Behavioral Health Community Programs: Services and Network Report

Response to a Request from the Colorado General Assembly Joint Budget Committee

November 1, 2025

Submitted to: Joint Budget Committee

COLORADO
Department of Health Care Policy & Financing

Contents

I. Executive Summary

The Department of Health Care Policy & Financing (HCPF) is submitting this report in response to a request for information from the Joint Budget Committee regarding the Colorado Medicaid behavioral health program. It includes an overview of the capitated behavioral health services provided in fiscal year (FY) 2023–24 and the performance of the behavioral health managed care entities (MCEs) in calendar year (CY) 2024, as well as highlighting critical changes to the behavioral health Medicaid program between the end of FY 2023-24 and the end of July 2025. The report provides an evaluation of the behavioral health system by measuring member access to care, provider network expansion and contracting timelines, and timeliness of payments to providers.

State Medicaid programs require continuous innovation and problem-solving to meet the needs of many stakeholders, including Health First Colorado (Colorado's Medicaid program) members and providers, while complying with state and federal regulations and honoring the mandate to manage taxpayer funds responsibly. HCPF is committed to continuing this important work with behavioral health. Details about how HCPF is working to achieve these goals during a challenging time of changes to Medicaid are provided in the report.

A. The Behavioral Health Capitated Benefit

HCPF is the single state agency responsible for administering Health First Colorado benefits as a part of the state's Medicaid program. For the reporting period of FY 2023-24, HCPF maintained contracts with eight Managed Care Entities (MCEs); seven Regional Accountable Entities (RAEs) and Denver Health Medicaid Choice, a Managed Care Organization (MCO) for Denver County. These MCEs were responsible for administering, managing, and operating the Medicaid capitated behavioral health benefit by ensuring members had access to a full continuum of medically necessary covered behavioral health services.

Colorado's managed care model connects members with behavioral health services, responds flexibly to emerging regional and member needs, and works within a state-determined behavioral health budget. MCEs develop and maintain regional networks

that ensure members have access to a full continuum of behavioral health services and coordination of primary care and connection to additional community based supportive services. The managed care model also allows the state to offer special federally approved services for people with serious mental illness, chronic addiction, and health-related social needs that can be difficult to support and reimburse under a fee-for-service model.

MCEs are required, by regulation and contract, to maintain a network of providers adequate to meet member needs based on utilization of services and to ensure quality care is provided in accordance with defined treatment goals in the least restrictive care setting appropriate for each member and to promote efficient and cost-effective care. MCEs are also accountable for meeting all federal requirements, including ensuring that members are accessing appropriate, medically necessary treatment.

MCEs are federally required to establish and maintain utilization management policies and procedures to safeguard against inappropriate care and services that do not meet medical necessity requirements. Utilization management policies include criteria and process for reviewing services provided, auditing financial and clinical records, setting appropriate limits on services, and in some cases, prior authorization requirements. With regard to prior authorization policies, Medicaid programs balance the need to deliver services in a timely manner with the need to manage member care and ensure members are receiving the right care for their situation. Most services do not require prior authorization. Details about services for which prior authorization is required can be found in HCPF's annual Parity Report[1].

B. Medicaid Sustainability

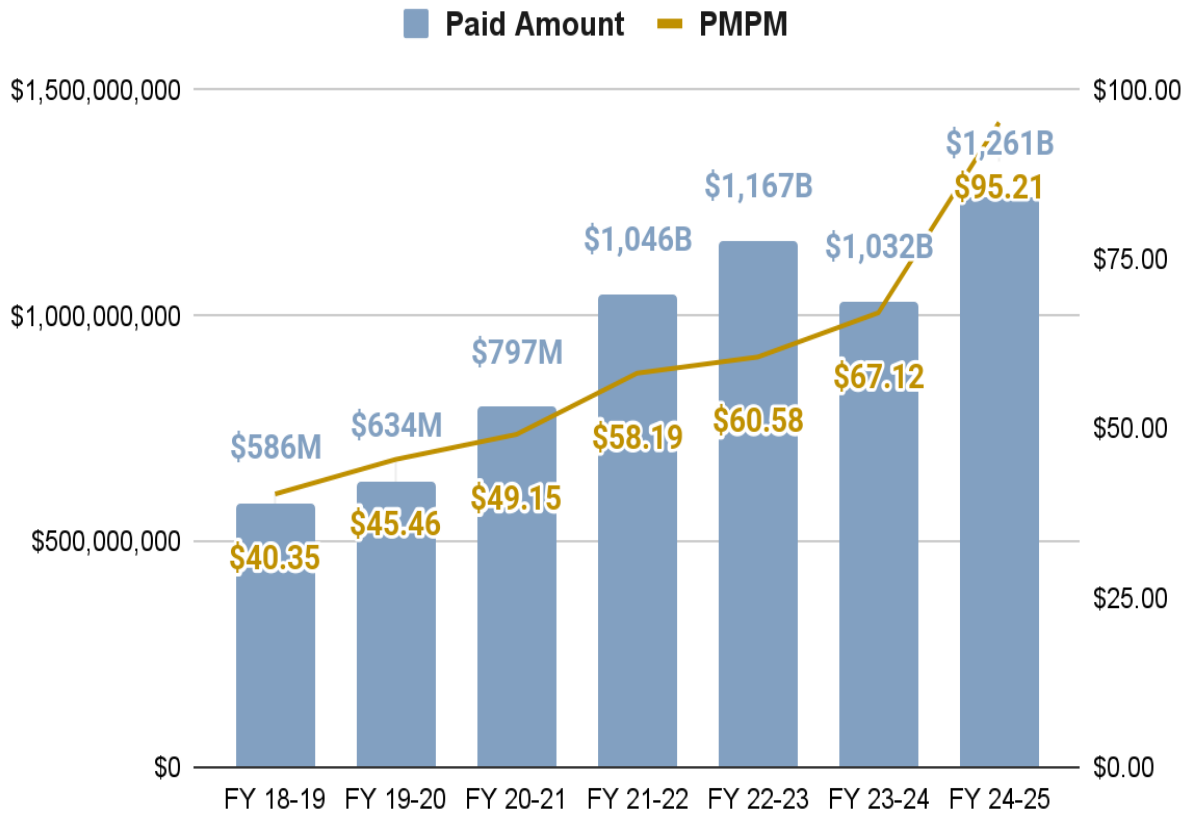
Throughout FY 2023-24 and CY 2024, HCPF has maximized opportunities such as the American Rescue Plan Act (ARPA) projects, and 1115 waiver authority to add new demonstrations, to build infrastructure and increase federal match funding. As the state has expanded behavioral health coverage and access and reduced barriers to care, the costs of mental health and substance use services have increased.

Facing significant budget limitations, and rising behavioral health budgets, HCPF developed the Medicaid Sustainability Framework in 2025 to ensure alignment and collaboration across stakeholders to manage Medicaid claim expenses within available revenues to cover them and to do so through a new services and legislative directives

[1] https://hcpf.colorado.gov/parity

to expand care are met, and that there are thoughtful and strategic approach, given the state's multi-year fiscal challenge, which has been further heightened by the passing of H.R.1. These actions include the use of Medically Unlikely Edit reviews, audits, payment model adjustments, utilization review, and data monitoring to determine appropriate limits on location and providers for services. These sustainability actions are essential to ensure that budget reductions are precise, balanced, and limit disruption to patient care and provider experience. Sustainability activities are also necessary to preserve the progress the state has made in this work. During this same period (from 2018 to 2025), HCPF has increased access to behavioral health services by 41%, more than doubled the total number of Medicaid contracted behavioral health providers, improved independent provider satisfaction, and expanded coverage across the continuum in partnership with the state Behavioral Health Administration. The growth in the provider network, increased provider rates, addition of new benefits and behavioral health (BH) transformation initiatives led to a 115% increase in paid BH services FY 2018-19 ($586M) to FY 2024-25 ($1,261B); increasing at +23% trend rate per year.

