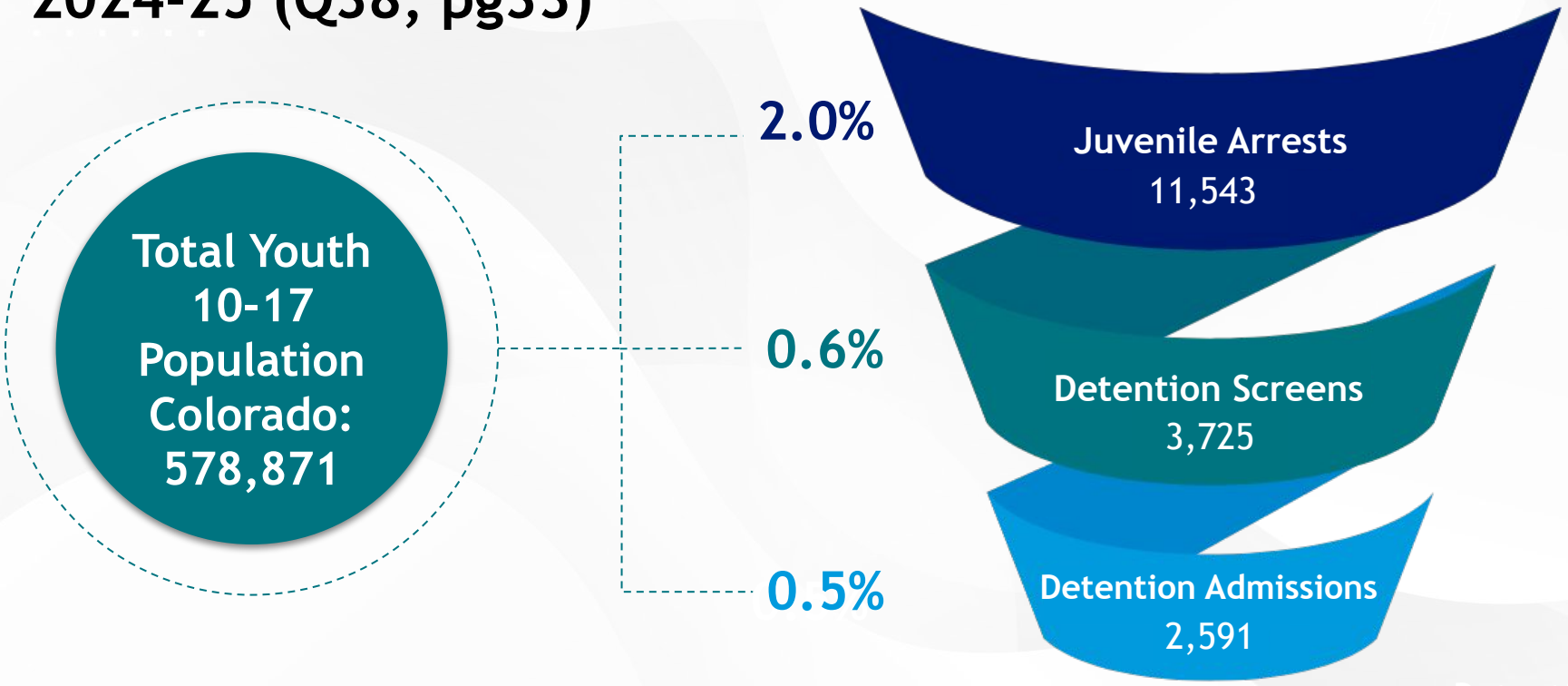
DYS Continuum of Services



DYS Detention Continuum



Juvenile Justice Detention Landscape Fiscal Year 2024-25 (Q38, pg33)



Youth Detention Demographics

DYS has seen a decline in the number of juvenile arrests, youth detained, detention screens and admissions.

1,138 youth

+42% Increase in new detention admissions with a violent charge since fiscal year 2021

799

140 youth

+49%

Increase in new detention admissions for homicide or manslaughter from fiscal year 2021

94

HB25-1146 Updates (Q39, pg35)

Body-Worn Cameras

- Pilot program due to start February 2026
- Pilot sites - Spring Creek (commitment) and Prairie Vista (detention)

