Final Report

Behavioral Health Facility Licensing Task Force
Findings and Recommendations

December 1, 2018

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The Honorable John Hickenlooper
Governor, State of Colorado

Dear Governor Hickenlooper,

Pursuant to the request from your office dated June 20, 2018, the Behavioral Health Facility Licensing Task Force met from June through November 2018 to analyze current licensure and program oversight of behavioral health care entities. This included laws, regulations, guidance and practice, with the goal of making recommendations to improve and streamline licensing and certification for behavioral health entities. This report includes the findings and recommendations of the Task Force.

The members of the Task Force believe that efficient and effective licensing is needed to ensure the health, safety and welfare of Colorado citizens seeking quality mental health and substance use services. The findings and recommendations in this report would lead to a flexible licensure framework that would allow innovative, integrated models of care and reduce regulatory overlap to allow behavioral health entities to better meet the behavioral health needs of Coloradans.

Sincerely,

Members of the Behavioral Health Facility Licensing Task Force

Task Force Mission and Process

The Behavioral Health Facility Licensing Task Force was charged with completing a comprehensive review of the current licensing and certification of behavioral health facilities across Colorado. The group was tasked with analyzing laws, regulations, guidance and practice in behavioral health licensing in order to inform recommendations to improve and streamline the oversight of the system. More specifically, the Task Force was asked to:

- Review licensing and other program approval processes across state agencies related to behavioral health care entities, and make recommendations to align and consolidate regulations;
- Identify gaps in licensing and credentialing standards, focusing on increasing the flexibility of departments to adapt to future changes; and
- Identify areas of collaboration and make recommendations to better define the role of each state department related to behavioral healthcare licensing and other program approval efforts.

The Task Force met eight times between July and November 2018. These meetings included overviews of the current behavioral health system and presentations by the state departments involved in the management and oversight of behavioral health in Colorado. Moreover, these meetings included presentations by people with lived experience of mental health disorder, advocates, and providers of behavioral/mental health services specifically describing the complications and barriers within the current licensing structure. An overview of the discussions is provided in Appendix A. The Task Force identified a list of challenges and opportunities in the current behavioral health licensing system and prioritized those topics in order to better define the problem. Subsequently, members identified several guiding principles which were agreed upon as necessary for developing the future ideal state of behavioral health licensing. The recommendations contained herein represent the general consensus of the Task Force regarding improvements related to licensing behavioral health entities.

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Task Force Members

When creating the Task Force, Governor Hickenlooper specified the following participation:

- The Executive Director of the Department of Public Health and Environment, or his/her designee
- The Executive Director of the Department of Human Services, or his/her designee
- The Executive Director of the Department of Public Safety, or his/her designee
- The Executive Director of the Department of Health Care Policy and Financing, or his/her designee
- One member of an organization that operates crisis stabilization units or acute treatment units
- One member of an organization that operates a substance use disorder treatment or detox facility
- One member of an organization that operates community mental health centers
- One member of an organization that operates a hospital that is designated to provide behavioral health care under Article 65 of Title 27 of the Colorado Revised Statutes
- Two members of organizations representing patients of behavioral health care providers

In addition to the specific membership of the Task Force, there were many individuals from the relevant state agencies, behavioral health care providers, advocacy organizations, and others that contributed their time and energy to the process. The following table lists both members fulfilling a specific role and additional contributing members:

Name	Position	Department or Organization
Governor's Office		
Kyle Brown*	Policy Director, Health and Human Services	Governor's Office
Colorado Department of Public Health and Environment (CDPHE), Health Facilities and Emergency Medical Services Division		
Randy Kuykendall*	Director	Colorado Department of Public Health and Environment
Michelle Reese	Deputy Director	Colorado Department of Public Health and Environment
Kara Johnson-Hufford	Branch Chief, Health Facility Quality	Colorado Department of Public Health and Environment
Francile Beights	Policy Analyst	Colorado Department of Public Health and Environment
Lorraine Dixon-Jones	Policy Analyst	Colorado Department of Public Health and Environment
Cathy Stopfer	Intellectual and Developmental Disabilities Community Services Section Manager	Colorado Department of Public Health and Environment
Colorado Department of Human Services (CDHS), Office of Behavioral Health		
Cristen Bates*	Director of Strategy, Communications, and Policy	Colorado Department of Human Services
Ryan Templeton	Policy Advisor	Colorado Department of Human Services
Karen Mooney	Director of Compliance Administration	Colorado Department of Human Services

Name	Position	Department or Organization
Colorado Department of Health Care Policy and Financing (HCPF)		
Melissa Eddleman*	Behavioral Health Unit Supervisor, Delivery System and Payment Innovation Division	Colorado Department of Health Care Policy and Financing
Stacy Davis	Behavioral Health Program Policy Specialist, Delivery System and Payment Innovation Division	Colorado Department of Health Care Policy and Financing
Colorado Department of Public Safety (DPS), Division of Fire Prevention and Control		
Christopher Brunette*	Section Chief, Fire & Life Safety	Colorado Department of Public Safety
Robert Sontag	Branch Chief, Fire Prevention	Colorado Department of Public Safety
Providers		
Doyle Forrestal*	CEO	Colorado Behavioral Healthcare Council
Moses Gur	Director of Policy and Member Engagement	Colorado Behavioral Healthcare Council
Abigail Tucker*	Director	Community Reach Center
Jacki Kennedy*	Deputy Director	North Range Behavioral Health
Lori Banks*	CEO/COO	Community Crisis Connection
Steve Fisher*	Director of Clinical Services	Mental Health Center of Denver
Doug Muir*	Director of Service Line	Centura Health Corporation
Todd Merendino*	Quality Reviewer	Community Crisis Connections
JC Carrica	CEO	Southeast Health Group
Sharon Raggio	President and CEO	Mind Springs Health
Ed Hagins	COO	Center for Mental Health
Tom Chamberlain	Architect	Center for Mental Health
Advocates/Consumers		
Nancy Vandermark*	Chief of Planning and Strategy	Mental Health Colorado
Anne Meier	State Long Term Care Ombudsman	Disability Law Colorado
Aubrey Boggs*	Advocacy and Outreach Coordinator	Colorado Mental Wellness Network
* Individual is serving in a specific role, as outlined in the Governor's letter (see above bullets)		

Executive Summary

Introduction

Governor John W. Hickenlooper established the Behavioral Health Facility Licensing Task Force (Task Force) to develop comprehensive recommendations for improving Colorado's oversight of mental health and substance use disorder services, specifically as it relates to the licensing of behavioral health facilities in the state. Colorado is experiencing increasing demand for both mental health and substance use disorder (SUD) treatment, together known as behavioral health services. The Task Force included individuals who have accessed behavioral health services, mental health advocates, service providers representative of the various facility types, as well as the four state departments responsible for the oversight and management of mental health and substance use disorder services. The Task Force met eight times between July and November 2018 and worked to achieve general consensus to develop the final recommendations.

