

Title of Proposed Rule:	Behavioral Health Administration Provider Rules	
CDHS Tracking #:	22-10-21-02	
Office, Division, & Program: Quality & Standards Division, Behavioral Health Administration	Rule Author: Thomas Miller	Phone: 720.830.7484
		E-Mail: thomasl.miller@state.co.us

RULEMAKING PACKET

Type of Rule: *(complete a and b, below)*

- a. ☒ Board ☐ Executive Director
- b. ☒ Regular ☐ Emergency

This package is submitted to State Board Administration as: *(check all that apply)*

AG Initial Review		Initial Board Reading		AG 2 nd Review	☒	Second Board Reading / Adoption
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This package contains the following types of rules: *(check all that apply)*

Number	
	Amended Rules
X	New Rules
	Repealed Rules
	Reviewed Rules

What month is being requested for this rule to first go before the State Board?	September 2023
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What date is being requested for this rule to be effective?	January 1, 2024
Is this date legislatively required?	Yes

I hereby certify that I am aware of this rule-making and that any necessary consultation with the Executive Director's Office, Budget and Policy Unit, and Office of Information Technology has occurred.

Office Director Approval: _____ **Date:** _____

REVIEW TO BE COMPLETED BY STATE BOARD ADMINISTRATION

Comments:

Estimated 1st Board 2nd Board Effective Date
Dates: _____

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STATEMENT OF BASIS AND PURPOSE

Summary of the basis and purpose for new rule or rule change.

*Explain why the rule or rule change is necessary and what the program hopes to accomplish through this rule. **1500 Char max***

HB 22-1278 set out a certain powers and duties for the Behavioral Health Administration (BHA) and therein required the BHA to promulgate rules related to licensing Behavioral Health Entities (BHEs). Section 27-50-106 (1), C.R.S. transfers the licensing authority of the BHE license from the Colorado Department of Public Health and Environment (CDPHE) to the BHA. Section 27-50-107(3), C.R.S. gives the BHA authority to promulgate rules related to conditions that behavioral health programs and entities must meet for licensure, and 27-50-502 (1) gives the BHA authority to set minimum standards for the operation of BHEs within the state.

The BHA has developed these rules to align with the cafeteria style licensing model that is transferring from CDPHE, which is distinct from the current licensing structure that the BHA operates. Through this rule update, the BHA hopes to fulfill its statutory obligations in taking on the BHE licensing authority. In addition, the BHA hopes that this rule revision will co-create a people-first behavioral healthcare system that meets the needs of all people in Colorado, creates standards that promote the health and safety of individuals receiving behavioral health services in Colorado, and ensures that services accessed through the system are accessible, meaningful, and trusted.

Chapter 1 provides the majority of the definitions for terms used throughout the rule volume to create clarity and consistency. Authority for each chapter is addressed below.

Chapter 2 establishes the conditions that an agency must meet in order to be licensed as a BHE and the minimum standards for the operation of a BHE. Authority to promulgate these rules comes from sections 27-50-107 (3) (b), C.R.S. and 27-50-502 (1), C.R.S. respectively.

Chapter 3 establishes the standards that BHEs must follow when electing to provide mental health and substance use recovery supports. The authority to promulgate these service-specific requirements that apply to BHEs electing to provide this service comes from sections 27-50-502 (1), C.R.S. and 27-50-107 (3) (b).

Chapter 4 establishes the standards for BHEs electing to provide mental health and substance use outpatient services and high-intensity outpatient service. The authority to promulgate these service-specific requirements that apply to BHEs electing to provide this service comes from sections 27-50-502 (1), C.R.S., 27-50-106, C.R.S., 27-50-301(5), C.R.S. and 27-50-107 (3) (b), C.R.S.

Chapter 5 establishes the standards for BHEs electing to provide behavioral health residential services. The authority to promulgate these service-specific requirements that apply to BHEs electing to provide this service comes from sections 27-50-502 (1), C.R.S, 27-50-106, C.R.S., 27-50-301(5), C.R.S., 27-71-105 (1), C.R.S., and 27-50-107 (3) (b), C.R.S.

Chapter 6 establishes the standards for BHEs electing to provide behavioral health crisis and emergency services. The authority to promulgate these service-specific requirements that apply to BHEs electing to

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provide these services comes from sections 27-50-502 (1), C.R.S., 27-50-106, C.R.S., and 27-50-107 (3) (b), C.R.S.

Chapter 7 establishes the standards for emergency and involuntary commitment of a person with a substance use disorder. Authority for BHA administration of these programs is found in sections 27-50-105 (1) (pp), C.R.S. and 27-50-105 (1) (qq), C.R.S. Authority to promulgate rules required for the administration of these programs comes from sections 27-50-107 (3), C.R.S. and 27-50-502 (1), C.R.S.

Chapter 8 establishes standards for agencies seeking an endorsement to provide services for children and families. Rules include requirements for individual assessment, treatment, and patient rights. The authority for those standards comes from section 27-50-502 (1) (a) (l), C.R.S. Further, authority to promulgate these rules establishing additional competencies related to serving priority populations, including children, comes from section 27-50-502 (6) C.R.S., and for children, sections 27-50-301 (3)(c), C.R.S. and 27-50-301 (5), C.R.S., and 27-50-107 (3), C.R.S.

Chapter 9 establishes standards for agencies providing women's and maternal behavioral health treatment. Authority to promulgate rules establishing requirements for individual assessment, treatment, and patient rights comes from section 27-50-502 (1) (a) (i), C.R.S. authority to promulgate these rules establishing additional competencies related to serving priority populations comes from section 27-50-502 (6) C.R.S. Additionally, the BHA has authority to administer the treatment program for high-risk pregnant women created pursuant to sections 27-80-112, C.R.S. and 27-80-113, C.R.S.. Authority for BHA administration of this program is found in 27-60-105 (1) (bb), C.R.S. Authority to promulgate rules required for the administration of this program comes from section 27-50-107 (3) (a), C.R.S.

Chapter 10 establishes the standards for BHEs providing services to criminal justice involved individuals, including specific criminal justice programs. Authority for BHA administration of these programs is found in section 27-50-105 (1) subparts (vv), and (ww), C.R.S. Authority to promulgate rules required for the administration of this program comes from section 27-50-107 (3) (a), C.R.S. Also, authority to promulgate rules establishing requirements for individual assessment and treatment comes from section 27-50-502 (1) (a) (i), C.R.S. and applies here.

Chapter 11 establishes standards for facilities that are designated pursuant to Article 65 of Title 27 of the Colorado Revised Statutes. Authority for promulgation of these rules is found in sections 27-65-128, C.R.S and 27-50-107 (3), C.R.S. HB 22-1256 created new requirements around involuntary mental health treatment and this rule volume will incorporate those changes as well.

HB 22-1278 further required the BHA to establish a comprehensive and standardized behavioral health safety net system throughout the state. To do this, HB22-1278 creates Comprehensive Community Behavioral Health Providers and Essential Behavioral Health Safety Net Providers and requires the BHA to identify clinical and practice standards, as well as health and safety standards that these providers will be held to (Section 27-50-301 (3) (c), C.R.S.) and to develop a process for approving providers as behavioral health safety net providers.

Chapter 12 establishes standards for behavioral health safety net providers, including comprehensive community behavioral health providers and essential behavioral health safety net providers and the

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behavioral health safety net approval process. Authority to promulgate these rules is found in Section 27-50-107 (3) (c), C.R.S. and 27-50-301 (5), C.R.S. Included in this chapter are the standards that BHEs must meet when providing care coordination, care management, outreach, education and engagement, and outpatient competency restoration. The authority to promulgate these service-specific requirements comes from section 27-50-502 (1) (b), C.R.S.

An emergency rule-making (which waives the initial Administrative Procedure Act noticing requirements) is necessary:

- ☐ to comply with state/federal law and/or
- ☐ to preserve public health, safety and welfare

Justification for emergency:

State Board Authority for Rule:

Code	Description
26-1-107 (5), C.R.S. (2022)	State Board to promulgate rules
26-1-107, C.R.S. (2022)	State department rules to coordinate with federal programs
26-1-107, C.R.S. (2022)	State department to promulgate rules for public assistance and welfare activities.
27-50-107 (3), C.R.S. 27-50-502 (1), C.R.S.	Chapter 2
27-50-107 (3) , C.R.S. 27-50-502 (1), C.R.S.	Chapter 3
27-50-107 (3), C.R.S. 27-50-502 (1), C.R.S., 27-50-106, C.R.S., 27-50-301(5), C.R.S.	Chapter 4
27-50-107 (3), C.R.S. 27-50-502 (1), C.R.S. 27-71-105 (1), C.R.S., 27-50-106, C.R.S., 27-50-301(5), C.R.S.	Chapter 5
27-50-107 (3), C.R.S. 27-50-502 (1), C.R.S., 27-50-106, C.R.S.	Chapter 6
27-50-107 (3), C.R.S. 27-50-502 (1), C.R.S.	Chapter 7
27-50-502 (1) (a) (i), C.R.S. 27-50-502 (6), C.R.S.	Chapter 8

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27-50-301 (3)(c), C.R.S. 27-50-301 (5), C.R.S. 27-50-107 (3) C.R.S.	
27-50-502 (1) (a) (i), C.R.S. 27-50-502 (6) C.R.S. 27-50-107 (3), C.R.S.	Chapter 9
27-50-107 (3) (a), C.R.S.	Chapter 10
27-65-128, C.R.S.	Chapter 11
27-50-107(3)(c), C.R.S. 27-50-301 (5), C.R.S. 27-50-502 (1) (b) , C.R.S.	Chapter 12

Program Authority for Rule: *Give federal and/or state citations and a summary of the language authorizing the rule-making function AND authority.*

Code	Description
27-50-107 (3) , C.R.S. 27-50-502 (1), C.R.S.	Chapter 2
27-50-107 (3) , C.R.S. 27-50-502 (1), C.R.S.	Chapter 3
27-50-107 (3) , C.R.S. 27-50-502 (1), C.R.S., 27-50-106, C.R.S., 27-50-301(5), C.R.S.	Chapter 4
27-50-107 (3) , C.R.S. 27-50-502 (1), C.R.S. 27-71-105 (1), C.R.S., 27-50-106, C.R.S., 27-50-301(5), C.R.S.	Chapter 5
27-50-107 (3) , C.R.S. 27-50-502 (1), C.R.S., 27-50-106, C.R.S.	Chapter 6
27-50-107 (3), C.R.S. 27-50-502 (1), C.R.S.	Chapter 7
27-50-502 (1) (a) (i), C.R.S. 27-50-502 (6), C.R.S. 27-50-301 (3)(c), C.R.S. 27-50-301 (5), C.R.S. 27-50-107 (3) C.R.S.	Chapter 8
27-50-502 (1) (a) (i), C.R.S. 27-50-502 (6) C.R.S. 27-50-107 (3), C.R.S.	Chapter 9
27-50-107 (3) (a), C.R.S.	Chapter 10
27-65-128, C.R.S.	Chapter 11

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27-50-107(3)(c), C.R.S., 27-50-301 (5), 27-50-304(7), C.R.S. 27-50-502 (1) (b) and (6), C.R.S.	Chapter 12
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Does the rule incorporate material by reference?	X	Yes			No
Does this rule repeat language found in statute?	X	Yes			No

If yes, please explain.	The rule incorporates by reference: • 42 C.F.R. Part 2 • Americans with Disabilities Act • The American Society of Addiction Medicine Criteria • The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition • HIPAA • Required Formulary Psychotropic Medications: 2018 • SAMHSA's "Core Competencies for Peer Workers in Behavioral Health Services - 2018" • The Controlled Substance Act found at 21 U.S.C. § 823(g)(2) • Title 21, Food and Drugs, Chapter II, Code of Federal Regulations, Sections 1301.71 through 1301.77 • 21 C.F.R. Part 1300, 1301, and 1304 • 42 CFR Part 8 • Required formulary of psychotropic medications • Behavioral Health Administration DUI/DWAI Legal Supplement • Interlock Enhancement Counseling • Emergency Medical Treatment and Labor Act • Protection and Advocacy for Individuals with Mental Illness Act
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REGULATORY ANALYSIS

1. List of groups impacted by this rule.

Which groups of persons will benefit, bear the burdens or be adversely impacted by this rule?

Groups impacted by these rules include: behavioral health providers, individuals receiving services, and other state agencies including CDPHE, the Department of Health Care Policy & Financing (HCPF), and the Colorado Department of Human Services.

2. Describe the qualitative and quantitative impact.

How will this rule-making impact those groups listed above? How many people will be impacted? What are the short-term and long-term consequences of this rule?

Behavioral health providers: In some cases, currently licensed providers will be subject to additional requirements in order to ensure the quality of care they are providing. In other cases, they will be subjected to less administrative burden, including due to the BHA taking on authority of the BHE license (as many agencies are now regulated by both CDPHE and the BHA due to CDPHE's BHE authority). This rulemaking will also require behavioral health providers that do not receive public funding and are currently unlicensed to be licensed.

Individuals who receive services will benefit from this rule change as they will have access to higher quality and better regulated behavioral health services.

CDPHE will be relieved of their authority to issue and renew BHE licenses.

HCPF will be aligning benefits and payment to the new licensing and approval structures.

In the short term, additional providers will be subject to regulatory oversight and providers currently under regulatory oversight may have additional requirements. Providers may need to new licenses or approvals adopt new policies or procedures to align with the requirements. These additional requirements will increase provider accountability and expand levels of services they can provide. Many providers will also transition from being regulated by two State Departments to one, reducing administrative burden.

In the long term, this rulemaking will ensure that all entities providing behavioral healthcare in Colorado are appropriately regulated to protect the health, safety, and welfare of individuals served. Individuals will have access to high quality behavioral healthcare that is trusted and meaningful.

3. Fiscal Impact

*For each of the categories listed below explain the distribution of dollars; please identify the costs, revenues, matches or any changes in the distribution of funds even if such change has a total zero effect for any entity that falls within the category. If this rule-making requires one of the categories listed below to devote resources without receiving additional funding, please explain why the rule-making is required and what consultation has occurred with those who will need to devote resources. **Answer should NEVER be just "no impact" answer should include "no impact because...."***

State Fiscal Impact (Identify all state agencies with a fiscal impact, including any Colorado Benefits Management System (CBMS) change request costs required to implement this rule change)

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The BHA anticipates revenue from licensing fees to offset the increased financial burden it will be assuming in relation to taking over BHE licensing and safety net provider approvals. Funding was allocated to cover all other costs associated with the implementation of these rules across state departments.

The CDPHE will experience a fiscal impact as they will no longer have the authority for the BHE license starting in 2025, which will alleviate their current financial burden of BHE administration.

HCPF will need to create new enhanced payment structures for safety net providers that may differ from their current reimbursement structure which may create a fiscal impact.

County Fiscal Impact

There is no anticipated fiscal impact for counties because they will not be responsible for the administration of any parts of these rules.

Federal Fiscal Impact

There is no anticipated fiscal impact at the federal level because they will not be responsible for the administration of any parts of these rules.

Other Fiscal Impact (such as providers, local governments, etc.)

Some providers that have not previously been licensed will be required to obtain a license and pay a licensing fee. Additionally, providers previously licensed by the BHA as substance use disorder providers will see an increase in licensing fees. Additionally, 27-65 providers will now be required to have individual licenses for each physical building instead of one license for an entire campus at one physical address. The BHA has made attempts to reduce provider burden associated with these rules, however providers that have not previously been licensed may see an increase in the administrative costs associated with complying with the licensing process and requirements. Behavioral Health Safety Net Providers will have a financial impact due to the required compliance with interpretation services and the requirement of documentation to be in multiple languages.

4. Data Description

List and explain any data, such as studies, federal announcements, or questionnaires, which were relied upon when developing this rule?

Reports developed by Colorado's Behavioral Health Task Force were utilized when developing this rule, including the licensing structure, standards to ensure health and safety and improve quality of care for individuals served by behavioral health providers. The Task Force Reports included data driven analysis of behavioral healthcare in Colorado.

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5. Alternatives to this Rule-making

Describe any alternatives that were seriously considered. Are there any less costly or less intrusive ways to accomplish the purpose(s) of this rule? Explain why the program chose this rule-making rather than taking no action or using another alternative. Answer should NEVER be just “no alternative” answer should include “no alternative because...”

No alternatives were considered because statute requires the BHA to promulgate rules related to the items described in section 27-60-107 (3).

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OVERVIEW OF PROPOSED RULE

Compare and/or contrast the content of the current regulation and the proposed change.

Rule section Number	Issue	Old Language	New Language or Response	Reason / Example / Best Practice	Public Comment No / Detail

STAKEHOLDER COMMENT SUMMARY

Development

The following individuals and/or entities were included in the development of these proposed rules (such as other Program Areas, Legislative Liaison, and Sub-PAC):

Behavioral Health Administration

Quality & Standards Division
Statewide Programs Division
Policy & External Affairs Division
Health Information Technology

Office of Civil and Forensic Mental Health (CDHS)

This Rule-Making Package

The following individuals and/or entities were contacted and informed that this rule-making was proposed for consideration by the State Board of Human Services:

All individuals subscribed to the BHA newsletter, which includes: substance use disorder providers; community mental health centers; community mental health clinics; hospitals; patient advocacy agencies; individuals and families with lived experience; and law enforcement.

Mental Health Colorado

Colorado Behavioral Healthcare Council

Colorado Provider's Association

Colorado Hospital Association

Colorado Community Health Network

Colorado Medicaid Behavioral Health Provider Network (COMBINE)

Consortium for Prescription Drug Abuse and Prevention

Individuals involved with the BHA's: Mental Health Advisory Board, Behavioral Health Planning and Advisory Council, Behavioral Health Administration Advisory Council

All currently licensed substance use disorder providers

Colorado Cross Disability Coalition

Other State Agencies

Are other State Agencies (such as HCPF or CDPHE) impacted by these rules? If so, have they been contacted and provided input on the proposed rules?

☒

Yes

☐

No

If yes, who was contacted and what was their input?

The BHA and CDPHE conducted meetings every other month to discuss topics related to the transition of the BHA license authority in the BHE-Implementation and Advisory Committee. The BHA and CDPHE developed guidance together and released a Transition FAQ document available on the BHA's Laws and Rules web page.

The BHA and HCPF met either weekly or biweekly throughout the drafting and stakeholdering process. HCPF provided extensive written comments on each rule chapter, which the BHA worked with HCPF to incorporate. HCPF feedback included subject matter expertise regarding service delivery as well as alignment with Medicaid requirements. Additional biweekly meetings were held to focus on Safety Net Approval and care management rules and ensure alignment on the requirements, and compatibility with existing and future state

frameworks and payment models. HCPF and BHA leadership worked closely to align on the scope of the safety net approval, and worked together to design the opt-in approach to safety net approval that removed an originally proposed requirement that individual providers accepting public funds would be required to be approved as safety net providers.

The BHA met with the CDHS Office of Children Youth and Families (OCYF) monthly to discuss the rules related to RCCFs and the current Mental Health designation and how the children and families endorsement intersects with current child welfare rules. The BHA and OCYF discussed the impact of the BHE license on current RCCFs providing SUD services and/or 27-65 designation.

The BHA met regularly with representatives from the CDHS Office of Civil and Forensic Mental Health (OCFMH) tasked with fulfilling the statutory requirements for HB22-1303 which creates 125 new community based residential beds (Mental Health transitional Living Homes) for individuals who are in need of additional support with daily living but do not require a hospital level of care. The bill tasks the BHA with creating regulations for these settings and the BHA worked with OCFMH to develop a framework that seeks to ensure the health and safety of individuals in this setting and fulfills and establishes standards around the service provision requirements in these settings. OCFMH provided written feedback and suggestions on the proposed rules at each stage of the draft which the BHA worked with OCFMH to incorporate this feedback.

OCFMH provided written feedback to the BHA regarding safety net approval, including feedback related to whether safety net approval should be entirely optional, the operationalization of the no refusal requirements, data collection related to Individuals who are turned away from care by a safety net provider, and was extensively involved in the creation of the section around outpatient competency restoration.

The BHA met twice with OCFMH to discuss feedback related to the 27-65 designation. This included feedback on staffing requirements, accessibility of individual rights, reporting requirements, clarification of BHE licensing applicability, the definition of a secure treatment facility, and qualifications required of staff to perform specific functions such as medication ordering and seclusion/restraint.

The BHA met with OCFMH to discuss feedback related to outpatient competency restoration requirements which were developed as part of the required services to be provided by comprehensive community behavioral health providers.

The BHA met with DORA to discuss alignment of provisions related to scope of practice and supervision and oversight of licensed clinicians.

The BHA met with the Department of Corrections Interstate Commission for Adult Offender Supervision to discuss alignment of rule processes for individuals seeking services related to the criminal justice system with charges outside of Colorado.

Sub-PAC

Have these rules been reviewed by the appropriate Sub-PAC Committee?

☐

Yes

☒

No

Name of Sub-PAC	Not applicable		
Date presented			
What issues were raised?			
Vote Count	<i>For</i>	<i>Against</i>	<i>Abstain</i>
If not presented, explain why.			

PAC

Have these rules been approved by PAC?

☐ Yes ☒ No

Date presented	Not applicable		
What issues were raised?			
Vote Count	<i>For</i>	<i>Against</i>	<i>Abstain</i>
If not presented, explain why.			

Other Comments

Comments were received from stakeholders on the proposed rules:

☒ Yes ☐ No

If "yes" to any of the above questions, summarize and/or attach the feedback received, including requests made by the State Board of Human Services, by specifying the section and including the Department/Office/Division response. Provide proof of agreement or ongoing issues with a letter or public testimony by the stakeholder.

Stakeholdering of a first draft of these proposed rules began in December 2022. A total of 5 public stakeholder sessions were conducted throughout December 2022 and January 2023. Eight hundred and eleven stakeholders registered for at least one of these sessions and 683 stakeholders attended one of these sessions with 319 unique stakeholders in attendance across the 5 stakeholder meeting sessions.

In addition to the offered stakeholder sessions, stakeholders were also able to provide thoughts and feedback through January 11, 2023 on the proposed rule updates through an online survey. There were 62 submissions from 23 unique email addresses from December 2, 2022 - January 11, 2023. Additionally, 11 stakeholders submitted feedback to the Safety Net Licensing team dedicated email cdhs_bharulefeedback@state.co.us.

December 2, 2022 - This session discussed authority, definitions, and Behavioral Health Entity (BHE) licensing standards and covered General Statutory Authority and Definitions and General Behavioral Health Entity Licensing Standards.

A total of 165 stakeholders registered for this session and 151 stakeholders attended this session.

December 9, 2022 - This session discussed BHA new comprehensive safety net provider services and covered Outreach, Education, and Engagement Services, Behavioral Health Recovery Supports, and Outpatient Competency Restoration.

A total of 148 stakeholders registered for this session and 129 stakeholders attended this session.

December 16, 2022 - This session discussed continuum of services, credentialing, and covered Behavioral Health Outpatient Services, Behavioral Health High-Intensity Outpatient Services, Behavioral Health Residential Services, Withdrawal Management (WM) Services, Emergency and Involuntary Substance Use Disorder Commitments,

A total of 127 stakeholders registered for this session and 157 stakeholders attended this session.

January 4, 2023 - This session discussed population-specific, crisis services, and covered Emergency and Crisis Behavioral Health Services, Services for Children, Youth and Families, Gender Responsive Treatment, and Criminal Justice Services.

A total of 197 stakeholders registered for this session and 157 stakeholders attended this session.

A total of 500 comments/questions were received and are summarized below:

- General Statutory Authority and Definitions: 16
- General Behavioral Health Entity Licensing Standards: 132
- Outreach, Education and Engagement Services: 40
- Behavioral Health Recovery Supports: 54
- Behavioral Health Outpatient Services: 24
- Behavioral Health High-Intensity Outpatient Services: 28
- Behavioral Health Residential Services: 60
- Emergency and Crisis Behavioral Health Services: 46
- Emergency and Involuntary Substance Use Disorder Commitments: 6
- Services for Children, Youth, and Families: 5
- Gender Responsive Treatment 7
- Outpatient Competency Restoration: 12
- Criminal Justice Services: 24
- Withdrawal Management (WM) Services: 19
- General: 27

These comments and responses are available in the initial packet filed to the Secretary of State on January 31, 2023 (Tracking Number 2023-00076).

Comments from the following chapters were also received during the initial stakeholder period. These chapters were not presented to the board at the initial hearing in March. The number of comments is summarized below and are included in the comments and responses:

- Safety Net Approval: 42
- Care Coordination: 45
- Designation of Facilities for the Care and Treatment of Individuals with Mental Health Disorders (Title 27, Article 65, C.R.S.): 51

An initial presentation of the rule chapters noted above was made to the State Board of Human Services on March 3. This was an informational hearing. Written testimony was received from 13 stakeholders. Additionally, a subset of these stakeholders provided oral testimony. In total 101 distinct comments were received and recorded from testimony and are addressed in this packet. An emphasis of the testimony was to delay the promulgation of these rules in order to allow more time for stakeholder engagement. A statutory deadline extension was granted through the passage of HB 23-1236 and as such the BHA engaged in extensive stakeholdering throughout the months of May and June 2023. The rules that were proposed for stakeholder feedback during this period included changes incorporated based on the feedback and testimony received at the SBHS hearing on March 3, 2023. The stakeholder engagement opportunities in May and June included:

- Six Town Halls reviewing content of rules
- Four Lived Experience Listening Sessions
- Seven In-Person Listening Sessions held in Denver, Breckenridge, Durango, Cañon City, Pueblo, Grand Junction, and Fort Collins
- Office Hours
- Meetings with targeted provider groups and advocates
- Feedback survey and email inbox for written comments

During this period of re-engagement, the BHA received a total of 1,193 comments on all chapters of rule. This includes comments collected at meetings as well as through the feedback survey and email inbox.

A summary of the stakeholder engagement is shown below:

General	
It would be great to have a flow chart for when the BHE requirements go into effect, based on your provider type and when your license expires	Thank you for your feedback. The BHA can create written guidance on this.
For agencies who receive a provisional designation between now and 12/31/23, will they need to comply with the new 1/1/24 rules since their actual designation/license will start after 1/1/24? Going through our first designation process now, let's say we get in some time this fall. We are an outpatient BH clinic.	If you apply now and receive a provisional or regular license now, the rules that apply are those that are currently in effect. The new rules won't apply until they become ratified and effective January 1, 2024.
If my license renewal is before all this goes effective, I'll be under the old stuff?	That is correct. Currently licensed or designated providers will be required to comply with the current regulations until their license or designation is up for renewal in 2024.
In regards to the changes for 27-65, I know some rules were supposed to go into effect in August 2022 and have trainers ready for this process?	The BHA is currently hiring staff for training and anticipate those trainings will begin in October.
Why is 10 licensed providers the number decided on for provider organization?	Thank you for your question. The 10 licensed or certified providers requirement is based on current practice at CDPHE. The BHA has sought to reach a balance between those seeking regulation of all

	independent mental health providers and those seeking no regulation.
Make sure same expectations for supervision across all.	Thank you for your comment. The new supervision of personnel section may be found in 2.6.1 that outlines supervision expectations. This applies to any provider licensed as a BHE.
For comprehensive providers, we need a readiness plan to ensure we're ready to apply to become a safety net provider.	The BHA can create a resource for comprehensive safety net providers to explain the requirements and prepare them for application.
Ask that you consider places within the rules where brain injury screening could be suggested or mandated. For example, if an ACES screen is being completed it may be beneficial to also do a brain injury screen. Brain injury screening can be done in as little as 15 minutes using a questionnaire and the training to learn to administer the screen can be completed in under an hour. People who have experienced a brain injury are more likely to struggle with behavioral health, become justice involved and are at a significantly higher risk for suicide. I've had some conversations with partners within the BHA and look forward to partnering with you.	Thank you for your comment. We are not making any changes at this time, but may consider this as a recommendation for a future rule revision.
With this, how does this affect veterans? Do they go to reg hospital or go to VA? Or can they say they don't want to go to one of these BH providers?	From the perspective of these rules, we can speak to who can be part of this safety net system. A VA hospital could be approved as an Essential Behavioral Health Safety Net Provider and would therefore be held to these standards.
Need to be infrastructure and training for these providers. Seems there is a capacity, education and service issue, how will BHA offer technical assistance?	The Quality and Standards Division of the BHA is increasing its staffing to meet the need for more licensing managers, who can provide technical assistance.
We have concerns with the licensing period being switched to a 1 year period vs 2 years in addition to the licensing fee being increased to over \$1,800 vs the \$200 that it previously was. This large increase in fees and shortened periods will hinder small businesses from being able to provide much needed services. Such a large increase seems unethical and should be reconsidered.	The original proposed licensing fees were carried over from CDPHE. The BHA formulated a new fee schedule based on the feedback received. The BHE license is statutorily required to be renewed annually.
A lot of consternation about universal screening, will it be compatible with EHR. Specific to crisis assessment.	The BHA cannot create tools that would be compatible with each individual agency's EHR. However, the BHA is using options such as delayed enforcement or other measures to facilitate implementation of new forms and processes.
Care coordination vague in Ch 2.	Thank you for your comment. The care coordination activities required of BHEs are meant to be basic care navigation activities. Safety net providers will be held to more extensive requirements for care coordination, which can be found in Chapter 12.
BHE licensure going in place 1/1, those licensed now need to immediately apply or grandfathered	There will be a transition year between January 2024 and January 2025. An agency applies for the BHE

until renewal?	license through the BHA once their current license has expired and they need to apply for renewal.
How many new licenses are we anticipating?	Currently, CDPHE holds 32 behavioral health entity licenses that will be transferred to the BHA.. There will be about 700 licensed SUD agencies that would be applying for the BHE license. The number we currently do not have an estimate for is private SUD facilities that will newly be required to be licensed.
Would like engagement with communities, especially rural communities to be broad.	During our May and June Stakeholder events, BHA staff held events throughout Colorado, including in rural areas such as Durango, Summit County, and Canon City. The BHA will continue to pursue opportunities to hear this perspective in future stakeholder engagement opportunities.
Is it possible to create rules or regulations that vary based on location or urban or rural?	The BHA is not creating regulations specific to location at this time.
How do we create rule that is more encompassing for what we're wanting the behavioral health system to look in Colorado? We want this to be community-led but it doesn't feel like we're being heard.	The BHA is committing to continually engaging with the people of Colorado through this process of system transformation. This initial rule rewrite is only the first step in the process, and the BHA will undergo regular revisions in the future to create an improved regulatory system.
Can we say that our community or county is known as a collective? This would allow us to fall under the Safety Net system and then we can follow what is predicated upon approval not necessarily the license? Thinking of how FQHCs work and if this is possible to view county government's in a similar fashion.	The BHA cannot advise as to how your organization is incorporated or organized. If your organization meets the regulatory requirements for organizations that may be approved as safety net providers, your organization may apply.
I have concerns about the rule changes and how they will affect patient care by EMTs and Paramedics. There seems to be very little guidance from the state, but it looks like we are full speed ahead for a July 1 implementation date. I am not sure how we can possibly train up thousands of EMTs, paramedics, firefighters, ski patrollers, etc. etc.	Thank you for your question. The BHA is statutorily called in 27-65-128, C.R.S., to provide technical assistance and training to "PROVIDERS, FACILITIES, COUNTIES, JUDGES, MAGISTRATES, INTERVENING PROFESSIONALS, AND CERTIFIED PEACE OFFICERS ON THE PROCEDURES UNDER THIS ARTICLE 65, WHICH TRAINING MUST INCLUDE AN UNDERSTANDING OF THE CRITERIA FOR INVOKING AN EMERGENCY MENTAL HEALTH HOLD PURSUANT TO SECTION 27-65-106, THE DEFINITION OF "GRAVELY DISABLED" AND HOW A PERSON WHO IS GRAVELY DISABLED MAY PRESENT PHYSICALLY AND PSYCHIATRICALY, AND SUGGESTED TEMPLATES AND RESOURCES TO BE USED BY FACILITIES TO MEET THE 13 REQUIREMENTS OF SECTION 27-65-106 (8)(a)(III) AND (8)(a)(VII)."
18 comments about licensing fees. Licensing fees cause undue burden on small SUD agencies and rural providers and are significantly higher than current SUD licensing fees.	The BHA has proposed an alternative fee structure that will take into account these factors.
How do we create a rule that operates differently in different parts of the state? What about an exception? Waivers?	The BHA is not creating regulations specific to location at this time. Any non-statutorily established rule is eligible to be waived, subject to a waiver application and review process.

No group should be required to be a part of the BHA as long as the BHA forces independent group practices to pay to be a part of the BHA and requires unnecessary hoops to jump through. DORA regulates our performance and ability to serve our community and how we run our businesses should be entirely up to us to do so as independent practitioners as it always has been. Independent practices should not be forced to be a part of the BHA and pay to be a part of something against our will. We already have DORA as a regulatory agency. We get to decide to work with, or not work with insurance payers due to their rules, we should be able to do the same thing for the BHA.	The BHE license was established statutorily in 2019 (HB 19-1237) to regulate behavioral health agencies and that authority has been transferred to the BHA as of January 1, 2024. The BHA is required to promulgate rules for the BHE license and ensure compliance to those rules.
I have to provide CJ, SUD, DV, and I am the only one offering these services. I rent in two areas and drive 75 miles back and forth and this can take me out of business. This is opposite from what the concern is with mental health treatment for clients. As a provider I feel totally unsupported. Always more paperwork, more cost, clients need more time. I'm rural and a lot of our clients can't afford the service they're needing. It will go to probation and then the taxpayers to pay. I don't understand the lack of consideration for the need of the constituents in the state.	The BHA acknowledges that the behavioral health system in Colorado needs transformative change in order for it to work better for Coloradans. The construction of the safety net system is critical to make sure those who are publicly, un- or under-insured can access the behavioral health services they need. The BHA is taking the burden of smaller providers into consideration and making changes such as removing the requirement for Facility Guideline Institute (FGI) reviews and reducing licensing fees.
I have a question, licensed addiction counselor and intern and was attending for policy for masters. With raise in fees where is the extra money going?	The reason that fees have increased for SUD providers is because of the Behavioral Health Entity license, which is required by statute to be cash funded and support the licensing work done for it. This licensing work has historically been paid for from other funding sources, such as the federal block grant and General Fund.
I think the small 1 and 2 clinician practices are represented. Ten or more clinician agencies are struggling. No providers available and other providers are closing so we're inundated with clients. They don't want to work for a small income. We can't pass that to clients. It's this round rat race of never enough time and resources. I perpetually hear that there is all this money being poured into MH and SUD. Where is it because it's not coming to me? We get extra fees and extra paperwork. That's my perspective from a non community agency but still a large agency.	There will be opportunities for enhanced reimbursement rates by being approved as a safety net provider. The BHA also offers grants and funding opportunities that can be found on the BHA website.
Thank you for voicing the increasing costs of treatment including the ever increasing documentation requirements and oversight. It is too much.	Thank you for your comment.
I am a ten provider agency, am I a community mental health center?	The distinction of a "community mental health center" will not be a part of the new regulatory structure. Mental health providers with over ten fully licensed

	clinicians would be a licensed behavioral health entity.
What will the waiver process look like?	The waiver is an online Google form. The length of time it would take to complete depends on the rule in questions and the justification of the waiver. Once a waiver is submitted, it is reviewed by the BHA's Waiver Committee and the agency is informed of the outcome and allowed opportunity for due process.
Will our providers have point people to navigate these licensing transitions?	Each facility will have a licensing manager assigned to them that can help answer questions regarding licensing transitions.
What will be the grace period for full rule implementation after Jan 1?	There is a provision written into the rules for delayed enforcement until April 1, 2024. Currently licensed agencies will only come under the new regulations when their license is up for renewal.
If I am going to hire a tenth clinician, do I need to get a BHE license before I hire that person?	Yes, in order to be in compliance the license should be obtained prior to the hire of the tenth clinician.
Can you provide a provider peer? Is that possible to have that built into the system?	As a state agency, the BHA is not able to provide this type of support. However, the BHA will continue to create spaces where providers can connect with us and with each other.
I am doing some research into eligible HIE participants in Colorado, and I was curious if OBH/BHA has ever promulgated any regulations governing Emergency Service Patrols, as authorized by 27-81-115, C.R.S.? If so, where are those regulations located, as I did not find them in the current Behavioral Health regulations.	Up to this point, OBH/BHA has not promulgated rules for emergency services patrols using this authority. However, this is something that the BHA is considering for a future rule update after the current rulemaking process.
Great job providing all the information	Thank you for your comment.
I've been getting the emails and good job in laying it all out. It's an opportunity to get involved in the meat of things. I will definitely be involved.	Thank you for your comment.
The more oversight agencies that are created keep creating more and more rules to micro manage providers and treatment. Why is there no discussion on making providing services easier for providers rather than more expensive and restrictive?	The Behavioral Health Entity license is streamlining and reducing the oversight that behavioral health providers are subject to. Currently mental health providers are required to hold a license from CDPHE and a designation from the BHA, and SUD providers are required to seek a SUD license through the BHA. The BHE creates a single, flexible licensing category for all behavioral health providers under a single state agency. This will make it easier to provide a variety of behavioral health services. The BHA will continue to refine this rule volume on a regular basis and seek additional opportunities to relieve provider burden.
I am passionate about social justice. Currently I'm a council member of the Rare Disease Advisory Council for the state of Colorado. Thanks for listening! Together we can create an inclusive sustainable future, one that is not based on discrimination or genetics, that is fair, equitable and honest. The key is to create oversight and accountability. Thanks for	Thank you for your comment.

listening!	
Rules overlook inpatient units and where this lives, would love more clarity. The flowchart is confusing for hospitals.	There has been clarification written into Chapter 2 regarding hospitals and being exempt from the BHE license. The BHA is working on revision to the "Who Needs a BHE" document to clarify this as well.
What's important to me as an individual receiving services is accessibility, the co-creation of creating a service plan, acceptance of insurance types and ensuring that providers are qualified to work with me.	Thank you for your comment. These provider regulations include provisions for service plans to be individually directed and for services to be accessible and responsive to the needs of individuals. While the BHA does not have the authority to require providers to accept certain types of insurance, the BHA is committed to building a safety net system for those with public insurance or are un- or under-insured.
As an individual receiving services, I want to feel respected and informed during treatment and understand what the expectation is of me during treatment and of them as the provider and more availability of providers.	Thank you for your comment.
6 comments around waitlist times and frustrations with receiving access to care. Specifically accessing care in community mental health centers is noted as a challenge.	The BHA is aware of this challenge, and the safety net system is being constructed with this challenge in mind. Accessibility to care is a particular focus of safety net provider approval.
Most important thing for Deaf community is to receive therapy. We need to find someone that is ASL qualified or Deaf interpreter because we do need someone that is knowledgeable about our culture and community to provide services or interpret for us. Recommend requiring a certain level of skill or qualification for interpreters used by providers.	Thank you for your comment. The BHA requires more time to research and potentially implement a requirement for a certain level of interpreter skill and will consider this in a future update. Meeting with the Deaf/Hard-of-Hearing community was incredibly beneficial to the rule process and language was added in Chapters 2 and 11 about protection of hand movement and interpreters.
2 comments about this. It is difficult living in a rural community and there is only one provider with limited hours. This is not okay for individuals in crisis, especially youth who are ready to receive help. What can we expect providers to be accountable for?	This issue will be addressed with the creation of the safety net system. The BHA will be building a network of safety net providers to ensure that needs are met throughout each part of the state.
I think more access to telehealth is really valuable, especially in rural areas as this is easier to be able to see providers.	Thank you for your comment.
I don't feel that Coloradans know the standards that their providers are held to on state rules and laws and I wonder how we can better inform individuals receiving care. We need to do a better job of informing people who are receiving services of what their rights are and how they know if their providers are not following the regulations.	Thank you for your comment. The provider regulations require that providers educate individuals about their rights and provide information about how to bring disputes to the provider or grievances to the BHA. Grievances will be investigated by the BHA to ensure that providers are operating in compliance with regulations.
Provider turnover negatively impacts my care as each provider tells me something different, they don't know me, they can't remember my diagnosis or what I tell them since I see them so infrequently. This is not helpful for rapport building.	Thank you for your comment and voicing your experience with this particular issue.
Are the standards of care the same for	Standards for a licensed Behavioral Health Entity are

community behavioral health care versus private practice? Providers need to stop shoving pills down people's throats and misdiagnosing them. Also the label of having been incarcerated impacts how I receive care. Not enough providers and providers are prescribing certain things that counteract with my medications, etc. It's nice when my provider remembers who I am and what we talked about previously. Turnover impacts care and the continuity of care. There is a workforce crisis.	the same regardless of payer source. The BHA is committed to addressing workforce shortage issues and has developed a Workforce Plan in order to do this. Grievances about care provided by individual providers can be reported to the BHA and/or DORA.
It is traumatizing and triggering to have to retell the story over and over again. This information should be documented in individual notes, and shouldn't have to retell the story. At the start of services and getting to know the therapist, have them be able to tell in their own words and timelines. Then new personnel can look at the timeline and look and ask specific questions without having to repeat themselves. Education is a big piece here and must educate every single person that is involved so everyone is aligned.	Thank you for your comment. We understand the difficulty this can cause. In our screening and assessment portion we have stated that previous information may be used to help avoid redundant retelling and re-triggering to the individual.
Do these new rules change anything with how Providers work with CDPHE to obtain a license as well?	BHEs will no longer be licensed with CDPHE once they transition their license over to the BHA throughout 2024. For agencies with other types of licenses through CDPHE, nothing will be changing.
Individuals in crisis or on M1 holds that are deaf and deaf/blind need the ability to still use their hands to communicate and that there is someone there to communicate with them.	Thank you for your feedback. Added the following: "7. POLICIES AND PROCEDURES MUST ALSO INCLUDE DETAILS ON HOW SECLUSION, RESTRAINT, AND/OR PHYSICAL MANAGEMENT WILL BE ALTERED TO INCLUDE ANY NECESSARY ACCOMMODATIONS THE INDIVIDUAL MAY NEED, INCLUDING BUT NOT LIMITED TO CHANGING EMERGENCY INTERVENTIONS TO NOT RESTRAIN HANDS AND ABILITY TO COMMUNICATE FOR THOSE INDIVIDUALS THAT USE SIGN LANGUAGE."
First of all, I appreciate the updated rule structure that provides consistency for outpatient services of all types. I also appreciate the changes to personnel requirements that are more clear – the structure of basic credential requirements and then training by endorsement type makes a lot of sense. I also would like to recognize the significant improvements to clarity in rules for DUI services and bulking up of the section for specialized services, previously known as DUI/DWAI behavioral health services.	Thank you for your feedback.
Have any of the tentative rules been added to LADDERS in the P&P section? For example, currently LADDERS includes 21.210.1.B regarding Agency Staff Qualifications (the 50%	LADDERS will not reflect any of the new rules until they are in effect.

licensed staff reference), but I don't see that standard in the current standards.	
How are new licensing BHE requirements for CMHCs expected to impact their prescribers (psychiatrists, PMHNPs, PAs) and other medical staff (Rns, MAs)?	BHE requirements are the same regardless of whether the facility is currently a CMHC or not. There are no significant changes regarding prescribers and other medical staff from current BHE regulations.
We are concerned as a small group practice about needing to be designated to have a BHE license, this is a problem for most small IPN providers as we do not own our own space so we often lease/rent space in some older buildings and have no control over their safety set ups and may not pass all BHE fire code requirements. We also run off of FT, PT, provisionally licensed clinicians, and interns. Putting a number on how many providers we have to have to apply for BHE licensure needs to be very clear language. Full time needs to be defined as working 35-40 hours or more as a clinician. Fully licensed needs to be defined so that it does not include provisionally licensed or interns into our headcount. Adding more fees and hoops to jump through really limits the ability for small practices to continue to practice and provide services. The IPN provides most services to the Colorado community and making it more difficult for them to continue to practice and make profit will be a problem for the community to continue to get access to care.	The BHA has sought to reach a balance between those seeking regulation of all independent mental health providers and those seeking no regulation. The BHA is proposing to move forward with a requirement that providers with 10 or more fully licensed, full time equivalent (FTE) clinicians must obtain a BHE license. The defined terms "candidate," "intern," and "counselor-in-training" from Chapter 1 are not used here.
I like the thought of having one license and endorsements added on. I believe this is much easier for everyone involved especially the provider.	Thank you for your comment.
The ever increasing rule making, rule updating, and rules dictating documentation are burdensome and restrictive to interactions with clients. Provider burnout is rampant, and the auditing process is demoralizing. It is far beyond verifying adequate documentation of the client experience and has moved into self serving micro management supporting the existence of the oversight process. The rules are convoluted and difficult to navigate as any attempt to get clarification on practical application of any rule only leads to references to other locations and that leads to more rabbit holes of searching. If the goal is to make the BHA self supporting - perhaps consider reducing the amount of people dedicated to making more rules and criticizing the manner in which every 'i' is dotted and 't' is crossed. Consider the need for the endless bureaucracy that is increasing demands on providers to justify it's own existence. Rather than increasing revenue please consider	The Behavioral Health Entity license is streamlining and reducing the oversight that behavioral health providers are subject to. Currently mental health providers are required to hold a license from CDPHE and a designation from the BHA, and SUD providers are required to seek a SUD license through the BHA. The BHE creates a single, flexible licensing category for all behavioral health providers under a single state agency. The BHA has consolidated and streamlined some chapters of rule to increase readability and reduce the number of cross-section references. There are provisions in rule for tiered inspections, meaning less frequent or less extensive auditing for agencies with a strong history of compliance. The BHE license is statutorily required to be cash funded, meaning that the licensing fees cover the cost of licensing activity, which is the reason for increased

reducing expenses and eliminating excessive oversight.	fees. The BHA has proposed a different fee schedule than what was originally released in the draft.
Really appreciate the BHA's rewrite on this!!	Thank you for your comment.
When do these rules go into effect?	Thank you for your question. Rules will go into effect 01/01/2024.
More of a general question: The BHA laws and rules site mentions that the BHE license will allow a provider will hold the single BHE license with different endorsements for various services at multiple locations. Does it allow for a single BHE license with multiple endorsements for co-located services at a single site location?	Yes, a site under a BHE can have multiple endorsements co-located at that site.
Hoping to get a definitive answer to something I've heard mixed responses to; would we need a residential endorsement (chap 8) needed to operate an ATU (chap 9)?	ATUs do not need a residential endorsement pursuant to the residential services chapter (now Chapter 5) to operate an ATU. They require an ATU endorsement, and also compliance with Chapter 2, including overnight/24 hour standards in that chapter.
It's challenging for small providers to provide services, and create all the policies and procedures needed, and ensure compliance to those policies and procedures.	The BHA is required to create standards for Behavioral Health Entities (BHEs), which requires the creation of policies and procedures for providing services. The objective is to find a balance between appropriate oversight and reducing administrative burden. The BHA will continue to explore ways to reduce administrative burden, especially on small providers.
Expanding services to be allowed via telehealth is very helpful.	Thank you for your comment.
Please clarify on which documents require signatures. Signatures can be challenging to collect via telehealth depending on the EHR system.	Thank you for your comment. The initial assessment, comprehensive assessment, service plan, and progress notes must all have signatures. This is stated in each portion of rule language. The BHA may also develop a written guidance sheet with this type of information for easy reference.
Will BHA have authority to enforce laws against providers that are not Safety Net members?	The providers that fall under the authority of the BHA's provider rules include comprehensive and essential safety net providers, licensed Behavioral Health Entities, facilities with a 27-65 designation, agencies with Controlled Substance Licenses, and agencies with Recovery Support Services Organizations licenses.
One of the barriers I've run into is finding MH therapist who are culturally competent. I'm queer and disabled and I don't feel I've been to therapist who are culturally competent. Family member due to their illness, physical disabilities would often have to cancel at the last minute but it has gotten better with telehealth and there are reminders that way but there's a lack of access for a lot of disability types including cognitive disabilities. A lot of times when people look at DEI they forget to look at disability, I hope that the BHA is working with the disability community as we have a lot of unique barriers to mental	Thank you for your comment. The rule draft includes provisions to address this feedback. All licensed providers are required to be trained in working with the populations they serve, which would include individuals with disabilities. Telehealth provisions are included in this rule volume for the first time. The BHA has been engaged with disability advocate groups throughout this rule revision process.

health and a lot of us have MH co-occurring with physical health.	
Individual who identifies as queer. Difficulty finding providers who understand that experience or share that experience. Grateful for the robust peer support network in Colorado. I'm also looking for spaces that are person-driven and really take my experiences into consideration and I want to be the person driving what my services look like. I've found this hasn't happened as much. Person-driven aspect to all of this.	Thank you for your comment and perspective. The rule draft includes several provisions to address this feedback, including co-creation of a service plan, training for providers specific to the populations they serve, and honoring individual preferences for services.
I've been to providers, like psychiatrists, that have said to me that this is the medication that is right for you and me providing feedback that the medication is making me feel weird. I don't like it but the provider says that this is medication that you take with this diagnosis. I don't feel like I have a voice and feeling like I have to self-advocate a lot. Or if a therapist and I don't really mix well together, could I be provided to another but have been ignored.	Thank you for your comment. If you are experiencing an issue with your provider, there are a few options to address this within and outside of these proposed regulations. Within these regulations, there are provisions for dispute resolution within the agency, and submitting a grievance with the BHA. There is also the option of submitting a complaint to the Department of Regulatory Agencies (DORA) about a specific licensed or certified provider.
Barriers are created when intakes are required in-person, etc and it's not responsive to the needs of the community.	This rule draft includes provisions for telehealth to reduce barriers to accessing services.
I have had the experience of people handing me paperwork and I have hand issues and I can't do it. And people give me attitude because I don't look disabled because I have an invisible disability. A lot of people can't do paperwork due to disabilities.	Thank you for your comment. The provider regulations require that providers be trained to ensure that services are physically and programmatically accessible.
Is the BHA communicating with DORA regarding regulations, ratios, and so on? Is the BHA making sure that updated rules align with DORA regulations? When the scope of work changed for CACs, it put more stress on the SUD provider community.	Thank you for the question. Regarding this current rule packet, the BHA presented the proposed supervision requirements in Chapter 2 to ensure there were no identified conflicts or concerns, and that the proposed supervision language would support DORA's standards, without overstepping them. The BHA intends to involve DORA in future rule revision processes as well.
There have been several trainings identified that the BHA will provide. When will those be ready? On what platform can they be accessed?	The BHA anticipates that 27-65 related training will be available starting in October. More information will be provided about how to access this training.
There seems to be an overgeneralization of the use of named assessments tools, i.e ASAM and ACES, rather than letting the behavioral health agency and/or employee decide what assessment tools are appropriate to use.	Thank you for your comment. ASAM Criteria is the nation's most comprehensive guideline set for placement, continued stay, and transfer/discharge of patients with addiction and will continue to be used in our rule volume. The ASAM Criteria is not a specific assessment product, and outlines standards for an assessment. The provider may select an assessment tool that utilizes these standards. For ACEs, we have clarified that any trauma-informed screening may be utilized instead of specifically calling out ACEs.
The structure of the endorsement types is unclear and complicated. Can you include a	Thank you for your feedback. We are working on a number of resources now, and this is one of them.

graph or workflow to indicate how the base endorsements, sub endorsements and other endorsements fit together? For example, does the Children and Family Sub endorsement relate to a specific base endorsement or the Agency as a whole?	We'll plan to announce new resources like this in the new Quality & Standards newsletter when they become available.
Content is very divided between chapters making it difficult to fully understand all requirements. For example, we must look in 11 different places to determine what training needs our staff need to meet.	The BHA has consolidated several chapters to streamline the rule volume and increase ease of readability. In addition, the BHA will develop technical assistance documents to help providers understand what applies to them.
There is a significant increase in training requirements increasing time away from providing services.	Thank you for your feedback. The BHA wants to ensure that providers are appropriately trained to provide high quality services. The BHA has received feedback that certain populations feel that providers do not understand how best to serve them, and training is intended to address that.
There are several "required forms" that must be used. This is an additional administrative burden and expense to add into the Electronic Health Record. It will likely take a year to make these changes in our Electronic Health Record.	The BHA is employing delayed enforcement to allow agencies time to adapt to new processes.
We respectfully urge the BHA to institute a delayed enforcement period after the January 1 effective date, just as was planned after the October effective date. If the rules will only be formally adopted by the State Board of Human Services in November, that gives the entities that choose to pursue comprehensive status two months—over the holidays—to develop policies and procedures, train staff and reprogram EHRs. An enforcement date of April 1, 2024 (with, of course, exceptions for issues that immediately affect life, health and safety) will enable providers to maximize their ability to operate in this new environment, ultimately leading to less disruption to services and increased thoughtfulness in the implementation of the changes required.	Thank you for your comment. The BHA is moving forward with a delayed enforcement date of April 1, 2024.
The mandatory licensing of all clinics with 10 or more providers places undue burden on behavioral health clinics. It also is not equitable with licensing of medical clinics, which do not have to comply with such licensing requirements. Finally, there are many programs which already meet Joint Commission requirements. So, such licensing would be redundant.	The BHE license was established statutorily in 2019 (HB 19-1237) to regulate behavioral health agencies and that authority has been transferred to the BHA as of January 1, 2024. The 10 or more provider provision establishes which facilities must seek this license, and is aligned with CDPHE's current practice in licensing BHEs. The BHA has sought to reach a balance between those seeking regulation of all independent mental health providers and those seeking no regulation.
As a small provider I have concerns about the	Thank you for your feedback. The BHE license was

annual requirements for renewal and the amount of responsibilities and time that renewal process can take away from serving clients.	established with an annual renewal timeframe at CDPHE, and that annual renewal is required per statute. The BHA does include provisions for tiered inspections, or less frequent or extensive inspections, for agencies with a strong history of compliance.
Do FQHCs need to obtain BHE licenses for their integrated health services?	FQHCs are required to obtain a BHE license if they meet the definition of a Behavioral Health Entity.
Will the rules include the new Veteran's services bill?	HB 23-1088 Veterans Mental Health Session Reimbursement Program does not include authority to promulgate provider regulations, so this bill is not reflected in these proposed rules.
Rural areas operate with informal agreements and asking for a formal contract may be a barrier, mismatched.	The BHA is not proposing different rules for different areas of the state at this time. For any regulation that causes an undue hardship and is not statutorily established, a waiver application may be submitted and considered by the BHA.
I hope that we can look forward to a CCBHC-type model. Updated CCBHC guidance in March 2023.	Thank you for your comment.
Can there be a hardship application for small and/or rural providers for the fees?	The BHA has developed an alternate fee schedule. There is also a waiver process to apply to waive any non-statutory provision of rule, subject to the approval of the Waiver Committee, which would include the fee schedule.
Change the auditing approach to being helpful and not punitive, think through how small nitpicky things have waterfall effect (ex: electronic signature)	Thank you for your comment. The BHA's objective is to bring a provider back into compliance whenever possible. Licensing managers provide technical assistance, and move to adverse action only when necessary.
Parity still does not seem to be present for behavioral health.	The BHA continues to work toward parity in the behavioral health space and acknowledges that this will not be fully accomplished in this initial rulemaking process. The BHA invites stakeholders to continually engage in this conversation so that a behavioral health system can be built that is rooted in parity.
If we are currently licensed with CDPHE when is all shifts to the BHA will we be required to pay the initial or stay with the renewal fees?	The BHA is no longer proposing a difference between initial and renewal fees.
Will there be additional fees for Controlled substance license renewals as well?	CSL fees are remaining the same as we are not making changes to that license at this time.
Is the initial license base fee billed per organization or per office location?	The base BHE fee is billed per organization as the BHE is an entity wide license.
If already licensed as Mental Health Provider and CSL will we have a third licensing fee for SUD?	Thank you for your question. There will not be additional fee as the BHE base fee covers both the mental health and SUD services. CSL is still separate and those rules are not changing at this time.
Behavioral Health Entity (BHE) Licensing Strategy: A top concern of this group of stakeholders is the BHA's overall Behavioral Health Entity (BHE) licensing structure and strategy, particularly what – if anything – is required of providers that do not hold a BHE license. We believe the lack of guidance across	Providers that are not required to hold a BHE license would be accountable to the BHA if they choose to be a safety net provider. Safety net rules do include requirements such as background checks, critical incident reporting, staff supervision that mirror some of the licensing requirements.

this rule volume inadvertently jeopardizes the quality of care for individuals seeking mental health and substance use services. We believe that exempting small practices providing services under the credentials of a rendering professional is important to incentivize private providers to serve Medicaid members. However, we are concerned that using the definition of 10 or fewer licensed providers allows large practices that are operating as facilities to avoid meeting critical quality standards. If a group has 10 licensed providers and each licensed provider supervises 8 unlicensed providers, this would be a group of 80 providers, larger than most substance use facilities. We propose that the exemption from licensing should apply to providers with 10 total behavioral health providers. Further, we request that additional quality standards be imposed for providers approved to provide safety net services that are not licensed as BHEs. This includes FQHCs, hospitals, and small group or individual practices operating under a DORA license only. Because of the particular vulnerability of individuals served in the safety net system, we believe that basic behavioral health standards related to clinical supervision, quality monitoring, background checks, and individual rights should apply to all providers. This concern could be accomplished by adding requirements to follow certain parts of BHE Chapter 2 licensing standards.	The BHA is proposing to move forward with the 10 fully licensed clinician requirement for which providers require a BHE license. The BHA has sought to reach a balance between those seeking regulation of all independent mental health providers and those seeking no regulation. Providers not regulated by the BHA would be accountable to their individual license through the Department of Regulatory Agencies (DORA).
Mental Health and Substance Use Provider Licensing Parity: While we appreciate the different statutory histories of mental health and substance use provider licensing, we are extremely concerned about requiring additional standards for substance use providers compared to mental health providers. As currently written, a mental health group practice of 80 or more providers could operate with no licenses other than their professional licenses under DORA. In contrast, a single DORA-licensed provider providing substance use services would require a BHE license. As you know, the workforce shortage extends to substance use providers, and the shortage of substance use services across the state is alarming. We urge the BHA to re-examine the overarching rule framework to address this imbalance in requirements. If it is determined that the only way to do this is through statutory change, we offer our assistance in advocating for those changes.	The BHA acknowledges that the way that substance use providers and mental health providers have historically been regulated is bifurcated. There is a statutory requirement for all previously licensed SUD and MH providers to obtain a BHE license, which continues the bifurcation at this time unless there is a statutory change. In response to this issue, the BHA has addressed some issues of burden that were of particular concern for SUD providers, such as changing the licensing fees and removing the requirement for a Facility Guidelines Institute (FGI) review.

We understand the BHA's desire to not impose undue burden on BH providers, and we agree with that mission as well. However, we see that many of our providers who are safety net are partners subjected to higher quality standards of care than independent and smaller practices. But, all providers, whether engaged in the safety net or not, contribute to the reputation of BH in Colorado, and form part of the overall experience of those who testified about concerns and difficulty within BH in Colorado as part of the BHTF process which led to these rule changes. We believe there needs to be a standard of consistency for licensure of providers and would like to express our agreement with Mental Health Colorado's proposed compromise approach recommendation, as stated: "We believe that exempting small practices providing services under the credentials of a rendering professional is important to incentivize private providers to serve Medicaid members. However, we are concerned that using the definition of 10 or fewer licensed providers allows large practices that are operating as facilities to avoid meeting critical quality standards. If a group has 10 licensed providers and each licensed provider supervises 8 unlicensed providers, this would be a group of 80 providers, larger than most substance use facilities. We propose that the exemption from licensing should apply to providers with 10 total behavioral health providers." Additionally, we advocate for consistency of mental health and SUD staffing and supervision requirements. It seems, at present, that there is a higher standard of supervision necessary for SUD services, and would like to see mental health services aligned, either via reduction in SUD staffing requirements, raising of MH staffing requirements, or a combination of the two.	The BHA is proposing moving forward with the 10 fully licensed provider requirement for BHE licensure at this time. The BHA has sought to reach a balance between those seeking regulation of all independent mental health providers and those seeking no regulation. Proposed clinical supervision requirements are the same for both mental health and substance use disorder providers, and are found in Part 2.6.1.
I appreciate the recognition of outreach, education and early intervention services that have an important place in the continuum of care prior to formal assessment and diagnosis.	Thank you for your comment.
Specifically, we recommend that a clear flow chart in the procedure manual that documents the evaluation and screening timelines, relevant locations, and required procedures at each step (denoting who completes those procedures) would be incredibly helpful to support implementation of these changes coupled with trainings provided by the BHA as early as possible before Jan. 1, 2024.	Thank you for this recommendation. The BHA will consider this when putting together technical assistance resources.

As a Federally Qualified Health Center (FQHC), we're not required to become a BHE if we want to become approved as a Safety Net Provider, correct?	Correct. FQHCs that are not required to be licensed BHEs may apply to be approved as a Safety Net Provider by demonstrating their status as an FQHC.
Has the BHA thought about how the requirements for a BHE license will de-incentivize SUD providers or any provider from asking about SUD since there are more regulations and a larger fee?	The BHA acknowledges that a way that substance use providers and mental health providers have historically been regulated is bifurcated. There is a statutory requirement for all previously licensed SUD and MH providers to obtain a BHE license, which continues the bifurcation at this time. In response to this issue, the BHA has addressed some issues of burden that were of particular concern for SUD providers, such as changing the licensing fees and removing the requirement for a Facility Guidelines Institute (FGI) review.
Could we have more alignment on what is required in contract versus what is required for rule?	The BHA is working internally to align these processes as much as possible.
Why are bachelor-level personnel not included in rules, such as skills training, case management, outreach, engagement?	Thank you for your question. The BHE agency is responsible, as stated in Part 2.6.C.2, that all personnel providing direct care have appropriate credentials and are acting within their scope of practice. The BHE shall also have policies and procedures regarding staffing listed in Part 2.6.E.
Is there a one pager or cheat sheet that visualizes how all of the differences licenses live and who they are for?	Thank you for your feedback. We are working on a number of resources now, and this is one of them. We'll plan to announce new resources like this in the new Quality & Standards newsletter when they become available.
Definitions (Chapter 1)	
1.2 "ADMISSION" MEANS THAT POINT IN AN INDIVIDUAL'S RELATIONSHIP WITH AN ORGANIZED TREATMENT SERVICE WHEN THE INTAKE PROCESS HAS BEEN COMPLETED AND THE INDIVIDUAL IS ELIGIBLE TO RECEIVE THE SERVICES AND ACCEPTS THESE SERVICES. Involuntary clients who do not "accept services" are admitted. Modify language to include individuals who do not accept but are legally required to participate in treatment	Language referencing accepting services has been removed to account for this scenario.
1.2 Need a definition for cultural competency to provide a foundation for this concept in the system. It would include language access, cultural barriers and strengths etc. Add a definition of cultural competency	Thank you for your comment. We no longer use cultural competence in the rules and have changed language to say Culturally and Linguistically Appropriate Services.
Add "IOP" and "PHP" acronyms in the definitions of these services.	These acronyms have been added to the definitions.

Add definition of unlicensed social worker since they commonly work in the BH field.	Thank you for your comment. Unlicensed social workers are covered by the various definitions of candidate and licensee in Part 1.3.
There is no definition of care management though used in Chapter 4.	Thank you, this definition was initially located in chapter 4. Currently, this term is defined through the set of service requirements contained in the care management section now in Chapter 12.
Chapter 1: ASAM and DSM, no later editions are incorporated. I know the next edition of ASAM will be out and will these rules need to be revised to incorporate the next edition?	The BHA will consider when and how to incorporate the 4th edition of ASAM in a future rule revision process. This process will involve stakeholder engagement. Until that time, the 3rd edition of ASAM included in the rules will stand.
Definitions, harm reduction seems specific to SUD and I think there are some harm-reduction that are broader, thinking about risky behaviors leading to pregnancy, etc. Could we have a broader definition?	The definition of "harm reduction" has been broadened in response to this feedback.
I have a question about a definition that was in the previous draft of rules, that I can no longer locate. It stated that a Provider Organization is defined as 10 or more licensed mental health providers as a BHE. Has this been removed entirely or moved to a different section? If it was moved, would you please let me know where I can find it?	The provider organization resides in Chapter 1.
In Chap 1, ACE is defined but it's incomplete. ACE is an evidence based screening tool that goes beyond what is listed in the definitions. The definition needs to outline how the ACE is used, who controls the ACE tool design. There are a ton of ACE tools such as the ACE, PEARLS, ACE-QI, and others. Providers need to know what the BHA wants us to do with the ACE as well.	Thank you for your comment. Language has been clarified in Chapter 8 around the inclusion of ACEs and/or a similar screener. Providers will be allowed to use a trauma-informed screener of their choosing.
Colorado Access is in support of the following comment from Mental Health Colorado: We understand and support a balance between minimizing regulatory burden on small providers while simultaneously ensuring quality of care for clients. As such, we support the Behavioral Health Administration's (BHA) proposal to exempt very small independent practices from licensure as a Behavioral Health Entity (BHE). Nonetheless, we believe that the threshold of 10 licensed providers would allow medium and large providers to operate without a facility license. In our experience, there are licensed providers who supervise 5 or more unlicensed providers. As a result, this proposed rule could allow provider organizations with 50 or more total providers to operate without a facility license. We believe that this has the potential to compromise quality of care for our members. For this reason we propose that the language in Chapter 2, section 2	Thank you for your comment. The BHA is proposing to move forward with the 10 fully licensed clinician requirement for which providers require a BHE license at this time. The BHA has sought to reach a balance between those seeking regulation of all independent mental health providers and those seeking no regulation.

be modified as follows: "PROVIDER ORGANIZATION" MEANS A CORPORATION, PARTNERSHIP, LIMITED LIABILITY COMPANY, BUSINESS TRUST, ASSOCIATION, OR ORGANIZED GROUP OF PERSONS, WHETHER INCORPORATED OR NOT, WHICH IS IN THE BUSINESS OF BEHAVIORAL HEALTH CARE DELIVERY OR MANAGEMENT AND THAT INCLUDES TEN (10) OR MORE FULL TIME EQUIVALENT (FTE) FULLY LICENSED OR CERTIFIED MENTAL HEALTH-CARE PROVIDERS UNDER THE PROVIDERS' PROFESSIONAL PRACTICE ACT. THE EXCEPTION TO THE 10 PROVIDER REQUIREMENT IS ANY SIZE ORGANIZATION PROVIDING TWENTY-FOUR (24) HOUR OR OVERNIGHT COMMUNITY-BASED SERVICES. Alternatively, language could be added that requires provider organizations of any size that oversee unlicensed providers or practitioners	
Page 3 1.2 General Definitions E. Page 3 Proposed: Add Language to E – “or parental abandonment;” E. DIVORCE OR SEPARATION OF PARENTS AND/OR CAREGIVERS OR PARENTAL ABANDONMENT;	Thank you for your comment. Language has been added to say ““ADVERSE CHILDHOOD EXPERIENCES (ACES)” MEANS TRAUMATIC EVENTS THAT OCCUR BEFORE THE AGE OF EIGHTEEN (18) YEARS OLD. ACES CAN INCLUDE BUT ARE NOT LIMITED TO: A. ABUSE, WHICH CAN BE EMOTIONAL, VERBAL, PHYSICAL OR SEXUAL; B. NEGLECT, EITHER PHYSICAL OR EMOTIONAL; C. WITNESSING OR EXPERIENCING DOMESTIC VIOLENCE; D. SUBSTANCE MISUSE BY A MEMBER OF THE HOUSEHOLD; E. DIVORCE OR SEPARATION OF PARENTS AND/OR CAREGIVERS OR PARENTAL ABANDONMENT; F. MENTAL ILLNESS OF A MEMBER OF THE HOUSEHOLD; AND; G. LOSS OF A MEMBER OF THE HOUSEHOLD; H. ATTEMPT TO COMMIT OR DEATH BY SUICIDE OF A MEMBER OF THE HOUSEHOLD; AND, I. INCARCERATION OF A MEMBER OF THE HOUSEHOLD.
Page 3 1.2 General Definitions Page 3 Proposed: Add Language – Add H: H. HAVING A MEMBER OF THE HOUSEHOLD ATTEMPT OR DIE BY SUICIDE.	Thank you for your comment. Language has been added to say ““ADVERSE CHILDHOOD EXPERIENCES (ACES)” MEANS TRAUMATIC EVENTS THAT OCCUR BEFORE THE AGE OF EIGHTEEN (18) YEARS OLD. ACES CAN INCLUDE BUT ARE NOT LIMITED TO: A. ABUSE, WHICH CAN BE EMOTIONAL, VERBAL, PHYSICAL OR SEXUAL; B. NEGLECT, EITHER PHYSICAL OR EMOTIONAL; C. WITNESSING OR EXPERIENCING DOMESTIC VIOLENCE; D. SUBSTANCE MISUSE BY A MEMBER OF THE HOUSEHOLD; E. DIVORCE OR SEPARATION OF PARENTS AND/OR CAREGIVERS OR PARENTAL

	ABANDONMENT; F. MENTAL ILLNESS OF A MEMBER OF THE HOUSEHOLD; AND; G. LOSS OF A MEMBER OF THE HOUSEHOLD; H. ATTEMPT TO COMMIT OR DEATH BY SUICIDE OF A MEMBER OF THE HOUSEHOLD; AND, I. INCARCERATION OF A MEMBER OF THE HOUSEHOLD.
Page 5 Paragraph 5 1.2 General Definitions Proposed Edit: "CONTINUUM OF CARE" OR "BEHAVIORAL HEALTH CONTINUUM OF CARE" MEANS MULTIPLE OPPORTUNITIES FOR ADDRESSING BEHAVIORAL HEALTH PROBLEMS AND DISORDERS. THIS INCLUDES THE FOLLOWING COMPONENTS: PROMOTIONS STRATEGIES TO REINFORCE THE CONTINUUM OF CARE; PREVENTION STRATEGIES WHICH ARE INTENDED TO PREVENT OR REDUCE THE RISK OF DEVELOPING A BEHAVIORAL HEALTH ISSUE; EARLY INTERVENTION STRATEGIES; TREATMENT WHICH FOCUSES ON PROVIDING SERVICES FOR INDIVIDUALS DIAGNOSED WITH A BEHAVIORAL HEALTH DISORDER; AND, RECOVERY WHICH ARE SERVICES TO SUPPORT THE INDIVIDUAL'S ABILITY TO LIVE PRODUCTIVELY IN THE COMMUNITY.	Thank you for your comment. This change has been made in response.
Page 8 Paragraph 2 1.2 General Definitions Proposed Alternative Definition: "HARM REDUCTION" MEANS AN SOCIAL JUSTICE APPROACH THAT EMPHASIZES ENGAGING DIRECTLY WITH INDIVIDUALS WHO USE SUBSTANCES WHOSE ACTIONS (OR BEHAVIORS) PLACE THEM AT RISK FOR A VARIETY OF ADVERSE MENTAL HEALTH, SUBSTANCE USE DISORDER OR PHYSICAL HEALTH OUTCOMES. TO PREVENT OVERDOSE AND INFECTIOUS DISEASE TRANSMISSION, IMPROVE THEIR PHYSICAL, MENTAL, AND SOCIAL WELLBEING, AND OFFER OPTIONS FOR ACCESSING SUBSTANCE USE DISORDER TREATMENT AND OTHER HEALTH CARE SERVICES. SPECIFICALLY, HARM REDUCTION IS A SET OF PRACTICAL STRATEGIES AND IDEAS AIMED AT REDUCING POTENTIAL NEGATIVE	Thank you for your comment. The harm reduction definition has been changed in response to this feedback.

CONSEQUENCES ASSOCIATED WITH A VARIETY OF ACTIONS (OR BEHAVIORS). THESE STRATEGIES AND APPROACHES INCLUDE BUT ARE NOT LIMITED TO SAFER DRUG USE, SAFER SEX, MEDICATION ADHERENCE, MANAGED DRUG USE, ABSTINENCE, MEETING EVERY PERSON "WHERE THEY'RE AT," AND ADDRESSING ENVIRONMENTAL CONDITIONS ALONG WITH THE ACTIONS (OR BEHAVIORS) THEMSELVES. MOST FREQUENTLY ASSOCIATED WITH SUBSTANCE SUE, OVERDOSE PREVENTION AND INFECTIOUS DISEASE TRANSMISSIONS PREVENTION, HARM REDUCTIONS ALSO APPLIES TO OTHER HEALTH RISK BEHAVIORS, INCLUDING SAFE SEX, EATING DISORDERS, TOBACCO USE AND CUTTING/SELF HARMING BEHAVIORS. IMPORTANTLY, HARM REDUCTION APPLIES EQUALLY TO PERSONS WITH MENTAL HEALTH, SUBSTANCE USE DISORDER, AND PHYSICAL HEALTH RISK FACTORS AND IS CRITICAL FOR WHOLE PERSON CARE. HARM REDUCTION STRATEGIES AND APPROACHES DO NOT FOLLOW A UNIVERSAL DEFINITION OR FORMULA FOR IMPLEMENTATION.