Detention Beds

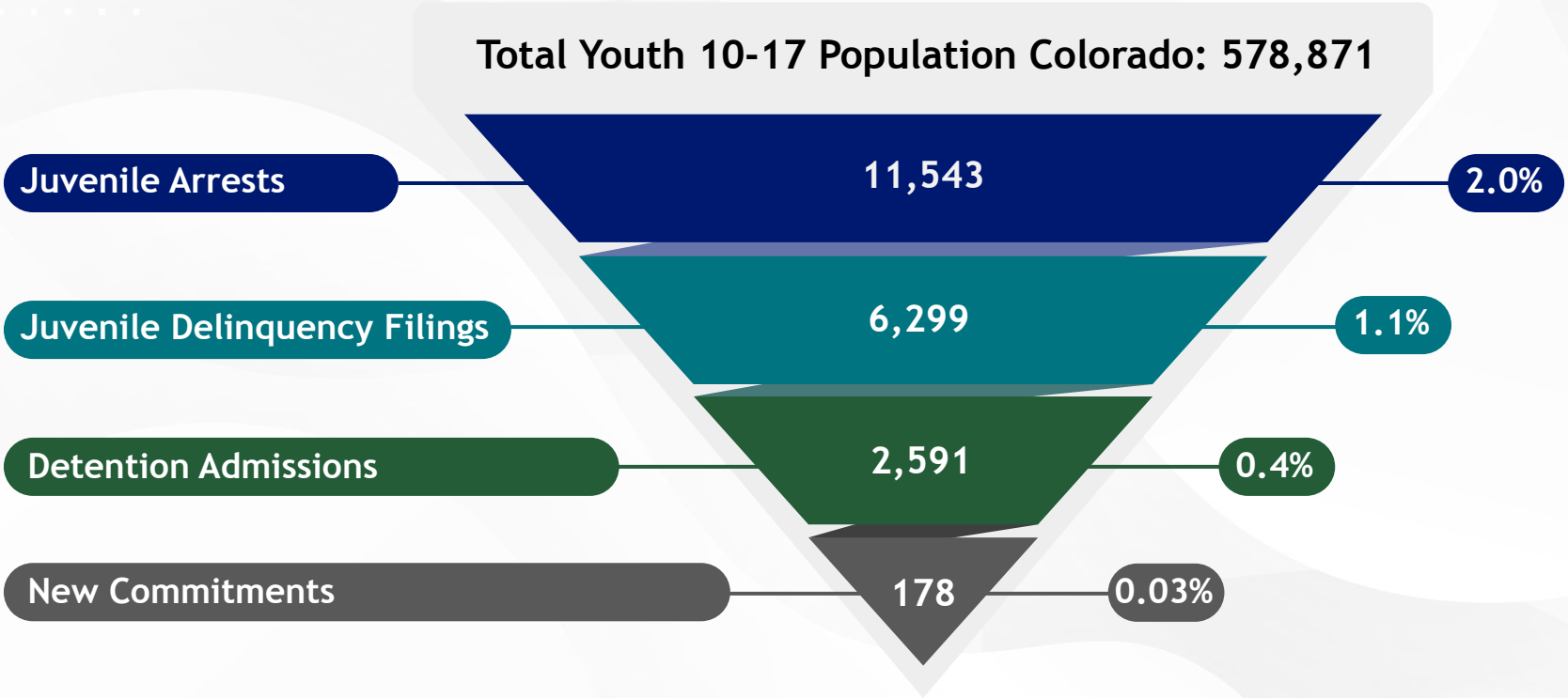
- 215 regular beds, 39 emergency beds
- Bed usage increasing

Youth Awaiting Available Placements

- Request for proposal has been submitted
- Timeline for the report on or before July 1, 2027

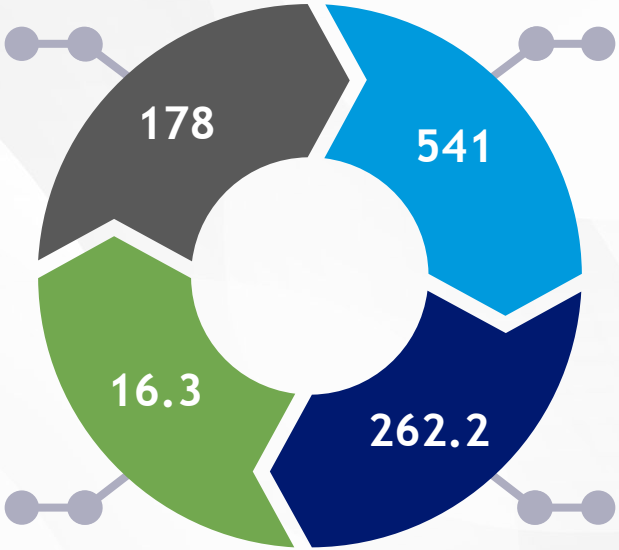

State-operated secure youth center residential placement
Commitment
Step-down community-based residential placement