Colorado Medicaid Behavioral Health Amounts Paid by Year, Total volume and Per member Per month



C. Behavioral Health Utilization FY 2023–24

In FY 2023–24, 23.8% of Health First Colorado members accessed capitated behavioral health services, including mental health and substance use disorder (SUD) services. This percentage of members seeking behavioral health support represents a 25% increase in behavioral health service utilization when compared to member use over the previous four years, where utilization ranged between 18%-19%. Primary drivers for this increase include legislatively funded and supported expansion of benefits, increased access through provider networks, and expanded service capacity. While increased access has been an express goal of this administration and recent policies, HCPF will continue to work with the RAEs and community partners to monitor growth and ensure access is appropriate and that participating Medicaid provider behaviors comply with state and federal policies and guidance.

By the end FY 2023-24, member enrollment in the ACC averaged 1,274,668, which included 84,171 members enrolled in Denver Health Medicaid Choice. Colorado Medicaid members who access behavioral health services do not pay a copay or a deductible. Utilization trends for members under the behavioral health capitation are listed below. Trends across time are also included.

- 303,542 unique members used capitated behavioral health services. Among that group, 66.47% (201,766) used mental health services, 16.17% (49,077) used SUD services, and 54.87% (166,564) used B3 services.
- Of the 201,766 unique members who utilized mental health services, 201,327 (99.78%) received outpatient mental health services. Inpatient hospital mental health services were used by 11,534 (5.72%), and 3,499 (1.73%) received residential mental health services.
- Of the 49,077 unique members who utilized SUD services, 44,574 (90.82%) used outpatient services. 10,687 (21.78%) received residential treatment and 3,945 (8.04%) used inpatient hospital SUD services.

D. Provider Network, Credentialing, and Contracting

Each MCE is responsible for establishing a network of providers in their region to serve the needs of members. These networks must include residential and inpatient hospital facilities, safety net providers; and the individual, small, and medium sized providers that make up the independent provider network (IPN). As of quarter 4 of FY 2024-25, MCEs have expanded their practitioner networks and met greater than 90% of time and distance, exceeding required network adequacy metric standards.

By the end of FY 2023-24, there were 12,478 MCE-contracted behavioral health providers, compared to 11,417 at the end of FY 2022-23.

MCEs are required to complete the credentialing and contracting process, or deny network admission, within 90 days for at least 90% of all provider applications. In the last month of calendar year 2024, the percentage of providers credentialed and contracted within 90 days across all MCEs was at or above 93%.

E. Claims Processing and Provider Payments

In compliance with federal regulations, HCPF requires MCEs to adjudicate and pay 90% of all clean claims within 30 days of receiving them, and 99% of clean claims within 90 days of receipt. RAEs pay most of their claims much faster. In December 2024, six RAEs paid 91% or more of their claims within seven days and all RAEs paid 87% or more of their claims within 14 days. The percentage of adjudicated claims paid within 30 days across all MCEs was at or above 99.2%.

Timeliness of Processing Provider Claims within Contract Requirements Paid in December 2024, by RAE

RAE	% of Clean Claims Paid within 7 days	% of Clean Claims Paid within 14 days	% of Clean Claims Paid within 30 days
RAE 1	92.40%	99.05%	99.62%
RAE 2	82.59%	87.74%	99.20%
RAE 3	91.20%	92.89%	99.22%
RAE 4	90.99%	94.47%	99.68%
RAE 5	93.07%	94.98%	98.96%
RAE 6	96.49%	99.52%	99.56%
RAE 7	96.49%	99.52%	99.56%

F. Improving Behavioral Health Services Statewide

HCPF continues to work with providers, MCEs, and state agencies to improve the provider experience in contracting, credentialing, and reimbursement with the goal

of expanding the behavioral health safety net in Colorado and increasing access for members. Initiatives include:

- Implementation of the third phase of the Accountable Care Collaborative (ACC Phase III) which launched on July 1, 2025 and included the selection of RAEs for four new regions, aligning with the Behavioral Health Administration systems.
- Developing the Colorado System of Care (CO-SOC) framework, in collaboration with the Behavioral Health Administration (BHA), to serve children and youth with complex or high acuity behavioral health needs.
- Receiving approval from the Centers of Medicare and Medicaid Services (CMS) for the following 1115 Waiver Demonstrations submitted as amendments to the current 1115 Waiver SUD Demonstration "Expanding the Substance Use Disorder (SUD) Continuum of Care": HRSN Demonstration, SMI/SED Demonstration and Reentry Demonstration.
- Monitoring and oversight to support the past five years of behavioral health transformations and ensure continual and sustainable access.

G. Change In Payment Delivery

Beginning July 1, 2025, HCPF changed payment processes for three covered behavioral health services. The Short-term Behavioral Health and Behavioral Health Secure Transportation benefits transitioned from direct fee-for-service (FFS) to coverage under the RAE's behavioral health capitation. The Permanent Supportive Housing benefit transitioned from the behavioral health capitation to FFS.

Colorado was awarded a one-year Certified Community Behavioral Health Clinics (CCBHC) Planning Grant in December 2024 to create a state infrastructure and implementation timeline with supporting policies and financial and payment model analysis. HCPF and the BHA plan to submit a proposal for Colorado's participation in the 2026 CCBHC Demonstration Program in early 2026. If selected, participation in the demonstration must then be approved by Colorado's state legislature.

II. Introduction and Overview of the Behavioral Health Capitated Benefit

A. Colorado's Behavioral Health Capitated Benefit

HCPF is the single state agency responsible for administering Health First Colorado. Through the Accountable Care Collaborative, HCPF contracted with five MCEs to administer, manage, and operate the Medicaid capitated behavioral health benefit by providing medically necessary covered behavioral health services in seven

geographic regions. HCPF also contracted with Denver Health Medicaid Choice (DHMC), a Managed Care Organization (MCO), to provide services in the Denver metro region. As required by C.R.S 25.5-5-402, DHMC delivered capitated physical health care benefits in the Denver metro region and subcontracted with the Regional Accountable Entity (RAE) in Region 5 to administer the capitated behavioral health benefit. MCEs have primary accountability for promoting optimized behavioral health and wellness for all members and providing or arranging for the delivery of medically necessary behavioral health services made up of both mental health (MH) and SUD care. Within the capitated behavioral health budget, managed care programs are able to pay variable rates to providers based on the need in the region and set up higher rates for specialty services or special cases.

Regions of the Accountable Care Collaborative (ACC) Phase II

The managed care model offers several advantages for members. It helps with coordination of behavioral health services and allows the state to offer special benefits for people with Serious Mental Illness (SMI) that would not be available under a fee-for-service model. (These services, called “alternative” or “B3” services, are discussed in detail in the next section.) The managed care model also allows HCPF to respond quickly and flexibly to emerging needs, such as the need for

behavioral health telehealth during the pandemic. Importantly, the managed care model allows the state to track progress on metrics and adjust policies or practices when the state is not getting the most value for its health care dollars.

