Issues to be Prepared for When Talking with Legislators

Layoffs/Program Closures

For centers that have had to implement RIFs: What you might hear

"Why did you have to lay off staff/close X program? I've heard that clients are struggling to get care now."

Points to cover when responding – Speak briefly to what happened and why; focus on how you're caring for clients; note ongoing fiscal challenges/uncertainty resulting from BH reforms and insufficient state funding; instill confidence by explaining what you are doing to ensure your future stability

- Perfect storm of impacts on your organization:
  - Increased uncompensated care resulting from PHE unwind
  - Cost of implementing/complying with new regulatory structure
  - Uncertainty about new PPS (esp. reconciliation impact), difficulty of budgeting for that
  - Other center-specific impacts (e.g., loss of local contracts/grants)
- Measures you took to address the shortfall before resorting to RIFs.
- How you managed transitions in care for affected clients.
- Where you stand now re: staffing and funding.
- Caution about ongoing fiscal challenges related to insufficient funding for the BH system that's been created.
- Explain what you are doing to ensure your center's financial stability going forward.

For centers that have not had to implement RIFs: What you might hear
"I've been reading about layoffs at other community mental health centers – are you planning to let staff go or close programs?"

Points to cover when responding – Explain why your center wasn't as affected by the perfect storm; caution that you're operating in the midst of significant ongoing financial uncertainty; instill confidence by explaining what you are doing to ensure your future stability

- Factors that affected CMHCs over the last year (see above) and why your center was less affected.
- Caution about ongoing challenges related to insufficient funding for the BH system that's been created.
  - While your center came out of 2024 in decent shape, the reality is that all are operating in a cumbersome, expensive system at a time of significant budget uncertainty and increasing costs.
- Explain what you are doing to ensure your center's financial stability going forward.

Mergers

For centers that have not merged with other organizations: What you might hear
"It looks like a lot of CMHCs are merging with other providers. Are you planning to do that?"

Points to cover when responding:

- System/funding uncertainty that requires all historic CMHCs to look at the right business model that will enable them to best continue serving their communities.
- Factors you have to consider as you do that.
- Measures you're taking to ensure your center's financial stability.
- Obviously, don't share your future business plans but don't make unequivocal statements about what you will/won't do.

For centers that have merged with FQs: What you might hear
"Why did you merge? Do you think others will do the same?"

Points to cover when responding:

- Factors that led to your decision.
- Resulting benefits to your organization/your community.
- Measures you took to ensure that your CMHC mission and historic focus on priority populations, including SMI adults and SED children, will continue as the new organization is formed or the acquisition is completed. (E.g., formal agreements and/or governance structures, detailed transition plans, engaging stakeholders and/or establishing or continuing client and family advisory groups, and monitoring performance and outcomes.)
- Don't speculate about what others might do but note ongoing system/funding uncertainty and that every historic CMHC must look at the right business model that will enable them to best continue serving their communities.

BHA: Concerns about effectiveness, funding, duplication with other state agencies

As you respond, keep in mind that CBHC is committed to working collaboratively with the BHA to address our concerns and ensure the successful implementation of a high-quality and sustainable behavioral health system for all Coloradans.

What you might hear
"What do you think of the BHA?"

Points to cover when responding

- CBHC supported the creation of the BHA, and we continue to work closely with BHA staff as they address the challenges of implementing this complex new system.
- At the same time, we have a lot of concerns about the structure that has been developed:
  - Minutely detailed requirements devalue provider expertise, add costs to the system, increase provider burnout, and are adversely affecting client experience and access to care.
    - Offer examples, e.g.: time-consuming and intrusive crisis and comprehensive assessments that are not patient-centered or trauma-informed.
    - Note that, by requiring Medicaid and uninsured patients to essentially "prove" they need care, these assessments work against parity and perpetuate discrimination and stigma.
  - No refusal requirement for violent clients endanger staff and others, including clients and their family members.
- We continue to have many concerns about the system the BHA is tasked with developing:
  - By expanding the definition of "safety net" and trying to be all things to all people—without adding new funding to enable that—it inadvertently undermines the traditional safety net for adults with serious mental illness and children with serious emotional disturbance.
  - Increased complexity instead of creating a more efficient and streamlined way of regulating and financing community behavioral health.
  - New providers, new requirements, and expanded benefits have all added new costs to the system—but no new funding has been put into the system.
    - Same size pie, smaller pieces.
  - As this system was being created, there was never an estimate of how much it would cost or planning about where the funding would come from.
    - Working with BHA to identify funding a long-overdue actuarial study.
- Ask the legislator to keep an eye on the implementation of the BHASOs and the evolution of the regulatory system.

PPS

What you might hear

"I've heard about concerns with the new Medicaid payment model. Are they working out the kinks on that? Have you lost money as a result of it?"