Juvenile Justice Filtering Process to Commitment Fiscal Year 2024-2025



Youth Commitment Stats (Q40, pg35)

New Commitments



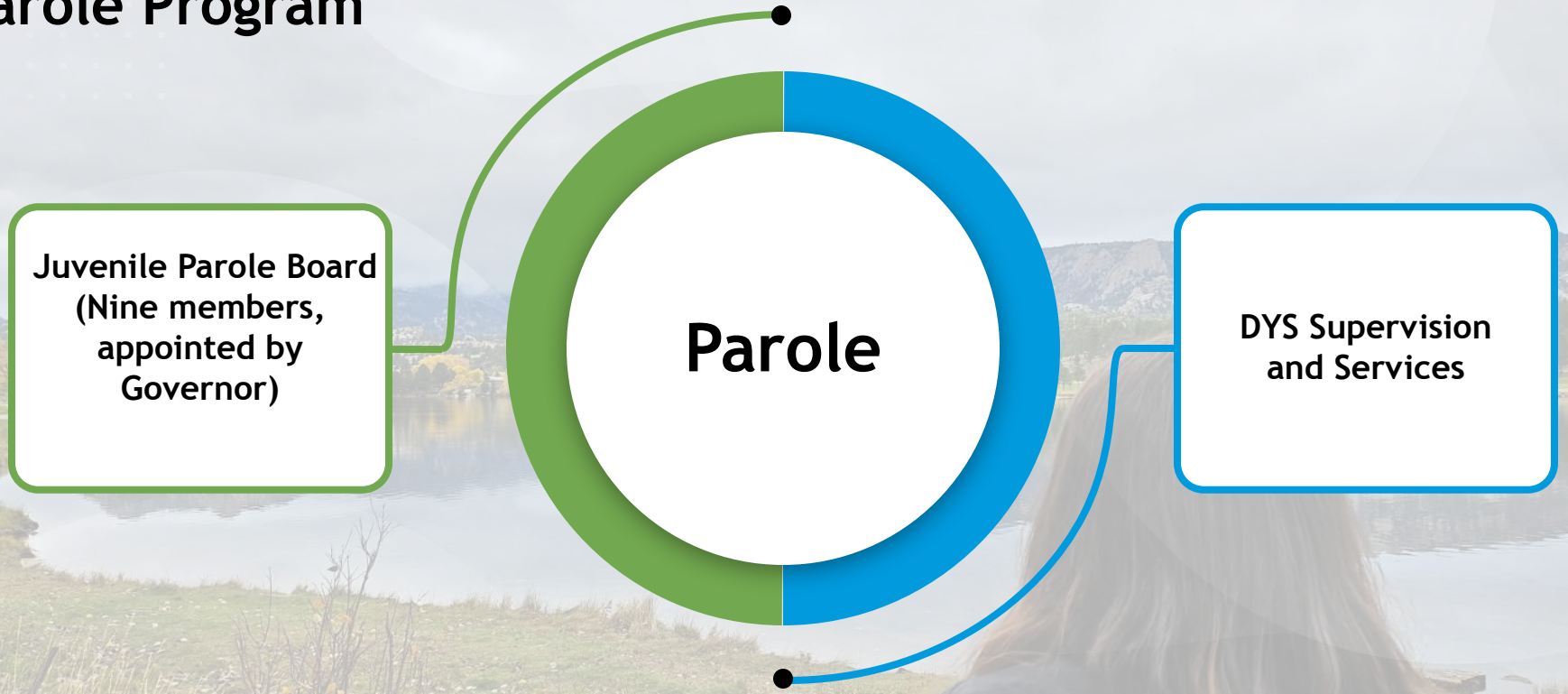
# of Youth Served
Number of individual youth served

Average Length of Stay

Average Daily Population

Fiscal year 2024-25

Parole Program



Parole Stats

6.8 months
Average Length of Service

280
Number of Youth Served

107.6
Average Daily Population

Lookout Mountain
Youth Services Center

(Q42, pg38) (Q43, pg39)

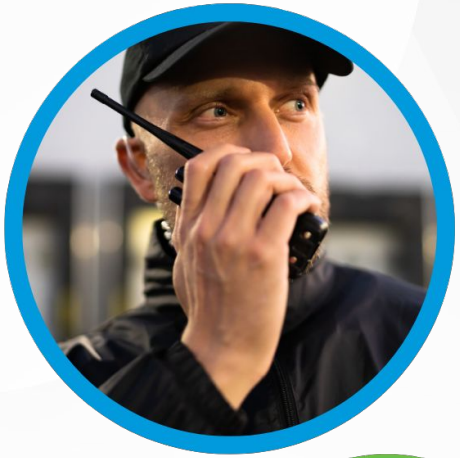
LMYSC has undergone substantial changes over the last several years.