The Task Force determined that Colorado's behavioral health system provides a variety of effective services that assist people in their immediate and ongoing behavioral health needs. The behavioral health system's services have become more necessary than ever; however, the availability of services and providers varies from region to region and is particularly lacking within Colorado's rural communities. Compounding the problem are the barriers within the current regulatory framework. This framework does not promote continuums of care that allow for integrated services based on community needs, provide a streamlined process for becoming a new provider, or allow for innovation in response to consumer demand. This is due to fragmented, overlapping and even conflicting state agency oversight requirements.

These system inadequacies create significant problems for people with behavioral health needs, their families and the service organizations that seek to contribute to solutions. Not only do these complex barriers contribute to the lack of parity of oversight as it relates to physical, mental and behavioral health, but such systems do not assure the same base level of consumer protections across different types of care. Moreover, individuals and families are faced with limited access to services that integrate both mental health and substance use disorder treatment, especially within acute settings.

The Task Force offers a vision and set of guiding principles in order to drive improvements to Colorado's behavioral health system to ultimately create a comprehensive continuum of care and structure of licensing and oversight that allows for innovation and flexibility for possible future models that may not yet exist. The Task Force believes that Colorado's system should allow for treatment of acute and ongoing co-occurring disorders while also integrating the licensing processes for both mental health and substance use disorder (including alcohol) needs. Moreover, these principles are underscored by the belief that a licensing system should remain flexible for entities to add and/or modify services without requiring a different or additional license, so to remain responsive to Coloradans' needs. In whole, such principles ultimately aim to reduce the licensing burden currently experienced by behavioral health providers and recipients of services by clarifying and simplifying the process through which a behavioral health provider seeks a license. The Task Force thus offers its recommendations in the spirit of invitation to further engage in ongoing work on the issues raised in this report. In

several cases, it recommends that additional stakeholders be convened to continue the analysis and planning for future integration and streamlining. The Task Force sees its recommendations as an initial road map, and looks forward to further conversations with a much wider range of participants in the coming years.

Summary of Recommendations

- Recommendation #1: Establish a Behavioral Health Entity License at the Colorado Department of Public Health and Environment (CDPHE). This new license category type will be required to provide community-based behavioral health services in the state, regardless of the funding sources paying for those services. The license function should exist solely at CDPHE, and the existing Colorado Department of Human Services (CDHS) program approval responsibilities should be transferred to CDPHE and incorporated into the CDPHE licensure process.

- Recommendation #2: Create a Behavioral Health Licensing Advisory Committee to implement and advise on the new Behavioral Health Entity License. The committee should include CDPHE, DHS, the Department of Public Safety (DPS), and the Department of Health Care Policy and Financing (HCPF) as well as a wide array of stakeholders including service providers, consumer advocates, and consumers.

- Recommendation #3: Establish a distinct, non-licensing oversight function at CDHS focused on monitoring providers that receive public funds administered by the CDHS.

- Recommendation #4: Continue CDHS' responsibilities for system and service coordination for community-based behavioral health services including the managing of the state plan for SUD treatment, the purchasing of behavioral services, and "27-65" designation in accordance with Colorado Revised Statutes (C.R.S.) Title 27, Article 65.

- Recommendation #5: Continue the Life Safety Code and fire prevention oversight responsibilities at the Colorado Department of Public Safety (DPS), while strengthening that agency's partnership with CDPHE; continue the requirements of DPS for a certificate of compliance prior to the issuance of a license; and establish a "single entry point" process at CDPHE modeled after the current liaison process between CDPHE and DPS.

- Recommendation #6: Create a licensing guide for entities seeking to become licensed Behavioral Health Entities to provide a clear understanding of the licensing process, including establishing CDPHE as the "single entry point" for Behavioral Health Entity licensing activities.

- Recommendation #7: Seek statutory changes during the 2019 legislative session, as needed, to implement the previous recommendations. The legislation should establish phased-in implementation. The legislative initiative will require collaboration and coordination from the state agencies and the provider representatives involved in the Task Force.

The Task Force achieved general consensus on all seven recommendations. Members expressed support and commitment for the recommendations as a package. However, the Task Force recognizes that the Governor and the General Assembly will consider each recommendation on its merits. Irrespective of which recommendations are chosen to advance, the Task Force believes that it is important to establish an advisory body composed of stakeholders to support implementation. The advisory body should be adequately staffed and funded.

Scope

This report focuses on the regulatory framework for behavioral health services provided in community-based settings, with the exception of community-based mental health inpatient and residential treatment for children (which is overseen by the CDHS' Division of Child Welfare). In this report, behavioral health services encompass both mental health and substance use disorder services. The term "community-based" is used to mean services provided outside of a hospital or outside of an institutional setting such as nursing homes and assisted living residences.

Background

Current State Oversight Processes

The oversight frameworks for mental health and substance use disorders (SUDs) are separate and distinct. Mental health services are overseen by three agencies, namely the Colorado Department of Public Health and Environment (CDPHE), the Colorado Department of Human Services (CDHS) and the Colorado Department of Public Safety (DPS). In contrast, SUD services are overseen solely by CDHS.[1] This section discusses the current regulatory framework followed by the associated problems that have been encountered.

Oversight of Community-Based Mental Health Services. Community-based mental health services are delivered by the following facilities:

- *Community Mental Health Clinics* (CMH Clinics) - provide outpatient care and consultative community services for the prevention, diagnosis and treatment of emotional or mental disorders primarily for a specialized demographic or specialized in a specific continuum of care practice (defined in §27-66-101, C.R.S., and 2 CCR 502-1, 21.100).
- *Crisis Stabilization Units* (CSUs) - which provide short term, bed-based[2], crisis stabilization services in a 24-hour environment that allows for a safe and therapeutic milieu for individuals that cannot be served in a less restrictive environment. These facilities may utilize a delayed egress device to alert staff when a client attempts to leave (defined in 2 CCR 502-1, 21.400).
- *Acute Treatment Units* (ATUs) - provide 24-hour, bed-based, intensive psychiatric stabilization services and care for individuals who do not necessarily require inpatient hospitalization or can be served in this setting in lieu of hospitalization. The facility is more intensively staffed and secure than other stabilization services (defined in §25-1.5-103, C.R.S., and §27-66-101, C.R.S., 6 CCR 1011-1 Chapter 6, and 2 CCR 502-1, 21.290).