Points to cover when responding

NOTE: impacts vary greatly across centers, so focus on key policy concerns that affect all

- We've long supported the movement to a prospective payment system
- This PPS has details that still need to be worked out
- The state's model works well for some centers, not all – depends on their payer mix, their familiarity with tracking encounters
- Overarching concerns that must be worked out:
    - Doesn't align with CCBHC – the state is figuring out how to implement CCBHC, this piece is crucial
    - Cost-based but doesn't reflect current costs
    - Funding model is not grounded in a real functional premise
    - Even though it's cost-based, there are many unfunded programs that PPS still doesn't cover adequately (give examples)
- Ask legislator to urge HCPF to align PPS with CCBHC and keep an eye on impacts to providers going forward

Violence Against Healthcare Workers

BACKGROUND: As you'll recall, there have been multiple efforts and dueling bills over the last couple of years to address violence against healthcare workers. The Colorado Hospital Association sought to increase penalties against perpetrators; the Colorado Nurses Association sought to increase nurse staff ratios; Mental Health Colorado wanted to mandate new policies and trainings and extended the focus beyond hospitals to comprehensive behavioral health providers. A bill proposal this year will incentivize hospitals to protect their staff. None of these proposals has addressed the issues CBHC members face.

What you might hear

"There's been a lot of discussion in this building over the last couple of years about violence against healthcare workers. Is that an issue for you? How do you think we should address that?"

Points to cover when responding

- None of the proposals we've seen address challenges specific to those our members face.
- Explain the kinds of assaults your staff have faced, and the ongoing secondary trauma for other staff.
- Comprehensive behavioral health providers are required by state law to see violent patients unless the provider deems them to be outside the provider's capacity and expertise—allowed to ask BHASO to refer patient to another provider in that case, but that kind of care coordination takes time.
- Law enforcement is often unwilling to transport those patients when we call for help because they don't know where to take them and are advised against doing so because of a concern about risk and liability.
- Still leaves our providers vulnerable, and hospitals have resources we don't (e.g., the ability to restrain patients).
- What we need:
    - Better support from law enforcement – in the rare circumstances when that level of force is required for individual and public safety
    - Additional guardrails about serving violent patients (e.g., specific allowances to treat in secure settings, by telehealth, etc.)
    - A fuller continuum of intensive services and community residential care (i.e., the "Missing Middle)

Access to care/wait times

What you might hear

"There seems to be challenges with Coloradans getting timely appointments for mental health care" or a personal/constituent anecdote about wait times/wait lists.

Points to cover when responding

- CMHCs are working hard to ensure that all Coloradans get the behavioral health services they need when they need them.
- Address generalizations about wait times: drill down to learn more
    - Is the issue about getting in to see a prescriber or being admitted to a program? Or is it about access to a counselor for outpatient treatment?
    - What kind of service does someone need? Is there a discrepancy between what the patient and/or family want and what has been recommended based on a clinical assessment?
    - Does the individual have Medicaid or private insurance?

- Explain what your center does to provide timely care—e.g., how you manage same-day scheduling—but why some services can't be provided on a same-day basis
- Explain factors affecting wait times, e.g.,:
    - Workforce shortages exist, especially for prescribers and high-intensity programs.
    - Evidence-based practice requirements for certain types of care that limit the caseload of the clinicians providing those services.
    - Patient preferences about the location or characteristics of the clinicians they want to see.
    - Resource and referral options may look different depending on geographic location.
- If they cite an issue with your center offer to look into the circumstances and get back to them with more information within the bounds of patient confidentiality.

Explain policy and procedure for making referrals if a need cannot be met in a timely manner due to capacity or expertise.

New Medicaid Payment Model (PPS)

What you might hear

"I've heard about concerns with the new Medicaid payment model. Are they working out the kinks on that? Have you lost money as a result of it?"

Points to cover when responding

NOTE: impacts vary greatly across centers, so focus on key policy concerns that affect all

- We've long supported the movement to a prospective payment system
- This PPS has details that still need to be worked out
- The state's model works well for some centers, not all – depends on their payer mix, their familiarity with tracking encounters
- Overarching concerns that must be worked out:
    - Doesn't align with CCBHC – the state is figuring out how to implement CCBHC, this piece is crucial
    - Cost-based but doesn't reflect current costs
    - Funding model is not grounded in a functional premise
    - Even though it's cost-based, there are many unfunded programs that PPS still doesn't cover adequately (give examples)
- Ask legislator to urge HCPF to align PPS with CCBHC and keep an eye on impacts to providers going forward

General negativity

What you might hear

“The system is the way it is because providers weren't getting the job done.”

Points to cover when responding

- Don’t be defensive but provide facts based on your center’s experience.
- CMHCs were created to serve the most vulnerable in their communities. It’s a calling for us to serve individuals with serious mental illness, those with co-occurring substance use disorder, and children with serious emotional disturbance.
- Nobody is competing to serve those individuals. It’s difficult work that can burn out clinicians and is barely financed by the state. Many of the services we provide are not reimbursable by Medicaid or commercial insurance (give examples), so we must be supported by capacity funding from the BHA and other sources, such as grants or investments at the county or municipal level.
- CMHCs offer a tangible return on investment: “Our center serves (number) of clients every year, most of whom need multiple types of services, for an average of $xxxx/client.” (NOTE: Average across CMHCs is less than $2000/client/year.)
- Remind them of your mission and reassure them that your organization remains committed to serving as the community mental health center in your region.
- Offer to follow up on any specific issues they identify.

Specific legislation

What you might hear

"What do you think about (X bill)?"

Points to cover when responding:

- Refer to CBHC position document (we'll share with you that morning).
  - If we don’t have a position, note that.
- Talk about how your patients/clinicians are affected by the general issue covered by the bill.
- Ask the legislator how they view it.
- Offer to have CBHC lobby team follow up.