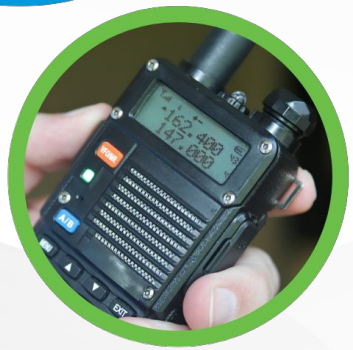
All youth and a majority of staff were transferred in August.

LMYSC has since opened a youth assessment and a transition unit, with youth and staff currently at the facility.

CDHS is evaluating staffing and youth populations to ensure continued success of the facility.

R-01 Division of Youth Services Safety Through Technology (Q44, pg43)





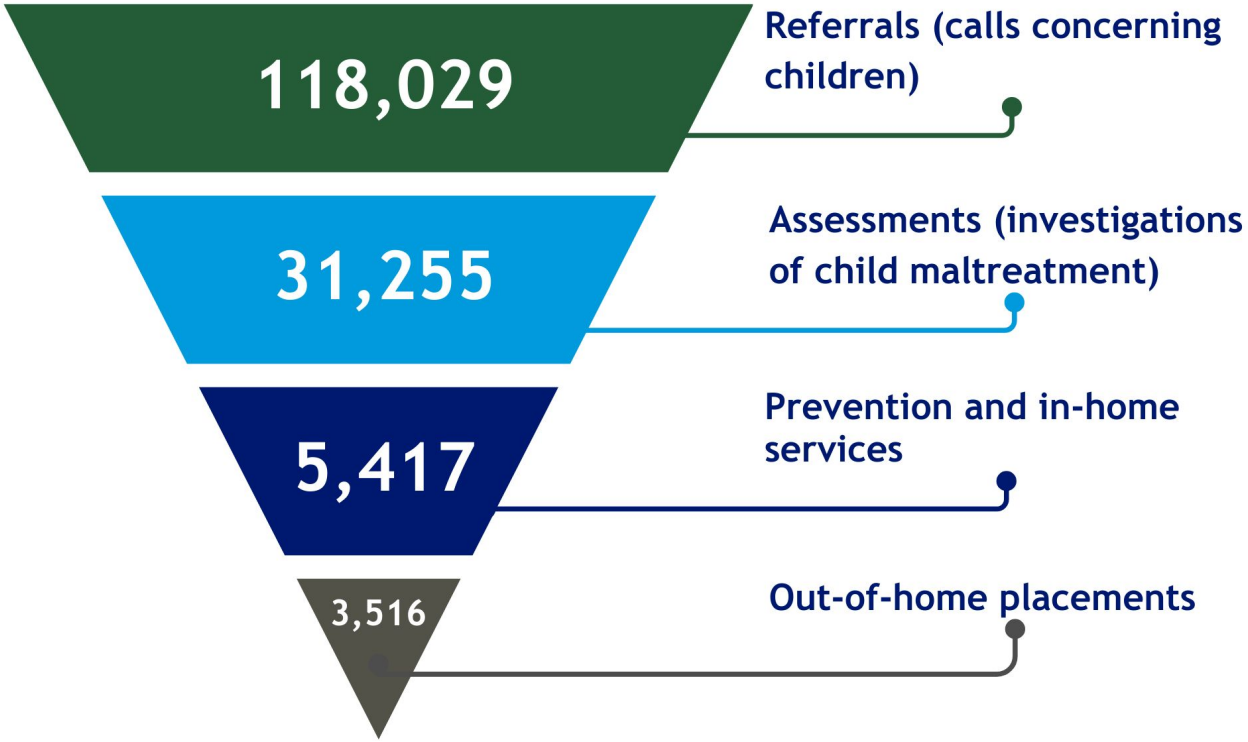
- Current model of radios is no longer supported
- CDHS uses radios to allow all staff to hear and respond quickly and efficiently
- Updated radios will prevent critical communication failures