Page 10
Paragraph 7
1.2 General Definitions
Note: MAT is proven as a standalone treatment, even without counseling. Medication FOR Addiction Treatment (MAT) is the contemporary language used to describe the approach to treating a variety of alcohol and substance related conditions.
Proposed Alternative Definition:
"MEDICATION ASSISTED FOR ADDICTION TREATMENT," OR "MAT" SERVICES, MEANS THE USE OF MEDICATIONS, WITH OR WITHOUT THE COMBINATION OF COUNSELING AND BEHAVIORAL THERAPIES, TO PROVIDE A WHOLE-PERSON APPROACH TO THE TREATMENT OF SUBSTANCE USE DISORDERS. MEDICATIONS USED IN MAT ARE APPROVED BY THE UNITED STATES FOOD AND DRUG ADMINISTRATION (FDA) AND MAT PROGRAMS ARE CLINICALLY DRIVEN AND TAILORED TO MEET EACH INDIVIDUAL'S NEEDS. MAT SERVICES MAY INCLUDE

Thank you for your comment. The language has been changed to "WITH OR WITHOUT THE COMBINATION..." in response.

MEDICATIONS FOR OPIOID USE DISORDER (MOUD) SERVICES FOR THE SPECIALIZED TREATMENT OF OPIOID USE DISORDER (OUD).	
Page 12 Paragraph 3 1.2 General Definitions Proposed Added Language: “peer supports” “OUTPATIENT TREATMENT” MEANS BEHAVIORAL HEALTH SERVICES PROVIDED TO AN INDIVIDUAL IN ACCORDANCE WITH THEIR SERVICE PLAN ON A REGULAR BASIS IN A NON-OVERNIGHT SETTING, WHICH MAY INCLUDE, BUT NOT BE LIMITED TO, INDIVIDUAL, GROUP, OR FAMILY COUNSELING, CASE MANAGEMENT, PEER SUPPORTS OR MEDICATION MANAGEMENT.	Thank you for your comment. This language has been added.
Chapter 1 - definitions, (use of “minor” under definition for Legal Guardian, but not defined independently) including the definition of “youth” within Ch. 15 would be helpful.	Thank you for your comment. Youth is defined in Chapter 1 as anyone under the age of twenty-one (21). Minor is defined in Chapter 11 as anyone under the age of eighteen (18) to provide clarity.
BHE General License Requirements (Chapter 2)	
“Provider Organization” definition: Entities with 10 or more licensed providers supervising other staff, could be quite large (100 or more total providers), concerned that medium to large organizations would be exempt from any facility quality standards. Suggest limiting to 10 behavioral health providers and changing language to “THAT INCLUDES TEN (10) OR MORE FULL TIME EQUIVALENT (FTE) FULLY LICENSED OR CERTIFIED MENTAL HEALTH-CARE PROVIDERS	Thank you for this feedback. At this point, the 10 fully licensed provider requirement is moving forward in the proposed rules. The BHA has sought to reach a balance between those seeking regulation of all independent mental health providers and those seeking no regulation.
2.4: We strongly request that to obtain a BHE license providers and entities must complete cultural competence training as they are required to in the early childhood licensing requirements.	The BHE license requires the following personnel training: “TRAINING SPECIFIC TO THE PARTICULAR NEEDS OF THE POPULATIONS SERVED, INCLUDING THE PROVISION OF PERSON-CENTERED, TRAUMA-INFORMED, HARM REDUCTION- FOCUSED, PHYSICALLY AND PROGRAMATICALLY ACCESSIBLE, AND CULTURALLY AND LINGUISTICALLY RESPONSIVE SERVICES.”
Concern over the governing body definition and explanation in Chapter 2. We signed contracts and the broader board definition was not included. It seems that the definition removed the executive team from the governing body. Previously this was allowed	Thank you. The BHA will consider how this can be better aligned in contract.
It seems inequitable that individual SUD providers are required to seek BHE	The BHA acknowledges that the way that substance use providers and mental health providers have

endorsement and MH providers can practice in groups of fewer than 10. This really discourages individual SUD providers to remain in practice and will likely reduce access to care.	historically been regulated is bifurcated. There is a statutory requirement for all previously licensed SUD and MH providers to obtain a BHE license, which continues the bifurcation at this time unless there is a statutory change. In response to this issue, the BHA has addressed some issues of burden that were of particular concern for SUD providers, such as changing the licensing fees and removing the requirement for a Facility Guidelines Institute (FGI) review.
Two comments requesting clarity that hospitals are not considered BHEs.	This has been clarified in Part 2.3.D.
If a hospital would like to become a safety-net provider, does it have to become a BHE? If a facility is not a BHE but provides some of the services that require endorsements, are they required to follow the rules? Are they required to get an endorsement even though they are not a BHE?	Hospitals are not required to obtain a BHE license. If a hospital is seeking a safety net approval, the hospital would need to follow safety net approval standards, which includes providing services in conformity with endorsement chapters for the services provided.
Can you provide any clarity around how clinics should "count" the 10 providers required for BHE licensure? Is it 10 "full time" providers or 10 fully licensed providers period, regardless of whether they are part-time or contracted or not?	The ten (10) or more licensed or certified behavioral health care providers must be full-time equivalent to need a BHE unless they meet any of the other BHE requirements. The definitions of candidate, counselor-in-training and intern have been defined in Part 1.3 of the rules.
For the new Finger Printing rule- will we need to go back and ensure all staff have finger printing completed prior to this rule going into effect?	Compliance with this rule would not necessarily be required once the rule goes into effect, but would be required once the provider is applying for a license or renewing a license under the new regulations.
For outpatient services within an RCCF, are we required to get a BHE if we have less than 10 licensed mh professionals?	Thank you for your question. RCCFs shall obtain a BHE license if they are currently, or would have been previously, subject to any of the following: BHE licensure issued by the Department of Public Health and Environment; Licensed by the BHA as an approved treatment program for the treatment of substance use disorders (per Section 27-81-106); or Approved or designated as a clinic or center by BHA (per Section 27-50, C.R.S. or 27-66, C.R.S.). If none of the criteria apply to the RCCF, the agency must obtain a BHE license only if it meets the following Provider Organization definition: "A corporation, partnership, limited liability company, business trust, association, or organized group of persons, whether incorporated or not, which is in the business of behavioral health care delivery or management and that includes ten (10) or more full time equivalent (FTE) fully licensed or certified mental health-care providers under the providers' professional practice act. The exception to the 10 provider requirement is any size organization providing twenty-four (24) hour or overnight community-based services, unless holding a facility license from another entity to provide such overnight services."
Chapter 2: What happens for agencies that are currently in process of obtaining their license	The BHA can work with CDPHE to take over the application if it is not yet completed. If it seems to be

through CDPHE and they aren't fully licensed come 1/2024? This timeline seems to be influenced by how long the FGI review is taking, how will this limbo state be addressed?	close to getting to the January timeline and the initial application is not yet approved, the BHA/CDPHE will talk with you to figure out next steps to make it an individualized process. The BHA is proposing to remove the FGI review requirement in its implementation of the BHE license.
Chapter 2: I've raised this question in another setting but because different people are here today, I wanted to raise it again. HB22-1236 language created confusion around the new timelines. The date of the transition from CDPHE over to BHA looks like there is potential for both entities to oversee the license for a period of time and it was our understanding from policy team and rules team that you got a legal opinion that BHA trumps that oversight. We are quite nervous about the potential of being overseen by 2 regulatory agencies. Wasn't aware that informal opinions are not available to external audiences and very important for any provider to see that language and that we have absolute clarity that we will only be overseen by one agency at a time. Language here states switch over from CDPHE to BHA but because of that issue that happened literally 59th minute created considerable fuzziness about that and need absolute clarity in writing from somebody about that.	The licensed agency will only be overseen by the State Department holding the license. Written guidance can be provided to clarify this.
Chapter 2: Are there specific sections of the rules that you define as "health, safety and welfare"? What are the types of rules that will not be enforced? I am concerned about any further delay of enforcement as I think it hinders the BHA from enforcement of regulation that is specifically designed to protect the public.	There is not a specific section of rule that covers this. This will depend on provider type and what endorsement the provider has. In this type of situation, the BHA would be looking for deficient practice that correlates to potential harm to an individual.
Chapter 2: Transition - thinking about timeline for org. That is currently licensed and transitions after Jan 1 time, those of us that have EHR can be tricky. Has there been any discussion with CDPHE that we can receive waivers to have some pieces of new rule to be in compliance early or maybe some extension past April 1 in terms of specific rules and how that might connect with an EMR?	Delayed enforcement pieces can be helpful and if an agency's assessment coming over to the BHA is more aligned with CDPHE regs, that is not an apparent issue for health, safety, welfare and the BHA would not take any adverse actions while the agency is in transition. The BHA cannot speak to CDPHE authority or how CDPHE would handle that specific situation.
Chapter 2: 2.4 question - 2.2.3.A.3 following are considered outpatient endorsements, does that mean that an endorsement is not needed to provide those services listed there?	This list is describing which of the service endorsements are considered outpatient services. The endorsement is needed to provide these services.
Chapter 2: 2.4 bullet point that says BHE endorsements are location specific, will we need 1 BHE for all 3 and endorsements for each location with 3 MHTLH? thinking about providers that have multiple locations and thinking specifically for MHTL homes	Yes, there would be one BHE license for the agency and endorsements per each location.

Just clarifying who a CBI background check is required for (2.18.C). Is it just the CEO for a non-profit, or does it include all Board Members as well.	In the case of a non-profit, a CEO suffices.
Chapter 2: 2.5.C says governing body if board of directors to delegate to executive and management team and #10 allows developing P&P in accordance with part 2.5 D - where confusing to me is 2.5.C allows delegation of P&P, but 2.5.D states governing body is responsible for p&P and not allowing responsibility to the executive team and seems to be in conflict. Also there in D I still find that confusing where it says annual review of changes and then in last sentence says review every 3 years. #1 changes shouldn't just be reviewed annually and should be when they happen and by the executive team when creating them and that governing body be reviewing and not something that should be the responsibility of the governing body when the board is a volunteer board.	Thank you for your feedback. Language regarding the review of policies every three years has been made consistent, the requirement to review changes as they happen has been added, and language has been clarified to include that the executive team may be responsible for the policies and procedures.
Chapter 2: 2.6.1.D - does this include those that we can bill Medicaid for behavioral health services but not licensed?	Thank you for your question. Yes, we worked with HCPF to ensure these individuals were included and referenced in 2.6.1.C.2.b and 2.6.1.D.4.
Chapter 2: CBHC has numerous comments on 2.7, many of which stem from the fact that the requirements reflect hospital-specific issues that don't create sufficient flexibility for smaller community-based providers.	The BHA is proposing to remove the FGI review process from BHE licensing requirements.
Chapter 2: Will the FGI review be required for this application as well? The biggest concern is how long it takes. There are facilities that submitted in September of last year and are still in the review queue. And for places that are offering outpatient MH services, it is a significant delay and cost. The FGI review is eating up a significant period of time, which has a negative impact on the ability to open services that are much needed for the community. (The BHA received 1 other similar comment.)	The BHA is proposing to remove the FGI review process from BHE licensing requirements.
2.11.G We appreciate the various requirements of providers. We are concerned that the responsibility for care coordination is diffuse and would like to see the responsibilities of BHEs at base, essential safety net providers, comprehensive safety net providers, BHASOs, RAEs, and BHA. It will be critical to understanding any gaps or duplicative responsibilities across the various entities.	Thank you for your comment. BHEs have basic care coordination requirements that focus on referrals and navigation. Behavioral health safety net providers will be held to more robust care coordination requirements, as found in Chapter 12. Comprehensive providers will also be required to provide care management, which are outreach focused services for individuals who may need additional support to access the care that they need across multiple systems. The requirements of BHASOs and the BHA will be outlined within administrative rules, and the BHA is collaborating closely with HCPF in regards to RAEs to ensure that every individual can access the care

	coordination they need without duplicating services across systems and providers.
Chapter 2: 2.12.2 Are there specific credential requirements for staff completing the initial assessment?	Thank you for your questions. Language has been added to say: "AN INITIAL ASSESSMENT MUST BE COMPLETED BY A LICENSEE, LICENSED ADDICTION COUNSELOR (LAC), A CERTIFIED ADDICTION SPECIALIST (CAS), OR A LICENSURE CANDIDATE PERFORMING WITHIN THE SCOPE OF THEIR PRACTICE. BHES MUST MEET TIMELINE REQUIREMENTS SET FORTH IN APPLICABLE ENDORSEMENT CHAPTERS. SEE ENDORSEMENT CHAPTERS 4 THROUGH 10 FOR ADDITIONAL INITIAL ASSESSMENT REQUIREMENTS."
I wanted to know when we renew our BHE license as a comprehensive provider in May (with CDPHE), should we apply for the separate BHE crisis license then or wait and apply on July 1 st with the BHA?	Thank you for your question. You will renew your BHE license with CDPHE when it is up for renewal in May, and when it is time to renew the BHE license in 2024, you will transition over to the BHA and add appropriate endorsements, including the crisis services endorsement.
There are considerations to use specialized type of assessment for the Deaf and hard of hearing so that should be used than the regular assessments that clinicians typically use	Thank you for your comment. There are no specific assessment tools required by the BHA. As long as the assessment meets the criteria outlined in the initial assessment and/or the comprehensive assessment, providers may use the tool of their choice.
Chapter 2: 2.12.2 Appreciate pieces around parity. Looking at screening under initial assessment but if we think about outpatient that will need to be completed by 10 days and wondering if those infectious disease - doing within 10 days is not much time for relationship building and ask if we can push that out? People shy away from this that early and is a barrier to care. Other thing is if you look at 11.A, past risk factors and pregnancy - I believe that there are MH conditions that put folks at risk as well and ask that you move to more general screening?	Thank you for your comment. This was placed in the initial assessment with the recognition that many individuals receiving services do not stay in treatment for the full 60 days. The BHA wants to ensure those individuals are receiving resources and services for HIV needs. At the BHA, we are working towards balancing receiving care in a timely manner and striving to make sure individuals feel comfortable and safe when discussing more intimate conversations. We will continue to have conversations on how to be more thoughtful around this. Thank you for your comment around risk factors and pregnancy screening, we have moved this to be any behavioral health disorder associated with these risk factors to be more inclusive.
2.12.2.B Need to add screening for level of care needed to determine if current provider/level of care is likely to be the most appropriate level to meet the individual's needs. THE INITIAL ASSESSMENT (INCLUDING INFORMATION GATHERED AS PART OF THE PRELIMINARY SCREENING AND RISK ASSESSMENT) INCLUDES, AT A MINIMUM: 12. PRELIMINARY DETERMINATION OF LEVEL OF CARE NEEDED	Thank you for your comment. This has been added into the screening section.
2.12.3.A.9 Psychiatric, medical or both? Please change to PSYCHIATRIC ADVANCE	Thank you for your comment. Clarified to state medical and psychiatric advance directives. This is included in

DIRECTIVES	the individual record as well.
2.13.1.A.2 Living across the street from a catchment area line should not be a reason for treatment ineligibility. Please add h. ADMISSION CRITERIA TO ENSURE TREATMENT IN THE LEAST RESTRICTIVE SETTING BASED ON THE INDIVIDUAL'S LEVEL OF CARE NEEDS. THE FOLLOWING MUST NOT BE THE SOLE REASON FOR TREATMENT INELIGIBILITY: h. PLACE OF RESIDENCE	Thank you for your comment. This language has been added.
2.13.1.A.5.d Discharges for inappropriate behavior are particularly concerning to DLC. Often, what CMHC staff qualify as 'behavioral challenges or problems' are related to the client's disability, and the client should be given the opportunity to request a reasonable accommodation for what is manifesting as 'behavioral challenges or problems.' Frequently, the client's disability is affecting communication between them and CMHC staff, and the client's inappropriate behavior could be mitigated or even resolved with a communication accommodation. Connecting the client with the BHE's ADA Coordinator before discharging them for inappropriate behavior could prevent clients from unnecessarily searching for another provider and having their treatment and services interrupted. It would also allow the ADA Coordinator to be a sort of internal auditor and review if the discharge is appropriate." Add (5) PRIOR TO DISCHARGING AN INDIVIDUAL FOR BEHAVIOR, THE BHE MUST, UNLESS THE INDIVIDUAL REFUSES, CONNECT THE INDIVIDUAL TO ITS ADA COORDINATOR TO EXPLORE A REASONABLE ACCOMMODATION. "	Thank you for your comment. Providers will use care coordination to ensure the individual is receiving appropriate services. BHEs are not required to have an ADA coordinator.
2.13.1.A.5.e This recommendation is also based on the frustrating he said, she said (they said, they said) type of situation in which the clients say that they were denied services by the CMHC while the case managers and CMHC staff say that the client refused services. It would be clarifying for clients and advocates if the BHEs were required to provide clients with a written discharge notice with the reason for the client's discharge. This type of termination notice, along with written notification of a client's appeal rights, is mandatory for public benefits eligibility notifications, and BHE service notifications, particularly for discharge / service termination, should be held to the same	Thank you for your comment. This has been added.

standard. "Add (5) WRITTEN NOTIFICATION OF DISCHARGE WITH REASON(S) FOR DISCHARGE (6) WRITTEN NOTIFICATION OF BHE AND BHA DISPUTE AND GRIEVANCE PROCEDURES "	
2.15.2.A.5. A BHE'S POLICIES AND PROCEDURES REGARDING WHEN THE USE OF RESTRAINT, SECLUSION, AND/OR PHYSICAL MANAGEMENT IS APPROPRIATE, AND THE CONDITIONS UNDER WHICH THESE TECHNIQUES MAY BE IMPLEMENTED, MAY BE MORE STRICT, BUT MUST NOT BE LESS STRICT THAN IS REQUIRED BY THIS CHAPTER. The word "strict" may not be the best choice as it could be interpreted in reverse. Recommend: A BHE'S POLICIES AND PROCEDURES REGARDING WHEN THE USE OF RESTRAINT, SECLUSION, AND/OR PHYSICAL MANAGEMENT IS APPROPRIATE, AND THE RESTRICTIONS CONDITIONS UNDER WHICH THESE ON THE USE OF THESE TECHNIQUES, THE BHE MAY IMPOSE MORE, BUT NOT FEWER, RESTRICTIONS ON THE USE OF THESE TECHNIQUES THAN IS MAY BE IMPLEMENTED, MAY BE MORE STRICT, BUT MUST NOT BE LESS STRICT THAN IS REQUIRED BY THIS CHAPTER.	Thank you for your feedback. The suggested language has been added.
2.16.A.4. "ANY OCCURRENCE WHEN AN INDIVIDUAL CANNOT BE LOCATED FOLLOWING A SEARCH OF THE BHE, THE BHE GROUNDS, AND THE AREA SURROUNDING THE BHE, AND: a. THERE ARE CIRCUMSTANCES THAT PLACE THE INDIVIDUAL'S HEALTH, SAFETY, OR WELFARE AT RISK; OR, b. THE INDIVIDUAL HAS BEEN MISSING FOR EIGHT HOURS." It seems like this would apply to minors, court ordered individuals and individuals in residential treatment settings, not everyone. If an adult leaves a session prematurely and leaves the grounds, it isn't a critical incident. Clarify the intention to apply to voluntary adults or not.	Thank you for your feedback. This specific type of occurrence is statutorily required to be reported per 27-50-510(1)(c), C.R.S.
2.16.A.5. 5. MEDICATION DIVERSION/ERROR: ANY MEDICATION	Thank you for your feedback. Medication diversion and error have been separated into two list items for

DIVERSION AS DEFINED IN PART 1.2 OF THESE RULES OR MEDICATION ERROR THAT RESULTED OR COULD HAVE RESULTED IN HARM TO THE INDIVIDUAL. IF THE DIVERTED DRUGS ARE INJECTABLE, THE BHE SHALL ALSO REPORT THE FULL NAME AND DATE OF BIRTH OF ANY INDIVIDUAL WHO DIVERTED THE INJECTABLE DRUGS, IF KNOWN. It seems that medication diversion and medication errors are very distinct types of occurrences with vastly different responses. It seems that these two types of occurrences should be addressed separately.	clarity in response to this comment.
2.16.A.10. ANY OCCURRENCE INVOLVING MISAPPROPRIATION OF AN INDIVIDUAL'S PROPERTY, MEANING PATTERNS OF OR DELIBERATELY MISPLACING, EXPLOITING, OR WRONGFULLY USING, EITHER TEMPORARILY OR PERMANENTLY, AN INDIVIDUAL'S BELONGINGS OR MONEY WITHOUT THE INDIVIDUAL'S CONSENT. The term "pattern" Suggests that an individual incident of exploitation is not reportable. Is that the intent? It seems that staff stealing from a client should be reportable regardless of a pattern having been established. Recommend adding: ANY OCCURRENCE INVOLVING MISAPPROPRIATION OF AN INDIVIDUAL'S PROPERTY, MEANING PATTERNS OF LOSS OR SINGLE INCIDENTS OF DELIBERATELY MISPLACING, EXPLOITING, OR WRONGFULLY USING, EITHER TEMPORARILY OR PERMANENTLY, AN INDIVIDUAL'S BELONGINGS OR MONEY WITHOUT THE INDIVIDUAL'S CONSENT.	Thank you for your feedback. This change has been made.
2.9.A.7.b. Many clients call DLC saying that they were denied services by the CMHC, but when we review the CMHC's records for that client, the case managers and CMHC staff say that the client refused services. This turns into a frustrating he said, she said (they said, they said) type of situation. It would be clarifying for clients and advocates if the BHEs were required to have clients sign a refusal form or otherwise indicate in the client's record that it was an informed refusal of services and not just a miscommunication about when services start and end, which services are being offered, etc.	Thank you for this feedback. The suggested language has been added.

b. INDIVIDUAL CONSENTS MUST INCLUDE CONSENT TO TREATMENT. Add: IF THE INDIVIDUAL IS REFUSING TREATMENT OR AN ASPECT OF TREATMENT, THE BHE SHALL HAVE THE INDIVIDUAL SIGN A FORM TO CONFIRM THEIR REFUSAL.	
2.10.A.4. Representative should not be involved in the care of the individual THE BHE SHALL DESIGNATE A REPRESENTATIVE, WHO MUST BE AVAILABLE TO ASSIST INDIVIDUALS IN RESOLVING DISPUTES, AND WHO SHALL MAY NOT HAVE INVOLVEMENT IN THE CLINICAL OR REGULAR CARE OF THE INDIVIDUAL.	The BHE's representative may or may not have involvement in the care of the individual. In the case of a BHE with a single provider, this requirement would be overly burdensome. In the case that the individual needs to take the dispute beyond this representative, they may submit a grievance with the BHA.
2.11.G.4.g. "WHEN PROVIDING A REFERRAL, THE REFERRAL MUST INCLUDE, AS APPLICABLE TO THE INDIVIDUAL AND IN ACCORDANCE WITH INDIVIDUAL CONSENT, INFORMATION REGARDING: . . . " If the BHE has granted a client reasonable accommodations in accordance with the ADA (for example, accommodations for effective communication, such as only communicating with the client in person or over the phone), these accommodations should be included with the referral. This will support the client's transition to another provider. Add: " (10) REASONABLE ACCOMMODATIONS"	Thank you for your comment. This has been added.
2.12.2.B. THE INITIAL ASSESSMENT (INCLUDING INFORMATION GATHERED AS PART OF THE PRELIMINARY SCREENING AND RISK ASSESSMENT) INCLUDES, AT A MINIMUM: Need to add screening for level of care need to determine if current provider/level of care is likely to be the most appropriate level to meet the individual's needs Add the bolded text: THE INITIAL ASSESSMENT (INCLUDING INFORMATION GATHERED AS PART OF THE PRELIMINARY SCREENING AND RISK ASSESSMENT) INCLUDES, AT A MINIMUM: 12. PRELIMINARY DETERMINATION OF LEVEL OF CARE NEEDED	Thank you for your comment. This language has been added to the screening portion.
2.13.2.A.4 In 2021, Colorado passed a statute	Thank you for your comment. This statute is specific to

that authorizes Supported Decision-Making as a less restrictive alternative to guardianship and outlines the requirements for a legally recognized Supported Decision-Making agreement. COLO. REV. STAT. §§ 15-14-801--806 (West 2023) (effective Sept. 7, 2021); see also THE ARC COLO., Colorado's Supported Decision Making Agreement for Adults with a Disability, <https://thearcofco.org/wp-content/uploads/2021/07/Supported-Decison-Making-Agreement-Rev.-7.7.21.pdf> (last updated July 7, 2021). All BHA rules should reflect this change in Colorado law and support less restrictive alternatives to guardianship. Here is DLC's fact sheet on Supported Decision-Making for more information: <https://disabilitylawco.org/sites/default/files/uploads/pdf/Supported%20Decision%20Making%20Fact%20Sheet.pdf>. "THE SERVICE PLAN MUST BE SIGNED BY ALL PARTIES INVOLVED IN THE DEVELOPMENT OF THE PLAN, INCLUDING THE INDIVIDUAL, OR THE INDIVIDUAL'S PARENT, OR LEGAL GUARDIAN, OR **SUPPORTER** IN CASES WHERE THE INDIVIDUAL IS A CHILD; OR THE INDIVIDUAL HAS A COURT-APPOINTED LEGAL GUARDIAN AND HAS NOT CONSENTED TO SERVICES WITHOUT THE INVOLVEMENT OF THE LEGAL GUARDIAN; OR THE INDIVIDUAL HAS A SUPPORTER THROUGH A SUPPORTED DECISION-MAKING AGREEMENT

a. A COPY OF THE SERVICE PLAN MUST BE OFFERED TO THE INDIVIDUAL, OR TO THE INDIVIDUAL'S PARENT, OR LEGAL GUARDIAN, OR **SUPPORTER** AS APPROPRIATE.

b. THE BHE MUST INCLUDE DOCUMENTATION IN THE INDIVIDUAL RECORD IN CASES WHERE THE PLAN IS NOT SIGNED BY THE INDIVIDUAL OR THE THE INDIVIDUAL'S PARENT, OR LEGAL GUARDIAN, OR **SUPPORTER** IF INVOLVED IN THE DEVELOPMENT OF THE PLAN, AND IN CASES WHERE OFFERING THE SERVICE PLAN TO A PARENT, OR LEGAL GUARDIAN, OR **SUPPORTER** IS CONTRAINDICATED.

*This should be changed throughout the rules. Whenever there is a reference in the rules to "LEGAL GUARDIAN," it should be changed to "LEGAL GUARDIAN OR SUPPORTER" to reflect this change in Colorado's statutes."

adults with disabilities and does not apply to supporters for children. The supporter may still be involved in the service planning but their signature is not required.

Does BHE auditing switch to less frequent audits?	Audits will occur at the time of renewal on an annual basis, or in the case of a grievance or other investigation. There is an opportunity for tiered inspections added into the rules, which would allow for less frequent audits or audits with a narrower scope in the case of a BHE with a history of strong compliance with the rules.
Chapter 2: 2.27 So this is only required if a referral from the criminal justice system comes to a treatment center, not just required for any tx center treating OUD?	Thank you for your question. At this time it will only be “required” as mandatory treatment referral from the criminal justice system. However, the fentanyl education website is available to anyone that would like to go through the curriculum for free. The requirement was placed in Chapter 2 as this referral may come to any type of service that a BHE may be providing SUD treatment.
How are we addressing if someone needs supervision, how is this determined so a brand-new candidate is not working with a complex individual, this is placed in 2.6.1.D	Thank you for your question. Part 2.6.1.D.2 addresses the minimum frequency that candidates are to receive clinical supervision. The BHE agency is responsible, as stated in Part 2.6.C.2, that all personnel providing direct care have appropriate credentials and are acting within their scope of practice. The BHE shall also have policies and procedures regarding staffing listed in Part 2.6.E.
Chapter 2: Part 2.27 Is communication with the supervising officer/referring legal entity required if the client does not consent?	Thank you for the question. No, if the individual receiving services chooses not to consent to this communication, the provider may not communicate with the supervising entity. The provider must follow federal guidelines around record sharing and work with the individual receiving services around this expectation.
Chapter 2: Part 2.27 Can you say more about how this Fentanyl Education course is integrated in Medications for Opioid Use Disorder (MOUD) services provided by a BHE/agency?	Thank you for the question. The proposed rules require active collaboration with an outside entity or that the agency has MOUD services available on-site. MOUD needs to be provided to the individual should they want to participate in it. It is not required that all clients served engage in MOUD services, but that it needs to be available to them.
Chapter 2: Part 2.27.6 For the purpose of Part 2.27.6, does “clinically necessary” vary from “medically necessary?” How might reimbursement be impacted if the service is determined to no longer be “clinically necessary” and the communication with the legal system is satisfied, but the service remains “medically necessary?”	Thank you for the question. HCPF was involved in this rule development process and did not identify any reimbursement issues with the proposed language. The BHA consulted with HPCF about this specific question and clarified that “Medical Necessity” is required for Medicaid billing. This is a more broad term that encompasses both “Medically Indicated” and “Clinically Indicated” services. It is not possible for a service to be “Medically Indicated” without concurrently meeting the threshold of “Clinically Indicated” so there is not an anticipated reimbursement concern with the language in this Part 2.27.6.
2.27: It is unclear what the online fentanyl education has to do with BHEs. Are they required to facilitate participation in the BHA fentanyl education program? To provide this	Thank you for your feedback. This is a requirement of all BHEs that provide SUD treatment. The fentanyl education is completed through the free BHA created online curriculum. The BHE is to conduct an

material as part of OUD treatment?	assessment to determine what, if any, additional treatment the individual would benefit from and provide that therapeutic treatment along with MOUD resources/services either on site or through direct referral.
2.27 Would like more detail on what is needed for changed education needs. For example more specifics on how the education on Fentanyl needs to look?	Thank you for your feedback. This is a requirement of all BHEs that provide SUD treatment. The fentanyl education is completed through the free BHA created online curriculum. The BHE is to conduct an assessment to determine what, if any, additional treatment the individual would benefit from and provide that therapeutic treatment along with MOUD resources/services either on site or through direct referral.
2.4.A Does the BHE have an endorsement that covers all locations or does each location have its own set of endorsements?	Each location will have its own set of endorsements.
2.11.D.1 What is the purpose of having separate identification of mental health emergency services and SUD emergency services?	Thank you for your comment. The distinction between mental health and SUD has been removed.
2.12 Must a BHE provide a screening, initial assessment and the comprehensive assessment (ALL 3) or can they just provide the comprehensive assessment? Requiring all 3 seems redundant.	Thank you for your question. Agencies are not required to do all three. These are the minimum requirements and the comprehensive assessment can include information that was gathered during the screening and initial assessment so it is not redundant.
2.23.D Would this mean that BHE is required to provide all documentation to the BHA for any accreditation, such as CARF?	Thank you for your comment. Yes the BHE is required to provide all documentation to the BHA for any accreditation if requested.
2.27 Does fentanyl disorder treatment and education apply to all services provided by all endorsements?	Thank you for your question. Yes, 2.27 applies to all service levels providing SUD services.
2.12.3.C - Using the ASAM tool/criteria for determining the appropriate level of care is only appropriate for placing consumers with addiction, however it is written that the ASAM will be used with all individuals seeking services as part of the comprehensive assessment.	Thank you for your comment. The language currently states "FOR BHES THAT HAVE OR ARE SEEKING A SUD SUB-ENDORSEMENT FOR ANY LEVEL OF CARE, ASSESSMENTS MUST:". This is specific to SUD sub-endorsements not all individuals seeking care.
2.8.B.5 - It is written that the out-of-state offender questionnaire is required for all consumers. However, it was only for individuals entering SUD services. Requiring this questionnaire is a barrier to treatment, not trauma informed, and discriminatory against persons with legal backgrounds seeking treatment.	Thank you for your comment. This has been clarified to state it only applies if you're providing SUD services.
I request that you remove all facility FGI requirements. The regulations already ensure facility compliance and safety without the FGI guidelines having to be met, this is an additional expense to providers which does not serve individuals.	The BHA is proposing to remove FGI review requirements from the rules.
I oppose rule changes that require SUD	The BHA is including a provision for tiered inspections

treatment providers to have annual or more frequent surveys. This is an additional cost and providers that have a positive record for compliance should not be penalized.	in the rules, meaning that under certain circumstances providers with positive compliance records may be eligible for less frequent or intensive routine audits. The requirement for annual renewal of the BHE license is required per statute.
Recommend clarity/more direct language on the one-time outpatient endorsement fee	The BHA has revised its fee schedule, including language about which fees apply when. The BHE has also developed a separate document related to the fee schedule, including examples.
Concern about timeframe in issuing licenses and how long BHA will take. Hearing that CDPHE takes a long time to process applications.	Thank you for your comment. There is now a requirement to complete processing of all applications within 90 days in 2.19.J.
Section 2.4.A.4 endorsements considered residential/overnight endorsements. For that matter, Acute Treatment Unit services are not listed under 2.4.A.3 endorsements considered outpatient service endorsements, either. The language in Section 9.9.1 that, "ALL AGENCIES PROVIDING ACUTE TREATMENT SERVICES SHALL MEET THE RESIDENTIAL/OVERNIGHT STANDARDS IN PART 2.26," as well as Section 2.26.A, "A BHE PROVIDING RESIDENTIAL AND/OR OVERNIGHT SERVICES AS DEFINED IN PART 2.4.A.4," appear to indicate that Acute Treatment Unit services are residential/overnight services as defined in 2.4.A.4, yet they are not listed under Section 2.4.A.4 as an endorsement option. Clarification as to why it is not included would be helpful, particularly if there is a specific rationale for why it is not included.	The omission of ATU from the list was an error and is now included in the draft.
2.5.C.10 and 2.5.D are confusing. 2.5.C says that the governing body may delegate operations and management responsibilities to an executive, who may delegate responsibilities to an executive team, including . . . (10) developing, implementing, and annually reviewing policies in accordance with part 2.5.D of this chapter. 2.5.D says: THE GOVERNING BODY SHALL BE RESPONSIBLE FOR ENSURING THE DEVELOPMENT AND IMPLEMENTATION OF THESE POLICIES AND PROCEDURES, AND MUST ANNUALLY REVIEW ANY CHANGES TO POLICIES AND PROCEDURES FOR THE BHE. THE GOVERNING BODY SHALL ENSURE COMPLIANCE WITH THE POLICY REQUIREMENTS IN THIS SUBPART AND AS FOUND ELSEWHERE IN THIS CHAPTER. EVERY THREE (3) YEARS, THE GOVERNING	Thank you for your feedback. The allowance of delegation to an executive team has been added to Part 2.5.D. Part 2.5.D.2 has been removed. Language has been clarified around the timeframes required for policy review.

BODY SHALL REVIEW ALL POLICIES AND PROCEDURES. 1. These seem to be contradictory in that 2.5.C says the governing body may delegate policy review while 2.5.D says governing body must (a) review changes to policies and (b) review all policies. 2. These timeframes—and what is required during those timeframes—are inconsistent and not clear in that 2.5.C says annual review of policies, whereas 2.5.D. says (a) annual review of policy changes, and (b) review of policies every three years. In addition, 2.5.D.2 says (emphasis added): IF THE GOVERNING BODY HAS DELEGATED THE RESPONSIBILITY FOR DEVELOPMENT, IMPLEMENTATION, AND/OR ANNUAL REVIEW OF POLICIES TO A CLINICAL DIRECTOR OR ADMINISTRATOR AT THE ENDORSEMENT LEVEL, <u>THE GOVERNING BODY SHALL APPROVE SUCH POLICIES</u> AND ENSURE THEIR IMPLEMENTATION AND REVIEW. This further confuses the issue of whether the governing body has to review policies or whether that responsibility can be delegated, as allowed by 2.5.C. Requiring the governing body to approve policies essentially requires it to review them—unless a governing body is going to approve policies it hasn't reviewed, based on the review of its executive leadership.	
My name is Kalynn Smith. I am a Certified Addiction Specialist and Executive Director of the Routt County Alcohol Council in Steamboat Springs, Colorado. Our program, RCAC, operates as one of the only local agencies located in Northwest Colorado. We have been running DUI groups since November of 1976, making our program one of the oldest agencies in the State of Colorado. When Dr. Tom Traynor first established our program in the 1970s, it was one of the first in the State to pursue evidence-based practice for involuntary addiction treatment outside of a 12-step model. Dr. Traynor was applying CBT, motivational interviewing, and other psychological approaches to addiction prior to the creation of RR or SMART recovery. Although he turned down the offer to write the Driving With Care curriculum, he was extremely well versed in its	Thank you for your comment. The BHA takes these concerns seriously and has proposed an alternate fee schedule with reduced fees for smaller providers.

methodology and offered a cognitive based approach even before it became adopted by the State.

However, I do not write to you today to celebrate our contributions to this industry or rest on the laurels of our history within the field. I write to you today to speak out against what feels like an assault on agencies like ours. In the past several years, the State has issued policy after policy that make small, rural programs buckle under the weight of ever-increasing bureaucratic strain.

I am writing to you as a voice for agencies that are, and always have been the antithesis to the profitable, corporate model. The decision to drastically increase the fees associated with license renewals is just the most recent and egregious example of State mandates intensifying the obstacles faced by small programs. The State did not simply double renewal fees, they increased them by more than 17 times the amount paid in previous years. This is a 1750% increase in the most basic operational fees required for our license. For a small agency like RCAC, this fee comprises 2% of our overall income. Again not 2% of our profit- literally 2% of our total income. For us, this translates to 3 months of rent at our office, or payroll for an administrative employee for an entire month. For us, this feels like writing on the wall. Because this fee hike disproportionately affects agencies operating in rural areas, it feels tantamount to the State pushing out small local services in favor of corporate for-profit mental health care. By burdening small, local agencies with exorbitant costs, we risk deepening the mental health crisis in our underserved communities, leaving our neighbors without the care they so desperately need.

I truly believe that every provider in the field of court-mandated substance use treatment got involved out of a desire to help people in their local communities. No one in our field does this work because it is easy or profitable. It is a trying and difficult job that is underpaid, under-served, and often discouraging. Yet, I keep pushing forward in this field because every day I see the positive change it creates within my clients and within my community. It breaks my heart to think that State oversight is increasingly making this already challenging job even harder. The State should be supporting us, not crippling us in our efforts to serve clients. While I understand the importance of funding and resource allocation, it is my sincere belief that this hike in fees places an unjust burden on

small rural districts of Colorado that are already chronically underserved in mental health and substance resources. As I am sure you know, small agencies like ours play a vital role in providing personalized care tailored to specific needs of rural people in rural places. One of the greatest advantages of smaller agencies is their ability to provide a high level of personalized care. This care is unattainable within the confines of an outsourced corporate healthcare model operating out of major metropolitan areas that are hours away from the clients they serve. How can non-local agencies even respond to local concerns or recommend resources that are unique to where the client lives? This should not be the model that the State seems to be increasingly favoring.

If fees-hikes and stifling administrative expectations continue to increase at this rate, all small local agencies will buckle under the strain and go out of business. In my personal experience, I have already seen this happening to neighboring agencies. The amount of profit generated should not be the litmus test of successful mental health care models. The most profitable agency is rarely the best in terms of client care. Yet, they will be the only models able to afford the fees, administrative staff, and oversight expectations that are becoming the norm for State's new model.

I am not a voice for the largest number of clients, yet I speak at the top of my lungs for the 100 clients that I have. As a small, rural agency I will continue to offer care in my local community that fosters a sense of trust, familiarity, and comfort crucial to the healing process. We will continue to prioritize the well-being of our clients over financial gain, so we may provide a level of care that is holistic, compassionate, and community-centric.

In closing, I urge you to reevaluate the fee structure associated with license renewals for mental health agencies. The decision to impose a fee increase that is 17.5 times higher than the previous cost of renewal is an outrageous measure that undermines the very essence of community care. Please reconsider this policy that threatens the existence of essential small agencies. Do not force us to divert our scarce resources from client care to bureaucratic obligations, hampering our ability to maintain quality services. I implore you to reconsider this decision and take into account the invaluable contributions of small, neighborhood mental health agencies. Instead of pushing them towards the brink of closure, let us unite to

support and preserve these agencies, which are the lifeblood of our local community care. By fostering an environment that nurtures their growth and sustainability, we can ensure that individuals everywhere in Colorado receive the specialized care and attention they deserve. I write to you because I believe you will listen. I believe that we are not past the tipping point on the concerns I have raised. I write to you because I believe we can work together to build a stronger, more inclusive mental health system that prioritizes the needs of our community members above all else. By supporting small agencies, we can safeguard the well-being of our neighbors, cultivate resilience, and foster a society that values the importance of mental health. Thank you for your attention to this critical matter. I remain hopeful that, with your leadership and compassion, we can make a profound difference in what we are all fighting for: the people we serve.	
2.5 Governance C., 13. Proposed Edit: Strike “AND DOCUMENTING” 13. CONSIDERING AND DOCUMENTING THE USE OF INDIVIDUAL INPUT IN DECISION-MAKING PROCESSES IN ACCORDANCE WITH PART 2.5.D.3.i OF THIS CHAPTER.	Thank you for the feedback. The requirement to document use of individual input in decision making remains in the draft. This is so the BHA can monitor compliance with this requirement which creates opportunities for individuals receiving services to be heard by the agencies serving them.
2.5 Governance D., 2. Proposed Change – Remove that the governing body shall approve policies and ensure their implementation and review. 2. IF THE GOVERNING BODY HAS DELEGATED THE RESPONSIBILITY FOR DEVELOPMENT, IMPLEMENTATION, AND/OR ANNUAL REVIEW OF POLICIES TO A CLINICAL DIRECTOR OR ADMINISTRATOR AT THE ENDORSEMENT LEVEL, THE GOVERNING BODY SHALL APPROVE SUCH POLICIES AND ENSURE THEIR IMPLEMENTATION AND REVIEW. If allowed to delegate responsibility, why approve policies and ensure the implementation and review? Wouldn't that make the delegate moot? Recommend that this be removed.	Thank you for your feedback. This language has been removed.
2.6.1 Clinical Supervision B., 1 1. SUPERVISEE'S MANDATORY	Thank you for your feedback. This specific language is adapted from HCPF/RAE supervision standards.

DISCLOSURE STATEMENT THAT CLEARLY STATES THEY ARE UNDER SUPERVISION AND BY WHOM; The Disclosure statement should say that the BHE is responsible for appropriate supervision. Staff changes could lead to this having to be frequently changed.	
2.8 Individual Records A. Proposed Edit – Add exception for family therapy. A. A CONFIDENTIAL INDIVIDUAL RECORD MUST BE MAINTAINED FOR EACH INDIVIDUAL RECEIVING SERVICES FROM THE BHE. THIS RECORD MUST NOT CONTAIN PROTECTED HEALTH INFORMATION PERTAINING TO OTHER INDIVIDUALS RECEIVING SERVICES.	Thank you for your comment. Providers are not allowed to provide access to individual records unless each person involved in therapy consents to this, including during family therapy. This rule is not changing. Providers may keep multiple records for all individuals receiving services or in certain situations, the provider may keep one record for the identified individual receiving services, even if other participants are involved in therapy but the provider must be cautious of the ethical guidelines surrounding this.
2.8 Individual Records F. This is inconsistent with HIPAA. Under HIPAA we can and do charge a small fee. Recommendation to remove this section entirely. F. BHES MUST NOT CHARGE THE INDIVIDUAL OR DESIGNATED REPRESENTATIVE FOR INSPECTION OF THE INDIVIDUAL RECORD.	HIPAA allows for a fee for providing copies of the record. This provision speaks to inspection of the record, which the BHA is proposing to be free in order to ensure no barriers to individuals viewing their records.
2.9 Individual Rights A., 13, b., (1) 13. HAVE THE CONFIDENTIALITY OF THEIR INDIVIDUAL RECORDS MAINTAINED. a. A BHE MUST COMPLY WITH ALL APPLICABLE STATE AND FEDERAL LAWS AND REGULATIONS FOR RELEASE OF INFORMATION INCLUDING BUT NOT LIMITED TO 42 C.F.R. PART 2, SECTION 27-65-123, C.R.S. AND HIPAA. b. WHEN OBTAINING INFORMED CONSENT OR AN AUTHORIZATION FOR RELEASE OF INFORMATION, THE SIGNED RELEASE MUST STATE, AT A MINIMUM: (1) PERSONS WHO MAY RECEIVE THE INFORMATION IN THE RECORDS; This is more stringent than HIPAA 42 CFR Part 2 under the CARES Act – Recommendation: (1) TO PERSONS OR AGENCIES/PROVIDERS/ENTITIES WHO MAY RECEIVE THE INFORMATION IN THE RECORDS;	State regulations may be more stringent than federal regulations, and the BHA is choosing to propose this more strict standard that comes from current state regulations.

2.11 Individual Services Not sure this needs to call out MH vs. SUD emergency. Proposed Edit: 1. THE BEHAVIORAL HEALTH EMERGENCY SERVICES PROVIDED BY THE BHE, IF ANY, AND THE HOURS DURING WHICH SUCH BEHAVIORAL HEALTH EMERGENCY SERVICES ARE AVAILABLE. WITH A SEPARATE IDENTIFICATION OF THE MENTAL HEALTH DISORDER EMERGENCY SERVICES AND THE SUBSTANCE USE DISORDER EMERGENCY SERVICES PROVIDED BY THE BHE.	Thank you for your comment. This has been removed.
Page 28 2.11.G., 4, g. Not all referrals require this level of personal information. Proposed Edit: g. "WHEN PROVIDING A REFERRAL, THE REFERRAL MAY INCLUDE, AS CLINICALLY NECESSARY AND APPLICABLE TO THE INDIVIDUAL AND IN ACCORDANCE WITH INDIVIDUAL CONSENT, INFORMATION REGARDING:"	Thank you for your comment. We have added: "AS CLINICALLY NECESSARY AND APPLICABLE TO THE INDIVIDUAL." The "must" language is remaining because if the parts are clinically necessary they must be included.
2.12 Screening, Initial Assessment, and Comprehensive Assessment E. SCREENINGS SHOULD BE CONDUCTED IN PERSON UNLESS CONTRAINDICATED. IF CONTRAINDICATED, SCREENINGS MAY BE CONDUCTED VIA AUDIO-VISUAL OR AUDIO ONLY TELEHEALTH. CLINICAL RATIONALE MUST BE DOCUMENTED IN THE CASE OF A TELEHEALTH SCREENING. Screenings may be conducted via telehealth should also include if it the client's preference. Proposed Edit: E. SCREENINGS SHOULD BE CONDUCTED IN ACCORDANCE WITH CLIENT PREFERENCE AND GEOGRAPHIC LOCATION. SCREENING MAY TAKE THE FORM IN PERSON VISIT, OR VIA IN PERSON OR AUDIO-VISUAL OR AUDIO ONLY TELEHEALTH.	Thank you for your comment. The language allows the individual receiving services to consent to audio-visual or audio-only telehealth, and the rationale must be documented. No change is necessary.
2.12.2 Initial Assessment B.11., a., b., c., and d. B. THE INITIAL ASSESSMENT (INCLUDING INFORMATION GATHERED AS PART OF THE PRELIMINARY SCREENING AND RISK ASSESSMENT) INCLUDES, AT A MINIMUM: Note: We recognize dysregulated behaviors associated with mental health and substance use disorders can place you at risk for a variety health factors. The screening should	Thank you for your comment. Edit has been made to say "screened and appropriately referred."

only be done by physical health professionals (RN/APP/MDs). Proposed Edit: a. FOR PREGNANT INDIVIDUALS, THE BHE SHALL COORDINATE CARE AND ENSURE REFERRAL TO A PREGNANCY MANAGEMENT PROVIDER AND INFORM THE CLIENT OF THE POTENTIAL RISK AND COMPLICATIONS TO PREGNANCY WITH UNTREATED SUBSTANCE USE DISORDER AND MENTAL HEALTH CONDITIONS. SHALL BE SCREENED FOR PAST AND PRESENT RISK FACTORS ASSOCIATED WITH SUBSTANCE USE DISORDERS AND THAT ARE ASSOCIATED WITH: b. PREGNANCY COMPLICATIONS, INCLUDING RISKS TO THE HEALTH OF THE PREGNANT INDIVIDUAL AND FETUS; c. ACQUIRING AND TRANSMITTING HUMAN IMMUNODEFICIENCY VIRUS/ACQUIRED IMMUNE DEFICIENCY SYNDROME (HIV/AIDS), TUBERCULOSIS (TB), HEPATITIS A, B, OR C, AND OTHER INFECTIOUS DISEASES; AND, d. IF CLINICALLY INDICATED BY THE PRESENCE OF CONTINUING RISK FACTORS, SCREENING MUST BE CONDUCTED AT A MINIMUM ON A QUARTERLY BASIS.	
2.16 Critical Incident Reporting A., 2. A. A CRITICAL INCIDENT INCLUDES BUT IS NOT LIMITED TO THE FOLLOWING: 2. DEATH: INCLUDING THE DEATH OF AN INDIVIDUAL INSIDE OF OR OUTSIDE OF THE BHE'S PHYSICAL LOCATION WHILE AN INDIVIDUAL IS RECEIVING SERVICES OR WHERE AN INDIVIDUAL HAS ATTEMPTED TO RECEIVE SERVICES AT THE BHE WITHIN THE PAST THIRTY (30) CALENDAR DAYS.	"FROM THE BHE" has been added to this provision.
2.16 Critical Incident Reporting A., 4. A. A CRITICAL INCIDENT INCLUDES BUT IS NOT LIMITED TO THE FOLLOWING: 4. ANY OCCURRENCE WHEN AN INDIVIDUAL WHO IS ON A HOLD, CANNOT BE LOCATED FOLLOWING A SEARCH OF THE BHE, THE BHE GROUNDS, AND THE AREA SURROUNDING THE BHE, AND: If a client is not on a hold or commitment, they have a right to leave a treatment facility.	Thank you for your feedback. This specific type of occurrence is statutorily required to be reported per 27-50-510(1)(c), C.R.S.
2.27.4 Support Systems B., 2., c. Proposed Edit – Add language: "make reasonable attempts to" c. MAKE REASONABLE ATTEMPTS TO	Thank you for your feedback. The language has been changed to reflect this feedback to: "MAKE REASONABLE DOCUMENTED ATTEMPTS TO ENSURE..."

ENSURE THAT ALL INDIVIDUALS RECEIVING TREATMENT KNOW HOW TO ADMINISTER THE OPIOID ANTAGONIST IN CASE OF EMERGENCY, AND	
Thank you for moving the timeframe for the comprehensive assessment to 60 days from the start of treatment. This will be very helpful for us as we engage with our clients.	Thank you for your feedback.
-CCHN continues to be interested in exploring the nuances around SUD services and BHE licensure. In FQHCs, which offer team-based care (i.e. a BH provider/LAC on the team, along with a physician, medical assistant, etc.), the structure and oversight around SUD services is very high. We are concerned that a BHE license is an administratively burdensome step for FQHCs that are screening for and addressing SUD for their patients. We look forward to continued partnership to work with you on solutions.	Thank you for your comment. FQHCs that meet the definition of a Behavioral Health Entity would be required to obtain a BHE license.
One thing I noticed in CDPHE rules is a much more medical model and trying to adapt p&p was very difficult. Things that we needed to have p&p for were not even applicable. Something that can be considered. Lang. from CDPHE reg is hospital focused and not to behavioral health providers - example administrators.	Thank you for your comment. The BHA has carried over a significant portion of CDPHE's regulations and has made some adjustments to account for this difference, and is open to continually adjusting these regulations to right size them for behavioral health providers.
Safety Net Approval (formerly Chapter 3; now Chapter 12)	
UNLESS IT IS DETERMINED THAT AN INDIVIDUAL'S NEEDS FALL OUTSIDE THE SCOPE AND CAPACITY OF THE BEHAVIORAL HEALTH SAFETY NET PROVIDER, PURSUANT TO PARTS 3.5.2 AND 3.6.2 OF THIS CHAPTER, THE BEHAVIORAL HEALTH SAFETY NET PROVIDER SHALL NOT REFUSE TO TREAT AN INDIVIDUAL BASED ON THE INDIVIDUAL'S: We understand the statutory underpinning on this language. We respectfully request, though, that the rules reflect the system in which providers are operating, and consider and reflect the roles of BHA and the BHASOs in supporting providers in complying with these rules.	Thank you for your comment. The roles of the BHA and BHASOs will be outlined within administrative rules.
(3) REFUSE ANY DRUG, TEST, PROCEDURE, SERVICE OR TREATMENT AND TO BE INFORMED OF RISKS AND BENEFITS OF THIS ACTION; Does this need a caveat to allow for court orders? See comment at 3.4.1.F above. We understand the patient rights at issue here, but how does this requirement fit with the "no refusal" requirement if a patient is refusing to engage in treatment?	If a patient is refusing to engage in treatment, that would be distinct from a provider refusing to provide treatment. However, for example, if an individual refused to submit to drug testing but was still seeking to engage in other services or therapies, the provider should not refuse to provide other services.
(15) FORMULATE MEDICAL AND PSYCHIATRIC	Thank you for your comment. This language is part of the

ADVANCE DIRECTIVES AND HAVE THE AGENCY COMPLY WITH SUCH DIRECTIVES, AS APPLICABLE, AND IN COMPLIANCE WITH APPLICABLE STATE STATUTE. This needs to be done with the person's primary care physician. Suggest changing to "Assist the member in connecting with their primary medical doctor to formulate..."	individual rights section and does not refer to supporting an individual in formulating any advance directives but rather reflects the individual's right to formulate, and the agency's responsibility to comply with advance directives if the patient has formulated and supplied the directive.
3.4.1.F.6 - this is great and I appreciate the sentiment, we do need to make sure we include all disabilities, so they cannot refuse someone with TBI, someone who is Deaf or Hard of hearing, etc. Just need to add language around all disabilities.	Thank you for your comment. This language comes directly from HB22-1278 which does call out some specific disabilities and co-occurring disorders; however TBI, deaf or hard of hearing would also be covered under the no refusal criteria through this part and/or part 10.
3.4 F Divide into required and by contract. REQUIRED NO REFUSAL= Cannot refuse based on discharge from state hospital, criminal justice involvement, child welfare involvement, co-occurring SUD, disability, IDD, ADL limitation history of aggression, place of residence, age, race, creed, color, sex, sexual orientation, gender, identity, expression, marital status, national origin, ancestry or tribal affiliation. MAY BE ABLE TO LIMIT BASED ON THESE CRITERIA IN CONTRACT with established and uniformly applied admission/exclusion criteria-child/adult speciality, current aggression, behavioral, clinical or behavioral presentation (clinical specialty), ability to pay and may opt not to meet 27-65 by holding OP certs but must not refuse people based on being in involuntary treatment under a certification that another entity holds.	Thank you for your comment. The no refusal requirements are statutory requirements of all behavioral health safety net providers; however, application of the standard criteria can be used to determine that an individual is outside the clinical scope of practice or capacity of an agency, including when an essential behavioral health safety net provider is contracted to work with a specific subset of priority populations.
Should not refuse based on involuntary treatment status (either 27-65 or SUD involuntary) but not required in rule to hold certs. If they hold certs, this could be an enhanced responsibility/payment in contractual agreement with the BHASO/BHA/RAE (need to double check that it is allowable to have an entity treating someone under a certification who is not holding the certification in 27-65)	Thank you for your comment. We have removed the requirement for essential behavioral health safety net providers to be designated for outpatient certifications.
How do you enforce a no refusal model and when those providers fail to follow through on those rules they are held to?	As part of both the statutory and regulatory requirements, both essential and comprehensive providers will be required to document when a refusal occurs and the individuals needs that were assessed to fall outside the scope of that provider. Comprehensive community behavioral health providers will also be required to obtain approval from the BHA or its designee prior to refusing care to an individual, in line with the statutory requirements for comprehensive providers. In both instances, the BHA will be reviewing the data on refusals, and ensuring that providers are not in violation of the no refusal requirements when referring individuals to alternate providers for care.

General question re: refusal - what about people who have sex offenses? I know that there are some municipalities/cities/etc who have strict rules around SOs. Is this a valid reason for refusal?	In the event that a law somehow prohibited an individual with sex offenses from seeking treatment from an agency, that would be a valid reason to refuse treatment. However, comprehensive community behavioral health providers are required to serve individuals in home or community settings or using telehealth methods when necessary for the individual to access treatment, and options such as this must be explored prior to refusing care to an individual.
EXCEPT WHEN APPROVED TO SERVE A SPECIFIC SUBSET OF PRIORITY POPULATIONS IN ACCORDANCE WITH SUBPART (A), THE ESSENTIAL BEHAVIORAL HEALTH SAFETY NET PROVIDER SHALL EMPLOY OR CONTRACT WITH PERSONNEL WITH THE APPROPRIATE EXPERTISE TO SERVE INDIVIDUALS WHO ARE PART OF THE IDENTIFIED PRIORITY POPULATIONS AND/OR ARE IDENTIFIED WITHIN THE NO REFUSAL REQUIREMENTS OF PART 3.2.9. Suggest rephrasing to "shall employ, contract or develop referral relationships with personnel..."	Thank you for your comment. The intention is that essential providers will have personnel with the scope of practice to serve individuals within the identified subset of priority populations the provider will serve. The intention would not be for the provider to have referral relationships in place of their own personnel in this instance.
3.6.2.C.1 - This seems contrary to the no refusal provisions. A comprehensive provider should only be able to not accept someone for services (at that time)if an assessment reveals that they need a level of care that is not provided such as WM, inpatient, CSU. They should retain responsibility to coordinate care and accept them once the need for a higher level of care has been addressed. What is to prevent a CMHC or other CBHP from just saying that they don't treat IDD or personality disorders and then just turn them away?	Thank you for your comment. This criteria has been removed.
3.4.F - No refusal for all consumers seems to indicate that Safety Net Providers need to be able to provide all services, including inpatient and CSU. Is that correct?	Thank you for your comment. A provider is able to coordinate care to transition an individual to a level of care that the agency does not provide. This would not be considered a refusal.
-In general, the rules are quite prescriptive, which will make it difficult for all providers (not just FQHCs) to meet every requirement. If the goal is to expand the Behavioral Health safety-net, offering more flexibility to providers to achieve specific outcomes (rather than regulating how they get to the outcomes) may lead to more providers opting into the safety net role.	Thank you for your comment. We have attempted to remove some of the more prescriptive requirements, where it was supported by stakeholder input. This included removing equity plans from essential providers, adjusting the care coordination requirements and in particular removing some of the previous assessment language from care coordination, responsive to stakeholder feedback. We continue to invite feedback on specific places where additional flexibility in the rule would still allow for an enforceable rule while also allowing more flexibility for providers to achieve the intended outcomes.
3.3. and 3.7 - Reference to FQHCs 3.3 - Approval A.1 .a and 3.7.1.E.1. a - Initial Approval "... FOR FACILITIES, INCLUDING BUT NOT LIMITED TO	Thank you for your comment. We have made this change.

FEDERALLY QUALIFIED HEALTH CENTERS, THAT ARE EXEMPT FROM LICENSURE BUT REQUIRE FEDERAL CERTIFICATION, THE AGENCY SHALL PROVIDE DOCUMENTATION TO DEMONSTRATE CURRENT CERTIFICATION.” Recommendation: change “certification” to “recognition”	
Recommendation: be specific about what agency is referencing to disambiguate between a provider or agency.	Thank you for your comment. Agency is defined in Chapter 1.
3.5. 1. E – FQHCs strive to be open night and weekend hours when possible, to meet the needs of their patients, however staffing shortages are making expanded hours difficult to staff with trained and competent providers. Requirements to provide night and weekend hours may not be achievable and should be a goal but not a requirement for safety net providers.	Thank you for your comment. We have adjusted this language to allow for some additional flexibility in acknowledgement of the feedback received and the current workforce challenges.
3.5.2.C.1. The definition of “warm handoff” in this section is unclear, and CCHN is also concerned about the administrative burden put on providers to coordinate this handoff, especially for uninsured patients.	Thank you for your comment. Warm handoff is defined in Chapter 1.
3.5.2.E. CCHN is concerned with the additional reporting requirements described in this section. We are interested in determining how this could be built into existing reporting requirements, rather than adding new requirements.	Thank you for your comment. These data requirements are statutory. At this time the requirement in rule is for providers to maintain this information. How the BHA will collect this information from providers is still being determined and the BHA is working to reduce administrative burden in the data reporting processes.
We are concerned that the processes and practices of integrated behavioral health in primary care settings are not well incorporated into the rules. This could limit FQHC participation as Essential BH SN providers and could limit other primary care practices from moving into integrating behavioral health in the future.	Thank you for your comment. We have incorporated a number of changes into the rules based on specific feedback from integrated care providers and invite ongoing feedback for future iterations of the rule.
3.4.2 Care coordination CCHN is supportive of care coordination requirements and in most cases, FQHCs are already doing care coordination for their patients, however FQHCs and other providers would need additional support from the state or state contractors to reach the requirements in rule. CCHN’s recommendation is that rules are modified so that the following are not requirements, although they could be goals to work toward for both the state and providers. Specifically: 3.4.2 - C – The comprehensive assessments and service plans described would require a higher level of training for care navigators at some FQHCs, and state infrastructure to facilitate it. 3.4.2 - C. 2 - Patients access multiple services in	Thank you for your comment. The state infrastructure is actively being developed by the BHA in partnership with our state partners. Language around assessment has been changed to focus on instead ensuring that agencies are identifying an individual's needs and goals, and then developing a service plan to support the individual in reaching those goals. Screenings and identification of needs does not need to be done by one distinct individual and can be a compilation of screenings and assessments already taking place in these integrated care settings by a number of different personnel including primary care physicians, licensees as defined within the rules, and other personnel providing care coordination support.

the community at once and most require treatment planning. Putting the responsibility on providers to call and get updates on patients' care plans at other organizations is an unrealistic expectation, and would add significant administrative burden.	
3.5.2 Screening, Triage, and Care Coordination in Alignment with No Refusal Requirements E., 3. E. THE ESSENTIAL BEHAVIORAL HEALTH SAFETY NET PROVIDER SHALL TRACK THE FOLLOWING INFORMATION FOR ALL INDIVIDUALS WHO WERE REFERRED TO ALTERNATIVE SERVICES PURSUANT TO THIS PART: 3. THE OUTCOME AND TIMELINESS OF THE REFERRAL; AND Proposed Alternative: Date of referral and date response from receiving agency	Thank you for your comment, we have edited the rule in alignment with this recommendation.
When a comprehensive provider is not able to provide services to an individual, what is the realistic alternative? Isn't that the purpose of a safety net?	Thank you for your comment. Because behavioral health safety net providers will not provide all services, such as in-patient or residential levels of care, there are instances when a comprehensive provider will not be the right provider to serve an individual at that time. Additionally, in some cases a provider might not have availability to see a patient within the timeframe required for the individual's needs.
Minimum threshold of voting on boards with lived experience. CCBHC standard seems like that can be relied on for standard in that area.	Thank you for your comment. We have attempted to strike a balance between the conflicting feedback we have received on this issue. To do so we have clarified the language to require that the individuals and or parents of individuals with lived experience have meaningful experience accessing services for behavioral health conditions. We have also received feedback that it can be challenging to recruit board members that also have the expertise needed to accomplish some of the other key roles of a board. As such, we believe at this time 50% would be an unattainable threshold for providers and would limit participation in the safety net. We have written that at least 2 board members must have this experience and the board must show how they are incorporating this and other lived experience feedback into decisions. This is something we will continue to revisit in future rule revisions also, as the industry adjusts to some of these new requirements and builds capacity to reach a higher threshold of lived experience membership on governance boards.
I know SAMHSA as a whole 51% of the board has to have lived experience defined as mental health and substance use trauma. That is a ratio to consider too.	Thank you for your comment. We have attempted to strike a balance between the conflicting feedback we have received on this issue. To do so we have clarified the language to require that the individuals and or parents of individuals with lived experience have meaningful experience accessing services for behavioral health conditions. We have also received feedback that it

	can be challenging to recruit board members that also have the expertise needed to accomplish some of the other key roles of a board. As such, we believe at this time 50% would be an unattainable threshold for providers and would limit participation in the safety net. We have written that at least 2 board members must have this experience and the board must show how they are incorporating this and other lived experience feedback into decisions. This is something we will continue to revisit in future rule revisions also, as the industry adjusts to some of these new requirements and builds capacity to reach a higher threshold of lived experience membership on governance boards.
Requiring that a provider's board have both individuals with mental or substance use disorders and parents of children with such disorders limits a provider's ability to get the necessary expertise to oversee a complex organization. We respectfully request this be revised to create additional flexibility for the organizations while still ensuring that these voices are heard: "lived experience with MH and/or SUD, and/or parents of children with MH and/or SUD."	Thank you for your comment. We have attempted to strike a balance between the conflicting feedback we have received on this issue. To do so we have clarified the language to require that the individuals and or parents of individuals with lived experience have meaningful experience accessing services for behavioral health conditions. We have also received feedback that it can be challenging to recruit board members that also have the expertise needed to accomplish some of the other key roles of a board. As such, we believe at this time 50% would be an unattainable threshold for providers and would limit participation in the safety net. We have written that at least 2 board members must have this experience and the board must show how they are incorporating this and other lived experience feedback into decisions. This is something we will continue to revisit in future rule revisions also, as the industry adjusts to some of these new requirements and builds capacity to reach a higher threshold of lived experience membership on governance boards.
Governance Requirements: People with lived experience deserve a voice within entities responsible for providing care. Within Chapter 3.6.4 (C), the rules direct the board in control and direction of comprehensive community behavioral health providers to include people with lived experience and parents of children with mental health and substance use needs as voting members. We appreciate this requirement; however, we urge the BHA to modify the requirement to stipulate that a BHE board must have at least 50 percent of its voting members who identify as having lived experience with a mental health or substance use disorder. Additionally, we recommend paying these individuals for their time and value to ensure a focus on equity and a seat at the table for underrepresented communities.	Thank you for your comment. We have attempted to strike a balance between the conflicting feedback we have received on this issue. To do so we have clarified the language to require that the individuals and or parents of individuals with lived experience have meaningful experience accessing services for behavioral health conditions. We have also received feedback that it can be challenging to recruit board members that also have the expertise needed to accomplish some of the other key roles of a board. As such, we believe at this time 50% would be an unattainable threshold for providers and would limit participation in the safety net. We have written that at least 2 board members must have this experience and the board must show how they are incorporating this and other lived experience feedback into decisions. This is something we will continue to revisit in future rule revisions also, as the industry adjusts to some of these new requirements and builds capacity to reach a higher threshold of lived experience membership on governance boards.
3.6.4 (C)	Thank you for your comment. We have attempted to

o Language still includes AND indicating that the board member must have all of the lived experience vs OR C. THE BOARD IN CONTROL AND DIRECTION OF THE COMPREHENSIVE COMMUNITY BEHAVIORAL HEALTH PROVIDER SHALL INCLUDE VOTING MEMBERS THAT HAVE LIVED EXPERIENCE WITH MENTAL HEALTH DISORDERS AND SUBSTANCE USE DISORDERS AND PARENTS OF CHILDREN WITH MENTAL HEALTH DISORDERS AND SUBSTANCE USE DISORDERS. "3.6.4 GOVERNANCE Proposed edit: C. THE BOARD IN CONTROL AND DIRECTION OF THE COMPREHENSIVE COMMUNITY BEHAVIORAL HEALTH PROVIDER SHALL INCLUDE VOTING MEMBERS THAT HAVE LIVED EXPERIENCE WITH MENTAL HEALTH DISORDERS AND/OR SUBSTANCE USE DISORDERS AND/OR PARENTS OF CHILDREN WITH MENTAL HEALTH DISORDERS AND/OR SUBSTANCE USE DISORDERS."	strike a balance between the conflicting feedback we have received on this issue. To do so we have clarified the language to require that the individuals and or parents of individuals with lived experience have meaningful experience accessing services for behavioral health conditions. We have also received feedback that it can be challenging to recruit board members that also have the expertise needed to accomplish some of the other key roles of a board. As such, we believe at this time 50% would be an unattainable threshold for providers and would limit participation in the safety net. We have written that at least 2 board members must have this experience and the board must show how they are incorporating this and other lived experience feedback into decisions. This is something we will continue to revisit in future rule revisions also, as the industry adjusts to some of these new requirements and builds capacity to reach a higher threshold of lived experience membership on governance boards.
3.6.4 GOVERNANCE C. Proposed edit: C. THE BOARD IN CONTROL AND DIRECTION OF THE COMPREHENSIVE COMMUNITY BEHAVIORAL HEALTH PROVIDER SHALL INCLUDE VOTING MEMBERS THAT HAVE LIVED EXPERIENCE WITH MENTAL HEALTH DISORDERS AND/OR SUBSTANCE USE DISORDERS AND/OR PARENTS OF CHILDREN WITH MENTAL HEALTH DISORDERS AND/OR SUBSTANCE USE DISORDERS.	Thank you for your comment. We have attempted to strike a balance between the conflicting feedback we have received on this issue. To do so we have clarified the language to require that the individuals and or parents of individuals with lived experience have meaningful experience accessing services for behavioral health conditions. We have also received feedback that it can be challenging to recruit board members that also have the expertise needed to accomplish some of the other key roles of a board. As such, we believe at this time 50% would be an unattainable threshold for providers and would limit participation in the safety net. We have written that at least 2 board members must have this experience and the board must show how they are incorporating this and other lived experience feedback into decisions. This is something we will continue to revisit in future rule revisions also, as the industry adjusts to some of these new requirements and builds capacity to reach a higher threshold of lived experience membership on governance boards.
Can you define care coordination in connection to the CPT code	Care coordination is a term that is defined in statute (27-60-202, C.R.S.). We have used this definition within the rules.
I can assess people for 13 things they may need related to CC but I need to identify in the patient's words what their goals are and what needs to happen to help them reach that goal. What is most important to that person at that time is what the care coordination should focus on.	Thank you. We have adjusted the care coordination requirements to be more reflective of person centered goal setting.