[1] As used in this report, state oversight means licensing and approval of providers. There may be other types of oversight, such as credentialing for payment or professional oversight of individuals providing service.

[2] The term "bed based" is used to mean that there will be overnight stays. This differentiates them from services that are "residential," such as services provided in assisted living residences.

- *Community Mental Health Centers* (CMH Centers) - provide a broad array of services for the prevention and treatment of behavioral health disorders typically in a particular community or location. CMH Centers also provide regional coordination for any person in the center's catchment area, but such coordination is typically associated with the disbursement of public funds (defined in §27-66-101, C.R.S., and 2 CCR 502-1, 21.200.41).

It is important to consider the licensing of community-based mental health services in the context of CDPHE's other licensure responsibilities. CDPHE licenses a wide array of facility types that deliver care ranging from acute (such as hospitals and birth centers) to residential (such as nursing homes, assisted living residences and group homes for persons with developmental disabilities). State statutes at §25-1.5-103, C.R.S., and §25-3-102, C.R.S., establish a general licensure framework that gives responsibilities to both CDPHE and DPS. CDPHE's regulations and oversight are aimed at ensuring facilities meet standards focused on protecting clients' health, safety and welfare. These "quality of care" standards are wide-ranging, from administrative and policy requirements (e.g., governing boards, policies, records), to patient care and protection standards (e.g., patient rights, required disclosures, staffing levels, emergency preparedness plans). DPS monitors compliance with fire protection standards.[3]

State statutes at §25-1.5-103(1)(c)(II) create a modified oversight structure for community-based mental health services. In addition to requiring these facilities to meet the standards of the general licensure framework, mental health service providers must also obtain program approval from the CDHS. The concept of program approval acknowledges CDHS' overarching responsibilities to promote the availability and accessibility of community-based mental health services throughout the state. In this capacity, CDHS is charged by statute to purchase community mental health services (§27-66-104, C.R.S.) and manage the behavioral health crisis response system (§27-60-104, C.R.S.). However, in some ways program approval is duplicative and burdensome, since it requires facilities to meet some of the quality of care standards common to the general licensure framework. "Program approval" is not defined in statute. As a result, it has been implemented such that some functions parallel the licensing functions carried out by CDPHE. However, program approval also involves quality oversight and program integrity functions related to the use of public funds. Table 1 illustrates the general licensure framework versus the modified framework for community-based mental health services.

[3] Fire protection standards only apply if services are delivered at the facility. For example, fire protection standards do not apply to home health agencies, since they deliver services to clients in their homes.

Table 1. Comparison of the General and Modified Licensure Framework

Licensure Framework	CDPHE *Issues a license based on quality of care standards*	DPS *Issues a certificate of compliance verifying the facility meets fire protection standards*	CDHS *Issues program approval based on quality of care standards*
General framework (applies to most licensed health care facilities)	√	√	n/a
Modified framework (applies only to community-based mental health facilities)	√	√	√

Oversight of Substance Use Disorder (SUD) Services. SUD services in Colorado range from outpatient services to medically-monitored intensive residential services. The continuum of care is based on categories defined by the American Society of Addiction Medicine (ASAM) in its patient placement criteria guidance titled The ASAM Criteria (2014). The ASAM Criteria and the specific services provided in Colorado are shown in Appendix B. In addition to the criteria established by ASAM, some SUD withdrawal management and treatment facilities dispense controlled substances, such as methadone. These providers include Medically Monitored Withdrawal Management (detox) programs, Opioid Treatment Programs, or Opioid Medication Assisted Treatment Programs regulated through 2 CCR 502-1, 21.300-320. They are licensed by CDHS pursuant to Title 27, Article 80, Part 2 of the Colorado Revised Statutes.

In contrast to the multi-agency licensure framework for mental health services, community-based SUD services are regulated only by the CDHS. CDHS issues SUD approvals as well as SUD licenses.[4] While SUD licenses are required for all facilities that dispense controlled substances, SUD approvals are otherwise required only for providers that receive public funding, such as Medicaid and federal block grants, or those serving the criminal justice population. Notable exceptions are facilities that dispense controlled substances, which in addition to obtaining a license must also obtain SUD approval, whether or not they receive public funding.

Identified Problems

The Behavioral Health Task Force identified the following problems with the current oversight processes:

- Gaps, duplication and conflicts within the current statutes, regulations and oversight processes
- Lack of parity between the level of consumer protection standards for physical health, mental health and substance use disorder services

[4] Both CDHS and CDPHE use the term "license." CDPHE licenses mental health facilities and CDHS licenses SUD treatment facilities that dispense controlled substances. The administrative processes used by the respective agencies are different and are not coordinated.

- Barriers to the delivery of integrated mental health and SUD services, especially for acute care, which promote service silos rather than a continuum of care
- Inflexible regulatory requirements that prevent innovation and responsiveness to ongoing changes in client needs.

These systemic problems are explored in further detail below.

Gaps, Duplication and Conflicts in the Regulatory Framework

- Gaps - Unclear Statutory Requirements. The statutory provisions pertaining to community-based mental health services are not uniform. While the licensure requirements regarding community mental health centers and acute treatment units are explicit, they are less clear for crisis stabilization units and community mental health clinics. Due to statutory ambiguity, CSUs do not have their own license category and are licensed under 6 CCR 1011-1, Chapter 9 – Community Clinics and Community Clinics and Emergency Centers, resulting in work-arounds that require facilities to obtain and annually renew numerous waivers from CDPHE regulations. This situation creates undue administrative burden for both service providers and CDPHE. In addition, the lack of statutory clarity regarding mental health clinics has led to uneven monitoring. Because it is unclear whether licensure is mandatory, mental health clinics only receive a license upon request.[5]

- Gaps - Lack of Familiarity with Fire Protection Standards. In order to obtain a license, facilities must receive a certificate of compliance (CoC) from the Colorado Department of Public Safety to demonstrate that they meet fire protection standards. The process to obtain the CoC may require considerable lead time, since DPS or local fire departments review the facility's architectural plans and may require corrections that involve changes to the physical plant. Sometimes, new facilities do not become aware of the need to obtain a CoC until they initiate the licensure process with CDPHE. Facilities with timelines for opening that do not account for the time needed to obtain a CoC may experience significant delays in opening, with implications for meeting statutory requirements, financing, staffing, and anticipated availability of services for the community.