In addition to the MCEs in FY 2023-24, the Behavioral Health Administration (BHA) was actively planning to stand up Behavioral Health Administrative Service Organizations (BHASOs), designed to support the behavioral health needs of Medicaid members. The purpose of the BHASOs is to consolidate SUD treatment and crisis services and include services offered by comprehensive community behavioral health centers statewide for all Coloradans. Although RAEs and BHASOs are similar, there are differences between populations served and function. The shared goals are to improve services to Coloradans, improve coordination and efficiencies across the system and create consistency for providers while reducing administrative burden. BHASOs were selected and announced in 2024 and launched effective July 2025. New RAEs were also selected in 2024 and launched as ACC Phase III in July of 2025.

B. Behavioral Health Services Offered

Behavioral health is complex and often requires services from a care team and/or multiple providers. The Medicaid benefit includes outpatient services such as individual and group therapy, medication management, psychiatrist services, high intensity outpatient programs (HIOP) including partial hospitalization (PHP) and intensive outpatient programs (IOP). The benefit also covers emergency and crisis services, as well as residential and inpatient hospital treatment.

The behavioral health benefit also covers alternative wraparound services - the previously mentioned “B3 services”. These include prevention, early intervention, Clubhouses, Drop-in Centers, Vocational Services, Assertive Community Treatment, Residential Mental Health Treatment, Respite Care, Recovery Services, and Peer Support. These B3 services are one of the greatest flexibilities supported through a managed care system. **Over half (54%) of individuals with behavioral health needs benefit from these services every year; that is nearly 13% of the total Medicaid population.**

These B3 services offer members a way to connect within their communities and develop life skills and a network of support. These services can be especially important for members with SMI, and those who have co-occurring MH and SUD diagnoses, complex medical needs, cognitive disorders, or are involved with criminal justice systems. As the impacts of H.R. 1 and work requirements are implemented, case management and vocational services will be especially important in helping

individuals with mental health and substance use disorder connect with employment, education, and volunteer programs required to maintain Medicaid coverage.

As a part of the Medicaid Sustainability Framework, HCPF is reviewing the costs and benefits of the b3 program, to ensure that the program is working as intended, increasing low cost services to help keep people well and out of the higher cost services, like hospitalization.

Table 1. Overview of Services Covered by the Inpatient, Outpatient and B3 Services within the Behavioral Health Capitated Benefit FY 2023-24

Outpatient Services	Inpatient and Residential Services	Wraparound, Intensive Support B3 Services
• Individual, group, and family therapy • Medication management • Psychiatrist services • Outpatient hospital psychiatric services	• Emergency and crisis services • Inpatient hospital psychiatric care • Residential and inpatient substance use disorder (SUD) treatment • Residential and inpatient withdrawal management	• Prevention/Early Intervention • Clubhouses/Drop-in Centers • Vocational Services • Assertive Community Treatment • Residential Mental Health Treatment • Respite Care • Recovery Services/Peer Support

C. Behavioral Health Utilization Management

Federal laws and regulations require state Medicaid programs use utilization management (UM) to safeguard against unnecessary utilization and to assure payments are consistent with efficiency, economy, and quality of care. Federal regulations allow managed care plans to place appropriate limits on services for the purposes of UM, most prominent of which is the use of service authorization requests, also called prior authorization requests (PARs). Each MCE has its own UM program for behavioral health services to reduce waste and promote efficient and cost-effective care.

Because Medicaid can only pay for medically necessary services, MCEs are required to make a medical necessity determination when processing a request for authorization of services and as part of the review of claims submitted. This means when a provider delivers or recommends a specific service or treatment modality for care based on a diagnosis and clinical interview/assessment, an MCE must consider the medical necessity criteria established in 10 CCR 2505-10 section 8.076.1.8 and section 8.280.4E when approving or denying authorization and payment for services.

All MCEs are required to use nationally-recognized UM tools, such as Interqual, 3M, or Milliman Clinical Guidelines (MCG) to process prior authorization requests (PAR). In the spaces where additional agreement or standardization across MCEs is necessary, HCPF has facilitated agreement for a uniform approach by building consensus with the MCEs and issuing a set of standards to minimize unnecessary administrative burden for providers.

One example of state standardization is the UM process used for members under age 21. For this population, HCPF worked with the MCEs to create clinical guidelines to identify appropriate levels of care because there were not uniform guidelines to apply. These have been published as the Colorado Statewide Standardized Utilization Management (SSUM) Guidelines for Youth Under 21 Years Old. All MCEs are required to use these guidelines from July 1, 2023.

Another example of state standardization of UM guidelines is in the treatment delivery of SUD services. Under the state's 1115 SUD waiver demonstration the expansion of SUD services requires providers to use the American Society of Addiction Medicine (ASAM) criteria to assess level-of-care placement for members needing SUD services. For residential and inpatient services, these level of care determinations are reviewed by MCEs as part of the authorization process. **During 1115 SUD Demonstration Year 4 (January to December 2024), the average length of time it took RAEs to respond to a facility's request for authorization of initial services was under the required standard of 72 hours.**

During CY 2024, providers made 4,194 total initial requests, RAEs issued 4,042 initial authorizations, and 94% of these authorizations were issued within 72 hours. Since January 1, 2022, the number of initial authorization days has been standardized across all MCEs. Effective January 2024, the standard allowable days for initial authorization was increased to more accurately reflect the average lengths of stay observed for each level of care during the first two years of the demonstration.

HCPF provided annual reports on residential SUD service utilization in accordance with Senate Bill 21-137[2] reporting requirements for the first 3 years of the waiver. In 2024, the General Assembly passed Senate Bill 24-135[3], amending HCPF's reporting requirements in relation to SUD utilization management that was previously required through Senate Bill 21-137. HCPF published the final SUD Utilization Management report on July 1, 2024 which is an annual report including Demonstration Year 3 data

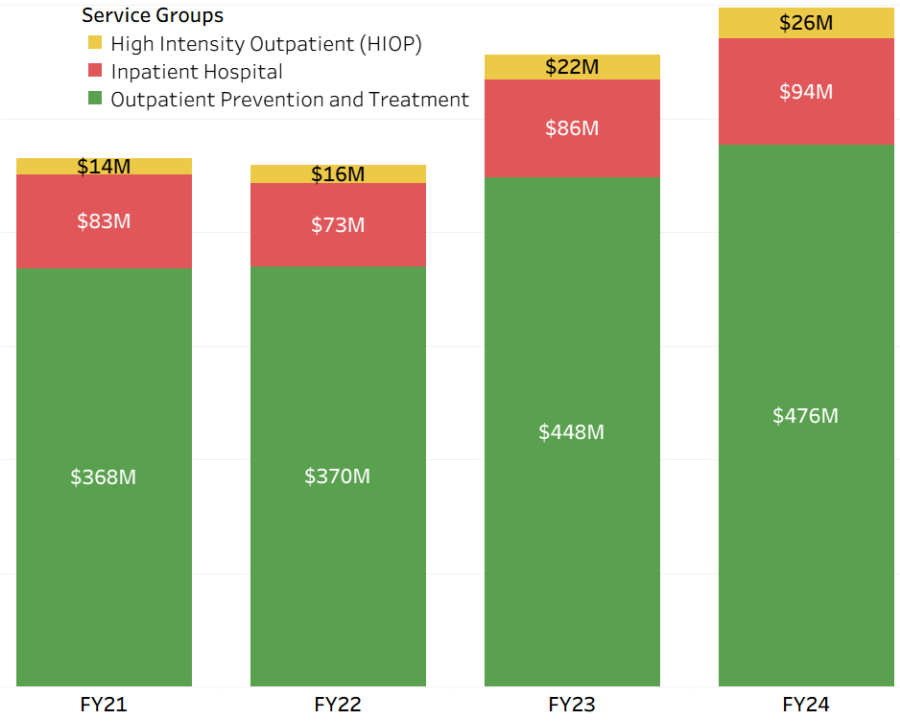
[2] https://leg.colorado.gov/bills/sb21-137
[3] https://leg.colorado.gov/bills/sb24-135

(January - December 2023). The report is posted on HCPF's Ensuring Full Continuum SUD Benefits webpage. HCPF continues to monitor SUD utilization as part of a larger utilization monitoring strategy.