With regards to care coordination, can you expand on what is meant by "conducting comprehensive assessments" and what all would be needed/required?	Thank you. We have adjusted the rules in an attempt to clarify the requirements and focus on identifying ind and goals and developing a service plan that addresses these goals. We have also ensured that where terms like assessment and screening are used that they align with the definitions in Chapter 1.
IF CARE COORDINATION ACTIVITIES NECESSARY TO MEET THE INDIVIDUAL'S NEEDS AND FULFILL THE SERVICE PLAN ARE BEING CARRIED OUT BY AN ALTERNATE ENTITY, THE BEHAVIORAL HEALTH SAFETY NET PROVIDER SHALL DOCUMENT THESE ACTIVITIES WITHIN THE RECORD AND SHALL BE RESPONSIBLE FOR DEMONSTRATING THAT THE INDIVIDUAL'S CARE COORDINATION NEEDS ARE BEING MET We understand and appreciate the intent behind this. However, demonstrating that the alternate entity is meeting all the individual's needs can be problematic. Similarly, patients may not choose to engage in the services that are laid out in the service plan. For example, if an individual is in low-acuity care and does not want to engage with a PCP despite health issues. We suggest striking "shall be responsible for demonstrating that the individual's care coordination needs are being met" and replacing with an alternative such as "and update as appropriate."	Thank you for your comment. The language has been changed accordingly: "IF CARE COORDINATION ACTIVITIES NECESSARY TO MEET THE INDIVIDUAL'S NEEDS AND FULFILL THE SERVICE PLAN ARE BEING CARRIED OUT BY AN ALTERNATE ENTITY, THE BEHAVIORAL HEALTH SAFETY NET PROVIDER SHALL DOCUMENT THE RESPONSIBILITIES OF EACH ENTITY WITHIN THE RECORD, AND UPDATE IN RESPONSE TO CHANGES IN THE INDIVIDUAL'S NEEDS AND/OR PREFERENCES, AND THE ALTERNATE ENTITY'S INVOLVEMENT."
What if another entity is already providing care coordination for an individual?	All of the care coordination responsibilities are as applicable to the individual. If activities are already being completed by another entity the safety net provider can document that and update the service plan as the individual's needs change or the alternate entity's responsibilities change.
3.4.1.G.1 - does this mean all providers are expected to do care coordination?	Yes. All behavioral health safety net providers are required by statute to provide care coordination.
3.4.2.B - "IF A DIFFERENT ENTITY IS PROVIDING CARE COORDINATION, THE BEHAVIORAL HEALTH SAFETY NET PROVIDER SHALL COORDINATE WITH THE ENTITY TO ENSURE THE INDIVIDUALS WHOLE PERSON HEALTH NEEDS ARE BEING MET. THE SERVICE PLAN MUST DOCUMENT THE RESPONSIBILITIES OF THE CARE COORDINATION ENTITY (ADD: AND THE BEHAVIORAL HEALTH SAFETY NET PROVIDER) AND ONGOING COORDINATION TASKS (ADD: OF EACH ENTITY.)"	Thank you for your comment. We made edits to align with this suggestion.
The term Care Coordination (Chapter 3) and Care Management (Chapter 4) are easily mistaken for one another. Can there be different terms used? How are they different?	Thank you for your comment. Statute calls out care management as distinct from care coordination, and outlines care management as a service that is being provided specifically by comprehensive providers. We have made changes to the structure of these chapters

	to clarify the requirements that apply to each provider type.
3.4 G No change except to remove care coordination through continuum. This should be addressed in care coordination expectations and may be that across service levels, would be responsibility of intermediary to do care coordination.	Thank you for your comment. This is a requirement of the safety net as a whole, as identified in statute, which is what this requirement is referencing. The provider specific requirements are found in 12.4.3 and 12.6.
3.4.2 Not sure that all of this should be essential requirements; Certainly should coordinate care within the episode they are providing and do assessment and service planning AND coordinate with any other Care Coordination Entity but the other responsibilities might go to the intermediary and comprehensive provider who would be required to provide navigation assistance.	Thank you for your comment. Care coordination, including navigation, is a key requirement of the essential providers, and a main reason that they will be eligible for enhanced payments, beyond what a BHE or IPN who opts not to participate in the safety net, would be required to provide. All of these requirements are as applicable to the individual so may not be required depending on the individual's needs, other providers involved in their care, etc.
3.4.1 G PROACTIVELY ENGAGING PRIORITY POPULATIONS WITH ADEQUATE CARE COORDINATION THROUGHOUT THE CARE CONTINUUM Essential providers may be only responsible for one level of care, therefore having them coordinate across the continuum is not reasonable. Suggest modifying language to arranging for transitions and coordinating with BHA and designees to participate in coordination of care. PROACTIVELY ENGAGING PRIORITY POPULATIONS WITH ADEQUATE TRANSITION CARE COORDINATION AND COLLABORATE WITH THE BHA AND ITS DESIGNEES ON COORDINATION OF CARE THROUGHOUT THE CARE CONTINUUM	Thank you for your comment. This is a requirement of the safety net as a whole, as identified in statute, which is what this requirement is referencing. The provider specific requirements are found in 12.4.3 and 12.6. Further, an essential provider may act as the primary care coordination entity for an individual in which case it is their responsibility to coordinate with other providers delivering different levels of care, external services, etc.
3.4.2 A care coordination, to be person-centered must be collaborative with the individual. BEHAVIORAL HEALTH SAFETY NET PROVIDERS SHALL WORK WITH THE INDIVIDUAL TO IDENTIFY SERVICE NEEDS AND PROVIDE CARE COORDINATION TO INDIVIDUALS THROUGHOUT THEIR EPISODE OF CARE, IN ACCORDANCE WITH THE INDIVIDUALS NEEDS.	Thank you for your comment.
Care Coordination Entity should be defined and might be used in other parts of this document when referring to BHA and designees or intermediaries.	Thank you for your comment. This term was removed.
• 3.4.2(c) o Transition planning – can this be case management not Care Coordination	Thank you for your comment. We have aligned the language in rule with the statutory terms and requirements.
3.4.2 Care Coordination C.,1., a. Proposed Edit: Strike subjective language of high-quality.	Thank you for your comment. We have made this edit.

a. SERVICE PLANS MUST ADDRESS ACCESS TO HIGH-QUALITY ACUTE AND CHRONIC PHYSICAL AND BEHAVIORAL HEALTH CARE, PEER SUPPORT NETWORKS, SOCIAL SERVICES, HOUSING, EDUCATIONAL SYSTEMS, AND EMPLOYMENT	
Are all independent providers required to become safety net providers?	No, becoming approved as a comprehensive or essential safety net provider is optional.
How do providers become SN providers?	The rule outlines the application and approval process that providers will follow to become approved. In order to be approved providers will demonstrate compliance with the safety net requirements outlined in Chapter 12 (previously 3).
This language could be used as a back door to violating the exclusion criteria included in HB 22-1278.	Thank you for your comment. Providers are not able to violate the exclusion criteria unless the provider has used the established standard criteria to determine that the individual is outside the scope and capacity of the provider. This process aligns with the statutory requirements.
Is there a difference between a “comprehensive BH safety net provider” and a “comprehensive community behavioral health provider”? Different terms are used in the statute and the rules.	The term used throughout statute and these rules is comprehensive community behavioral health provider, which is the term that the BHA will continue to recognize and use.
On pg. 14 and pgs. 19-20, the data collection is only made available upon request by the BHA. This data should be required to be reported to the BHA quarterly and required to be used by the BHA to inform how to strengthen the safety net	Requirements for how the BHA and or its designees will collect and utilize this data are not the role of the provider and therefore are not written into these provider rules.
Will the data on referrals that need to be tracked be required to be put into a network/data base developed by the BHA or can this be captured by safety net providers in the patient charts?	The way that it is written into rule is that it needs to be information that could be presented to the BHA in a report.
3.4.4 Consider moving this to comprehensive so does not apply or reduce the requirements to reflect the scope of the providers. Consider moving regional needs assessment, data monitoring and response to BHASO/RAES	Thank you for your comment. The requirement for an equity plan has been moved to apply only to comprehensive providers in line with this comment.
3.6.2 Consider transferring the responsibility for tracking individuals who receive alternative services to the BHASO/BHA since they will be approving these. This would provide them with data to shape their regional planning and contracts with essential providers. It seems like a monitoring role that should be done by another party.	Thank you for your comment. This requirement is a statutory requirement for behavioral health safety net providers and has been written into provider rules accordingly.
Page 3 3.4.1 General Requirements F., 3. F. ...BASED ON THE INDIVIDUAL'S: 3. READINESS TO TRANSITION OUT OF THE	Thank you for your comment. We have kept this language as it appears in statute.

COLORADO MENTAL HEALTH HOSPITAL AT PUEBLO, THE COLORADO MENTAL HEALTH HOSPITAL AT FORT LOGAN, OR ANY OTHER MENTAL HEALTH INSTITUTE OR LICENSED FACILITY PROVIDING INPATIENT PSYCHIATRIC SERVICES OR ACUTE CARE HOSPITAL PROVIDING STABILIZATION BECAUSE THE INDIVIDUAL NO LONGER REQUIRES INPATIENT CARE AND TREATMENT Proposed Edit: Add language “transfer status” 3. TRANSFER STATUS OUT OF THE COLORADO MENTAL HEALTH HOSPITAL AT PUEBLO, THE COLORADO MENTAL HEALTH HOSPITAL AT FORT LOGAN, OR ANY OTHER MENTAL HEALTH INSTITUTE OR LICENSED FACILITY PROVIDING INPATIENT PSYCHIATRIC SERVICES OR ACUTE CARE HOSPITAL PROVIDING STABILIZATION BECAUSE THE INDIVIDUAL NO LONGER REQUIRES INPATIENT CARE AND TREATMENT	
When you say that walk-in centers are included in "emergency/crisis", does the same requirements apply to the other crisis services such as Crisis Stabilization Units and Respite under CO Crisis Services? If people show up at any provider with crisis as an essential provider, when I'm thinking about crisis, is this just WIC or is mobile or respite included? A lot of those essential providers might be providing those other levels of care.	Essential providers may provide any one or more of the crisis levels of care in order to be approved as an essential behavioral health safety net provider.
Not all community BH providers are able to offer all those crisis services - e.g., ATUs. This is especially a concern in rural areas. Is there an opportunity for some flexibility in those crisis service requirements?	Thank you for your comment. The requirement has changed to read as follows: a. THE COMPREHENSIVE COMMUNITY BEHAVIORAL HEALTH PROVIDER SHALL PROVIDE CRISIS MANAGEMENT SERVICES THAT ARE AVAILABLE AND ACCESSIBLE 24-HOURS A DAY. THESE SERVICES MAY INCLUDE:
Crisis services CSU/ATU stuff doesn't fit with community providers. Has that language changed? Doesn't seem to align with HCPF and their payment model	The rule has been adjusted to read: a. THE COMPREHENSIVE COMMUNITY BEHAVIORAL HEALTH PROVIDER SHALL PROVIDE CRISIS MANAGEMENT SERVICES THAT ARE AVAILABLE AND ACCESSIBLE 24-HOURS A DAY. THESE SERVICES MAY INCLUDE: (1) WALK-IN CRISIS SERVICES (2) CRISIS STABILIZATION UNITS (3) ACUTE TREATMENT UNITS

	(4) MOBILE CRISIS SERVICES (5) RESPITE CARE SERVICES
So safety net providers would have to have a referral relationship of some time with other pieces of the crisis continuum and I assume WM as well	Yes, a referral relationship would be expected.
3.6.1.2.a. It is unreasonable to require each comprehensive provider to offer each of these services. The MSO currently determine which organizations receive crisis funding for WIC, CSU/ATU, mobile and respite. Currently, there is only one WIC required per MSO region. Suggest rephrasing to "shall provide AT LEAST ONE CRISIS MANAGEMENT SERVICE... such as:"	This rule now reads: a. THE COMPREHENSIVE COMMUNITY BEHAVIORAL HEALTH PROVIDER SHALL PROVIDE CRISIS MANAGEMENT SERVICES THAT ARE AVAILABLE AND ACCESSIBLE 24-HOURS A DAY. THESE SERVICES MAY INCLUDE: (1) WALK-IN CRISIS SERVICES (2) CRISIS STABILIZATION UNITS (3) ACUTE TREATMENT UNITS (4) MOBILE CRISIS SERVICES (5) RESPITE CARE SERVICES
Comprehensive providers should offer emergency/crisis services to include mobile response, emergency medication refills, same day access etc but should not require 24/7 services. Since the HCPF rates for comprehensive providers are based on outpatient services, I don't think we want to require that they provide residential. They can still provide them but it shouldn't be a requirement of a comprehensive provider. If this is what the language intended, clarify.	This rule now reads: a. THE COMPREHENSIVE COMMUNITY BEHAVIORAL HEALTH PROVIDER SHALL PROVIDE CRISIS MANAGEMENT SERVICES THAT ARE AVAILABLE AND ACCESSIBLE 24-HOURS A DAY. THESE SERVICES MAY INCLUDE: (1) WALK-IN CRISIS SERVICES (2) CRISIS STABILIZATION UNITS (3) ACUTE TREATMENT UNITS (4) MOBILE CRISIS SERVICES (5) RESPITE CARE SERVICES
It seems that a Safety Net Provider should be available to their clients to address urgent needs. Maybe we need to think distinctly about emergencies--immediately life threatening go to CCS or 911 and "Urgent" needs that are likely to become emergencies in 24 hours to be the responsibility of the safety net provider. An example would be a medication refill-- it isn't an emergency but the provider has an obligation to take care of it so it doesn't become an emergency, sending the client to CCS is not the right answer. IF THE INDIVIDUAL REQUIRES CRISIS OR EMERGENCY SERVICES THAT	Comprehensive providers are required to make available services to meet urgent needs within one business day. If an individual requires immediate support with an emergency or crisis outside of outpatient hours, the individual would need to access crisis services either through Colorado Crisis Services or other means.

THE AGENCY DOES NOT PROVIDE, THE ESSENTIAL BEHAVIORAL HEALTH SAFETY NET PROVIDER SHALL ENSURE THE INDIVIDUAL IS CONNECTED TO THE STATE CRISIS SYSTEM FOR IMMEDIATE ACCESS TO A SERVICE PROVIDER. THE AGENCY MUST HAVE A WAY TO ADDRESS URGENT NEEDS THAT ARE NOT YET BUT LIKELY TO BECOME EMERGENCIES DURING EVENINGS AND WEEKENDS.	
3.6.1 C 2 Eliminate the 24/7 services, this should be outpatient crisis care only 2. CRISIS/EMERGENCY a. THE COMPREHENSIVE COMMUNITY BEHAVIORAL HEALTH PROVIDER SHALL PROVIDE CRISIS MANAGEMENT SERVICES THAT ARE AVAILABLE AND ACCESSIBLE 24-HOURS A DAY AND INCLUDE: (1) WALK-IN CRISIS SERVICES (2) CRISIS STABILIZATION UNITS (3) ACUTE TREATMENT UNITS (4) MOBILE CRISIS (5) RESPITE CARE SERVICES	Thank you for your comment. Comprehensive providers are required to provide emergency/crisis services, which are 24 hour services. The requirement has been adjusted to reflect that they are providing one but do not need to provide each of the sub-services.
Comprehensive providers should screen for Medicaid eligibility THE COMPREHENSIVE COMMUNITY BEHAVIORAL HEALTH PROVIDER MUST ENSURE: 1. NO INDIVIDUALS ARE DENIED BEHAVIORAL HEALTH CARE SERVICES, INCLUDING BUT NOT LIMITED TO CRISIS MANAGEMENT SERVICES, BECAUSE OF AN INDIVIDUAL'S INABILITY TO PAY FOR SUCH SERVICE, AND 2. ANY FEES OR PAYMENTS REQUIRED BY THE AGENCY FOR SUCH SERVICES WILL BE REDUCED OR WAIVED TO ENABLE THE AGENCY TO FULFILL THE ASSURANCE DESCRIBED IN CLAUSE (1). 3. SCREEN INDIVIDUALS FOR ELIGIBILITY FOR MEDICAID AND PROVIDE THEM WITH ASSISTANCE WITH ENROLLMENT IF LIKELY TO BE ELIGIBLE	Thank you for your comment. These requirements already exist within other parts of the rules for these providers.
3.6.1 Requirements C., 1., d. Proposed Edit: Replace "immediately" with "promptly"	This has been clarified as follows: d. IF AN ESTABLISHED INDIVIDUAL PRESENTS WITH AN EMERGENCY OR CRISIS NEED, APPROPRIATE ACTION IS TAKEN IMMEDIATELY AND

d. IF AN ESTABLISHED INDIVIDUAL PRESENTS WITH AN EMERGENCY OR CRISIS NEED, APPROPRIATE ACTION IS TAKEN PROMPTLY, INCLUDING ANY NECESSARY SUBSEQUENT OUTPATIENT FOLLOW-UP.	SUBSEQUENT OUTPATIENT FOLLOW-UP IS PROMPTLY COORDINATED AND DELIVERED
3.6.1 Requirements C., 2., a. It's unreasonable to require each comprehensive provider to offer each of these services. The MSO currently determines which organizations receive crisis funding for WIC, CSU/ATU, mobile and respite and they designate the WIC required per MSO region. 2. CRISIS/EMERGENCY a. THE COMPREHENSIVE COMMUNITY BEHAVIORAL HEALTH PROVIDER SHALL PROVIDE CRISIS MANAGEMENT SERVICES THAT ARE AVAILABLE AND ACCESSIBLE 24-HOURS A DAY AND INCLUDE: Proposed Edit: a. THE COMPREHENSIVE COMMUNITY BEHAVIORAL HEALTH PROVIDER SHALL PROVIDE AT LEAST ONE CRISIS MANAGEMENT SERVICE THAT IS ARE AVAILABLE AND ACCESSIBLE 24-HOURS A DAY, SUCH AS:.	Thank you for your comment. This rule now reads: a. THE COMPREHENSIVE COMMUNITY BEHAVIORAL HEALTH PROVIDER SHALL PROVIDE CRISIS MANAGEMENT SERVICES THAT ARE AVAILABLE AND ACCESSIBLE 24-HOURS A DAY. THESE SERVICES MAY INCLUDE: (1) WALK-IN CRISIS SERVICES (2) CRISIS STABILIZATION UNITS (3) ACUTE TREATMENT UNITS (4) MOBILE CRISIS SERVICES (5) RESPITE CARE SERVICES
Chapter 3-Behavioral Health Safety Net Provider Approval CRISIS/EMERGENCY: THE COMPREHENSIVE COMMUNITY BEHAVIORAL HEALTH PROVIDER SHALL PROVIDE CRISIS MANAGEMENT SERVICES THAT ARE AVAILABLE AND ACCESSIBLE 24 HOURS A DAY AND INCLUDE: WALK-IN CRISIS SERVICES; CRISIS STABILIZATION UNITS; ACUTE TREATMENT UNITS; MOBILE CRISIS SERVICES; RESPITE CARE SERVICES. This requirement that Comprehensive Behavioral Health providers MUST provide all of these services will potentially have a large negative impact on clients in rural and frontier areas. As a center that provides services in these locations, the language does not leave room for the provider to have referral paths or partnerships with other providers to make sure this broad continuum of crisis services are available to clients. As a provider dedicated to expanding access, we recently have built a crisis stabilization unit and ATU, but these are complex and can be difficult to provide appropriate staffing for in our rural counties. According to the language here, even though we would be able to provide all of the required outpatient services, provide care	This rule now reads: a. THE COMPREHENSIVE COMMUNITY BEHAVIORAL HEALTH PROVIDER SHALL PROVIDE CRISIS MANAGEMENT SERVICES THAT ARE AVAILABLE AND ACCESSIBLE 24-HOURS A DAY. THESE SERVICES MAY INCLUDE: (1) WALK-IN CRISIS SERVICES (2) CRISIS STABILIZATION UNITS (3) ACUTE TREATMENT UNITS (4) MOBILE CRISIS SERVICES (5) RESPITE CARE SERVICES

management and work with involuntary clients, we would be required to add yet other levels of care. This type of rigid requirement is likely to reduce the number of providers who may consider providing such comprehensive services. If the language could allow for providers to be able to plan for referral pathways for these levels of care, it would be more reasonable. The language is available for essential safety net providers, but there is no flexibility in the comprehensive behavioral health requirements.	
There is ambiguity on whether or not 27-65 endorsement	Comprehensive providers will be required to hold a 27-65 designation.
Please consider allowing recovery supports-only providers to become a safety net provider in the future.	Thank you for your comment.
What concerns me is the loose definition of lived experience. We want lived experience of those that have accessed these behavioral health systems.	Thank you for your comment. We have added some additional clarity through the following language that specifies that individuals must have lived experience accessing care for a behavioral health condition: VOTING MEMBERS THAT HAVE LIVED EXPERIENCE WITH ACCESSING SERVICES FOR MENTAL HEALTH AND/OR SUBSTANCE USE DISORDERS, WHICH MAY INCLUDE PARENTS OF CHILDREN WITH MENTAL HEALTH AND/OR SUBSTANCE USE DISORDERS WHO HAVE SUPPORTED THEIR CHILDREN IN ACCESSING SERVICES FOR MENTAL HEALTH AND/OR SUBSTANCE USE DISORDERS.
When you have all these entities that you are speaking of, I have a brain injury and when you don't have providers that are knowledgeable about that, it becomes complicated and we have to reach out to other states. Given dx that don't fit and is a hard process. Understand you have these programs but where do you find these providers and expertise.	Safety Net providers will be held to no refusal requirements based on specific criteria and some are specific to co-occurring disorders and TBI, DD and SUD and MH conditions. Moving forward, approved Safety Net providers should be a place where individuals can receive treatment when they present with co-occurring conditions and must have staff that have competency in addressing those concerns.
Episode of care is not a term that applies in the same way to FQs. In order to ensure that FQs are able to meet these standards there needs to be more clarity about this term. What are we referring to in this context?	Thank you, we have removed this term. Care coordination terms shall be provided on an ongoing basis to an individual, as needed to meet the individual's needs.
Health centers are already doing comprehensive assessments. The way this is defined here is so broad that it encompasses everything that we are doing - from our medical providers, to BH professionals, to unlicensed staff that do some of the screening. because its so broad its easy for people to carve things out People are pulling the pieces they do out and ignoring the rest It's so big it needs to be broken down and clarified	Thank you for your comment. The state infrastructure is actively being developed by the BHA in partnership with our state partners. Language around assessment has been changed to focus on instead ensuring that agencies are identifying an individual's needs and goals, and then developing a service plan to support the individual in reaching those goals. Screenings and identification of needs does not need to be done by one distinct individual and can be a compilation of screenings and assessments already taking place in these integrated care settings by a number of different personnel including primary care physicians, licensees

	as defined within the rules, and other personnel providing care coordination support.
Is assessment in this context defined? Is there a better term?	We have reviewed the use of the terms assessment and screening throughout this part to ensure that use of the terms aligns with how these terms are defined in Chapter 1.
Assessment - because it spans across multiple providers in integrated care settings - hard to capture in one place	Language around assessment has been changed to focus on instead ensuring that agencies are identifying an individual's needs and goals, and then developing a service plan to support the individual in reaching those goals. Screenings and identification of needs does not need to be done by one distinct individual and can be a compilation of screenings and assessments already taking place in these integrated care settings by a number of different personnel including primary care physicians, licensees as defined within the rules, and other personnel providing care coordination support.
I share concern that the definition is so broad and overcompassing that it would be difficult - i would want to know how we would be assessed in meeting these requirements because of our limited resources compared to what we can do and what we can connect patients to	Language around assessment has been changed to focus on instead ensuring that agencies are identifying an individual's needs and goals, and then developing a service plan to support the individual in reaching those goals. Screenings and identification of needs does not need to be done by one distinct individual and can be a compilation of screenings and assessments already taking place in these integrated care settings by a number of different personnel including primary care physicians, licensees as defined within the rules, and other personnel providing care coordination support.
Related to populations we serve - if there is some sort of eval of our effectiveness in connecting there needs to be consideration of the really challenging populations we are working with	Thank you for your comment. We understand that individuals can present with diverse and sometimes intensive needs. As such, we have adjusted this section to focus on person centered goal setting and service planning and compliance monitoring will focus on these elements.
We need trust that what we are doing is assessing the client's needs The more we define that you have to assess this way for this thing the more barriers there are for actually providing that care We need processes that recognize the work that is already happening in these safety net (FQ) clinics We see the need for standards and we want this to match with the organic processes we have in place vs interfere	Thank you for your comment. We have attempted to make adjustments to better align with current practices in FQHCs and invite ongoing feedback on how to align these care coordination requirements with existing practices in integrated care settings. We continue to be open to ongoing feedback on this topic for future rule revisions.
Because behavioral health is happening in an integrated setting we want to make sure that fqs don't have to think differently or put in place processes that actually prevent that integration because they'll have to do 10 extra steps	Thank you for your comment. We have attempted to make adjustments to better align with current practices in FQHCs and invite ongoing feedback on how to align these care coordination requirements with existing practices in integrated care settings. We continue to be open to ongoing feedback on this topic for future rule revisions.

Want to make sure that the documentation can be done by whoever is doing it on the fq side (be that unlicensed individual, md, etc.)	Thank you for your comment. As long as personnel are appropriately trained and acting within their scope of practice, documentation can be done by a variety of personnel involved in the care of the individual.
Does register complaints include event reporting? RAEs already require event reporting, and so does BHA - there is also a lot of extreme events that take place around and in some of these facilities because of the individuals we serve and that could create undue burden around reporting	We have adjusted the complaints language to be consistent with the grievance terminology defined and used throughout the rules. Critical incident reporting is separate from grievance reporting.
Concerned about the equity plans - we are working towards this end but this requirement seems like it could create burden in ways that are unsustainable given current staffing shortages	Thank you for your comment. We have made adjustments to add flexibility to this requirement and allow this to align with other efforts and requirements of providers such as QMPs, outreach, education and engagement plans, and others.
Consider requiring a full equity plan of comprehensive providers only but leave cultural/linguistic services plan as requirement for essential providers.	Thank you for your comment. We have changed the rules to align with this recommendation.
B. EQUITY PLANS MUST BE DESIGNED TO IMPROVE TREATMENT ACCESS AND/OR OUTCOMES FOR PRIORITY POPULATIONS, AS IDENTIFIED BY THE BHA. Strike "as identified by the BHA" and replace with "as identified the BHE's Community Behavioral Health Treatment Needs Assessment."	We removed the language, as identified by the BHA, to prevent confusion that the BHA would dictate exactly what priority population must be targeted; however, priority population is a term defined within statute and carried over to this rule, and as such, when priority population is referred to in these rules it aligns with that definition.
C. AGENCIES SHALL IMPLEMENT STRATEGIES FROM THE EQUITY PLAN TO DECREASE THE DISPARITIES IN ACCESS AND OUTCOMES FOR PRIORITY POPULATIONS. Duplicative with (B) - suggest striking this. Could add "and implement" after "establish" in (A).	Thank you for your comment. We've made adjustments in alignment with these suggestions.
3.4.4 - Equity plan, what measures are providers to use to determine disparities between priority populations? This seems more like an administrative oversight function and adds administrative burden to provider.	Providers may use existing data to identify disparities, collaborate with community partners, utilize state and local reports, and more to inform their equity plans. Many providers are already aware of these disparities, and this offers a way to show that quality improvement efforts are aimed at addressing these in some way.
So Comprehensive providers don't have to do all the items under Essential providers like Withdrawal Management?	Correct, as it is currently written. Comprehensive providers are not required to provide WM but they can if appropriately endorsed to do so.
Will geographic location be factored in when a provider refers to another provider?	We've added language that providers should consider geographic location when issuing referrals.
How do comprehensive providers handle situations where a client might assault or threaten a staff person? Med switch should be factored in here	The rule clarifies that this requirement applies when the provider is made aware of an admission/discharge. We understand that health information systems do not currently enable this across all payers and providers and as such we have written the rule to account for that.
Will an RCO be eligible to be a comprehensive provider, or will they want to, without being an	Through statute, comprehensive could be a licensed BHE or an approved BH provider, which could be an

RSSO?	RCO or RSSO, but the RCO would also need to be properly licensed to provide all comprehensive safety net services, which includes clinical services.
Aggressive behavior resulting in the shortage of access to certain behavioral medications? Is that factored in here as well? Is it covered under the continuum of care? Certain BH medications there have been a shortage of them which has led to aggressive behavior and it is affecting housing and accessing care. Is this covered there? Manufacturer shortages are occurring.	Sometimes availability of medication is separate from providers prescribing that. For comprehensive providers to address related issues where an individual is receiving care and they run out, the provider needs to address this within one day.
Will de-escalation still include restraints and isolation?	Yes, it may if the situation requires and the provider has the appropriate policies and procedures in place. There are rules around use of restraint and seclusion in Chapter 2 and designated facilities in Chapter 11.
Is there a definition of underinsured?	Yes, this has been added.
Will there be oversight that is sufficient for these regs?	The BHA has a team in place that will oversee compliance for safety net providers.
I know historically the priority pops of getting people into treatment has been pregnant/parenting people and IV drug users. Is the big list of priority pops now replacing the few pops that have been the priority in the past?	This priority population for pregnant/parenting and IV drug users is specific to our block grant funding. This list does not replace those.
For the comprehensive community behavioral health provider portion, is IOP included in this expectation?	Yes, they are included. In our current rule draft, we did combine two separate chapters into one chapter that captures the full outpatient continuum of care. The requirement for comprehensive is to have sub-endorsements of both outpatient and IOP. MIP is not required.
What is the definition of "nights"?	This has been changed to evenings.
3.5.1 Are night/weekend hours a requirement for all Essential Behavioral Health Safety Net Providers or is that based on the community behavioral health assessment?	Evening and weekend hours are required as determined necessary to meet the needs of the populations served.
3.6.2D What will be the process for this?	Thank you for your comment. The BHA is working to develop these processes, including the role of the BHA and BHASO, as well as the specific support that will be

	provided by the BHA related to coordinating care for specific individuals and populations. These roles and processes will be outlined within BHA administrative rules.
How long will it take to receive approval?	The BHA will take action on a complete application within ninety (90) days.
Will there be a turnaround time requirement for the RAE or BHA to provide that approval? Commercial insurers are subject to requirements for prior auth. If we're going to institute something similar for Medicaid, there must be a requirement for timely authorization/approval.	The BHA will take action on a complete application for approval within ninety (90) days. These rules do not govern prior authorization processes that are related to payers.
If a patient is in the priority population and are unable to pay for IOP services, is it our responsibility to cover these costs as a facility?	The rule is specific that the facility in question should have a policy around people seeking services and inability to pay, which may include sliding scale fees or assistance in applying to Medicaid.
For the safety net requirement to provide services during extended hours (nights and weekends) does this have to be at every site the provider operates and does telehealth count?	This requirement applies to outpatient services delivered by the agency. It does not require every site to have extended hours. Telehealth is an allowable means of extending hours.
What does key health indicators mean? It is not defined here or in Chapter 1.	This term has been removed and already defined terms and requirements are present to meet the requirements of this.
We understand the intent behind this language and the statutory basis. Can you confirm if it applies in the case of individuals who chronically miss appointments. Are providers allowed to close out clients who, despite knowledge of attendance agreements and proactive outreach from the provider, continue to set and then miss appointments? It is appropriate for providers to set expectations/limits/boundaries on behaviors. We do not believe such flexibility goes outside the boundaries of the statute.	Thank you for your comment. We believe the intent of the legislation and rule would be that services such as care coordination or management and methods such as outreach would be utilized to attempt to find a way to engage those individuals prior to stopping services. In terms of enforcement, we would likely look for documentation indicating the efforts an agency made to engage an individual through those or other methods as evidence of compliance with the rule.
8. CLINICAL PRESENTATION OR BEHAVIORAL PRESENTATION IN ANY PREVIOUS INTERACTION WITH A PROVIDER; This seems to go beyond 27-63-105, which only includes the language at (7) above. As has been noted previously, our members have numerous stories of physical assaults and significant threats against both individuals and facilities. This language is extremely problematic when individuals have assaulted or made serious threats against staff. We respectfully request deleting this language.	HB 22-1278 expanded upon the no refusal criteria that was initially established in HB 19-222, which is the 27-63-105 C.R.S. referenced in this comment. This criteria 8. comes directly from 27-50-301 (4) (h) and is part of the statutory requirements for behavioral health safety net providers.
Can we clarify that this is within Colorado? We assume the intent is not to require providers to accept patients from other states.	When an individual is experiencing a behavioral health crisis the safety net system must be there to support that individual. In the event that an out of state resident is attempting to access services from a provider within Colorado the provider could provide care coordination to support the individual in accessing services in their

	home state.
While providers always seek to do this - and indeed, it lies at the root of co-responder and STAR-type programs - this language implies that police cannot be utilized in high-risk/immediate safety or similar situations when a quick response is needed. Suggest either striking "without the use of law enforcement" or rephrasing to "...treating high-acuity individuals in the least restrictive environment and training in working with law enforcement to mitigate adversity in interactions with police and other first responders."	Thank you for your comment. We have adjusted the language in alignment with this suggestion.
SERVICE PLANS MUST ADDRESS ACCESS TO HIGH-QUALITY ACUTE AND CHRONIC PHYSICAL AND BEHAVIORAL HEALTH CARE, PEER SUPPORT NETWORKS, SOCIAL SERVICES, HOUSING, EDUCATIONAL SYSTEMS, AND EMPLOYMENT OPPORTUNITIES AS NECESSARY TO FACILITATE WELLNESS AND RECOVERY OF THE WHOLE PERSON. Suggest striking high quality, as it is subjective.	Thank you for your comment. We have removed this language.
SERVICE PLANS MUST ADDRESS ACCESS TO HIGH-QUALITY ACUTE AND CHRONIC PHYSICAL AND BEHAVIORAL HEALTH CARE, PEER SUPPORT NETWORKS, SOCIAL SERVICES, HOUSING, EDUCATIONAL SYSTEMS, AND EMPLOYMENT OPPORTUNITIES AS NECESSARY TO FACILITATE WELLNESS AND RECOVERY OF THE WHOLE PERSON. Suggest changing as necessary to "as deemed appropriate by the provider and/or as requested by the individual or family to facilitate..."	We have made adjustments that align with this comment.
The safety net provider will, of course, strive to contract/coordinate with appropriately qualified partners, but cannot guarantee that entities outside the organization have all these qualifications.	We have adjusted the language in alignment with this suggestion.
2. SYSTEM-REPORTED OUTCOMES SUCH AS PREVENTABLE HOSPITALIZATIONS AND/OR HOSPITAL READMISSION, RATE OF FOLLOW-UP WITH INDIVIDUALS AND FAMILIES, LEVEL OF INDIVIDUAL OR FAMILY ENGAGEMENT, NUMBER OF SUBSTANTIATED COMPLAINTS OR APPEALS, AND TIMELINESS OF TRANSITIONS TO APPROPRIATE LEVELS OF CARE; This language seems like a carryover from hospital reporting requirements and are not germane to behavioral health safety net providers. Suggest striking.	Thank you for your comment. This language aligns with recommendations from the SB19-222 implementation plan. A provider is welcome to select other outcomes to measure their progress for this part.
2. COLLECT AND MAINTAIN UPDATED	Yes, this information can be obtained from third parties.

INFORMATION TO HELP UNDERSTAND THE COMPOSITION OF THE COMMUNITIES IN THE SERVICE AREA, INCLUDING THE PRIMARY SPOKEN LANGUAGES IN ORDER TO INFORM THE PROVISION OF CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES AND IMPROVE ACCESS FOR THESE COMMUNITIES Confirming that we can gather this information from third parties?	
VIA A LIVE CONVERSATION This is problematic in practice. Many individuals request communication only via text; many do not answer their phones; often voicemail boxes are full. And given the need for timely communication, such information cannot always be relayed in a face-to-face setting. Please strike this and replace with "promptly" or "in a timely manner."	Thank you for your comment. The BHA believes this remains best practice when transitioning the care of an individual to an alternate provider or entity. A provider could fulfill this requirement by having this conversation during a service visit, and if this was truly not appropriate or possible for the individual, in most cases the BHA will look for documentation of appropriate attempts or reasoning within the chart prior to taking enforcement action.
3.5.3 and 3.6.3 We respectfully request that the words "as BHA funding allows" be added. The list of priority populations in statute is much more extensive than before, and includes the very broad category of underinsured.	Thank you for your comment. These standards extend beyond payer or funding source and as such we have left this as is.
3.4.5(A)(7) TTY is obsolete technology. Please replace with videophones.	Thank you for your comment. We have made this change.
3.4.5(A)(5)(a) "Family friends or other individuals....." I think that is great and really important! Can be really confusing in the process especially related to MH and could have issues with family and important to keep those separate.	Thank you for your comment.
Is the safety net provider approval process separate from BHE licensing? What is the timeline to become a safety net provider?	The safety net provider approval process is separate from BHE licensure. A provider can apply to become a safety net provider any time after January 1, 2024.
3.6.1 - requirement for comprehensive utilization in home and telehealth - having community based is also important and having a requirement around that so not all telehealth and home. Some people don't want people in their homes for a lot of reasons.	Thank you for your comment. This is reflected within the rules.
3.2 - Does this need a definition of CBHP?	Thank you for your comment. The definition of comprehensive community behavioral health provider is located in Chapter 1.
3.3.2.a - I think this is incorrect. Doesn't 3.4 apply to all SN; 3.5 apply to Essential and 3.6 apply to comprehensive?	Thank you. This was corrected.
3.4.1.F.3 - Not sure how this works with an outpatient provider. how does one commence treatment if someone is not able to leave a facility or continue treatment once someone is in a facility? They do not generally allow outside	Thank you for your comment. This is statutory language that applies to safety net services that extend beyond just outpatient services.

providers.	
3.4.1.F.7 - Not sure this is fair to small OP providers. No one will sign up if this is required.	Thank you for your comment. This language is a statutory requirement of behavioral health safety net providers.
3.4.2.D.1.a - should service plans also identify more permanent sources of care like Medicaid if possible?	Thank you for your comment. This is addressed through care coordination requirements which include: IDENTIFYING THE INFORMATION, SOCIAL SERVICE, AND HEALTHCARE SYSTEMS THAT AN INDIVIDUAL WILL NEED TO ACCESS IN ORDER TO NAVIGATE SYSTEMS, MANAGE THEIR CARE AND ACHIEVE WHOLE PERSON HEALTH
3.4.3.A - "THE BEHAVIORAL HEALTH SAFETY NET PROVIDER'S POLICIES AND PROCEDURES MUST DEMONSTRATE HOW THE AGENCY WILL (ADD: ENSURE THAT CARE IS PROVIDED IN ALIGNMENT) WITH THE REQUIRED COMPETENCIES OF BEHAVIORAL HEALTH SAFETY NET PROVIDERS SET FORTH IN PART 3.4.1 OF THIS CHAPTER"	Thank you for your comment. We have made this change in the proposed rule.
3.4.3.B.1.a.1 - (ADD: "FULLY) PARTICIPATE IN ALL DECISIONS INVOLVING THE INDIVIDUAL'S CARE OR TREATMENT;"	Thank you for your comment.
3.4.3.B.1.a.4 - CHANGE "ABILITY" TO "DISABILITY"	Thank you for your comment. We have made this change.
3.4.3.B.1.a.5 - CHANGE "FIRST NAME" TO "FULL NAME" "BE INFORMED OF, AT A MINIMUM, THE FIRST NAMES AND CREDENTIALS OF THE PERSONNEL THAT ARE PROVIDING SERVICES TO THE INDIVIDUAL (ADD: INCLUDING THE NAME OF THE INDIVIDUAL SUPERVISING THE PRACTICE OF THE INDIVIDUAL PROVIDING CARE. BE INFORMED) THAT FULL NAMES AND QUALIFICATIONS OF THE SERVICE PROVIDERS MUST BE PROVIDED UPON REQUEST TO THE INDIVIDUAL OR THE INDIVIDUAL'S DESIGNATED REPRESENTATIVE;" i KNOW DORA requires this for licensed people, you have to give them your name, credentials, expectations, and how to complain	Thank you for your comment. In the event that DORA requires more than what is included here, and the provider is subject to DORA requirements, the provider shall comply with the DORA requirement.
3.4.4.A - Is a QM plan required of all SN providers? I don't see it anywhere.	Thank you for your comment. This part has been moved to a comprehensive provider requirement only.
3.4.4.B - are all SN providers expected to try to serve all priority pops of the BHA? For example, if rural and frontier people are a priority pop does a Denver based provider need to be competent in this area?	Thank you for your comment. The BHA has authority to determine priority populations on a state wide and/or regional basis to account for this.

3.4.4.D - ADD: "ACCESS AND OUTCOMES"	Thank you for your comment. We have made this change in the proposed rule.
3.4.4.D.1 - is this appropriate? These are very broad	Thank you for your comment. Options for monitoring outcomes include but are not limited to those listed here. A provider can determine other appropriate measures, and or add specificity to those listed to define an appropriate scope.
3.4.4.D.2 - "SYSTEM-REPORTED (ADD: ACCESS AND) OUTCOMES SUCH AS (ADD: ACCESS AND ENGAGEMENT IN CARE), PREVENTABLE HOSPITALIZATIONS AND/OR HOSPITAL READMISSION, RATE OF FOLLOW-UP WITH INDIVIDUALS AND FAMILIES, LEVEL OF INDIVIDUAL OR FAMILY ENGAGEMENT, NUMBER OF SUBSTANTIATED COMPLAINTS OR APPEALS, AND TIMELINESS OF TRANSITIONS TO APPROPRIATE LEVELS OF CARE;	Thank you for the comment. We have adjusted language in alignment with this.
3.4.4.D.3 - "UTILIZATION MEASURES SUCH AS NUMBER OF INDIVIDUALS OR FAMILIES SERVED, (ADD: CHARACTERISTICS OF INDIVIDUALS WHO FAIL TO ENGAGE IN SERVICES,) NUMBER OF SCREENINGS COMPLETED, OR NUMBER OF REFERRALS PROVIDED;	Thank you for your comment. We have made this addition.
3.4.5.A.7 - "AUXILIARY AIDS AND SERVICES ARE READILY AVAILABLE, AMERICANS WITH DISABILITIES ACT (ADA) COMPLIANT, AND RESPONSIVE TO THE NEEDS OF INDIVIDUALS WITH DISABILITIES (E.G., SIGN LANGUAGE INTERPRETERS, video phones, accessible forms and documents, etc. TELETYPEWRITER (TTY) LINES)."	Thank you, we have adjusted the TTY language to reflect videophones which are current practice. The requirement that forms be accessible exists within the individual rights.
3.4.5.A.9 - "AGENCIES ARE RESPONSIBLE TO TRAIN PERSONNEL ON INTERPRETATION AND TRANSLATION SERVICES AVAILABLE to facilitate treatment. TO INDIVIDUALS AND FAMILIES. THIS INCLUDES TRAINING PERSONNEL ON THE PROCEDURES TO ACCESS AND USE SUCH SERVICES." I changed this because interpretation is a two way street. They are interpreting for those of us who do use the dominant language as well as folks who do not.	We have adjusted this language.
3.5.1.A - Is this the correct reference?	Thank you for your comment. We have fixed this reference.
3.5.1.B.8 - 1326 adds (i) ADDITIONAL SERVICES THAT THE BEHAVIORAL HEALTH ADMINISTRATION DETERMINES ARE NECESSARY IN A REGION OR THROUGHOUT THE STATE -- Should this be	Thank you, we have added this back in to align with statute.

added here to give the BHA/BHASOs the ability to identify and recruit providers for additional services identified as needed?	
3.5.1.E - does not say extent --not sure if it should but this could be read to be every night and both weekend days or one weekend a month and one night a week	The expectation is the provider is providing services at times that are needed to make services available to the individuals they serve. As such this may vary by provider, area, etc.
3.5.2.D - Is there a requirement somewhere that all BH treatment providers must be able to respond to emergencies among their own clients? It seems like there should be a requirement -- sending enrolled clients with emergencies to CCS is not good safety net care.	Thank you, we removed the rule that suggested that providers should utilize Colorado Crisis Services if an individual is presenting with an emergent need on site or during service provision.
3.5.4.A - "ONLY PROVIDING RECOVERY SUPPORT SERVICES" This suggests that essential providers do not need to be treatment providers as indicated above. I wonder if this is left over from the old definitions.	Thank you for your comment. The BHA can identify other services as needed that can be provided by an essential provider. As such, we have maintained this language, which aligns with statutory requirements, to allow for necessary flexibility in the rule.
3.5.4.B.3 - Is "publicly funded" defined anywhere and does it include Medicaid? Also, not sure how this would work if the license doesn't entitle the provider to funding but they must enter into a funding agreement as a condition of licensing. Maybe it should say something about "willing to enter into a universal contract".	Thank you for your comment.
3.6.1 Requirements - BHE licensure?	Thank you for your comment. We have intentionally left this out to align with statute which allows behavioral health providers that are not required to be BHEs to be approved as comprehensive providers.
3.6.1.C.1.c - ADD: THE COMPREHENSIVE COMMUNITY BEHAVIORAL HEALTH PROVIDER SHALL HAVE A POLICY THAT INCLUDES HOW TELEHEALTH SERVICES ARE DEPLOYED, HOW INDIVIDUAL PREFERENCE FOR IN-PERSON SERVICES ARE ADDRESSED AND WHEN BASED ON DIAGNOSIS OR OTHER NEED TELEHEALTH SERVICES ARE NOT APPROPRIATE. THE COMPREHENSIVE BEHAVIORAL HEALTH PROVIDER SHALL HAVE POLICIES ADDRESSING THE SAFETY OF STAFF AND CLIENTS WHEN DELIVERING IN-HOME SERVICES.	Thank you. This has been added.
3.6.1.C.1.e - Does this exclude emergent needs? As mentioned above, it should include both emergent and urgent.	There are separate requirements here for responding to urgent versus emergency needs.
3.6.1.C.2.a - This "include" mean that all these services are required. I don't think that 24/7 services should be required for comprehensive providers. I strongly that these believe that the 24/7 services be removed. If a provider only offers	This has been adjusted. Providers are not required to provide all of these services but are required to have 24/7 services available.

mobile and in-home respite using community paramedics, would this exclude them? We need to separate requirements for 24/7 from comprehensive providers.	
3.6.2.B.3 - "CURRENT BEHAVIORAL HEALTH SYMPTOMS, AS APPLICABLE, INCLUDING SEVERITY, DURATION, MENTAL STATUS, WITHDRAWAL AND OVERDOSE POTENTIAL AND CHANGES OR IMPAIRMENTS IN FUNCTIONING DUE TO SYMPTOMS;"	Thank you. This language has been added.
3.6.2.B.5.c - "URGENT OR CRITICAL MEDICAL CONDITIONS, INCLUDING WITHDRAWAL AND OVERDOSE RISK; OR,"	Thank you. This language has been added.
3.6.2.G.3 - Are we going to decide/dictate what timeliness looks like so patients and families are not waiting 3-6 months for follow up care?	Because timeliness is highly dependent on individual need, clinical assessment, and also provider capacity, we have not spoken specifically to this in rule and instead providers must demonstrate their efforts to support individuals in accessing care within an appropriate timeframe for the individual's needs.
3.6.2.H.1 - there needs to be a process that the first agency provides whatever support they can until the person is accepted into services at the 2nd agency. Too often people are referred only to be rejected and without any support or services	Thank you, this is an existing requirement within the rule.
3.6.3.A.1 - except when they define them as outside of scope as allowed above?	Thank you for your comment. We have moved this criteria to apply only to essential providers.
3.6.4.A.3 - Is "PUBLICLY FUNDED" defined somewhere? Does it include Medicaid?	Publicly funded is not defined within the rules. The referenced rule requires the safety net provider to enter into a contract developed pursuant to the universal contracting requirements. Further a safety net provider cannot refuse to treat someone based on their insurer, so not specifically being referenced in this rule, safety net providers are required to serve individuals who are enrolled in Medicaid.
3.6.5.C - before accepting fees they should do a screen for medicaid eligibility and help them enroll if eligible or likely eligible	Thank you for your comment. Supporting someone in checking Medicaid eligibility would be part of the care coordination requirements.
3.7.2 - Maybe the requirement that then enter into a universal contract should be here rather than in governance.	Thank you for your comment. Supporting someone in checking Medicaid eligibility would be part of the care coordination requirements.
3.7.2.E.1.a - Wouldn't FQs have to demonstrate compliance with Chapter 3 to be approved?	Thank you for your comment. All behavioral health safety net providers must demonstrate compliance with Chapter 12 in order to be approved. This exists in Part 12.3.
3.7.2.E.4.c - Not sure that sole proprietorship is covered in governance so needs to be for essential providers	Thank you for your comment. The governance requirements for essential providers are statutory and have been written into rule accordingly.
3.5.2.E - The need to track information when referred to another provider seems like an extra administrative burden. The BHE should not be	Thank you for your comment. This is a statutory requirement for the approved behavioral health safety net provider.

held responsible for the outcome of the referral.	
3.6.1.E - Same day services would be incredibly difficult with current staffing shortages.	Thank you for your comment. This rule is written as "within one business day" which allows some flexibility beyond "same day".
It is unclear how the type of safety net provider is elected.	Thank you for your comment. When a provider applies for approval, they will indicate the type of approval they are seeking based on the services they will be providing.
3.6.2.D - Obtaining approval prior to referring a priority population to alternative services would be time consuming and delay getting the individual to the appropriate services.	Thank you for your comment. This is a statutory requirement for comprehensive providers that cannot be altered in rule. An explicit exemption of approval is present for emergencies when an individual requires crisis services that cannot be delivered immediately by the comprehensive provider.
3.6.1.C.1.b. INCLUDING NIGHT AND WEEKEND HOURS. We understand and agree with the intent of this language. Yet the ongoing workforce shortage makes this problematic. In addition, some of our members report having established such extended hours without seeing utilization by community members. We respectfully suggest adding or changing language in this section, e.g. "...provider shall STRIVE TO provide..." or "night and weekend hours WHEN FEASIBLE."	Thank you for your comment. We have adjusted this language to allow for some additional flexibility in acknowledgement of the feedback received and the current workforce challenges.
3.6.1.C.1.c. We agree that providers should have and use technology to meet client needs. At the same time, we cannot guarantee that clients will have or use the technology on offer. While we believe the first words of this section ("As necessary and appropriate") are designed to offer flexibility, we suggest also rephrasing this to "shall offer clinically appropriate..."	This requirement does not require a provider to use technology with every patient. Instead, a provider should have the ability to utilize different methods such as telehealth, in-home, in-community service delivery, to meet the diverse needs of individuals they serve.
3.6.1.C.1.d suggest changing immediately to promptly	Thank you for your comment, we have adjusted this requirement to read IF AN ESTABLISHED INDIVIDUAL PRESENTS WITH AN EMERGENCY OR CRISIS NEED, APPROPRIATE ACTION IS TAKEN IMMEDIATELY AND SUBSEQUENT OUTPATIENT FOLLOW-UP IS PROMPTLY COORDINATED AND DELIVERED for clarity.
3.6.1.C.1.e. suggest changing within one business day to promptly	Thank you for your comment. The BHA is keeping the requirement as within one business day.
3.6.2.E. What happens if the referral is not approved? If the provider believes they are not equipped to serve the individual, must they still provide services?	Thank you for your question. Regulation would require that this provider serve the individual. That said, the role of BHASOs and BHA, as well as the support that the BHA will provide directly related to care coordination for certain individuals and populations are still being developed and we have these types of scenarios in mind as we develop the processes and supports for providers and individuals.
3.6.2 F Individual demographics - please list.	Thank you for your comment. We have not specified this

	and will defer to providers to align with payer and data requirements on this matter.
4. ANY OTHER INFORMATION REQUIRED BY THE BHA. We recognize that this language comes from the statute. However, it would be helpful to have some parameters around it.	Thank you for your comment. We have removed this from the proposed rule.
3.3 Require BHA or CDPHE license for all Comprehensive providers (or FQHC federal designation) and approval plus DORA or other license for Essential providers	Thank you for your comment. Statute was explicitly changed to allow for additional flexibility here for behavioral health providers that may not be obligated to hold a license from BHA or CDPHE. Alos, though individual practitioners may require DORA licenses, and a safety net provider must ensure that personnel are operating within their scope of practice, because the agency and not the personnel is approved as the safety net provider, the approval process does not necessarily require evidence of a license from DORA in those cases.
Add compliance with chapter 2.16.Critical Incident Reporting if not facility licensed	Thank you for your comment. This has been added.
Add compliance with chapter 2.6.1 clinical supervision if not facility licensed	Thank you for your comment. This has been added.
Add compliance with chapter 2.6.D Background checks if not facility licensed	Thank you for your comment. This has been added.
Have completed threat assessments, set limits and policies/procedures. Concern about client rights vs. client responsibilities regarding aggressive behavior. Setting of limits and modeling of behavior. Want to make sure that there is flexibility to respond to individuals appropriately (ex: may need to contact police in certain situations)	The rules are not meant to prevent flexible and varied responses to individuals. As a safety net provider, agencies must have policies and procedures in place that promote the use of appropriate de-escalation techniques and respond safely to emergencies and situations where individuals may display aggression as a result of their behavioral health diagnoses.
3.6.4 Modify 3.6.4 to 50% of voting members are people with lived experience (consistent with CCBHC)	Thank you for your comment. We have attempted to strike a balance between the conflicting feedback we have received on this issue. To do so we have clarified the language to require that the individuals and or parents of individuals with lived experience have meaningful experience accessing services for behavioral health conditions. We have also received feedback that it can be challenging to recruit board members that also have the expertise needed to accomplish some of the other key roles of a board. As such, we believe at this time 50% would be an unattainable threshold for providers and would limit participation in the safety net. We have written that at least 2 board members must have this experience and the board must show how they are incorporating this and other lived experience feedback into decisions. This is something we will continue to revisit in future rule revisions also, as the industry adjusts to some of these new requirements and builds capacity to reach a higher threshold of lived experience membership on governance boards.

Require licensure as BHE or FQHC if this is not incorporated as base requirement	Thank you for your comment. Statute was explicitly changed to allow for additional flexibility here for behavioral health providers that may not be obligated to hold a license from BHA or CDPHE. Alos, though individual practitioners may require DORA licenses, and a safety net provider must ensure that personnel are operating within their scope of practice, because the agency and not the personnel is approved as the safety net provider, the approval process does not necessarily require evidence of a license from DORA in those cases.
If chapter 4 is retained rather than rolled into SN requirements, need to make reference to the requirement for comprehensive providers to be endorsed	Care management requirements are now located within Chapter 12 under the requirements for comprehensive providers.
Colorado Access is in support of the following comment from Mental Health Colorado: Since safety net providers serve our most vulnerable citizens, we believe that these providers have an additional obligation, regardless of license, to meet basic requirements related to critical incident reporting, clinical supervision, individual rights protections and provider background checks. As outlined in the proposed rule, safety net approval would afford these providers the opportunity for enhanced rates along with additional basic responsibilities. For this reason, we suggest the following additions to the chapter 3, section 4 requirements for all safety net providers, regardless of license. BEHAVIORAL HEALTH SAFETY NET PROVIDERS SHALL COMPLY WITH THE REQUIREMENTS OUTLINED IN CHAPTER 2.16 OF THE BHE RULES RELATED TO CRITICAL INCIDENT REPORTING. BEHAVIORAL HEALTH SAFETY NET PROVIDERS SHALL COMPLY WITH THE REQUIREMENTS OUTLINED IN CHAPTER 2.6.1 OF THE BHE RULES RELATED TO CLINICAL SUPERVISION. BEHAVIORAL HEALTH SAFETY NET PROVIDERS SHALL COMPLY WITH THE REQUIREMENTS OUTLINED IN CHAPTER 2.9 OF THE BHE RULES RELATED TO INDIVIDUAL RIGHTS. BEHAVIORAL HEALTH SAFETY NET PROVIDERS SHALL COMPLY WITH THE REQUIREMENTS OUTLINED IN CHAPTER 2.6 D OF THE BHE RULES RELATED TO BACKGROUND CHECKS.	Thank you for your comment. We have added these requirements to the rule.
Telehealth becomes enabling approach to inadequate staffing	Thank you for your comment. We have clarified that behavioral health safety net providers cannot provide

Some legit - some services not offered in rural community But concern that this results in substandard services when a service really should be provided in person Is there a way to build in responsibility for all safety net providers to provide services in person?	services exclusively via telehealth.
3.4.1 G Statute says "trauma informed care practices"-- replacing "considerations" with care moves from a best practice to looser requirement and limiting to promoting safe environment limits the scope of how trauma informed care is implemented TRAUMA-INFORMED CARE CONSIDERATIONS FOR CREATING A SAFE ENVIRONMENT	This requirement was removed as it was duplicative of the previous trauma informed care practices requirement.
3.4.2 D 1a Add income supports and health care and health insurance SERVICE PLANS MUST ADDRESS ACCESS TO HIGH-QUALITY ACUTE AND CHRONIC PHYSICAL AND BEHAVIORAL HEALTH CARE, PEER SUPPORT NETWORKS, SOCIAL SERVICES, INCOME SUPPORTS AND OTHER BENEFITS; HOUSING, EDUCATIONAL SYSTEMS, HEALTH INSURANCE AND EMPLOYMENT OPPORTUNITIES AS NECESSARY TO FACILITATE WELLNESS AND RECOVERY OF THE WHOLE PERSON.	Thank you, we have added additional clarification to this part.
3.4.3 B1a5 Additional disclosures about who is providing the care, their qualifications and the supervisor of the care. BE INFORMED OF, AT A MINIMUM, THE FULL FIRST NAMES AND CREDENTIALS OF THE PERSONNEL THAT ARE PROVIDING SERVICES TO THE INDIVIDUAL INCLUDING THE NAME OF THE INDIVIDUAL SUPERVISING THE PRACTICE OF THE INDIVIDUAL PROVIDING CARE. BE INFORMED THAT FULL NAMES AND QUALIFICATIONS OF THE SERVICE PROVIDERS MUST BE PROVIDED UPON REQUEST TO THE INDIVIDUAL OR THE INDIVIDUAL'S DESIGNATED REPRESENTATIVE;	Thank you for your comment, we have adjusted this to (5) BE INFORMED OF, AT A MINIMUM, THE FIRST NAMES AND CREDENTIALS OF THE PERSONNEL THAT ARE PROVIDING SERVICES TO THE INDIVIDUAL. FULL NAMES AND QUALIFICATIONS OF THE SERVICE PROVIDERS MUST BE PROVIDED UPON REQUEST TO THE INDIVIDUAL OR THE INDIVIDUAL'S DESIGNATED REPRESENTATIVE OR WHEN REQUIRED BY DORA;
3.4.5 A 1-2 1. DEVELOP AND MAINTAIN GENERAL KNOWLEDGE ABOUT THE RACIAL, ETHNIC, AND CULTURAL GROUPS IN THE SERVICE AREA, INCLUDING EACH KNOWN GROUP'S DIVERSE CULTURAL HEALTH BELIEFS AND PRACTICES, PREFERRED LANGUAGES, HEALTH AWARENESS, ACCESS TO ACCESSIBLE HEALTH INFORMATION, LITERACY, AND OTHER NEEDS IN ORDER TO INFORM THE PROVISION OF CULTURALLY AND LINGUISTICALLY RESPONSIVE SERVICES AND IMPROVE ACCESS AND	Thank you for the suggested language. We have made some changes to align with this feedback.

QUALITY OF SERVICES FOR THESE GROUPS 2.COLLECT AND MAINTAIN UPDATED INFORMATION TO HELP UNDERSTAND THE COMPOSITION OF THE COMMUNITIES IN THE SERVICE AREA, INCLUDING THE PRIMARY SPOKEN LANGUAGES IN ORDER TO INFORM THE PROVISION OF CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES AND IMPROVE ACCESS FOR THESE COMMUNITIES	
Modify to reflect that interpretation is two-way street-- used to ensure communication across those using dominant language and those not using dominant language. 7. AUXILIARY AIDS AND SERVICES ARE READILY AVAILABLE, AMERICANS WITH DISABILITIES ACT (ADA) COMPLIANT, AND RESPONSIVE TO THE NEEDS OF INDIVIDUALS WITH DISABILITIES (E.G., SIGN LANGUAGE INTERPRETERS, VIDEO, PHONES, ACCESSIBLE FORMS AND DOCUMENTS ETC. TELETYPEWRITER (TTY) LINES). 8. IMPLEMENT STRATEGIES TO RECRUIT SUPPORT AND PROMOTE PERSONNEL THAT IS REPRESENTATIVE OF THE DEMOGRAPHIC CHARACTERISTICS, INCLUDING PRIMARY SPOKEN LANGUAGES, OF THE COMMUNITIES IN THE AGENCY'S SERVICE AREA. 9. AGENCIES ARE RESPONSIBLE TO TRAIN PERSONNEL ON INTERPRETATION AND TRANSLATION SERVICES AVAILABLE TO FACILITATE TREATMENT. TO INDIVIDUALS AND FAMILIES. THIS INCLUDES TRAINING PERSONNEL ON THE PROCEDURES TO ACCESS AND USE SUCH SERVICES.	Thank you for your comment. We have made this change.
add requirement to screen for level of care needs 7. INFORMATION REQUIRED TO COMPLETE INITIAL SCREENING OF LEVEL OF CARE NEEDS	Thank you for your comment. Screening for level of care needed is present in the screening requirements.
3.5.4 A Need clarification This implies that a recovery support provider could be an essential provider without either a BHE license or an RSS license. It seems that this needs to be clarified. A RSS provider that provides no treatment services wouldn't be eligible to be licensed as a BHE and wouldn't be a DORA provider. How does all this interact?	Thank you for your comment. Though current state recovery supports are not one of the services that can be provided by an essential provider per statute, this is the statutory governance language that has been carried over.
Need to be explicit that comprehensive providers must meet "basic" safety net requirements in 3. 5	Thank you for your comment. The requirements of the essential providers are separate from those for the comprehensive providers. Where requirements apply to both provider types, the requirements have been built

	into Part 12.4.
3.6.2 A 3 Add screening for withdrawal potential CURRENT BEHAVIORAL HEALTH SYMPTOMS, AS APPLICABLE, INCLUDING SEVERITY, DURATION, MENTAL STATUS, WITHDRAWAL AND OVERDOSE POTENTIAL AND CHANGES OR IMPAIRMENTS IN FUNCTIONING DUE TO SYMPTOMS;	Thank you for your comment. We have added the suggested language related to withdrawal and overdose.
3.6.2G 3 Somewhere in rule or contract there need to be timeliness standards	Thank you for your comment.
3.6.2H Add requirement to continue to provide support until the second agency is able to serve the individual. H. THESE PROCESSES MUST APPLY AT THE TIME OF INITIAL SCREENING, AND ANY TIME REASSESSMENT INDICATES THE INDIVIDUAL'S NEEDS HAVE CHANGED AND FALL OUTSIDE OF THE SCOPE OF THE AGENCY.	Thank you for your comment. This requirement is included within this section already.
1. WHEN AN AGENCY INITIATES A TRANSITION IN CARE FOR AN INDIVIDUAL OR FAMILY UNDER THE CARE OF THE AGENCY, WHETHER THE TRANSITION IS TO AN ALTERNATE AGENCY OR AN ALTERNATE LEVEL OF CARE WITHIN THE AGENCY, (a) THE AGENCY MUST NOTIFY THE INDIVIDUAL OR FAMILY VIA A LIVE CONVERSATION; AND (b) THEN ENSURE THAT APPROPRIATE STEPS ARE TAKEN TO TRANSITION THE INDIVIDUAL OR FAMILY; AND (c) CONTINUE TO PROVIDE SUPPORT TO THE INDIVIDUAL OR FAMILY UNTIL THE ALTERNATE AGENCY HAS INITIATED CARE.	Thank you for your comment. This requirement is included within this section already.
E. THE APPLICANT SHALL PROVIDE THE FOLLOWING INFORMATION: (X) POLICIES, PROCEDURES, PERSONNEL RECORDS AND INDIVIDUAL RECORDS DEMONSTRATING COMPLIANCE WITH CHAPTER 3 RULES (X) ENDORSEMENTS FOR SPECIFIC SERVICES PROVIDEDAdd the requirement that all provider demonstrate compliance with chapter 3 rules?	These requirements are already built into other parts of the chapter.
Add language about unresolved quality concerns. 3.7.3 DENIAL OF APPROVAL A. THE BHA MAY DENY AN AGENCY'S APPROVAL AS A BEHAVIORAL HEALTH SAFETY NET PROVIDER AND ANY ACCOMPANYING ENDORSEMENTS FOR REASONS INCLUDING BUT NOT LIMITED TO, THE FOLLOWING:	Thank you for your comment. Enforcement history, which is already included in these criteria, include findings of complaints, and provider's fulfillment of plans of correction related to complaints and deficiencies.

9. THERE ARE MULTIPLE UNRESOLVED CLIENT COMPLAINTS OR PLANS OF CORRECTION ABOUT THE QUALITY OF SERVICES	
3.4.2(A) o Clarification on what kind of applications are expected to be filled out with assistance	Thank you for your comment. These applications may include applications for medicaid, or other benefits that the individual may be eligible for and may require in order to address health needs and or health related social needs.
3.4.3 (1)(a)(5) o Does this include informing individuals of the credentials of medical providers, care coordinators, etc...? Does this include everyone who could potentially have contact with this client? Ex. A provider is out of the office and another provider sees the individual one time only. o This will require new forms	This speaks to a client's right to request and be informed of this information. We are not requiring specific forms for this purpose, however clinicians must also follow all DORA requirements for mandatory disclosure, when applicable to their scope of practice.
• 3.4.5(A)(2) o Please verify that this can be a part of the needs assessment and should include the CLAS or is it something different? o Please verify that this will be every three (3) years	The outreach, education and engagement service requirements and CLAS requirements are distinct, however if a provider completes or obtains an assessment that addresses the requirements of both, that is permissible. CLAS requirements are not associated with a specific timeline.
3.5.3 (B) Does the training mean they have the expertise? o Define Expertise or remove ▪ Replace expertise with scope	Thank you for your comment. We have removed this language.
• 3.5.3 (C) o Define Appropriate Expertise	Thank you for your comment. We have removed this language.
• 3.6.2 o Combine with 3.5.2 or name this section something different (Largely repetitive) o No definition for Expert or Expertise	Thank you for your comment. The reason for this is that these sections apply to essential and comprehensive providers respectively. To ensure clarity for the requirements of each distinct provider type some of this information has been repeated.
• 3.6.3 o Combine with 3.5.3 or name this section something different (Largey repetitive)	Thank you for your comment. The reason for this is that these sections apply to essential and comprehensive providers respectively. To ensure clarity for the requirements of each distinct provider type some of this information has been repeated.
3.6.4 o This is repeated informaiton (with the exception of bullet C) o Combine with 3.5.4 or name this section something different (Largey repetitive)	Thank you for your comment. The reason for this is that these sections apply to essential and comprehensive providers respectively. To ensure clarity for the requirements of each distinct provider type some of this information has been repeated.
3.7.1 o Transferring BHE from CDPHE to BHA what does the letter of intent proces look like? Is there a specific form?	This section applies to providers seeking safety net approval, which is separate from BHE licensure.
The issue of interpreters, addressed in	Thank you for your comment. We have reviewed federal

3.4.5.A.5.a, is also addressed in federal law—section 1557 of the Affordable Care Act and its implementing regulations (specifically, 42 CFR Part 92, Subpart B, Section 92.101). I ask that these two be compared, and the rule be modified, if necessary, to ensure that complying with the rule would not cause a BHE to violate federal law. 3.4.5.A.5.a says: AN INDIVIDUAL MAY CHOOSE TO USE A FAMILY MEMBER OR FRIEND AS AN INTERPRETER ONLY AFTER BEING INFORMED OF THE AVAILABILITY OF FREE INTERPRETER SERVICES, UNLESS THE EFFECTIVENESS OF SERVICES IS COMPROMISED OR THE INDIVIDUAL'S CONFIDENTIALITY IS VIOLATED. The language in the federal law is that an entity “shall not . . . Rely on an adult accompanying an individual with limited English proficiency to interpret or facilitate communication, except . . . (A) In an emergency involving an imminent threat to the safety or welfare of an individual or the public, where there is no qualified interpreter for the individual with limited English proficiency immediately available; or (B) Where the individual with limited English proficiency specifically requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide such assistance, and reliance on that adult for such assistance is appropriate under the circumstances.”	requirements and aligned this language accordingly.
3.7, which sets forth the Procedures for Approval (as a Behavioral Health Safety Net Provider) and BHA Oversight creates an administrative burden for entities that have already been licensed by the BHA as a BHE. 3.7.1.B requires an entity to notify the BHA of their intent to seek approval by submitting a letter of intent. That seems reasonable. However, 3.7.1.E requires the entity to submit much of the same information (e.g., list of governing body and officers) and many of the same documents (e.g., insurance certificates and articles of incorporation) that were submitted for the BHE license. WellPower asks that the BHA review this section and make modifications that would eliminate the need for this redundancy.	Thank you for your comment. We are working within our licensing system to determine how providers who are already licensed will be able to avoid duplicate submission of this information.
3.4.1 General Requirements F., 4. F. ...BASED ON THE INDIVIDUAL'S: 4. INVOLVEMENT IN THE CRIMINAL OR	Thank you for your comment.

JUVENILE JUSTICE SYSTEM Proposed Edit – Add language: 4. INVOLVEMENT IN THE CRIMINAL OR JUVENILE JUSTICE SYSTEM (UNLESS INTERSTATE COMPACT RULES PREVENT TREATMENT)	
CHA would recommend removing the language when a comprehensive provider is not able to provide services to an individual because we see this as the goal of the safety net.	Thank you for your comment. Because behavioral health safety net providers will not provide all services, such as in-patient or residential levels of care, there are instances when a comprehensive provider will not be the right provider to serve an individual at that time.
The chapter states that you must obtain approval from the BHA before referring to a priority population individual. Why is this not the case for all individuals trying to seek safety net services?	This is a statutory requirement for comprehensive community behavioral health providers that is distinct from the essential behavioral health safety net providers.
What are the mechanisms and programs that the BHA will use to regulate the approval of a safety net provider? How does this process work?	Processes for approval, enforcement, and adverse action are outlined in Chapter 12.
How will you audit for Safety Net Approval? How quickly will you begin auditing?	Providers will need to demonstrate compliance with the safety net requirements in order to be approved as a behavioral health safety net provider. This will include policies and procedures, personnel training requirements, meeting governance requirements, etc.
Thinking about the priority population definition, how does this work when private insurance doesn't cover most of this?	The priority populations definition is specific to individuals who are uninsured, underinsured, publicly insured, or whose income is below a set standard. A privately insured individual may be considered underinsured due to a lack of coverage for behavioral health services.
Chapter 3: Is there a fee for Safety Net Approval? Will organizations that have existing Safety Net contracts be grandfathered in for approval?	The BHA does not intend at this time to charge a fee for approval as a behavioral health safety net provider. Providers will not be grandfathered into approval, but we have streamlined the approval process given that it can be predicated upon existing licenses or certifications.
Chapter 3: How will providers be notified of safety net providers in the community?	OwnPath will allow providers and the public to search for Behavioral Health Safety Net Providers in the community based on a number of criteria including the services provided and populations served.
Chapter 3: Can you clarify that the chapter 3 Safety Net Provider rules will apply to all providers seeking reimbursement from Medicaid and/or other public sources of funding? Specifically would they apply to HCPF provider types: Independent providers billing under their individual license (e.g Licensed Behavioral Health Clinician (38) Licensed Psychologist (37), Nurse Practitioner (41), Physician (05), Physician Assistant (39)); Behavioral Health Crisis Line (Type 88); Community Clinic (Type 86); Community Mental Health Center (Type 35); Group practices (Type 25); Behavioral Health	Behavioral health safety net approval is optional. A provider may seek approval if they wish to be considered for enhanced rates for serving priority populations and meeting the safety net requirements. Any BHE or behavioral health provider, as defined in 27-60-101 can be approved.

Crisis line (Type 88); Federally Qualified Health Center (Type 32); Hospital – Mental (Type 02); Indian Health Services- Federally Qualified Health Center (FQHC) (Type 61); Non-Physician Practitioner -Individual (Type 24); Non-Physician Practitioner – Group (Type 25); Psychiatric Residential Treatment Facilities (PRTF) (Type 30); Qualified Residential Treatment Programs (QRTF) (Type 68); Recovery Support Services Organization (Type 89); Rural Health Clinic (Type 45); School Health Services (Type 51); Substance Use Disorder Clinics (Type 64)	
Chapter 3: Curious if this new rule prohibits provider agency for discharging clients from services based on lack of client engagement? Medical Necessity rules require that clients be engaged in/benefitting from treatment. Obviously, an agency would make all reasonable efforts to remove barriers and address issues which may be preventing clients from benefiting from services.	The rules do not state that an individual cannot be discharged if there is no longer medical necessity for treatment. Individuals at risk for discharge due to disengagement should be identified and offered additional support such as care management services to promote engagement.
Chapter 3: 3.2.1 – Federally Qualified Health Centers (FQHCs) are exempt from licensure by state agencies per 6 CCR 1011-1 Chapter 9, Section 2.3.B.1. This language is confusing for FQHCs so we would recommend changing to something like: “All BH Safety Net Providers....., Federally Qualified Health Centers, as defined in the Federal Social Security Act, 42 U.S.C. sec. 1395x (aa)(4) are exempt from state facility licensure and may seek approval to become BH Safety Net Providers” – or something like that. Just making it clear that FQHCs can be approved as Behavioral Health (BH) safety providers without licensure from a state department. (this is the intent of the law – see section pages 52, 97, 210, and 213 of HB22-1278, which separates out FQHCs from other licensed facilities.) 3.3.8 (F) (1)– Similar recommendation, FQHCs are not licensed so this is confusing. There needs to be another way - perhaps a Medicaid ID number for the entity, Notice of Award from Health Resources and Services Administration (HRSA) or something similar.	Thank you for your comment. We have added clarification into 3.2.1 and 3.3.8 to address your concern. However, FQHCs providing Substance Use Treatment, and subsequently are required by HB22-1278 to obtain a BHE license, are not exempt from licensure.
Chapter 3: In regards to the priority populations outlined in Chapter 3, do these replace the current list of state defined priority populations (i.e., women who are pregnant and using drugs by injection; Women who are pregnant; Persons who use drugs by injection; Women with dependent children; Persons who are involuntarily committed to treatment)?	Priority populations are defined in HB 22-1278 as people who are (A) UNINSURED, UNDERINSURED, MEDICAID-ELIGIBLE, PUBLICLY INSURED, OR WHOSE INCOME IS BELOW THRESHOLDS ESTABLISHED BY THE BHA; AND (B) PRESENTING WITH ACUTE OR CHRONIC BEHAVIORAL HEALTH NEEDS, INCLUDING BUT NOT LIMITED TO INDIVIDUALS WHO HAVE BEEN

	DETERMINED INCOMPETENT TO STAND TRIAL, ADULTS WITH SERIOUS MENTAL ILLNESS, AND CHILDREN AND YOUTH WITH SERIOUS EMOTIONAL DISTURBANCE. HB22-1278 also allows the BHA to identify other priority populations who meet the above criteria and may require prioritization on a regional or statewide basis. This would include the populations mentioned like people who are pregnant who also meet the above criteria. These BHA priority populations are distinct from Block grant priority populations and HCPF priority populations, and where referenced within the rule, the term has the meaning noted within Chapter 1.
Chapter 3: Actual priority populations are not listed in the Rule. Other sections where priority populations are mentioned have different definitions from the Substance Abuse Mental Health Services Administration (SAMHSA) Block Grant definitions. This is confusing and should be corrected.	Thank you for your comment. The definition of priority populations is in alignment with HB22-1278. This is the definition of priority populations throughout all chapters.
Chapter 3: Can you please also outline how "provider provides services at locations that meet the needs of the populations served?" How will the BHA enforce this?	Thank you for your comment. This requirement was removed from this revision and may be revisited in the future.
Chapter 3: Is there a definition of "timely manner?"	Thank you for your comment. This term has been removed to remove ambiguity.
Chapter 3: The reference to "some nights and weekend hours" is inadequate. There needs to be minimum access standards outlined.	3.4.1(C)(1a) states that Community Behavioral Health Providers shall "provide outpatient clinical services during times that ensure accessibility and meet the needs of the individual population to be served, including some nights and weekend hours." At this time, we do not intend to specify required hours. Comprehensive providers are required to have 24 hour crisis services in addition to what is required here for outpatient services. The requirement for evening and weekend hours is specific to outpatient services, with the intention of providing for additional availability for individuals receiving routine outpatient services. The word "some" was also removed to make this statement more specific.
Chapter 3: We greatly appreciate the safety net provider standards – how will they be enforced to ensure patients are able to receive placements in the appropriate level of care?	Thank you for your comment. Part of this oversight will come from BHASOs, which the BHA is currently co-creating with the people of Colorado and our partner state agencies. Chapter 12 also includes the methods that the BHA will utilize these standards for approved providers, including enforcement and adverse actions. These processes will parallel existing enforcement processes for licensed entities. The BHA's goal is always to support agencies in returning to compliance when issues arise.