- Duplication and Conflicts - Regulations. CDPHE issues the license after a facility has obtained program approval from CDHS, in accordance with statute. Licensure and program approval are both based on quality of care requirements. Although the intent may have been to establish distinct responsibilities for each regulatory agency, in practice, there is considerable overlap, including instances where CDPHE and CDHS regulations are in direct conflict. For example, CDPHE requires CSUs to be licensed as Community Clinics, while CDHS allows for CSUs to be licensed as community clinics or as ATUs. As another example, CDPHE and CDHS require occurrence/critical incident and grievance reporting that is not consistent or streamlined across departments. Duplicative and conflicting requirements have led to regulatory burden for providers as they try to navigate the requirements as well as administrative burden for regulatory agencies as they attempt to reconcile the standards. Providers report this duplication can also cause disruptions in care, waste in

[5] It is assumed that requests for licensure help ensure eligibility for private insurance reimbursement.

the system, and challenges in meeting statutory requirements and community expectations.

Lack of Parity in Oversight

- Substance Use Disorder (SUD) services grew out of the criminal justice system and are coercive while mental health services grew from a more voluntary model. These histories influence how consumers in these systems are viewed (e.g., stigma) as well as the focus of oversight and levels of consumer protection between the two fields.

- Insufficient Consumer Protections. With limited exceptions, community-based mental health services must be licensed by CDPHE in order to do business in the state, entailing oversight by CDPHE, CDHS, and DPS. Further, if mental health agencies also want to provide publicly-funded SUD services, they must also obtain SUD approvals. Notably, the oversight for SUD facilities and agencies is less stringent, since they are not subject to CDPHE's health facility licensure standards or DPS' fire protection and life safety standards. Although SUD providers that dispense controlled substances must be licensed by CDHS, other SUD providers only have to obtain an SUD approval if they receive public funding. To the extent that SUD providers are not regulated, there is no consistent way for consumers to verify whether the providers meet quality care standards or to obtain redress if they believe that they have received substandard care. Further, no SUD providers are subject to fire protection standards. Clients receiving residential SUD services experience comparable levels of impairment as clients receiving mental health services; therefore, there should be parity in terms of protections. The lack of parity is illustrated in Table 2, below.

Table 2. Lack of Parity in Oversight

	CDPHE *Issues a health facility license*	**DPS** *Issues a CoC*[6]	**CDHS** *Issues a Mental Health program approval*	**CDHS** *Issues an SUD license*	**CDHS** *Issues an SUD* approval
Mental Health Providers					
Community mental health centers	√	*	√	n/a	√**
Acute treatment units	√	√	√	n/a	√**
Crisis stabilization units[7]	√***	√	√	n/a	√**
Community mental health clinics	*	*	*	n/a	√**
SUD Providers					
SUD agencies	n/a	n/a	n/a	n/a	√
Facilities that dispense controlled substances	n/a	n/a	n/a	√	√

* Community mental health centers obtain a CoC only if they are providing direct services to clients. Centers may choose to only provide regional coordination for mental health services.

** Mental health providers only need to obtain SUD approvals if they choose to deliver SUD services.

*** Crisis stabilization units do not have their own licensing category, and instead are licensed under 6 CCR 1011-1, Chapter 9 – Community Clinics and Community Clinics and Emergency Centers, requiring CSUs to seek waivers from regulatory requirements in that chapter that do not apply in a CSU setting.

[6] CoC stands for certificate of compliance.

[7] Statutory authority is unclear.

Barriers to the Delivery of Integrated Services

- Provision of Integrated Services. Currently, SUD services cannot be provided under a community-based mental health license except in ATUs. (The statutory definition of an ATU at §25-1.5-103(2)(a), C.R.S., expressly permits the provision of SUD treatment.) This situation leads to service silos which ultimately prevent a seamless continuum of care within one facility space and have led to difficulties in reimbursement for the appropriate services for individuals with co-occurring disorders. As a result, providers must demonstrate a clear delineation with regard to staffing, client care records and how client care spaces will be maintained. If they co-locate services, they must separate the spaces using a 2-hour firewall, which is particularly costly unless the facility is new construction. These service silos and separation requirements mean that an individual with both mental health and substance use disorder treatment needs cannot have their needs met in a single location. This is particularly problematic for individuals needing acute treatment for both mental health and substance use disorders (i.e., concurrent withdrawal management and crisis mental health treatment services).

Inflexible Regulatory Requirements

- When CSUs were established, CDPHE did not have the authority to create a separate licensing category that would have closely reflected the purpose and standards for a CSU, and had to do the best it could to "fit" CSUs into an existing licensing category. Although doing so allowed CDPHE to license CSUs, it is a case of trying to "fit a square peg in a round hole."

- The current system prevents providers from modifying their delivery systems in response to changing client needs. Two main factors were identified as hindrances to innovation – licensure categories delineated in statute that narrowly define the kind of care that can be provided and regulations across state departments that are not coordinated. The current licensure categories limit the types of services that can be provided to: outpatient mental health, or bed-based crisis stabilization, or substance use disorders, but not all three under the same license. Providers should not have to seek separate licenses to deliver services to the same population. Further, obtaining a license should not require the navigation of multiple jurisdictions and the burdens that creates (e.g., administrative time focused on determining requirements, drawing staff time away from clinical work), unless those jurisdictions have coordinated oversight processes.

Guiding Principles

The Task Force identified a set of guiding principles that govern its recommendations. These principles encompass a broad set of factors that the new licensing system should address. These guiding principles fall into the same categories used for the problems that were identified -- gaps, duplication and conflicts within the current statutes, regulations and oversight processes; lack of parity between the level of consumer protection standards for physical, mental health and substance use disorder services; barriers to the delivery of

integrated mental health and SUD services, which promote service silos rather than a continuum of care; and inflexible regulatory requirements that prevent innovative responses to changes in client needs. In addition, in order to minimize service disruption, it was recognized that the existing regulatory structure should remain in place until such time as there is a clearly articulated approach to change, preferably in response to new legislation and/or regulation. In accordance with these guiding principles, any new behavioral health licensing structure should:

Reduce Gaps, Duplication and Conflicts in the Regulatory Framework

- **Reduce the licensing and program approval burden on behavioral health providers by clarifying, consolidating and simplifying the process through which a behavioral health provider seeks/is granted a license.** Under the current system, providers must navigate and comply with requirements from local fire/building departments, DPS' Division of Fire Prevention and Control for Life Safety Code requirements, and CDHS' Office of Behavioral Health for program approval prior to being eligible for a license from CDPHE. From the provider perspective it is common for one agency to hold programmatic expectations that contradict facility requirements from another agency, making it difficult to establish, sustain and operate facilities that are responsive to consumer needs.
- **Clarify CDPHE, CDHS, and DPS roles related to regulation and oversight of behavioral health providers.** The current system, with both CDPHE and CDHS having oversight regarding quality, and CDPHE and DPS both having a function related to licensing, can be confusing and lead to overlapping requirements. Clear delineation of departmental responsibilities related to behavioral health licensing and oversight should reduce both confusion and overlap. See Appendix C for more detail on current and proposed future departmental roles.