Utilization Management and Outpatient Behavioral Health

In 2022, Colorado passed SB 22-156, Medicaid Prior Authorization and Recovery of Payment, which prohibited any prior authorization for outpatient psychotherapy. In discussions with RAEs and stakeholders, HCPF understood the intent of this bill was to address an administratively burdensome process that led almost always to an approval, and therefore did not forecast any budgetary impact. However, from FY 2021-22 to FY 2023-24, following the prohibition of PARs for psychotherapy services, HCPF saw a +$38M increase, despite the significant reduction in caseload. This included a 61% increase in 25+ visits per year and a 98% increase in 56+ visits per year. The data analysis was conducted by the state's independent actuaries and led to the Department identifying the removal of psychotherapy PARs as one of the key drivers of inappropriate cost increases. During the 2025 special legislative session, Governor Polis and the Colorado General Assembly took a number of actions to address significant state budget limitations. One of those actions was to remove the prohibition on psychotherapy prior authorization for more than 24 services per year.

HCPF Behavioral Health payments to providers FY 2021-24



An overview of the Medicaid specific budget reductions can be found on the FY 2025-26 HCPF Budget Reductions Fact Sheet.

III. Medicaid Sustainability

A. ARPA Funds Closeout

HCPF approached the American Rescue Plan Act (ARPA) projects with the intention to build an infrastructure and program capacity that would be sustainable beyond ARPA.

High-Intensity Outpatient Service Providers - ARPA 3.06 Project

Through the ARPA 3.06 project, HCPF distributed a total of $26 million to Colorado's RAEs to support the expansion of High-Intensity Outpatient (HIOP) behavioral health services. These are services beyond traditional individual or group therapy or integrated care - programs like partial hospitalization, intensive outpatient, high fidelity wraparound, or transitional supports. Each RAE region received and granted $3.7 million to contracted Medicaid providers with a focus on building infrastructure for HIOP services and supporting members transitioning to the community from a higher level of care. The RAEs distributed 122 grant awards to 92 unique providers across the state. This project provided an opportunity for providers to invest funds into developing the physical and technological infrastructure, as well as the workforce needed to expand the delivery of HIOP services to Medicaid members. Outcomes of the project include the addition of 17 new HIOP providers to the network, the launch of 50 provider online training modules, and an increase in the availability and utilization of HIOP services. The expansion addressed gaps in the behavioral health safety net system, particularly in the transition from institutional to community-based outpatient care.

Permanent supportive housing for Medicaid members - ARPA 3.07 Project

Through the ARPA 3.07 project, funding, the Statewide Supportive Housing Expansion (SWSHE) Pilot Project provided grant funding for 28 Permanent Supportive Housing organizations across the state of Colorado. The goals of the pilot were twofold: to expand pre-tenancy and tenancy support services for people experiencing homelessness with the highest unmet health needs, and to inform Medicaid policy and systems change to create a more permanent funding source for supportive housing providers across the state. Both goals were met. The SWSHE pilot was completed on Sept. 30, 2024 with the pilot serving 869 members and creating a solid foundation for HCPF's 1115 Health Related Social Needs (HRSN) waiver amendment request submitted in August 2024 and approved by CMS in January 2025.

American Indian/Alaska Native Culturally Responsive Services Capacity Grants - ARPA 3.08 Project

Through the ARPA 3.08 project, $3 million in grant funding was provided to two tribal partners to improve service availability and access for tribal members regardless of their proximity to tribal land. Funding was provided for Denver Indian Health and Family Services (DIHFS), and was used to accomplish the following: The successful purchase of a vehicle to support client transportation, the purchase of a mobile health vehicle to provide behavioral health services in homes and communities for people who cannot otherwise access care, crisis intervention training for staff, supporting staff to obtain additional credentials for delivering more behavioral health services, operation of the Denver-based mobile outreach vehicle, and the renovation of a health clinic that offers behavioral health and MAT services to tribal members.

The funding provided to the Southern Ute Indian Tribe (SUIT) was used to: establish a new treatment center, install play therapy and physical therapy equipment, purchase a mobile clinic and equipment to provide MAT treatment and other services, develop recovery residences, and conduct street outreach and mobile services to improve engagement in treatment services.

B. Sustainability Framework

In May of 2025, HCPF prepared the Medicaid Sustainability: Behavioral Health and Managed Care Actions memo to clarify FY 2025-26 expectations with the RAEs to ensure alignment with the Medicaid Sustainability Framework. Following a period of rapid growth of networks and service expansion in the behavioral health space over the last several years, and recognizing state fiscal challenges and evolving the evolving fiscal impacts of H.R.1, it is critical for HCPF to evaluate and monitor the impact of changes that have implemented to behavioral health services and the effects of those changes on Medicaid behavioral health cost trends. Some examples include:

- A 115% increase in paid BH services FY 2018-19 ($586M) to FY 2024-25 ($1,261B); increasing at +23% trend rate per year[4]
- Residential services from FY 2020-21 to FY 2023-24 increasing from $24M to $84M

[4] The growth in the provider network, increased provider rates, addition of new benefits and BH transformation initiatives led to a 115% increase in paid BH services.

- Outpatient services went from $465M to $596M from FY 2020-21 to FY 2023-24[5]
- A 286% increase in paid peer services from FY 2021-22 to FY 2023-24 almost a +95% trend per year[6]
- From FY 2021-22 to FY 2023-24, following the prohibition of PARs for psychotherapy services, saw a +$38M increase, despite the significant reduction in caseload. This included a 61% increase in 25+ visits per year and a 98% increase in 56+ visits per year.

While confirming HCPF's values and priorities, the memo outlines the serious risk that comes without action to manage trends, clarifies expectations of the RAEs and lays out a direction for behavioral health care: to preserve necessary services for vulnerable members in fiscally responsible ways. HCPF has identified strategies that allow maintenance of the broadest array of services while complying with the Medicaid Sustainability Framework. As HCPF aligns with the Medicaid Sustainability Framework, quality care remains a priority. HCPF has prioritized quality care, and plans to use cost and quality metrics to support continued development of provider networks by targeting specific areas of need within each network to grow access to services needed within each community. The Joint Budget Committee in the 2025 legislative and Special Session approved a number of change to the behavioral health system, including reductions in behavioral health incentive programs, limiting peer services to specific provider types and services, reducing funding for underutilized provider training services, and removing the restriction on prior authorization for psychotherapy services.