Chapter 3: How will the standard criteria address discharges from general and psychiatric hospitals?	If the hospital is approved as a safety net provider, then the hospital would follow the standard criteria in alignment with the regulations.
Chapter 3: We request minimum access standards for outpatient services beyond some nights and weekend hours. Crises often happen outside of those hours	Thank you for your feedback. Comprehensive providers are required to have 24 hour crisis services in addition to these requirements for outpatient services.
Chapter 3: I am curious about how a BH Safety Net Provider would actively obtain work/referrals for a specified service. Would they subcontract with a Behavioral Health Administrative Service Organizations (BHASO) or Comprehensive BHE?	The rules do not require or prohibit that a safety net provider contract with a comprehensive community behavioral health provider/BHE, though a comprehensive provider may choose to enter into such partnership as a means of providing the required services. Administrative rules, separate from these provider rules, will address BHASO processes.
Chapter 3: I am wondering how confidentiality and 42 Code of Federal Regulations (CFR) part 2 works with this? Do you imagine calling this care-coordination? Calling it care coordination might be true for medical referrals, not sure it can be called care coordination with social/community/natural resources.	All services shall be carried out in compliance with 42 CFR Part 2. The care coordination requirements go beyond medical referrals and include assisting an individual to access the resources they need to achieve whole person health, including social and community resources.
Chapter 3: Wondering how individuals' wishes for the follow up and tracking fit into this? We have fair to poor rates of receiving calls back from individuals.	An individual maintains their right to choose or refuse to engage in treatment. Care coordination requirements do not limit this.
Chapter 3: When all goes well, this feels workable. When someone is angry/frustrated, it seems less trackable and less likely to wait for BHASO approval. Does the BHASO really want to know that we are referring the individual to Meals on Wheels before we do it?	The BHA or its designee does not need to approve all referrals, but does need to approve in the event that an individual is being denied behavioral healthcare by the Comprehensive Community Behavioral Health Provider, in accordance with the requirements and standard criteria in this section. This is a statutory requirement.
Chapter 3: Is this tracking expected for services in conjunction with the comprehensive provider? instead of the comprehensive provider?	The tracking requirements are for safety net providers that are referring individuals to other providers, pursuant to the applicable rules in Chapter 12.
Chapter 3: How will the approval be requested? Do you mean applicable to the endorsements as part of the BHE license? Safety Net is not described as a license, but an approval.	Chapter 12 outlines the process for initial approval.
Chapter 3: How will we be paid for services for commercially insured consumers if we are unable to match with a licensed provider and therefore unable to bill?	Part 3.2.11 addresses the process for agencies to provide care coordination and facilitate a transition to alternate care in the event that the agency does not have the treatment capacity or clinical expertise to provide services to the individual. If an individual cannot be matched to an appropriate clinician, the agency would follow this process.
Chapter 3 (3.2.11): This screening requirement in 3.2.11 is significant and likely to result in the need to employ more staff to facilitate these screening conversations. Two things need to be considered here: the workforce shortage and the additional	Thank you for your comment. The screening requirements align with the requirements for all BHEs, with the addition of screening for factors related to key social determinants of health. This is incorporated to address the statutory requirement that the safety net

funding needed to hire, pay and retain available workforce members.	system TRIAGE INDIVIDUALS WHO NEED SERVICES OUTSIDE THE SCOPE OF THE BEHAVIORAL HEALTH SAFETY NET SYSTEM. (27-50-301, C.R.S.)
Chapter 3: (3.2.9 (G-H)): How can we assess if the aggressive behavior is a symptom of a mental health disorder, particularly if behavior is presented at initial assessment, and we can not consider behavioral presentation in any previous interaction with providers. We already have a provider shortage. I imagine it will increase if we ask staff to continue to see consumers who have acted aggressively.	Parts 3.2.11, 3.3.2, and 3.4.2 outline the processes that safety net providers must follow when a priority population individual presents for services. Subject to the requirements of these parts, an agency may facilitate a transition to an alternate provider or level of care in the instances like you note, however the provider does have the responsibility to provide care coordination and ensure the individual is not turned away without the assistance needed to access care.
Chapter 3: Is this screening outlined in Chapter 3 in addition to what is outlined in Chapter 2?	This section has been clarified and no longer references chapter 2, though screening requirements for safety net providers do match and build upon the ch 2 requirements. Safety net providers do have an additional requirement to assess for RISK FACTORS AND KEY HEALTH INDICATORS RELATED TO SOCIAL DETERMINANTS OF HEALTH, which are outlined in 3.2.11. This is incorporated to address the statutory requirement that the safety net system TRIAGE INDIVIDUALS WHO NEED SERVICES OUTSIDE THE SCOPE OF THE BEHAVIORAL HEALTH SAFETY NET SYSTEM. (27-50-301, C.R.S.)
Chapter 3: Are there requirements that apply to Safety Net Providers but not all BHEs?	Thank you for your question. Equity plans are a requirement of Comprehensive Community Behavioral Health Providers only.
Chapter 3 (3.3.4): The Cultural/Linguistic Services required by 3.3.4 are more challenging in a large metropolitan/diverse area. This too may result in needing to have additional staff to meet the requirements.	Thank you for your comment. We received a number of stakeholder comments in support of this section. These requirements apply with federal CLAS guidelines, Colorado Medicaid requirements, and are important for ensuring equitable access for individuals across Colorado. We have made changes to ensure these align with HCPF requirements and federal law to prevent any conflicts.
Chapter 3: It is our understanding that Independent Provider Network (IPNs) can be approved as Essential Providers if they are providing one of the services (e.g., outpatient) but they do not have to be licensed as a BHE. The reasoning behind that is still not clear.	If an agency meets the definition of a BHE, they must be licensed as a BHE and may be approved as Essential Behavioral Health Safety Net Provider. If a provider is not required to be licensed as a BHE, they are still, per HB 22-1278, able to seek approval as a Essential Behavioral Health Safety Net provider.
Chapter 3: The distinction between “approval” “designation” and “licensure” for different types of providers is unclear.	Thank you for your comment. We have added a section for authority and applicability to the start of applicable chapters to clarify this.
Chapter 3: Does a Comprehensive Provider have to provide all 4 crisis services (walk in, Crisis Stabilization Unit (CSU), mobile and Respite)?	Thank you for your comment. Comprehensive providers must provide 24/7 crisis services, but this does not mean they are required to operate each of the crisis service types you have noted.
Chapter 3: 2B seems to indicate that a comprehensive provider must offer all 4 crisis	Thank you for your comment. Comprehensive providers must provide 24/7 crisis services, but this does not

service components. If this is intended, it will likely significantly limit the number of current providers who are interested in this designation.	mean they are required to operate each of the crisis service types you have noted.
Chapter 3: Members note they have not received clear guidance on how to apply to be a safety net provider, though the term is defined in Chapter One. It is not listed as an endorsement under the BHE, so it is unclear if this will be a separate process and if that process will be specified in rule or elsewhere.	Thank you for your comment. This process is outlined in Chapter 12.
Chapter 3: Can providers build partnerships to offer required respite care?	Comprehensive providers can provide partnerships with other service providers in order to provide services including respite services. Respite services are not required of comprehensive community behavioral health providers based on changes made based on stakeholder feedback.
Chapter 3: Are there standards or procedures for how the BHASOs will coordinate with the Regional Accountable Entities (RAEs)?	BHA administrative rules will be co-created with the people of Colorado in the coming year, and will address standards for BHASOs.
Chapter 3: How will oversight be structured for the BH Safety Net Providers if they are not licensed by/through the BHA?	Safety Net Providers will be approved by the BHA, and the BHA has been given statutory authority to enforce the safety net standards as part of the approval, per HB 22-1278. These processes for enforcement and adverse action are found in Chapter 12.
Chapter 3: (3.2.9) lists circumstances under which a Behavioral Health Safety Net Provider shall not refuse to treat an individual. This is stated as an absolute and there is cause for concern. In some circumstances the Safety Net Provider needs to have some leeway or be able to exercise some discretion. Here are three examples: (F) With regard to activities of daily living – depending on what is going on, an individual may not meet the regulatory requirements to be able to stay in an Assisted Living Residence overseen by the Comprehensive Provider. (G) Aggressive behavior due to mental illness/substance use may cause an individual to be “out of control” or refuse to participate in outpatient treatment. In such cases it is unclear how effective treatment will be. Also, if an individual threatens or previously threatened a staff member that is still working for the organization, the organization must be able to support and protect staff. (I) Place of residence – It may be unreasonable to treat someone whose physical address is geographically too far from where we provide services to safely or efficiently meet the needs of	Thank you for your feedback. These requirements are a statutory requirement to ensure that the Behavioral Health Safety Net is functioning in a manner that ensures that no individual is turned away without appropriate care or coordination. Providers are able to exercise discretion by triaging the individual and facilitating a transition to the appropriate level of care or a provider with the appropriate training or expertise, in compliance with the processes for triage, screening, and care coordination outlined in Parts 3.2.11, 3.3.2, and 3.4.2, as applicable to the provider. These portions of Chapter 3 have now been moved to Chapter 12.

the person/family.	
Chapter 3: 3.4.5(C): As a matter of common practice, CMHCs currently include consumers and/or family members on their boards. We agree with BHA that, as we transition to the comprehensive community behavioral health provider designation, it is essential to maintain such avenues for consumer input. However, this wording seems to state that providers' boards must have four members with lived experience. It is important to understand that community behavioral health providers are complex organizations, and require a variety of expertise on their boards: not only lived experience but financial, legal, health care operations and financing, public policy, etc. We do not believe it is appropriate for a state regulator to dictate board makeup and governance for the entities it oversees, and suggest that this wording be changed to "include at least one voting member with lived experience for themselves or a family member with mental health disorders or substance use disorders."	Thank you for your comment. We have attempted to strike a balance between the conflicting feedback we have received on this issue. To do so we have clarified the language to require that the individuals and or parents of individuals with lived experience have meaningful experience accessing services for behavioral health conditions. We have also received feedback that it can be challenging to recruit board members that also have the expertise needed to accomplish some of the other key roles of a board. As such, we believe at this time 50% would be an unattainable threshold for providers and would limit participation in the safety net. We have written that at least 2 board members must have this experience and the board must show how they are incorporating this and other lived experience feedback into decisions. This is something we will continue to revisit in future rule revisions also, as the industry adjusts to some of these new requirements and builds capacity to reach a higher threshold of lived experience membership on governance boards.
Chapter 3: This association recommends ensuring that language around licensure exemption for Federally Qualified Health Centers (FQHCs) is very clear throughout the regulations. While we understand that FQHCs will need BHA approval to serve as Essential BH Safety-Net Providers, we recommend doing this in the least administratively burdensome way possible. One suggestion would be to use Regional Accountable Entity (RAE) agreements for BH Safety Net provider approval. While contracts may not be able to be shared in their entirety, approval could be based on the fact that a contract with the RAE to provide BH services exists. This association fully supports the BHA working with Health Care Policy and Finance (HCPF) to ensure this process is efficient and does not leave out FQHCs as large providers in the BH safety net.	Thank you for your comment. We have added clarification into Parts 3.2.1 and 3.3.8 to address your concern. However, FQHCs providing Substance Use Treatment, and subsequently are required by HB22-1278 to obtain a BHE license, are not exempt from licensure.
Care Management (formerly Chapter 4; now embedded into Chapter 12)	
(3) INDIVIDUALS EDUCATION TO SUPPORT SELF-MANAGEMENT, INCLUDING EDUCATION REGARDING WARNING SIGNS FOR INCREASING SUPPORT NEEDS Same comment as a 4.3.A.2.b - suggest rephrasing to "...must involve the individual, their family as appropriate, and their service providers..."	This requirement applies to all elements of care management. At times we have not repeated family and /or other supports for the sake of brevity but that does not remove this overarching requirement. CONVENING PERSONS INVOLVED IN THE INDIVIDUAL'S SERVICES, INCLUDING HEALTHCARE AND COMMUNITY-BASED SERVICE PROVIDERS, FAMILY MEMBERS AND OTHER PERSONS IDENTIFIED BY

	THE INDIVIDUAL, TO WORK COLLABORATIVELY WITH THE INDIVIDUAL FOR THE PURPOSE OF SERVICE PLANNING AND COORDINATION, IN ORDER TO FACILITATE WELLNESS, SELF-MANAGEMENT, AND RECOVERY OF THE WHOLE PERSON.
e. THE COMPREHENSIVE COMMUNITY BEHAVIORAL HEALTH PROVIDER WILL MAKE AND DOCUMENT REASONABLE ATTEMPTS TO CONTACT INDIVIDUALS WHO ARE DISCHARGED FROM HOSPITAL OR ED SETTINGS WITHIN 24 HOURS OF DISCHARGE. THIS MAY INCLUDE COMMUNITY BASED OUTREACH AS APPLICABLE TO THE INDIVIDUAL. It is very difficult to get this information. Will the BHA assist with notifications, especially for individuals who don't have Medicaid?	Thank you for your comment. We understand that this information is not always available and have written the rule to account for this.
4.4.A. Six months apart Assumes that this level of care management will be long-term/on-going, however, that's not how patterns of high intensity care occur. Additionally, treatment/service planning only occurs in 6 month increments per these rules. As an alternative, "care management involves at least two contacts per month with the individual. Whenever possible, at least one contact will be face to face within a 6 month time period."	Thank you. We have reworked this section and removed the specific timeframes and frequency requirements to instead focus on person centered planning and service delivery that accounts for the needs of the individual.
4.4.A ADDITIONAL SUPPORTS From whom? Case manager, clinician and/or provider?	Because care management involves activities that will be carried out by a team that likely includes clinicians and other staff, we have avoided defining who is responsible for which activities.
B. AT A MINIMUM, THE AGENCY WILL CONVENE A TEAM MEETING WITH RELEVANT MULTIDISCIPLINARY TEAM MEMBERS AT LEAST TWICE PER YEAR. ADDITIONAL MEETINGS MUST BE SCHEDULED AS NEEDED TO ALIGN WITH INDIVIDUAL NEEDS INCLUDING RISING RISK, AND SERVICE PLAN ADAPTATIONS. This type of communication/coordination may happen via a meeting or via internal email as coordination needs arise. Our larger members have caseloads of hundreds of clients per team. Also, as noted above, this language assumes that this level of care management will be long-term/on-going. However, that's not how patterns of high intensity care occur. Suggest rephrasing to "At least twice per year the multidisciplinary treatment team shall review and coordinate treatment needs for the individual. Additional formal consultation must be scheduled as needed..."	Thank you. We have reworked this section and removed the specific timeframes and frequency requirements to instead focus on person centered planning and service delivery that accounts for the needs of the individual.

THE AGENCY MUST DOCUMENT GOAL PROGRESS IN ACCORDANCE WITHIN THE RECORD. Delete "in accordance." The agency must document goal progress within the record.	Thank you. This typo was corrected.
Care Coordination and Care Management: Our existing care coordination and care management mechanisms have historically failed to support Coloradans and their families in navigating our siloed and complex system. The status quo of relying on providers has often resulted in delays in access, fragmented services, and unaffordable care. While elements of care coordination and care management by providers are highlighted across various chapters, we are very concerned that the lack of a comprehensive approach to care coordination leaves significant gaps in accountability. As it currently reads, there are multiple instances – Chapters 3, 4, 14, and 15 – in which it is unclear if discharged individuals will be provided with the appropriate support and a warm handoff to their next step. When leaving a facility, an individual should have their next appointment scheduled, transportation discussed and coordinated, and contact information for additional resources (housing, food, etc.). Further, individuals should expect timely access to appropriate care when the level of expertise needed exceeds their provider's capacity. Without a consumer-oriented approach to care coordination and care management, we will undoubtedly continue to leave people on the streets, behind bars, and without access to proper care and resources. Because the Behavioral Health Administrative Services Organizations (BHASOs) are still in development alongside the new Regional Accountable Entity (RAE) regions, it is difficult to ensure the system envisioned through this rule volume consolidates our siloed behavioral health networks into one streamlined, efficient, person-centered approach to support whole-person care. We urge the BHA to prioritize care coordination and care management that includes care navigation and extends across levels of care, providers, and other needed resources. We further request that the BHA explore ways to reduce the conflict of interest related to providers delivering care coordination and having incentives to provide that care themselves, at least for those individuals and families with the most complex needs.	Thank you for your comment. In addition to the ongoing work to develop BHASOs and define the role the BHA will play in providing care coordination to specific individuals and populations, where these recommendations overlap with provider responsibilities we have incorporated rules that address the topics and concerns noted here, including follow up care, navigation to health and social service resources, etc.
Consider incorporating into Chapter 3 unless the grand plan is to expand the requirements for care	Thank you. Care management requirements were moved to Chapter 12 as part of the safety net approval

management to include a possible care management endorsement that might move the system toward more conflict free care management.	chapter.
4.3 A Needs to reflect that the individual is a partner in determining how these services are delivered and that the individual has a choice of provider CARE MANAGEMENT MAY INCLUDE BUT NOT BE LIMITED TO, AS NECESSARY TO ADDRESS THE ASSESSED NEEDS OF AN INDIVIDUAL: 1. WORKING COLLABORATIVELY WITH THE INDIVIDUAL AND THEIR SUPPORT SYSTEM TO DEVELOP A SERVICE PLAN THAT AFFORDS THEM CHOICE IN HOW TO FACILITATE WELLNESS, SELF MANAGEMENT AND RECOVERY OF THE WHOLE PERSON. 1.2 CONVENING INDIVIDUALS INVOLVED IN THE INDIVIDUAL'S SERVICES, INCLUDING HEALTHCARE AND COMMUNITY-BASED SERVICE PROVIDERS AND PERSONS IDENTIFIED BY THE INDIVIDUAL, FOR THE PURPOSE OF SERVICE PLANNING AND COORDINATION, IN ORDER TO FACILITATE WELLNESS, SELF-MANAGEMENT, AND RECOVERY OF THE WHOLE PERSON.	We have made edits to align with this language.
4.3 A 2 a Add additional risks such as loss of benefits, income instability, risk of child and/or adult endangerment; risk of deportation/detainment RISKS MAY INCLUDE BUT ARE NOT LIMITED TO RISK OF GRAVE DISABILITY, RISK OF DANGER TO SELF OR OTHERS, RISK OF INSTITUTIONALIZATION, RISK OF INCARCERATION, RISK OF OVERDOSE, RISK OF HOUSING INSTABILITY, RISK OF LOSS OF STATE OR FEDERAL BENEFITS, RISK OF INCOME INSTABILITY, RISK OF CHILD AND ADULT ENDANGERMENT, RISK OF DEPORTATION/DETAINMENT AND RISK FOR OUT OF HOME PLACEMENT FOR A YOUTH.	Thank you. We have added these.
4.3. A 2 b Need to include advocates and family RISK ASSESSMENT MUST INVOLVE THE INDIVIDUAL AND THEIR FAMILY, ADVOCATES AND SERVICE PROVIDERS TO THE EXTENT THEY CHOOSE, BE DONE ON AN ONGOING BASIS AND BE ADDRESSED WITHIN THE SERVICE PLAN.	Thank you. The care management rules specify as an overarching requirement that services must be carried out with the individual's support system, and thus this is not specified within each rule.
Expand definition of crisis beyond just MH and SUD 5. PROACTIVELY IDENTIFY AND WORK	Thank you. We have expanded the description of risk assessment to include these.

WITH THE INDIVIDUAL AND THEIR SUPPORT SYSTEM TO AVERT CRISES TO INCLUDE RISK FOR EVICTION, ARREST, BENEFIT LOSS, SYMPTOM INSTABILITY DUE TO DELAYS IN ACCESS TO TREATMENT INCLUDING MEDICATIONS, LONG TERM HOUSING STABILITY AND LOCATING SPECIALTY PROVIDERS.	
4.3 A 5 b THE AGENCY SHALL BE PROACTIVE IN IDENTIFYING IMPENDING CARE TRANSITIONS AND IMPLEMENT THESE PROCEDURES ANY TIME THAT THE COMPREHENSIVE COMMUNITY BEHAVIORAL HEALTH PROVIDER IS MADE AWARE THAT A CARE TRANSITION MAY BE IS OCCURRING.	Thank you. We have added language to align with this recommendation.
4.3 A 5 d WHENEVER POSSIBLE, AS SOON AS THE AGENCY IS AWARE OF A POTENTIAL DISCHARGE, THE AGENCY SHALL WORK WITH THE DISCHARGING FACILITY AHEAD OF DISCHARGE TO FACILITATE A SEAMLESS TRANSITION, IN ACCORDANCE WITH CARE COORDINATION REQUIREMENTS. 1. THE AGENCY SHALL MAINTAIN PROCEDURES TO PROACTIVELY IDENTIFY INDIVIDUALS UNDER THEIR CARE WHO ARE ADMITTED TO HOSPITALS OR OTHER 24/7 FACILITIES AND ESTABLISH PROCEDURES TO ENSURE THAT TRANSITION PLANNING OCCURS AS SOON AS PRACTICAL BEFORE DISCHARGE.	The existing rules are in line with this suggested language.
4.4 A These requirements are not person centered, some individuals will want in person contacts and others will not. AT A MINIMUM, CARE MANAGEMENT INVOLVES AT LEAST TWO CONTACTS PER MONTH WITH THE INDIVIDUAL. ANNUALLY, AT LEAST TWO CONTACTS WILL BE FACE-TO-FACE, APPROXIMATELY SIX MONTHS APART. ADDITIONAL SUPPORTS MUST BE PROVIDED AT THE FREQUENCY NEEDED TO MEET THE NEEDS AND PREFERENCES OF AN INDIVIDUAL AND PROMOTE WHOLE PERSON HEALTH. THIS DETERMINATION MUST BE BASED ON THE ONGOING ASSESSMENT OF THE INDIVIDUAL'S NEEDS AND PREFERENCES, AND MUST BE APPROPRIATELY DOCUMENTED WITHIN THE INDIVIDUAL'S SERVICE PLAN.	Thank you. We have reworked this section and removed the specific timeframes and frequency requirements to instead focus on person centered planning and service delivery that accounts for the needs of the individual.
4.4 B Remove assumption of a team and prescriptive nature of language AT A MINIMUM, TO THE EXTENT THAT OTHER PROVIDERS ARE INVOLVED IN CARE, THE AGENCY WILL CONVENE REGULARLY COORDINATE CARE ACROSS OTHER PROVIDER	This requirement has been changed to be less proscriptive and reflective of the individual's needs and their support system.

ORGANIZATIONS. THIS MAY INCLUDE A TEAM MEETINGS OR OTHER STRUCTURED DISCUSSIONS CONVENING A TEAM MEETINGS WITH RELEVANT MULTIDISCIPLINARY TEAM MEMBERS AT LEAST TWICE PER YEAR. ADDITIONAL MEETINGS MUST BE SCHEDULED AS NEEDED TO ALIGN THE SERVICE PLAN WITH INDIVIDUAL NEEDS INCLUDING RISING RISK OR CHANGING NEEDS., AND SERVICE PLAN ADAPTATIONS.	
4.2 o What is the definition of “Complex”? Who receives these services?	BHA provider rules do not address who receives a service, but rather the rules a provider must follow when a provider is delivering a service.
• 4.3 (A)(5)(e) o How do we know when members are discharged from EDs? How will this go into the BHASO expectations?	This rule has been written to account for the fact that providers may not be notified of an admission and would not be responsible for this requirement in that event.
• 4.6 (A-C) o Seek clarification regarding population served? Is this cultural? Population can vary by person. What level are we looking to create training? How do we show that our training satisfies this requirement?	The populations served would apply to essential providers that have been approved to serve a subset of priority populations, as defined within these rules. Agencies shall determine the training necessary for different staff who may be assigned to work with different populations.
• 4.2 Definitions o Recommend specifying that care management has many models of care that address population specific needs. How will the different levels of and specialty in care management be addressed for population specific needs (i.e., ICM for SMI population with comorbid conditions, TCM for SMI population that is homeless, TOC model for ED/Hospital to home models, etc.). •	Thank you. These rules are intended to create a baseline for care management services. Specific models may be used for specific populations, under certain programs and grants, etc. In these cases, fidelity to those models is not within the scope of these rules and may be clarified through other means such as contracts with the BHA and/or BHASOs.
4.3 Scope of Services o A2: Will there be a specific care management/case management assessment that is standardized? It would be useful and help manage the quality of care to have a standardized tool or clear set of expectations, as with the comprehensive mental health assessment, crisis assessment, etc. If we want to standardize care management/case management than perhaps we standardize the assessment tool. o	There will not be a specified assessment. Agencies may develop and or utilize assessments that meet the requirements outlined within this section, which we believe allows for appropriate flexibility for providers.
A5.c: Consider adding in language about completing medication reconciliation so that med errors do not result in avoidable readmission an/or ER use. Consider setting expectation for length of time between discharge date and follow-up appointment, such as within 7 days. o	Thank you, medication reconciliation is included in the care management section. In regards to time frame, the rule includes the following requirement: “THE COMPREHENSIVE COMMUNITY BEHAVIORAL HEALTH PROVIDER WILL MAKE AND DOCUMENT REASONABLE ATTEMPTS TO CONTACT INDIVIDUALS WHO ARE DISCHARGED FROM THOSE SETTINGS WITHIN 24 HOURS OF DISCHARGE. THIS MAY INCLUDE COMMUNITY BASED OUTREACH AS APPLICABLE TO THE NEEDS

	OF THE INDIVIDUAL.”
A5d: “Whenever possible...” seems too loose of language. It seems that there should be an expectation that the provider will work with any facility where a person is admitted to in order to facilitate a solid transition plan. The only time this would be “possible” is if the provider does not know the person is in a facility or does not know which facility. •	Thank you for your comment.
4.4 Frequency I would think for intensive care management that we may want to have a multidisciplinary team meeting more than twice per year, given the complexities, risks, and intensity of needs, possibly quarterly formal staffings with the care team and more often as indicated. As I understand this, it is not standard care coordination services; rather intensive care management/case management. Some models would require monthly so twice per year for the care team to meet does not seem intensive and with a smaller caseload this would be manageable. •	Thank you. We have reworked this section and removed the specific timeframes and frequency requirements to instead focus on person centered planning and service delivery that accounts for the needs of the individual.
4.5B: Is this stating that the external or alternative agency conducting any care coordination needs to document in the comprehensive provider’s EHR? I don’t think this is reasonable. I think there needs to be expectation of service coordination with care team members but I don’t think we can require people to document in external EHRs. •	Thank you for your comment. This does not require an external provider to document in a comprehensive provider’s EHR.
4.6 Personnel and Training o How will this service be billed? What will the procedure code or codes be for this service as this has impact on what credentials are permissible/required?	The BHA continues to work closely with HCPF to ensure alignment with billing.
Pg 1, Letters B & C: Who will the providers be that are the Comprehensive Community Behavioral Health Provider Agencies? How will this differ from the RAE’s care coordination? Is B. is referring to community mental health center’s like NRBH and the care coordination and service plans they make? Is C. referring to RAE’s since they don’t provide “comprehensive community behavioral health” but their care coordinators (may) provide care management too?	Thank you. Providers who wish to be approved as comprehensive community behavioral health providers will seek approval per the process in Chapter 12. This is an optional approval and is not required for any providers in particular. Care management is meant to be consistent with some of the case management work being done at CMHCs currently. Administrative rules will outline the role of BHASOs and the BHA, and the BHA is coordinating with HCPF to establish continuity and alignment with RAEs while avoiding duplication of services.
Pg 2, Deliberate and coordinating assessment (What does that mean? What assessment is this? Is there going to be a tool used like the CANS?) It seems they are describing the CANS and how it is currently being used to assess risk and direct care coordination. In these rules they’re giving the agency providing care management a lot of	For the purposes of care management we have moved away from the assessment language and have instead focused on the agency’s requirement to identify an individual’s support needs and develop a person centered-plan. Because individuals will also be receiving clinical services along with care management, endorsement specific assessment requirements will also apply which is where there is additional specificity

latitude with the policies and procedures they make to meet these requirements, and it seems like they're giving latitude with the assessment used and when it is conducted, too, so that it is specific to the individual's needs. Will there be approved assessments or one specific, like the CANS? Is it intentionally being left vague/open as what assessment can be used? Do we want to create minimum language around assessments and when they are done, etc? We feel anyone from the care team should be able to request an assessment or an updated assessment, not just the care coordinator.	around timeframes, and what is included in the assessment. Within the rule, the BHA will not specify a specific tool such as the CANS, and providers may utilize assessments of their choosing that meet the requirements of the rule.
4.3 Scope of Services Service Plans The service plan appears to be like a Wrap Plan or crisis plan. I believe that the case management associated with the Medicaid Waivers, result in service plans. Those service plans dictate much of what the children on these waivers receive in terms of provider, service, frequency, etc. I think that service plans referred to in BHA Chapter 4 are similar in scope and function. The rules state that care management includes Pg.1-2: "CONVENING INDIVIDUALS INVOLVED IN THE INDIVIDUAL'S SERVICES, INCLUDING HEALTHCARE AND COMMUNITY-BASED SERVICE PROVIDERS AND PERSONS IDENTIFIED BY THE INDIVIDUAL, FOR THE PURPOSE OF SERVICE PLANNING AND COORDINATION, IN ORDER TO FACILITATE WELLNESS, SELF-MANAGEMENT, AND RECOVERY OF THE WHOLE PERSON." It seems they are assuming these participants would see the service plan. However, they don't spell it out. They don't specify who should see or receive copies of the service plan and that would be helpful so there can be accountability. Resulting service plan shall be available to all members of care team including the individual or their guardian/custodian, could go under 4.3 A 1.	Thank you for your comment. These service plans would be distinct from those developed for individuals receiving waiver services. Individual rights to access their health records would apply to the service plan.
Pg 3, d—"whenever possible" language—who decides when this is possible or impossible? Pg 3, d--How will the Agency know (timely) an individual has been in the ED or admitted to the hospital to effectively assess and discharge plan?	If an agency was not aware of or notified of an admission then it would not be possible for them to engage in the discharge planning. If an agency is aware of an admission and for any other reason unable to facilitate discharge planning the barriers would need to be documented in the record along with all efforts made to fulfill the requirement.
Pg 4: Is Care Management considered the highest level of care coordination that an	Thank you for your comment. We have moved away from specific requirements within rule, and have instead

individual could receive? Will there be additional levels within Care Management that would dictate amount and types of contact? If this is the most intensive level of care coordination, it seems the minimum needs to be more intensive and reflect that. Two face to face contacts a year and two check ins/contacts (phone, email, etc) monthly does not seem to reflect intense support. Who is deciding the level of support and when/how to increase or decrease? *This rule seems vague and would allow for a lot of inconsistency and individual's needs may not be met adequately. The rule begins with Pg. 4: "A. AT A MINIMUM..." and then: "...ADDITIONAL SUPPORTS MUST BE PROVIDED AT THE FREQUENCY NEEDED TO MEET THE NEEDS OF AN INDIVIDUAL AND PROMOTE WHOLE PERSON HEALTH." Likewise with the meetings they are required to convene, "B. AT A MINIMUM..." and then: "MEETINGS MUST BE SCHEDULED AS NEEDED TO ALIGN WITH INDIVIDUAL NEEDS INCLUDING RISING RISK, AND SERVICE PLAN ADAPTATIONS."	made the requirements more dependent upon individual need.
Pg 3, e—Could this be written as "individuals and their guardians/custodians if applicable"	Care coordination requirements should always be carried out in accordance with all other laws and regulations including those which address the involvement of legal guardians and representatives.
Pg. 4 --How often will the on-going assessments be completed? Are those assessment shared with the individual, family, team? There should be mandated reassessment at points to ensure that individual's level of need is known and being supported.	We have clarified that service plan revisions should be updated when the team determines there is a change in the service needs of the individual or there is an assessment of new or heightened risk for the individual. Ongoing risk monitoring shall be an iterative process carried out by individuals involved in the individual's care.
Pg 4.6 A 2—What is meant by vary? Doesn't this statement effectively negate the directive value of #1? Could it say "The training requirements of personnel may be specific toward specialized populations served" or something along those lines?	Thank you for your comment. This clause is meant to clarify that not all personnel will require the same training and this is allowable as long as the training aligns with the populations that the personnel is providing services to.
Will counties/other stakeholders be involved in development of policies and procedures around these rules?	Agencies delivering care management services are able to develop their own policies and procedures based on the processes they determine.
There is an opportunity to make 4.3 a lot clearer. Suggest first defining what might be included and then clarifying the requirements if each of those elements is being delivered.	Thank you for your comment. We have made revisions to this section to add clarity to the requirements related to identifying an individual's needs and then developing a person-centered service plan to address the individual's goals related to identified needs.
Need to more clearly define "contacts". Voicemail	Thank you. We have removed some of the prescriptive

should not be sufficient, nor mailed information. Make sure it's clear this is bidirectional. From our group's point of view what we have heard when working with children with high acuity needs - critical these are face to face definitely not papermail. Simply sharing a list of resources is not sufficient.	requirements related to contacts to ensure these are more person-centered and determined based on the needs of the individual. However, at the same time we have focused on the community based outreach focus of these services to emphasize the importance of bi-directional communication and interaction when carrying out care management.
4.2 DEFINITIONS Note: This definition should be included in chapter 1. “CARE MANAGEMENT” IS AN INTENSIVE LEVEL OF SUPPORT TO ADDRESS THE COMPLEX NEEDS OF INDIVIDUALS REQUIRING MULTIPLE PARTNERS ACROSS SECTORS TO WORK TOGETHER AS A TEAM WITH THE INDIVIDUAL AND FAMILY. CARE MANAGEMENT REQUIRES DELIVERY OF CARE COORDINATION SERVICES AT A HIGHER FREQUENCY AND/OR FOR A GREATER LENGTH OF TIME, IN ADDITION TO OUTREACH AND ENGAGEMENT WITH THE PERSON AND TEAM TO BUILD NECESSARY TRUST AND SUPPORT. How/who is this intensive level of support meant for? How is this different from the case management/care coordination currently provided by CMHCs. How does this align with care management provided by the RAEs? The BAHSOs. These types of clients can get confused and overwhelmed when contacted by multiple care management entities.	Thank you for your comment. Care management is meant to be consistent with some of the case management work being done at CMHCs currently. Administrative rules will outline the role of BHASOs and the BHA, and the BHA is coordinating with HCPF to establish continuity and alignment with RAEs while avoiding duplication of services.
4.3 SCOPE OF SERVICES A., 2., b. Proposed Edit: Add language – “, their family as appropriate,” b. RISK ASSESSMENT MUST INVOLVE THE INDIVIDUAL, THEIR FAMILY AS APPROPRIATE, AND THEIR SERVICE PROVIDERS, BE DONE ON AN ONGOING BASIS AND BE ADDRESSED WITHIN THE SERVICE PLAN.	The requirement to involve the individual's support systems applies to all care management activities i this section: CONVENING PERSONS INVOLVED IN THE INDIVIDUAL'S SERVICES, INCLUDING HEALTHCARE AND COMMUNITY-BASED SERVICE PROVIDERS, FAMILY MEMBERS AND OTHER PERSONS IDENTIFIED BY THE INDIVIDUAL, TO WORK COLLABORATIVELY WITH THE INDIVIDUAL FOR THE PURPOSE OF SERVICE PLANNING AND COORDINATION, IN ORDER TO FACILITATE WELLNESS, SELF-MANAGEMENT, AND RECOVERY OF THE WHOLE PERSON.
4.3 SCOPE OF SERVICES A., 5., c., (3) Proposed Edit: Proposed Edit: Add language – “And Familial” (3) INDIVIDUAL AND FAMILIAL EDUCATION TO SUPPORT SELF-MANAGEMENT, INCLUDING EDUCATION REGARDING WARNING	The requirement to involve the individual's support systems applies to all care management activities i this section: CONVENING PERSONS INVOLVED IN THE INDIVIDUAL'S SERVICES, INCLUDING HEALTHCARE AND COMMUNITY-BASED SERVICE PROVIDERS, FAMILY MEMBERS AND OTHER PERSONS IDENTIFIED BY THE INDIVIDUAL, TO WORK

SIGNS FOR INCREASING SUPPORT NEEDS	COLLABORATIVELY WITH THE INDIVIDUAL FOR THE PURPOSE OF SERVICE PLANNING AND COORDINATION, IN ORDER TO FACILITATE WELLNESS, SELF-MANAGEMENT, AND RECOVERY OF THE WHOLE PERSON.
Page 4 4.4 FREQUENCY A. A. AT A MINIMUM, CARE MANAGEMENT INVOLVES AT LEAST TWO CONTACTS PER MONTH WITH THE INDIVIDUAL. ANNUALLY, AT LEAST TWO CONTACTS WILL BE FACE-TO-FACE, APPROXIMATELY SIX MONTHS APART. ADDITIONAL SUPPORTS MUST BE PROVIDED AT THE FREQUENCY NEEDED TO MEET THE NEEDS OF AN INDIVIDUAL AND PROMOTE WHOLE PERSON HEALTH. THIS DETERMINATION MUST BE BASED ON THE ONGOING ASSESSMENT OF THE INDIVIDUAL'S NEEDS, AND MUST BE APPROPRIATELY DOCUMENTED WITHIN THE INDIVIDUAL'S SERVICE PLAN. Assumes that this level of care management will be long-term/on-going, however, that's not how patterns of high intensity care occur. Additionally, treatment/service planning only occurs in 6 month increments per these rules. As an alternative, "care management" involves at least two contacts per month with the individual. Whenever possible, at least one contact will be face to face within a 6-month time period.	10/25/23 Thank you. We have reworked this section and removed the specific timeframes and frequency requirements to instead focus on person centered planning and service delivery that accounts for the needs of the individual.
4.4 FREQUENCY B. B. AT A MINIMUM, THE AGENCY WILL CONVENE A TEAM MEETING WITH RELEVANT MULTIDISCIPLINARY TEAM MEMBERS AT LEAST TWICE PER YEAR. ADDITIONAL MEETINGS MUST BE SCHEDULED AS NEEDED TO ALIGN WITH INDIVIDUAL NEEDS INCLUDING RISING RISK, AND SERVICE PLAN ADAPTATIONS. Again, assumes that this level of care management will be long-term/on-going, however, that's not how patterns of high intensity care occur. Additionally, treatment/service planning only occurs in 6 month increments per these rules. As an alternative, "at least once within a 6 month time period."	Thank you. We have reworked this section and removed the specific timeframes and frequency requirements to instead focus on person centered planning and service delivery that accounts for the needs of the individual.
Chapter 4 (December 2022 Draft Comments)	
Chapter 4: Regarding many of the questions and	Thank you for your comment. Many revisions were

comments regarding care coordination and case management, the two are distinct (as is care navigation). Perhaps it would be good for the Behavioral Health Administration (BHA) to put out a communication about how it is defining these terms. The federal law for the Long Term Services and Supports (LTSS) system refers to “conflict free case management,” not care coordination. Care coordination is a clinical service that supports care at the place of service. A good primer on care coordination can be found here: https://www.ahrq.gov/ncepcr/care/coordination.html	made in this round of revisions to streamline provider requirements and remove additional terms that were causing confusion. Care coordination has been defined in alignment with the statutory definition per Colorado law.
Chapter 4: To clarify, “care management” is different from “care coordination?”	Yes, all behavioral health safety net providers are required by statute to provide care coordination. Care management, is a service that will be provided by comprehensive providers and is designed to be an outreach focused level of support for individuals who present with more intensive needs, multiple system involvement, etc.
Chapter 4: I am very concerned that this care coordination plan does not support “conflict free” care coordination, as the long-term services and supports system has been federally mandated to implement.	Thank you for your comment. Federal mandates for conflict free case management are referencing something that is distinct from the services defined here as care coordination.
Chapter 4: The term "ensure consent" may unintentionally support coercion of individuals to sign release of information (ROIs). It may be better to use another word other than "ensure" or to emphasize attempts to help the individual understand the benefits and risks of providing an ROI.	Rule language was adjusted to remove the word ensure and address this feedback.
Chapter 4: With the distinction in levels of care coordination and care management, are all of these activities anticipated to be reimbursable under T1017 for Targeted Care Management or will new codes be added to the coding manual to support these distinctions?	The BHA is working with Health Care Policy and Finance (HCPF) to align payment and services, and to develop the value based payment structures that essential behavioral health safety net providers and comprehensive community behavioral health providers will be eligible to receive.
Chapter 4: Is care coordination a separate endorsement? Also, would Department of Transportation (DOT) return-to-work Substance Use Disorder (SUD) services come under the rubric of BH safety net provision? I think I saw somewhere that Colorado DOT operates separately?	Care coordination requirements are a requirement for all approved behavioral health safety net providers, and have been moved into chapter 12 to reflect that. . Rules specific to DOT programs are not part of this rule volume or BHA authority.
Chapter 4: Is there a document that outlines each of these care coordination definitions so they can be looked at side by side?	Thank you for your comment. With the recent revisions we have removed some of the complexity previously present in the rules and as such providers should only need to reference the single care coordination definition located in Chapter 1.
Chapter 4: How will the BHA coordinate and partner with the Department of Health Care Policy	Thank you for your comments. The BHA is continuing to work with our partner state agencies including HCPF, as

& Financing to avoid duplication or disruption between the Behavioral Health Administrative Service Organizations (BHASOs) and the RAEs?	well as the people of Colorado, to co-create the BHASOs. Administrative rules governing the BHASOs will be developed in the coming year.
Chapter 4: How will the referrals between the safety net provider, BHASO, and potentially RAE operate?	Thank you for your comment. The BHA is continuing to work with our partner state agencies including HCPF, as well as the people of Colorado, to co-create the BHASOs. Administrative rules governing the BHASOs will be developed in the coming year.
Chapter 4: How will the BHA and BHASOs support care coordination across provider types?	Thank you for your comment. The BHA is continuing to work with our partner state agencies including HCPF, as well as the people of Colorado, to co-create the BHASOs. Administrative rules governing the BHASOs and outlining the BHA's role in care coordination will be developed in the coming year.
Chapter 4: What is the definition of "timely manner" for care coordination?	Thank you for your comment. This term has been removed from this chapter to avoid ambiguity.
Chapter 4: 4.2.5(C): INFORMATION SHARING. Does this mean the who or the what to be released? Not clear what this means. Are we to document that a family member of a client would like to receive such and such information with the client's permission?	Preferences for shared information may include both what and to whom information is to be released, the method of information sharing, language preferences, etc.
Chapter 4: What is the oversight for care coordination?	Care coordination requirements will be overseen pursuant to licensing and approval requirements for providers. Additionally, the role of the BHA and BHASOs will be outlined in administrative rules.
Chapter 4: Do you have a risk stratification tool to determine what level clients need per the care management levels?	The levels of care coordination have been removed from the proposed rules.
Chapter 4: [In response to care coordination plan presented] When the task force voted to create the BHA they voted that the "BHA would establish a structure for regional support that offers care coordination and management." The blueprint says that there will be a "clear and single point of entry" for coordination. This care coordination plan appears to be the system we currently have, vs. the system the task force envisioned.	These rules are limited in scope, and create the minimum standards for entities providing care coordination services. BHASOs will be established as the structure for regional support. BHASOs, and the administrative rules governing BHASOs will be co-created with the people of Colorado in the coming year.
Chapter 4: I agree with others and am also confused by the care coordination plan presented. It seems to go directly against the Behavioral Health Task Force (BHTF) Recommendations - See Page 17 of the BHTF Report: https://drive.google.com/file/d/1HWWh6Kx94HH7FQeCWG7zazfuiGNY36vO/view	These rules are limited in scope, and are meant to create the minimum standards for safety net providers required to provide care coordination and/or care management services. The BHA is working to define the role of the BHA and BHASO, as well as the specific support that will be provided by the BHA related to coordinating care for specific individuals and populations. These roles and processes will be outlined within BHA administrative rules.
Chapter 4: I agree with others that the focus of care coordination here seems to be very provider based. The BHTF heard a lot of feedback about how care coordination across providers is	These rules are limited in scope, and are meant to create the minimum standards for safety net providers required to provide care coordination and/or care management services. The BHA is working to define the

needed. It may be that it just isn't clear how this would work on the ground. If an individual is cycling through multiple provider organizations such as withdrawal management, emergency departments, crisis stabilization, mobile crisis, outpatient mental health treatment, how would care coordination work? Who would be responsible?	role of the BHA and BHASO, as well as the specific support that will be provided by the BHA related to coordinating care for specific individuals and populations. These roles and processes will be outlined within BHA administrative rules.
Chapter 4: We are concerned with adding levels and related requirements for care coordination that are different from those that already exist through HCPF and the RAEs, creating potential confusion between the systems and who is accountable for what. Many clients with complex needs have Medicaid and are also identified by the RAEs who have their own care coordination requirements. It would be helpful to see alignment and language that speaks to how decisions are made as to who is accountable for coordination when multiple care coordination entities are involved.	Thank you for your comment. Many revisions have been made to address these concerns, including removing the levels, and focusing on the person-centered and person-specific care planning requirements associated with care coordination. Administrative rules will outline the role of BHASOs and the BHA, and the BHA is coordinating with HCPF to establish continuity and alignment with RAEs while avoiding duplication of services.
Chapter 4: Since we are providing definitions for "Care Coordination," "Care Management," and "Case Management," will these differing services be reflected in the Coding Manual? Feels like we are creating new services without understanding credential levels and Current Procedural Terminology (CPTs).	Thank you for your comment. We are working with our partners at HCPF to ensure alignment with services in the coding manual.
What about ROI's and appropriate sharing of protected health information (PHI)?	Thank you for your comment. We have added clarification that all information sharing should occur IN COMPLIANCE WITH FEDERAL AND STATE LAWS, INCLUDING BUT NOT LIMITED TO HIPAA AND 42 C.F.R. PART 2. The requirements for Safety Net Providers, including when they are required to provide care coordination, are found throughout Chapter 12.
For Safety Net Providers, when are we required to provide Level 1 Care Coordination?	Care coordination levels have been removed to prevent some of this confusion. However, safety net providers must provide care coordination to all individuals as necessary to meet the needs of the individual. The requirements have been updated to emphasize the person-centered, goal-centered nature of these requirements.
How are the requirements under 4.2.4 different from requirements of service planning and initial assessment?	These requirements include service planning and assessment of individual needs outside of behavioral healthcare in alignment with care coordination

	requirements.
Feels like Rule should not include a line regarding BHA discretion.	Thank you for your comment.
Do we need to document attempts to obtain an ROI? How are we expected to staff for these services, which are currently not covered by any billable code (i.e.	This requirement has been removed from this section. Providers must comply with all laws and regulations regarding obtaining authorization to release information, and further providers must provide care coordination in alignment with the rule, as applicable to the needs of the individual.
Are care plans separate from Treatment or Service Plans?)? Same with Crisis Plans.	The language has been clarified and standardized across this chapter to align with the terms defined in Chapter 1.
Are Comprehensive Safety Net Providers to develop Care Coordination Agreements? How will the external providers be held accountable to enter into the care coordination agreements and provide such information as discharge dates/summaries?	Based on stakeholder feedback, care coordination agreements were removed and will not be required at this time.
Chapter 4: (4.2.4.H): Consider “Actively facilitate ‘warm’ connections when transitioning individuals to other levels of care coordination. 4.3.3.E: Consider “Actively facilitate ‘warm’ connections when transitioning individuals to other levels of care coordination.	Thank you for your feedback. These requirements have been revised based on this and other feedback and reference warm handoffs, as defined in Chapter 1.
Chapter 4: (4.2.4.I): Consider Monitoring an individual's progress, engagement, and satisfaction with treatment, recovery and care coordination through appropriate assessment measures at the discretion of the BHA.”	Thank you for your comment. We have adjusted language to incorporate this feedback and align with the suggestion.
Chapter 4: (4.2.4.II): Does this mean that the BHA is going to provide the assessment measures or that they are going to determine whether the used assessment measure is appropriate?	The BHA will not require a specific assessment. A provider has the flexibility to identify or develop assessment measures that meet the requirements of the rule.
Chapter 4: (4.2.5.D): Consider revisited periodically, such as during transitions of care or when there are new diagnoses or conditions	Thank you for your comment. We have adjusted language to incorporate this feedback and align with the suggestion.
Chapter 4: (4.2.5.G.h): To include physical health, behavioral health and other recovery and supportive services that may be part of the care plan. 4.2.5.G.i: Consider adding language that restates that this is inclusive of physical health and behavioral health.	Thank you for your comment. We have adjusted language to incorporate this feedback and align with the suggestion.
Chapter 4: (4.2.5.F): Consider adding language restating coordination with services providers in physical health, behavioral health, and other areas of social needs.	Thank you for your comment. We have adjusted language to incorporate this feedback and align with the suggestion.
Chapter 4: (4.2.5.G.g): Consider adding	Thank you for your comment. We have adjusted

language that is inclusive of services and supports that are not treatment, such as recovery services.	language to incorporate this feedback and align with the suggestion.
Chapter 4: (4.2.5): INFORMATION SHARING (D). Recommend change to: “Seek” rather than ensure.	Thank you for your comment. This requirement was removed from this section.
Chapter 4: Level 3 sounds like requirements for Assertive Community Treatment (ACT) program; does this qualify?	Care coordination rules are no longer structured in three levels. Though models such as ACT may mirror some requirements of care management, these rules are not meant to require a specific model, or alter the requirements for implementing existing models to fidelity, as required to comply with any other rules or contracts.
Chapter 4: Will comprehensive providers have members with comprehensive health records with essential services documented in the comprehensive health record?	If an individual is receiving care coordination from a Comprehensive Community Behavioral Health Provider and is also receiving a behavioral health service from an Essential Behavioral Health Safety Net Provider, then according to care coordination requirements, these services may be documented in the comprehensive record as part of the comprehensive service plan, information sharing, or other care coordination activity.
Chapter 4: (4.4.4.C.3): include recovery services, not only treatment; for reference to advanced directives, is this for medical advanced directives, psychiatric advance directives, or both?	Recovery supports were added here and the rule was clarified regarding the requirement for psychiatric advance directives.
Chapter 4: (4.5.6): Does this include all bed-based services such as CSU, ATU, crisis residential respite, SUD residential continuum, and the children and youth residential treatment levels? If so, we may want to clarify this more.	Based on stakeholder feedback, this requirement has been removed from the rules at this time and may be revisited during a future revision.
Chapter 4: (4.5.9): Consider a base contract/agreement template for all comprehensive behavioral health providers with the base standard requirements/expectations and additional expectations can be added on as indicated.	Based on stakeholder feedback, this requirement has been removed from the rules at this time and may be revisited during a future revision.
Chapter 4: How will the BHA ensure the care coordination requirements do not add to the already burdensome paperwork and assessments required for services? Will the state provide a portal or mechanism for data sharing?	Thank you for your comment. Care coordination agreements have been removed from this rule revision and may be revisited at a future time. This adjustment was made in order to reduce the administrative burden and some of the paperwork requirements that were originally proposed.
Chapter 4: (4.3.3.A): Will there be a standardized template for this comprehensive assessment? Or will care coordination providers be able to create their own assessments with the items listed here, and additional items per the discretion of each provider?	Thank you for your question. Providers can create their own assessments with the items listed here, and additional items per the discretion of each provider, as long as the requirements of the rule are met.
Chapter 4: (4.4.1): ”....engaging intentionally with	Thank you for your comment. We have adjusted

the person and health care partnership to build necessary trust and support.” Do we want to include other social supports and services?	language to incorporate this feedback and align with the suggestion.
Chapter 4: (4.4.4.A): Consider wellness, self-management, and recovery	Thank you for your comment. We have adjusted language to align with the suggestion.
Chapter 4: (4.4.4): LEVEL THREE CARE MANAGEMENT. How will we know if someone is a Level II or Level III as they seem very similar except for the contact prescription?	Thank you for your comment. Determining what services an individual requires are outside the scope of this rule, which establishes the standards a provider must follow when providing the service.
Chapter 4: (4.4.2): LEVEL THREE CARE MANAGEMENT. If the person needs this level of care management, the contacts required don't seem to fit the need.	Thank you. We have reworked this section and removed the specific timeframes and frequency requirements to instead focus on person centered planning and service delivery that accounts for the needs of the individual.
Chapter 4: (4.4.3): LEVEL THREE CARE MANAGEMENT. Recommend change to: "the care manager will convene OR ATTEND a team meeting with relevant multidisciplinary....." 4.4.3: Recommend change to: "the care manager will convene OR ATTEND a team meeting with relevant multidisciplinary....."	Thank you. We have reworked this section to be less prescriptive and instead focus on person centered planning and service delivery that accounts for the needs of the individual.
Chapter 4: (4.4.4 (A)): LEVEL THREE CARE MANAGEMENT. Again, recommend adding: "Convening OR ATTENDING the individual's multidisciplinary team..." This care management work typically happens within multiple systems simultaneously and doesn't just live with one care manager at a time so it's unrealistic to think that only one entity might be delivering "care management" services for an individual.	Thank you. We have reworked this section to be less prescriptive and instead focus on person centered planning and service delivery that accounts for the needs of the individual.
Chapter 4: 4.5 CARE COORDINATION AGREEMENTS FOR COMPREHENSIVE COMMUNITY BEHAVIORAL HEALTH PROVIDERS. This whole section is incredibly burdensome and "care coordination agreement" is vague. What is specified as "an Agreement" in this language? Is this a formal Memorandum of Understanding (MOU) or Care Compact that requires extensive internal review similar to contracting? If so, this is requiring BH entities to develop an agreement with every healthcare entity in its region that might serve their client. Recommend the BHA create a definition for "Care Coordination Agreement" as part of this rule. Is the BHA going to wait to enforce this rule once federal regulations around 42 CFR are more relaxed and aligned with HIPAA, making it easier for healthcare entities to share patient information?	Thank you for your feedback.. We have reviewed this section and removed the requirements for care coordination agreements with external entities. The requirements have been simplified to require follow-up with individuals who have been discharged from hospitals and emergency departments and to focus on the care coordination requirements for discharge and facilitating transitions.

Will the BHA be providing statewide funding for Comprehensive Community Beh Health Providers to build the necessary health information sharing platforms with these other healthcare entities that is legally compliant with HIPAA and 42 CFR in order to accomplish these care coordination agreements? This issue has plagued communities for decades and no clear solutions have been developed or presented statewide to implement so how can the BHA start requiring this without the necessary funding and technical assistance to achieve this? Recommend removing this whole section from the rules until the BHA can add more clarity and resources to this issue.	
Chapter 4: (4.5.4): CARE COORDINATION AGREEMENTS FOR COMPREHENSIVE COMMUNITY BEHAVIORAL HEALTH PROVIDERS. The burden of developing these agreements should not fall to all of the individual entities and FQHCs, this burden should fall to the state agencies that oversee FQHCs and Community Beh Health Providers to develop these agreements statewide. Recommend removing this requirement.	Thank you for your feedback. We have reviewed this section and removed the requirements for care coordination agreements with external entities. The requirements have been simplified to require follow-up with individuals who have been discharged from hospitals and emergency departments and to focus on the care coordination requirements for discharge and facilitating transitions.
Chapter 4: (4.2.5.G.a): Should “health status” be defined?	Thank you for your comment. This term has been removed.
All safety net providers should be required to do this. How are they not required to outreach to the community and proactively try to engage individuals? This endorsement should be required for safety net providers.	Thank you for your feedback. Statutorily outreach, education, and engagement services are only required of comprehensive providers.
Do we have to as an entity providing services do we need to provide the strategic plan to BHA during application? Not concerned about timing on this, just on what we need to have ready for the application. Agrees strategic plan after assessment.	Thank you for your question. The assessment process needs to happen prior to developing a strategic plan, both of which are post application.
Clarifications made to the role of communication with BHASOs in relation to community needs assessment	Thank you for your feedback. With passage of HB 23-1236 the timeline for BHASO implementation was pushed out to July 1, 2025. At this time rules for BHASOs have not been created. Provider rules will be updated in a future revision to include interactions/communication with BHASO entities.
Payment side, who bears the cost vs designee vs. provider? When using an outside assessment or designee. Different if the provider does the assessment themselves or using an existing assessment?	Thank you for your questions about BHASOs with the cost of the community assessment. With passage of HB 23-1236 the timeline for BHASO implementation was pushed out to July 1, 2025. At this time rules for BHASOs have not been created and it is unclear what will be included or not in the BHASO structure.

What expertise and resources will BHA provide to support completion of community assessments? Does BHA expect to "approve" plans?	Thank you for your questions. Now found in Part 12.6.8.A of the Safety Net rules, general provisions for the completion of the community assessment were expanded to include assessments completed by other community entities, the BHA, or BHA designee may be used as long as they meet the minimum assessed criteria found in 12.6.8.B.
Many communities have already developed a community assessment and we are already working with them to meet the needs. This will be duplicative work. Are we able to utilize the processes already in place by developing our strategic plan from the current assessment?	Thank you for your questions. Now found in Part 12.6.8.A of the Safety Net rules, general provisions for the completion of the community assessment were expanded to include assessments completed by other community entities, the BHA, or BHA designee may be used as long as they meet the minimum assessed criteria found in 12.6.8.B.
If these rules apply only to comprehensive providers, should this be a separate endorsement or just be incorporated into Chapter 3?	Thank you for your question. After receiving such feedback, Chapter 5 is now included in the Safety Net chapter, now found in Part 12.6.8, to reduce confusion.
5.3.A & B This communicates that there will only be one comprehensive provider in a geographic area which may not be the case. To reflect this and move away from "catchment areas", it seems like service areas and service populations is more descriptive. It seems that the focus of this assessment (as compared with a PIN or BHASO assessment) is that it examines the provider's own practices and priorities and ability to reprioritize to better fill community gaps--so more internally focused. The proposed changes to language are intended to reflect this. "AGENCIES MUST COMPLETE AN ASSESSMENT OF THE COMMUNITY BEHAVIORAL HEALTH TREATMENT NEEDS WITHIN THE GEOGRAPHICAL AREA THAT THEY SERVE THEIR SERVICE AREA. IF THE AGENCY IS COMPLETING, OR HAS COMPLETED, A COMMUNITY BEHAVIORAL HEALTH ASSESSMENT FOR ANOTHER GOVERNMENT ENTITY OR PROJECT, OR THROUGH A THIRD-PARTY, THOSE ASSESSMENTS MAY BE USED FOR THE PURPOSE OF THIS PART 5.3. ASSESSMENTS OF COMMUNITY BEHAVIORAL HEALTH TREATMENT NEEDS OF APPLICABLE SERVICE GEOGRAPHICAL AREA AND POPULATIONS IN NEED BY THE BHA OR A DESIGNEE OF THE BHA MAY BE USED FOR THE PURPOSE OF THIS PART 5.3. IF USING PREVIOUSLY COMPLETED ASSESSMENT(S) FOR THE PURPOSE OF THIS PART 5.3, COMMUNITY BEHAVIORAL	Thank you for your feedback. This suggested language has been added.

HEALTH NEEDS ASSESSMENT MUST NOT BE OLDER THAN THREE (3) YEARS. B. THE COMMUNITY BEHAVIORAL HEALTH TREATMENT NEEDS ASSESSMENT MUST INCLUDE, BUT IS NOT LIMITED TO, THE FOLLOWING: ENGAGE AND INTERVIEW COMMUNITY STAKEHOLDERS THAT ADDRESS SOCIAL DETERMINANTS OF HEALTH; DEFINE THE COMMUNITY THE AGENCY SERVES BY GATHERING INFORMATION INCLUDING, BUT NOT LIMITED TO, DEMOGRAPHICS OF THE COMMUNITY, DATA ON ACCESS TO CARE, CLIENT GRIEVANCES AND COMPLAINTS, SOCIAL DETERMINANTS OF HEALTH, AND PRIORITY POPULATION DATA; AND ASSESS UNMET NEEDS IN BEHAVIORAL HEALTH TREATMENT LEVELS OF CARE IN THE COMMUNITY.	
5.3.D.4 Add cultural centers/organizations b. OFF-SITE EVENTS AND INTENTIONAL ENGAGEMENT WITH PRIORITY POPULATIONS. THAT MAY INVOLVE BUT IS NOT LIMITED TO:(1) BROAD COMMUNITY INVOLVEMENT;(2) COMMUNITY PARTNERS THAT ADDRESS SOCIAL DETERMINANTS OF HEALTH IN SERVING PRIORITY POPULATIONS IN ASSESSED AREA;(3) LOCAL LAW ENFORCEMENT; AND (4) LOCAL PUBLIC HEALTH DEPARTMENTS; (5) CULTURAL CENTERS/ORGANIZATIONS.	Thank you for your feedback. This suggested language has been added.
5.3.G AT THE TIME OF LICENSE RENEWAL OR AT ANY OTHER ADDITIONAL TIME REQUESTED BY THE BHA, AGENCIES MUST SUBMIT A DATA OUTCOMES REPORT AND AN UPDATED STRATEGIC PLAN FOR THE FOLLOWING LICENSURE YEAR INCLUDING A SUMMARY OF OUTREACH, EDUCATION, AND ENGAGEMENT EFFORTS OF THE PREVIOUS YEAR AND DEVELOPED GOALS CREATED FROM THESE EFFORTS. There does not appear to be any enforcement of these requirements. Incorporate into Chapter 3 where the requirements are clearly tied to licensing approval or add some language about consequences of failure to comply with requirements.	Thank you for your feedback. After receiving such feedback, Chapter 5 is now included in the Safety Net chapter, now found in Part 12.6.8, to reduce confusion. Enforcement of the comprehensive safety net required services is covered in that chapter found in Part 12.8.
5.3 F o Clarify expectations regarding what is meant my “data interpretation.” Is	Thank you for your feedback. This was left broad on purpose to allow for flexibility within agencies of how they interpret and present their data to the BHA.

interpreting data on a daily basis acceptable?	
5.3 GENERAL SERVICE PROVISIONS B., 1. B. THE COMMUNITY BEHAVIORAL HEALTH TREATMENT NEEDS ASSESSMENT MUST INCLUDE, BUT IS NOT LIMITED TO, THE FOLLOWING: 1. ENGAGE AND INTERVIEW COMMUNITY STAKEHOLDERS THAT ADDRESS SOCIAL DETERMINANTS OF HEALTH; "Interview" has a specific meaning to researchers and evaluators, could this word be changed to "include perspectives" "obtain feedback" or other less restrictive terminology? As written, we would need to conduct individual interviews with people and that's incredibly time intensive and expensive.	Thank you for your feedback. This language has been modified to "obtain feedback".
All safety net providers should be required to outreach to the community and proactively try to engage individuals. This endorsement should be required for safety net providers.	Thank you for your feedback. Statutorily this is only required of Comprehensive Behavioral Health Providers within the safety net system at this time.
Behavioral Health Recovery Supports (formerly Chapter 6; now Chapter 3)	
6.1 AUTHORITY AND APPLICABILITY The scope of this endorsement is not clear. Does it apply to independent RSSOs, DORA licensed providers, BHEs providing peer services? Clarify the summary and applicability and relationship to RSSO licensure	This part has been updated with the following language: C. ALL BHES OR SAFETY NET PROVIDERS PROVIDING RECOVERY SUPPORT SERVICES RENDERED BY PEER SUPPORT PROFESSIONALS SHALL MEET THE STANDARDS IN THIS CHAPTER. IF THE AGENCY REQUIRES A BHE LICENSE, THE AGENCY MUST COMPLY WITH CHAPTER 2. D. THIS CHAPTER DOES NOT APPLY TO LICENSED RECOVERY SUPPORT SERVICES ORGANIZATIONS. REGULATIONS FOR LICENSED RECOVERY SUPPORT SERVICES ORGANIZATIONS ARE FOUND IN SECTION 21.600.
6.1.A RECOVERY SUPPORT SERVICES INCLUDE A VARIETY OF RECOVERY-FOCUSED SERVICES AND SUPPORTS FOR INDIVIDUALS WITH A BEHAVIORAL HEALTH DISORDER AND/OR WHO ARE IN RECOVERY FROM A BEHAVIORAL HEALTH DISORDER. THESE SERVICES ARE RENDERED BY PEER SUPPORT PROFESSIONALS.	This change has been made in response to your feedback.
6.1.C. Large categories of items outside scope are missing. 1. PERFORMING CLINICAL/DIAGNOSTIC ASSESSMENTS, SERVICE PLANNING, OR	The language has been changed to the following: 1. PERFORMING CLINICAL/DIAGNOSTIC ASSESSMENTS, SERVICE PLANNING, OR TREATMENT;

TREATMENT; 2. OBSERVING OR COLLECTING SPECIMENS FOR DRUG TESTING	2. DRUG AND/OR ALCOHOL TESTING, MONITORING, AND/OR COLLECTION OF TOXICOLOGY SAMPLES.
6.1.D. "D. AGENCIES ENDORSED PURSUANT TO THIS CHAPTER 6 MUST SUBMIT JOB DESCRIPTIONS OF ALL PEER SUPPORT PROFESSIONAL POSITIONS. IF THE AGENCY IS LICENSED AS A BHE, THIS MUST BE DONE IN ACCORDANCE WITH PART 2.6.E OF THESE RULES. " This is related to the scope question above, do you really want all BHE, DORA providers and RSSOs submitting job descriptions? For what purpose? How will BHE used these? Eliminate this requirement but instead require compliance with chapter 2.6 requirements.	This requirement was added in response to stakeholder feedback. The purpose of the submission of job descriptions is for the BHA to review the job descriptions for peer support professionals to ensure they are within the scope as defined by the recovery supports endorsement. If an agency is a BHE, they would already be doing this in compliance with Chapter 2 and this would not require additional action.
6.1 Peer support professionals have to disclose their name, contact information and supervisor's name and contact information to clients? Add 6.1E PEER SUPPORT PROFESSIONALS SHALL PROVIDE THE INDIVIDUAL WITH A WRITTEN DISCLOSURE AT THE TIME OF FIRST CONTACT THAT INCLUDES (1) THEIR FULL NAME; (2) THEIR CONTACT INFORMATION; (3) THEIR QUALIFICATIONS; (4) THEIR ROLE IN WORK WITH THE INDIVIDUAL; (5) THEIR SUPERVISOR'S NAME; (6) THEIR SUPERVISOR'S CONTACT INFORMATION; (7) THE EMPLOYER'S NAME.	Thank you for your feedback. This language has been incorporated.
6.2.C. Is there a distinction between "Certified Peer Support Professionals" and "Peer Support Professionals"? If so, the distinction does not seem clear and if not, the terms seem to be used interchangeably. Clarify the meaning or use of the term "Certified Peer Support Professional"	Peer support professionals may be certified or complete all required training. Language has been changed to "peer support professional with a certification credential" to clarify.
6.2.C.2. AT LEAST 200 HOURS OF EXPERIENCE AS A PEER SUPPORT PROFESSIONAL; This is related to the comment above. The certified distinction isn't clear so it could be interpreted that all Peer Support Professionals need 200 hours. Clarify the meaning or use of the term "Certified	Language has been changed to "peer support professional with a certification credential" to clarify.

Peer Support Professional"	
6.3 It seems like we are missing protections for individuals in the area of staff screening for providers that are not licensed by another entity. Add requirements to comply with Ch 2.6. C-I to apply to RSS providers that are not BHE	The only providers that are not BHEs that would be providing service in conformity with this chapter would be comprehensive safety net providers. There is a requirement for safety net provider approval that personnel must have background checks performed.
How does the BHE affect Peer Support Professionals?	Agencies licensed as a BHE that employ peer support professionals will need to ensure that they are following the requirements of the recovery supports chapter. This means the peer support professionals employed by a BHE will be required to have certain training or certification, receive supervision, and have a scope of work as outlined in the rules among other requirements. It is the responsibility of the BHE to ensure these requirements are followed.
An RCO that is NOT an RSSO would be required to follow these rules, is that correct? Even if contracting with an MSO?	No, that is not the case. An RCO that is choosing to operate as usual is not required to follow these regulations. If they are contracting with a Safety Net provider to provide recovery services, then yes, they need to follow these rules for recovery supports.
How are we expected to document the Supervision requirements?	The following specificity has been added: "SUPERVISORS SHALL DOCUMENT SUPERVISION DATE, TIME, DURATION, AND TOPICS DISCUSSED."
I have issues with CH6. on here it talks about it can be helpful to have a connection with someone who has been through what you have been going through. PSP person-centered summary, I have problems with this and am triggered by this. The term "coaching" is problematic. We see individuals as the experts on their road to recovery. I would like to see coaching taken out and put in recovery-experiences.	The term "coaching" is included because it is the term used by some peer support professionals to describe their work. Chapter 6 includes an extensive list of recovery supports that peer support professionals may provide. In response to this comment, the following language was added: 12. OTHER ACTIVITIES SUPPORTING THE RECOVERY EXPERIENCE OF AN INDIVIDUAL.
In ch 6 it talks about supervising peer support specialist around individuals will have to prove to BHA. Supervisors of peer support professionals will have to demonstrate the following...what would that demonstration look like in order for the BHA to regulate that supervision?	The BHA would request documentation of the training required of peer support professional supervisors.
I would like to focus on Chapter 6, 6.2 PERSONNEL QUALIFICATIONS AND TRAINING. I just want to make sure you understand that a Peer Specialist has the right to be certified or not. The choice is on the Peer Specialists. I was in the beginning one of the state advocated to develop what the certification would look like in Colorado. I was also on the Colorado Peer and	Peer support professionals providing recovery support services pursuant to the recovery supports endorsement have the option of being trained in all SAMHSA Core Competencies or obtaining a certification credential.

Family Specialist certification board members for some time and then the board became a committee. As in the beginning it has never been a request for all Peer Specialists to be certified. This part I am addressing makes it sound like we have no choice and have to be certified. We have asked from the beginning we have the right to choose. I work two jobs from two different agencies and I am not required to be certified. I do documentation on each job as required by agency and Medicaid and I do this not on any certification. There are many jobs in Colorado for Peer Specialists to work without certification. We kept the ability to have our choice because it is very expensive and Peer Specialist are poor people and we do the work for low pay. This profession pays very little. In comparison with the certification, we are asked to withhold the highest standards then any other professional Provider. I have researched and have learned this from other Ethics, Certifications and Licensing of other providers. We are asked to pay a ton more money to be certified. We were told that if an agency wants us to be certified then it was the responsibility on the agency, center and such, to pay for our Certification And this is not happening. To be blunt, it is all about the money for the state certification and not about us as providers. As it stands now, the only time Peer Specialists are encouraged or told to get certified is only for the Medicaid billing and this is the recommendation the state has set forth. For all and any other services we do not need to bill for services. My understanding is there is only one number that was assigned for Peer Specialists services and I am yet to see this number. This is the only reason a person needs to get certified and it should be on the agency as it was stated in the beginning to help if this is what the agency or center wants. I ask to have it in this document stating the certification is the choice of the Peer Specialist and not a requirement as it has always been.	
We believe that the requirements to follow certain sections of Chapter 2 should apply to Recovery Support Services Organizations licensed under Chapter 6 who are not required to be licensed as a BHE. These organizations are also serving very vulnerable individuals and doing so using peer support professionals. There should be basic	These types of basic requirements exist in the Recovery Support Services Organization (RSSO) licensing rules found in Section 21.600 and are not changing at this time.

requirements for governance, training, supervision, quality monitoring, and individual rights protections. Because we strongly support the use of peer support professionals, we offer our assistance in refining these licensing requirements to balance the burden with individual protections. Striking this balance is essential for a successful licensing approach.	
6.2. (C)&(D) o Is there a way to verify a peer certification? This is going to be a requirement however there is no centralized peer certification regulating body. o Will there be a separate payment?	The status of certification would be verified with the issuing body of the certification. Payment mechanisms for recovery support services rendered by peer support professionals are not changing at this time.
Behavioral Health Outpatient Services (formerly Chapter 7; now Chapter 4)	
That will help remove a lot of barriers and this will help a lot (regarding removal of the previously proposed max of 50% candidate rule)	Thank you for the feedback.
Just changed from community to private provider in the last two weeks, learning lots of new stuff. Want to get a new peer program going and ran into some stuff, idk where I read it, I saw something about something coming up for the 50% supervision for licensed staff and I had some questions about that because trying to have that level of people with licensure when trying to build our number of licensed and credentialed and people providing services in CO seems like a very high number especially as licensed people are providing supervision already. Seems an unbalanced number.	Thank you for your feedback. The 50% ratio requirement has been removed and clinical supervision requirements were added to Part 2.6.1.
Outpatient and IOP, thank you for moving WM into it. Level 1 and 2, we must have a policy about when someone must be discharged, is this anywhere else? 7.5.3.A.6, why is this required but it's nowhere else in outpatient?	Thank you for the feedback. Discharge and Admission requirements are found in Chapter 2 in Part 2.11 and are applicable to most service levels, including outpatient. Please note that the new ambulatory WM levels (Level 1-WM and Level 2-WM) include language that exempts them from the formal discharge summary requirements in Chapter 2, and allows the existing medical model for documentation of movement out of these services.
General WM, there's a piece that we want them to withdraw but we also want them to go through outpatient but sometimes they are separate and there's one spot that says WM complements treatment and I want to make sure it's not required	Thank you for the feedback. This is correct in that treatment is not mandatory for WM, though when provided together success rates for individuals are higher which is why the complementary language is used. This is aligned with ASAM 3rd Edition Criteria.
7.3.1A This language suggests individuals will be considered for higher levels of care first, instead of the "least restrictive" language used previously. I would suggest changing to "outpatient services are generally intended for	Thank you for the feedback. This is from current rule language 2 CCR 502-1 21.210.6 and not changing at this time.

individuals who are assessed as needing a minimally restrictive treatment environment.”	
7.3.4 B-E This seems burdensome for the individual to attend so many services. If a BHE has an established process to provide the comprehensive assessment as a same day service, would this be acceptable? Is the screening always required or can an assessment by qualified personnel be provided instead?	Thank you for your feedback. Chapter has been moved so now Part 4.3.4 provides the minimum standards that must be achieved by a BHE for documentation timeliness. If a BHE has a pre-established process that allows assessments and service plans to happen prior to the calendar days stated in Part 4.3.4, the BHE may continue to follow their process.
7.3.4 versus 7.6.4, section D.: 7.6.4 states treatment services be provided between the initial assessment and the comprehensive assessment, is this allowed only for intensive outpatient or for outpatient as well?	Thank you for your feedback. Language was updated in now Part 4.3.4.D that completion of the comprehensive assessment does not preclude the initiation of services.
Thank you for moving WM in this chapter! Parts 7.5.3.6 and 7.8.3.6 use the term “must” when referring to service provisions around discharges. Can you speak to why there needs to be a policy for circumstances under which individuals must be discharged? Should this be a “may” circumstance? Concern that using “must” will cause unnecessary confusion and disconnect in services.	Thank you for the feedback. Discharge criteria are included in the newly drafted ASAM 1-WM and ASAM 2-WM, in alignment with current ASAM 3rd Edition standards, and to be utilized as a guide for when it may be appropriate to transition an individual to another service. Per your suggestion, this language was changed to “may” instead of “must.”
7.6.1 Service Delivery and Settings (IOP) talking about people that meet that level or those who are higher level but stabilized, could this be an and/or not “or”	Thank you for your feedback. This has been changed to “AND/OR RECEIVING MEDICATION ASSISTED TREATMENT, AS DEFINED IN PART 1.2. OF THESE RULES, OR PHARMACOTHERAPY, AS DEFINED IN THIS PART 4.1.1”
7.6.1.Abut are stabilized and (please insert OR) receiving medication assisted treatment or pharmacotherapy	Thank you for your feedback. This has been changed to “AND/OR RECEIVING MEDICATION ASSISTED TREATMENT, AS DEFINED IN PART 1.2. OF THESE RULES, OR PHARMACOTHERAPY, AS DEFINED IN THIS PART 4.1.1”
7.6.2.E strike where we have MH disorders twice, strike one of the options	Thank you for your feedback. This has been corrected.
7.6.3.D Services may include, it calls out MAT but doesn't call out psychiatric or medication management, is this supposed to be, Psychiatry and addiction medication either included or excluded	Thank you for your feedback. This has been changed to “SERVICES MAY INCLUDE INDIVIDUAL THERAPY, GROUP THERAPY, MEDICATION ASSISTED TREATMENT (MAT) MONITORING AND/OR EDUCATION, PSYCHIATRIC MEDICATION EDUCATION AND/OR MONITORING, FAMILY THERAPY, PEER PROFESSIONAL SERVICES, EDUCATIONAL/OCCUPATIONAL GROUPS, RECREATIONAL THERAPY, AND OTHER THERAPIES AS DEEMED APPROPRIATE BY ASSESSMENT OF INDIVIDUAL IN SERVICE.”