Office of Children,
Youth & Families

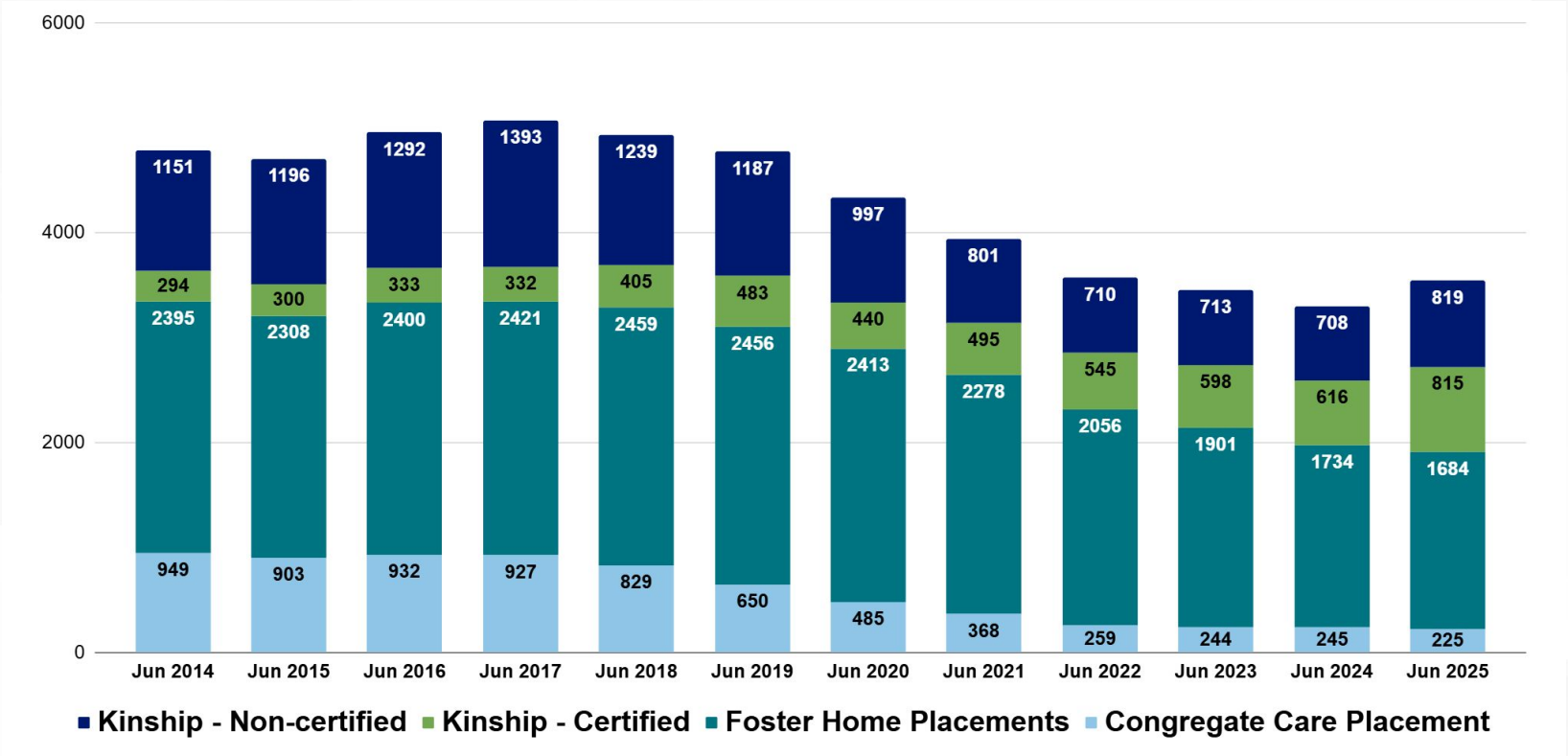
Division of Child Welfare

COLORADO
Department of Human Services

Child Welfare Services FY 2024-25



Out-of-Home Placements and Kinship Care



Kinship Foster Care Homes (Q51, pg52)

Certifications

Kinship foster care certifications increased **38%** since Sept. 2024 with SB24-008, including provisional certifications.

Growth

An increase of children placed with kin, from **~18%** of placements 15 years ago to nearly **50%** currently.