Increase Oversight Parity

- **Increase parity in the oversight of physical, mental health, and substance use providers.** The current licensing and oversight system has differing standards for physical health, mental health and substance use disorder providers, which contributes to issues around stigma and lack of access for non-physical health services. The differing oversight and regulation also contributes to a system which does not provide a consistent level of assurance across service types regarding the protection of the health, safety and welfare of Colorado's citizens.

Remove Barriers to the Delivery of Integrated Services

- **Allow treatment of co-occurring disorders to benefit consumers.** Behavioral health consumers do not exist solely within the "silos" of the existing regulatory framework. Oftentimes consumers need both mental health and substance use treatment. According to the 2017 National Survey on Drug Use and Health, 45 percent of individuals with a substance use disorder also have a mental health diagnosis, and 18 percent of those with a mental health disorder also have a substance abuse disorder.

The treatment of co-occurring disorders is especially important for individuals needing crisis/acute services. In the current system, those services cannot be provided in one location due to inflexible licensing and program approval requirements from multiple agencies.

- **Integrate the licensing processes for mental health and substance use (including alcohol) disorders to reduce the burden on providers.** CDPHE licensing is currently limited to certain models of mental health treatment (ATU, CSU, Community Mental Health Centers and Community Mental Health Clinics), and does not include substance use disorder or alcohol treatment. CDHS alone has oversight responsibilities regarding substance use disorder and alcohol treatment services, as well as partial oversight over mental health services through the program approval function.

- **Allow a continuum of care to be provided.** Both mental health and substance use disorder services involve a continuum of treatment—from crisis and stabilization services to ongoing treatment. Currently, these services are provided under different license types, resulting in individuals who need services having to access different providers and locations as their needs change. Allowing a continuum of care under a single license would also allow providers to be more responsive to individuals' needs.

Increase Flexibility of Regulatory Requirements

- **Allow flexibility for entities to add and/or modify services without requiring a different, additional license.** Behavioral health entities may need to modify the services they provide based on the changing needs in the communities and populations they serve. The current licensing system does not allow this flexibility.

- **Allow flexibility within a broad license category for regulating agencies to be responsive to how behavioral health service delivery takes place, and allow new, innovative service types without having to create an entirely new license category.** As new, innovative treatment models/options emerge, the licensing system has lagged behind, causing a "square peg in a round hole" situation where providers are licensed as medical facilities, oftentimes with several waivers of rule requirements that are not appropriate for a behavioral health provider. Various nuances in behavioral health treatment are not captured or well-addressed under the existing licensing categories. The current difficulties in licensing CSUs are a good example of some of these challenges. In addition, providers that wish to modify the services they provide in order to meet the needs of their community or the population they are serving may have limits on what they can do based on the type of license they have. An option for achieving this flexibility would be the implementation of a "cafeteria-style" Behavioral Health Entity license under which a provider would meet a set of general standards regarding operation, patient rights, recordkeeping, etc., and then pursue one or more types of services, or pathways, to be provided under the license. A draft framework for this type of license is included in Appendix A.

- **Ensure compliance with federal law and allow providers to seek federal certification when desired/possible.** The use of federal funds through both grants and the state/federal Medicaid program is a critical piece of behavioral health funding in Colorado. Any licensing changes should ensure these important funding avenues remain available and are not jeopardized by consolidating oversight functions**.**

Maintain the Status Quo until Changes are Implemented

- **Prevent service disruption while changes are implemented.** It is important that changes to the oversight of community-based behavioral health services do not hinder access to care or disrupt existing providers and processes. There is an expectation that existing processes will continue until clear, well-communicated phased-in implementation occurs, rather than a piecemeal approach that will create a moving target for both providers and regulatory agencies.

Recommendations

The Task Force identified a number of recommendations to restructure the regulation and oversight of community-based behavioral health services in Colorado. The following recommendations work together to implement a system that addresses the problems identified by the Task Force. The seven recommendations are designed to meet the needs of consumers, providers, and regulators.

1. Establish a Behavioral Health Entity License at CDPHE that will be required in order to provide community-based behavioral health services in the state, regardless of the funding sources paying for those services. The license function should exist solely at CDPHE, and CDHS program approval responsibilities as required for licensing should be transferred to CDPHE and/or otherwise incorporated into the CDPHE licensure process[8]. The Behavioral Health Entity License should include and replace existing license requirements for:
    a. Community-based mental health entities currently licensed as CSUs, ATUs, community mental health clinics and community mental health centers.
    b. Community-based substance use and alcohol treatment not currently licensed by CDPHE, including substance use disorder services and social detox.
    c. Future community-based mental health or substance use or alcohol treatment services and service modalities resulting from innovation, funding changes, etc.

    The Behavioral Health Entity License should meet the requirements of the guiding principles enumerated above: allowing for treatment of co-occurring disorders, integrating mental health and substance use disorder treatment, allowing for a continuum of care within a single facility under a single license, allowing the flexibility for providers to change services without requiring a new license, increasing parity in the licensing and oversight of mental health and substance use disorder services, ensuring compliance with federal law, allowing for providers to seek federal

[8] This restructuring will require changes to §25-1.5-103(1)(c)(II) C.R.S., §25-3-102(2), C.R.S., §27-66-104, C.R.S., §27-66-105, C.R.S., §27-80-103(1), C.R.S., §27-81-106(5), C.R.S., and §27-82-103, C.R.S.

certification as desired/possible, and clarifying/simplifying the licensure process to the extent possible.