7.7.2.C Agencies providing PHP services, must ensure personnel receive consultation services, this one is a requirement that they have supervision in-person within 2 days and nowhere else says it must be in-person	Thank you for your feedback. Telehealth has been added for all consultation/supervision options in this chapter.
7.7.2.E.1 Will there be specific trainings created or approved for this purpose? What is the criteria for a training to qualify as meeting this requirement?	Thank you for your feedback. The specifics of the training requirements were left broad intentionally to be flexible with agency needs and population specifics.
Court-ordered outpatient piece, how do we build a whole system around outpatient commitments, build the whole system to serve those individuals well.	Thank you for your feedback. Through creation of the Safety Net system and those new rules found in Chapter 12, we believe it is a step in the right direction of creating high quality services needed to effectively engage and treat those ordered to outpatient commitments.
Would that be 16 and under in another group for MIP?	Thank you for your feedback. That is correct and that information can be found in Part 4.4.
Will the social detox model be going away in Colorado? It appears level 1 will be medical and does not include social detox options. Talking about 3.2 level of care and what it will look like with new ASAM and what 4th edition may look like in CO and internally talking about how that will look and address it	Thank you for the question. The ambulatory withdrawal management levels of care being added through this rule update (Level 1-WM and Level 2-WM) align with the ASAM Criteria 3rd Edition standards. A future and separate rule promulgation process, that includes other key systems alignment with partnering agencies such as HCPF, is required before standards from the 4th Edition of the ASAM Criteria are adopted for the State of Colorado.
IOP and OP groups - limit of 12 clients. Does it matter if there are more than 1 therapist available?	Thank you for your question. This language has been revised to clarify that it is twelve (12) individuals receiving services.
Is it 12 people per group, or 12 people per facilitator?	Thank you for your question. This language has been revised to clarify that treatment groups must not exceed twelve (12) individuals receiving services.
Group limit of 12 jives with CMS standards.	Thank you for your comment.
Will there be reimbursement for early intervention and education services aside from the Medicaid code for screening? We have a team that is fully integrated into the community providing support groups, education and early intervention but none of those services are currently reimbursable it would be great to be able to find a way to maintain this team (without grant funding) going forward.	Thank you for your feedback. Billing and payment processes are outside the scope of the provider regulations.

7.3 - Are all outpatient services whether MH or SUD considered ASAM level 1?	Thank you for your question. Outpatient services sub-endorsement includes treatment for mental health and SUD services, which includes ASAM Level 1.0 type services.
7.6.1.F - Is this for MH IOPs as well? Not sure why would need affiliation with MAT program	Thank you for your feedback. Individuals attending mental health services may still present with co-occurring needs and best practice is to have a referral process available for MAT.
7.6.4 - Timelines for screenings and assessments seem to be the same for all levels of outpatient care. This does not seem logical or fit the amount of information needed to provide a higher level.	Thank you for your feedback. The timeliness standards were developed through stakeholder feedback and will remain at this time.
I support the removal of regulations that require a specific percentage of SUD treatment staff have CAT/CAS certification.	Thank you for the feedback.
I oppose the limitations being proposed to SUD outpatient treatment group sizes and restricting size to 12 participants. I support more flexible language such as "groups size shall not regularly exceed 12". The availability of licensed clinical staff and the inflated wages are such that having a hard cap presents a significant cost to providers that is not made up by Medicaid or commercial reimbursement rates.	Thank you for your feedback. We are moving forward with 12 individuals receiving services for group size as standard best practice from Yalom, SAMHSA, and CMS standards.
Thank you for removing the 50% rule!	Thank you for your feedback.
7.5.1.D LEVEL 1-WM SERVICES OFFERED BY AGENCIES THAT DO NOT PROVIDE BEHAVIORAL HEALTH SERVICES WITHIN THEIR AGENCY STRUCTURE MUST BE AFFILIATED WITH BHES OR OTHER NECESSARY PROVIDERS TO ENSURE THE TREATMENT NEEDS OF ALL INDIVIDUALS SERVED CAN BE MET. DOCUMENTATION OF THIS AFFILIATION MUST BE PRESENTED TO THE BHA, UPON REQUEST. What does affiliation mean? Referral relationship, formal agreement, part of the same entity? We have concerns about conflicts of interest and would like to see language around client choices and referrals to the RAE/BHASO throughout this chapter: PHP Support Systems (7.7.1 H,) and IOP Support Systems (7.6.1 F). Define "Affiliation"	Thank you for your feedback. Added to all levels of service in the chapter "REFERRAL(S) WILL BE PROVIDED IN COLLABORATION WITH THE INDIVIDUAL AND THEIR CHOICE(S) FOR REFERRED SERVICES". Affiliation is purposely left broad as it may be interpreted for different agency needs based on the populations served.

7.5.1.F.3.A INDIVIDUALS WHO ARE EXPERIENCING WITHDRAWAL FROM MORE THAN ONE CLASS OF SUBSTANCE, OR Shouldn't the qualifier under F.3.B also apply to F.3.A 3. DUE TO THE SAFETY CONCERNS INHERENT WITH WITHDRAWAL, THE FOLLOWING MAY NOT BE APPROPRIATE FOR LEVEL 1-WM SERVICES:A. INDIVIDUALS WHO ARE EXPERIENCING WITHDRAWAL FROM MORE THAN ONE CLASS OF SUBSTANCE, OR (1) IF THE MEDICAL PERSONNEL DETERMINES THAT AN INDIVIDUAL MEETING THE ABOVE CRITERIA CAN BE SAFELY AND EFFECTIVELY SERVED IN A LEVEL 1-WM SETTING, THE RATIONALE AND PLAN FOR SAFE MANAGEMENT AND SERVICES MUST BE DOCUMENTED IN THE INDIVIDUAL'S RECORD.	Thank you for the feedback. This suggestion has been incorporated by making the qualifier point "c" and changing the language in point c to "IF THE MEDICAL PERSONNEL DETERMINES THAT AN INDIVIDUAL MEETING ONE OR BOTH OF THE ABOVE CRITERIA CAN BE SAFELY AND EFFECTIVELY SERVED IN A LEVEL 1-WM SETTING, THE RATIONALE AND PLAN FOR SAFE MANAGEMENT AND SERVICES MUST BE DOCUMENTED IN THE INDIVIDUAL'S RECORD."
7.5.1.H H. INDIVIDUALS MAY PARTICIPATE IN LEVEL 1-WM SERVICES WITHOUT A FORMAL SUBSTANCE USE DISORDER DIAGNOSIS IF THERE IS INFORMATION PROVIDED BY COLLATERAL PARTIES INDICATES A HIGH PROBABILITY OF SUCH DIAGNOSIS. THE AGENCY MUST ENSURE FURTHER EVALUATION OF THIS PROBABLE DIAGNOSIS, EITHER COMPLETED WITHIN THE AGENCY OR THROUGH REFERRAL TO A BEHAVIORAL HEALTH PROVIDER. When would it be possible that a provider could not collect enough information from the individual to make a diagnosis of intoxication or withdrawal? Would this be if an individual was actively intoxicated/ If so, wouldn't the provider need to know what kinds of substances were used by some means in order to initiate treatment? If the person is too intoxicated to provide information to the provider to diagnose, should they be treated in an outpatient setting? Suggestion - Consider striking this provision.	Thank you for the feedback. This standard aligns with 3rd Edition ASAM Criteria that allows services to proceed at Level 1-WM and Level 2-WM without a formal diagnosis. An example of this may be an individual underreporting the severity or frequency of their substance use while collateral information from a loved one or other permitted source demonstrates the need for these services in order for the individual to remain safely in community. Removing this provision would hinder such individuals from receiving services while allowing rapport and further evaluation to occur, and will remain in rule at this time.
7.5.1.H - COORDINATION AND TRANSITION INTO ONGOING OR CONCURRENT TREATMENT SERVICES TO OCCUR SUCCESSFULLY. Suggestion: COORDINATION AND TRANSITION INTO ONGOING OR CONCURRENT TREATMENT SERVICES TO OCCUR SUCCESSFULLY BASED ON SCREENING OR ASSESSMENT OF NEEDS.	Thank you for your feedback. This was added to Level 1 and Level 2 WM.

7.6.1.f - AGENCIES PROVIDING IOP SERVICES MUST HAVE DIRECT AFFILIATION OR CLOSE COORDINATION THROUGH REFERRAL TO MORE AND LESS INTENSIVE LEVELS OF CARE. AGENCIES MUST ALSO HAVE A DOCUMENTED REFERRAL SYSTEMS IN PLACE FOR MEDICAL, PSYCHIATRIC, AND MEDICATION ASSISTED TREATMENT NEEDS. According to ASAM, an IOP level of care should provide individuals with "medical, psychological, psychiatric, laboratory and toxicology services which are available through consultation or referral. Psychiatric and other medical consultation is available within 24 hours by telephone and within 72 hours in person." and "emergency services, which access to "emergency services, which are available by telephone 24 hours a day, 7 days a week when the treatment program is not in session"(The ASAM Criteria, 3rd Ed, p198) While the hotline can address some emergent needs, we believe that providers should be available to to share information and coordinate care for their clients in the event of an emergency during a treatment stay. Suggestion: "1. AGENCIES PROVIDING IOP SERVICES MUST HAVE DIRECT AFFILIATION OR CLOSE COORDINATION THROUGH REFERRAL TO MORE AND LESS INTENSIVE LEVELS OF CARE. AGENCIES MUST ALSO HAVE A DOCUMENTED CONSULTATION PROCESS THROUGH INTERNAL STAFF OR OTHER AFFILIATION IN PLACE FOR MEDICAL, PSYCHIATRIC, AND MEDICATION ASSISTED TREATMENT NEEDS. A. REFERRAL(S) WILL BE PROVIDED IN COLLABORATION WITH THE INDIVIDUAL. B. ENROLLED CLIENTS SHALL HAVE ACCESS TO EMERGENCY SERVICES 24/7 WHEN THE TREATMENT PROGRAM IS NOT IN SESSION. "	Thank you for your feedback. Suggested language was added.
7.6.4.C D. AS SOON AS IS PRACTICABLE UPON ADMISSION, BUT NO LATER THAN SIXTY (60) CALENDAR DAYS FROM THE FIRST DATE OF SERVICES, THE AGENCY MUST COMPLETE A COMPREHENSIVE ASSESSMENT IN ACCORDANCE WITH PART 2.12.3 OF THESE RULES. THE REQUIREMENT THAT THE COMPREHENSIVE ASSESSMENT BE COMPLETED WITHIN 60 DAYS DOES NOT PRECLUDE THE INITIATION OR COMPLETION	Thank you for your feedback. The timeliness standards in the chapter will remain as drafted at this time.

OF THE COMPREHENSIVE ASSESSMENT OR THE PROVISION OF TREATMENT DURING THE INTERVENING 60 DAY PERIOD. In an IOP program the individual is receiving 9 or more hours a week of care, if no assessment is completed for 60 days this is 50 hours of treatment provided with no comprehensive assessment. This seems like an excessive amount of treatment provided with no comprehensive assessment completed. How can an individualized service plan be implemented without assessment information. When you are seeing individuals 3 or more times a week, it seems reasonable to complete an assessment within two weeks to mirror the completion of the service plan. Suggestion: D. AS SOON AS IS PRACTICABLE UPON ADMISSION, BUT NO LATER THAN SIXTY (60) FOURTEEN (14) CALENDAR DAYS FROM THE FIRST DATE OF SERVICES, THE AGENCY MUST COMPLETE A COMPREHENSIVE ASSESSMENT IN ACCORDANCE WITH PART 2.12.3 OF THESE RULES. THE REQUIREMENT THAT THE COMPREHENSIVE ASSESSMENT BE COMPLETED WITHIN 14 60 DAYS DOES NOT PRECLUDE THE INITIATION OR COMPLETION OF THE COMPREHENSIVE ASSESSMENT OR THE PROVISION OF TREATMENT DURING THE INTERVENING 14 60 DAY PERIOD.	
7.7.1.H According to ASAM, an PHP level of care should provide individuals with "medical, psychological, psychiatric, laboratory and toxicology services which are available through consultation or referral. Psychiatric and other medical consultation is available within 8 hours by telephone and within 48 hours in person." and "emergency services, which access to "emergency services, which are available by telephone 24 hours a day, 7 days a week when the treatment program is not in session"(The ASAM Criteria, 3rd Ed, p 208) While the hotline can address some emergent needs, we believe that providers should be available to to share information and coordinate care for their clients in the event of an emergency during a treatment stay. The current language is ambiguous about the responsibility of the program to provide emergency information for the purpose of coordination of care. Suggestion: AGENCIES PROVIDING PHP SERVICES MUST PROVIDE INFORM	Thank you for your feedback. The language will remain as drafted at this time.

INDIVIDUALS RECEIVING TREATMENT HOW TO ACCESS EMERGENCY SERVICES BY TELEPHONE TWENTY-FOUR (24) HOURS PER DAY, SEVEN (7) DAYS PER WEEK WHEN THE PROGRAM IS NOT IN SESSION. AT MINIMUM, AGENCIES MUST PROVIDE EMERGENCY SERVICES INFORMATION THAT INCLUDES CONTACT INFORMATION FOR SERVICES PROVIDED BY THE BEHAVIORAL HEALTH CRISIS RESPONSE SYSTEM CREATED PURSUANT TO SECTION 27-60-103, C.R.S.	
7.7.1.H According to ASAM, an PHP level of care should provide individuals with "medical, psychological, psychiatric, laboratory and toxicology services which are available through consultation or referral. (The ASAM Criteria, 3rd Ed, p 208) Suggestion: "3. AGENCIES PROVIDING PHP SERVICES MUST HAVE A DOCUMENTED CONSULTATION PROCESS THROUGH INTERNAL STAFF OR OTHER AFFILIATION FOR MEDICAL, PSYCHIATRIC, AND MEDICATION ASSISTED TREATMENT NEEDS.	Thank you for your feedback. Suggested language has been added.
7.7.4.D In a PHP program the individual is receiving 20 or more hours a week of care, if no assessment is completed for 60 days this is 160 hours of treatment provided with no comprehensive assessment. This seems like an excessive amount of treatment provided with no comprehensive assessment completed. How can an individualized service plan be implemented without assessment information. When you are seeing individuals 5 or more times a week, it seems reasonable to complete an assessment within one week along with a service plan. Suggestion: "D. AS SOON AS IS PRACTICABLE UPON ADMISSION, BUT NO LATER THAN SIXTY (60) TEN (10) CALENDAR DAYS FROM THE FIRST DATE OF SERVICES, THE AGENCY MUST COMPLETE A COMPREHENSIVE ASSESSMENT IN ACCORDANCE WITH PART 2.12.3 OF THESE RULES. THE REQUIREMENT THAT THE COMPREHENSIVE ASSESSMENT BE COMPLETED WITHIN 10 60 DAYS DOES NOT PRECLUDE THE INITIATION OR COMPLETION OF THE COMPREHENSIVE ASSESSMENT OR THE PROVISION OF TREATMENT DURING THE INTERVENING 10 60 DAY PERIOD.	Thank you for your feedback. The timeliness standards in the chapter will remain as drafted at this time.

7.7.4.E In a PHP program the individual is receiving 20 or more hours a week of care, if no assessment is completed for 60 days this is 160 hours of treatment provided with no comprehensive assessment. This seems like an excessive amount of treatment provided with no comprehensive assessment completed. How can an individualized service plan be implemented without assessment information. When you are seeing individuals 5 or more times a week, it seems reasonable to complete an assessment within one week along with a service plan. Suggestion: THE INDIVIDUAL SERVICE PLAN MUST BE CREATED, IN ACCORDANCE WITH PART 2.13.2 OF THESE RULES, WITHIN FOURTEEN (14) TEN (10) CALENDAR DAYS AFTER INITIAL ASSESSMENT.	Thank you for your feedback. The timeliness standards in the chapter will remain as drafted at this time.
7.8.3.F This is an important concept for ALL WM programs. It appears that this may have been cut and pasted without changing the level of care. Suggestion: "LEVEL 2 3.2-WM PROGRAMS SHALL PROVIDE ASSESSMENTS OF INDIVIDUAL READINESS FOR TREATMENT AND INTERVENTIONS BASED ON THE SERVICE PLAN AND THE ASSESSMENTS AND INTERVENTIONS SHALL BE DOCUMENTED IN THE INDIVIDUAL'S RECORD. Ensure that these requirements are incorporated in all WM levels of care."	Thank you for your feedback. This has been edited.
7.2.1.C - adapted to meet cultural needs Suggestion: ALL SERVICES PROVIDED MUST BE ADAPTED TO THE INDIVIDUAL'S DEVELOPMENTAL STAGE AND PHYSICAL AND CULTURAL AND COMPREHENSIVE NEEDS	Thank you for your feedback. Suggested language has been added.
7.2.2 PERSONNEL B., 1. 1. PERSONNEL MUST HAVE SUPERVISOR CONSULTATION AVAILABLE WITHIN ONE (1) HOUR VIA IN-PERSON OR BY TELEPHONE TO DISCUSS, WHEN WARRANTED CRISIS AND/OR EMERGENCY SITUATIONS. Propose to include remote supervision and via telehealth.	Thank you for your feedback. Suggested telehealth language has been added for consultation/supervision.

7.3.2 PERSONNEL C. C. AGENCIES PROVIDING OUTPATIENT SERVICES MUST ENSURE TREATMENT PERSONNEL HAVE SUPERVISOR CONSULTATION AVAILABLE WITHIN TWENTY-FOUR (24) HOURS VIA IN-PERSON OR BY TELEPHONE TO DISCUSS, WHEN WARRANTED, AT MINIMUM, PSYCHIATRIC OR MEDICAL CONCERNS OF INDIVIDUALS RECEIVING SERVICES. Propose to include telehealth supervision.	Thank you for your feedback. Suggested telehealth language has been added for consultation/supervision.
7.3.2 PERSONNEL C., 1. 1. PERSONNEL MUST HAVE SUPERVISOR CONSULTATION AVAILABLE WITHIN ONE (1) HOUR VIA IN-PERSON OR TELEPHONE TO DISCUSS, WHEN WARRANTED CRISIS AND/OR EMERGENCY SITUATIONS. Propose to include telehealth consultation.	Thank you for your feedback. Suggested telehealth language has been added for consultation/supervision.
7.3.3 SERVICE PROVISIONS C. Propose to add language: "and family, when appropriate." C. WHEN REFERRAL(S) ARE NEEDED TO BEST MEET THE INDIVIDUAL ASSESSED NEEDS, REFERRAL(S) WILL BE PROVIDED IN COLLABORATION WITH THE INDIVIDUAL AND FAMILY, WHEN APPROPRIATE.	Thank you for your feedback. This addition was not added at this time and will be reviewed for future revisions.
7.4 MINOR IN POSSESSION (MIP): EDUCATION AND TREATMENT SERVICES STANDARDS Suggest this be moved to the criminal justice section. It's confusing being in the general OP section.	Thank you for your feedback. MIP is not a criminal offense and does not fit within the constructs of the Criminal Justice chapter.
Residential Services (formerly Chapter 8; now Chapter 5)	
Chapter 8: Requiring treatment programs to provide/accommodate MAT. I feel it is crucial to specify that RESIDENTIAL programs must accommodate ALL MAT options (suboxone and methadone) or provide reasons why methadone is not feasible/barriers to this. In the age of fentanyl, suboxone is often not adequate in preventing cravings/withdrawal and people should not have to choose between residential treatment and medications. The current language refers to "MAT" but programs could still deny patients because they are on methadone.	Thank you for the feedback. This requirement already exists in Chapter 2 regulations for all BHEs. In Part 2.11, we have added "ANY" before MAT to make sure this is adequately addressed in response to this comment.
Group sizes will be capped at 12. Is there going	Thank you for the comment. The maximum number of

to be a waiver from group size based on fellowship programs so they don't dissolve.	attendees in a group is intended for clinically-focused groups, which likely would not impact fellowship or supportive-type groups. In the case that this does impact the group, the rule would be eligible for a waiver application subject to the approval of the Waiver Committee.
Received 13 comments and concerns about the future of Level 3.2-WM services with the anticipated 4th Edition of ASAM.	Thank you for the feedback. These proposed rules are based on the 3rd Edition of ASAM and will remain in effect until the BHA promulgates new rules that are specific to the 4th Edition of ASAM. This will be its own stakeholder process and involve all impacted systems, including HCPF.
Is there a training requirement for Medication Assisted Treatment (MAT)? That should be across-the-board, just some basic training to ensure the knowledge base is present and to connect people, when applicable.	Thank you for the suggestion. This has been added to Chapter 2 and is more broadly applicable.
Comment regarding WM integration: Really appreciate the BHA's rewrite on this!!	Thank you for your comment.
Are we letting courts determine a level of care? I saw it said provider will determine length of stay, but should they be able to refer to residential without an assessment?	Thank you for the question. The language in these proposed rules is reflective of current state practices, in which individuals are referred to a certain level of care based on an assessment process completed by a Criminal Justice (CJ) agent. The rules then require the provider to evaluate for placement, services, and length of stay congruence, then address discrepancies with the CJ agent, and document the result of that discussion.
One major issue is that 3.2-WM does not require a full clinical staffing pattern. It has the oversight of someone with a CAS, and staff are working towards CAT or CAS, but that leads to a disconnect with documentation. The staff that are there every day are not credentialed and this leads to a disconnect with Medicaid and MSOs that "ding" us during audits. Need to look at alignment, as this causes a lot of issues.	Thank you for the feedback. This alignment will require more time and systems involvement than can be completed in this rule promulgation and will be considered in a future rule update.
What is the timeline, and is the new standard going to be 3.7. We will not be able to staff.	Thank you for this question, related to the State of Colorado future alignment with 4th Edition ASAM standards. A timeline and expectation for this future rule process has not been set.
For Counselors-in-training, what are they in training to be? CAT? CAS? in a master's program?	The definition of counselors-in-training can be found in Part 1.3 in Chapter 1. This includes those in training for such professions as psychologists, social workers, LPCs, and addiction counselors.
Are CAT's included in CIT? Are CAS's?	Yes, CATs and CASs in their training prior to receiving their certifications would be included in the CIT definition.
Is co-occurring a requirement, or an extra service that can be billed separately for 3.5?	Co-occurring is not a requirement for the 3.5 endorsement. An agency can choose to provide only 3.5 SUD services, or can add co-occurring. However, these regulations do not speak to billing procedures.
Is there a change in frequency for required documentation for weekly planned treatment	Thank you for the question. Stakeholder input was split over the minimum frequency of documentation

activities to daily in therapeutic communities?	required in an ASAM 3.5 level of care, as this is a high-intensity service and weekly documentation reflects lower residential needs. The proposed rules now strike a balance between the feedback received, as follows: 1. Daily progress notes are required for the first thirty (30) days of the residential stay for all individuals receiving ASAM 3.5 services, 2. Daily progress notes remain required for anticipated length of stay of three months or less, and 3. Weekly progress notes are permissible after the first 30 days in situations where anticipated length of stay is more than three months.
Some of the training requirements in this chapter would be more broadly applicable to BHEs, and are not only specific to withdrawal management. Should these be placed in a more broadly applicable chapter and then the training that is specific to the withdrawal management population and setting highlighted?	Thank you for the feedback. The more broadly applicable trainings were added to Chapter 2 provisions.
Part 8.x states that the WM agency must post procedures for periods of high census, but that does not make much sense. Is the intention of this to alert to divert status? If so, it should say that.	Thank you for the feedback. A "DIVERT STATUS" definition was added and the related rules modified to read: THE AGENCY MUST CONSPICUOUSLY POST PROCEDURES FOR RESPONDING TO CIRCUMSTANCES AND EVENTS THAT WARRANT ENTERING A DIVERT STATUS.
Regarding Part 8.7.4.C.1 Observation and Monitoring Requirements - What are we doing with these vitals that are required to be taken every 2 hours? My agency is struggling with the portion of this rule that allows the non-medical staff to make the determination of what the individual's "baseline" is. This is more of a medical determination and is out of scope for non-medical personnel.	Thank you for the feedback. The language in these proposed rules is reflective of current state practices in Level 3.2-WM, and is intended to ensure individual health, safety and welfare.
Regarding Part 8.7.4.C.1 Observation and Monitoring - My agency is a 3.2-WM and I want to second that question about the vitals every 2 hours. Keep in mind that individuals in this setting may have gone without sleep for a number of days, and if you don't have a medical provider to help decide what the individual's "baseline" is, you just keep taking vitals and now disrupting their sleep.	Thank you for the feedback. The language in these proposed rules is reflective of current state practices in Level 3.2-WM, and is intended to ensure individual health, safety and welfare.
Will Assisted Living Residences (ALR) currently licensed with CDPHE move to the BHA license with a residential endorsement or remain with CDPHE?	Both of those facilities will remain licensed as ALRs with CDPHE at this time.
Facility 1 is providing long term care. Employees assist individuals with ADL's and care	

coordination. The typical stay is 3-10 years. The consumers have long term care Medicaid and a HCBS waiver. The facility operates and is overseen 24/7/365. The consumers receive mental health services on site. Facility 2 provides short term transitional care to stabilize mental health symptoms. The typical stay is 1 month. The consumers have regular Medicaid and no waivers. The facility operates and is overseen 24/7/365. The consumers receive intensive mental health services on site.	
8.5.3.G - A Comprehensive preadmission assessment seems to be extra documentation for individuals entering Residential. Would a screening provide enough information to determine appropriateness of level of care?	Thank you for the comment. The comprehensive pre admission assessment information becomes part of the individual's record and can then be utilized to inform proper placement for required services. A screening is unlikely to capture the information required.
It seems unclear whether Assisted Living Residences (ALR) will be licensed under chapter 8. ALR fits the definition of ALR in Chapter 1 and 8, however the sections in Chapter 8 only cover programs specializing in Substance Use services.	Thank you for the question. Facilities currently licensed as ALRs will remain licensed by CDPHE at this time.
8.7.4.A - Completing initial paperwork will not always be practicable within 3 hours of arrival due to the level of functioning of consumers entering Detox services.	Thank you for the comment. This timeframe was selected to be practicable in most situations. If this expectation is not practicable with a particular individual, the agency should document this in the client record as an exception.
8.5.2 H It seems that given the risk involved in driving around a client without any visual supervision, the background check findings should have been delivered and reviewed before an individual can provide transportation. H. PERSONNEL PROVIDING NON-MEDICAL TRANSPORTATION TO INDIVIDUALS MUST MEETS THE FOLLOWING REQUIREMENTS: 5. HAS COMPLETED A COLORADO OR NATIONAL-BASED CRIMINAL HISTORY RECORD CHECK,AND THE RESULTS OF THE CHECK HAVE BEEN REVIEWED BY THE AGENCY.	Thank you for the comment. All documentation that is submitted as part of one's personnel file is expected to be reviewed by the agency.
8.6.4 A & 8.10.4 A Add a requirement for level of care screening. AGENCIES MUST COMPLETE AND DOCUMENT THE FOLLOWING ITEMS IN THE INDIVIDUAL'S RECORD WITHIN TWENTY-FOUR (24) HOURS OF ADMISSION: (5) SCREENING FOR APPROPRIATENESS FOR THE LEVEL OF CARE	Thank you for your comment. We have added the following in response: B. SCREENINGS AND ASSESSMENTS CONDUCTED IN ACCORDANCE WITH 5.6.4(A) SHALL BE USED TO DETERMINE APPROPRIATENESS FOR THIS LEVEL OF CARE.
3.5 is a high intensity level of care. If weekly progress notes can be allowed, the individual probably is more appropriate in acuity for a 3.1	Thank you for your feedback. The BHA has included your suggestion in the proposed rules.

program. Further, during the first month of residential treatment, there should be increased monitoring. It seems more appropriate to require daily notes for three months and then if the person stays longer, move to weekly notes. PROGRESS NOTES MUST BE PRESENT IN THE INDIVIDUAL'S RECORD, IN ACCORDANCE WITH PART 2.13.3 OF THESE RULES. THE MINIMUM FREQUENCY OF PROGRESS NOTE COMPLETION FOR THIS LEVEL OF CARE MAY VARY, DEPENDING UPON THE INDIVIDUAL'S TIME IN THE LEVEL OF CARE, ANTICIPATED LENGTH OF STAY FOR OF INDIVIDUALS SERVED BY THE AGENCY. 1. FOR THE FIRST 30 DAYS OF THE STAY, DAILY PROGRESS NOTES ARE REQUIRED; 2. 1. AFTER THE FIRST 30 DAYS WHEN THERE IS AN ANTICIPATED LENGTH OF STAY OF THREE (3) MONTHS OR LESS: CONTINUED REQUIRED DAILY PROGRESS NOTES. 2. 3. AFTER THE FIRST 30 DAYS WHEN THERE IS AN ANTICIPATED LENGTH OF STAY OF MORE THAN THREE (3) MONTHS: REQUIRED MINIMUM OF WEEKLY PROGRESS NOTES.	
Add requirement that 3.7 personnel understand MAT as it relates to withdrawal from opioids PERSONNEL MUST BE TRAINED IN, AND EVALUATED IN KNOWLEDGE OF THE FOLLOWING AREAS BEFORE PROVIDING SERVICES INDEPENDENTLY: 1. WITHDRAWAL MANAGEMENT AND MEDICATION ASSISTED TREATMENT;	Thank you for the feedback. A training requirement regarding MAT services was added to Chapter 2, to be more broadly applicable. Review language at Part 2.5.1.1 for details.
Medical Directors should also review occurrences such as reportable medication errors, deaths and the program's medical policies 2. THE MEDICAL DIRECTOR'S RESPONSIBILITIES MUST INCLUDE, AT MINIMUM: g. REVIEW OF CRITICAL INCIDENTS THAT ARE REPORTABLE TO THE STATE; h. REVIEW OF ADMISSION, MEDICAL EXCLUSION AND MEDICAL CARE POLICIES AT LEAST ANNUALLY	Thank you for the feedback. This change has been added to the draft.
8.1.1 o Should this definition include the scale and frequency?	Thank you for the comment. We were unable to find content relevant to the citation in the residential services Chapter 8. If this comment is related to IOP services, Service Provision section provides the expectations for contact hours and planned format of treatment services.
• 8.1.4 (A) - (E) o (C) Audio Only Telehealth is not congruent with the coding manual. BHA needs to connect with HCPF.	Thank you for the comment. We are unable to find the citation or contact provided in the residential services Chapter 8. If this comment was intended for the Outpatient services chapter and utilization of audio-only services, this was reviewed with HCPF and

	is a permissible service.
• 8.1.6 (A) - (E) - o Observation: We can currently run IOP with bachelor level staff – this proposal is in contrast to the promise to the for the behavioral health aide position that should address staffing issues	Thank you for the comment. We are unable to find the citation or content provided in the residential services Chapter 8. If this comment was intended for the Outpatient services chapter regarding IOP services, this allows for Counselors-in-Training and Interns to be part of the treatment personnel, up to 25%, with supervision and co-signatures.
• 8.1.8 (A) - (F) - o Sometimes there will be multiple LOC's and this needs to be clarified in the rule. We'd like to see what this looks like in practice with multiple LOC's	Thank you for the comment. We are unable to find the citation or content provided in the chapter search.
• 8.2 - o Requesting clarification because we have IP what does this mean for licensing?	Thank you for the comment. We are unable to find the citation or content provided in the chapter search.
8.3.1 SERVICE DELIVERY AND SETTING B., 1. B. THE AGENCY MUST HAVE PHYSICAL BARRIERS SUCH AS DOORS AND WALLS AND PERSONNEL OVERSIGHT OF ACTIVITIES TO ENSURE SAFETY FOR ALL PERSONNEL AND INDIVIDUALS SERVED. THIS MANAGEMENT MAY ALSO INCLUDE, BUT IS NOT LIMITED TO: Propose edit: 1. PERSONNEL OVERSIGHT, SUCH AS WORK STATIONS THAT SEPARATE LIVING SPACE ASSIGNMENTS, THAT ENSURES SAFETY FOR ALL PERSONNEL AND INDIVIDUALS SERVED	Thank you for the suggestion. The inclusion of “such as” provides more guidance without being prescriptive, and we will move forward with that language.
8.4.3 GENERAL PROVISIONS C., 2 Proposed edit: Strike “all” 2. THE AGENCY MUST DEVELOP POLICIES AND PROCEDURES REGARDING HOUSE RULES WHICH INCLUDES A LIST OF ALL POSSIBLE ACTIONS WHICH MAY BE TAKEN BY THE AGENCY IF ANY RULE IS KNOWINGLY VIOLATED	Thank you for the suggestion. This requirement is intended to provide the individual receiving services with a full understanding of what may occur if a House Rule is knowingly violated, and requires the list of actions to be comprehensive in order to achieve that intention.
Emergency and Crisis Behavioral Health Services (formerly Chapter 9; now Chapter 6)	
9.5.3.C: I do not see any kind of resource navigation in tasks of the agency. Many people are in crisis because they need connection to resources like food, housing, financial assistance, etc. Resource navigation or a warm handoff to resource navigation should be here. 9.3.B How will the agency prove that they are	9.5.3.C - Thank you for your feedback. 9.5.3.A states “WALK-IN CRISIS SERVICES MUST INCLUDE SCREENING AS DEFINED IN PART 2.12.1, TRIAGE, CRISIS ASSESSMENT, AND REFERRALS TO APPROPRIATE RESOURCES. INDIVIDUALS IN CRISIS MUST BE SCREENED AND TRIAGED WITHIN FIFTEEN (15) MINUTES OF ARRIVAL.”. 9.5.3.C.4 discusses referral and warm handoff requirements as

able to work with these different populations? Many agencies say they can work with people with cognitive disabilities or other disabilities and have no competency whatsoever working with us. 9.8.2 If the state wants to invest in more peer based respite models, these criteria do NOT fit with what the states that do it right do for peer respites. These states include Wisconsin and Massachusetts. I think that Peer respite should be a separate thing as the criteria should be different. (Perhaps that will come with peer support professional rule making?) For instance, peer respites in the state I mentioned ARE for people who are in crisis and meet hold criteria. This is part of why peer respites exist. Because forced hospitalization doesn't work for people and people in crisis need peer based models that aren't carceral.	well. 9.3.B - Thank you for your question. Facilities will keep personnel training in personnel files in such competencies that the BHA may request at any time. As an individual seeking services, you are also able to request credentials and training information from whom you are receiving services. 9.8.2 - Thank you for your suggestion. This is something we will be looking into for future rule revisions.
9.7.4 Mobile Crisis This has changed completely, 2 clinician response, this increases costs, this has cut out services to jails, detox centers, those are places that consume those services. Confusion around what exists in statewide programs, contracts or regulations and how they work together.	Thank you for your feedback. The definition of paired mobile response states: "PAIRED MOBILE RESPONSE" MEANS A MOBILE CRISIS RESPONSE IN WHICH TWO PERSONNEL RESPOND, ONE PERSON ON SCENE AND THE OTHER PERSON ON SCENE OR VIA TELEHEALTH. BOTH MEMBERS OF THE PAIRED RESPONSE SHOULD BE CRISIS PROFESSIONALS. Please note this does not mean two clinicians must respond, rather two personnel and one of those members may respond via telehealth. While both members still need to be "crisis professionals", this means mobile crisis team members will need to complete training from the BHA, not that they must be clinician level.
9.7.4.A and 9.7.4.C is concerning that mobile crisis teams are required to have access to 24/7 peer support professionals. This is not always possible in rural communities, especially with lack of reception, internet, etc. How are we supposed to comply with this? This will put us out of business.	Thank you for your feedback. The 24/7 peer support professional requirement has been removed from the crisis chapter entirely.
How are we supposed to comply with the peer support specialists training from the BHA when that training hasn't occurred yet? It says statutorily that we must be certified by July 1, 2023 but the training isn't available.	Thank you for your question. The crisis professional training will be available in Fall 2023.
If telehealth is not available in certain areas but you're saying that a mobile response requires 24/7 peer support professional access and you have a laptop that it freezes. How are we supposed to comply with this? we need funding on this	Thank you for your feedback. The 24/7 peer support professional requirement has been removed from the crisis chapter entirely.
With Crisis intervention, often it's 1st responders,	Thank you for your question. Because the BHA does not

is there anything that says if it is a BH crisis, that there's an actual BH therapist or someone there to intervene rather than have it go straight to CJ or law enforcement? How do we get that? Would that be the department of justice for law enforcement? How do we get them intertwined with the BHA. They don't know what a BH or MH crisis is. They only know what the statute says, they don't know what is criminal versus BH crises.	regulate law enforcement, there are limitations on that. We do have rules regulating mobile crisis response. Ideally, Mobile Crisis teams are intervening prior to law enforcement and that if law enforcement gets involved, they are helping people get connected to services. The BHA also has a number of required training for involuntary services. We will be training law enforcement, EMS, court systems etc.
Concern about WIC requiring an on site crisis professional. Can this be done through telehealth?	Thank you for your question. WICs must always have a crisis professional on site, this may not be done through telehealth.
For WIC Safety Planning, Referrals, & Follow up: remove "be attempted" from :Appointments should be attempted to be scheduled within seven (7) business days of referral	Thank you for your feedback. Language has been changed to "AGENCY PERSONNEL MUST MAKE DOCUMENTED EFFORTS TO SCHEDULE FOLLOW-UP APPOINTMENTS WITHIN SEVEN (7) BUSINESS DAYS OF REFERRAL."
Regarding: "Follow up by a member of the responding team". Consider clarifying this language, you're not saying the exact same staff that initially responded to the individual crisis have to be the ones to do follow up. It can be any staff member who can do the follow up	Thank you for your feedback. Correct, any personnel providing crisis response services may provide follow up. Clarifying language has been added.
If a CSU is not 27-65 designated how will they be able to manage a person on a hold or certification? Does that mean they would have to referral out for coordinated care?	Thank you for your question. If the CSU is not designated to provide such 27-65 services, then the CSU would need to coordinate with another provider.
When you say 24/7 access to peers have been removed; is there a minimum requirement to access?	Thank you for your question. We have added language to clarify this "A PEER SUPPORT PROFESSIONAL MUST BE AVAILABLE FOR FOLLOW UP SERVICES WITHIN ONE BUSINESS DAY OF THE CRISIS RESPONSE."
Regarding "be referred by personnel with BH crisis system", previously it was only mobile crisis or WIC who could do the referral. Does this mean that now CSU can refer?	Thank you for your question. We received feedback that the previous language that only included mobile or WIC personnel referrals was restrictive. This change was made so more individuals have the opportunity to receive respite care services. Current rule language would suggest that CSUs and any other provider part of the BH crisis system may refer individuals to respite assuming that it is the most appropriate treatment setting.
I didn't see any staffing guidance/ratio requirements/credentials in this [ATU] section, will that be added?	Thank you for your question. Because ATUs will be 27-65 designated, all 27-65 personnel requirements will apply here. Because of this, we have not added any other requirements to this part. Please see Chapter 11 for those requirements.
If WICs will be required to prevent elopement to those on a M1, does that mean that WICs will need to have the ability to follow restraint criteria and be locked facilities? How can you prevent elopement in a "hands-off" facility?	Thank you for your question. WICs must be 27-65 designated. The option to use seclusion and restraint is available, but not required.

So for facilities that choose not to use seclusion or restraint, is there guidance on how to prevent elopement? We are not utilizing seclusion or restraint. If someone on a M1 is going to run out the door and elope we're calling police and getting them help in that way but we're not running after them and tackling them. So the facility is not using seclusion and restraint or a locked facility.	Thank you for your question. We do not speak to alternatives. If a facility is using seclusion and restraint, the BHA is interested in ensuring that it is done in compliance with the regulations and to ensure the safety of individuals, but we do not regulate to any specific alternatives. This is an area of deep concern for all of us because restraint and seclusion, though could be argued, is used for protection, it can also be a traumatic event for individuals. Because of this, we are not requiring a facility to do restraint and seclusion, but if they choose to, they must do so in accordance with the regulations. A facility does need to consider how they will address such situations and develop policies and procedures around that and think about other alternatives that can address the same purpose. This may be individual specific also when you consider a trauma informed approach.
We only use physical management (on our ATU); not S&R. Is this an acceptable alternative on the WIC (elopement of someone on a hold)?	Thank you for your question. We are not requiring seclusion and restraint, rather it is an option if the facility chooses to use it. If not using seclusion and restraint, the facility needs to put alternate policies and procedures to prevent elopement for individuals on an M1 hold. Though please note the changes to the physical management rules as well.
Follow up on CSU. so they will not have free egress and not locked or secured in nature.	Thank you for your question. ATUs will be a locked setting as they are required to obtain a 27-65 designation. CSUs, if choosing to obtain a 27-65 designation, will also have to be locked.
But in order to be a CSU, an entity has to be an ATU or Community Clinic to be a CSU you have to be an ATU or community clinic, and to be an ATU you would have to be 27-65 designated.	Thank you for your feedback. That is correct for previous rules at CDPHE. With passage of HB 19-1237, ATUs and CSUs are now licensed as BHEs. In regards to ATUs being designated, ATU is an endorsement type, and CDPHE has required ATUs to be 27-65 designated. Now there will be two separate endorsements for CSUs and ATUs and ATUs will be required to obtain a 27-65 designation. It will be optional for a CSU to obtain a 27-65 designation.
We could suggest each mobile crisis response intervention requires offering peer specialist support services as a follow-up to the initial mobile crisis intervention. The follow-up peer outreach, if accepted by the individual served by MCR, shall be offered within one business day of the crisis intervention.	Thank you for your suggestion. Peer language has been added. Follow up requirements have been updated to reflect follow-up to be provided within 24 hrs of services being provided to an individual.
9.2 - Definition of Crisis Professional includes "Crisis professional training approved by the BHA, specific to crisis assessment management, de-escalation, safety planning and all relevant laws and provisions" What does this training look like, is it currently available?	Thank you for your question. This training is not yet available. The BHA anticipates the training to be available in the Fall to be ready for providers to meet their regulatory requirements starting January 1, 2024. When available, it will be posted to the BHA website.
9.3.B - Rule talks about each component within the Behavioral Response system as a whole	Thank you for your question. Crisis providers wanting to participate in the crisis response system must be

identified must be capable of servicing all consumers even those unable to pay. Does this suggest that any program that might be a part of the system needs to be contracted within the Crisis Response system?	contracted with an administrative services organization (ASO). This will be changing with the upcoming BHASO implementation.
9.5.2.A - Does the WIC program need the 27-65 designation for that location or the agency as a whole?	Thank you for your question. All Walk In Crisis centers are required to obtain a 27-65 designation. This is address/unit-specific to the facility that will be providing such services.
9.5.1.C - "Walk-in crisis service agencies must collaborate with the Crisis response system" what does this mean?	Thank you for your question. Behavioral health crisis response system means other provider types within the crisis response system (ex: mobile crisis collaborating with a CSU).
9.5.3.C.3 - How is it indicated that a WIC will be able to do physical health screening?	Thank you for your question. Clarifying language added "PHYSICAL HEALTH SCREENS MAY BE PROVIDED BY QUALIFIED WIC PERSONNEL OR THROUGH COORDINATION OR /REFERRAL TO A MEDICAL PROVIDER."
9.5.2.D - Not sure how to manage and prevent elopement of individuals on holds while adhering to patient rights.	Thank you for your feedback. Facilities must create policies and procedures to manage and prevent the elopement of individuals on holds.
9.5.2.H - Required follow up services may not always be possible, depending on the individuals current financial, housing, support and/or communication availability.	Thank you for your feedback. A follow-up attempt must be made and documented in the individual's record.
9.5.4.D - WIC: Must have Crisis professional on site at all times seems difficult to manage considering current staffing limitations.	Thank you for your feedback. A crisis professional must be on site at all times. A number of credential levels may become crisis professionals, which is intended to relieve current staffing restrictions.
Crisis and emergency services it states, "must have the ability to manage and prevent elopement of individuals on an M1" does this mean that WIC's will be able to put hands on and utilize seclusion/ restraint as needed? Does this allow for the WIC to be locked or will it maintain as egress?	Thank you for your question. WICs are required to obtain a 27-65 designation. WICs will have the option to use seclusion and restraint, but it is not required. Regulations do not specify that the WIC needs to be locked or remain as egress, so either option is permissible.
With the ATU designation going away, what will this mean for centers that currently have both CSU and ATU units? Will the IMD rules apply for units that are on the same property? Concern: this will further decrease accessible beds in the state. Also, we will need to renegotiate all contracts due to CSU not being reimbursed by many private insurance companies. When will these changes go into effect?	Thank you for your feedback. We are no longer combining ATU and CSU into one service type. ATU and CSU will remain in their current state.
Could there be language in the crisis chapter of "provide or ensure a referral path to..." the required crisis services/levels of care	Thank you for your question. There are multiple areas within the crisis chapter that speak to direct referrals and warm handoffs.

Pg. 5: I really appreciate the call out to work with hospitals on clearance practices to avoid individuals in the ED for the purpose of verifying medical stability. However, where's the accountability for this to actually happen? WICs should be required to have an individual available to perform medical clearances in the personnel requirements section on pg. 8.	Thank you for your question. WICs are required to be able to complete a physical health screen, if indicated.
Mobile crisis should continue to support a crisis wherever it occurs, including hospitals that do not have full-time behavioral health staff or locations like residential child care facilities. If we do not allow dispatch to those locations, police will continue to be a part of the crisis system which is inappropriate and harmful to individuals.	Thank you for your feedback. Due to new federal requirements, mobile crisis is unable to respond to hospitals or other facilities.
9.9.2 STANDARDS FOR ACUTE TREATMENT SERVICES SUCH LOCATIONS SHALL COMPLY WITH THE STANDARDS INCLUDED IN PART 2.7 OF THESE RULES, UNTIL SUCH TIME AS AN FGI COMPLIANCE REVIEW IS TRIGGERED IN ACCORDANCE WITH PART 2.7.H OF THESE RULES, AT WHICH TIME FGI SHALL APPLY ONLY TO THE IMPACTED AREAS WHILE THE REMAINING AREAS CONTINUE TO COMPLY WITH PART 2.7 OF THESE RULES. Comment: Do/will FGI rules still apply at the ATU? I believe adjustments are being made overall regarding FGI so it may be that the chapter was not yet updated.	Thank you for your question. All FGI requirements have been removed.
Section 9.2 defines an Acute Treatment Unit as, "A AGENCY OR A DISTINCT PART OF A AGENCY, LICENSED PURSUANT TO THIS CHAPTER 9 FOR SHORT-TERM PSYCHIATRIC CARE, WHICH MAY INCLUDE TREATMENT FOR SUBSTANCE USE DISORDERS, THAT PROVIDES A TOTAL, TWENTY-FOUR-HOUR, THERAPEUTICALLY PLANNED AND PROFESSIONALLY STAFFED ENVIRONMENT FOR INDIVIDUALS WHO DO NOT REQUIRE INPATIENT HOSPITALIZATION BUT NEED MORE INTENSE AND INDIVIDUAL SERVICES THAN ARE AVAILABLE ON AN OUTPATIENT BASIS, SUCH AS CRISIS MANAGEMENT AND STABILIZATION SERVICES." Per this definition, it is unclear whether 23-hour high-acuity crisis observation services can be included under an Acute Treatment Unit endorsement or two separate and distinct	Thank you for your feedback. This is something we will be taking into consideration in future rule revisions. For now, all ATU and CSU rules, including definitions, will remain in their current state.

endorsements are required. Connections has pioneered the 23-hour observation crisis model of care, which provides 24/7, medically staffed (MD, NP, PA, RN), psychiatric crisis stabilization services for individuals who need more intense and individual services than are available in most outpatient settings. The model includes treating individuals of all levels of acuity, including co-occurring SUD, active withdrawal, patients brought involuntarily, and acute danger to self/others, stabilizing 65-70% in under 24 hours. Due to its sub-24-hour length of stay, Connections has in the past licensed some of its services as outpatient services, but if licensed as part of the ATU, it would allow for a seamless transition of care to residential/inpatient services if needed. While it is clear from Section 9.9.1 that, “ALL AGENCIES PROVIDING ACUTE TREATMENT SERVICES SHALL MEET THE RESIDENTIAL/OVERNIGHT STANDARDS IN PART 2.26,” if those standards are met, it is unclear whether the Acute Treatment Unit endorsement covers high-acuity crisis intervention services with an average length of stay of less than 24 hours. The regulations should clarify whether outpatient services, such as behavioral health high-intensity outpatient services and walk-in crisis services can be included under the Acute Treatment Unit residential/overnight endorsement.	
9.5.2 (F) o Duplicate?	Thank you for your question. This has been removed.
9.5.2 (H) o Requesting clarification regarding	Thank you for your feedback. Clarification has been added.
9.6.1 o BHA states license should be ATU our contract is CSU	Thank you for your comment. A Behavioral Health Entity (BHE) must obtain a base BHE license and may choose to obtain both or either an ATU or CSU endorsement.
9.7.3 (G) o What if the staff member does not work within the proposed 24-hour follow-up time frame? BHA states “member of the responding mobile crisis team”	Thank you for your question. Language has been added to clarify that anyone may do the follow up.
9.7.4 o Requesting clarification (A) & (E) contradict 9.5.2 (H)	Thank you for your comment. These are two different sections and discuss Mobile vs WIC requirements.
9.8.4 (A) o We do not serve children in respite; do we need this?	Thank you for your question. Serving children and families is not required, however, if a BHE chooses to serve that population, they must obtain the children and families endorsement in order to be in compliance.

9.9.2 (5) - o Would this mean the shortened assessment and full assessment? ▪ This does not reduce administrative burden. - o Does a licensed individual have to complete the comprehensive assessment?	Thank you for your question. If the initial crisis assessment indicated further treatment, the treating facility must also complete a comprehensive assessment. Please see comprehensive assessment information in Part 2.13.3 regarding who is eligible to complete it.
• 9.9.2 (B) o Do we have to have our staff trained as crisis professionals?	Thank you for your question. This is not required, however highly encouraged by the BHA and will make other requirements easier to maintain.
9.2: These two definitions do not seem aligned. What distinguishes the two levels/types of care? If the ATU can treat SUD and the CSU definition is silent, does this mean something? CSU talks about short term care but there is no discussion of LOS in the ATU definition. Align the definitions of ATU and CSU.	Thank you for your feedback. This is something we will be taking into consideration in future rule revisions. For now, all ATU and CSU rules, including definitions, will remain in their current state.
9.5.2.E: The meaning of "integrated care model" is not clear.	Thank you for your feedback. Please see the definition of "Integrated care model" in Part 6.2.
9.5.3.B: Receiving supervision from a licensee is not clear--does this mean that it can be a peer who is supervised by a licensee? It seems like this should be a Licensee or candidate. "PRIOR TO AN INDIVIDUAL LEAVING THE AGENCY, SCREENINGS MUST BE REVIEWED BY A CRISIS PROFESSIONAL WHO IS LICENSED OR A CANDIDATE RECEIVING SUPERVISION FROM A LICENSEE."	Thank you for your suggestion. This has been incorporated.
9.5.3.C.1.I: "IDENTIFYING AND ENGAGING NATURAL SUPPORTS"	Thank you for your suggestion. This has been incorporated.
9.5.3.C.2: 2. SUBSTANCE USE SERVICES: a. WALK-IN CRISIS AGENCIES SHALL PROVIDE HARM REDUCTION INTERVENTIONS, INCLUDING THE ADMINISTRATION OF OPIOID RECEPTOR ANTAGONISTS TO REVERSE AN OVERDOSE, IF NEEDED. b. EVALUATION OF WITHDRAWAL MANAGEMENT NEEDS. WALK-IN CRISIS AGENCIES MAY OFFER WITHDRAWAL MANAGEMENT SERVICES IF ENDORSED TO PROVIDE SUCH SERVICES. c. EVALUATION OF APPROPRIATENESS FOR MEDICATIONS FOR TREATMENT OF OPIOID ADDICTION AND LINKAGE TO PROVIDERS THAT CAN INITIATE TREATMENT AS INDICATED.	Thank you for your suggestion. This has been incorporated.
9.5.3.C.4: 4. REFERRALS: a. AGENCY PERSONNEL ARE RESPONSIBLE FOR REFERRALS AND WARM	Thank you for your suggestion. This has been incorporated.

HAND-OFFS TO HEALTH AND SOCIAL SERVICES AND SUPPORTS, INCLUDING WITHDRAWAL MANAGEMENT AND MEDICATION ASSISTED TREATMENT OF ADDICTION, AS NEEDED.	
9.7.2.A: A. MOBILE CRISIS SERVICES PROVIDE A TIMELY PAIRED MOBILE RESPONSE TO A BEHAVIORAL HEALTH CRISIS IN THE COMMUNITY. MOBILE CRISIS SERVICES MUST PROVIDE REFERRALS AND FACILITATE TRANSITIONS TO OTHER CRISIS AND WITHDRAWAL MANAGEMENT AGENCIES, BEHAVIORAL HEALTH AGENCIES, AND COMMUNITY-BASED SUPPORTS AS CLINICALLY INDICATED.	Thank you for your suggestion. Withdrawal management agencies fall under behavioral health agencies.
9.7.3.1.5: I. MOBILE CRISIS RESPONSE TEAMS WILL PROVIDE BRIEF INTERVENTION, STABILIZATION AND DE-ESCALATION SERVICES INTENDED TO MAINTAIN STABILITY IN THE COMMUNITY, WHENEVER POSSIBLE. THIS MAY INCLUDE BUT IS NOT LIMITED TO: 5. IMMEDIATE COORDINATION WITH OTHER CRISIS PROVIDERS WHEN NEEDED (E.G., WALK-IN CENTERS, CRISIS STABILIZATION UNITS, WITHDRAWAL MANAGEMENT SERVICES AND RESPITE, PSYCHIATRIC EMERGENCY SERVICES). 9.9.2.A.4.b: If the individual is voluntary, why do they need "permission" to exit the facility? They should just need assistance. Remove "AND/OR PERMISSION".	Thank you for your suggestion. These have been incorporated.
9.9.2.E: Facility standards should apply to all 24/7s somewhere in general licensing requirements rather than only applying to ATU and being in the crisis chapter. Please relocate facility standards to general licensing rules.	Thank you for your suggestion. At this time, ATU requirements will remain separate. Other general facility standards already live in Chapter 2.
9.7.4 PERSONNEL REQUIREMENTS C. EVERY MOBILE CRISIS RESPONSE TEAM MUST HAVE 24/7 ACCESS TO A PEER SUPPORT PROFESSIONAL WHO CAN BE INCLUDED IN THE MOBILE CRISIS RESPONSE TEAM, AND WHO MAY TAKE THE LEAD ON INITIAL ENGAGEMENT AND ASSIST WITH FOLLOW UP SERVICES. We would suggest each mobile crisis response intervention requires offering peer specialist support services as a follow-up to the initial mobile crisis intervention. The follow-up peer outreach, if accepted by the individual	Thank you for your suggestion. This has been incorporated.

served by MCR, shall be offered within one business day of the crisis intervention.	
It would behoove the BHA to look into how we can expand respite services and not just traditional respite with a medical model approach but there's tons of evidence around peer-run respite, a way that's more person-centered and outside of the medical paradigm.	Thank you for your feedback. This is something we will be looking into for future rule revisions.
Emergency and Involuntary Commitment Services (formerly Chapter 10; now Chapter 7)	
Does WM 3.2 need to be endorsed for EC?	Thank you for your question. WM 3.2 is not required to add on an Emergency Commitment (EC) endorsement; however, if the facility plans to or would like the option to accept individuals on ECs, they would need the endorsement.
These rules are very bare bones. It seems like organizations endorsed for EC or IC should require training on the court commitment process requirements, motivational interviewing etc.	Thank you for your feedback. This chapter comes from current regulations. We can consider adding additional content as needed in future rule revisions.
10.1.B - There are a lot of requirements here that are not captured in the rule, such as the 5 day requirement. Align and clarify requirements as referenced in 27-81-111, C.R.S.	Thank you for your feedback. This chapter comes from current regulations. We can consider adding additional content as needed in future rule revisions.
10.3.A - This assumes that it be developed by the agency - does this mean they need to go to statute to determine what should go in their policy? Please clarify	Thank you for your question. This chapter comes from current regulations. Facilities are responsible for their own policies and procedures and must be in compliance with rules and regulations.
10.3 (D): Will there be new forms?	Thank you for your question. This is the current state, as such, form will remain the same.
10.3 (F): Are we sending a BHA designated transfer forms?	Thank you for your question. Transfer forms are to be given to the individual and/or their legal representative, as well as the withdrawal management facility in which the individual is receiving treatment.
10.3.E: Shouldn't there be a requirement for screening for treatment need by the organization that authorized the commitment and then should that organization (the WM) be responsible to arrange for transfer rather than "may"? "IF INDIVIDUALS ON AN EMERGENCY COMMITMENT REQUIRE TREATMENT IN OTHER LICENSED AND APPROPRIATELY ENDORSED WITHDRAWAL MANAGEMENT PROGRAMS, TRANSFERS SHALL BE MANAGED BY THE PROGRAMS THAT INITIALLY AUTHORIZED THE COMMITMENTS."	Thank you for your suggestion. This has been incorporated.
10.3 F 1: Language should be more inclusive, change to "INDIVIDUALS AND/OR THEIR LEGAL REPRESENTATIVE; AND"	Thank you for your suggestion. This has been incorporated.
10.5.1: Who is responsible for this? The agency, the BHA, the delegate?	Thank you for your question. The agency is responsible for these requirements.
10.5.2 A 4: Add peer support professionals	Thank you for your suggestion. Peer support

	professionals may not be primary counselors.
10.1: IF UTILIZING PEER SUPPORT PROFESSIONALS, THE AGENCY MUST FOLLOW STANDARDS FOR RECOVERY SUPPORT SERVICES RENDERED BY PEER SUPPORT PROFESSIONALS IN ACCORDANCE WITH CHAPTER 6 OF THESE RULES.	Thank you for your suggestion. Peer language lives under the primary endorsement in which the facility seeks. Emergency and Involuntary commitments is not a primary endorsement, rather a population specific add on endorsement.
Children and Families Endorsement (formerly Chapter 11; now Chapter 8)	
Chapter 11 is missing school mental health providers, specifically School Psychologist's. There has to be cooperation between school and community regarding their mental health as they spend at least 35 hours/week in the school setting. Also COVID closure of schools had a direct and significant impact on our student's social-emotional development. Thank you for your time and consideration of my viewpoint.	Thank you for your comment. This is a statutory requirement under HB22-1278 which outlines the mental health professionals allowed to provide outpatient psychotherapy treatment. This is further outlined in 12-245-203.5 C.R.S. and school mental health providers are not included in statute.
How often are the comprehensive assessments supposed to be completed? Upon each visit?	Thank you for your question. Comprehensive assessments are only to be completed one time with a provider and then updates should occur at least every 6 months or if there is a change in functioning. This is outlined in Chapter 2 requirements and then level of care endorsements.
Can you please provide more clarity around what adolescent consent, ages 15 and over means. Can they consent to psychotropic medications?	Thank you for your comment. Consent by a parent or guardian to administration of psychotropic medications to a minor is needed unless there is a specific statutory exception. A youth 18 years of age or older can consent to receiving psychotropic medications without the consent of a parent or guardian. A youth 15 years of age or older may consent to receiving psychotropic medication without the consent of a parent in certain circumstances. These circumstances are: A minor that is 15 years of age or older "may give consent" to receiving medical, dental, emergency health, and surgical care if the minor: Lives separately from their parents or guardian; With or without the parents' or guardians' consent; and Manages their own financial affairs or has contracted a lawful marriage.
What is the age for minors to receive medications without parental consent? My agency does not consider "psychotherapy" to include medications, since medications are considered a "medical" intervention. Recommending allowing for the prescriber's clinical judgment to be considered.	Thank you for your comment. Consent by a parent or guardian to administration of psychotropic medications to a minor is needed unless there is a specific statutory exception. A youth 18 years of age or older can consent to receiving psychotropic medications without the consent of a parent or guardian. A youth 15 years of age or older may consent to receiving psychotropic medication without the consent of a parent in certain circumstances. These circumstances are: A minor that is 15 years of age or older "may give consent" to receiving medical, dental, emergency health, and surgical care if the minor: Lives separately from their parents or guardian; With or without the parents' or guardians' consent; and manages their own financial affairs or has contracted a lawful

	marriage.
Background checks and fingerprinting: Is this applicable to Family First and CYMHTA?	Thank you for your questions. Requirements for FFPSA and CYMHTA will fall under contract requirements and the administrative rules, which are currently being drafted. If administrative rules or contracts require background checks then providers shall adhere to those requirements.
For those new to Colorado, is an alternate to CBI acceptable?	Thank you for your question. Alternatives to CBI for those new to Colorado can be found in Chapter 2.
Is there room for change in the fingerprinting process for fully remote staff members?	Thank you for your questions. Any personnel having direct access to children and youth, who are licensed, approved or designated by the BHE will need to complete the background check requirements in Chapter 8. Direct care includes face-to-face or through telehealth modalities.
Physically direct or communication direct?	Thank you for your questions. Any personnel having direct access to children and youth, who are licensed, approved or designated by the BHE will need to complete the background check requirements in Chapter 8. Direct care includes face-to-face or through telehealth modalities.
I think it should be for the protection of the child. Things happen online.	Thank you for your comment.
11.3.1.A 2 comments regarding how the phrasing sounds like everyone in that agency has to undergo that FBI check rather than those that are working directly with the children.	Thank you for your comment. Clarity has been provided and this now says "IN ADDITION TO CRIMINAL BACKGROUND CHECKS REQUIRED UNDER PART 2.6.D OF THESE RULES, AGENCIES MUST, PRIOR TO THE HIRE OF NEW PERSONNEL OR ACCEPTANCE OF PERSONS FOR VOLUNTEER SERVICE IF THAT VOLUNTEER SERVICE INVOLVES UNSUPERVISED DIRECT CONTACT WITH CHILDREN RECEIVING SERVICES, SUBMIT TO THE FEDERAL BUREAU OF INVESTIGATION (FBI) A COMPLETE SET OF FINGERPRINTS TAKEN BY A QUALIFIED LAW ENFORCEMENT AGENCY TO OBTAIN ANY CRIMINAL RECORD HELD BY THE FBI, FOR EACH PROSPECTIVE EMPLOYEE OR VOLUNTEER. PAYMENT OF THE FEE FOR THE CRIMINAL RECORD CHECK IS THE RESPONSIBILITY OF THE AGENCY. NO DIRECT CONTACT WITH CHILDREN MAY TAKE PLACE UNTIL THE BACKGROUND CHECK IS CLEARED BY THE FBI."
11.4.A.2: Not clear what this means. Does it mean the parent/legal guardian gets medical info that BHE has or that the essential medical info is needed from the parent or guardian and what about a child that has consented to treatment on its own?	Thank you for your comment. This has been removed from the rules.
11.4.2.B: As it relates to A, we talk specifically about children that are 15 or older can consent to ROI, can we get guidance with regard to consent to ROI when a child is under the age of tx and has consented to tx without a parent or guardian.	Thank you for your question. Children, ages twelve (12) and above can consent to an ROI without the consent of a parent or legal guardian if the minor is knowingly and voluntarily seeking such services; and the provision of psychotherapy services is clinically indicated and necessary to the minor's well-being.