Benefits

- Minimizes trauma
- Increases permanency
- Preserves cultural identity and community connections

How We Resource Child Welfare Services

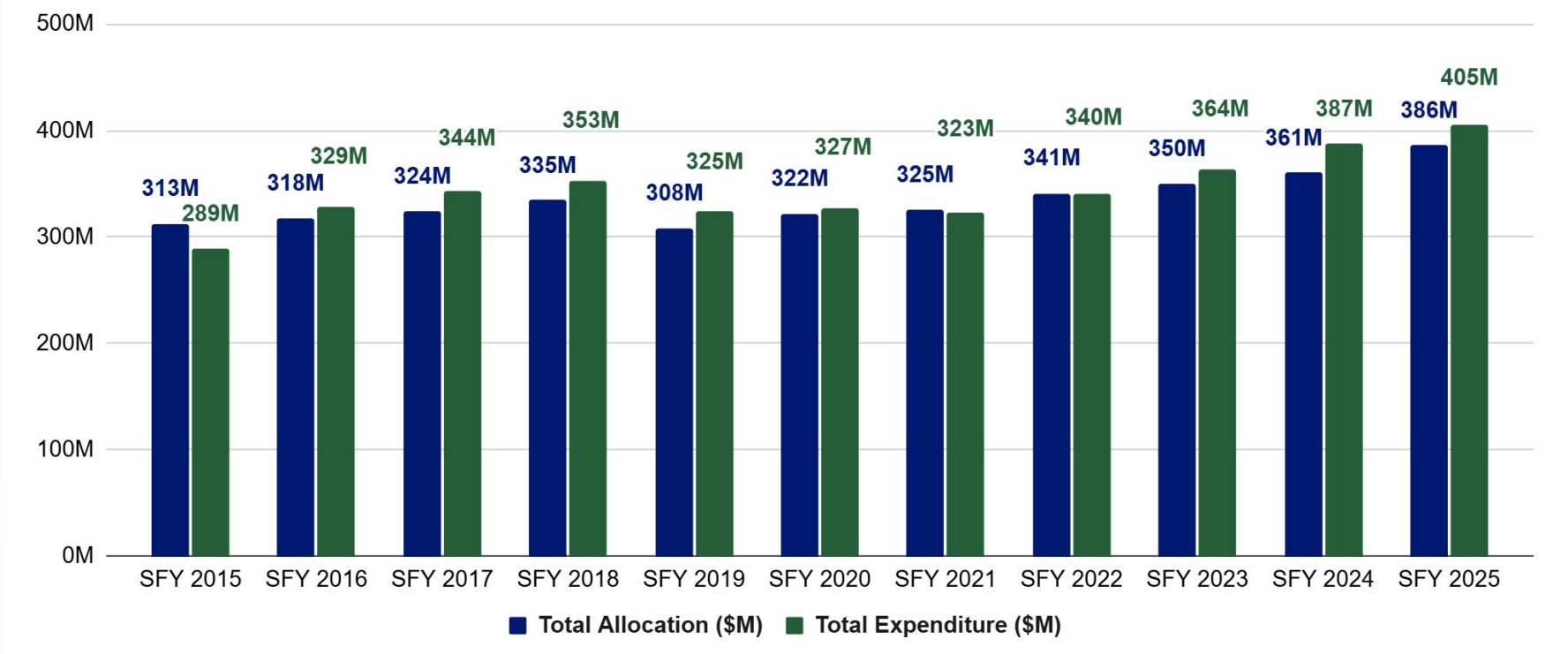
(Q52, pg53)
(Q53, pg54)
(Q54, pg55)

- Child Welfare Services (Block) $448,219,436
- Family and Children's Programs (Core) $73,743,979
- Child Welfare Staffing (SB15 242) $38,133,279
- Other sources:
  Adoption/Relative Guardianship Assistance
  Federal non-appropriated funds