In addition, to reduction and policy changes that help manage trend, HCPF has continued to identify opportunities to increase federal match for expanded behavioral health programs through 1115 Demonstration waivers authorized by the Colorado legislature. Following CMS approval of these demonstrations in January of 2025, HCPF sought approval for a reinvestment plan as required by CMS under 1115 waiver authority. The General Assembly passed Senate Bill 25-308[7] to create two cash funds to allow HCPF to implement federally matched Medicaid coverage of reentry services and health-related social needs, and to reinvest the state savings in the Department of Corrections, the Department of Local Affairs, and the Department of Human

[5] The service groups included High Intensity Outpatient ($14M in FY 2020-21 and $26M in FY 2023-24), Inpatient Hospital ($83M in FY 2020-21 and $94M in FY 2023-24) and Outpatient Prevention and Treatment ($368M in FY 2020-21 and $476M in FY 2023-24)
[6] The peer support services data included: Behavioral Health Outreach Service (H0023), Self-Help/Peer Services (H0038) and Skills Training and Development (H2014).
[7] https://leg.colorado.gov/bills/sb25-308

Services. Reinvestment of funds is required under federal law and must be done in alignment with the programs that have been financed through the 1115 waiver.

IV. Behavioral Health Utilization in FY 2023-24

A. Utilization of Behavioral Health Services

Estimates of the need for behavioral health care are available from surveys at both the national and state levels. National estimates indicate that 23.4% of adults report having had any mental illness over the past year, and 15.4% of youth and adolescents under age 18 report having had a major depressive episode in the past year.[8] Colorado survey data show similar trends. According to the most recent Colorado Health Access Survey, in 2023, 26.2% of Coloradans reported eight or more days of poor mental health in the 30 days prior to the survey.[9]

This report does not include utilization of behavioral health services paid fee-for-service, such as SUD emergency room services, and Medication Assisted Treatment(MAT); however information on the short-term behavioral health services (up to six visits) for low-acuity behavioral health needs at a member's primary care medical provider site can be found in the New and Changing Benefits section of this report.

In FY 2023-24, 23.8% of Medicaid members used capitated behavioral health services. This represents a 25% spike in the percentage of members utilizing behavioral health services when compared to the previous four fiscal years where 18%-19% of members utilized a behavioral health service**.** The largest utilization increase was in outpatient MH services. Driving these increases are some expected increases, like the expansion of SUD and peer benefits, increase in contracted providers, and increased capacity through training and grants. However, the removal of prior authorizations for psychotherapy services and the expansion of benefits without limitations led to unexpected and likely inappropriate increases in trend. The positive outcomes include a higher number of members seeking early intervention and lower acuity services grew, and more Medicaid members were able to access timely behavioral health care. Evidence suggests this should lead to a cost savings in emergency care, inpatient hospital care and residential care, though the PHE Unwind and increased nationwide rate of behavioral health diagnosis[10] make this impact measurement difficult. Further monitoring of services across the continuum

[8] SAMHSA. 2024 National Survey on Drug Use and Health.
[9] Colorado Health Institute. 2023 Colorado Health Access Survey.
[10] https://www.cdc.gov/nchs/products/databriefs/db444.htm

will be required. Statewide, in 2024 some of the most important vital behavioral health outcomes improved, with reductions in youth suicide[11] and overdoses[12].

Another contributing factor to the increase in percentage of members utilizing BH services is that as the PHE unwind was completed, the members who remained eligible have higher needs.

Figure 1. Total Count of Unique Members Accessing Behavioral Health Services FY 2019-20 to FY 2023-24

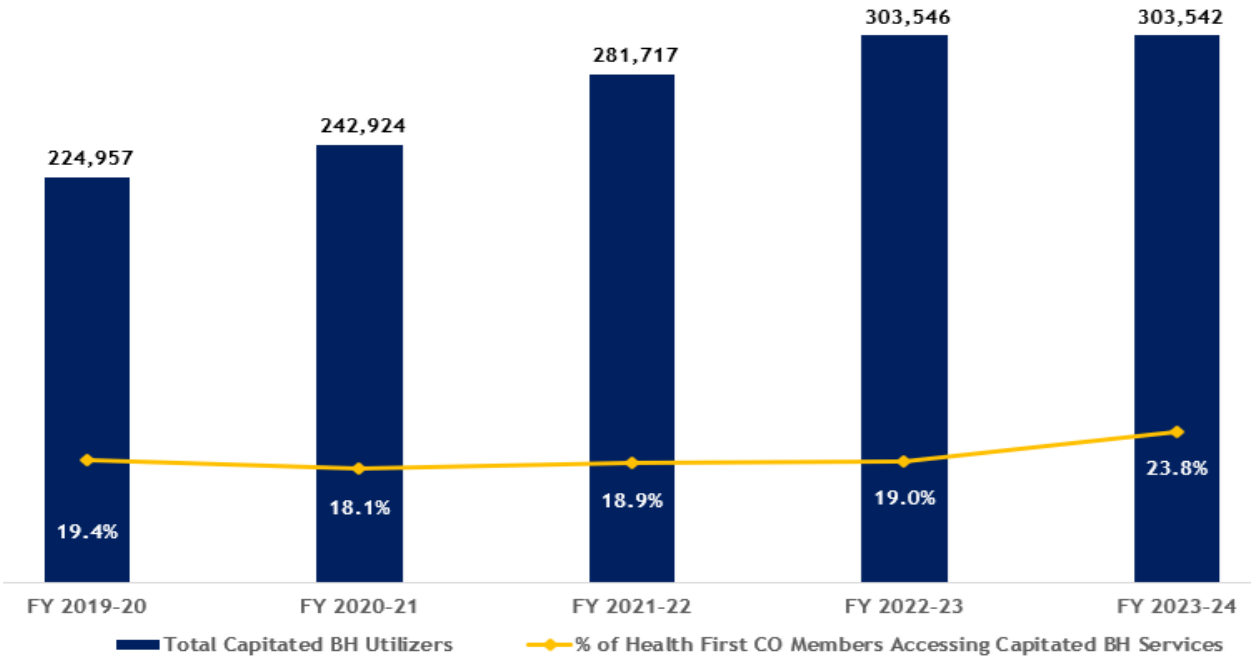


Table 2. Total Count of Unique Members Accessing Behavioral Health Services FY 2019-20 to FY 2023-24

	Total Capitated BH Distinct Utilizers	Average Monthly Member Enrollment	% of Members Utilizing Capitated BH
FY 2019-20	224,957	1,161,545	19.4%
FY 2020-21	242,924	1,343,597	18.1%
FY 2021-22	281,717	1,489,511	18.9%
FY 2022-23	303,546	1,594,150	19.0%
FY 2023-24	303,542	1,274,668	23.8%

[11] https://cdphe.colorado.gov/suicide-prevention
[12] https://cdphe.colorado.gov/colorado-drug-overdose-statistics

Utilization trends for the behavioral health capitation for FY 2023–24 are listed below. It is important to note that members could access multiple levels of care and multiple services for both MH and SUD conditions.

- 303,542 unique members used capitated behavioral health services. Members could receive inpatient and residential services, as well as outpatient and B3 services. The total accumulation of member counts below will equal more than 100% of the unique member count because many members receive more than one service. Of those who accessed a capitated behavioral health service, 66.47% (201,766) were for a primary mental health diagnosis, 16.17% (49,077) were for a primary SUD diagnosis.
- Of the 201,766 unique members of mental health services, 201,327 (99.78%) received outpatient mental health services. Inpatient services were used by 11,534 (5.72%) and 3,499 (1.73%) received residential mental health services.
- Of the 49,077 unique members of SUD services, 44,574 (90.82%) used outpatient services. 10,687 (21.78%) received residential treatment and 3,945 (8.04%) had an inpatient SUD stay.
- B3 services were used by 54.87% (166,564) members.