ACES given to child or parent? The wording is confusing	Thank you for your comment. The ACEs screen is to be provided to the child and if the parent or legal guardian are included in treatment, the ACEs screen shall be given to them separately. Language has been added to clarify that a trauma screen specifically designed for children and youth must occur but will no longer require this to be the ACEs screen.
Regarding using the ACE- we are wondering the purpose of the ACE screening tool. This is very duplicative with the CCAR (can we remove the CCAR?). It's also duplicative of the CANS for those agencies who use it. The ACE is not a very good trauma screening tool, is not an outcomes tool, is not a symptom severity tool, and is not even that good of a social determinants of health tool. So as a providing agency, what is the value added to the client's experience in us using the ACE?	Thank you for your comment. The CCAR is related to federal reporting and has been removed from provider regulations for service standards. Language has been added to provide clarity for any trauma screen or assessment, including but not limited to the ACEs can be administered. The goal is to ensure trauma screening is occurring that is specifically designed for children and youth.
Will the BHA provide guidance on which ACE tool should be used? Will providers be able to use PEARLS or similar ACE tools that are developmentally appropriate?	Thank you for your comment. Language has been clarified in the children and families chapter that any trauma assessment specific to children must be completed. This does not need to be the ACEs screen.
I've never heard of ACES being given to a child. I thought it was an adult tool	Thank you for your comment. Language has been included to clarify that any trauma screen, specific to children and youth may be used.
When I worked at Devereux Colorado our clinicians regularly did ACES on our kiddos who came to our services.	Thank you for your comment.
I would promote that all staff working with adults OR youth are background checked	Thank you for your comment. Chapter 2, base BHE requirements include background check requirements for all populations served.
If time allows, can we go back to chapter 11 related to background checks/finger printing? My specific question is: As ASOs are not BHEs, but the ASO provides the assessors for Family First and CYMHTA, is the ASO required to do background checks/fingerprinting of assessors?	Thank you for your questions. Requirements for FFPSA and CYMHTA will fall under the contract requirements and administrative rules, currently being drafted. If administrative rules or contracts require background checks then providers shall adhere to those requirements.
Either way that requirement would live in contract right, since the ASOs wouldn't have this endorsement?	Thank you for your question. Requirements for FFPSA and CYMHTA will fall under the contract requirements and administrative rules, currently being drafted. If administrative rules or contracts require background checks then providers shall adhere to those requirements.
I think it's kinda squishy whether ASOs will be BHEs depending on services they directly provide, and unsure whether assessors fall under direct clinical work?	Thank you for your question. ASOs will not be BHEs; however, contracts can require many of the same requirements as a BHE.
Is the staff credential requirement for psychotherapy services for ages 12-15 without parental consent or ages 12-17 without parental consent?	Thank you for your question. The language reads that any child over the age of 12 may consent to outpatient psychotherapy services without parental consent. The staff credential requirement would be for individuals ages 12 to 17.
Wondering if agencies must submit FBI check or	Thank you for your question. Clarity has been

the individual?	provided to state that the agency must conduct an FBI check on any new personnel.
Safety Net providers will have to comply with Ch 11?	Thank you for your question. Essential behavioral health safety net providers will need to comply with Chapter 8 unless they are otherwise approved to serve a subset of priority populations. Comprehensive community behavioral health providers must comply with Chapter 8.
11.4.1 - release - I don't understand who needs parental consent and when and when than records can and can't be released to parent/guardian. Very confusing and the rule doesn't clarify.	Thank you for your question. If the child is under the age of 12, then the BHE or provider must obtain parental or legal guardian consent. If they are 12 and older, the child may consent to outpatient psychotherapy services without the consent of the parent or legal guardian. If the child is 15 or over, they may consent to hospitalization without the consent of their parent or legal guardian. If the child is consenting to treatment without the consent of the parent or legal guardian, then the provider may not release the records to the parent or legal guardian without a ROI signed by the child. Children, ages twelve (12) and above can consent to an ROI without the consent of a parent or legal guardian if the minor is knowingly and voluntarily seeking such services; and the provision of psychotherapy services is clinically indicated and necessary to the minor's well-being.
11.5.B.3 - ACEs screen and make sure that definition is to be clear what ACEs is	Thank you for your question. Definitions are located in Chapter 1.
Concerns about 12-year-olds consenting to psychiatric medications, Family First and CYMHTA will be impacted by this. Also can you provide clarity about what is required for children under 12 years of age regarding parental consent? Do both parents need to provide consent, or does just one parental consent suffice? What about guidance for the provider around parental rights and guardianship?	Thank you for the feedback. The BHA has removed this language. Consent by a parent or guardian to administration of psychotropic medications to a minor is needed unless there is a specific statutory exception. A youth 18 years of age or older can consent to receiving psychotropic medications without the consent of a parent or guardian. A youth 15 years of age or older may consent to receiving psychotropic medication without the consent of a parent in certain circumstances. These circumstances are: A minor that is 15 years of age or older "may give consent" to receiving medical, dental, emergency health, and surgical care if the minor: Lives separately from their parents or guardian; With or without the parents' or guardians' consent; and Manages their own financial affairs or has contracted a lawful marriage. As for consent for children under the age of 12, if the parents are married, applicable laws apply that only one parent is required to consent. If the parents are divorced, providers must adhere to the legal documents outlining custody and decision-making.
Regarding medication, there can be a place in rule for requiring parents are given specific information about what to look for with medication, including education around this. Recommend focusing on the transition-planning portion of rule to provide guidance to both parents and children receiving this service.	Thank you for the feedback. We have added in language that says " a. IN ALL INSTANCES WHERE PRESCRIPTION PSYCHIATRIC MEDICATIONS ARE TO BE ORDERED AS A PART OF A MENTAL HEALTH TREATMENT PROGRAM, THE FOLLOWING INFORMATION SHALL BE PROVIDED, IN AN ACCESSIBLE MANNER, TO THE CHILD AND

	PARENT(S) OR LEGAL GUARDIAN(S). (1) THE NAME(S) OF THE MEDICATION BEING PRESCRIBED. (2) THE USUAL USES OF THE MEDICATION(S). (3) THE REASONS FOR ORDERING THE MEDICATION(S) FOR THE CHILD. (4) A DESCRIPTION OF THE BENEFITS EXPECTED. (5) THE COMMON SIDE EFFECTS AND COMMON DISCOMFORTS, IF ANY. (6) THE MAJOR RISKS, IF ANY. (7) THE PROBABLE CONSEQUENCES OF NOT TAKING THE MEDICATION(S). (8) ANY SIGNIFICANT HARMFUL DRUG OR ALCOHOL INTERACTIONS, OR FOOD INTERACTIONS. (9) APPROPRIATE TREATMENT ALTERNATIVES, IF ANY; AND, (10) THAT THE CHILD MAY WITHDRAW AGREEMENT TO TAKE THE MEDICATION AT ANY TIME."
The "medical necessity" definition can make or break a child or family's ability to receive services. What happens when a child or family does not meet "medical necessity" as defined in Chapter 11? Can we set a better transition plan in place for this scenario? What can the rules put in place for providers besides just calling the authorities or crisis line? How can the rules guide parents better, knowing that this is a gap in the way it is currently run now?	Thank you for the feedback. The BHA will take this suggestion back to the partnering agency (HCPF) for alignment, clarification, and reduction of silos across the system as much as possible. The intent is for the safety net system to fill the gaps in receiving services.
Family satisfaction surveys should be mandatory, including incorporation of the findings into services going forward.	Thank you for the feedback. The BHA will consider incorporating this in future revisions.
Can you provide clarification on the Assessment and Triage portion of Chapter 11?	Thank you for the feedback. Clarification was added to rule language that includes what the process should entail, including care coordination and support for children under the age of 18. The BHA is hopeful that a future revision process will allow for a focus on transition-age youth between 18 and 21 years of age, to ensure there is not a gap in services.
Can you provide clarification on the Service Plan Consent process for Chapter 11?	Thank you for the feedback. If a child is aged 12 or above, they should be included in the service plan development.
11.5.B - Comprehensive assessment for children is unclear related to ACES as well as the assessment of the parent and guardian social determinants and referrals made if needs are identified. This is beyond the scope of therapy. Will services be compensated for these additional tasks and assessments? There are more appropriate ways to assess trauma rather than using a formal assessment and the ACES may not be trauma informed.	Thank you for your comment. Additional language has been added to provide clarity that a trauma assessment specific to children must be completed using any standardized assessment tool. This can include ACEs but is not required. The intent of this is to inform treatment goals.
11.5 - How are services to be provided if parents or guardians refuse to be involved in treatment? Can BHE refuse to serve those children?	Thank you for your question. If the parent or legal guardian consents to the child receiving services, but does not wish to participate, the BHE or provider may still provide services to the child. If the parent or legal

	guardian does not consent then the BHE or provider may not provide services. This is specific to children under the age of twelve (12) as 12 and above can consent to their own treatment.
11.5.B.4 - Requiring a strength and needs assessment for 17 year olds that includes needs listed in this section seems above and beyond a transition for children and youth services to adult services.	Thank you for your comment. Clarity has been provided to say this will be assessed and/or triaged.
11.5 SCREENING AND ASSESSMENT OF CHILDREN THE COMPREHENSIVE ASSESSMENT MUST ALSO INCLUDE AN ACES SCREEN OF THE CHILD. PARENTS OR LEGAL GUARDIANS SHALL BE INCLUDED IN THE COMPLETION OF THE ACES, UNLESS INVOLVEMENT IN THE SCREEN IS CONTRAINDICATED, THEN THE CLINICAL RATIONALE MUST BE DOCUMENTED. THE ACES SHOULD BE COMPLETED SEPARATELY IF THE PARENT OR LEGAL GUARDIAN COMPLETES THE ACES. FOR CLARITY AND ACCURACY, A CHILD UNDER THE AGE OF TWELVE (12), MUST BE GIVEN THE OPTION TO ANSWER THE QUESTIONS VERBALLY TO THE PROVIDER. Comment: Confirming that the provider is able to determine which version of the ACES to administer based on age of the youth. PEARLS for ages 12-18?	Thank you for your comment. Language has been added to provide clarity that any trauma-informed screen may be administered as long as it is child specific.
11.4.1 (B) 1-5 Provide feedback and clarifying questions regarding the removal of certain staff (Candidate, LAC, MFT, and BA) positions • 11.6 (3) o What allowances are there for this proposal? 2 Generation approach	Thank you for your question. The staff requirements have been added back in. Bachelor-level positions are not included in statute. The Two Generation approach means focusing on both the child and parent or legal guardian as applicable for the success of the child.
11.3.1, CRIMINAL HISTORY RECORD CHECK, says (emphasis added): A. IN ADDITION TO CRIMINAL BACKGROUND CHECKS REQUIRED UNDER PART 2.6.D OF THESE RULES, <u>AGENCIES SERVING CHILDREN</u> MUST SUBMIT TO THE FEDERAL BUREAU OF INVESTIGATION (FBI) A COMPLETE SET OF FINGERPRINTS TAKEN BY A QUALIFIED LAW ENFORCEMENT AGENCY TO OBTAIN ANY CRIMINAL RECORD HELD BY THE FBI. PAYMENT OF THE FEE FOR THE CRIMINAL RECORD CHECK IS THE RESPONSIBILITY OF THE AGENCY. NO DIRECT CONTACT WITH CHILDREN MAY TAKE PLACE UNTIL THE BACKGROUND CHECK IS CLEARED BY	Thank you for your comment. Clarity has been provided and this now says "IN ADDITION TO CRIMINAL BACKGROUND CHECKS REQUIRED UNDER PART 2.6.D OF THESE RULES, AGENCIES MUST, PRIOR TO THE HIRE OF NEW PERSONNEL OR ACCEPTANCE OF PERSONS FOR VOLUNTEER SERVICE IF THAT VOLUNTEER SERVICE INVOLVES UNSUPERVISED DIRECT CONTACT WITH CHILDREN RECEIVING SERVICES, SUBMIT TO THE FEDERAL BUREAU OF INVESTIGATION (FBI) A COMPLETE SET OF FINGERPRINTS TAKEN BY A QUALIFIED LAW ENFORCEMENT AGENCY TO OBTAIN ANY CRIMINAL RECORD HELD BY THE FBI, FOR EACH PROSPECTIVE EMPLOYEE OR VOLUNTEER. PAYMENT OF THE FEE FOR THE CRIMINAL RECORD CHECK IS THE

THE FBI. The language, “agencies serving children,” makes it sound like this requirement refers to every employee of the agency. Please modify this language to make it clear that it applies only to those employees who will be working with children or in those programs for children.	RESPONSIBILITY OF THE AGENCY. NO DIRECT CONTACT WITH CHILDREN MAY TAKE PLACE UNTIL THE BACKGROUND CHECK IS CLEARED BY THE FBI.”
11.3.1, CRIMINAL HISTORY RECORD CHECK: A. IN ADDITION TO CRIMINAL BACKGROUND CHECKS REQUIRED UNDER PART 2.6.D OF THESE RULES, <u>AGENCIES SERVING CHILDREN</u> MUST SUBMIT TO THE FEDERAL BUREAU OF INVESTIGATION (FBI) A COMPLETE SET OF FINGERPRINTS TAKEN BY A QUALIFIED LAW ENFORCEMENT AGENCY TO OBTAIN ANY CRIMINAL RECORD HELD BY THE FBI. PAYMENT OF THE FEE FOR THE CRIMINAL RECORD CHECK IS THE RESPONSIBILITY OF THE AGENCY. NO DIRECT CONTACT WITH CHILDREN MAY TAKE PLACE UNTIL THE BACKGROUND CHECK IS CLEARED BY THE FBI. This is unclear who needs background checks.	Thank you for your comment. Clarity has been provided and this now says “IN ADDITION TO CRIMINAL BACKGROUND CHECKS REQUIRED UNDER PART 2.6.D OF THESE RULES, AGENCIES MUST, PRIOR TO THE HIRE OF NEW PERSONNEL OR ACCEPTANCE OF PERSONS FOR VOLUNTEER SERVICE IF THAT VOLUNTEER SERVICE INVOLVES UNSUPERVISED DIRECT CONTACT WITH CHILDREN RECEIVING SERVICES, SUBMIT TO THE FEDERAL BUREAU OF INVESTIGATION (FBI) A COMPLETE SET OF FINGERPRINTS TAKEN BY A QUALIFIED LAW ENFORCEMENT AGENCY TO OBTAIN ANY CRIMINAL RECORD HELD BY THE FBI, FOR EACH PROSPECTIVE EMPLOYEE OR VOLUNTEER. PAYMENT OF THE FEE FOR THE CRIMINAL RECORD CHECK IS THE RESPONSIBILITY OF THE AGENCY. NO DIRECT CONTACT WITH CHILDREN MAY TAKE PLACE UNTIL THE BACKGROUND CHECK IS CLEARED BY THE FBI.”
11.4 Rights of Children 1. PARENTS OR LEGAL GUARDIANS MUST BE CONTACTED WITHOUT THE CHILD'S WRITTEN OR VERBAL CONSENT, UNLESS NOTIFYING THE PARENT OR LEGAL GUARDIAN WOULD BE DETRIMENTAL TO THE CHILD'S HEALTH, SAFETY, OR WELFARE , AS AUTHORIZED BY SECTION 12-245-203.5(7) C.R.S., IF: 2. <u>ESSENTIAL MEDICAL INFORMATION IS NECESSARY FOR PARENTS OR LEGAL GUARDIANS TO MAKE INFORMED MEDICAL DECISIONS ON BEHALF OF THE CHILD.</u> 11.4.A.2 is not at all clear. Does it mean that the parent/legal guardian needs essential medical information that the BHE has in order to make informed medical decisions on behalf of the child that do not have to do with the BHE? Does it mean that essential medical info is needed from the parent/legal guardian? What about children who have consented to services on their own and have other rights to seek medical treatment? Please clarify this section.	Thank you for your comment. We have removed this language.

11.4.1.2.A Provide clarity around how this works with the current consent laws; language conflicts with 11.4.1.A.	Thank you for your question. Children, ages twelve (12) and above can consent to an ROI without the consent of a parent or legal guardian if the minor is knowingly and voluntarily seeking such services; and the provision of psychotherapy services is clinically indicated and necessary to the minor's well-being.
Please provide clarity around frequency of the comprehensive assessment	Thank you for your comment. This is outlined in Chapter 2 requirements and level of care endorsements.
We request clarity surrounding the frequency of the comprehensive assessments.	Thank you for your comment. This is outlined in Chapter 2 requirements and level of care endorsements.
Children age 12 and older can consent to out-patient therapy, is age 12 also the age of consent for medications?	Thank you for your comment. Consent by a parent or guardian to administration of psychotropic medications to a minor is needed unless there is a specific statutory exception. A youth 18 years of age or older can consent to receiving psychotropic medications without the consent of a parent or guardian. A youth 15 years of age or older may consent to receiving psychotropic medication without the consent of a parent in certain circumstances. These circumstances are: A minor that is 15 years of age or older "may give consent" to receiving medical, dental, emergency health, and surgical care if the minor: Lives separately from their parents or guardian; With or without the parents' or guardians' consent; and Manages their own financial affairs or has contracted a lawful marriage.
Only a "physician"?	Thank you for your comment. Consent by a parent or guardian to administration of psychotropic medications to a minor is needed unless there is a specific statutory exception. A youth 18 years of age or older can consent to receiving psychotropic medications without the consent of a parent or guardian. A youth 15 years of age or older may consent to receiving psychotropic medication without the consent of a parent in certain circumstances. These circumstances are: A minor that is 15 years of age or older "may give consent" to receiving medical, dental, emergency health, and surgical care if the minor: Lives separately from their parents or guardian; With or without the parents' or guardians' consent; and Manages their own financial affairs or has contracted a lawful marriage.
the law actually says for psychotherapy services which does not include medication services so are we changing definition	Thank you for your comment. Consent by a parent or guardian to administration of psychotropic medications to a minor is needed unless there is a specific statutory exception. A youth 18 years of age or older can consent to receiving psychotropic medications without the consent of a parent or guardian. A youth 15 years of age or older may consent to receiving psychotropic medication without the consent of a parent in certain circumstances. These circumstances are: A minor that is 15 years of age or older "may give

	consent” to receiving medical, dental, emergency health, and surgical care if the minor: Lives separately from their parents or guardian; With or without the parents’ or guardians’ consent; and Manages their own financial affairs or has contracted a lawful marriage.
11.4.2 Rights of Children in Hospitalization A. IN ADDITION TO THE INDIVIDUAL RIGHTS SPECIFIED IN PART 2.9 OF THESE RULES, CHILDREN WHO ARE FIFTEEN (15) YEARS OF AGE OR OLDER, WITH OR WITHOUT THE CONSENT OF A PARENT OR LEGAL GUARDIAN, HAVE THE RIGHT TO: CONSENT TO RECEIVE BEHAVIORAL HEALTH SERVICES FROM AN AGENCY OR A PROFESSIONAL PERSON, OR MENTAL HEALTH PROFESSIONAL PURSUANT TO SECTION 27-65-104(1) C.R.S.; 1. CONSENT TO VOLUNTARY HOSPITALIZATION FOR MENTAL HEALTH SERVICES; 2. OBJECT TO HOSPITALIZATION AND TO HAVE THAT OBJECTION REVIEWED BY THE COURT UNDER THE PROVISION OF SECTION 27-65-104, C.R.S.; AND, 3. CONSENT TO RELEASE OF INFORMATION. B. CHILDREN WHO ARE UNDER THE AGE OF FIFTEEN (15), HAVE THE RIGHT TO OBJECT TO HOSPITALIZATION AND TO HAVE A GUARDIAN AD LITEM APPOINTED PURSUANT TO SECTION 27-65-104(6)(b)(c), C.R.S. My question is: In the case of children under the age of fifteen (15) (as described in 11.4.2.B), who would consent to release of information? Would that be the guardian ad litem? The child? Would a court order be required? Would it be a parent or legal guardian (other than the GAL)?	Thank you for your question. If the child is under the age of 15 and hospitalized then the parent and/or legal guardian will need to consent to release of information.
Women’s and Maternal Behavioral Health Treatment (formerly Chapter 12; now Chapter 9)	
Title of ‘gender responsive’ treatment is confusing. I assumed that it meant ability to treat people of all gender identities in a confirming way. Agree with commenter above	Thank you for your comment. We have changed the title to “WOMEN’S AND MATERNAL BEHAVIORAL HEALTH TREATMENT” to provide more clarity.
Suggest a different title if statutorily able to reflect the current use of similar terminology.	Thank you for your comment. We have changed the title to “WOMEN’S AND MATERNAL BEHAVIORAL HEALTH TREATMENT” to provide more clarity.
This is very important quality material,	Thank you for your comment. We have changed the title to “WOMEN’S AND MATERNAL BEHAVIORAL

Understanding this chapter is really only applicable to certain programs to access certain benefits, we would encourage the BHA to look into other opportunities to weave these standards in other chapters or as a baseline for providers.	HEALTH TREATMENT” to provide more clarity around who these rules apply to.
“POSTPARTUM” MEANS THE PERIOD OF TIME FOLLOWING THE BIRTH OF A CHILD UP TO ONE YEAR. Thank you for taking our suggestion of “up to one year.”	Thank you for your comment.
12.1.2.A Will there be specific training created or approved for this purpose? What is the criteria for a training to qualify as meeting this requirement? Does lived experience in any of these areas count as experience?	Thank you for your comment. The BHA's learning management system (LMS) will create training specific to these requirements.
12.1.4.B "WHEN NOT CLINICALLY CONTRAINDICATED THE FOLLOWING TOPIC AREAS SHALL BE ADDRESSED IN TREATMENT OR THROUGH COMPREHENSIVE CARE COORDINATION, WHEN APPLICABLE:" Shouldn't this be aligned somehow with all the other care coordination work? Consider requiring the gender-responsive endorsement to have a care coordination endorsement and in addition requiring care coordination related to harm reduction associated with substance use during pregnancy, interventions related to child safety, trauma services, parenting and attachment services, reproductive health etc.	Thank you for your comment. Language has been changed to reference back to 2.10.G
12.1.4.C.10 Does that mean that BHEs are required to provide childcare in order to provide women's specific treatment?	Thank you for your comment. Only agencies that provide services pursuant to Section 25.5-5-2020(l)(R), C.R.S. also known as Special connections are required to provide childcare..
12.1.4.C ANY AGENCY THAT QUALIFIES TO PROVIDE SERVICES PURSUANT TO SECTION 25.5-5-202(1)(R), C.R.S. AND SECTION 27-80-112 C.R.S., IN REGARD TO THE TREATMENT PROGRAM FOR HIGH-RISK PREGNANT WOMEN, SHALL MAKE AVAILABLE, IN ADDITION TO SUBSTANCE USE AND ADDICTION COUNSELING AND TREATMENT: SECTION 25.5-5-202(1)(R): only requires outpatient SUD treatment for Medicaid-enrolled pregnant "women." We are not seeing how this cited statute dictates the services listed in this section.	Thank you for your comment. Language has been added to provide clarity to include 27-80-113 C.R.S.
12.1.4.C ANY AGENCY THAT QUALIFIES TO PROVIDE SERVICES PURSUANT TO SECTION 25.5-5-202(1)(R), C.R.S. AND	Thank you for your comment. This is outlining the requirements for serving this population. While this might be outlined in other endorsements, this is

SECTION 27-80-112 C.R.S., IN REGARD TO THE TREATMENT PROGRAM FOR HIGH-RISK PREGNANT WOMEN, SHALL MAKE AVAILABLE, IN ADDITION TO SUBSTANCE USE AND ADDICTION COUNSELING AND TREATMENT: SECTION 27-80-112 C.R.S: The statute doesn't seem to require any specific services except those that it seems like this list could be modernized. The only thing in this list that seem relevant to outcomes specific to pregnant women are health education, home visits, transportation, and child care. All of the others --assessment, rehabilitation, care coordination, counseling, and provider training are already covered in basic endorsements. It might make more sense to focus on the expectations that are distinct for pregnant women with SUD risk. "reduce the occurrence of poor birth outcomes."	ensuring providers serving this population make these services available.
12.1.5.A Why not include postpartum women/individuals? PREGNANT WOMEN/INDIVIDUALS AND POSTPARTUM WOMEN/INDIVIDUALS SHALL BE GIVEN PRIORITY ADMISSION TO TREATMENT FOR SUBSTANCE USE DISORDERS.	Thank you for your comment. Language has been added.
12.1.5 & 12.1.2.C (confusion between these two). What does "shall offer them within 48 hrs" mean?. One says "shall" and one says "every effort should be made"	Thank you for your comment. Language has been changed to align both parts.
12.1.5.D IF A PREGNANT WOMAN/INDIVIDUAL IS NOT ADMITTED TO TREATMENT WITHIN FORTY-EIGHT (48) HOURS OF FIRST CONTACT, THE REASON SHALL BE CLEARLY DOCUMENTED. IF THE INDIVIDUAL IS WORKING WITH A CARE COORDINATOR THROUGH THEIR MANAGED CARE ENTITY OR MANAGED SERVICE ORGANIZATION, THE CARE COORDINATOR SHALL BE INFORMED. INTERIM SERVICES SHALL BE PROVIDED CONSISTING OF THE FOLLOWING AT MINIMUM Shall be documented where? Please clarify.	Thank you for your comment. Language has been added to say "in their individual record".
12.1.5.E PREGNANT AND POSTPARTUM WOMEN/INDIVIDUALS SHALL BE LINKED TO PRENATAL AND POSTPARTUM CARE IMMEDIATELY AND BARRIERS TO ACCESSING PRENATAL AND POSTPARTUM CARE INCLUDING, BUT NOT LIMITED TO TRANSPORTATION TO CARE, MUST BE ADDRESSED AND DOCUMENTED. Shall be documented where? Please clarify.	Thank you for your comment. We have provided clarity that this is to be documented in their individual record.
12.1.5.F Does that mean that BHE's cannot	Thank you for your comment. Language has been

discharge an individual from services during the postpartum period who has declined postpartum care even if they are disengaged, transferred care, or completed their treatment goals?	added to provide clarity that if the individual has disengaged, transferred or completed their treatment goals
People in this category get to jump the line if there is a list of people waiting for services?	Thank you for your question. This is tied directly to federal block grant requirements regarding priority populations. If they meet federal priority population requirements they move to the front of the line.
We'd offer a few more topics for consideration in 12.1.2 (A): Prenatal substance exposure, including but not limited to FASD; Health equity and barriers to care	Thank you for your comment. Training states that it "may " includes but is not limited to. We have provided suggestions but providers may seek other training than what is listed. Prenatal substance exposure has been added.
chapter 12, how does 12.1.5 (A) fit in with safety net priorities and no refusals?	Thank you for your question. Block grant priority populations and Colorado Safety Net Priority populations have separate requirements even though they interact with one another. Women's and maternal behavioral health treatment will fall under the block grant requirements.
Chapter 12 great standards to have, wonder if you've thought about how this will interact with other chapters and wrapping this around with other chapters, seems like this chapter kind of others pregnant women	Thank you for your question. This is not a standalone chapter as this is population-specific. Providers who have this sub-endorsement must also have an endorsement for SUD services. This is an addition to what is already required in a level of care endorsement.
Gender responsive services is written as a women's behavioral health treatment program. This seems sexist in that men also have similar issues. This seems like an overstep when rationale for this chapter seems to be about regulating the SUD block grant priority population.	Thank you for your comment. The title has been changed to Women's and Maternal Behavioral Health Treatment to provide clarity around which population is to be served.
12.1 o Why is it a choice to provide gender responsive treatment? Gender responsive treatment may need a title change because language is shifting around pregnant and postpartum people. Some may interpret gender responsive treatment to mean transgender and/or trans fluid population.	Thank you for your comment. The title has been changed to Women's and Maternal Behavioral Health Treatment to provide clarity.
• 12.1.5 (A) o If care coordination services are being provided, would it be denial of services? This rule may need more flexible language to address situations where care coordination services are provided.	Thank you for your comment. Language has been adjusted to state admission and/or care coordination.
12.1.2.C says: AGENCIES SHALL OFFER ANY PREGNANT OR POSTPARTUM WOMEN/INDIVIDUALS ADMISSION TO TREATMENT WITHIN FORTY-EIGHT (48) HOURS AND SHALL DEMONSTRATE COMPLIANCE WITH PART 12.1.5.D. 12.1.5.C says: EVERY ATTEMPT SHALL BE	Thank you for your comment. Language has been adjusted to align between each section.

MADE TO ADMIT PREGNANT WOMEN/INDIVIDUALS TO TREATMENT WITHIN FORTY-EIGHT (48) HOURS OF FIRST CONTACT BETWEEN THE WOMAN/INDIVIDUAL AND THE ADMITTING PROGRAM. 12.1.5.D says, in part: IF A PREGNANT WOMAN/INDIVIDUAL IS NOT ADMITTED TO TREATMENT WITHIN FORTY-EIGHT (48) HOURS OF FIRST CONTACT, THE REASON SHALL BE CLEARLY DOCUMENTED. IF THE INDIVIDUAL IS WORKING WITH A CARE COORDINATOR THROUGH THEIR MANAGED CARE ENTITY OR MANAGED SERVICE ORGANIZATION, THE CARE COORDINATOR SHALL BE INFORMED. INTERIM SERVICES SHALL BE PROVIDED CONSISTING OF THE FOLLOWING AT MINIMUM: These timeframes and terminology are confusing. 12.1.2 says “shall offer,” whereas 12.1.5 says “every attempt shall be made.” 12.1.2 says “offer admission to treatment,” whereas 12.1.5 says “admit to treatment.” Please review these rules and clarify.	
Outpatient Competency Restoration Services (formerly Chapter 13; now embedded into Chapter 12)	
Is the idea that <u>only</u> designated Comprehensive Community Behavioral Health Providers can offer competency restoration services? I think clarity on that would be helpful.	Thank you for your comment. Statutorily this service type is required to be provided by Comprehensive Community Behavioral Health Providers within the safety net system. To reduce confusion, this chapter has been incorporated into the Safety Net Chapter, now found in Part 12.6.9. These services will also continue to be provided by non-Comprehensive providers in contract with OCFMH.
13.2 Reads like only comprehensive providers can hold this endorsement. Please clarify per comments made at the BHA town hall on 6.13 saying this is not the case.	Thank you for your comment. Statutorily this service type is required to be provided by Comprehensive Community Behavioral Health Providers within the safety net system. To reduce confusion, this chapter has been incorporated into the Safety Net Chapter, now found in Part 12.6.9. These services will also continue to be provided by non-Comprehensive providers in contract with OCFMH.
13.5 F It seems like we are creating rules that duplicate the OCFMH approval process. Could this endorsement simply be an OCFMH approval? Alternatively, would OCFMH be willing to give up oversight for the quality parts of their approval and that would go here. The more payment, no refusal/no discharge would go in their contract? At a minimum the endorsement review for competency and the OCFMH approval should be done at the same time.	Thank you for your feedback. The OCFMH approval is stated in now Part 12.6.9.A.1 (as Chapter 5 is now incorporated into the Safety Net Chapter) “COMPREHENSIVE COMMUNITY BEHAVIORAL HEALTH PROVIDERS MUST COMPLETE THE APPLICATION PROCESS WITH OUTPATIENT COMPETENCY RESTORATION SERVICES PROGRAM WITHIN THE OFFICE OF CIVIL AND FORENSIC MENTAL HEALTH (OCFMH), AND APPEAR ON THE OCFMH APPROVED OUTPATIENT COMPETENCY RESTORATION LIST PRIOR TO BHA APPROVAL.”

Criminal Justice Services (formerly Chapter 14; now Chapter 10)	
I have heard that we might be able to utilize masters level people for teaching DUI classes. In DV world might be able to use people non-licensed too. If we are so desperate for people to do these services why would we hurt the agencies that are doing these services but allowing people that haven't done the full CAS training or Masters to do services needing licensed clinicians. I am also a sole provider and do I have to survive this with my fellow colleagues that will struggle this as well. Doesn't make sense to me.	Thank you for your feedback. The changes made to personnel that may provide DUI services removed the CAS/LAC mandate allowing for other credentialed staff such as LPC and LPCC to provide DUI services upon receiving the curriculum training certification. The personnel credential requirements vary based on the Level of services being provided and can all be found in the DUI section of Chapter 10 in Parts 10.5 through 10.9.
Does this include providers for SOMB or DV treatment?	Thank you for your question. This does not apply to SOMB or DV treatment.
14.1.5(C) mean that providers are supposed to document their training in every client's record? It's not sufficient to keep that in a separate, staff-specific or HR area?	Thank you for your feedback. The language in this section has been edited for clarity that the documentation shall demonstrate the training received, not document the actual training.
Sorry, I think I missed the explanation for requiring 14.4.2 G - EDUCATION AND TREATMENT MUST BE A MINIMUM OF NINE (9) MONTHS OR AS REQUIRED BY THE REFERRING SUPERVISING ENTITY.	Thank you for your feedback. This is from the current state 2 CCR 502-1 21.230.1.G. The BHA was not able to make changes to things that are established across multiple systems like those time frames but we added the addition that the provider should address discrepancies in the court ordered time frame and the clinical necessity to advocate for the individual receiving services and document those communications/efforts as well as any discrepancies. This is something that we hope to look at in a future revision in working with other state partners that will inform this change.
How are you defining "qualified behavioral health professional"	Thank you for your feedback. The language has been changed to "personnel acting within their scope of practice" to mirror similar language from other chapters of rule.
Will the trainers for Driving with Care curriculum be adjusting their guidelines as they tend to deny those credentials?	Thank you for your question. We will work with the DUI Program manager to communicate changes with DUI curriculum trainers.
How are you going to communicate that change to the CJ and attorney system, we see a lot of individuals directed by council to start treatment before sentencing and with those with 4 or more it ends up with frustration. Want to make sure that there is communication with DOC, etc. Concern around what happens when the provider goes against what counsel might have advised	Thank you for your question. We will work with the BHA Criminal Justice programs department and other applicable state agencies, such as Department of Corrections (DOC) and Justice Department, to communicate the changes.
Please clarify again the 180 hours or 18 months minimum required. This can be adjusted according to provider assessment?	Thank you for your question. It is a minimum of 180 hours over minimum of 18 months. We are putting the emphasis on the progress through treatment - that is still the minimum and that still is in place, but shifting the focus on competencies and appropriately moving someone through the competencies.

14.3.2.A.1-2 In the absence of clinical justification for services that would allow treatment to be covered by health insurance, who is expected to pay for treatment?	Thank you for your feedback. Current state is that the individual mandated to attend treatment is expected to pay any costs either out of pocket or through insurance if applicable. Nothing was written into drafted rules to change the payment structure at this time.
14.5.11(H)(3)(a) says you must document the "actual admission and discharge dates from the prior provider," but the DRS system only lets you enter dates for one admission at a time -- so you can't bundle their hours and your hours into one DRS? You'd have to enter two separate DRSes?	Thank you for your question. That is correct. You do create a separate DRS for those hours you are granting credit for and then you have a separate DRS for those hours that you are providing.
14.5.11(H) Current rules indicate these hours should be documented in a separate DRS but that is not explicitly stated here, can that be included if it will continue to be the expectation?	Thank you for your feedback. Language was added to Part 10.5.11.H.3.a to clarify.
14.5.2.B Can DUI treatment credit be given for substance use disorder, mental health, or co-occurring disorder services provided by qualified professionals within the jail setting, as in jail-based behavioral health programs?	Thank you for your question. 10.5.11.F.4 states "ONLY PARTIAL TRACK CREDIT MUST BE CONSIDERED FOR TREATMENT COMPLETED EXCLUSIVELY IN A NON-COMMUNITY BASED FACILITY, SUCH AS WHILE INCARCERATED."
14.5.6.A.1 Where is this training available?	Thank you for your question. The BHA is actively working on developing training in the Learning Management System (LMS). Mandated training may be completed in the LMS once it is available, however it will need to be completed through other means by the agency until the LMS is available.
The EOP service length in 14.2.2 is written as though the duration is fixed at the beginning -- if the goal is to keep treatment customized to the individual, it would be helpful to include some language around re-assessment; sometimes clients no longer need that level of care after a month or two of EOP.	Thank you for your feedback. Language was added to clarify that continued screening/assessment is needed.
Concerned about conflict between QMAP standards in correctional programs.	Thank you for your feedback. QMAP standards are not addressed in the Criminal Justice services chapter. Future system alignment discussion may be required to fully address this concern adequately.
Important to have correctional population separated from other populations.	Thank you for your feedback.
I've got a question about Level II 4+, so many moons ago when it came into law there was one lone document that said we were not able to grant credit from an agency no more than two months prior to their sentencing. I don't know if you remember that document; I have it in paper form and you can't find it online anywhere. So there's not anything specifically written in rule as I've been able to find right now about that and I was just wondering if there was going to be some clarity around what is the presentence	Thank you for your question. The granting of credit is found in 10.5.11 and in part B of that section it states no more than two clinical contact hours a week may be granted. It also states in 10.5.11.F.1 "EDUCATION OR TREATMENT MUST HAVE OCCURRED AFTER THE DATE OF THE LAST DUI/DWAI OFFENSE."

credit vs the post sentence credit and then I think on maybe a previous town hall meeting a couple of weeks ago, maybe even in December I can't remember, that there was a max amount I think it was 2 hours a week but I can't remember the time frame prior to that. So could you please go over that?	
If an agency is closed and they are transferring over would this 2 hours a week apply to those that are transferring in?	Thank you for your question. If the information is documented on the DRS from the previous agency they don't need to repeat anything. If it wasn't and you have documentation that it was completed you have the ability to include that.
My main question I love that this is a requirement and driven through the CJ system but my question is what education has the CJ system had already that this is coming through them? If any and is this something that the providers will be responsible for because I think this is where the disconnect happens where when the BHA has rules and requirements for the providers that links back to the CJ system but then the CJ system is like who what where we didn't know we needed to do that and this is something that they need to be incorporated into their referral process and how much of that education expectation will fall back on the providers?	Thank you for your question. There is not anything in rule that states it is the provider's responsibility to educate the Criminal Justice referral partners.
Does this impact domestic violence treatment?	Thank you for your question. No, it does not.
The applicability and structure of this chapter is not clear. It clearly applies to all DUI ed and treatment programs but does it apply to STIRR residential and OP? Does it apply to all EOP/IOP or other OP programs that accept referrals from the criminal justice system? If so, would they first be endorsed as Residential or OP and then to accept individuals referred by CJ? That would mean that this chapter would address all the specific requirements of work with CJ involved clients such as assessment, collaboration with supervising entities, engagement in social support etc.	Thank you for your question. This is a population specific endorsement that must be held in addition to the outpatient endorsement if providing criminal justice outpatient services.
14.1.5.A Shouldn't this be just licensed and endorsement(s)? They all need to be licensed even if "just" DORA license or RSS endorsement right? Safety net approval is on top of the license as we understand it. Please clarify language.	Thank you for your comment. The Safety Net Approval is in addition to the license. There may be specific requirements that are needed specific to an agency as an Essential or Comprehensive provider of the safety net which is why the approval is listed.
14.2.1.A If EOP and IOP are regulated in Chapter 7, do providers need to be endorsed as EOP or IOP and then for this endorsement? Would just an overarching criminal justice	Thank you for your feedback. Language was added in 10.1.D " THIS CRIMINAL JUSTICE ENDORSEMENT AND ALL CORRESPONDING SUB-ENDORSEMENTS MAY NOT BE HELD ALONE,

treatment or criminal justice OP treatment endorsement need to be provided on top of the Chapter 7 endorsement? It may work to have a criminal justice Treatment endorsement that would apply to non-DUI programs accepting criminal justice-referred clients and this would be on top of Chapter 7 endorsements. Please clarify language.	BUT IN ADDITION TO APPROPRIATE CORRESPONDING OUTPATIENT ENDORSEMENT AND SUB-ENDORSEMENT(S) FOR THE TYPE OF SERVICES BEING PROVIDED PURSUANT TO CHAPTER SEVEN (7) OF THESE RULES.”
14.4.2.B Flagging that HB23-1268 changed some requirements and process.	Thank you for your feedback. The language in the draft does not change in light of HB 23-1268, as rule refers to following the statutory process of Section 17-27.1-101, C.R.S.
14.4.2.J We would request that written materials be available in different languages and modalities considering disabilities.	Thank Thank you for your feedback. Language was added to 10.4.2.J “THESE MATERIALS MUST BE PROVIDED IN THE LANGUAGE AND MODALITY THAT BEST MEETS THE INDIVIDUAL’S NEEDS”.
14.5.4.B.1 It seems like assessing the level of care needed should be a precursor to having a referral process.	Thank you for your feedback. Unfortunately the timeline for the assessment happens after sentencing. However through collaboration with the individual and the supervising entity appropriate treatment avenues can be found to better meet the needs of the individual while still following the sentenced treatment mandates.
14.5.6.A If providing DUI services by telehealth, should they be trained in specific approaches to deliver the material by telehealth and/or conduct therapeutic groups by telehealth? It is a skill to be able to conduct effective groups by telehealth especially with 12 people.	Thank you for your feedback. Telehealth rules for all endorsements are found in Part 2.10.B.
14.5.7.B Does this mean that a person should be in either group or individual but not both?	Thank you for your question. As stated in 10.5.7.B it is one or the other “...UNLESS CLINICAL REASON IS DOCUMENTED FOR CHANGE IN SERVICE DELIVERY.”
14.5.7.E Where is this assessed? Is it a screening or assessment requirement to determine the best mode of care (individual/group and tele/in person)? Would all of these agencies be required to meet ch 2? If so, there could be a requirement that they have a policy to determine when telehealth is indicated/contraindicated.	Thank you for your feedback. Telehealth rules for all endorsements are found in Part 2.10.B.
14.5.8.E This chapter does not define assent. Please define assent.	Thank you for your feedback. A definition of assent has been added.
14.5.9.D.1 If a provider says that it isn't possible because it isn't economically feasible to have a group of 3-5 youth, is this acceptable? The "when possible" seems to give too much wiggle room to providers to do what is economically beneficial even if not clinically appropriate. It is hard to see how having a 16 year old in a group with adults would every be clinically appropriate.	Thank you for your feedback. If there are not enough youth available, they will attend individual sessions as covered in 10.5.9.D.2 “2. PROVIDING INDIVIDUAL SESSIONS TO MEET THE DEVELOPMENTAL NEEDS OF THE YOUTH IF GROUP PLACEMENT IS NOT CLINICALLY INDICATED OR AVAILABLE”

14.5.11.G There is nothing about what happens if credits are not granted. What happens? Will they be coordinated to another program, additional services, resources, etc.? It might be an opportunity for the BHASO to step in to understand why the credits were not granted -- was it something within the client's control or not-- and how to help them complete those credits.	Thank you for your feedback. Language was added to 10.5.11.I "I. IF TREATMENT CREDITS ARE NOT GRANTED PURSUANT TO 10.5.11.G, THE INDIVIDUAL MUST COMPLETE ALL THE COURT MANDATED HOURS OF TREATMENT ASSIGNED BY THE REFERRING SUPERVISING ENTITY."
14.5.11.G.1 Is this telehealth? Please define virtual format or ensure consistent terminology is being used.	Thank you for your feedback. Language was changed to "virtual class and/or webinar format" to clarify.
14.8.D Should there be a requirement for engagement in treatment sessions, especially groups via telehealth? We understand there are potential quality and engagement issues with in-person groups for people in DUI treatment, but the telehealth allowance opens new opportunities for very low-quality care. It seems like there may be an opportunity now or in the future to enhance the quality of DUI care by requiring engagement in care through self-assessment or other means--maybe this is already built into the curricula and if so, great but it is concerning that we have a lot of process requirements --a minimum number of weeks, make-ups, how sessions are counted, etc -- if we don't have quality standards.	Thank you for your feedback. Language around engagement was not added at this time, though is a topic for discussion for the next chapter revision.
14.1.5(G) o This will require different languages including braille. This is copyrighted information so we cannot provide these translations o Part of treatment access is providing resources for different agencies	Thank you for the feedback. This requirement exists in current rule expectations, and is important for the individual receiving services.
• 14.3.1 (2) - o This seem contradictory ▪ Example: MRT is a pretty difficult group to complete if one client cannot operate at a level to complete this, are we still required to put the client in this group? ▪ What does the coordination of care look like to meet the individual needs? ▪ Who pays for this if the client does not meet the medical necessity for the service? ▪ What does it look like when the services are not available in the region?	Thank you for the feedback. These comments are challenging to find with the citation provided. If this comment is in reference to the criminal justice-involved services provisions that require placement based on the standardized offender assessment, these rules are largely adapted from the existing 21.230 section of rule. The same expectations that exist for group assignment, coordination, payment, and placement are carried over. No significant changes or additions are made with this proposed update.
14.5.3(B)(4)	Thank you for the comment. The universal provision efforts are still in progress.

o Regarding data exchange, when someone is receiving concurrent criminal justice services what does it look like at an agency level and what does it look like in the efforts that are changing with the universal provision efforts through the BHA? ▪ Example: Needs assessment was addressed, how will this be addressed?	
14.5.9 o If we do not have this setup for kids, are we required to offer this? o It feels unrealistic to expect a provider of DUI/DWAI services would have capacity and competency/ability/infrastructure to provide these services	Thank you for your feedback. Language was added “...OR ASSIST IN DIRECT REFERRAL AND CARE COORDINATION FOR THE INDIVIDUAL TO A PROGRAM THAT PROVIDES THESE SERVICES FOR YOUTH.”
14.6(E)(2) o This number is not matching the rest of the rules o Why would this group have a higher number of individuals than other levels? ▪ This is a low-risk group, the last thing we want to do is combine them with a lot of people increasing their interaction with higher level individuals	Thank you for your feedback. This is specific to the Level I Education group only, which is not a therapeutic group. All other therapeutic groups must comply with the twelve (12) individuals receiving services maximum.
• 14.9.7(B) o The 60-day requirement has been the standard and we wonder if perhaps 90 days would give more time to evaluate individuals in these programs	Thank you for your feedback. The sixty (60) day language in the draft will remain at this time.
27-65 Designation (formerly Chapter 15; now Chapter 11)	
15.5 DATA REPORTING REQUIREMENTS ALL 27-65 DESIGNATED FACILITIES - Please provide the template for the data reporting the first month in the year you want reported. That allows for recording to be done as the M-1s are done and ensures that we capture the data you want on the front end.	Thank you for your comment. The BHA is working on training and technical assistance materials to assist in implementation of these new data requirements.
“DISAGGREGATED NUMBERS” Previously, providers reported aggregated data. What kind of tools/training will BHA provide to help providers move to this disaggregated reporting?	Thank you for your comment. The BHA is working on training and technical assistance materials to assist in implementation of these new data requirements.
while i am in favor of collecting more data around holds and certs, i am worried about the admin burden this is going to cause. caring for pts on holds and certs is already very time consuming and when people are in crisis i fear this will slow the process down if all of the data collection is the responsibility of the person doing the hold/cert paperwork	Thank you for your feedback. While we understand administrative burden, our priority at the BHA is serving Coloradans in a way that adheres to the BHA values. As much as possible, clinicians should not be doing the data reporting.
Inconsistency in the data reporting requirements	Thank you for your feedback. Inconsistencies are

if it is involuntary medication, treatment, some require some things and others do not. Want to ask about those inconsistencies across the modalities.	typically caused because the BHA is asking different questions about those modalities.
I feel this is all wishful thinking. Most of these places aren't following the law. I'm afraid of getting medical care, the M1 hold almost killed me and took away all my rights, I was misunderstood and this was what put me in a M1 hold. I was sleep-deprived. Now I'm homeless again and My fear of wanting to go back to any doctor is rational, the conditions that put me in the first place are still at play. They're not following the laws. They took away my walker, wouldn't provide medication when I had a seizure and wouldn't allow phone calls, they took away my clothes. I don't trust the Department of Human Services. Even if you housed me in a hotel for 3 months, I wouldn't be able to share with you all the horrors I've experienced. I'm gender non-binary and I don't even feel safe for or able to feel heard. Should I even have hope for this?	Thank you for your valuable feedback that has informed change to these rules. Language was added to the individual rights section for individuals when receiving services either on a hold or under certification to have the right: "15. TO HAVE APPROPRIATE ACCESS TO NON-PSYCHIATRIC MEDICATIONS NECESSARY TO MAINTAIN AN INDIVIDUAL'S HEALTH, INCLUDING BUT NOT LIMITED TO PAIN MEDICATIONS THAT MAY BE CONTROLLED SUBSTANCES; 16. TO HAVE ACCESS TO THE INDIVIDUAL'S PERSONAL MEDICAL DEVICES INCLUDING BUT NOT LIMITED TO WALKERS, CANES, HEARING AIDS, AND GLASSES;". In addition to the new language listed above, provisions for addressing issues when a facility is not in compliance can be found in the grievance process of Part 2.18.
The crisis form needs to be developed with experts and provide sufficient time for hospitals to incorporate it into their EHR before being required to use it.	Thank you for your feedback. The crisis form will be distributed for stakeholder feedback upon finalization.
BHA received 48 comments during the stakeholdering process regarding the statutory change in HB 22-1256 to include in the list of individual rights during involuntary treatment the right to "keep and use" the individual's cell phone. Comments include multiple concerns for safety with the addition of the statutory right to the individual, staff, and other individuals receiving services at designated facilities.	Thank you for your feedback. This is statutory from 27-65-106(10)(a)(X), C.R.S. and with the passage of HB 23-1236 goes into effect January 1, 2024. We kept the implementation of this statutory right broad as different facilities will need to develop their own policies and procedures to adapt cell phones in their facility, and this language was added to the 27-65 policies and procedures Part 11.3.1.D.12.
Data reporting provisions, particularly in 12.5.2, 12.5.3, 15.5.9, need to be reviewed to ensure they do not violate 42 CFR Part 2 or HIPAA.	Thank you for your suggestion. All rules are reviewed by the Attorney General's Office to ensure there are no conflicts with other laws or regulations.
For the need to read rights prior to placing the transportation hold- can the rights that are on the current M2 form be used or should the rights that are included in the proposed rules be read?	Thank you for your question. All M forms have been updated to reflect proposed rule language and are now on the BHA website.
Are you able to clarify whether a minor of 15 -17 years can consent to In Patient treatment for Mental Health services? I have found CO revised statute 27-65-103 (2) from 2017 that states they can, however, I can't find it in the more current statute. Do you know if it was repealed or moved elsewhere?	Thank you for your question. Correct, this comes from 27-65-104, C.R.S.

Raised concern about misinformation on changes related to 27-65, including transportation holds, confusion about the ability of law enforcement officials to continue to write holds since removed from the “Intervening Professional” definition, liability for emergency medical services technicians. Requested guidelines for completion of the M0.5 form. Additionally invited BHA’s future 27-65 Training Coordination to attend the state Emergency Medical Services (EMS) conference in November as a collaborative presenter and recommended connection with the Emergency Medical Practice Advisory Council (EMPAC).	Thank you for your feedback. While certified peace officers have been removed from the “intervening professional” definition, they may still write holds. Future BHA training will include training on the updated M forms.
I was attending the Advisory Board for Service Standards and Regulations 27-65-131 on Friday and am almost certain I heard that the new proposed statutes regarding patient rights (including access to cell phone, required documentation of why patient was not allowed access, etc) will go into effect January 1, 2024 and not July, 1 2023. Can you confirm this?	Thank you for your question. Regarding patient rights and 27-65 related matters, yes, most provisions* in Chapter 11 will go into effect with the rest of the rules on January 1, 2024. *Please note there are a few changes in Chapter 11 that won't go into effect until July 1, 2024, all of which have been flagged in the Chapter . This does not include patient rights.
M1-Holds: Am I reading correctly that M-1 holds can be initiated <i>and</i> terminated by PAs and NPs? My understanding is that M-1 Holds can be placed and dissolved by PA and APRNs that have met the behavioral health training criteria. STC and LTCs still need to be initiated and terminated by professional persons.	Thank you for your question. Yes, both PAs and NPs fall under the “professional person” definition and may terminate an emergency mental health hold.
“Hospitals must notify BHA if they are unable to locate an appropriate placement option. The BHA is required to assist facilities with securing appropriate placement for patients on an emergency mental health hold.” Does this mean just for the initial evaluation? I.E. if a person is placed on a MHH in the community and needs eval (typically at an ER for example). Or does this carry over to after they’ve been initially evaluated at a 27-65 facility? I.E. we agree the person is acutely at risk for self-harm, they’re medically clear, but we can’t find an inpt psych facility to accept them for a multitude of reasons (e.g. beds are full, low staffing, etc). I hope it’s the former because the latter happens all the time and having to contact BHA every time this happens would be a lot.	Thank you for your question. Correct, the BHA will be able to assist with difficult to place individuals for the initial evaluation and from facilities. The BHA will be providing technical assistance and training to providers in order to create a standardized process.
Patient Rights: “Patients who want to waive their right to an attorney must do so in a hearing in front of a judge.” I take it this is only if they have capacity to make this decision and waive their right? Sometimes we see people who are	Thank you for your feedback. This section of rule does not create a right that can only be discharged in court. This section of rule only says that the individual shall not be denied the right to consult with an attorney.

psychotic or have neurocognitive problems and they may not have the capacity to make this decision, if this is the case, do we still have to go in front of a judge?	
M-1 Hold Discharge planning: There's a long list of things pts must receive upon discharge if they were placed on an M-1 Hold (summary, reason for termination, meds, safety plan, referrals, etc). Much of this information can be found in their records but they're not discharged with paperwork that has this written on their AVS upon discharge. Is this something that we have to provide physically to the patient upon discharge or is it enough to say that they have access to all of it through their medical records?	Thank you for your question. This requirement comes from 27-65-106 (8), C.R.S. and states "The facility shall provide each person detained for an emergency mental health hold discharge instructions." All discharge instructions must be completed and provided to the individual prior to discharge. If the individual refuses discharge instructions, that must be documented in their records.
Medical Director review of STC/LTC discharges – has there been much stakeholder feedback on this item? I have referred our directors to the feedback email as they have concerns on how this will be carried out operationally for such a large system like ours.	Thank you for your question. This requirement comes from 27-65-110 (6), C.R.S.
What was the goal/ purpose of structuring the previous Ch. 17 requirements into Ch. 15?	Thank you for your question. Chapter 11 is the former Chapter 17. Other chapters in the full rule packet were moved and combined which reduced the overall number of chapters.
Would the BHA be able to clarify which requirements are new pursuant to implementation of HB 22-1256? Specifically, which portions are the recommendations from statewide program staff experts and which are from other sources?	Thank you for your question. The main sources for this chapter are from current 2 CCR 502-1 rule, HB 22-1256, and HB 23-1236 along with federal guidelines from 42 C.F.R. 483. As you will see, the majority of this draft version is from HB 22-1256.
What is the purpose of the "involuntary emergency services designation"?	Thank you for your question. The purpose of the involuntary emergency services designation is to ensure that the facilities that serve individuals held involuntarily are regulated and overseen by a state department. This also allows for designation and/or certification to continue while an individual is being held in a medical unit.
How does the BHA envision that process to work?	Thank you for your question. We are inferring this question pertains to what the designation process will look like for those involuntary emergency service designated sites. An applicant must submit an application for designation through the LADDERS portal, here: https://socgov06.my.salesforce-sites.com/LADDERS . The current designation process is specified here: 21.120.4 DESIGNATION PROCEDURE. The proposed process is found in proposed rules Part 11.4.
Which portions are intended to apply to non-designed EDs?	Thank you for your question. The BHA does not have authority to regulate non-designated emergency departments.
Have the reporting provisions (particularly in 12.5.2, 12.5.3, 15.5.9 been reviewed by a data privacy expert or legal council to ensure they do not violate 42 CFR Part 2 or HIPAA?	Thank you for your question. The Attorney General's Office has reviewed this portion of rule.

The documentation language in 15.7.3(d) appears to impose new safety planning requirements requiring collaboration with family and other social supports- how does the BHA envision these requirements, similarly, how do they interact with patient privacy protections?	Thank you for your question. The citation reference of 15.7.3.D.2 (now 11.7.3.E.2) states “SAFETY PLANNING MUST BE DONE IN COLLABORATION WITH THE INDIVIDUAL IN CRISIS AND THEIR FAMILY MEMBERS AND/OR OTHER SOCIAL SUPPORTS (IF DESIRED BY THE INDIVIDUAL).” Patient privacy protections are covered under the proposed language that it is up to the discretion of the individual to choose collaboration if they desire for that to take place with family/social supports. Our understanding is EDs are already completing safety plans with patients at time of discharge, so hopefully this will require little to no change to current practice. The BHA does not specify what to use and it is up to the facility of what safety plan they prefer.
Flagging that our members would appreciate as much background as possible on these provisions. Patient/ staff safety are always important considerations that they weigh with as much independence as possible in these difficult situations.	Thank you for this context. The sources for the seclusion and restraint section are regulations from current 2 CCR 502-1, current CDPHE regulations for seclusion and restraint 6 CCR 1011-1 Ch 2 Part 8, Federal regulations from 42 CFR 483, 42 CFR 483 Subpart G for youth guidelines, and American Psychiatric Nurses Association (APNA) Standards of Practice for seclusion and restraint.
In the psychiatric medication section, does the BHA have a plan for when there are medication shortages?	Thank you for this question. We will build this as a point of policy and procedure that a facility will need to hold for these circumstances. This has been added to that section.
Is there additional background on the requirement to provide food every four hours?	Thank you for this question. This is from current BHA seclusion and restraint regulations 2 CCR 502-1 21.280.47.B.
Concerns around the common evaluation requirement and crisis assessment. Providers need to do assessment and regulatory bodies (JCO) that guide and all use different technology. A lot of EHR is flow sheets. Just some thoughtfulness that required universal assessment instead of paper templates because those templates don't work with modern healthcare and EHR systems. Specifics, this is all new and confusing, how will this work in practice? Crisis vs evaluation? And safety of the patient.	Thank you for your feedback. The crisis assessment happens initially to determine if an emergency mental hold is needed. This is a standard form created by BHA that you may incorporate into your EHR system. The “certification evaluation” (definition added to Chapter 11) is to be completed after the hold to determine whether a certification is needed.
Court notification when holds expire. When looking at statutory language, there are a lot of ways to interpret that. Some is reg, some is procedure, some is partnership to make sure ready to go live. Standardized process for how that court process is going to work. BHA's role is assisting people and the court process. BHA needs to coordinate those processes.	Thank you for your question. The BHA will be providing technical assistance and training to providers in order to create a standardized process.
From a timing standpoint, will BHA be ready to assist EDs with placement 24/7 by January 1, 2024?	Thank you for your question. With the BHA to support EDs and placements, we recognize the call of the legislation would require 24/7 staff. With the delay of BHASOs, the BHA is working to figure out how we are to go about this in the interim.

lang around access to food. Support but the lang is around incite to that. Work flows in hospitals from operations perspective around dietary services. May be different of snacks vs meals	Thank you for your feedback. That specific language is from the seclusion and restraint section and comes from current rule (5 CCR 502-1). The new rights section also includes language regarding appropriate access to food, water, etc.
Seclusion and Restraint language. Flag lang is close to the CDPHE rules, so it might be good to link those two together. Don't want us to be in a place where CDPHE rules are different from BHA rules. Cross reference for clarity between CDPHE and BHA to make sure one set of standards that hold commonality	Thank you for your feedback. The BHA is working to do a better job aligning between departments; however, the BHA is making some changes to these regulations and CDPHE is not currently undergoing a rule revision process at this time.
Trainings - Operation side of how this all ultimately gets implemented. Within BH space and outside of it.	Thank you for your comment. The BHA is working to build commonality and standardization where it will be helpful based on stakeholder feedback. There will be more information soon on future trainings.
15.3.27.65.C and D: This language seems to mean that facilities, including hospitals, must seek a 27-65 designation if they are going to provide involuntary services. However, we thought we heard in the June 21 townhall that hospitals would not be required to provide such services; rather, it would be voluntary. A subsequent comment in the chat noted that &quot;hospitals follow EMTALA,&quot; implying that is sufficient in place of state 27-65 designation. Our providers report numerous instances when hospitals do not accept or drop emergency holds or certs, releasing these seriously ill individuals back on the street or to other providers without a thorough handoff. In light of the serious personal and community safety issues that lead to involuntary commitments, and the civil liberties at stake, we believe it is essential for all hospitals to be 27-65 designated and to follow these state rules. That will protect patient rights and facilitate continuity of care if/when patients must be transferred to the care of other providers. Accordingly, we hope that we are interpreting this language correctly and misunderstood the discussion at the townhall.	Thank you for your feedback. This language speaks to the <i>optional</i> 27-65 designation for emergency departments. The BHA does not regulate hospitals, only specific units within a hospital that provide 27-65 services (ex: inpatient psychiatric units).
15.4.1.D: As you will recall, there was a lengthy discussion about this when we met with you June 9. We wish to confirm that our members' concern is the acknowledgement that BHA has received the application, and we suggest a 30-day window for BHA to provide that acknowledgement.	Thank you for your feedback. We have added language to rule to support a 30-day window.
15.5, data reporting requirements: We appreciate the comments at the June 21 townhall to the effect that BHA's data team will provide templates, technical assistance, instructional videos and office hours to assist providers in	Thank you for your comment.

submitting the disaggregated data being requested in this section.	
15.6.1.A and 15.6.3: We wish to confirm that providers may document and furnish existing policies and procedures to fulfill these obligations. We believe that was the response in our June 16 meeting but do not have clarity on that.	Thank you for your question. Yes, it is the licensee's obligation to submit a policy to operate in conformity with current regulations. If you believe an existing policy meets these regulations, you may submit those.
15.7.1.A: Under HIPAA, an authorization gives the provider permission to release information; it does not require them to release. This rule says, "the records must be made available." There are reasons HIPAA makes release permissive rather than mandatory. Are there circumstances under which records should be held back from a person's attorney and only released by subpoena? We are not clear about the reason for this requirement. HIPAA allows disclosure of records among medical providers without written patient consent as long as they are HIPAA-covered entities. Accordingly, we recommend separating this into two sentences, since release of records to the individual's attorney is the only one that would need consent.	Thank you for your question. HIPAA allows sharing of information for treatment, payment and healthcare operations without consent. This is permissive and some providers request consent to release information anyway. This is also based on minimum necessity and need to know requirements.
15.14.1.A.1: We are still unsure of how this compares with current requirements and are not sure this requirement is practicable. Mobile crisis, STAR (behavioral health staff only w/o law enforcement), and co-responders do not assist in detaining a person and cannot transport a person against their will. Mobile crisis does not transport at all. The other programs are not equipped to transport a person that is a risk to self, others, or gravely disabled.	Thank you for your feedback. This comes from 27-65-106(1)(a)(I), C.R.S. - "BEHAVIORAL HEALTH CRISIS RESPONSE TEAM", AS DEFINED IN 27-65-102 (4), C.R.S., MEANS A MOBILE TEAM THAT RESPONDS TO INDIVIDUALS IN THE COMMUNITY WHO ARE IN A BEHAVIORAL HEALTH CRISIS AND INCLUDES AT LEAST ONE LICENSED OR BACHELOR-DEGREE-LEVEL BEHAVIORAL HEALTH WORKER. A "BEHAVIORAL HEALTH CRISIS RESPONSE TEAM" INCLUDES, BUT IS NOT LIMITED TO, A CO-RESPONDER MODEL, MOBILE CRISIS RESPONSE UNIT, OR A COMMUNITY RESPONSE TEAM." As the statute states, a certified peace officer will be able to "REQUEST ASSISTANCE FROM A BEHAVIORAL HEALTH CRISIS RESPONSE TEAM FOR ASSISTANCE IN DE-ESCALATING AND PREPARING THE INDIVIDUAL FOR TRANSPORTATION" or, "INTERVENING PROFESSIONAL MAY REQUEST ASSISTANCE FROM A CERTIFIED PEACE OFFICER, A SECURE TRANSPORTATION PROVIDER, OR A BEHAVIORAL HEALTH CRISIS RESPONSE TEAM FOR ASSISTANCE IN DETAINING AND TRANSPORTING THE INDIVIDUAL, OR ASSISTANCE FROM AN EMERGENCY MEDICAL SERVICES PROVIDER IN TRANSPORTING THE INDIVIDUAL.". As such, the programs listed in the definition are statutorily required

	to provide the above services.
15.14.4.A: We respectfully suggest the addition of one of the following: 4. NOTWITHSTANDING THE FORGOING, ILLEGAL SUBSTANCES AND WEAPONS SHALL BE ADDRESSED THROUGH THE FACILITY'S PROCEDURES. <u>OR</u> 4. THE FACILITY SHALL DEVELOP WRITTEN POLICIES THAT INCLUDE, AT A MINIMUM, PROCEDURES FOR MANAGING INDIVIDUAL FUNDS OR PROPERTY THAT ADDRESS THE FOLLOWING: A. A WRITTEN INVENTORY OF ALL PERSONAL BELONGINGS, UPON ADMISSION. THIS INVENTORY SHALL BE SIGNED AND REVIEWED BY FACILITY PERSONNEL AND THE INDIVIDUAL, AND SHALL BE MAINTAINED IN THE INDIVIDUAL'S CLINICAL RECORD. B. A PROCESS FOR STORING INVENTORIED ITEMS IN A SECURE LOCATION DURING THE INDIVIDUAL'S STAY IN THE FACILITY. C. A PROCESS FOR STORING AND/OR DISPOSING OF ILLEGAL SUBSTANCES AND WEAPONS. D. A PROCESS FOR RETURNING APPROVED PROPERTY TO THE INDIVIDUAL UPON DISCHARGE, OR SENDING THE PROPERTY WITH THE INDIVIDUAL IF THEY ARE TRANSFERRED TO ANOTHER FACILITY FOR CARE AND TREATMENT. THE INDIVIDUAL AND FACILITY PERSONNEL SHALL SIGN THE INVENTORY FORM INDICATING THAT ALL ITEMS WERE RETURNED OR THAT ALL ITEMS WERE PRESENT IN THE BAG FOR TRANSPORT.	Thank you for your suggestion. We have incorporated the proposed language with the exception of point C as it is not to go in rule that it is a facilities responsibility to know/police what is legal/illegal for the individual to have on their person.
15.14.6: As you know, we initially expressed concern about the word "immediately" in this section, and you requested alternate language from us. After extensive discussion among our members, we will let this language stand.	Thank you for your comment.
15.17.20: We are concerned about the volume of required information for the records, particularly in the discharge summaries. Indeed, the discharge summary requirements amount to practically a full-	Thank you for your feedback. These requirements come from 27-65-106, C.R.S.

time job. Data collection and follow-up require human and financial resources that could otherwise be devoted to patient care.	
15.17.25.A: BHA's response to our question about the BHA making the determination about ending involuntary treatment noted that this will be part of the new care coordination system BHA is building and which goes into effect July 1, 2024. We have noted elsewhere and reiterate here that we worry about duplication of care coordination between BHA, BHASOs and RAEs. Having multiple, overlapping and potentially competing systems and requirements will only complicate things for patients as well as providers.	Thank you for your feedback. The BHA recognizes the need for standardization and coordination amongst different state departments and is working on ways to avoid any duplicative work.
15.18.3.B: BHA's response to our question about whether the language "the court may order..." is sufficiently strong was: "This is statute language 27-65-111(3); if the court does not issue the order, the agency holding the certification should be able to request a hearing; can you think of a reason the courts would not issue the order when they have sufficient evidence of non-compliance or decompensation?" In fact, our members find that courts in some counties know that the sheriff's department will not enforce a pick-up order unless the person meets an M1 hold. Police are not comfortable transporting sometimes even when on a hold, and secure transport is generally not an option. Accordingly, we respectfully request the opportunity to explore an interpretation of the statute that would enable stricter requirements.	Thank you for your feedback. We have taken note of this and will be looking further into this for future rule revisions.
Are you able to also confirm that in the statute with effective date 27-65-106, that Certified Police Officers can continue to place M1 holds beyond July 1 st , 2023?	Thank you for your question. Yes, Certified Peace Officer (CPO) was removed from the "Intervening Professional" legislative definition in HB 22-1256. However, CPOs are still able to initiate M1 holds. That is why they are now listed in proposed new rules separately from the intervening professional term.
Are there any distinction for adolescents regarding these rights? For example, can a guardian decide no cell phone access or is it the right of patients of any age to have access to their cell phone if they own one?	Thank you for your question. Statute does not speak to any distinction for adolescents regarding rights specific to cell phone use. All patient rights in Chapter 11 apply to <i>any</i> individual that is placed on an emergency mental health hold. There are <i>additional</i> rights for minors but none of which speak to cell phone use.
27-65 Regulations: there were additional parts	Thank you for your question. All M forms have been

about RN training in order for them to write the holds? Is the reg still the same and is the BHA providing the training? Timeframe? M1 form is supposed to change? Who is responsible for that?	updated and posted to the BHA website. The BHA also has two positions working on technical assistance, with more information coming soon. As BHA is required to train for 27-65, RNs will be a part of this.
Psychotropic medications, in ch 15, information must be provided and consent must be obtained, it does not specify which type of consent 15.8.1, could we say written or verbal or both, please have both. Need for this, including parent consent, to get flexibility when dealing with complicated families	Thank you for your feedback. We have added language that both written consent and verbal communication must be obtained.
Conflict with language that families shall be notified make sure there's distinction for the 18-21 kiddos	Thank you for your comment. We have clarified the definition of child and youth to make sure there is a distinction.
Are you able to also confirm that in the statute with effective date 27-65-106, that Certified Police Officers can continue to place M1 holds beyond July 1 st , 2023? I think I had some confusion because CPO was removed from the definition of certified peace office but, later language says that "Intervening Professional or Certified Peace Officer"	Thank you for your questions. Certified Peace Officer (CPO) was removed from the "Intervening Professional" legislative definition in HB 22-1256. However, CPO's are still able to initiate M1 holds. That is why they are now listed in proposed new rules separately from the intervening professional term as you provided in your email "an intervening professional or certified peace officer".
There are numerous new reporting requirements in this chapter. Will BHA use some or all of this information to assist with placements? It would be helpful to have a discussion about how the reports will be used to improve patient access and care.	Thank you for your question. The BHA uses the data collected to inform decision making for future services. This includes improvements to patient access and care. For example, if an overwhelming number of providers in a certain county/region indicate they needed help with placements significantly more than another county/region, the BHA will be able to make informed decisions about resource allocation for the future years. It is important to recognize that client-level data plays a huge role in reducing specific barriers in specific places to increase access to care. Previously, the BHA could discern the total number of people moving through the 27-65 services but were unable to report on who those people are and how they are connected to other state programs.
"27-65 Screening" Essentially, the same as "screening," as defined in 27-65-102 (30).	Thank you for your comment. Correct. This definition was taken directly from statute. We have removed "27-65" before screening to avoid confusion.
Statute uses the term "evaluation" in its definition of "screening." (See 27-65-102 (30)). Are they the same?	Thank you for your question. This has been changed to "comprehensive evaluation".
Please provide a definition of subsequent holds, including information such as if they are to be recorded on an M form; who can order the hold to continue; are they for an additional 72 hours; can they be issued more than once?	Thank you for your feedback. We have added a definition for "subsequent hold".
APRN is defined above, but then here it says "as defined in 12-255-104(1)." The definition above references 12-255-104(1) and adds other requirements to it	Thank you for your feedback. We have removed the definition of APRN in Chapter 11 as it is defined in Chapter 1.

Should PAs be mentioned in this definition ("physician") - either explicitly included or excluded?	Thank you for your question we have changed the definition to: "PHYSICIAN" MEANS AN INDIVIDUAL LICENSED TO PRACTICE MEDICINE IN THIS STATE PURSUANT TO ARTICLE 240 OF TITLE 12, C.R.S.
"THERAPY OR TREATMENTS USING SPECIAL PROCEDURES" - Vague. Other than the three therapies/treatments listed here, what requires "an additional, specific consent" that would make it fit this definition? Does EMDR fit this category?	Thank you for your questions. This definition has been changed to add clarity. EMDR would not be included since there isn't electricity, a feeding tube or changes in brain waves through magnetic manipulation involved.
15.3 - Existing 27-65 rules distinguish between 24-hour facilities and those providing outpatient services. That distinction is not clear to us in these rules.	Thank you for your feedback. This is for any facility seeking a 27-65 designation. We have gone through and made sure all titles and subtitles are most clear/reader friendly.
Some of our informants have read this language to mean that a facility must provide all these services. We believe that is not the intent - that, instead, this section is simply saying "you must follow the regs for the services you provide." Perhaps it would be more clear to rewrite this to say "which MAY include"	Thank you for your suggestion. This language has been changed.
"RECEIPT OF THE APPLICATION SHALL BE ACKNOWLEDGED IN WRITING AND STATE WHAT ADDITIONAL INFORMATION OR DOCUMENTS, IF ANY, ARE REQUIRED FOR REVIEW PRIOR TO AN INSPECTION." - It would be helpful to have timeframes, such as when after receipt the application will be acknowledged and how much time will be given for submitting additional information or documents.	Thank you for your feedback. This provision comes from the current rule. The BHA shall inform the applicant within 60 days after receipt of a complete application. This starts the clock for the application review timeline. Both the BHA and the applicant have timelines for submission and review. The review timeline does not start until we have all the information.
"A FACILITY THAT IS FOUND TO BE IN COMPLIANCE WITH THESE RULES SHALL BE APPROVED AS A FACILITY DESIGNATED TO PROVIDE MENTAL HEALTH SERVICES EFFECTIVE FOR UP TO A ONE (1) YEAR PERIOD. " - Currently two years. Can you explain the need for this change?	Thank you for your question. This is changing across all of licensing and designation. We are statutorily called to have this be annually unless otherwise stated in statute.
IF THE APPLICATION FOR DESIGNATION IS DENIED, THE REASON(S) FOR DENIAL SHALL BE PROVIDED IN A CERTIFIED LETTER. IF AN APPLICANT DISAGREES WITH THE DECISION, THEY MAY APPEAL (SEE PART 2.24.5 OF THESE RULES); OR UPON REMEDYING THE NOTED DEFICIENCIES, MAY RE-APPLY FOR DESIGNATION IN ACCORDANCE WITH PARTS 15.17.1.3 AND 15.4.1 OF THIS CHAPTER. - Suggest a copy of the letter be sent by email as well since so many people work remotely at least part of the time, and may not get a certified letter in as timely a manner. Also specify who	Thank you for your feedback. The letter should go to the contact (administrator or owner) in our LADDERS system. The BHA intends to send the notice by email as well, but has been advised against stating this specific provision in rule.

this should go to.	
"MAY REAPPLY FOR AN INITIAL DESIGNATION IN ACCORDANCE WITH PART 15.4.1 OF THESE RULES. " Recommend a grace period for late renewals rather than making it an initial designation.	Thank you for your recommendation. In this case, technically, the license is revoked. We do, under the Colorado Administrative Procedures Act Title 24 Article 4, have the ability to honor the current license, as the act says "a license shall remain valid until we take an adverse action against it".
Missing timeframes and definitions.	Thank you for your feedback. We have incorporated new definitions and timeframes as appropriate.
Any changes in this chapter reflect HB 1138 in process of who can ask for certification and some of those other nuances?	Thank you for your question. HB 1138 is not a part of this rule packet.
Exclusion of behavioral health clinics from being 27-65 designated, why? Can we make this clearer?	Thank you for your question. We are striking this to allow all providers to be designated.
Why Hawkins building?	Thank you for your question. We have removed the "Hawkins Building" specifier.
In the notice section, it states it must be read to them in their language, etc. but we've found it's helpful to have this in plain language, etc.	Thank you for your feedback. The BHA is working on getting rights translated into other languages and will consider providing plain language versions as well.
I think that adding "plain language" for rights advisement would help the licensing staff as well. Sometimes, they are looking for the technical language because that is what rule requires.	Thank you for your feedback. The BHA is working on getting rights translated into other languages and will consider providing plain language versions as well.
15.2 "Independent professional person" definition - The "Best Interest" standards are not defined in Chapter 15 and should be given the authority the Independent Professional Person has to a minor being admitted to the hospital. For example, see 15.15.2.A.4.c.	Thank you for your feedback. 11.15.2.A.4.c does refer to what "best interest" standards would be.
15.2 "Minor" definition - Could there be concerns for this definition as it could relate to foster care youth living in apartments with ILP stipends? A recommended change could be "Minor" means an individual under 18 years of age, including youth who are 15 years of age or older who are in foster care through DHS and receive and ILP stipend;...."	Thank you for your feedback. This language comes directly from 26-65-101, C.R.S. and we are unable to alter definitions that are defined in statute.
15.7.3.K - Shouldn't the managed care entity (not facility) do 15.7.3.I too? So instead write "The facility is not required to meet the requirements of this part 15.7.3.J through 15.7.3.L Also I think they are referring to Managed Care Entity (RAE's) not facility. 15.7.3.I is: THE FACILITY SHALL, AT A MINIMUM, ATTEMPT TO FOLLOW UP WITH THE INDIVIDUAL, THE INDIVIDUAL'S PARENT OR LEGAL GUARDIAN, OR THE INDIVIDUAL'S LAY PERSON AT LEAST FORTY-EIGHT (48) HOURS AFTER DISCHARGE.	Thank you for your suggestion. This language comes from 27-65-106(8)(d), C.R.S. It does state in 11.7.3.L "L. IF THE INDIVIDUAL IS ENROLLED IN MEDICAID, THE FACILITY IS NOT REQUIRED TO MEET THE REQUIREMENTS OF THIS PART 11.7.3.I THROUGH 11.7.3.L AND INSTEAD, THE FACILITY SHALL NOTIFY THE INDIVIDUAL'S RELEVANT MANAGED CARE ENTITY, AS DEFINED IN SECTION 25.5-5-403 (4), C.R.S., OF THE INDIVIDUAL'S DISCHARGE AND NEED FOR ONGOING FOLLOW-UP CARE PRIOR TO THE INDIVIDUAL'S DISCHARGE"
15.13.J - Recommended addition: Following evaluation and treatment secure transportation or non-emergent medical transportation (NEMT)	Thank you for your suggestion. This is something we will be looking into for future rule revisions. BHASOs and/or care coordination contracts may be better

shall be provided to the minor and their parent or guardian back to the minor's home should that be a need. We've had at least a few instances where a CH was placed for treatment far from home and it was a real hardship for parents/caregivers to get their children afterwards. With NEMT, we've heard that for CH, it will only transport the caregiver/adult if the CH is with them. For example, CH placed at Cedar Springs in CO Springs is ready for pickup after an emergency hold, but caregiver in Greeley doesn't have a car. How do they get them if the CH must be with them to use NEMT?	suited to address this issue rather than rule.
15.13.K - What does "A JUVENILE COMMITTED TO THE DEPARTMENT OF HUMAN SERVICES" refer to? A youth committed to DYS?	Thank you for your question. Yes, this means a child committed to the Division of Youth Services (DYS).
15.14.2.H (1&2) - Are there any options to appeal this decision if there is credible disagreement regarding the ability to be 'properly cared for without being detained'? What about chronically suicidal CH who are running, refusing medication and other forms of treatment? We have seen this become a revolving door where no meaningful improvement occurs because they're released quickly, without proper consultation with caregivers etc. who will attest that while the CH is stable in the hospital where they've received involuntary treatment, if they discharge to do voluntary treatment, they'll refuse treatment and the S/I will return.	Thank you for your question. 11.14.2.H (1&2) speak to whether or not an individual meets criteria for an emergency mental health hold or not.
15.14.2.M - How do they determine which is clinically appropriate? How does the BHA prevent a situation in which a CH is placed on an emergency mental health hold, the placement can't be found, so they are just sent home for outpatient treatment because that is the only option perceived to be available (but it's not clinically appropriate)? We have seen this turn into partial hospitalization up to 2 hours away from the caregiver's home or CH are sent home and continue to escalate beyond the parents' control.	Thank you for your question. It will be up to the clinician to determine what is clinically appropriate. The BHA will be providing technical assistance and training to providers in order to create a standardized process.
15.14.2.N.1 - For minors with GAL's or CYF's can those attorney's play this role, so an additional attorney isn't assigned?	Thank you for your feedback. This section of rule is from 27-65-106(7)(b) and states it is the court that appoints the attorney. The court also decides if already appointed counsel may represent the minor in your example, and that is outside the scope of what BHA includes in the provider rules.
15.14.3.* (.9, .15, .17, .20) - No limits on this for children? Foster children?	Thank you for your question. These apply to all individuals regardless of age.
15.15.1.A.2 - Why "may" and not must?	Thank you for your question. This comes from

	27-65-104(1), C.R.S.
15.15.2.A.4.c - "Likely to be beneficial" has become a reason to deny admission or medical necessity and can be related to assertions that the emergency behavior and/or mental health status of the CH is "baseline" for them.	Thank you for your feedback. This comes from 27-65-104(2), C.R.S. and states "THAT HOSPITALIZATION IS LIKELY TO BE BENEFICIAL, <i>IMPROVE CONDITION AND/OR PREVENT FURTHER REGRESSION.</i> " Hopefully the "improve condition and/or prevent further regression" helps with this issue.
15.9.13 - This section speaks to additional procedures and requirements for youth, the section only mentions seclusion and restraint, does that mean that these requirements are not necessary for physical management?	Thank you for your question. Upon reviewing and aligning with Colorado statute language has been added to provide clarity. Physical management for anyone under the age of 18 years old is considered restraint and must be treated as such. Anyone over the age of 18, physical management must not occur longer than one minute. If longer than one minute that is considered restraint pursuant to 26-20-120(6), C.R.S..
15.9.13.E - Does a physician need to be on site in order for youth programs to provide physical management in a crisis situation?	Thank you for your question. No, a physician does not need to be on site to provide physical management in a crisis situation. Though please also see that physical management rules have been updated to align with 26-20-120(6), C.R.S.
15.4.1 - How is the 27-65 designation selected?	Thank you for your question. This will be an option through the BHA LADDERS system.
Will co-responders working with LEOs be able to execute the M0.5?	Thank you for your question. No they will not.
We need time prior to go-live to build the forms/evaluations into our EMR - what will the allowances be for that process?	Thank you for your question. There will be a delayed enforcement period until April 1, 2024.
And how does one get the two years of experience doing this work if they can't do the eval until they have two years?	Thank you for your question. Language has been added to allow for a supervisor/professional person with appropriate credentials and experience to sign off on evaluations of those that do not hold two years experience.
So there will need to be an evaluation on the BHA form AND an additional crisis assessment?	Thank you for your question. That is correct.
Is there a plan to educate local courts on these changes?	Thank you for your question. Yes, BHA is in the process of hiring 27-65 specific trainers that will work with providers, judicial districts, hospitals, etc. to come into compliance on the new rules proposed from the statutory calls of HB 22-1256.
It is unclear what the crisis assessment and the evaluation timelines are.	Thank you for your feedback. The crisis assessment happens initially to determine if an emergency mental hold is needed. This is a standard form created by BHA. The "certification evaluation" (definition added) is to be completed after the hold to determine whether a certification is needed.
Why would you need to do a post EMH assessment? Why the need for an emergency mental health evaluation with the creationals listed when the hold has already taken place? What is the timeline it would need to take place by and how is this different from the inpatient intake process?	Thank you for your questions. The post EMH assessment or "certification evaluation" will need to be submitted to the courts when asking for certification. This evaluation will inform the need for additional treatment either voluntary or certified.