2. Create a Behavioral Health Licensing Advisory Committee to implement and advise on the new Behavioral Health Entity License, with the following composition and responsibilities:
    a. The Committee should include representatives from CDPHE, CDHS, DPS and HCPF; behavioral health providers representing the different current service types to be included in the BHE license; providers representing currently-unlicensed SUD services; and patients/advocates for patients receiving behavioral health services.
    b. The Committee should initially advise on implementation of the BHE license, including rule writing, developing guidance for providers, and working with HCPF to determine the changes necessary to maintain Medicaid funding for behavioral health services.
    c. After implementation, the Committee should continue to meet in an advisory capacity as part of CDPHE's stakeholder processes related to licensure.

3. Continue and clarify the purchasing-related oversight function at CDHS. This function establishes standards over and above the standards associated with the Behavioral Health Entity License and applies to providers participating in publicly funded programs administered by CDHS. Publicly funded programs include community mental health services purchased in accordance with §27-66-104, C.R.S., and SUD prevention and treatment services purchased in accordance with §27-80-106, C.R.S. This function should:
    a. Ensure compliance with requirements for federal financial participation.
    b. Target resources to priority services and communities.
    c. Protect program integrity, including both program quality and financial/contracting oversight. If the term "program approval" continues to be used in statute to describe these functions, it should be defined.

4. Continue and clarify CDHS and HCPF responsibilities for system and service coordination for community-based behavioral health services, including:
    a. Development of the State Plan for substance use disorder treatment programs in accordance with §27-80-102, C.R.S., and §27-81-103, C.R.S.
    b. Managing the crisis response system in accordance with §27-60-104, C.R.S.
    c. Maintaining responsibility for the care and treatment of persons with mental health disorders pursuant to Title 27, Article 65, C.R.S.
    d. Disbursement of public funds. The term "public funds" should be defined with respect to behavioral health oversight, and the roles of CDHS and HCPF for overseeing public funds should be clarified.

5. Continue and clarify Life Safety Code and fire protection oversight at DFPC, including:
    a. Continuing DFPC's role as a partner to CDPHE.
    b. Continuing CDPHE's requirements for a DFPC Certificate of Compliance prior to issuing or renewing a license, in accordance with §25-3-102(3), C.R.S.

c. Improving provider experiences through a "single entry point" process at CDPHE and a continued liaison process between CDPHE and DFPC.

6. Create "how to" licensing guides for entities wishing to obtain a behavioral health license. These guides will need to be created both now (for providers seeking a license prior to legislative/regulatory change) and after the changes are made. The information in the guides should include but not be limited to:
    a. Requirements for local building/fire inspections.
    b. DFPC Life Safety Code requirements.
    c. Processes and requirements for general licensing (standards that apply to all licensed entities regardless of type).
    d. Processes and requirements for the specific Behavioral Health Entity License.
    e. Establishing CDPHE as the "single entry point" for Behavioral Health Entity licensing activities to help providers navigate the licensure process.

7. Seek statutory changes during the 2019 legislative session, including the authority for rule promulgation as needed, to implement the previous recommendations, with phased-in implementation as follows:
    a. By late summer 2019, initiate the stakeholder process for drafting implementing rules to bring mental health provider types currently licensed by CDPHE into the Behavioral Health Entity licensing model, with a target for approval by the Board of Health in February 2021. All the relevant state agencies that will need to amend their regulations and processes to conform to the new licensing structure should be involved.
    b. In early 2021, initiate the stakeholder process to bring SUD service providers into the Behavioral Health Entity licensing model, with a target for approval by the Board of Health in 2023. All the relevant state agencies that will need to amend their regulations and processes to conform to the new licensing structure should be involved.

    CDPHE, DHS, DPS and HCPF should participate in the drafting of the proposed legislation with stakeholder input. In addition, the agencies should develop coordinated input during the fiscal note process to ensure the appropriate addition/movement of funding and FTE between departments and that there are adequate resources for rule promulgation and implementation.

Issues Still to be Addressed

The Task Force identified a number of issues that will need to be addressed in the future as part of the implementation of its recommendations. The following are some of the practical, detail-level issues that should be addressed by the committee charged with implementing the legislation and recommendations stemming from this report:

- <u>Funding of behavioral health oversight, including licensing.</u> CDPHE funds its licensing and oversight activities through licensing fees charged to entities seeking to become

licensed, or renewing or making changes to an existing license. Fees must cover the department's direct and indirect costs. Substance use disorder providers are currently not licensed by CDPHE and have not been subject to such fees.

- Behavioral Health "Inpatient" services vs. hospital inpatient services. It is important to clearly define inpatient services in the context of the behavioral health entity license, and to ensure that the behavioral health inpatient meaning is clear and distinct from the well-established meaning of inpatient in a hospital setting. This distinction clarifies that behavioral health entities do not have to comply with hospital inpatient standards.

- Clarifying "use of public funds" for behavioral health services, and ensuring access to these funds is not jeopardized by consolidating licensing and oversight functions. Both CDHS and HCPF fund behavioral health services through funds that could be argued are "public funds." The meaning of public funds should be carefully considered to determine the appropriate level of oversight through licensure or other methods to prevent unintended consequences and/or constraints on these funding sources.

- Licensing for providers with multiple physical locations. In CDPHE's existing licensing categories for mental health services (ATUs, community clinics, etc.) each location has a separate license. Whether a single license could encompass more than one location should be further evaluated, and should consider issues including, but not limited to, location-specific requirements (local building/fire codes, Life Safety Code inspections), licensing enforcement needs (e.g., if a single license were granted for multiple locations, would that mean that the entire license is in jeopardy if a single location is subject to enforcement), and ease for providers. Even if a license can include multiple locations, each location will be subject to the Certificate of Compliance requirements.

- Controlled Substance Licensing/Medication Assisted Therapy (MAT). MAT services are provided in an outpatient SUD setting and include the use of Methadone or another approved controlled substance by a person with opiate use disorder to decrease dependence on opioids. These services are currently licensed by CDHS in accordance with §27-80-204, C.R.S., and a license is required in order to operate, regardless of funding source. The Task Force has not determined the most appropriate placement of this oversight—whether it should move to CDPHE or remain at CDHS. However, the Task Force did determine that the oversight for these services should remain intact—that is, with a single agency and separate from the overarching behavioral health entity license, regardless of whether the regulatory agency is DHS or CDPHE.

- Implementation of Licensing SUD Service Types. SUD providers are not currently required to be licensed, and there will need to be education and outreach to those provider types.

- Evaluating Impacts of Changes to CDHS Program Approval Function. Different agencies and offices rely on CDHS' program approval for purposes outside of those addressed in this report. For example, a provider with CDHS program approval is considered to be

"accredited" for the purposes of HCPF and the Regional Accountable Entities (RAE). The working group should identify these additional uses and determine how a behavioral health entity license could fill that purpose.