Tables 3 through 6 show utilization of behavioral health services in FY 2023–24. For reference, average monthly member enrollment across all MCEs during this time period was 1,274,668 and average enrollment in Denver Health Medicaid Choice was 84,171.

Table 3. Unique Members Accessing Behavioral Health Services, FY 2023-24

	MH Services	SUD Services
Inpatient	11,534	3,945
Residential	3,499	10,687
Outpatient	201,059	44,246
High Intensity Outpatient	8,080	2,640
B3 Services (SUD, MH and Co-Occurring)	166,564	

Table 4. Unique Members Accessing Inpatient and Residential Behavioral Health Services, FY 2023-24, by MCE

MCE	Inpatient MH Services	Residential MH Services	Inpatient SUD Services	Residential SUD Services
RAE 1	2,154	724	813	1,968
RAE 2	682	210	147	684
RAE 3	2,564	733	960	2,152
RAE 4	834	361	138	1,094
RAE 5	1,485	655	561	1,715
RAE 6	1,549	263	656	1,443
RAE 7	1,840	290	503	984
Denver Health	622	313	1,023	1,023

Table 5. Unique Members Accessing Outpatient Behavioral Health Services, FY 2023-24, by MCE

MCE	Outpatient MH Services	Outpatient SUD Services	B3 Services
RAE 1	36,527	8,006	22,121
RAE 2	12,486	2,977	10,645
RAE 3	45,990	9,068	41,564
RAE 4	19,169	5,823	18,289
RAE 5	23,874	6,003	23,812
RAE 6	28,927	5,825	21,963
RAE 7	30,662	5,932	20,721
Denver Health	10,811	3,334	12,327

Table 6. Total Count of Unique Members Accessing Behavioral Health Services through a Community Mental Health Center (CMHC) [effective July 1, 2024, Comprehensive Safety Net Provider- CSNP] in Comparison to Other Providers, FY 2023-24

	Members Using Capitated BH Services	CMHC	Other Providers	% of the Total Subpopulation that Received a Service at a CMHC**
Capitated Behavioral Health Overall	303,542	81,755	263,483	26.93%
Mental Health Services	201,766	68,049	161,077	33.73%
Substance Use Disorder Services	49,077	6,957	45,844	14.18%
B3 Services	166,564	57,611	127,732	34.59%

**Members could have also received one or more services from another provider

B. Behavioral Health Incentive Program Indicators

In FY 2023–2024, the Behavioral Health Incentive Program (BHIP) began implementing three CMS core quality measures to assess program performance. Performance on all three CMS core measures improved compared to the previous fiscal year and performance on the two other indicators also improved from the baseline measurement year (FY 2022-23). These measures include:

1. **Engagement in outpatient SUD treatment:** Percent of members with a new episode of SUD who initiated outpatient treatment and who had two or more additional services for a primary diagnosis of SUD within 30 days of the initiation visit.
2. **Follow-up within 7 days after an inpatient hospital discharge for a mental health condition:** Percent of member discharges from an inpatient hospital episode for treatment of a covered mental health diagnosis to the community or a non-24-hour treatment facility who were seen on an outpatient basis by a mental health provider within seven days.
3. **Follow-up within 7 Days after an emergency department visit for a SUD:** Percent of member discharges from an emergency department episode for treatment of a covered SUD diagnosis to the community or a non-24-hour

treatment facility who were seen on an outpatient basis by a behavioral health provider within seven days.

4. **Follow-up after a positive depression screen:** Percent of members engaged in mental health service within 30 days of screening positive for depression.
    a. **Note:** Performance for this measure is not included in table 7 due to pending updates to the measure calculation.
5. **Behavioral health screening or assessment for foster care children:** Percentage of foster care children who received a behavioral screening or assessment within 30 days of RAE enrollment. This metric was intended to incentivize collaboration between counties and RAEs. It is not a reflection of all behavioral health assessments for children in foster care, and many external factors affect it. Statewide RAE performance has improved by more than double since the metric was created in FY 2017–18.

Table 7. BHIP performance by RAE, FY 2023-24

RAE	Engagement in Outpatient SUD treatment	Follow-up within 7 days of discharge for a MH condition	Follow-up within 7 days of ED visit for SUD	BH assessment for children in foster care
RAE 1	27.98%	32.58%	27.30%	17.23%
RAE 2	31.42%	25.45%	22.17%	15.71%
RAE 3	28.89%	36.33%	30.66%	17.28%
RAE 4	13.40%	30.14%	26.33%	34.27%
RAE 5	31.22%	32.84%	28.34%	39.23%
RAE 6	24.44%	34.94%	23.22%	16.24%
RAE 7	21.06%	27.96%	25.54%	18.28%

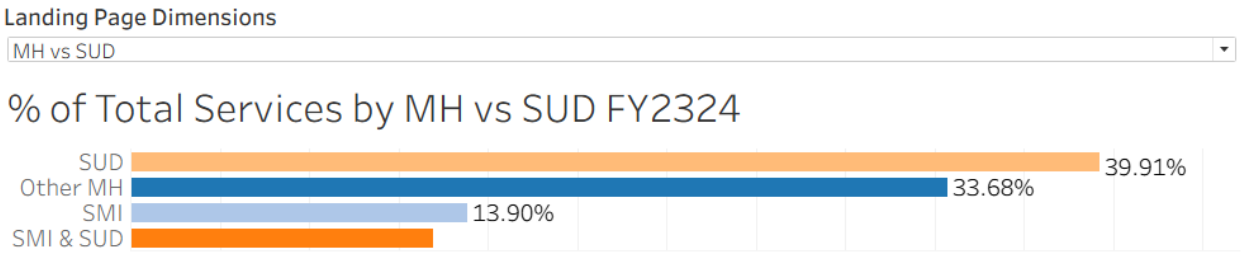
Note: Indicator 4 Depression Screening is not presented here due to pending updates to the measure calculation.
Key: Green = Met target

C. Behavioral Health Dashboard

HCPF has a behavioral health dashboard that provides updates on MH, SUD and B(3) services. This dashboard supports analysis of services accessed by members. The behavioral health dashboard allows HCPF to track trends in behavioral health encounter data provided by the RAEs. This dashboard informs reports, such as this

one, as well as policy and billing changes, budget forecasts, decision items and legislative proposals.

Figure 2. Example of behavioral dashboard that provides breakout of encounter data



V. Provider Network, Credentialing, and Contracting

A robust provider network helps ensure equitable access to behavioral health care. HCPF continues to work with MCEs on provider networks and other ways to improve access to care, which is often affected by race, ethnicity, socioeconomic status, age, sex, disability status, sexual orientation, gender identity, and residential location. Medicaid members are traditionally at high risk for poor health outcomes, so access to the right providers is a particular priority. Each region of the state has a unique member base, provider network, and community stakeholders. Each region also has unique challenges in addressing disparities and meeting the needs of populations that often do not have the access to care they need.

This section describes the behavioral health provider network, including the types of behavioral health providers that contract with MCEs, the process of credentialing and contracting, and BH provider network development strategy.