Will facilities need to report grievances to the BHA grievance portal, or is it just to allow individuals receiving service and their family members to submit grievances?	Thank you for your question. This refers to grievances filed by individuals receiving services through the facility's internal grievance process: this is covered in Chapter 2, "Dispute Resolution".
How does this standard in Chapter 2 apply to facilities designated to provide 27-65 services that are, as I understand, not required to license as a BHE? Chapter 2 consistently addresses BHE...	Thank you for your question. There is language in Chapter 11 for the different designated services that state they must follow specific cited areas of Chapter 2, such as the dispute resolution and critical incident reporting.
So, will a facility licensed by CDPHE also need to report occurrences to the BHA?	Thank you for your question. The licensed and designated BHA facility will need to follow reporting requirements specified in Chapter 2.
The critical incident reporting requirements greatly exceed current occurrence reporting expectations of CDPHE. This will call for facilities to create duplicate processes to fulfill two different sets of expectations. Can you revisit the expectations for critical incident reporting for CDPHE licensed facilities with a 27-65 designation that are not a BHE?	Thank you for your question. Critical incident reporting is already required for all designated facilities (CDPHE licensed psychiatric hospitals). The BHA will continue to need/require notice of client issues.
What is the difference in the processes? So many of the patients we treat are marginalized and may not be able to advocate for themselves or have family members to do it. Providers turn into their main advocates.	Thank you for your question. The BHA is hopeful the upcoming safety net system will help marginalized patients as well as the future of BHASOs and care coordination.
lot of work at non-designated and receive on a hold or come in the door and need assessment for a hold. Still unclear to what form? We all have a lot of questions. The way it was communicated was confusing. Crisis assessment first and M1 application hold, then evaluation.	Thank you for your question. The certification evaluation will be specific to what you will need to provide your court officers with if someone refused services and needs to be placed on an involuntary short/long term certification. The certification evaluation will be completed by an intervening professional. Crisis assessments may be completed by a crisis professional that is licensed or someone that is receiving supervision from a licensee.
All patients on a MHH need to have an evaluation done within 24 hours - currently. My understanding is that this is a standardization of what needs to be included in the evaluation.	Thank you for your comment. Correct, "CRISIS ASSESSMENT MUST BE COMPLETED WITHIN TWENTY-FOUR (24) HOURS" and "CERTIFICATION EVALUATIONS MUST BE COMPLETED IN FULL ON A BHA-CREATED FORM WITHIN 72 HOURS OF ADMISSION WHEN DETERMINING CERTIFICATION".
So it sounds as though IP hospitals will need to complete the eval since field clinicians are not putting certs on clients. Many rural CMHCs do have the capacity to provide certifications.	Thank you for your question. If your CMHC is unable to complete the certification evaluation, you will need to partner with another facility that is able to complete it.
it would be helpful If you all provided a flowsheet or diagram of what you are talking about (to include steps and associated required documents)	Thank you for your feedback. Yes, that will be part of our training curriculum as we move through the remainder of the year.
So, RCCFs and QRTPs would need to be designated? What was that date again? For submitting data	Thank you for your question. Currently, RCCFs and QRTPs are designated to take an individual on a short/long-term certification. That essentially is not changing. If an RCCF wants to continue with that, they would need to apply and go through that process.

Sadly, facilities will need guidance at least a year in advance to make sure they are tracking data correctly going into the actual reporting deadline. Which means all procedures and guidance needs to be final by July 1, 2023 wanted to flag we have tech experts dig in on ehr build on timeline but are hearing timeline is a year in advanced	Enforcement in general with data will also fall under delayed enforcement unless it affects the health, safety, or welfare of an individual receiving services. The BHA will delay enforcement until April 1, 2024. Please note with the passing of HB 23-1236, data reporting requirements do not start until July 1, 2024.
I don't see that the definition of "professional person" in 27-65 changed with HB 22-1256. Was there subsequent legislation that changed that?	Thank you for your question. The definition of professional person did not change, the definition of intervening professional did. Please see "intervening professional" definition in Part 11.2.
How will people on med/surg floors who also need involuntary psych treatment (like MHH to STC) be handled? Will all the med/surg floors need to be designated? Historically, care has been provided by a psych consult team and the person would be transferred to the psych unit once medically stable. Will that change?	Thank you for your question. EDs may get designated so patients can move throughout medical floors. An alternative would be creating a facility placement agreement internally.
I'm looking at CRS 27-65-102 definitions and didn't see APRNs there.	Thank you for your comment. While APRNs are not specifically called out in the statutory definition, we received a lot of feedback requesting whether APRNs fall under "a person licensed to practice medicine in this state" which is why it is now specified in rule.
Definition of "discharge summary" please The summary that the treating professional competes in the chart, or the discharge instructions given to the Individual?	Thank you for your feedback. We have added a definition for "Discharge summary" as well as added language to clarify that the discharge summary is to be both in the individual's care record and available to the individual as discharge instructions. It is also to be documented in the clinical record if the individual accepted the discharge instructions.
The language in Title 27-65 for APRN reads "A registered professional nurse as defined in section 12-255-104 (11) who by reason of postgraduate education and additional nursing preparation has gained knowledge, judgment, and skill in psychiatric or mental health nursing"	Thank you for your comment. 12-255-104(11), C.R.S. refers to the definition for a "registered professional nurse". The definition for APRN can be found in 12-255-104(1), C.R.S.
we greatly appreciate BHA's understanding of the need for delayed enforcement until April 1 (understanding, of course, the need for enforcement when there is an immediate threat to life, health or safety). All providers will need time to develop the policies and procedures, train staff and reprogram EHRs. Especially given that the rules will be approved 11/1 and take effect just 2 months later, after the holidays	Thank you for your feedback. The BHA is working hard to ensure providers have everything they need in order for a smooth transition.
Please remove "if requested"	Thank you for your feedback. This language comes from 27-65-102 (8), C.R.S.
Subsequent involuntary MH hold, refers to current language of M1's? But, not allowable until Jan 1st, 2024?	Thank you for your question. Correct, subsequent holds are not allowable until rules go into effect on January 1, 2024.
how many times can you place an additional	Thank you for your question. One additional

hold-subsequent involuntary hold.	subsequent hold may be placed.
Thank you for additional guidance! As much training and support as possible here would be appreciated- facilities are unfortunately dealing with an increase in violence against HCWs leading to serious injury surrounding seclusion/ restraint confusion	Thank you for your comment. The BHA is working hard to create a strong technical assistance and training plan.
Appreciate that change to 10ft - also ensures we are able to follow other rules that say seclusion rooms have to be 100 sq ft	Thank you for your comment.
Clarifying question, placement facility agreements must be updated at least twice a year but we only upload to BHA at the time of our license renewal (one time a year), correct?	Thank you for your question. Placement facility agreements are to be updated at least every other year and will be submitted with license renewal.
15.12.E - I think this language needs to be biennial, not bi-annual, correct?	This has been corrected. The language is now "every other year" to avoid confusion.
8 hours is robust	Thank you for your feedback. This requirement comes from 27-65-107, C.R.S.
Why not allow the call at point of contact instead of receiving facility?	Thank you for your question. Individuals do have a right to make a call at point of contact, unless that right is revoked for safety reasons by the transferring professional. The receiving facility may make the call for the individual if they are unable. Please refer to Part 11.13.
Please clarify: The new M1 and M.5 is available on 7/1/23, does that also mean the new M forms can be used 7/1/23	Thank you for your question. Correct, new M forms are available now and must be used starting July 1, 2023.
will the right be given to the individual in their native language?	Thank you for your question. Yes, rights will be given to individuals in their native language.
Thanks for the translation support!	Thank you for your comment.
I would love all the data collection, discharge summary info, and follow-up requirements to be met, but i just don't think this is practical. How is the person doing the crisis eval supposed to have time to do all this? They may not be able to see pts within 8 hrs if this is the case. Are you, in fact, thinking the person doing the crisis eval will do all this? If not, who? We all have staffing challenges as it is. Seems like you need to hire a work force just to meet these requirements.	Thank you for your feedback. These requirements come from 27-65-106, C.R.S. It will be up to the facility to figure out the workflow of these requirements.
there are still voluntary rights forms for adults as well, correct?	Thank you for your question. Rights forms do not differentiate between voluntary and involuntary individuals.
Is there a hard stop date for the new m forms or can we transition off the remaining forms we have?	Thank you for your question. While this is not written into rule, the expectation would be to transition over to the new forms.
what is the timeline on the safety assessment? as soon as possible needs a timeline	Thank you for your question. Safety assessments must be completed within 24 hours.
"Periodically" also should be defined.	Thank you for your feedback. This is statutory language and not defined.
Can we clarify the use of youth vs minor in the rules? Particularly for the different rules for the	Thank you for your question. Please see the definition of "minor" in Part 11.2 and the definition of "youth" in

18-21 year old range - ex: 15.9.13 as 18-21 would be admitted to an adult inpatient unit.	Part 1.2.
Isn't the proposed age for consenting to meds 12+?	Thank you for your question. The overarching rule is that consent by a parent or guardian to administration of psychotropic medications to a minor is needed unless there is a specific statutory exception. A youth 18 years of age or older can consent to receiving psychotropic medications without the consent of a parent or guardian. A youth 15 years of age or older may consent to receiving psychotropic medications without the consent of a parent/guardian in circumstances where that youth is emancipated. These circumstances are: A minor that is 15 years of age or older "may give consent" to receiving medical, dental, emergency health, and surgical care if the minor: Lives separately from their parents or guardian; With or without the parents' or guardians' consent; and Manages their own financial affairs or has contracted a lawful marriage.
Do minors 15 and older have the explicit right to consent specifically for psychiatric medications without the consent of a parent/guardian?	Thank you for your question. The overarching rule is that consent by a parent or guardian to administration of psychotropic medications to a minor is needed unless there is a specific statutory exception. A youth 18 years of age or older can consent to receiving psychotropic medications without the consent of a parent or guardian. A youth 15 years of age or older may consent to receiving psychotropic medications without the consent of a parent/guardian in circumstances where that youth is emancipated.
clarify that new designation optional for emergency medical facilities - common for individuals on medical floors to be on a hold. Does that apply only to holds or also to certification? Would that designation also allow for a ED to place an emergency certification?	At this point the BHA does not have statutory authority to require that EDs seek and maintain designations. However, the BHA is welcome to accept applications for those who are seeking voluntary designation. The facility can place an emergency hold through the authority of the specific staff of the ED. EDs can start the process for individuals on certification, but that is a court process. These circumstances are: A minor that is 15 years of age or older "may give consent" to receiving medical, dental, emergency health, and surgical care if the minor: Lives separately from their parents or guardian; With or without the parents' or guardians' consent; and Manages their own financial affairs or has contracted a lawful marriage.
Related to 15.9.13, do these additional procedures need to be applied for use of physical management or just seclusion and restraint. Physical management may need to be added to that section	Thank you for your feedback. Physical management language has been updated to reflect that any type of physical management of a person under the age of 18 is considered restraint. Any physical management lasting longer than one minute is also considered restraint pursuant to 26-20-120, C.R.S.
Minor vs youth?	Thank you for your question. Please see the definition of "minor" in Chapter 11 and the definition of "youth" in Chapter 1. Minor language was used to mirror HB22-1256 language and youth language is used in seclusion and restraint to mirror the language from 42 CFR federal requirements.

Isn't adding the summary of detainment in the DC Summary redundant with the MHH paperwork itself which was provided to the patient?	Thank you for your question. This requirement comes from 27-65-106 (8)(a)(I), C.R.S.
For transportation rights, does that only include M 0.5 individual rights, which are separate from transport of an individual on an Emergency Mental Health Hold?	Thank you for your question. The M0.5 is the transportation hold form and there is a separate transportation rights form, labeled M0.51.
15.3 27-65 Designation Requirement (p. 6) The following statement in section D, read in context with the definitions in 15.2, would require any facility that provides “involuntary services” to receive a designation: D. In order to provide involuntary services described in this Chapter 15, a facility must receive a designation based on their substantial compliance with the service standards described in this chapter. The definition of “27-65 services” or “involuntary services” means “services provided pursuant to Title 27, Article 65, C.R.S.” A “facility” is defined broadly to include a public hospital or a licensed private hospital that “provides treatment for individuals with mental health disorders.” That would include emergency medical services facilities that provide care for patients meeting the criteria for an M-1 hold pursuant to C.R.S. § 27-65-106. Section D could be clarified as follows: D. In order to provide involuntary services described in this Chapter 15, a facility, other than an emergency medical services facility, must receive a designation based on their substantial compliance with the service standards described in this chapter.	Thank you for your feedback. Language has been changed to reflect all suggestions.
15.4.1 Application process (p. 7) Section C allows a facility to seek to exclude Saturdays, Sundays, and holidays from the 72-hour limitation on detaining persons for evaluation and treatment. However, that exception will no longer be in C.R.S. § 27-65-106(5) when the HB 22-1256 changes go into effect January 1, 2024. A plain reading of the amended version of 27-65-106 is that the 72-hour time limit continues on arrival at a designated facility and that, if the designated facility cannot complete the evaluation before	Thank you for your feedback. Language has been changed to reflect all suggestions.

the M-1 hold expires, it may place the person on a subsequent M-1 hold and must immediately notify the BHA and lay person: (7)(b) . . . If the person has been recently transferred from an emergency medical services facility to a facility designated by the commissioner and the designated facility is able to demonstrate that the facility is unable to complete the evaluation before the initial emergency mental health hold is set to expire, the designated facility may place the person under a subsequent emergency mental health hold and shall immediately notify the BHA and lay person. Section C should be deleted or the rules can be revised to reflect this change in procedure as of January 1, 2024.	
15.5.2 Seventy-two (72) hour treatment and evaluation (emergency mental health holds) (p. 10-11) The heading of this section or the first sentence should clarify that this data set is for designated facilities: The designated facility is required to maintain a data set sufficient to report the following disaggregated numbers to the BHA annually by July 1 . . . The reporting provisions under section 8 (e.g. medical complications, historical aggressions/combativeness) are not required to be reported by emergency medical services facilities pursuant to C.R.S. § 27-65-106(9)(a). Those reporting requirements are covered under 15.5.9, which is specific to all emergency medical services facilities (whether designated or not). The same clarification should be made in the following sections that apply to data sets for designated facilities, not emergency medical facilities that only have reporting obligations under C.R.S. § 27-65-106(9)(a): 15.5.3 Short and long-term certifications (p. 13) The designated facility is required to maintain a data set . . . 15.5.4 Voluntary individuals (p. 15) The designated facility is required to maintain a data set . . . 15.5.5 Involuntary medications (p. 15) The designated facility is required to maintain a data set . . .	Thank you for your suggestion. Clarifying language has been added to 11.5.2 - 11.5.8.

15.5.6 Involuntary treatments (p. 16) The designated facility is required to maintain a data set . . . 15.5.7 Electroconvulsive therapy (ECT) procedures (p. 16) As defined in section 13-20-401, C.R.S., the designated facility is required to maintain data sets . . . 15.5.8 Imposition of legal disability or deprivation of a right (p. 17) The designated facility is required to maintain data sets . . .	
15.7.3 Documentation in individual records (p. 26-27) It's unclear what the statutory authority is for some of this section. There is nothing in C.R.S. § 27-65-106 (as of January 1, 2024) that mentions the screening and initial assessment documentation under B that would be applicable to an emergency medical services facility. Section D.1 requires emergency medical services facilities to develop crisis safety plans with individuals who are not placed on M-1 holds prior to discharge or transfer. Pursuant to C.R.S. § 27-65-106(8)(a), however, the requirement for a safety plan at discharge only applies to a person "detained for an emergency mental health hold." Section D seems redundant with the requirements under E that follow C.R.S. § 27-65-106(8)(a) as well as the new requirements for BHA. Under C.R.S. § 27-65-128, in addition to proactively training providers and facilities on the procedure under Title 27, Article 65, the BHA is required to provide suggested templates and resources to be used by facilities to meet the requirements of 27-65-106(8)(a)(III) and (8)(a)(VII). These are the requirements for the discharge instructions for each person detained on an emergency mental health hold for: • A safety plan for the person and, if applicable, the person's lay person where indicated by the person's mental health disorder or mental or emotional state, • Information on how to establish a psychiatric advance directive if one is not presented.	Thank you for your feedback. 11.7.3.A states emergency medical services facilities are exempt from the initial assessment and service plan. The BHA will be providing technical assistance and training to providers in order to create a standardized process.
15.13 Procedures for involuntary transportation holds (p. 51) After G, there should be a reference to a provision added with HB 23-1236 to C.R.S. §27-65-107(3)(b): If a person detained pursuant to this section is transported to an emergency medical services facility, the involuntary	Thank you for your feedback. The three hour language has been changed to "immediately or within 8 hours."

transportation hold expires upon the facility receiving the person for screening by an intervening professional. Section H states that an individual must be screened within three hours after arrival at the facility to determine if the person meets the criteria for an M-1 hold. This requirement is stricter than what is in current statute. Under C.R.S. § 27-65-107(4)(a)(I), a person on a transportation hold has the right to receive a screening within eight hours after being presented to the facility.	
15.13.2 Individual rights for receiving individuals on involuntary transportation holds (p. 53-54) Because a transportation hold expires once a person is received at an emergency medical services facility, the only provision applicable to these facilities is Section B regarding the phone call. The other provisions would only apply to outpatient mental health facilities or designated facilities. An option would be to create a new 15.13.2 specific to individual rights for receiving individuals on involuntary transportation holds at emergency medical services facilities that would include the information in B and to create a separate section 15.13.3 for rights for receiving individuals on involuntary transportation holds at an outpatient mental health facility or facility designated by the commissioner. That would be everything in sections A, C, D, and E. Patient rights are recognized for emergency medical services facilities under current CDPHE regulations and the federal Medicare Conditions of Participation for Hospitals. In addition, the federal EMTALA screening and stabilizing obligations for hospitals with EDs applies once the patient is received at an emergency medical services facility. Federal EMTALA guidance recognizes that patients with psychiatric emergencies “if determined dangerous to self or others, would be considered to have an EMC” (emergency medical condition) requiring screening and stabilization.	Thank you for your feedback. The current rule language will remain.
15.14.5 Individual rights for receiving individuals on emergency mental health holds (p. 62) This section seems duplicative with 15.14.3 and again goes beyond the plain language of C.R.S. § 27-65- 106(10)(a) and (10)(b) which do not require that all of the rights in part 15.14.13 (including voting, letter writing, and petitioning a court for a less restrictive setting) be provided to the patient in writing with an advisement of such rights by the facility.	Thank you for your feedback. These requirements come from 27-65-107, C.R.S.
15.15.1 Consent and rights of a minor (p. 64) Section B uses expansive language that any	Thank you for your feedback. This language is statutory from 27-65-119(5) and will stay as drafted.

individual receiving evaluation and treatment “pursuant to any of the provisions of Article 65” is entitled to a written copy of all the individual rights enumerated, including for minors. “Any” of the provisions includes the provisions related to transportation holds and emergency mental health holds. Those provisions have separate patient rights sections and neither C.R.S. § 27-65-106 nor C.R.S. § 27-65-107 require these rights to be provided in writing. This section would be more appropriate for the inpatient setting. Of note, prior to the changes with HB 22-1256, the 72-hour hold period began once the patient was admitted to the “treatment and evaluation” facility (prior C.R.S. § 27-65-105(4)), so some of the provisions regarding letter writing, voting, petitioning, etc. would be more applicable for an inpatient setting rather than in an emergency department.	
BHA Town Hall Chapter 15 (June 21, 2023) On slide 28 of the June 21st BHA Town Hall on Chapter 15, a “professional person” is defined to include a person licensed to practice medicine, which “includes advanced practice registered nurses (APRNs).” Page 6 of 6 BHA Draft Chapter 15 Rules (draft May 8, 2023) June 22, 2023 While APRNs serve a fundamental role in treating mental health patients, they are not licensed to practice “medicine.” Physicians are licensed to practice medicine under the Medical Practice Act while nurses, including APRNs, are licensed to practice nursing under the Nurse Practice Act. Under the Medical Practice Act, the “practice of medicine” means: using the title M.D., D.O., physician, surgeon, or any word or abbreviation to indicate or induce others to believe that one is licensed to practice medicine in this state and engaged in the diagnosis or treatment of persons afflicted with disease; injury; or a behavioral, mental health, or substance use disorder, except as otherwise expressly permitted by the laws of this state enacted relating to the practice of any limited field of the healing arts; . . . 1 Under the Nurse Practice Act, “practice of advanced practice registered nursing” means: an expanded scope of professional nursing in a scope, role, and population focus approved by the board, with or without compensation or personal profit, and includes the practice of professional nursing.2 An APRN shall practice in accordance with the standards of the	Thank you for your feedback. The BHA is proposing to continue to allow the “professional person” definition to include APRNs.

appropriate national professional nursing organization and have a safe mechanism for consultation or collaboration with a physician or, when appropriate, referral to a physician. Advanced practice registered nursing also includes, when appropriate, referral to other healthcare providers.³ This is consistent with the definition in the draft Rule 15.2: “Physician” means an individual licensed to practice medicine in this state. That does not include advanced practice registered nurses (APRNs).	
15.4.2.D Take out "may" will strengthen the requirements. You could add a follow-up to being denied or clarify that there is a path forward. Suggestion: IF THE FACILITY IS NOT ABLE TO COME INTO COMPLIANCE WITHIN ONE HUNDRED AND EIGHTY (180) CALENDAR DAYS FROM THE DATE OF INITIAL PROVISIONAL LICENSE GRANTED, THE APPLICATION SHALL BE DENIED.	Thank you for your suggestion. This comes from the current rule and the language will remain.
15.4.3.A We are concerned about the admin burden of 60 days. Do facilities have enough staff to track this? If we have few facilities with this endorsement, what happens when they fail to do this in time? Across the board, is the BHA considering sending notifications to facilities when they need to renew or be re-designated? Having a proactive system will hopefully help providers navigate these requirements, but understand the logic of this stringent timeline.	Thank you for your question. The BHA does notify facilities to renew license/designation.
15.4.5.A Would recommend extending the timeline from 30 days to 60 days or whatever may be standard. 30 days seem too quick. Are 10 days from the time they notify the BHA within that 30-60 day timeline or 10 days from the facility not being designated to provide these services? Please clarify. Also, what happens if there is no receiving facility near by and someone was still on a hold? This is very concerning. Suggestion: IF A FACILITY MAKES A CHANGE IN ITS DESIGNATION STATUS OR DECIDES TO DROP ITS DESIGNATION, IT SHALL NOTIFY THE BHA IN WRITING NOT LATER THAN SIXTY (60) CALENDAR DAYS PRIOR TO THE DESIRED EFFECTIVE DATE. THE FACILITY SHALL SUBMIT A WRITTEN PLAN FOR THE TRANSFER OF CARE FOR THE INDIVIDUALS WITH MENTAL HEALTH DISORDERS IF THE FACILITY WILL NO LONGER TREAT THOSE INDIVIDUALS. THIS	Thank you for your feedback. This language comes from current rule and will remain the same. Correct, this would mean 10 days from the facility not being designated. The BHA will provide technical assistance and training for facilities in order to create a standardized process.

PLAN SHALL BE SUBMITTED NO LATER THAN TEN (10) BUSINESS DAYS PRIOR TO THE EFFECTIVE DATE OF....	
15.5.1.C.2 It seems like the BHA, in conjunction with CDPHE should have the ability to sanction directly - why would this go the office of the ombudsman that does not hold any sanction power? Suggestion: IF A FACILITY REFUSES TO PROVIDE THE STATUTORILY REQUIRED REPORT, A COMPLAINT MAY BE SUBMITTED TO THE BHA IN CONJUNCTION WITH CDPHE.	Thank you for your question. This language comes from current rule 2 CCR 502-1 and will remain as written.
15.5.1.D This misstates HIPAA. While this is true with tiny data sets, this seems to indicate that all reports are confidential. Anything without PHI or where PHI can be scrubbed should NOT be confidential.	Thank you for your feedback. This language comes from the current rule. All reports coming from facilities will include PHI and therefore HIPAA rules apply. Any dataset released to the public for this program will have to be aggregated because the entire dataset is a record of individuals' treatment which is PHI. It is good to note that HIPAA covers two types of personal information: PHI and PII. Both have to be removed to share data with the public, not just PHI.
15.5.2.A.1.b if they did age at admission this would make the data free of PHI and more usable	Age at admission will be calculated with the admission date and date of birth by the BHA analyst. Date of Birth is needed when no other unique identifier is offered as it is used in conjunction with First and Last name to create a unique identifier.
General throughout CH15: Consider changing "GENDER" to "GENDER IDENTITY"	Thank you for your feedback. Language has been changed to reflect this.
15.5.3.A.8&.9: TYPO	Thank you for your feedback. Statute requires both date and time.
15.5.3.A.12&13: What is the rationale of including this data point as part of short-and long-term certs and no where else?	Thank you for your question. Employment and housing status is to be collected only for short and long term certification reports as emergency departments only report on holds, not certifications. Demographics must be included on certification reports under Section 27-65-131, C.R.S.
15.5.4.A: Important to add data requirements on outcomes (were they stabilized, did they have to be transferred to another facility, what was the outcome there, etc.) It is critical to understand what is happening at these facilities to help identify further gaps.	Thank you for your suggestion. This is something we will be looking into for future rule revisions as disposition data for voluntary individuals is not required by statute. At least 80% of the individuals using 27-65 services are voluntarily accessing services.
15.5.5.A: Important to add data requirements on outcomes (were they stabilized, did they have to be transferred to another facility, what was the outcome there, etc.) It is critical to understand what is happening at these facilities to help identify further gaps.	Thank you for your feedback. This is more ambiguous than above because medications are typically given the duration of an individual's hold or certification. By collecting client-level data, the BHA will now be able to see the outcomes of an individual's hold or certification AND the medications administered. While not correlative, there is an associative link there that can now be explored further.
15.5.6: same as above and add outcomes per	Thank you for your feedback. This is something we will

episode (6)	be looking into for future rule revisions.
15.7.2.C: "WHEN A FAMILY MEMBER REQUESTS THE LOCATION AND FACT OF ADMISSION OF AN INDIVIDUAL WITH A MENTAL HEALTH DISORDER PURSUANT TO SECTION 27-65-123 (1) (G), C.R.S., THE TREATING PROFESSIONAL PERSON OR THE PROFESSIONAL PERSON'S DESIGNEE, WHO MUST BE A PROFESSIONAL PERSON, SHALL DECIDE WHETHER TO RELEASE OR WITHHOLD SUCH INFORMATION, RATIONALE SHALL BE DOCUMENTED IN THE INDIVIDUAL'S RECORD REGARDING THE DECISION TO RELEASE OR WITHHOLD SUCH INFORMATION. THE LOCATION MUST BE RELEASED UNLESS THE TREATING PROFESSIONAL PERSON OR THE PROFESSIONAL PERSON'S DESIGNEE DETERMINES, AFTER AN INTERVIEW WITH THE INDIVIDUAL, THAT RELEASE OF THE INFORMATION TO A PARTICULAR FAMILY MEMBER WOULD NOT BE IN THE BEST INTERESTS OF THE INDIVIDUAL."	Thank you for your suggestion. This language has been incorporated.
15.7.2.G.1: Some concerns about the professional person's ability to do what they want despite the patient's ability to make an informed decision. Seems like a slippery slope and it is not clear how this interacts with the following two sections.	Thank you for your feedback. This language comes from 27-65-124, C.R.S. and will remain.
15.7.2.G.4.d: What about the information that is withheld?	Thank you for your feedback. Please see Part 11.7.2.C.
15.7.3.B: Should this include mental health treatment history? As noted above, should there be a standard to include housing and employment status? why or why not?	Thank you for your question. This information will be gathered during the crisis assessment.
15.7.3.E.4: "IF THE INDIVIDUAL'S MEDICATIONS WERE CHANGED OR THE INDIVIDUAL WAS NEWLY PRESCRIBED MEDICATIONS DURING THE EMERGENCY MENTAL HEALTH HOLD, A CLINICALLY APPROPRIATE SUPPLY OF MEDICATIONS, AS DETERMINED BY THE JUDGMENT OF A LICENSED HEALTH-CARE PROVIDER, FOR THE INDIVIDUAL UNTIL THE INDIVIDUAL CAN ACCESS ANOTHER PROVIDER OR FOLLOW-UP APPOINTMENT; A FOLLOW UP APPOINTMENT SHALL BE SCHEDULED AT THE TIME OF DISCHARGE."	Thank you for your suggestion. Language has been added in regard to follow-up assistance.
15.7.3.H: Does STATEWIDE CARE COORDINATION mean BHASO?	Thank you for your question. With the passing of 23-1236 the timeline for BHASO implementation was pushed out to July 1, 2025 and is still in the process of being created. When further details on care coordination and the BHASO structure/roles are created, the BHA will provide those to the State.
15.7.3.N: "INVOLUNTARY EMERGENCY	Thank you for your suggestion. This language has

SERVICES FACILITIES MUST ENSURE THAT AN INDIVIDUAL AND AUTHORIZED CAREGIVER AND/OR FAMILY MEMBER(S) RECEIVE FOLLOW UP BY PHONE OR TELEHEALTH WITHIN 24 HOURS, CONDUCTED BY ANY MEMBER OF THE RESPONDING TEAM OR BY AN ASSOCIATED HOSPITAL FOLLOW-UP PROGRAM. PURPOSE OF THE FOLLOW UP SHALL BE DOCUMENTED IN THE INDIVIDUAL'S RECORD."	been added.
15.8.1.A: Include ensuring that medication do no interfere or interact with medications that someone is taking for non psych reasons.	Thank you for your suggestion. Language has been added.
15.8.1.B: "IF AN INDIVIDUAL HAS ESTABLISHED AN ADVANCE DIRECTIVE CONCERNING PSYCHIATRIC MEDICATION AND THE ADVANCE DIRECTIVE IS STILL IN EFFECT, THE PHYSICIAN OR ADVANCED PRACTICE REGISTERED NURSE SHALL FOLLOW THE DIRECTIVE UNLESS IT IS DETERMINED THAT DOING HAS SERIOUS LASTING CONSEQUENCES TO THE INDIVIDUAL CONTRAINDICATED IN A PSYCHIATRIC EMERGENCY. THE RATIONALE FOR OVERRIDING AN ADVANCE DIRECTIVE SHALL BE CLEARLY NOTED IN THE PATIENT RECORD."	Thank you for your suggestion. Language has been added in regard to documentation.
15.8.3.C.2: "Assault on another individual" and "self-destructive behavioral" should be defined.	Thank you for your feedback. At this time we will not be defining these terms. Technical assistance and training will be provided by the BHA on all changes to 27-65.
15.8.5.B: Include the reason for the initial use of involuntary medication	Thank you for your suggestion. Language has been added.
15.9.1.G: Is "WITH THE SECLUSION IS NECESSARY " a typo? Remove.	Thank you for your question. Yes, this was a typo and has been corrected.
15.9.3.E: Does this include all personnel or those just participating in physical management? This is unclear.	Thank you for your question. This is specified in Part 11.9.3.A.
15.9.3.G: Again who? All personnel or just those participating in physical management?	Thank you for your question. This is specified in Part 11.9.3.A.
15.9.5.C: "Consumer and Personnel" seem like old language. "TO ENSURE THE SAFETY OF EACH INDIVIDUAL AND PERSONNEL, EACH FACILITY SHALL DESIGNATE EMERGENCY PHYSICAL MANAGEMENT TECHNIQUES TO BE UTILIZED DURING EMERGENCY SITUATIONS. "	Thank you for your suggestion. This language has been changed.
15.9.7.C: What does "face-to-face" mean? In-person? Virtual?	Thank you for your question. Either modality is allowable. It is up to the facility to write policy and procedure on how the assessment will be completed.
15.9.7.I: We have a few issues here. As mentioned above, defining "physically	Thank you for your feedback. This language was changed to mirror the harm to self or others language

combative," "actively assaultive," and "self-destructive" is needed. We also believe there should be a process where a client can identify alternative interventions at a time when they are not escalated. They should get support and an opportunity to express what works, and then staff should facilitate that before resulting in restraint. We are continually concerned about the overreliance on restraint as a method to manage very sick people. Documentation of each attempt is also critical to ensure accountability.	found earlier in the Part 10.9.
15.9.10.A: "AN INDIVIDUAL WHO IS IN SECLUSION/RESTRAINT MUST BE OBSERVED IN-PERSON BY A TRAINED FACILITY PERSONNEL AT NO MORE THAN SIX (6) FEET PHYSICAL DISTANCE FROM THE INDIVIDUAL. "	Thank you for your suggestion. This language has been added.
15.9.10.G: How can we ensure there are limits to leaving a person for two hours with no break? "PERSONNEL MUST DOCUMENT RELIEF PERIODS GRANTED; RELIEF PERIODS SHALL NOT EXCEED TWO HOURS WITH NO BREAK TO THE INDIVIDUAL."	Thank you for your feedback. The period being referenced is relief from seclusion or restraint and would be considered the "break" that must be offered to the individual. The language drafted will remain.
15.9.10.J.1: "APPROPRIATE TOILETING DOES NOT INCLUDE THE USE OF ADULT DIAPERS IF NOT TYPICALLY USED BY THE INDIVIDUAL WHEN NOT RESTRAINED OR SECLUDED. IF SOILED, ADULT DIAPERS MUST BE CHANGED IMMEDIATELY."	Thank you for your suggestion. This language has been added.
15.13.A.1: Unclear about the intent of "A FACILITY DESIGNATED BY THE COMMISSIONER OR OTHER CLINICALLY APPROPRIATE FACILITY DESIGNATED BY THE COMMISSIONER." Are these inpatient mental health facilities?	Thank you for your question. This language refers to any facility that has the ability to treat individuals on mental health holds (27-65 designated facilities).
15.13.H: Unclear about the intent of "A FACILITY DESIGNATED BY THE COMMISSIONER OR OTHER CLINICALLY APPROPRIATE FACILITY DESIGNATED BY THE COMMISSIONER." Are these inpatient mental health facilities?	Thank you for your question. This language refers to any facility that has the ability to treat individuals on mental health holds (27-65 designated facilities).
15.13.H: Three hours seems long – would request 1.5-2 hours.	Thank you for your feedback. This language has been changed to "immediately or within 8 hours."
15.13.1.A.1: Any room to negotiate here? 8 hours is long.	Thank you for your feedback. This requirement comes from 27-65-107, C.R.S.
15.13.1.A.3: FACILITY MAY TEMPORARILY RESTRICT AN INDIVIDUAL'S ACCESS TO PERSONAL CLOTHING OR PERSONAL POSSESSIONS UNTIL A SAFETY ASSESSMENT IS COMPLETED - How does this interact with the 8 hours? Is it for 8 hours once they arrive or until they determine if they need to be restricted? If restricted,	Thank you for your question. The 8 hours starts upon the arrival of an individual. The BHA will be providing technical assistance and training to providers in order to help facilities understand the new rules related to 27-65.

documentation is recommended regarding why. Please clarify.	
15.13.2.E: They need to not be allowed to take the phone of a Deaf person if the place they are going does not have a videophone. Also, it should be said that annoying other people with a phone and repeated calls are not a danger. People can always use the block function.	Thank you for your feedback. Language has been added to now Part 11.13.2.D.1.a "IF AN INDIVIDUAL SPEAKS SIGN LANGUAGE AND THEIR RIGHTS TO THEIR CELL PHONE HAS BEEN DENIED, WHEN COMMUNICATING OUTSIDE THE FACILITY THEY MUST HAVE ACCESS TO COMMUNICATION DEVICES THAT PROVIDE WRITTEN/VIDEO/CLOSED CAPTION."
15.14.1.A.1: DETAINING AND TRANSPORTING THE INDIVIDUAL OR AN EMERGENCY MEDICAL SERVICES PROVIDER IN TRANSPORTING THE INDIVIDUAL; OR, -- what about evaluating in the field?	Thank you for your question. This rule language speaks to procedures after an individual is placed on an emergency mental health hold (after a crisis assessment has been completed).
15.14.1.G: There should be a requirement to be care coordinated by the provider or BHASO. They should not just be discharged and it should be a warm handoff. These instances should also be tracked and reported. If a facility is allowing holds to expire on a regular basis this is a problem because you are holding people for the maximum time period without evaluation and treatment.	Thank you for your feedback. The BHA's care coordination process is still being built. The BHA will be providing technical assistance and training to assist and inform this practice and will be added to rule in future revision.
15.14.3.A.4: These rights are not included in the involuntary transportation hold section, is there a specific reason?	Thank you for your question. These rights come directly from 27-65-106(10)(a)(III), C.R.S. and are specific for emergency holds.
15.14.3.A.5: These rights are not included in the involuntary transportation hold section, is there a specific reason?	Thank you for your question. These rights come directly from 27-65-106(10)(a)(IV), C.R.S. and are specific for emergency holds.
15.14.3.A.6: Do/ can we want to say they can contact an advocate if an attorney is not available? "EXCEPT THAT, UNLESS SPECIFIED IN THIS PART 15.14.2.N OF THESE RULES, THE FACILITY IS NOT REQUIRED TO RETAIN AN ATTORNEY ON BEHALF OF THE INDIVIDUAL BUT MUST ALLOW THE INDIVIDUAL TO CONTACT AN ATTORNEY OR A NON-ATTORNEY ADVOCATE;"	Thank you for your suggestion. This language comes from 27-65-106(10), C.R.S. and cannot be changed at this time.
15.14.3.A.10.c: Establish timeline for "AS SOON AS POSSIBLE" "A LICENSED MEDICAL PROFESSIONAL OR A LICENSED MENTAL HEALTH PROFESSIONAL SHALL CONDUCT A SAFETY ASSESSMENT WITHIN TWO HOURS. THE LICENSED PROFESSIONAL SHALL DOCUMENT IN THE INDIVIDUAL'S MEDICAL RECORD THE SPECIFIC REASONS WHY IT IS NOT SAFE FOR THE INDIVIDUAL TO POSSESS THE INDIVIDUAL'S PERSONAL CLOTHING OR PERSONAL POSSESSIONS."	Thank you for your suggestion. This language comes from 27-65-106(10), C.R.S. and cannot be changed at this time.

15.14.3.A.10.d: Replace “PERIODICALLY” with “HOURLY”	Thank you for your suggestion. This language comes from 27-65-106(10), C.R.S. and cannot be changed at this time.
15.14.3.A.14: “TO HAVE APPROPRIATE ACCESS TO ADEQUATE WATER, HYGIENE PRODUCTS, AND FOOD AND TO HAVE THE INDIVIDUAL’S NUTRITIONAL NEEDS MET IN A MANNER THAT IS CONSISTENT WITH RECOGNIZED DIETARY PRACTICES; TO HAVE APPROPRIATE ACCESS TO NON-PSYCHIATRIC MEDICATIONS NECESSARY TO MAINTAIN AN INDIVIDUAL’S HEALTH, INCLUDING BUT NOT LIMITED TO PAIN MEDICATION THAT MAY BE CONTROLLED SUBSTANCES.”	Thank you for your suggestion. This language has been added.
15.14.3.A.22: “TO HAVE FREQUENT AND CONVENIENT OPPORTUNITIES TO MEET WITH VISITORS. EACH INDIVIDUAL MAY SEE THE INDIVIDUAL’S ATTORNEY, CLERGYPERSON, NON-ATTORNEY ADVOCATE, PARALEGAL, EXTERNAL PEER SUPPORT PROFESSIONAL, OR PHYSICIAN AT ANY TIME;”	Thank you for your feedback. This comes directly from 27-65-119, C.R.S. and is unable to be changed at this time.
15.17.1.C: Why are ATUs and CSUs called out separately Shouldn't they already be licensed under chapter 2?	Thank you for your question. While ATUs and CSUs may already have a Behavioral Health Entity License (BHE) pursuant to Chapter 2, this section is specifically speaking to the additional 27-65 designation.
15.17.8D.1: This should always be possible, either a catheter or adult incontinence products and assistance with clean up if needed	Thank you for your feedback. This is something we will be looking into for future rule revisions.
15.17.8.D.3: What if the person requires this level of treatment? We can say people with some disabilities do not need this restriction why do we force it on others?	Thank you for your feedback. This is something we will be looking into for future rule revisions.
15.17.8.D.5: What is the rationale for this? If they have nursing staff and are able to prescribe medications for withdrawal, (and have the expertise, why would there be a prohibition on treating SUD? Also, this indicates any risk for withdrawal symptoms as exclusion criteria. This could include risk for mild withdrawal.	Thank you for your question. This language has been changed to “HAS ACUTE WITHDRAWAL SYMPTOMS, IS AT RISK OF WITHDRAWAL SYMPTOMS, OR IS INCAPACITATED DUE TO A SUBSTANCE USE DISORDER AND FACILITY DOES NOT HAVE APPROPRIATE CAPACITY/ENDORSEMENTS TO ADDRESS ISSUES OF WITHDRAWAL.”
15.17.9.A.1: They should not be allowed to charge people for a service they do not agree to. Also if someone has insurance, the state needs to assure they are placed in their network.	Thank you for your feedback.
15.17.17.A: What does this mean?	Thank you for your question. This means an individual may self-administer oxygen, if appropriate. Otherwise, facility staff would need to administer.
15.17.20.A.4: “INDIVIDUAL’S SEX, DATE OF BIRTH, GENDER, MARITAL STATUS AND SOCIAL SECURITY NUMBER, WHERE NEEDED FOR MEDICAID OR EMPLOYMENT	Thank you for your suggestion. This language has been added.

PURPOSES;"	
15.18.1.B: "PROVIDERS THAT POSSESS AN ESSENTIAL OR COMPREHENSIVE SAFETY NET APPROVAL PER CHAPTER 3 MAY BECOME DESIGNATED TO PROVIDE INVOLUNTARY OUTPATIENT CARE AND TREATMENT TO CERTIFIED INDIVIDUALS."	Thank you for your suggestion. Safety net status does not impact a provider's ability to become 27-65 designated. This language is no longer in rule.
15.18.1.C: Be sure that the additional chapter 2 requirements added to Chapter 3 are incorporated here directly or by reference to the safety net approval requirements	Thank you for your suggestion. The safety net requirement has been removed from this chapter.
15.18.3: "THE FACILITY RESPONSIBLE FOR PROVIDING SERVICES TO AN INDIVIDUAL ON A CERTIFICATION ON AN OUTPATIENT BASIS SHALL PROACTIVELY REACH OUT TO THE INDIVIDUAL TO ENGAGE THE INDIVIDUAL IN TREATMENT ON A WEEKLY BASIS AND INCLUDING VISITS TO THE INDIVIDUAL'S KNOWN PLACES OR RESIDENCE. DOCUMENTATION OF VISITS AND ATTEMPTS SHALL BE REQUIRED."	Thank you for your suggestion. This language has been added.
15.2 "Intervening Professional" D. - When will we receive this specific mental health training identified by the BHA for RN's? This would need to be provided months prior to 1/1/24 in order to incorporate into existing curriculum.	Thank you for your feedback. The BHA is finalizing training plans. Once these are finalized they will be communicated to designated providers.
15.2 Definitions (J) suggests the option to obtain 27-65 or not. This is unclear. "EMERGENCY MEDICAL SERVICES FACILITY" MEANS A GENERAL HOSPITAL WITH AN EMERGENCY DEPARTMENT OR A FREESTANDING EMERGENCY DEPARTMENT, AS DEFINED IN SECTION 25-1.5-114, C.R.S. AN EMERGENCY MEDICAL SERVICES FACILITY IS NOT REQUIRED TO BE, BUT MAY ELECT TO BECOME, DESIGNATED FOR 27-65 SERVICES BY THE COMMISSIONER.	Thank you for your feedback. This definition is referring to emergency departments. Emergency departments or "emergency medical services facilities" may voluntarily elect to become 27-65 designated, but it is not required.
15.3.C & 15.3.D: Is this suggesting that medical hospitals seek designation? There is later language that seems to provide a specific emergency services designation. (C) ANY FACILITY LICENSED BY A STATE AGENCY TO INCLUDE THE COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT OR THE DIVISION OF CHILD WELFARE WITHIN THE COLORADO DEPARTMENT OF HUMAN SERVICES PROVIDING INVOLUNTARY MENTAL HEALTH SERVICES WHETHER INPATIENT OR OUTPATIENT, SHALL SEEK A 27-65 DESIGNATION. (D) IN ORDER TO PROVIDE INVOLUNTARY SERVICES DESCRIBED IN THIS CHAPTER 17, A FACILITY MUST RECEIVE A DESIGNATION BASED ON THEIR SUBSTANTIAL	Thank you for your question. This would fall outside of the 27-65 designated facility rules.

COMPLIANCE WITH THE SERVICE STANDARDS DESCRIBED IN THIS CHAPTER. 15.3.1.B.1 references separate designation requirements for psych units within a medical setting. Question: When there is a medical patient in a medical setting with acute medical needs who also needs psych meds but won't take them voluntarily and is not on a hold or cert, is there a mechanism for providing involuntary meds outside of a designated facility?	
15.7.3.A – exempt from completing comprehensive assessment as described in 2.12.3, later 15.17.20.B “INITIAL AND COMPREHENSIVE ASSESSMENTS SHALL COMPLY WITH THE REQUIREMENTS OF PART 2.12.2 AND 2.12.3 AND MUST BE COMPLETED WITHIN 24 HOURS OF ADMISSION.” – Direct contradiction.	Thank you for your feedback. 11.7.3.A exempts involuntary emergency services facilities from completing the comprehensive assessment. 11.17.20.B refers to requirements for inpatient services.
15.7.3.C. Documentation in Individual Records: Crisis Assessments must be completed in full on a BHA created form. When will facilities receive this form? As healthcare systems, we are subject to many regulatory entity requirements beyond the BHA and will require a build within the electronic health record to modify any documentation requirements. In order to comply with a 7/1/23 requirement, we must receive the form in February '23.	Thank you for your question. We have added the following language: “THE ELEMENTS FROM THIS FORM CAN BE INTEGRATED INTO A FACILITY'S ELECTRONIC HEALTH RECORD.” The BHA is working hard to get the crisis assessment finalized and posted to the website. Please note there will be a period of delayed enforcement to give facilities some room to incorporate changes.
15.7.3.E.1-15: D/C Summary and Care Coordination instructions must contain: This is extensive. If this applies to non-designated facilities, we will need much more time to integrate into our EMR in order to comply.	Thank you for your feedback. This comes from 27-65-106, C.R.S.
15.8.3.E.1.c This particular rule language is concerning in that it weighs in on discontinuing a psychiatric medication that may be determined medically necessary as part of a psychiatric emergency. I think another alternative is needed, i.e. something along the lines of what else could be done when or if the required consultation cannot be completed.	Thank you for your feedback. This language comes from current BHA rule 2 CCR 502-1 (21.280.35.3).
15.9.1.G – Appears to be a typo in the last line (should be ‘when the seclusion is necessary’) IN ADDITION TO THE CIRCUMSTANCES DESCRIBED IN THIS PART 15.9.1.F, A FACILITY THAT THAT IS DESIGNATED BY THE COMMISSIONER OF THE BEHAVIORAL HEALTH ADMINISTRATION IN THE STATE DEPARTMENT TO PROVIDE TREATMENT PURSUANT TO SECTIONS 27-65-106, 27-65-108, 27-65-109, OR 27-65-110, C.R.S., TO AN INDIVIDUAL WITH A MENTAL HEALTH DISORDER, AS DEFINED IN SECTION 27-65-102, C.R.S., MAY USE SECLUSION TO	Thank you for your feedback. This has been corrected.

RESTRAIN AN INDIVIDUAL WITH A MENTAL HEALTH DISORDER WITH THE SECLUSION IS NECESSARY TO ELIMINATE A CONTINUOUS AND SERIOUS DISRUPTION OF THE TREATMENT ENVIRONMENT.	
15.9.1.H.6 - What is meant by “For the purpose of protection”?	Thank you for your question. Please see Part 11.9.1.H.6 (a&b) for this information.
15.9.3.: Staff Training – Who does this staff training requirement apply to? Designated facilities only?	Thank you for your question. All personnel training in Chapter 11 only applies to 27-65 designated facilities.
15.9.3.G. Staff Training - There are differences in terminology and ages related to what is a minor and what is a youth. In addition, can we eliminate the requirement for semi-annual training when working with youth? Staff will receive training at hire and annual. Adding additional intervals based on the ages of patients creates an unsustainable administrative burden.	Thank you for your question. Please see the “minor” definition in this Chapter 11 and the “youth” definition in Chapter 1. At this time, the semi-annual training for youth is staying in rule.
15.9.5, 15.9.6, 15.9.7: Use of Seclusion/Restraint/PM- who do these requirement apply to?	Thank you for your question. These requirements apply to all 27-65 designated facilities that employ these emergency intervention techniques.
15.9.5.E.1 - How do they define, “transitional measures?”	Thank you for your question. We have added a definition for “transitional measures”.
15.9.10 This rule requires seclusion observation within 6 feet of the individual. Per the BHA town hall on 6/21/23, this would be changing to 10 feet. Is that confirmed? 15.9.13 Additional procedures and requirements for youth (defined as 18-21) – if they are over the age of 18 (the age of majority in the state of Colorado) and are capable of exercising all of their health privacy rights under HIPAA, we can't legally disclose this information unless given written permission. Statute language: NOTIFICATION OF PARENT(S) AND/OR LEGAL GUARDIAN(S) 1. THE FACILITY MUST NOTIFY THE PARENT(S) AND/OR LEGAL GUARDIAN(S) OF THE INDIVIDUAL WHO HAS BEEN IN SECLUSION OR RESTRAINT AS SOON AS POSSIBLE AFTER THE INITIATION OF EACH EMERGENCY SAFETY INTERVENTION. 2. THE FACILITY SHALL DOCUMENT IN THE INDIVIDUAL'S RECORD THAT THE PARENT(S) OR LEGAL GUARDIAN(S) HAVE BEEN NOTIFIED OF THE EMERGENCY SAFETY INTERVENTION, INCLUDING DATE AND TIME OF THE NOTIFICATION AND THE NAME OF PERSONNEL PROVIDING THE NOTIFICATION.	Thank you for your question. That is correct, 10 feet. “When applicable” language has been added to the notification process.
15.10.1 ECT: Is reporting required for programs that do not treat involuntary patients? If an ECT program treats involuntary patients, do they require 2765 designation? 15.10.2. In reviewing	Thank you for your question. Any facility treating individuals on mental health holds must obtain a 27-65 designation.

section on involuntary services this seems to imply if you treat involuntary patients with ECT or other forms of therapeutic alternatives then 27-65 is needed. If a program only treats voluntary patients, then 27-65 is not required? Please clarify.	
15.13.2.A. What are the BHA expectations regarding documentation we can verify if rights were provided to the individual at the commencement of transport?	Thank you for your question. The rights verification can be found on the M0.51 form.
15.14.2.M. Can they more clearly outline the role at the BHA we can contact and what that process of engagement will look like, when we cannot locate a placement?	Thank you for your question. The BHA will be providing technical assistance and training to providers in order to create a standardized process.
15.15.2.A.3 How do they define, "careful investigation?"	Thank you for your question. The BHA will be providing technical assistance and training to providers in order to create a standardized process.
The medication management section in 15.7.3.E.4 is another area that will require significant procedural support from the BHA. Emergency medical services facilities do not often change/ prescribe new medications and there are also instances where facilities do not have pharmacies available at the time of discharge, nor would the facility know when the individual was able to access another provider.	Thank you for your feedback. Rule language states "IF", it is not required the emergency medical facilities change or prescribe new medication. If it is, it should be documented.
15.3 27-65 Designation Requirement (p. 6) The following statement in section D, read in context with the definitions in 15.2, could inappropriately and unintentionally be interpreted to require any facility that provides "involuntary services" to receive a designation: D. In order to provide involuntary services described in Ch. 15 a facility must receive a designation based on their substantial compliance with the service standards described in this chapter. The definition of "27-65 services" or "involuntary services" means "services provided pursuant to Title 27, Article 65, C.R.S." A "facility" is defined broadly to include a public hospital or a licensed private hospital that "provides treatment for individuals with mental health disorders." That would include emergency medical services facilities that provide care for patients meeting the criteria for an M-1 hold pursuant to C.R.S. § 27-65-106. Section D could be clarified as follows: D. In order to provide involuntary services described in this Chapter 15, a facility, other than an emergency	Thank you for your feedback. This definition is statutory and cannot change.

medical services facility, must receive a designation based on their substantial compliance with the service standards described in this chapter.	
15.4.1 Application Process 15.4.1.C allows a facility to seek to exclude Saturdays, Sundays, and holidays from the 72-hour limitation on detaining persons for evaluation and treatment. However, that exception will no longer be in C.R.S. § 27-65-106(5) when the HB 22-1256 changes go into effect January 1, 2024. A plain reading of the amended version of 27-65-106 is that the 72-hour time limit continues on arrival at a designated facility and that, if the designated facility cannot complete the evaluation before the M-1 hold expires, it may place the person on a subsequent M-1 hold and must immediately notify the BHA and lay person. Recommendation is Strike 15.4.1.C	Thank you for your suggestion. This has been removed.
15.6.1.C sets forth strict staffing requirements for designated facilities. Would request additional information on the regulatory justification for these staffing requirements.	Thank you for your question. It is the facility's obligation to submit a policy to operate in conformity with current regulations. If the facility believes an existing policy meets required regulation, they may submit that. We did however add to 11.6.1.C.3 "3. INPATIENT STAFFING RATIOS DO NOT APPLY TO OUTPATIENT CERTIFICATION SERVICES."
15.7.3.C while we recognizes the need for uniformity in the type of crisis form assessment, facilities should be able to build this form into their EHR. The wording of this section implies facilities must use a separate, BHA form outside of existing channels for patient documentation. Add to 15.7.3.C The elements from this form can be integrated into a facility's electronic health record.	Thank you for your suggestion. This language has been added.
The 15.7.3.D.1 safety plan documentation requirement wording appears to go beyond far beyond the standard established by HB 22-1256 and also appears to incorrectly apply the requirement to individuals who were not placed on emergency mental health holds. Recommendation 15.7.3.D.1 emergency services facilities will develop crisis safety plans with individuals who are detained for an	Thank you for your feedback. Safety planning is necessary in order to reduce the chances of an individual escalating to the point of needing to be placed on an emergency mental health hold again.

emergency mental health hold prior to discharge with individuals who are not placed on emergency mental health holds prior to discharge or transfer	
15.7.3.D.2 places requirements on collaboration with family/other social supports, but does not establish clear standards for how to determine if that action is desired by the individual in crisis or how to identify those other social supports. While facilities often do this if desired by the patient/available, it should not be in regulation. Recommendation is strike 15.7.3.D.2	Thank you for your suggestion. The BHA will be providing technical assistance and training to providers in order to create a standardized process (27-65-128, C.R.S.).
15.7.3.D.3 should note that often facilities do not have information on psychiatric and medical advance directives. Recommendation: Add to 15.7.3.D.3 The safety plan should include information about psychiatric and medical advance directives if available and desired by the individual	Thank you for your suggestion. The BHA will be providing technical assistance and training to providers in order to create a standardized process (27-65-128, C.R.S.).
Follow up - This process will be incredibly burdensome for facilities to comply with. Request significant education and training as well as procedural guidance updates throughout this summer and fall to ensure compliance.	Thank you for your feedback. The BHA will be providing technical assistance and training to providers in order to create a standardized process.
15.9 Seclusion and Restraint This section is consistent with existing requirements that facilities follow pursuant to standards for hospitals and health facilities; however, we note that it is possible for these regulations to shift in the future, which could cause a misalignment – we would recommend cross referencing regulation to ensure continued alignment. Cut this section and cross reference existing regulation in 6 CCR 1011-1:2-8.1	Thank you for your feedback. The referenced CDPHE regulations were one of the main sources in drafting these regulations along with current BHA seclusion, restraint, and physical management rules 2 CCR 502-1 21.280.4, 26-20-120(6), C.R.S., federal regulations of 42 CFR 483 Subpart G, and the American Psychiatric Nurses Association national rules for seclusion and restraint. Alignment of rules across agencies is something we will continue to collaborate in future revisions as we continue to develop these rules.
15.13 Procedures for involuntary transportation holds As noted above, transportation holds end when the individual gets to the receiving facility. Additionally, the timelines in this section appear to be out of alignment. Insert following 15.13.2.A: If a person detained pursuant to this section is transported to an emergency medical services facility, the involuntary transportation hold expires upon the facility receiving the person for screening by an intervening professional.	Thank you for your suggestion. This language has been added.

15.14.2 Court Orders for Screening and Evaluation There's a typo in line three of section H. "Detail" should be "detain." Would also recommend re-titling this section as it refers to non-court ordered provisions of C.R.S. § 27-65-106 as well. 15.14.2 Court Orders and Emergency Mental Health Hold Procedures Court Orders for Screening & Evaluation Section N.3 should include a second sentence consistent with C.R.S. § 27-65-106(7)(b) that "The BHA is responsible for actively assisting the facility in locating appropriate placement for the person."	Thank you for your feedback. The typo has been corrected. The second sentence referenced will be going into the BHA administrative rules rather than live in these provider rules.
15.14.3 The title of this section refers to rights "for emergency mental health holds" but it goes beyond the statutory requirements of C.R.S. § 27-65-106(10)(a). There is no requirement in that statute that requires the rights to be explained and provided in written form. In addition, provisions in A.1 (which appear to be taken from C.R.S. § 27-65-103), are not required to be provided in writing to patients on an emergency mental health hold in an emergency medical services facility. Recommendation: Strike 15.14.3.A and must be explained to the individual and provided in written form	Thank you for your feedback. This language comes from 27-65-119(5), C.R.S.: "(5) Any individual receiving evaluation or treatment under any of the provisions of this article 65 is entitled to a <i>written copy</i> and verbal description in a language or modality accessible to the person of all the rights enumerated in this section, and a minor child must receive written notice of the minor's rights as provided in section 27-65-104 (6)(g). A list of the rights must be prominently posted in all evaluation and treatment facilities in the predominant languages of the community and explained in a language or modality accessible to the respondent. the facility shall assist the respondent in exercising the rights enumerated in this section."
15.14.3 Some specific points of clarification: For emergency medical services facilities, where patients are detained on an M-1 hold typically in an emergency department setting, there is nothing in C.R.S. § 27-65-106(10)(a) that gives patients the right under 15 to receive and send sealed correspondence, or under 16 to have access to letter-writing materials and postage. There is no right to petition the court under 21, in the ED setting for release to a less restrictive setting. The voting rights in section 24 are also not in C.R.S. § 27-65-106 and would not be appropriate for a patient on an M-1 hold in an emergency medical services facility. Recommendation: Strike 15.14.3.A.15, 15.14.3.A.16, 15.14.3.A.21, and 15.14.3.A.24	Thank you for your feedback. These additional rights are from current 2 CCR 502-1 BHA rule 21.280.26.C and will stay. We moved item 21 to now section 11.14.4.C.
15.14.3 In addition, C.R.S. § 27-65-106(10)(a)(XVII) limits the right to visitors	Thank you for your feedback. Suggested language has been incorporated to add clarity and reduce

“in accordance with the facility’s current visitor guidelines,” not as under 22 to have “frequent and convenient opportunities to meet with visitors.” The safety of all patients and staff is paramount in the ED setting. Recommendation: Edit 15.14.3.A.22 to include “to have frequent opportunities to meet with visitors in accordance with the facilities guidelines.”	repetitiveness.
15.14.3 Subsection 23, states that only the “professional person” (physician or psychologist) may deny one of these rights. C.R.S. § 27-65-106(10)(b), however, allows any “licensed provider involved in the person’s care” to deny a right as appropriate in the interests of safety or patient destabilization. A physician may not be immediately available, particularly in smaller rural facilities, and a nurse, PA, or APRN may need to make this decision in an urgent situation. The regulation should not place restrictions beyond language that was agreed to by stakeholders in statute. Recommendation: Edit 15.14.3.A.23 to read “An individual’s rights may be denied for good cause by any licensed provider involved in the person’s care only by the professional person providing treatment.”	Thank you for your suggestion. The definition for “professional person” is not limited to a physician or psychologist: "PROFESSIONAL PERSON" MEANS A PERSON LICENSED TO PRACTICE MEDICINE IN THIS STATE, A PSYCHOLOGIST LICENSED TO PRACTICE IN THIS STATE, AN ADVANCED PRACTICE REGISTERED NURSE, OR A PERSON LICENSED AND IN GOOD STANDING TO PRACTICE MEDICINE IN ANOTHER STATE, AN ADVANCED PRACTICE REGISTERED NURSE LICENSED TO PRACTICE IN ANOTHER STATE, OR A PSYCHOLOGIST LICENSED TO PRACTICE AND IN GOOD STANDING IN ANOTHER STATE WHO IS PROVIDING MEDICAL OR CLINICAL SERVICES AT A TREATMENT FACILITY IN THIS STATE THAT IS OPERATED BY THE ARMED FORCES OF THE UNITED STATES, THE UNITED STATES PUBLIC HEALTH SERVICE, OR THE UNITED STATES DEPARTMENT OF VETERANS AFFAIRS.
15.14.2.K Evaluations This section establishes that the evaluation must be completed by someone with two years of experience in behavioral health safety and risk assessment working in a health care setting; however, under these new standards it would be impossible to get two years of experience and thus be able to complete the evaluation. Recommendation: Request that the BHA work with council to either remove this language in legislation or address a necessary statutory fix to avoid a shortage of staff able to complete evaluations.	Thank you for your feedback. We have added the following language “1. IF THE PROFESSIONAL PERSON CONDUCTING THE EVALUATION DOES NOT HOLD TWO (2) YEARS EXPERIENCE, THEY MAY CONDUCT THE EVALUATION AND A PROFESSIONAL PERSON THAT HOLDS THE REQUIRED EXPERIENCE MUST REVIEW, PROVIDE CLINICAL CONSULTATION AS NEEDED, AND PROVIDE THEIR SIGNATURE TO THE EVALUATION.”.
15.14.6 Court Notification Facilities do not have a process or communication pipeline with the courts to make the type of notification being requested. Recommendation: Request that the BHA develop a process wherein the facility notifies the BHA who makes the appropriate notification to the court and establishes that process directly with the courts.	The BHA will be providing technical assistance and training to providers in order to create a standardized process.

15.16.2.A Involuntary Emergency Services Designation Emergency medical services facilities are frequent and necessary locations for M-1 holds given the nature of the services they provide. This currently occurs without a voluntary new designation type. As these services already occur in emergency medical services facilities, adding a new voluntary designation type would be unnecessarily confusing without providing patient or facility value. Recommendation: Strike 15.16.2.A	Thank you for your feedback. The new Involuntary Emergency Services Designation option comes from HB22-1256.
15.5 DATA REPORTING REQUIREMENTS ALL 27-65 DESIGNATED FACILITIES - Please provide the template for the data reporting the first month in the year you want reported. That allows for recording to be done as the M-1s are done and ensures that we capture the data you want on the front end.	Thank you for your feedback. This template is in progress. BHA data experts plan to create a "how to use" video for this as well as plan to provide technical assistance and training.
"DISAGGREGATED NUMBERS" Previously, providers reported aggregated data. What kind of tools/training will BHA provide to help providers move to this disaggregated reporting?	Thank you for your feedback. This template is in progress. BHA data experts plan to create a "how to use" video for this as well as plan to provide technical assistance and training.
" FACILITIES SHALL OUTLINE CRITERIA" - We assume that we can point to existing HR policies in this regard, correct?	Thank you for your question. Language has been added to reflect: "FACILITIES SHALL OUTLINE CRITERIA IN <i>THEIR</i> POLICIES AND PROCEDURES".
providers previously reported aggregated data. What kind of tools/training will BHA provide to help providers move to this disaggregated reporting?	Thank you for your question. This training will be provided by the data specialists at the BHA; more updates to come.
When you say July 1st, 2024 for the new data requirements, does that mean that for calendar year 2024 due by 7/1/25, we'll have to submit half of the year as is in current state and the other half using the new requirements? If so, that will be very difficult and cause a lot of extra work for facilities. I would strongly recommend changing the data requirements go live to align with a calendar year per the reporting requirements. Additionally, please note that there are several new requirements that require builds in our EHR. These builds take a long time alone, and then we need to ensure we can capture the data. This means facilities will need approximately a full year to prepare for this.	Thank you for your question. That is correct. Effective dates have been aligned with the data reporting period in rule.
15.5 Data reporting- what is the necessity for submitting non-aggregated PHI for voluntary patients not subject to the provisions of 2765? This seems to go beyond minimum necessary thresholds. In addition, there is so much detail required, this is going to create a tremendous administrative burden. We can't take this to Epic while it is in draft form, so we can't even	Thank you for your questions. It is important to note that about 80% of the people who access 27-65 services in the state of Colorado do so voluntarily. Therefore to have a complete picture of these services, how, and to whom they are provided, we need this type of data for voluntary individuals as well as involuntary.

start the process yet. The data request requires patient identifiers whereas it previously was aggregated, so that requires way more detail with hundreds of data elements. Burden of reporting is great throughout this document. The data reporting requirement appear excessive. What is the necessity for the state to have this extensive data in a non-aggregated format (disclosures of which will have to be accounted for under HIPAA, unlike a limited data set)? Has the state considered how it will protect highly sensitive data? How is the safety of the data transmission assured protected against inappropriate access, especially given that the submission process is via email? Some of the information will be subject to the strict privacy protections of 42 CFR Part 2, under which even a state regulation requiring disclosure would be insufficient to allow disclosure without patient consent. How will the privacy protections of Part 2 patients be considered given that there is no exception to release that data on a Part 2 program patient? Is the BHA a covered entity under HIPAA? Given the risk of cyber-attacks, how will health care entities be assured that this sensitive information is protected? As a healthcare system, the data reporting requirements will require 2 sets of policies for the release of information: We will need one set for medical patients whose data is not subject to the data reporting provisions of Chapter 17 and another set of policies for patients whose data will be released to the BHA. Further, we will need a process for carving out information protected under Part 2 to ensure that such information is only provided if the patient consents to disclosure to the State. It seems stigmatizing that patients who are treated for behavioral health conditions will have reduced privacy protections re: the release of their private information in order to comply with the BHA requirements. Regarding reporting requirements in general, historically the BHA (OBH at the time) had committed to the creation of a system by their D&E unit that would allow facilities to extract data to inform facility-specific data needs, i.e. the ability to pull statewide treatment information or region-specific treatment information for purposes of grant writing. Will these data reporting requirements result in that being made available?	All reports coming from facilities will include PHI and therefore HIPAA rules apply. Any dataset released to the public for this program will have to be aggregated because the entire dataset is a record of individuals' treatment which is PHI. It is important to note that HIPAA covers two types of personal information: PHI and PII. Both have to be removed to share data with the public, not just PHI. The BHA will be able to provide more insight into treatment with the new data being collected and we will be able to build regional and facility-specific reports. Whether or not facilities will be able to pull that data themselves to create reports is still being discussed internally at the BHA.
15.5.2.A.3.h – should be 'Licensed Addiction Counselor' - licensed addiction counselor only appears under 'Facility- or Community-Based Personnel' definition).	Thank you for your suggestion. This has been corrected.

There are 'Addiction Counselor' listed in two sections (one of which specifies that this individual is licensed pursuant to the relevant statute), one 'Licensed Addiction Counselor under 'Facility- or Community-Based Personnel' definition.	
Any changes to reporting take a significant amount of time to change in a hospital's electronic health record – we appreciate the BHA's recognition that any reporting changes will likely require regulatory flexibility to ensure that facilities are not being penalized for failing to track/ report data for data requests that will not be finalized until November 2023 at the earliest (meaning at least four months to build the capability into an electronic health record to begin tracking the data).	Thank you for your feedback. The BHA is working hard to create training and provide technical assistance in order to help providers with a smooth transition.
15.5.2.A.6. I am not certain this needs to be in the reporting requirements, as the BHA would have records of any placement assistance requests received from facilities	Thank you for your suggestion. This has been removed.
15.5.3.A.11.e Do they mean the documentation is not located or the individual is not located?	Thank you for your question. This language has been clarified to "UNABLE TO LOCATE RESPONDENT FOR TREATMENT".
There are a number of places with consistencies between data requirements. For example, employment and housing status for Short and long-term certs but no where else. What is the rationale? Additionally, there are a few places where there are lack of definitions (self-destructive behavior, physically combative, etc.). We would like to see some definitions and clarity around those terms.	Thank you for your feedback. Data reporting requirements come from statute. The BHA is not proposing definitions for these terms at this time.
15.5.9.D Are we simply attesting to the fact we maintain a record?	Thank you for your question. No, these are the disposition categories for individuals released from the emergency involuntary hold.
while i am in favor of collecting more data around holds and certs, i am worried about the admin burden this is going to cause. caring for pts on holds and certs is already very time consuming and when people are in crisis i fear this will slow the process down if all of the data collection is the responsibility of the person doing the hold/cert paperwork	Thank you for your feedback. While we understand administrative burden, our priority at the BHA is serving Coloradans in a way that adheres to the BHA values. As much as possible, clinicians should not be doing the data reporting.
will these data reporting requirements be integrated into any of the new forms?	Thank you for your question. Data reporting requirements will not be integrated into any of the M forms at this time.
Will clients need to give permission to disclose this personal information to the State?	Thank you for your question. The BHA is a HIPAA-compliant entity, meaning we are able to receive datasets with client PHI and PII through encrypted channels.
15.5.2, 15.5.3, 15.5.9 Reporting Requirements Federal privacy law and subsequent regulation requires covered	Thank you for your feedback. These rules have been reviewed by the Attorney General's Office. 11.5.2 specifies these data reporting requirements are to be

entities to limit the use or disclosures of protected health information to the minimum necessary standard intended for the purpose (45 CFR 164.502(b)). Strongly recommends that the BHA consult legal counsel to avoid a conflict with patient privacy protections in the Health Insurance Portability and Accountability Act (HIPAA) and 42 CFR Part 2. Federal law's preference is always to submit de-identified data. Clarify wording in 15.5.2 and 15.5.3 to apply only to designated facilities. The same clarification should be made in the following sections that apply to data sets for designated facilities, not emergency medical facilities that only have reporting obligations under C.R.S. § 27-65-106(9)(a): The designated facility is required to maintain a data set sufficient to report the following disaggregated numbers to the BHA annually by July 1 . . . 15.5.3 Short and long-term certifications The designated facility is required to maintain a data set . . . 15.5.4 Voluntary individuals The designated facility is required to maintain a data set . . . 15.5.5 Involuntary medications The designated facility is required to maintain a data set . . . 15.5.6 Involuntary treatments The designated facility is required to maintain a data set . . . 15.5.7 Electroconvulsive therapy (ECT) procedures As defined in section 13-20-401, C.R.S., the designated facility is required to maintain data sets . . . 15.5.8 Imposition of legal disability or deprivation of a right The designated facility is required to maintain data sets . . . Additionally, EHR builds can only happen once all procedures and forms are finalized and take at minimum four months. Provide reporting guidance and hold trainings utilizing finalized data elements at least six months prior to any expectation of data While most of these provisions would require EHR updates	completed by 27-65 designated facilities, 11.5.2 and 11.5.3 fall under 11.5.2. The BHA will be providing technical assistance and training to providers.
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15.5.2.8 (challenges encountered with placement) and 15.5.2.9 (reason behind the hold) would both require significant, complex EHR builds and administrative changes. Additionally, these items are both incredibly subjective and documentation could include many scenarios that are not articulated. Strike section 15.5.2.8 and 15.5.2.9. Transportation holds become void when a patient crosses the receiving facility threshold – this was recently reaffirmed by HB 23-1236 in 27-65-107(b) and the receiving facility should not be responsible for reporting on them. Strike section 15.5.2.10	
“15.6.3 PERSONNEL TRAINING REQUIREMENTS FOR 27-65 DESIGNATED FACILITIES” Facilities already provide annual training to staffs, and track it. So just want to confirm that this language allows facilities to document their existing training and submit it to you, without necessarily having to develop new trainings.	Thank you for your question. This language has been changed for clarification: “FACILITIES DESIGNATED FOR 27-65 SERVICES UNDER THESE RULES SHALL DEVELOP POLICIES AND PROCEDURES FOR PERSONNEL TRAINING CURRICULUM AND SCHEDULES IN ORDER TO MEET THE FOLLOWING REQUIREMENTS.”
“UPON THE INDIVIDUAL’S WRITTEN AUTHORIZATION, TO THE INDIVIDUAL’S ATTORNEY OR THE INDIVIDUAL’S PERSONAL PHYSICIAN. “ Doesn’t HIPAA’s privacy rule allow disclosure of records between medical providers without written patient consent as long as they are HIPAA-covered entities?	Thank you for your question. This language comes from 27-65-118(1)(a), C.R.S. and must remain.
“THIS SECTION PROVIDES FOR THE RELEASE OF INFORMATION ONLY AND IS NOT DEEMED TO AUTHORIZE THE RELEASE OF THE WRITTEN MEDICAL RECORD WITHOUT AUTHORIZATION BY THE INDIVIDUAL OR AS OTHERWISE PROVIDED BY LAW.” Is it possible to make the succeeding sections (C, D, etc.) subsections of (A) and (B)? Some of our folks are reading (C), for example, to mean that the treating professional can decide whether to release or withhold information against the individual’s wishes. Of course, that’s not the intent, and (A) makes that clear. But because of the way this is set up, people are not necessarily referring back to the governing language at (A).	Thank you for your suggestion. This feedback has been incorporated.
“IF JUDICIAL REVIEW IS REQUESTED BY THE INDIVIDUAL, THE COURT SHALL HEAR	Thank you for your feedback. This language comes from 27-65-124(6) C.R.S.