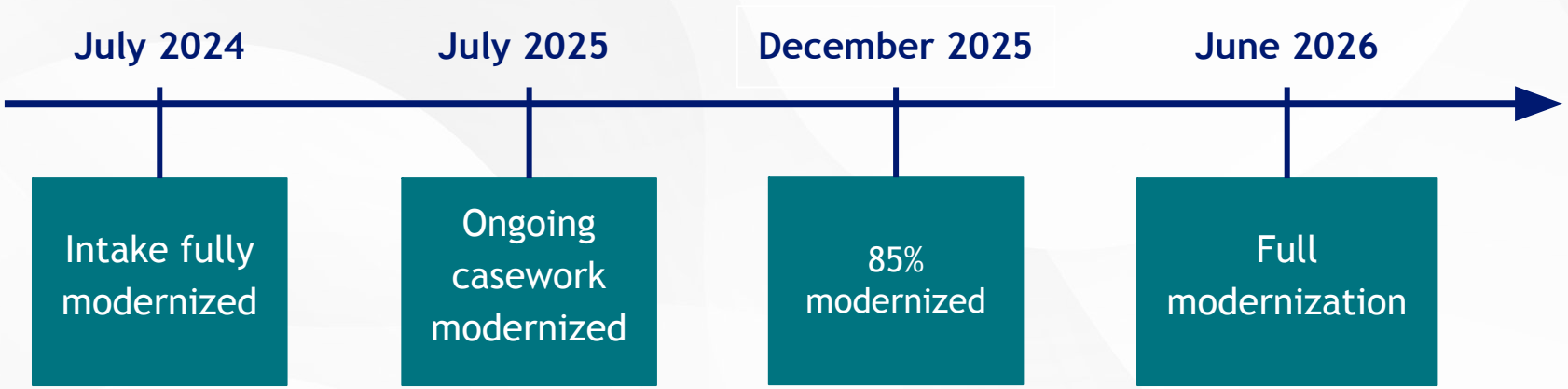
Adoption & Relative Guardianship Assistance (Q45, pg44) (Q46, pg45) (Q47, pg46) (Q48, pg47)

- $69.1 million in a dedicated line item
- 90% General and Federal fund and a 10% county match
- Provides cash subsidies to families
- Adoption Subsidy Tool

Total Allocation vs. Total Expenditure SFY 2015-2025 ($M)



Trails Mod (Q6, pg7)



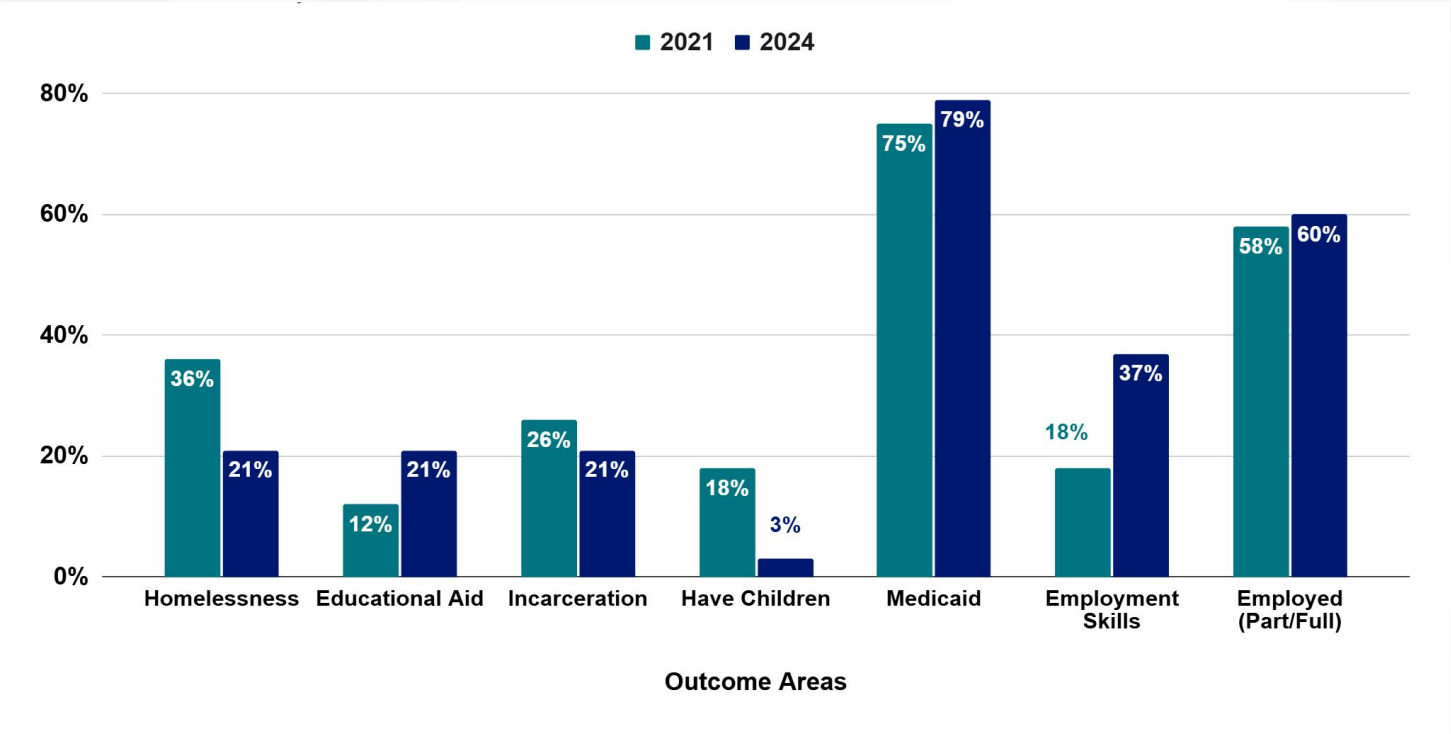
- Counties appreciate regular monthly updates and fixes
- Most county staff operate out of Trails Mod