Additional Issues for Future Study

The scope of the Task Force was focused on community-based behavioral health services for adults. However, the Task Force recognizes that there is also a need for an evaluation of additional issues that came up during its discussions, but that are outside of its defined scope, including the following:

- Oversight and Regulation of Inpatient and Residential Behavioral Health Services for Children. There is an increasing need for access to mental health and substance use treatment services for children. Both the CDHS' Division of Child Welfare, and OBH have oversight roles, and an evaluation of the oversight of such services could be appropriate to identify any regulatory gaps, lack of parity, and barriers to innovation that might exist for those services.

- Sober Living Residences. There is no mechanism for regulating or providing oversight for services commonly known as sober living residences, leaving consumers and their families in a position of "buyer beware." There are rapidly increasing numbers of sober living residences in Colorado.

- DUI Treatment Services. The provider requirements regarding court-ordered DUI treatment, established in §42-4-1301.3, C.R.S., were not included in the Task Force's discussions. It is possible that being a licensed behavioral health entity will be adequate for meeting referral requirements, but these requirements should be considered in evaluating whether DUI services should be included in the Behavioral Health Entity License. Representatives from the Criminal Justice system were not involved in this Task Force, and should have a role in any future stakeholder processes around this issue.

Appendix A: Overview of Task Force Discussions and DRAFT Behavioral Health Entity License Framework

The Behavioral Health Task Force met eight (8) times between July and November 2018. In practice, meetings were focused on presentation and discussion of information, with "homework" for Task Force members between meetings to be presented and discussed at the next meeting, proceeding through the following topics:

- The role of the Task Force, including discussion and agreement on the scope of services to be included in the Task Force's work and the goals and guiding principles to be used as a framework for the Task Force's decisions. The Task Force identified the services it was trying to address as being community-based and not hospital-based.

- The current state of oversight and regulation of behavioral health services in Colorado, including licensing and certification at CDPHE; program approval, certification, licensing and service purchase functions at CDHS; Life Safety Code inspections and responsibilities at DFPC (within DPS); and purchase of services at HCPF. In discussing these various responsibilities, the Task Force identified numerous problems, from the confusion caused by the same word meaning unique things at different agencies (e.g., "license"), to larger issues such as inconsistent regulations (e.g., CDHS rules allow CSUs to be licensed as ATUs but CDPHE's rules do not).

- The various levels of physical building approvals required of facilities providing behavioral health services, including local fire and building codes, Life Safety Code inspections and the issuance of Certificates of Compliance by DFPC, and Facility Guidelines Institute (FGI) standards included in the licensing process at CDPHE. FGI is a national standard document that provides minimum guidelines for the planning, design and construction of health facilities to ensure patient safety and functionality. FGI works with many organizations to develop the guidelines and other practical publications that use the best available research evidence. Additional discussions centered around when each requirement comes into play and how these varying requirements contributed to burdens on providers and provider frustrations, delays and difficulties in getting some facilities up and running. There was also discussion of external constraints on the flexibility to make changes in this area, from federal prohibitions on "co-mingling" or providing multiple services in the same location for certified facilities, to DFPC's authority being limited to facilities that are licensed by CDPHE, as well as the contractor/ subcontractor relationship between CDPHE and DFPC. The Task Force discussed the need for a "toolkit" or other resource for providers to understand the different types of requirements and when those requirements apply to a project or building.

- The history of the different types of behavioral health services, how that history has influenced how those services are currently regulated, and what that means for providers and consumers. For example, treatment of Substance Use Disorder (SUD) services grew out of the needs of the criminal justice system while mental health services have grown out of a more voluntary model. These histories influence how

consumers in these systems are viewed (e.g., stigma) as well as the focus of oversight and varying levels of consumer protection between the two fields. These discussions led to the Task Force seeking an oversight and regulatory system that increases parity for the different types of behavioral health services, as well as supporting behavioral health needs as equal to physical health needs.

- The potential avenues available for addressing the gaps and difficulties in the oversight and regulation of the different types of behavioral health services. The Task Force considered both the pros and cons of making incremental changes to the existing licensing structure in order to "clean up" some of the more egregious problems while also considering leaving licensing, regulation and oversight as a function of multiple state agencies. Through such analyses, the Task Force decided to consider a single behavioral health license category, and as part of this discussion and evaluation, the Task Force started to codify the Guiding Principles of what any new licensing system should address. (Note: These Guiding Principles can be found on page 17 of this report.) The task force discussed and developed a potential behavioral health licensing framework in response to those guiding principles (see next page):

DRAFT Behavioral Health Entity License Framework—As Considered by the Task Force

Base License--Entities must meet a foundational set of requirements for the over-arching Behavioral Health Entity License, which might include:

Consumer/Client general standards
- Assessment
- Patient Rights

Administrative/Operational standards
- Governance
- Administrative Functions—client records, personnel (files, policies, training), admission and discharge criteria, policies and procedures
- Quality Assurance/QMP

Physical Plant standards
- Life Safety Code-general issues
- Environmental- infection control, housekeeping, maintenance
- FGI Standards