A. Behavioral Health Providers

For this reporting period FY 2023-24, HCPF separated outpatient service providers into two categories: Community Mental Health Centers (CMHCs) and the Independent Provider Network (IPN). HCPF has further broken down the IPN into Federally Qualified Health Centers (FQHCs) and all other independent providers.

1. Independent Provider Network

The independent provider network (IPN) is broadly defined as any outpatient behavioral health provider enrolled in Medicaid and contracted with an MCE that is not licensed or designated as a community mental health center. IPN providers include a range of provider types including individual behavioral health clinicians,

behavioral health group practices with and without prescribers and federally qualified health centers.

2. **Federally Qualified Health Centers (FQHCs)**

FQHCs are community-based health care providers that receive funds from the federal Health Resources and Services Administration (HRSA) Health Center Program to provide primary care services in underserved areas. They must meet a stringent set of requirements, including providing care on a sliding fee scale based on ability to pay and operating under a governing board that includes patients. FQHCs may be Community Health Centers, Migrant Health Centers, Health Care for the Homeless, and Health Centers for Residents of Public Housing. The defining legislation for FQHCs (under the Consolidated Health Center Program) is section 1905(l)(2)(B) of the Social Security Act.

Behavioral health providers contract directly with RAEs for services each provider will offer. RAEs are obligated by HCPF to offer contracts to all willing and qualified FQHCs, Comprehensive Providers, Regional Health Connectors, and Indian Health Care Providers to ensure that a safety net of services are provided in each region. Each MCE is responsible for establishing a statewide network of behavioral health providers to serve the needs of members. These networks must include both safety net providers and IPN providers. Within each provider type, there is a wide variation in size, location, services delivered, and business models.

In FY 2023-24, HCPF collaborated with BHA on significant behavioral health system reform with the goal of expanding access to care and enhancing the quality of care delivered to all people in Colorado. In July 2024, the Behavioral Health Administration (BHA) revised the Colorado Safety Net Structure, requiring licensure and endorsements through revised regulations. In coordination with the BHA, HCPF created new provider types for enrollment and aligned reimbursement models with the new safety net providers. From July to December 2024, 19 providers enrolled under a new HCPF provider type called the Comprehensive Safety Net Provider (CSNP), including all former CMHCs. These new behavioral health safety net providers were built on national best practices and were created in partnership with key stakeholders to improve quality, service offerings, accountability, and opportunities for more sustainable provider reimbursements.

- A Comprehensive Safety Net Provider (CSNP) is a licensed behavioral health organization approved by the BHA to provide care coordination and all

behavioral health safety net services, either directly or through formal agreements with behavioral health providers in the community or region.

- An Essential Safety Net Provider (ESNP) is a licensed behavioral health organization approved by the BHA to provide care coordination and at least one safety net service.

More information about safety net providers can be found on the Safety Net and Crisis Services webpage.

B. Provider Enrollment, Contracting and Credentialing

Behavioral health providers that want to be reimbursed for care to Medicaid members must first enroll as a Health First Colorado provider, as required by both state and federal regulation. This verifies that a provider is eligible to provide services and is acting within their legal scope of practice. Enrollment requirements vary by provider type.

The time involved in this process can vary depending on the completeness and accuracy of the application. Timeliness is essential for this process, and HCPF has taken steps to improve timeliness by providing education and support for completing the application correctly and completely. However, timeliness must be balanced with thoroughness to protect both taxpayers and Health First Colorado members from potential fraud and abuse.

Once enrolled with HCPF as a Medicaid provider, behavioral health providers may pursue contracting with any MCE to offer services to members of that region of the state. Each MCE establishes its own contracts with its providers setting requirements and reimbursement rates, within the parameters of the MCE's agreement with HCPF. MCEs pay claims and authorize behavioral health services under the capitated behavioral health benefit.

The first step in the contracting process is credentialing. Credentialing allows MCEs to evaluate practitioners and facilities based on the identified standards, such as the National Committee for Quality Assurance (NCQA) standards. The credentialing process involves a uniform application, the Colorado Health Care Professional Credentials Application, that allows for a streamlined and standardized process.

MCEs must complete the credentialing and contracting processes or deny network admission within 90 days for at least 90% of all provider applications. MCEs are required to use the Council for Affordable Quality Healthcare, Inc. (CAQH) Verified™ application for verification of primary source documents for the credentialing and

re-credentialing processes. MCEs may not require any additional documentation from individual providers for the purposes of credentialing unless documentation is needed to clarify a question.

Table 8 shows the percentage of providers credentialed and contracted within 90 days in calendar year 2024.

Table 8. Percentage of Providers Credentialed and Contracted Within 90 Days for CY 2024, by MCE

CY 2024	RAE 1	RAE 2	RAE 3	RAE 4	RAE 5	RAE 6	RAE 7	Denver Health
Jan 2024	100%	91%	98%	100%	98%	100%	100%	98%
Feb 2024	100%	95.5%	100%	95.7%	100%	100%	100%	100%
Mar 2024	100%	100%	100%	100%	100%	100%	100%	100%
Apr 2024	100%	93.3%	90%	93.3%	90%	100%	100%	90%
May 2024	100%	95.2%	80%	95.2%	80%	100%	100%	80%
Jun 2024	100%	100%	100%	100%	100%	100%	100%	100%
Jul 2024	100%	100%	96%	100%	96%	97%	97%	96%
Aug 2024	100%	90%	100%	94.4%	100%	100%	100%	100%
Sep 2024	100%	100%	92%	100%	92%	100%	100%	92%
Oct 2024	100%	80%	100%	80%	100%	97%	97%	100%
Nov 2024	100%	94%	100%	94%	100%	100%	100%	100%
Dec 2024	100%	94.4%	93%	94.4%	93%	100%	100%	93%

Key: Yellow = Did not meet requirement

In January 2022, MCE contracts were adjusted to codify the standard that contracting decisions be complete within 90 days of receiving a written request to contract for 90% of applications. Overall MCE's have continued to improve credentialing and contracting timelines. HCPF monitors their performance on a monthly basis. When performance has fallen below standards within a reporting period, MCE's quickly identify the issue for non-compliance and implement new processes, resolving issues in the following month. The Behavioral Health Accountability Dashboard includes MCE-contracted quarterly behavioral health

provider totals and accountability metrics for each region, and the monthly reports can found on the Behavioral Health Reform webpage.

C. Network Management

A top priority that HCPF has set is quality care. Federal and state managed care regulations require strict monitoring of provider access and adequacy to ensure members' needs are met. Through HCPF's contracts with RAEs, HCPF expects RAEs to maintain a network of providers adequate to meet member needs based on utilization of services. The RAEs are contracted to determine which providers are part of their regional network and demonstrate quality outcomes for Medicaid members. The RAEs look at regional and provider-specific data, as well as quality care and audit data to make determinations about which providers are contracted in their region. HCPF formally monitors behavioral health network adequacy through annual network adequacy reports and quarterly reports on network development. All network data submitted to HCPF is validated and reviewed for accuracy by a third-party external quality review organization. In addition, HCPF also uses monthly UM and other dashboard data to inform timely member access to behavioral health services as an indicator of provider networks meeting member needs. In regions where providers are limited due to national workforce shortages, RAEs have adopted innovative strategies to build the capacity of their networks so they can deliver comprehensive behavioral health services. They may contract with new providers from other state systems (e.g., child welfare or criminal justice), establish new service modalities (e.g., telehealth), create value-based payments, recruit new providers or provide grants and technical assistance to help existing provider practices expand their capacity to serve new populations or offer new services.