Services for Youth in Child Welfare (Q49, pg48) (Q55, p56)

Foster Youth in Transition Est. 2021

Fostering Success State Grant Program Est. 2021

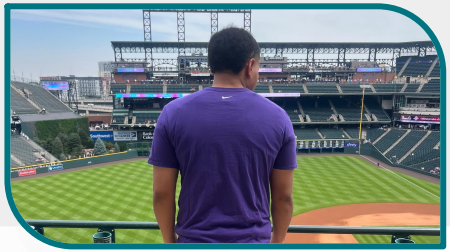
Vouchers Youth Experiencing Homelessness Est. 2023



HB 23-1307 - Provider Incentives Update (Q41, pg36)

At a glance:

- Incentive funds approved for **17 youth** across **8 counties**
- Contracted beds have served **61 clients** in the last **12 months**
- Secured youth detention beds with three providers for youth detention



How incentives were used:

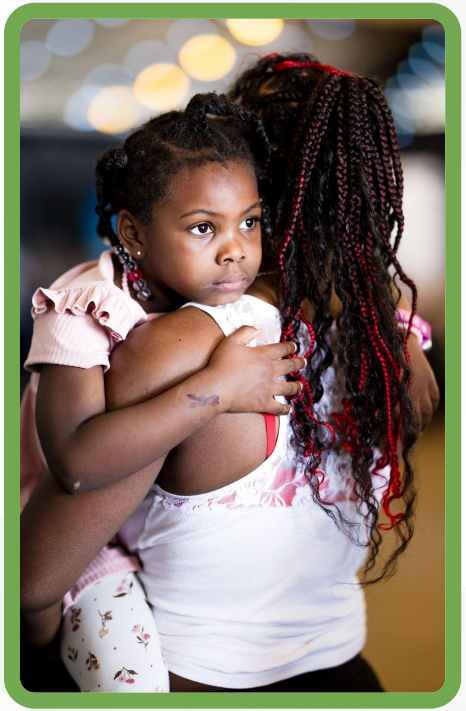
- Additional staffing and supervision
- Case management and therapeutic services
- Private treatment, mentoring and after school activities
- Educational supports

Youth with High-Acuity Needs (Q50, pg50)

Children and youth considered to have “highly acute” behavioral health needs require more intensive services, treatment and staffing.

ABA and Day Treatment (R-02, Leg-01) (Q56, pg57) (Q57, pg57) (Q58, pg58) (Q59, pg58) (Q60, pg58) (Q61, pg59)

- Adds $561,540 TF / $477,309 General Fund and 4.6 FTE in FY 2026-27;
- $583,444 TF / $495,927 General Fund and 5.0 FTE ongoing.
- Funds licensing and monitoring of unlicensed ABA therapy facilities.
- Updates statute to revise “day treatment” and add ABA-specific standards.
- Expands oversight of programs, staff, and service quality to reduce abuse and neglect.



ABA and Day Treatment Cont.

- Why is day-treatment facility licensure important?
- What does day-treatment facility licensure mean?
    - Health and safety requirements
    - Prevent harm
    - Consistent, clear standards of practice
    - Facility staff have the training and competencies

Foster and Adoptive Parent Recruitment, Training and Support Reduction (Q65, pg61)

- Reduces $150,000 General Fund in FY 2026-27 and ongoing
- Program is discretionary; no direct impact to client benefits
- Reductions spread across: contracts, outreach, paid media, video production, and events
- Activities can be scaled down to minimize impacts on recruitment and retention

Hotline for Child Abuse and Neglect Reduction (R-16) (Q66, pg61) (Q67, pg63)

- Reduces $629,000 General Fund in FY 2026-27 and ongoing
- Savings achieved through Fall 2024 transition to cloud-based technical platform
- Operational costs significantly reduced
- 24/7 Hotline operations remain fully supported with no service disruption

Thank you!
Questions?