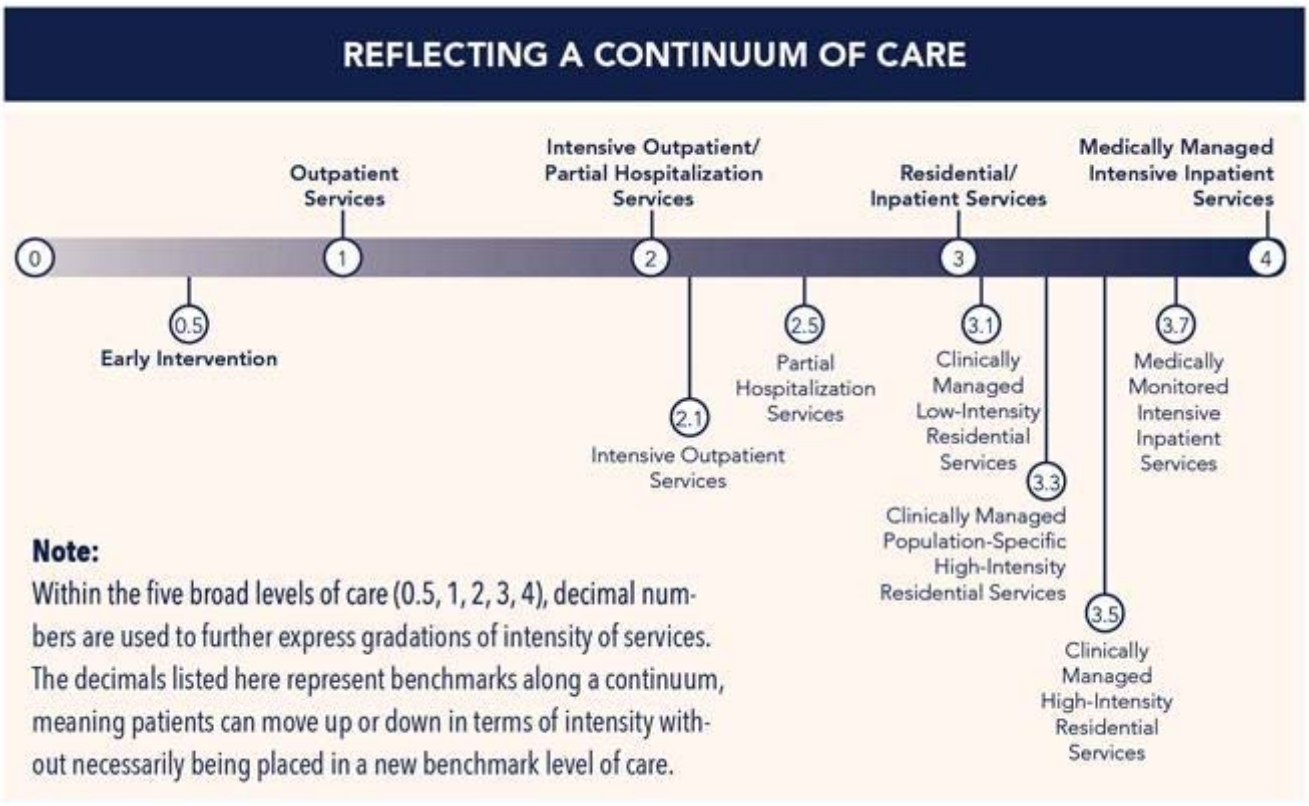
Licensed Pathways—In addition to the Base License (above), entities must meet standards specific to one or more service pathways. Standards specific to services pathways might include:

- Patient Care Plans
- Staffing (numbers and types of professionals)
- Seclusion and restraint
- Pharmaceutical services
- Locked/delayed egress or other pathway-specific Life Safety Code issues

<table>
<tr><th>CMH Center</th><th>CMH Clinic</th><th>CSU</th><th>ATU</th><th>Controlled Substance</th><th>Other SUD</th><th>NEW</th></tr>
<tr><td rowspan="2">Rules for this pathway should not prevent CMS certification (42 CFR 482.900-485.918). Rules should also ensure continued access to CMS or block grant funding</td><td rowspan="2"></td><td>Although they are currently licensed under 6 CCR 1101-1, Chapter 9, Community Clinics and Community Clinics and Emergency Centers, CSUs require a lot of waivers--the regulations for this pathway should be drafted specifically for CSUs.</td><td>6 CCR 1101-1, Chapter 6, Acute Treatment Units is specific to ATUs, but some requirements are set in statute. Moving these requirements from statute to rule would increase flexibility for the future</td><td>A separate pathway because this meets the working definition of license</td><td>Includes the SUD treatment continuum other than a controlled substance license. This might be multiple pathways.</td><td rowspan="2">In the future when additional service models are created, additional pathways could be added to the licensing structure without impacting the other pathways and general requirements.</td></tr>
<tr><td colspan="2">It might be possible to have a single pathway that would encompass both CSU and ATU services at some point in the future. Doing so would require statutory and regulatory change.</td><td colspan="2">In the final behavioral health licensing model, these pathways could possibly be combined.</td></tr>
</table>

Appendix B: Classifications of SUD Services

ASAM Criteria. The continuum of care as defined by the American Society of Addiction Medicine (ASAM) criteria is shown in Figure 1, below.



Colorado's Continuum of Care. Below is a list of SUD treatment services provided in Colorado.

ASAM Level	Service
1	Outpatient Treatment (up to 9 hours per week of therapeutic contact)
2.1	Intensive Outpatient Treatment (between 9 and 20 hours per week of therapeutic contact)
2.5	Partial Hospitalization (between 20 and 40 hours per week of therapeutic contact)
3.1	Transitional Residential Treatment (5 hours per week of treatment, people are usually living and working and going to school rather than attending treatment as their primary activity)
3.3	Nursing home or long term care--here people receive care for medical or developmental issues, with substance use disorder treatment being a secondary activity
3.5	High Intensity Clinically Managed Treatment Services - clinical care itself accounts for 5 hours per week of treatment (or more) but the interventions are based upon interactions between peers within a treatment milieu, rather than being directed by professional staff
3.7	High Intensity Medically Managed Treatment Services -here the clinical care is combined with treatment for other behavioral health conditions, as well as medical monitoring of any conditions that a client/patient may have that need attention
3.2 WM	WM- this is withdrawal management, where withdrawal is supervised by trained counselors who have specific protocols to follow should a patient experience complications from withdrawal. Typically no

	medical staff on site. Patients with more severe withdrawal profiles are generally diverted to receive medical care and not treated at Level 3.2WM
3.7 WM	This is medically monitored withdrawal management, and medication may be used here to alleviate the symptoms of withdrawal. It is typically used for withdrawal from alcohol, possibly benzodiazepines and sometimes opiates if medically necessary (note, withdrawal from opiates is not medically dangerous in the absence of medical conditions, however the patient generally experiences extreme discomfort)

Appendix C: Current and Proposed Departmental Roles

The proposed Behavioral Health Entity (BHE) licensure framework is designed to fit in with the existing department roles and responsibilities of the three departments.

	Role of CDPHE	Role of CDHS	Role of DPS
Current roles and responsibilities	Licensure of health facilities, which includes facilities that provide outpatient, inpatient and residential services for acute and chronic physical health needs, mental health, and for persons with intellectual and developmental disabilities.	Accessibility and availability of mental health services, which involves responsibilities that include but are not limited to: - Development of SUD treatment state plan - Purchase of community- based mental health services - Management of crisis response system and regional CMHC coordination	Assuring compliance of fire protection standards
Proposed roles and responsibilities associated with the BHE license	Licensure of behavioral health entities (including program approval functions moved over from CDHS). Providers may have either mental health services, or SUD services, or both.	Assuring program integrity when the BHE receives public funding	Issuing CoCs to BHEs