THE MATTER WITHIN TEN (10) DAYS AFTER THE REQUEST,” Just confirming that BHA has jurisdiction to write rules governing the court's behavior?	
“ADVANCE DIRECTIVES” We do not believe it is appropriate to require an inquiry about advanced directives as part of the initial screening and assessment. In a crisis situation, the focus is on immediate safety.	Thank you for your feedback. Language has been changed to “PSYCHIATRIC ADVANCE DIRECTIVES”.
“NOTIFICATION TO THE INDIVIDUAL'S PRIMARY CARE PROVIDER, IF APPLICABLE “ ADD: “AND KNOWN”	Thank you for your suggestion. Suggested language has been added.
“MANAGED CARE FACILITY, AS DEFINED IN SECTION 25.5-5-403 C.R.S.” There is no definition of "managed care facility" at 25.5-5-403 - should this say "managed care organization" or "managed care entity"?	Thank you for your question. Language has been changed to “managed care entity”.
“IF THE PSYCHIATRIC EMERGENCY HAS ABATED BECAUSE OF THE EFFECT OF PSYCHIATRIC MEDICATIONS AND THE PHYSICIAN OR ADVANCED PRACTICE REGISTERED NURSE “ Should this include PAs?	Thank you for your question. Language has been changed to “AUTHORIZED PRACTITIONER” which can include PAs with proper training according to the definition.
“AN INDIVIDUAL WHO IS IN SECLUSION/RESTRAINT MUST BE OBSERVED IN-PERSON BY FACILITY PERSONNEL AT NO MORE THAN SIX (6) FEET PHYSICAL DISTANCE FROM THE INDIVIDUAL.” This may place staff within kicking distance. A greater distance would be safer for staff.	Thank you for your feedback. Language has been changed to “TEN (10) FEET.”
With crisis and M1 holds it is very important that folks that are deaf and deaf/blind that they are still able to use their hands and that there is someone there that can communicate with them.	Thank you for your feedback. Language has been added to policies and procedures to reflect this.
“THE CERTIFIED PEACE OFFICER MAY REQUEST ASSISTANCE FROM A BEHAVIORAL HEALTH CRISIS RESPONSE TEAM FOR ASSISTANCE IN DETAINING AND TRANSPORTING THE INDIVIDUAL “ How does this compare with current requirements? Mobile Crisis, STAR van, and co-responders do not assist in detaining a person and cannot transport a person against their will. Mobile Crisis doesn't transport at all. The other programs are not equipped to transport a person that is a risk to self, others, or gravely disabled.	Thank you for your question. “BEHAVIORAL HEALTH CRISIS RESPONSE TEAM”, AS DEFINED IN 27-65-102 (4), C.R.S., MEANS A MOBILE TEAM THAT RESPONDS TO INDIVIDUALS IN THE COMMUNITY WHO ARE IN A BEHAVIORAL HEALTH CRISIS AND INCLUDES AT LEAST ONE LICENSED OR BACHELOR-DEGREE-LEVEL BEHAVIORAL HEALTH WORKER. A "BEHAVIORAL HEALTH CRISIS RESPONSE TEAM" INCLUDES, BUT IS NOT LIMITED TO, A CO-RESPONDER MODEL, MOBILE CRISIS RESPONSE UNIT, OR A COMMUNITY RESPONSE TEAM. Language has been changed from: "assistance in detaining and transporting" TO: "assistance in de-escalating and preparing the individual for transportation".
15.14.2.H: Some of our centers report that law enforcement in their areas is reluctant to	Thank you for your feedback. This language comes from 27-65-106(5), C.R.S.

transport to certain hospitals because they believe the hospital "will not hold the patient anyway." There is concern about exacerbating that reluctance by making hospitals even less willing to hold the patient. We'd like to discuss, make sure we understand how this compares to current requirements and learn more about the feedback you've received from hospitals on this.	
"ALL INVENTORIED PROPERTY SHALL BE RETURNED TO THE INDIVIDUAL UPON DISCHARGE" Does this include illegal substances and weapons?	Thank you for your question. We have added policy language around this, but will not be forcing facilities to police inventory.
15.14.6.A - "Immediately" is likely not practical. What happens when this is on the weekends or evenings? Suggest we change this to "shall, by the next business day, notify..."	Thank you for your feedback. This language comes from 27-65-106(7)(b), C.R.S.
"MANAGE AND PREVENT ELOPEMENT OF INDIVIDUALS ON AN EMERGENCY MENTAL HEALTH OR EMERGENCY TRANSPORTATION HOLDS" Does this mean that seclusion/restraint/ physical management and/or locking the doors will be allowed within a free standing WIC?	Thank you for your question. ATUs and WICs are required to obtain a 27-65 designation. CSUs may choose to become designated or not. WICs will have the option to use seclusion and restraint, but do not have to.
11.17.4.C"EVERY PETITION FOR LONG-TERM CARE AND TREATMENT MUST INCLUDE A REQUEST FOR A HEARING BEFORE THE COURT PRIOR TO THE EXPIRATION OF SIX (6) MONTHS AFTER THE DATE OF ORIGINAL CERTIFICATION " Should this say that a petition for an extension must be filed prior to 30 days before the Long-term certification expires?	Thank you for your feedback. The proposed changes have been added.
"AN ORDER FOR LONG-TERM CARE AND TREATMENT MUST GRANT CUSTODY OF THE INDIVIDUAL TO THE BHA FOR PLACEMENT WITH AN FACILITY OR FACILITY DESIGNATED BY THE COMMISSIONER TO PROVIDE LONG-TERM CARE AND TREATMENT. " How is it indicated that the BHA is granted custody for placement? Not clear what that means.	Thank you for your question. This is statute language (27-65-110(4), C.R.S. The BHA would be responsible for certified individuals under the care coordination circumstance. Clarifying language has been added: <i>"physical custody."</i>
15.17.4.L - These provisions may not be practical in the case of an emergency.	Thank you for your feedback. This is a statutorily required timeframe (27-65-110(6), C.R.S.).
"HAS ACUTE WITHDRAWAL SYMPTOMS, IS AT RISK OF WITHDRAWAL SYMPTOMS, OR IS INCAPACITATED DUE TO A SUBSTANCE USE DISORDER." If a provider were to get a substance use endorsement, it would not make sense for them not to accept a patient at risk for withdrawal. This language is inconsistent with the desire to move towards co-occurring treatment as a state. In addition, it has always been common practice to treat co-occurring withdrawal on behavioral health units.	Thank you for your feedback. The following was added to 11.17.8.D: "5. HAS ACUTE WITHDRAWAL SYMPTOMS, IS AT RISK OF WITHDRAWAL SYMPTOMS, OR IS INCAPACITATED DUE TO A SUBSTANCE USE DISORDER AND FACILITY DOES NOT HAVE APPROPRIATE CAPACITY/ENDORSEMENTS TO ADDRESS ISSUES OF WITHDRAWAL."
15.17.13.A - Confirming that this language	Thank you for your question. You are correct in that

allows facilities to have arrangements with other providers for these services, not to have these personnel on-site themselves.	providers services do not necessarily need to be personnel staffed on site.
15.17.13.A.1 - Some patients will not consent to a physical examination. How will this term be defined?	Thank you for your question. 11.17.13.A.1.a states "IF THE INDIVIDUAL REFUSES TO COMPLETE A PHYSICAL EXAMINATION, DOCUMENTATION MUST BE HELD IN THE CLINICAL RECORD OF FACILITY EFFORTS."
15.17.18.A - How will these terms be defined? ("SERIOUS ILLNESS, SERIOUS INJURY")	Thank you for your question. These are defined in Part b of that section.
15.17.17.B - Not all persons have an emergency contact or feel comfortable providing that information in a crisis setting.	Thank you for your feedback. The language has been changed to read as "THE POLICY SHALL INCLUDE A REQUIREMENT THAT THE FACILITY NOTIFY AN EMERGENCY CONTACT, IF ONE HAS BEEN PROVIDED..."
15.17.20.F.1.a - "AT LEAST TWENTY-FOUR (24) HOURS IN ADVANCE OF DISCHARGE OR TRANSFER" There are times that a person needs to be discharged more immediately than 24 hours, e.g., when an individual physically harms another individual. In these cases, the person is discharged from the treatment program to a more appropriate setting. It would not be appropriate to wait 24 hours for that discharge to occur.	Thank you for your feedback. This section is specific to the discharge summary documentation required, as stated in Part 1, not that a person can not be discharged without 24 hour advance notice.
15.17.25.A - "...TERMINATES AS SOON AS THE PROFESSIONAL PERSON IN CHARGE OF TREATMENT OF THE INDIVIDUAL AND THE BHA DETERMINE THE INDIVIDUAL HAS RECEIVED..." What is the reason and process for including the BHA in the decision to end involuntary treatment? Is that for both inpatient and outpatient or just inpatient?	Thank you for your question. This requirement comes from 27-65-112, C.R.S. and is effective July 1, 2024. The BHA will be providing technical assistance and training to providers in order to create a standardized process. This is for involuntary treatment on a short or long term certification, not outpatient certification.
15.18.2.A.3 - This may become a barrier to transferring a client out of a hospital. What is the rationale for this requirement?	Thank you for your question. The facility must document attempts to obtain physical examination information if not available.
15.18.3.B - Is this enough persuasion to make it a reliable recourse? What if the court does not issue such an order?	Thank you for your question. This language comes from 27-65-111(3), C.R.S. If the court does not issue the order, the agency holding the certification should be able to request a hearing.
If patients on certs can request a change to voluntary status, how does that work and what exactly does that mean? Current state, they can't contest until it is up. Patients always want to get off cert. Does this mean everytime they ask this they have a court hearing? That is going to be a lot.	Thank you for your question. The BHA will be providing technical assistance and training to providers in order to create a standardized process.
Certs on physical exams, they don't want to do that. One of the challenges, how can you force them to go to a physical health doc for an exam or force them to get blood drawn.	Thank you for your comment. If an individual refuses a physical examination, that must be documented in the chart.
Bringing someone to hospital when on a certification but not necessarily on the hold, but then the problem is that the hospital denies them because they aren't acute enough. Is there	Thank you for your question. The BHA is unable to force a facility or hospital to accept individuals on a hold or certification, the BHA will have the ability to assist with difficult to place individuals, however,

a way for individuals on certifications to always meet medical necessity?	medical necessity is not something the BHA is able to determine.
Outpatient certs, is law enforcement changing their rules regarding pickup if pt not abiding by certification? How are we going to get law enforcement to comply with enforcement?	Thank you for your question. 27-65-111(3) directs enforcement of outpatient certifications and does direct that if the court decides that outpatient is not meeting the needs of the individual and they are decompensating, a certified peace officer or secure transportation provider will provide transport for the individual to the least restrictive designated facility. Training will be provided to judicial districts and law enforcement on these statutory requirements.
BHA responsible for implementation of 27-65, recent issue is that most of them want to make the 27-65 mandatory trainings	Thank you for your comment. BHA is in the process of hiring 27-65 training staff that will assist in the training and technical assistance of implementation.
For Transportation Holds- did the need to read the new patient rights go into effect in august of 2022? They aren't on the current M forms	Thank you for your question. All updated M forms, including the new transportation rights form, are now available on the BHA website.
Cell phones: Does this apply to both minors and adults?	Thank you for your question. Yes, that is correct.
Does C.R.S. 27-65-106 still go into effect 7/1/23?	Thank you for your question. 27-65-106, C.R.S. goes into effect July 1, 2024.
Regarding who can do an evaluation for a mental health hold and the credentials they must have is this pushed back to Jan 2024 too? We are wondering how one gets 2 years of risk assessment in a health care setting if they can't do these assessments until they have the 2 years? Options for supervision?	Thank you for your feedback. We have added the following language "1. IF THE PROFESSIONAL PERSON CONDUCTING THE EVALUATION DOES NOT HOLD TWO (2) YEARS EXPERIENCE, THEY MAY CONDUCT THE EVALUATION AND A PROFESSIONAL PERSON THAT HOLDS THE REQUIRED EXPERIENCE MUST REVIEW, PROVIDE CLINICAL CONSULTATION AS NEEDED, AND PROVIDE THEIR SIGNATURE TO THE EVALUATION."
Does this apply to patients on a short-term certification or only MHH?	Thank you for your question. 27-65-119, C.R.S. extends the same right to respondents receiving care on short and long term certification.
If we are intervening and putting somebody on a hold, while we are attempting to place them, is this restriction applicable in that situation? Before they are placed on a unit?	Thank you for your question. Yes, that is correct.
One of the big concerns I have about these rules, there are many places where I feel like they're essentially a resuscitation of the statute with the change being changing person to individual. I really look to the regulations to be telling me how to implement the statutes, not just repeating the statutes. I want more guidance and more help in the regulations. Is this what we will see in final regs or will we get more help or will we just be getting a repeat of it.	Thank you for your feedback. Because there was so much content in HB22 - 1256 about a complex process and system, our priority was to make sure the majority of it got into rule for provider awareness.
Who can do mental health hold evals with the requirement in regards to having two years of risk assessment in a healthcare setting and how one would go about getting those two years if they couldn't do those assessments until they had 2 years? We are having some workforce issues and just trying to figure out we are going	Thank you for your feedback. We have added the following language "1. IF THE PROFESSIONAL PERSON CONDUCTING THE EVALUATION DOES NOT HOLD TWO (2) YEARS EXPERIENCE, THEY MAY CONDUCT THE EVALUATION AND A PROFESSIONAL PERSON THAT HOLDS THE REQUIRED EXPERIENCE MUST REVIEW,

to meet that section. My team has someone that has an MSW but not LCSW and someone with a license but not in healthcare setting for 2 yrs. How do you get that requirement? How do we get new clinicians that can do them if they don't have two years? Hoping for clinical supervision or collaboration etc to get around that.	PROVIDE CLINICAL CONSULTATION AS NEEDED, AND PROVIDE THEIR SIGNATURE TO THE EVALUATION."
As of July 1st, we will no longer be able to do subsequent holds, would it still be illegal under old rules unless certification?	Thank you for your question. Yes, that is correct.
Form standardization, what will that look like?	Thank you for your question. All updated M forms can be found on the BHA website.
Care coordination and nights/weekends?	Thank you for your question. The BHA is working to figure out what this will look like.
Lot of questions about the data reporting section 15.5.1. Some of is enforcement and no enforcement at BHA for hospitals CDPHE licensed facility and report to ombudsman and doesn't seem right.	Thank you for your feedback. All 27-65 data reporting requirements are for any provider providing these services, and does include emergency departments. The ED requirement is new and in statute 27-65-106(9) and begins 7/1/24.
Hospitals may have problems and hope the process will be cleaner than it has been	Thank you for your feedback. The BHA is hopeful the process will be cleaner than it has been in the past with upcoming rule changes.
Inconsistency in the data reporting requirements if it is involuntary medication, treatment, some require some things and others do not. Want to ask about those inconsistencies across the modalities.	Thank you for your question. Inconsistencies are typically caused because the BHA is asking different questions about those modalities.
Do we expect the expected crisis assessment format by July? Once we have rules will there be a crosswalk to old OBH rules?	Thank you for the question. The BHA is actively working on the standardized crisis assessment and plans to get it out to 27-65 providers as soon as possible. The BHA will train all 27-65 providers on the HB 22-1256 changes.
Chapter 15: can you confirm that M-1 holds can be initiated by PAs and NPs now, but they cannot terminate them? The termination needs to be done by a "Professional Person?"	Thank you for the question. Yes that is correct, and you can find this information in the definition section under "Intervening Professional" in Part 11.2.
What aspects of Chapter 15 go into effect when?	Thank you for the question. Chapter 11 is anticipated to go into effect with the other BHE and Safety Net rules that are currently proposed, effective January 1, 2024.
providers previously reported aggregated data. What kind of tools/training will BHA provide to help providers move to this disaggregated reporting?	Thank you for your question. The BHA's data team will provide templates, technical assistance, instructional videos and office hours to assist providers in submitting the disaggregated data being requested in this section.
• 15.5.1 o Data reporting requirements are now from aggregate to disaggregate. Will need to have an idea of how the BHA wants to receive data from us by providing us with updates to our data sheets/etc...	Thank you for your feedback. The BHA's data team will provide templates, technical assistance, instructional videos and office hours to assist providers in submitting the disaggregated data being requested in this section.
Clarification regarding distinguishing 27-65 outpatient services versus 27-65 24-hour facilities. The old rules clearly distinguished this.	Thank you for your feedback. The section titles distinguish the type of 27-65 facility being addressed in that section.
All local hospitals report they are not a 27-65	Thank you for your feedback. Passing of HB 22-1256

facility, and therefore, cannot accept anyone on a 27-65 hold in the emergency room. This results in barriers to placements if the placement facilities require specific medical tests for clearance. In a specific example, the individual that was released from jail in a prior example was released to the Crisis Walk-in Center because both local hospitals refuse to accept individuals from a jail released to the emergency room for a psychiatric evaluation.	opened the door for emergency medical services facilities to become 27-65 designated. This new section is found in Part 11.16.
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17.5.5.A.1.j., Minor semantics request that is a blip in the grand scheme of things: Could they replace “they” with “the individual?”	Thank you for your suggestion. This language has been changed to “the respondent” to match statutory language following legal review.
Some facilities history report differences in short-term versus long-term care and treatment. Appreciative that the rule clearly states that there is not a difference between the two designations. This was an issue with Parkview inpatient in the past, but with that facility closed this may not be an issue for our region.	Thank you for your comment.
Appreciative that the emergency medical services is back in the rules as a hold zone for 27-65. In the past an ED can push back on 27-65 clients stated that they are not a designated facility. Having this in the rule is very helpful.	Thank you for your comment. Please note that 27-65 designation of emergency departments is not statutorily required. The rules will only be applicable to EDs who voluntarily elect to become designated for 27-65 services.
Would you be able to obtain most of the Data Reporting requirements from our CCARs and Google Forms for B (2) (page 14) the certified clients and B (3) (page 15) the voluntary clients?	Thank you for your question. At the current time, the Google Form will not be sufficient for Certification data.
Will the BHA training on M-1 holds include information on how to reconcile both EMTALA obligations and the patient rights included in HB 22-1256, including the right to a cell phone?	Thank you for your question. The BHA plans to review EMTALA to better understand its intersection with 27-65 statute.
Hospitals are held to incredibly strict standards by the Centers for Medicare & Medicaid Services and the Emergency Medical Treatment & Labor Act (EMTALA). Without the opportunity to review proposed changes in greater detail, it is impossible to ensure that the proposed regulatory changes align with federal law.	Thank you for your comment. We are working under a statutorily established timeline to have rules effective January 1, 2024. This is the first iteration of an ongoing rule revision process.
What is the reasoning for Certification discharges to require the signature of both the professional person AND the medical director – seems like an extra step that may not be necessary.	Thank you for your question. This is a statutory requirement. Please see 27-65-109(9), C.R.S.
17.5.5(D)(3): Should the word “assent” be added here (individual’s consent or assent) as was done in 17.5.5(D)(1)?	Thank you for your feedback. The term “assent” has been removed from Chapter 11 entirely to match statutory language.
17.5.5(A)(2), (C)(5): We question the use of the term “professional person” in these sections since that term is defined to include a licensed psychologist and a licensed psychologist does not have prescribing authority at this time. Physician assistants, however, do and should be	Thank you for your feedback. This language has been corrected to “physician or APRN”.

included in the definition.	
17.5.5(A)(1): Change the word “custodian” to “parent” so the added language is consistent with the rest of the paragraph.	Thank you for your feedback. This language has been changed.
17.5.3(A)(2): Recommend this be narrowed down rather than referring just to Chapter 17. Staff does not need to know all of the chapter (such as the regulations around designation application).	Thank you for your feedback. This is from current 2 CCR 502-1 regulations. This is a matter we will be revisiting in future revisions and your feedback will be considered at that time.
17.5.2(d)(a): Pharmacist is not listed in Chapter 2 as someone who can administer medications. Regulations should be consistent.	Thank you for your feedback. Part 2.13.1(E) currently reads as "ENSURE MEDICATIONS ARE ADMINISTERED ONLY BY LICENSED OR CERTIFIED PERSONNEL ALLOWED TO ADMINISTER MEDICATIONS UNDER THEIR OWN SCOPES OF PRACTICE, OR AN UNLICENSED PERSONNEL WHO ARE QUALIFIED MEDICATION ADMINISTRATION PERSONS (QMAPS), HAVING PASSED A COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT APPROVED COMPETENCY EVALUATION FOR MEDICATION ADMINISTRATION." This would include pharmacists.
17.5.2(1)(b): What about controlled substances being used under the direction of other health care providers licensed to prescribe, such as advanced practice nurses and physician's assistants?	Thank you for your question. Part 17.5.2(1)(b) currently reads as "The FACILITY shall not employ or allow any individual who is under the influence of a controlled substance, as defined in Sections 18-18-203, C.R.S., 18-18-204, C.R.S., 18-18-205, 18-18-206, C.R.S., and 18-18-207, C.R.S., or who is under the influence of alcohol in the workplace. This does not apply to employees using controlled substances under the direction of a physician and in accordance with their health care provider's instructions, as long as it does not pose a safety risk to the employee, other employees, or individuals."
17.5.12(D)(3): Suggest changing “counsel” to “an attorney” to be consistent with the rest of the rule.	Thank you for your feedback. This language has been changed to be consistent with the rest of the rules.
17.5.11(K): “...INDIVIDUAL WHO IS CONFINED INVOLUNTARILY THE FACILITY STAFF REQUESTS THE INDIVIDUAL TO SIGN IN VOLUNTARILY” The use of the phrases “in voluntarily” and “involuntarily” in the same sentence is confusing. We request this be clarified.	Thank you for your feedback. This language comes from 27-65-103(5)(a), C.R.S.
17.5.11(I)(1)(a)(i): Says, in part, “With the guardian’s consent for as long as the ward agrees.” What if the guardian consents and the ward doesn't agree?	Thank you for your question. The section above, Part 11.14.3.1.a, indicates that this is a provision for voluntary treatment. The ward must agree to voluntary treatment otherwise it would be involuntary treatment. So if the ward doesn't agree, this particular patient right wouldn't apply because we would be talking about involuntary treatment.
17.5.11(H)(7)(a): It is not clear to whom <u>“THE INDIVIDUAL’S DESIGNEE”</u> refers.	Thank you for your comment. This language comes from 27-65-106(4)(d), C.R.S. We have added "THE INDIVIDUAL'S LAY PERSON DESIGNEE" for clarification.
17.5.11(H)(1) and (2): It appears that these should be combined.	Thank you for your feedback. There are two ways for an individual to be placed on an emergency mental

	health hold: 1) by an intervening professional, or 2) by the court. This only outlines the court option, so they are two separate processes.
17.5.10(J) (1) (d): Recommendation matching language to: (I) Client Rights on p. 84 "TO HAVE REASONABLE ACCESS TO TELEPHONES OR OTHER COMMUNICATION DEVICES AND TO MAKE AND TO RECEIVE CALLS OR COMMUNICATIONS IN PRIVATE"	Thank you for your feedback. This patient right is meant to be different. This patient right is specific to involuntary transportation holds. While it is confusing, we must align with the statute. Please see 27-65-107(4)(a)(IV), C.R.S..
17.5.10(A)(2), 17.5.11(A)(1) and (2): Appreciative that the emergency medical services is back in the rules as a hold zone for 27-65. In the past an ED can push back on 27-65 clients stated that they are not a designated facility. Having this in the rule is very helpful.	Thank you for your comment. Please note this is OPTIONAL designation for emergency departments and not required by law.
Should we include a licensed psychologist (LP?)	Licensed psychologists are included in the definition of "Professional person" in Chapter 1 (Part 1.3).
17.5.1(A): Please provide report tool in adequate time for organizations to strategize for change.	The BHA will be working on this over the next couple months. We anticipate sending a new 27-65 data reporting template to designated providers 2-3 months prior to this rule going into effect.
17.4.H: Suggest the denial be sent by email and certified letter since so many people are working remotely.	Thank you for your feedback. The language will stand as drafted.
Do they also have to adhere to emergency medication regulations?	Thank you for your question. Yes, all 27-65 designated facilities must adhere to Part 11.8 - Psychiatric Medications.
What does "L staff person" mean?	That was a typo. This has been corrected to read as "staff person".
Should we include a licensed psychologist (LP)?	Licensed psychologists are included in the definition of "Professional person" in Chapter 1 (Part 1.3).
Is "placement" the word we want to use in the era of FFPSA where the focus is on treatment rather than placement?	The term "placement" is used throughout Article 65 of Title 27, C.R.S.
17.2.R.4: When will we receive this specific mental health training identified by the BHA for RN's? This would need to be provided months prior to 7/1/23 in order to incorporate in existing curriculum.	Thank you for your comment. We are in the process of hiring training staff for the 27-65 team that will assist in this training process before rules go into effect January 1, 2024
17.3.C and D: Is this suggesting that medical hospitals seek designation? There is later language that seems to provide a specific emergency services designation. (C) ANY FACILITY LICENSED BY A STATE AGENCY TO INCLUDE THE COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT OR THE DIVISION OF CHILD WELFARE WITHIN THE COLORADO DEPARTMENT OF HUMAN SERVICES PROVIDING INVOLUNTARY MENTAL HEALTH SERVICES WHETHER INPATIENT OR OUTPATIENT, SHALL SEEK A 27-65 DESIGNATION. (D) IN ORDER TO PROVIDE INVOLUNTARY SERVICES DESCRIBED IN THIS CHAPTER 17, A FACILITY	Thank you for your question. This would apply to hospitals that have inpatient psych units. The hospital itself is regulated by CDPHE, however, their inpatient psych units will also need to be 27-65 designated. 27-65 designation of emergency departments is separate and optional.

MUST RECEIVE A DESIGNATION BASED ON THEIR SUBSTANTIAL COMPLIANCE WITH THE SERVICE STANDARDS DESCRIBED IN THIS CHAPTER.	
17.2 Definitions (J) suggests the option to obtain 27-65 or not. This is unclear.	Correct. Emergency medical services facilities (Emergency Departments) are NOT required to obtain a 27-65 designation. If they choose to apply, this gives them the ability to move patients on holds within the hospital.
"17.3.1, A1a references separate designation requirements for psych units within a medical setting. Question: When there is a medical patient in a medical setting with acute medical needs who also needs psych meds but won't take them voluntarily and is not on a hold or cert, is there a mechanism for providing involuntary meds outside of a designated facility?"	Thank you for your question. The rules for non-designated medical facilities would fall under Colorado Office of Public Health and Environment (CDPHE).
17.5.1 Data reporting- what is the necessity for submitting non-aggregated PHI for voluntary patients not subject to the provisions of 2765? This seems to go beyond minimum necessary thresholds. In addition, there is so much detail required, this is going to create tremendous administrative burden and I don't that we can build the Epic capacity for this by July. We can't take this to Epic while it is in draft form, so we can't even start the process yet. The data request requires patient identifiers whereas it previously was aggregated, so that requires way more detail with hundreds of data elements. Burden of reporting is great throughout this document.	Thank you for your feedback. Data requirements in Chapter 11 come directly from 27-65-131, C.R.S.
"The data reporting requirement appear excessive. What is the necessity for the state to have this extensive data in a non-aggregated format (disclosures of which will have to be accounted for under HIPAA, unlike a limited data set)? Has the state considered how it will protect highly sensitive data? How is the safety of the data transmission assured protected against inappropriate access, especially given that the submission process is via email? Some of the information will be subject to the strict privacy protections of 42 CFR Part 2, under which even a state regulation requiring disclosure would be insufficient to allow disclosure without patient consent. How will the privacy protections of Part 2 patients be considered given that there is no exception to release that data on a Part 2 program patient? Is the BHA a covered entity under HIPAA? Given the risk of cyber-attacks, how will health care entities be assured that this	Data requirements in CH11 come directly from 27-65-131, C.R.S. Our data team is working diligently to ensure data will be protected. Email will not be an option for submission.

sensitive information is protected? As a healthcare system, the data reporting requirements will require 2 sets of policies for the release of information: We will need one set for medical patients whose data is not subject to the data reporting provisions of Chapter 17 and another set of policies for patients whose data will be released to the BHA. Further, we will need a process for carving out information protected under Part 2 to ensure that such information is only provided if the patient consents to disclosure to the State. It seems stigmatizing that patients who are treated for behavioral health conditions will have reduced privacy protections re: the release of their private information in order to comply with the BHA requirements."	
"17.5.6: Seclusion, Restraint, and Physical Management: Does this mean all of the rules in this section apply to our non-designated areas? B under this section goes on to provide some context around what designated emergency facilities are. The following rules covering seclusion and restraint apply to all 27-65 DESIGNATED FACILITIES AND/OR UNITS, AS WELL AS DESIGNATED EMERGENCY DEPARTMENTS AND PLACEMENT FACILITIES. IF A FACILITY HAS DECIDED TO use physical management, restraint or seclusion, THE FACILITY SHALL USE PHYSICAL MANAGEMENT, RESTRAINT OR SECLUSION ONLY IN ACCORDANCE WITH THE RULES IN THIS SECTION. "	Thank you for your question. This only applies to the areas that are designated with the BHA.
17.5.6.B.- unclear last sentence, seems to be a typo	Thank you for your feedback. This typo has been corrected.
17.5.6.H.6- What is meant by "For the purpose of protection"?	"Thank you for your question. 11.9.1.H.6 states ""6. FOR THE PURPOSE OF PROTECTION, UNLESS: a. THE RESTRAINT OR SECLUSION IS ORDERED BY A COURT; OR, b. IN AN EMERGENCY, AS PROVIDED FOR IN THIS PART 11.9.1.F.1 ABOVE.""
17.5.6- J.: Staff Training – Who does this staff training requirement apply to? Designated facilities only?	Thank you for your question. Yes, all information in this chapter is specific to facilities seeking a 27-65 designation.
17.5.6- J. 7 Staff Training - There are differences in terminology and ages related to what is a minor and what is a youth. In addition, can we eliminate the requirement for semi-annual	This section no longer uses the term "youth", "PERSONNEL MUST DEMONSTRATE KNOWLEDGE AND APPLICATION OF TRAINING ON AN ANNUAL BASIS FOR PERSONS OVER THE

training when working with youth? Staff will receive training at hire and annual. Adding additional intervals based on the ages of patients creates an unsustainable administrative burden.	AGE OF TWENTY-ONE (21), AND ON A SEMI-ANNUAL BASIS WHEN WORKING WITH INDIVIDUALS TWENTY (20) YEARS OLD AND YOUNGER." The semi-annual training comes from federal regulations 42 CFR 483 Subpart G.
17.5.6- K through T: Use of Seclusion/Restraint-who do these requirement apply to?	Thank you for your question. These requirements apply to any facility that is 27-65 designated.
17.5.6- Q1-This wording is confusing. What is required within 6 ft, what is required every 15 minutes, and what is Q4 referring to re: in person vs. digital monitoring?	Thank you for your question. This has been updated and now reads as: "An individual who is in seclusion/restraint shall be observed in person by PERSONNEL AT NO MORE THAN TEN (10) FEET FROM THE INDIVIDUAL" meaning an individual who is in seclusion/restraint must be observed in person by facility personnel and that personnel must be no more than 10 feet from that individual. The next sentence reads as "At least every fifteen (15) minutes, PERSONNEL SHALL MONITOR ANY INDIVIDUAL HELD IN MECHANICAL RESTRAINTS" meaning any individual in mechanical restraints must be monitored by personnel at least every 15 minutes. Q4 "Cameras and other electronic monitoring devices shall not replace face-to-face observations" means that digital monitoring is NOT allowable in replacement of face-to-face (in person) monitoring.
17.5.11.H.11 lists professionals who can provide evaluations. This list is the same as the 17.2.R Definition of Intervening Professional with one exception: 17.2.R includes a licensed addiction counselor and 17.5.11.H.11 does not including a licensed addiction counselor. Is this difference intentional?	Thank you for your question. Yes, this difference is intentional. The definition of "Intervening Professional" can be found in 27-65-102(20), C.R.S. and the rule language regarding professionals who can provide evaluations can be found in 27-65-106(6)(b), C.R.S.
17.6.8.C: Documentation in Individual Records: Crisis Assessments must be completed in full on a BHA created form. When will facilities receive this form? As healthcare systems, we are subject to many regulatory entity requirements beyond the BHA and will require a build within the electronic health record to modify any documentation requirements. In order to comply with a 7/1/23 requirement, we must receive the form in February '23.	Thank you for your feedback. With the passing of HB 23-1236 all rules have been delayed to January 1, 2024, with the exception of the new 27-65 data requirements that were pushed to July 1, 2024.
17.6.8.E through M: D/C Summary and Care Coordination instructions must contain: This is extensive. If this applies to non-designated facilities, we will need much more time to integrate into our EMR in order to comply.	Thank you for your feedback. This comes directly from 27-65-106(8), C.R.S.
17.7.10 Environment and Safety (A) All individuals being treated under these regulations shall receive such treatment in a clean and safe environment with opportunities for privacy. (B) A FACILITY shall only place an individual in a bedroom with video monitoring due to good cause and safety or security reasons WHICH MUST BE NOTED IN THE INDIVIDUAL RECORD. Individuals shall be notified in writing	Thank you for your feedback. This was a typo and has been edited. Any rules in Chapter 11 only apply to designated facilities.

when placed in bedrooms with video monitoring capabilities. (C) Each FACILITY shall maintain reasonable security capabilities to guard against the risk of unauthorized departures. The least restrictive method to prevent an unauthorized departure shall be used. (D) An unlocked FACILITY may place an individual in seclusion to prevent an unauthorized departure when such departure carries an imminent risk of danger for the individual or for others. Under those circumstances, the seclusion procedures in PART 7.5.6. Seems they didn't finish this sentence and I don't know what section they are referring to. Does this apply to non-designated facilities as well as designated?	
17.7.13.B: Is a designated inpatient facility within a medical hospital required to have a placement agreement?	Thank you for your question. Yes, each designated facility is required to have a placement agreement with one or more medical hospitals regardless of location.
What is a designated Emergency Department? Are ED's required to be designated if treating involuntary patients?	No, this is an optional designation. Emergency departments that choose to get a 27-65 designation are able to place individuals on a medical unit while on a hold or certification when needed.
Is there a definition of examination, assessment, and observation? The terms appear to be used interchangeably through the document.	Thank you for your question. A definition for "assessment" may be found in Chapter 1. The remaining terms passed AG review and do not need to be defined.
17.3: Historically, some members have reported differences in short-term versus long-term care and treatment from the 27-65 facilities with which they work. It appears that the proposed rule holds both types to the same standards.	Thank you for this comment. Correct, short and long-term care and treatment will be held to the same standards.

The following are changes were made to the rules since First Reading:

Rule Section	Feedback or Explanation, if applicable	Rule Change
Chapter 1 Changes		
1.1 Authority and Applicability	Feedback from State Board to add a timeframe of reviewing rules and returning to State Board annually.	"C. ON AN ANNUAL BASIS, THE BHA WILL REVIEW THE EFFECTIVENESS OF THESE RULES AND PRODUCE A WRITTEN REPORT OF THE RESULTS OF THIS REVIEW TO THE STATE BOARD OF HUMAN SERVICES. THIS REVIEW WILL INCLUDE ENGAGEMENT WITH STAKEHOLDERS AND MAY INCLUDE, BUT IS NOT LIMITED TO, ANALYSIS OF GRIEVANCE DATA AND TRENDS IN ENFORCEMENT ACTIONS TAKEN BY THE BHA. THE BHA WILL PROVIDE THIS REPORT ANNUALLY TO STATE BOARD OF HUMAN SERVICES (SBHS) BY SEPTEMBER 1 STARTING SEPTEMBER 1, 2024.

		THE BHA WILL PRESENT INFORMATION IN THE REPORT TO SBHS AT THE BOARD'S NEXT SESSION FOLLOWING SUBMISSION OF THE WRITTEN REPORT UNLESS THE BOARD AND THE BHA AGREE THAT PRESENTATION OF THE REPORT OCCUR AT A DIFFERENT SESSION OF THE BOARD. IF IT IS DETERMINED BASED ON THIS REVIEW THAT CHANGES TO THESE RULES ARE ADVISED, THE BHA SHALL PROPOSE THESE CHANGES TO THE STATE BOARD OF HUMAN SERVICES FOR PROMULGATION IN ACCORDANCE WITH SECTION 26-1-107, C.R.S."
1.2 "DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, FIFTH EDITION, TEXT REVISION," OR "DSM-5-TR" definition		Added American Psychiatric Association website for purchase of resource (https://www.psychiatry.org), and struck the term "individual" from definition.
1.2 "Facility" definition	Edited facility and provider organization definitions to provide additional clarity within the BHE definition. Together, the changes did not alter who is a BHE, but streamlined how this term is defined.	"FACILITY," AS USED IN THE DEFINITION OF BHE SET FORTH ABOVE IN PART 1.2 OF THESE RULES, MEANS A BEHAVIORAL HEALTH ENTITY LICENSED BY THE DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT; AN ENTITY SEEKING TO PROVIDE BEHAVIORAL HEALTH SAFETY-NET SERVICES AS LISTED IN SECTION 27-50-301(3); OR A PUBLIC OR PRIVATE "TREATMENT FACILITY" REQUIRED TO MEET THE APPROVAL STANDARDS ESTABLISHED UNDER SECTION 27-81-106, C.R.S.; AN ENTITY PROVIDING EMERGENCY OR CRISIS BEHAVIORAL HEALTH SERVICES; AN ENTITY PROVIDING BEHAVIORAL HEALTH RESIDENTIAL SERVICES; OR AN ENTITY PROVIDING WITHDRAWAL MANAGEMENT SERVICES.
1.2 "FENTANYL EDUCATION" definition	Definition was not in Chapter 1 and moved from 2.27 to Part 1.2	Moved the definition as is from 2.27 to Part 1.2
1.2 "Full time equivalent" (FTE) definition	Definition added for clarity.	"FULL TIME EQUIVALENT" (FTE) MEANS THE SCHEDULED WORKING HOURS FOR PERSONNEL DIVIDED BY THE NUMBER OF HOURS IN A FULL TIME WORKWEEK FOR THE ENTITY. FOR EXAMPLE, IF THE ENTITY CONSIDERS FORTY HOURS TO BE A FULL-TIME WORKWEEK, THEN A PERSONNEL WORKING TWENTY HOURS PER WEEK WOULD HAVE AN FTE OF 0.5.

1.2 "Interlock Enhancement Counseling," or "IEC" definition		Added that curriculum is available to providers of DUI/DWAI services at no cost through the BHA.
1.2 - "Letter of Intent" (LOI) definition	Reduced administrative burden by removing requirement for a letter of intent when requesting a change or modification to a license.	Removed requirement to submit a LOI for change/modification to BHE license or Safety Net approval.
1.2 "Opioid Antagonist" definition		Added "OPIOID ANTAGONIST" HAS THE SAME MEANING PROVIDED IN SECTION 17-1-113.4(4)(b), C.R.S.
1.2 "Provider organization" definition	Edited facility and provider organization definitions to provide additional clarity within the BHE definition. Together, the changes did not alter who is a BHE, but streamlined how this term is defined.	"PROVIDER ORGANIZATION," AS USED IN THE DEFINITION OF BHE SET FORTH ABOVE, MEANS A CORPORATION, PARTNERSHIP, LIMITED LIABILITY COMPANY, BUSINESS TRUST, ASSOCIATION, OR ORGANIZED GROUP OF PERSONS, WHETHER INCORPORATED OR NOT, WHICH IS IN THE BUSINESS OF BEHAVIORAL HEALTH CARE DELIVERY OR MANAGEMENT AND THAT (A) INCLUDES TEN (10) OR MORE FULL TIME EQUIVALENT (FTE) FULLY LICENSED OR CERTIFIED PROFESSIONALS PROVIDING DIAGNOSTIC, THERAPEUTIC, OR PSYCHOLOGICAL SERVICES FOR BEHAVIORAL HEALTH CONDITIONS BEHAVIORAL HEALTH CARE PROVIDERS UNDER THE PROVIDERS' PROFESSIONAL PRACTICE ACT., OR (B) PROVIDES TWENTY FOUR (24) HOUR OR OVERNIGHT COMMUNITY-BASED BEHAVIORAL HEALTH SERVICES, UNLESS HOLDING A FACILITY LICENSE FROM ANOTHER ENTITY TO PROVIDE SUCH OVERNIGHT SERVICES.
Chapter 2 Changes		
2.12.1.G.1.a Screening	Licensed behavioral health entities that provide crisis care or withdrawal management are not considered a "private treatment program". § 17-27.1-101(2)(d), C.R.S. This means that behavioral health entities that provide crisis care or withdrawal	Addition of language to exclude crisis and withdrawal management services from needing to complete an out-of-state offense screening. a. THIS DOES NOT APPLY TO CRISIS SERVICES FOUND IN CHAPTER 6 OF THESE RULES OR WITHDRAWAL MANAGEMENT SERVICES FOUND IN CHAPTERS 4 AND 5 OF THESE RULES.

	management do not have to comply with the requirement of being registered with the compact administrator or that persons be registered with the interstate compact office. § 17-27.1-101(5), C.R.S. More broadly, licensed behavioral health entities that provide crisis care or withdrawal management do not have to comply with § 17-27.1-101, C.R.S.	
2.12.2.B.11 Initial Assessment	Concern around requiring full care coordination for pregnancy screening for individuals and how this is outside the scope of the licensee.	Modified language to say "SCREENING ALL INDIVIDUALS FOR CURRENT PREGNANCY STATUS AND DESIRE TO BECOME PREGNANT WITHIN THE NEXT YEAR. IF NOT PREGNANT OR DESIROUS OF PREGNANCY IN THE NEXT TWELVE (12) MONTHS, INDIVIDUALS MUST BE ASKED IF THEY WANT ACCESS TO CONTRACEPTIVE/FAMILY PLANNING CARE, AND THE INDIVIDUAL MUST BE APPROPRIATELY REFERRED. SUCH CARE MUST BE COORDINATED ON BEHALF OF THE INDIVIDUAL."
2.14.7.C Use of Restraint (change duplicated in same section of 11.9.7)		Added language: "C. WITHIN ONE (1) HOUR OF THE INITIATION OF THE ORIGINAL ORDER FOR THE EMERGENCY SAFETY INTERVENTION, AN AUTHORIZED PRACTITIONER, TRAINED IN THE USE OF EMERGENCY SAFETY INTERVENTIONS AND PERMITTED TO ASSESS THE PHYSICAL AND PSYCHOLOGICAL WELL BEING OF THE INDIVIDUAL, SHALL CONDUCT A FACE-TO-FACE ASSESSMENT OF THE PHYSICAL AND PSYCHOLOGICAL WELL BEING OF THE INDIVIDUAL INCLUDING BUT NOT LIMITED TO: ..."
2.14.7.E (change duplicated in same section of 11.9.7)		Added language: "E. THE DECISION TO RESTRAIN MUST BE BASED ON A CURRENT CLINICAL ASSESSMENT, AND MAY ALSO BE BASED ON OTHER RELIABLE INFORMATION INCLUDING INFORMATION THAT WAS USED TO SUPPORT THE DECISION TO TAKE THE INDIVIDUAL INTO CUSTODY FOR TREATMENT AND EVALUATION. THE FACT THAT AN INDIVIDUAL IS BEING EVALUATED OR TREATED UNDER SECTIONS 27-65-106 THROUGH 27-65-111 [EFFECTIVE JULY 1, 2024], C.R.S., MUST NOT BE

		THE SOLE JUSTIFICATION FOR THE USE OF RESTRAINT.”
2.14.10.I Observation & Care of Individuals in Seclusion and Restraint (change duplicated in same section of 11.9.10)		Added language: “I. THE INDIVIDUAL MUST HAVE ACCESS TO FLUIDS AND TOILETING UPON REQUEST OR DURING OFFERED RELIEF PERIODS, BUT MUST AT MINIMUM BE OFFERED EVERY TWO (2) HOURS.”
2.14.13.I Additional Procedures and Requirements for Seclusion/Restraint of a Youth (change duplicated in same section of 11.9.13)		Added language: “I. WITHIN ONE (1) HOUR OF THE INITIATION OF THE ORDER OF THE EMERGENCY SAFETY INTERVENTION A PHYSICIAN, OR OTHER AUTHORIZED PRACTITIONER TRAINED IN THE USE OF EMERGENCY SAFETY INTERVENTIONS AND PERMITTED TO ASSESS THE PHYSICAL AND PSYCHOLOGICAL WELL BEING OF THE YOUTH, MUST CONDUCT A FACE - TO - FACE ASSESSMENT OF THE PHYSICAL AND PSYCHOLOGICAL WELL BEING OF THE INDIVIDUAL INCLUDING BUT NOT LIMITED TO:...”
2.18.D.1; 2.21.B; 2.23E;	Reduced administrative burden by removing requirement for a letter of intent when requesting a change or modification to a Safety Net approval.	SUBMIT NOTIFICATION A LETTER OF INTENT TO THE BHA
2.24.2.B	Added language to clarify that conditions for denying an initial license apply also to revocation and suspension.	THE BHA MAY REVOKE OR SUSPEND AN EXISTING LICENSE IF ONE OR MORE INDIVIDUALS OR ENTITIES IDENTIFIED IN THE RESPONSE TO PART 2.18.D.3 OF THIS CHAPTER HAS A CONTROLLING OR OWNERSHIP INTEREST IN THE BHE AND: 1. HAS BEEN THE SUBJECT OR PARTY TO ANY OF THE ACTIONS DESCRIBED IN PART 2.18.D.10.a: 2. HAS A FELONY OR MISDEMEANOR CONVICTION OF A CRIME OF MORAL TURPITUDE AS DESCRIBED IN PART 2.18.D.11.b OF THIS CHAPTER.
Chapter 4 Changes		
4.4.2.D		Language updated to “AND DOCUMENT THE DETERMINATION TO NOT INCLUDE PARENTAL OR GUARDIAN INVOLVEMENT AND REASONING FOR THIS DETERMINATION.”

4.4.3.D		Language updated to “AND DOCUMENT THE DETERMINATION TO NOT INCLUDE PARENTAL OR GUARDIAN INVOLVEMENT AND REASONING FOR THIS DETERMINATION.”
Chapter 5 Changes		
5.11.3.B.3		Added “PURSUANT TO SECTION 21.300 OF 2 CCR 502-1” in withdrawal management sections where the specific CSL citation was missing
Chapter 8 Changes		
8.3 Rights of Children	Received feedback around clarification for age of consent for children.	8.3.B. SECTION 27-65-104(1), C.R.S. ALLOWS CHILDREN WHO ARE FIFTEEN (15) YEARS OF AGE OR OLDER, WITH OR WITHOUT THE CONSENT OF A PARENT OR LEGAL GUARDIAN, TO KNOWINGLY CONSENT TO MENTAL HEALTH SERVICES, WHICH INCLUDES THE PROVISION OF PSYCHOTROPIC MEDICATIONS.
Chapter 10 Changes		
10.1.2.A, B, and C Assessment and Placement in Services		Changed “an initial assessment and treatment” to “placement”
10.4.2.D General Provisions		Changed from “assessment provided” to “placement recommendation(s) provided”
10.9.4.a.4 and 10.9.7.B Level II Four Plus Service Planning and Reviews		Added an “availability” notation for multidisciplinary team members, restructured rule into two clear sentences to avoid confusion.
Chapter 11 Changes		
11.1.B.2 Authority	Concern from stakeholders about implementation timelines for new rules	Proposed change to delayed enforcement from April 1, 2024 to July 1, 2024.
11.1.C Authority	Feedback from State Board to add a timeframe of reviewing rules and returning to State Board annually.	Added ““C. ON AN ANNUAL BASIS, THE BHA WILL REVIEW THE EFFECTIVENESS OF THESE RULES AND PRODUCE A WRITTEN REPORT OF THE RESULTS OF THIS REVIEW TO THE STATE BOARD OF HUMAN SERVICES. THIS REVIEW WILL INCLUDE ENGAGEMENT WITH STAKEHOLDERS AND MAY INCLUDE, BUT IS NOT LIMITED TO, ANALYSIS OF GRIEVANCE DATA AND TRENDS IN ENFORCEMENT ACTIONS TAKEN BY THE BHA. THE BHA WILL PROVIDE THIS REPORT ANNUALLY TO SBHS BY SEPTEMBER 1 STARTING

		SEPTEMBER 1, 2024. THE BHA WILL PRESENT INFORMATION IN THE REPORT TO SBHS AT THE BOARD'S NEXT SESSION FOLLOWING SUBMISSION OF THE WRITTEN REPORT UNLESS THE BOARD AND THE BHA AGREE THAT PRESENTATION OF THE REPORT OCCUR AT A DIFFERENT SESSION OF THE BOARD. IF IT IS DETERMINED BASED ON THIS REVIEW THAT CHANGES TO THESE RULES ARE ADVISED, THE BHA SHALL PROPOSE THESE CHANGES TO THE STATE BOARD OF HUMAN SERVICES FOR PROMULGATION IN ACCORDANCE WITH SECTION 26-1-107, C.R.S."
11.2 - "Certification Evaluation"	Confusing role of the certification evaluation and difficult to understand who needs to complete it.	Removed definition entirely from this rule volume. Chapter 11 now uses "crisis evaluation" and "standardized evaluation form" and refers back to statute for clarity.
11.2 "Emergency Medical Services Facility"	To align with changes elsewhere in the chapter, recommendation was to edit the definition.	Definition now reads: "EMERGENCY MEDICAL SERVICES FACILITY" MEANS A GENERAL HOSPITAL WITH AN EMERGENCY DEPARTMENT OR A FREESTANDING EMERGENCY DEPARTMENT, AS DEFINED IN SECTION 25-1.5-114(5), C.R.S. AN EMERGENCY MEDICAL SERVICES FACILITY IS NOT REQUIRED TO BE, BUT MAY ELECT TO BECOME, A FACILITY DESIGNATED OR APPROVED BY THE COMMISSIONER .DESIGNATED FOR 27-65 SERVICES BY THE COMMISSIONER.
11.2 "Facility Personnel"		Definition now reads: "FACILITY PERSONNEL" OR "COMMUNITY- BASED PERSONNEL" MEANS: A. A PROFESSIONAL PERSON AS DEFINED IN THIS CHAPTER; A REGISTERED PROFESSIONAL NURSE AS DEFINED IN SECTION 12-255-104 (11), C.R.S. WHO BY REASON OF POSTGRADUATE EDUCATION AND ADDITIONAL NURSING PREPARATION HAS GAINED KNOWLEDGE, JUDGMENT, AND SKILL IN PSYCHIATRIC OR MENTAL HEALTH NURSING; A LICENSED MARRIAGE AND FAMILY THERAPIST, AS DEFINED IN SECTION 12-245-501(3), C.R.S., LICENSED PROFESSIONAL COUNSELOR, AS DEFINED IN SECTION 12-245-601(2), C.R.S., OR LICENSED ADDICTION COUNSELOR, AS DEFINED IN SECTION 12-245-801(10), C.R.S., WHO BY REASON OF POSTGRADUATE EDUCATION AND ADDITIONAL PREPARATION HAS GAINED KNOWLEDGE, JUDGMENT, AND SKILL IN PSYCHIATRIC OR CLINICAL MENTAL HEALTH

		THERAPY, FORENSIC PSYCHOTHERAPY, OR THE EVALUATION OF MENTAL HEALTH DISORDERS; OR, A LICENSED CLINICAL SOCIAL WORKER LICENSED AS DEFINED IN SECTION 12-245-404(7), C.R.S.”
11.2 - “Individual”	Concerns related to “individual” definition and its meaning in Chapter 11 and how it corresponds to “respondent”.	Added definition of “individual” specific to Chapter 11.
11.2 - “Professional Person	APRN initially added to the “professional person” definition, this caused concern from multiple stakeholders regarding scope of practice.	APRN has been removed from the definition and the definition now references the statute.
11.2 “Protection and Advocacy for Individuals with Mental Illness Act (PAIMI Act)”		Removed incorporation by reference information from the definition.
11.3.1.D 27-65 Designation Requirement	Received feedback asking for timeline of review of policies and procedures match timelines from Chapter 2 for BHE of every three years.	Changed review timeline to every three years.
11.3.1.D 27-65 Designation Requirement	Clarification was needed on the policy and procedure section in reduction of administrative burden for policies and procedures of facilities with a BHE or are Safety Net approved in addition to being 27-65 designated.	Revised and added language that 27-65 designated facilities that are also a BHE or have Safety Net Approval do not need to submit duplicate policies and procedures (P&P) unless the P&P does not include 27-65 designated services.
11.3.2.A.7 Critical Incident Reporting	Received feedback to align language across this section.	Added language “of an individual” to ensure language across 11.3.2.A aligned.

11.3.2.B Critical Incident Reporting	Received feedback to align critical incident reporting (CIR) language with Chapter 2 from 24 hours to one (1) business day.	CIR language has been replaced in Chapter 11 and aligned with Chapter 2 language to match one (1) business day.
11.3.2.E.4 Critical Incident Reporting		Added language “UNLESS IT WOULD VIOLATE ANY OTHER FEDERAL OR STATE LAW.”
11.5.9.I & J	Concerns related to statutory interpretation of what is required for Emergency Medical Services facilities to report.	After further legal review this 11.5.9 section was amended and points I and J were removed
11.7.3.D & E Documentation in Individual Records	Concerns related to “certification evaluation” and who is to complete it.	“Certification Evaluation” language was removed and replaced with “THE BHA-CREATED STANDARDIZED EVALUATION FORM PURSUANT TO 27-65-106(6)(b)”. The standardized evaluation form reflects a checklist of items facilities are to complete rather than an evaluation.
11.7.3.F.1 Documentation in Individual Records	Received feedback to clarify what individuals are to complete safety plans.	Clarifying language added to reflect “INDIVIDUALS WHO ARE DETAINED OR ASSESSED/EVALUATED”
11.7.3.F.3 Documentation in Individual Records	Received feedback to add in clarifying language.	Clarifying language added to reflect “THE SAFETY PLAN SHOULD INCLUDE INFORMATION ABOUT HOW TO ESTABLISH A PSYCHIATRIC AND MEDICAL ADVANCE DIRECTIVE IF ONE IS NOT PRESENTED.”
11.7.3.G Documentation in Individual Records	Received feedback that “discharge summary” and “discharge instructions” throughout the chapter was confusing.	Changed language to “discharge instructions” to align with statutory language.
11.7.3.G.9 Documentation in Individual Records	Received feedback to move psychiatric and medical advance directives to the discharge instructions section rather than the safety planning section.	Language has been removed from 11.7.3.F.3 and discharge instructions language was reflected to include both medical and psychiatric advance directives.
11.7.3.L Documentation in Individual Records	Received feedback to add language for clarity regarding denial of follow-up care.	Added language to clarify that “ANY DENIAL OF AUTHORIZATION FROM THE INDIVIDUAL SHALL BE DOCUMENTED IN THE INDIVIDUAL RECORD.”

11.7.3.P Documentation Individual Records	Received feedback to align follow-up requirements throughout the chapter and change from 24 hours to 48 hours.	Language changed from 24 hours to 48 hours.
11.8.1.A Informed Consent	Received feedback around the confusion for age of consent for psychiatric medications and was asked to make this clearer.	After further legal review the language was changed to: “IN ALL INSTANCES WHERE PRESCRIPTION MEDICATIONS ARE TO BE ORDERED AS A PART OF A MENTAL HEALTH TREATMENT PROGRAM, THE FOLLOWING INFORMATION IN THESE PART 11.8.1.A THROUGH 11.8.1.DJ SHALL BE PROVIDED, CONSISTENT WITH FEDERAL AND STATE LAW, TO THE INDIVIDUAL AND LEGAL GUARDIAN(S) AND COMMUNICATED BOTH WRITTEN AND VERBALLY. FOR INDIVIDUALS, BETWEEN THE AGES OF FIFTEEN (15) AND EIGHTEEN (18), THE FOLLOWING INFORMATION MAY BE PROVIDED TO THE INDIVIDUALS’ PARENT(S) OR LEGAL GUARDIAN(S). EXCEPT WHEN A MINOR PROVIDES EXPRESS CONSENT, THE FOLLOWING INFORMATION SHALL NOT BE PROVIDED TO PARENT(S) OR GUARDIAN(S) OF A MINOR THAT IS FIFTEEN (15) YEARS OF AGE OR OLDER WHO IS LIVING SEPARATELY AND APART FROM THE MINOR’S PARENT OR LEGAL GUARDIAN(S) AND IS MANAGING THE MINOR’S OWN FINANCIAL AFFAIRS, REGARDLESS OF THE MINOR’S SOURCE OF INCOME, OR WHO IS MARRIED AND LIVING SEPARATELY AND APART FROM THE MINOR’S PARENT OR LEGAL GUARDIAN(S)....”
11.8.3.E.1 Involuntary Psychiatric Medications	Received concerns that changing the timeframe under Involuntary Psychiatric Medications may have a negative impact.	Language has been changed from 24hrs back to 72hrs to match current rule language and address concerns around negative impact.
11.9.6.B and C Use of Seclusion (Change was also made to corresponding section of 2.14.6)	Received feedback to change the list of professionals that conduct the one hour assessment to match language from the Joint Commission.	After further legal review on proposed changes, the new language reads as: “B. WITHIN ONE (1) HOUR OF THE INITIATION OF THE ORIGINAL ORDER FOR THE EMERGENCY SAFETY INTERVENTION, AN AUTHORIZED PRACTITIONER, SUCH AS A REGISTERED NURSE OR PHYSICIAN ASSISTANT, TRAINED IN THE USE OF EMERGENCY SAFETY INTERVENTIONS AND PERMITTED TO ASSESS THE PHYSICAL AND PSYCHOLOGICAL WELL BEING OF THE

		INDIVIDUAL, SHALL CONDUCT A FACE-TO-FACE ASSESSMENT OF THE PHYSICAL AND PSYCHOLOGICAL WELL BEING OF THE INDIVIDUAL INCLUDING BUT NOT LIMITED TO: 1. THE INDIVIDUAL'S PHYSICAL AND PSYCHOLOGICAL STATUS; 2. THE INDIVIDUAL'S BEHAVIOR; 3. THE APPROPRIATENESS OF THE INTERVENTION MEASURES; AND; 4. ANY COMPLICATIONS RESULTING FROM THE INTERVENTION. WHEN THE ONE (1) HOUR ASSESSMENT DESCRIBED IN THIS PART 11.9.6.B IS CONDUCTED BY A REGISTERED NURSE OR A PHYSICIAN ASSISTANT, THAT PERSONNEL MUST CONSULT WITH THE ATTENDING PHYSICIAN WHEN THE ASSESSMENT IS COMPLETED.”
11.9.7.C & D (Change was also made to corresponding section of 2.14.7)	Received feedback to change the list of professionals that conduct the one hour assessment to match language from the Joint Commission.	After further legal review on proposed changes, the new language reads as: “ C. WITHIN ONE (1) HOUR OF THE INITIATION OF THE ORIGINAL ORDER FOR THE EMERGENCY SAFETY INTERVENTION, AN AUTHORIZED PRACTITIONER, SUCH AS A REGISTERED NURSE OR PHYSICIAN ASSISTANT, TRAINED IN THE USE OF EMERGENCY SAFETY INTERVENTIONS AND PERMITTED TO ASSESS THE PHYSICAL AND PSYCHOLOGICAL WELL BEING OF THE INDIVIDUAL, SHALL CONDUCT A FACE-TO-FACE ASSESSMENT OF THE PHYSICAL AND PSYCHOLOGICAL WELL BEING OF THE INDIVIDUAL INCLUDING BUT NOT LIMITED TO: 1. THE INDIVIDUAL'S PHYSICAL AND PSYCHOLOGICAL STATUS; 2. THE INDIVIDUAL'S BEHAVIOR; 3. THE APPROPRIATENESS OF THE INTERVENTION MEASURES; AND; 4. ANY COMPLICATIONS RESULTING FROM THE INTERVENTION. WHEN THE ONE (1) HOUR ASSESSMENT DESCRIBED IN THIS PART 11.9.6.B IS CONDUCTED BY A REGISTERED NURSE OR A PHYSICIAN ASSISTANT, THAT PERSONNEL MUST

		CONSULT WITH THE ATTENDING PHYSICIAN WHEN THE ASSESSMENT IS COMPLETED.”
11.9.10.I Observation & Care of Individuals in Seclusion and Restraint (Change was also made in corresponding section of 2.14.10.I)		New language reads: “I. THE INDIVIDUAL MUST HAVE ACCESS TO FLUIDS AND TOILETING UPON REQUEST OR DURING OFFERED RELIEF PERIODS, BUT MUST AT MINIMUM BE OFFERED EVERY TWO (2) HOURS.”
11.9.13 Additional Procedures and Requirements for Seclusion/Restraint of a Youth		Added required language “...42 C.F.R. 441.151, THE FEDERAL REGULATIONS ISSUED BY THE UNITED STATES SECRETARY OF HEALTH AND HUMAN SERVICES FOUND AT 42 CFR PART 441.151 (FEB.2023), WHICH ARE HEREBY INCORPORATED BY REFERENCE. NO LATER EDITIONS OR AMENDMENTS ARE INCORPORATED. THESE REGULATIONS ARE AVAILABLE AT NO COST FROM THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES, SUBSTANCE ABUSE & MENTAL HEALTH SERVICES ADMINISTRATION, OFFICE OF COMMUNICATIONS, 5600 FISHERS LANE, ROCKVILLE, MD 20857 OR AT HTTPS://WWW.ECFR.GOV/CURRENT/TITLE-42 . THESE REGULATIONS ARE ALSO AVAILABLE FOR PUBLIC INSPECTION AND COPYING AT THE BEHAVIORAL HEALTH ADMINISTRATION, 710 S. ASH STREET, UNIT C140, DENVER, CO 80246, DURING REGULAR BUSINESS HOURS. THIS REQUIRES...”
11.14.3.A.10 & 16 Individual Rights for Emergency Mental Health Holds		11.14.3.A.16 was removed and language to clarify that personal medical devices was included under “personal possessions” in 11.14.3.A.10 was moved into this part.
11.14.3.A.15 Individual Rights for Emergency Mental Health Holds	Received feedback to add parameters around an individual's right to appropriate access to non-psychiatric medications.	Language was added to clarify that non-psychiatric medications are to be “ORDERED AND/OR OVERSEEN BY A PHYSICIAN OR OTHER AUTHORIZED MEDICAL PRACTITIONER OF RECORD.”
11.14.3.A.17 & 18	Received feedback to review rights portions for clarity.	Moved these rights to 11.14.3.A.9.a and 11.17.5 to match statute and struck these 17 and 18 parts.
11.14.3.A.22 Individual Rights for Emergency Mental Health Holds (now 11.14.3.A.20)	Further clarification was needed to identify who can deny the rights of an individual.	Added language to match statute “223. AN INDIVIDUAL'S RIGHTS MAY ONLY BE DENIED IF THE ITEM, PROGRAM, OR SERVICE CAUSES THE INDIVIDUAL TO DESTABILIZE OR CREATES A DANGER TO THE INDIVIDUAL'S SELF

		OR OTHERS, AS DETERMINED BY A LICENSED PROVIDER INVOLVED IN THE INDIVIDUAL'S CARE. THE RIGHTS OF AN INDIVIDUAL THAT ARE LISTED IN THIS SECTION MAY BE DENIED FOR GOOD CAUSE ONLY BY THE PROFESSIONAL PERSON PROVIDING TREATMENT. DENIAL OF ANY RIGHT MUST IN ALL CASES BE ENTERED INTO THE INDIVIDUAL'S TREATMENT RECORD. INFORMATION PERTAINING TO A DENIAL OF RIGHTS CONTAINED IN THE INDIVIDUAL'S TREATMENT RECORD MUST BE MADE AVAILABLE, UPON REQUEST, TO THE INDIVIDUAL, OR THE INDIVIDUAL'S ATTORNEY; AND..."
11.16 Involuntary Emergency Services	Received feedback to remove the section entirely because it is optional and therefore confusing to live in rule.	Removed section 11.16 and updated all citations to reflect the change
11.17.6.A Individual Rights Restrictions for Short-Term and Long-Term Care Treatment	Further review was needed to clarify who can deny the rights of an individual.	Post further legal review, language was added "A. AS SET FORTH IN SECTION 27-65-1179, C.R.S., AN INDIVIDUAL'S STATUTORY RIGHTS, AND RIGHTS LISTED IN PARTS 11.14.3 AND 11.17.5 OF THIS CHAPTER, MAY BE LIMITED OR DENIED IF ACCESS TO THE RIGHT WOULD ENDANGER THE SAFETY OF THE INDIVIDUAL OR ANOTHER PERSON IN CLOSE PROXIMITY AND MAY ONLY BE DENIED BY AN PERSON INVOLVED IN THE INDIVIDUAL'S CARE. 1. A PERSON INVOLVED IN THE INDIVIDUAL'S CARE MEANS A PERSON THAT IS EITHER PROVIDING CARE DIRECTLY TO THE INDIVIDUAL OR DIRECTING THE CARE OF THE INDIVIDUAL."
11.17.20.C.4 Content of Records	Feedback received to expand on what personnel are able to attend the monthly service plan review.	Language for this section is now: "C. FOR INDIVIDUALS CERTIFIED TO SHORT-TERM OR LONG-TERM TREATMENT, THE SERVICE PLAN SHALL BE REVIEWED, AND REVISED IF NECESSARY, AT LEAST MONTHLY BY THE PERSONNEL RESPONSIBLE FOR THE PLAN, THE TREATING PROFESSIONAL PERSON, ANY ADDITIONAL PERSONNEL INVOLVED IN CARE AS THE FACILITY DETERMINES IS NECESSARY FOR THE REVIEW, THE INDIVIDUAL, AND THE LEGAL GUARDIAN..."
11.18.4.B.1 Individual Rights for Involuntary Outpatient Treatment	Resulting change needed due to change	Updated the language for this section to match 27-65-111(6)(a)

[Effective July 1, 2024]	of professional person definition.	
11.18.4.B.1.a Individual Rights for Involuntary Outpatient Treatment [Effective July 1, 2024]	Needed language on how to move through discrepancy between professional person and APRN with psychiatric training when they are in disagreement on determining if an individual may move to voluntary status.	Added: “a. IF A DISCREPANCY EXISTS FOR THE DETERMINATION OF VOLUNTARY STATUS BETWEEN THE PROFESSIONAL PERSON AND THE ADVANCED PRACTICE NURSE WITH TRAINING IN PSYCHIATRIC NURSING, THE DETERMINATION FOR THE INDIVIDUAL TO CHANGE TO VOLUNTARY STATUS MUST DEFER TO THE ASSESSMENT FROM THE PROFESSIONAL PERSON.”
Chapter 12 Changes		
12.5.1.E.1.b.	Removed the explicit allowance for telehealth to emphasize that evening and weekend hours must include service times that meet the needs of the individual population to be served.	THESE EXTENDED HOURS MAY INCLUDE SERVICES PROVIDED VIA TELEHEALTH.
12.5.3 I	Added to align with data reporting requirements for essential providers. This was deleted in error from the draft initially submitted.	4. WHETHER THE INDIVIDUAL WAS DISCHARGED FROM A HIGHER LEVEL OF CARE TO A LOWER LEVEL OF CARE AND, IF SO, WHAT LEVEL OF CARE THE REFERRING PROVIDER WAS SEEKING TO DISCHARGE THE INDIVIDUAL FROM.
12.5.5.C	Adjusted board requirements to be either 51% voting members with lived experience, or, at least 2 voting members with lived experience and an additional requirement to demonstrate how the board is collecting and considering feedback from individuals with lived experience in making board decisions.	THE GOVERNING BOARD OF THE COMPREHENSIVE COMMUNITY BEHAVIORAL HEALTH PROVIDER MUST EITHER: 1. BE COMPOSED OF AT LEAST 51% VOTING MEMBERS THAT HAVE LIVED EXPERIENCE WITH ACCESSING SERVICES FOR MENTAL HEALTH AND/OR SUBSTANCE USE DISORDERS, WHICH MAY INCLUDE PARENTS OF CHILDREN WITH MENTAL HEALTH AND/OR SUBSTANCE USE DISORDERS WHO HAVE SUPPORTED THEIR CHILDREN IN ACCESSING SERVICES FOR MENTAL HEALTH AND/OR SUBSTANCE USE DISORDERS; OR

		2. THE GOVERNING BODY OF THE COMPREHENSIVE COMMUNITY BEHAVIORAL HEALTH PROVIDER SHALL INCLUDE AT LEAST TWO (2) VOTING MEMBERS THAT HAVE LIVED EXPERIENCE WITH ACCESSING SERVICES FOR MENTAL HEALTH AND/OR SUBSTANCE USE DISORDERS, WHICH MAY INCLUDE PARENTS OF CHILDREN WITH MENTAL HEALTH AND/OR SUBSTANCE USE DISORDERS WHO HAVE SUPPORTED THEIR CHILDREN IN ACCESSING SERVICES FOR MENTAL HEALTH AND/OR SUBSTANCE USE DISORDERS. 4a. IN ADDITION, THE GOVERNING BODY SHALL DEMONSTRATE HOW IT COLLECTS, CONSIDERS AND IMPLEMENTS INPUT AND FEEDBACK FROM INDIVIDUALS AND FAMILIES CURRENTLY RECEIVING SERVICES IN GOVERNING BODY DECISIONS.
12.6.1.g through n.	A set of requirements was duplicated in error.	Deleted g through n.
12.6.1.K 12.6.3.D	Extended initial and renewal safety net approval from one to two year duration, with annual inspections.	THE DURATION OF THE INITIAL APPROVAL WILL BE TWO (2) ONE (1) YEARS FROM THE DATE OF ISSUANCE. 1. THE BHA MAY CONDUCT ANNUAL INSPECTIONS DURING THE TWO (2) YEAR APPROVAL DURATION, IN ADDITION TO ANY OTHER INSPECTIONS INDICATED IN SECTION 12.6.6.G. THE DURATION OF THE RENEWAL APPROVAL WILL BE TWO (2) ONE (1) YEARS FROM THE DATE OF ISSUANCE. 1. THE BHA MAY CONDUCT ANNUAL INSPECTIONS DURING THE TWO (2) YEAR APPROVAL DURATION, IN ADDITION TO ANY OTHER INSPECTIONS INDICATED IN SECTION 12.6.6.G.
12.6.1.E.2 ; 12.6.4.B; 12.6.6.E	Reduced administrative burden by removing requirement for a letter of intent when requesting a change or	SUBMIT NOTIFICATION A LETTER OF INTENT TO THE BHA

	modification to a Safety Net approval.	
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