The tables below show the number of behavioral health providers and practitioners contracted with an MCE. Independent behavioral health providers and practitioners are a valued and necessary part of the behavioral health network in all regions. Behavioral health practitioners consist of individual psychiatrists and licensed psychologists, group psychiatry and psychology practices, psychiatric prescribers, licensed clinical social workers, licensed marriage and family therapists, licensed professional counselors, licensed addiction counselors, and behavioral health physician assistants.

Table 9. Number of MCE-Contracted Behavioral Health Providers (by Unique National Provider Identifier), by Quarter

Fiscal Year and Quarter	Number of Contracted Behavioral Health Providers

FY 2023-24 Q1	12,105
FY 2023-24 Q2	12,092
FY 2023-24 Q3	12,269
FY 2023-24 Q4	12,478

Note: Enrolled providers were counted by unique NPI. Missing, duplicated or invalid NPIs were excluded.

Table 10. Number of MCE-Contracted Behavioral Health Practitioners at the End of CY 2024, by MCE

MCE	2024 Year-End Total of Behavioral Health Practitioners
RAE 1	5,534
RAE 2	4,692
RAE 3	9,277
RAE 4	4,693
RAE 5	9,285
RAE 6	9,507
RAE 7	9,507
Denver Health	9,285

Note: The number of MCE-contracted Behavioral Health Practitioners does not include group psychiatry and psychology practices.

HCPF and MCEs continue to build the provider network for residential and inpatient SUD treatment. From January to December 2024, 15,352 residential and inpatient hospital SUD services were utilized by 8,201 unique members. The decrease in total members served (from 10,899 in 2023 to 8,201 in 2024) is likely driven by the increased coverage and capacity for high intensity outpatient services like partial hospitalization (20 hours per week of mixed type outpatient care) and intensive outpatient (10 hours per of mixed type outpatient care). During this same period 2,904 unique members used high intensity outpatient services, a 23% increase from January to December 2023 (2,341). This supports the goal of providing a continuum of care where lower acuity services are utilized at higher rates while higher acuity services are utilized at lower rates and/or for shorter durations.

With growing provider networks to support the broad community of providers who participate in the behavioral health network, HCPF holds a variety of behavioral health provider office hours for technical assistance and forums for educational

overviews and to collect feedback from providers and other stakeholders each month as well as meeting individually with providers upon request to explain the enrollment and contracting process and answer policy questions.

D. Regional Accountable Entity and Behavioral Health Administrative Service Organization Alignment

In FY 2024-25, HCPF worked closely with the BHA to plan for the alignment of regions and work performed by the RAEs, as contractors overseeing behavioral health service delivery for Medicaid members, and the BHASOs, as contractors overseeing statewide behavioral health services for all Coloradans and paying for service of uninsured and underinsured Coloradans. One of the key focus areas identified as needing clear and detailed alignment was care coordination responsibilities, recognizing the need to collaborate as more Coloradans in the post public health emergency will continue to cycle on and off of Medicaid. HCPF and the BHA worked together to align their RAE and BHASO scopes of work around care coordination to ensure that members transitioning between their care coordination systems as a result of cycling on and off Medicaid do not experience duplication of efforts nor gaps in care. Beginning July 1, 2025, these requirements include:

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

VI. Claims Processing and Provider Payments

MCEs are responsible for processing behavioral health claims that fall within the capitated behavioral health benefit and paying providers the contracted rate. In compliance with federal regulations, HCPF requires MCEs to adjudicate and pay 90% of all clean claims within 30 days of receiving them, and 99% of clean claims within 90 days of receipt – a contract requirement of ACC Phase II. Across the reporting period, MCEs consistently met these standards, with performance in the final month reaching

or exceeding 99.2% of clean claims paid within 30 days. Two exceptions were noted in January and February 2024, when results dipped below the required threshold. In each case, the MCE identified the drivers of the shortfall, implemented corrective action measures, and returned to compliance the following month. This monitoring is part of HCPF's broader oversight framework, which emphasizes continuous performance improvement and transparency.

Providers submitting claims to their MCE must provide adequate documentation and adhere to the provider's contract with the MCE. Claims are denied if they do not meet medical necessity requirements, but more often, they are denied due to inaccurate billing and documentation. For example, claims may be denied due to the use of the wrong modifier (a code that indicates details of a procedure or service). In 2024, HCPF creates a comprehensive set of self-guided provider trainings to help providers understand billing processes, among other key policies, to help support the provider experience and accurate billing practices. These are available in the HCPF Provider Training Library.

Each MCE has a call center and provider relations staff to help providers with billing questions. They are required to respond to provider questions within two days.

Table 11. Timeliness of Processing Provider Claims within Contract Requirements Paid within 30 days, CY 2024, by MCE

CY 2024	RAE 1	RAE 2	RAE 3	RAE 4	RAE 5	RAE 6	RAE 7	Denver Health
Jan 2024	99.97%	89.18%	95.47%	92.70%	94.63%	99.88%	99.88%	94.63%
Feb 2024	94.01%	85.74%	99.29%	93.03%	99.32%	98.62%	98.62%	99.32%
Mar 2024	99.97%	98.33%	99.44%	99.04%	99.67%	99.48%	99.48%	99.67%
Apr 2024	99.83%	99.94%	99.58%	99.99%	99.64%	99.70%	99.70%	99.64%
May 2024	99.24%	99.96%	99.39%	99.95%	99.57%	99.71%	99.71%	99.57%
Jun 2024	99.76%	99.69%	99.17%	99.86%	99.86%	99.64%	99.64%	99.86%
Jul 2024	99.86%	99.69%	99.20%	99.83%	99.45%	99.33%	99.33%	99.45%
Aug 2024	98.43%	99.88%	99.55%	99.95%	99.64%	99.98%	99.98%	99.64%
Sep 2024	94.92%	99.87%	98.91%	99.93%	99.15%	99.59%	99.59%	99.15%
Oct 2024	97.09%	99.73%	98.49%	99.80%	99.25%	99.59%	99.59%	99.25%
Nov 2024	99.62%	99.68%	99.12%	99.86%	99.38%	99.99%	99.99%	99.38%

Dec 2024	99.62%	99.20%	99.22%	99.68%	98.96%	99.56%	99.56%	98.96%

Key: Yellow = Did not meet requirement

VII. Quality Oversight Practices

A. Managed Care Provider Escalation Request

In February of 2022, HCPF created a communication form for the IPN. Since that time, the form has evolved and expanded into a web-based tool for providers to escalate any issues they are encountering when working with one or more MCEs to escalate the issue to HCPF's attention. This tool has been valuable for HCPF to identify challenges that providers may be experiencing in real time, and allow HCPF to facilitate problem solving between providers and MCEs when necessary.

Providers initially are asked to present issues directly to MCEs for resolution, however there are situations where the providers need additional support. This escalation form process provides additional monitoring and oversight into how MCEs are addressing provider concerns. The insight gained allows for development of improved processes between the provider network, MCEs, and HCPF for the benefit of member access.

Since 2022, HCPF has received 452 unique provider concerns from 224 unique providers through this form. Providers may select multiple reasons when submitting concerns, therefore the illustration below does not represent unique outreach counts.

Figure 3. Total count of provider concerns by the category of concern, FY 2024-25

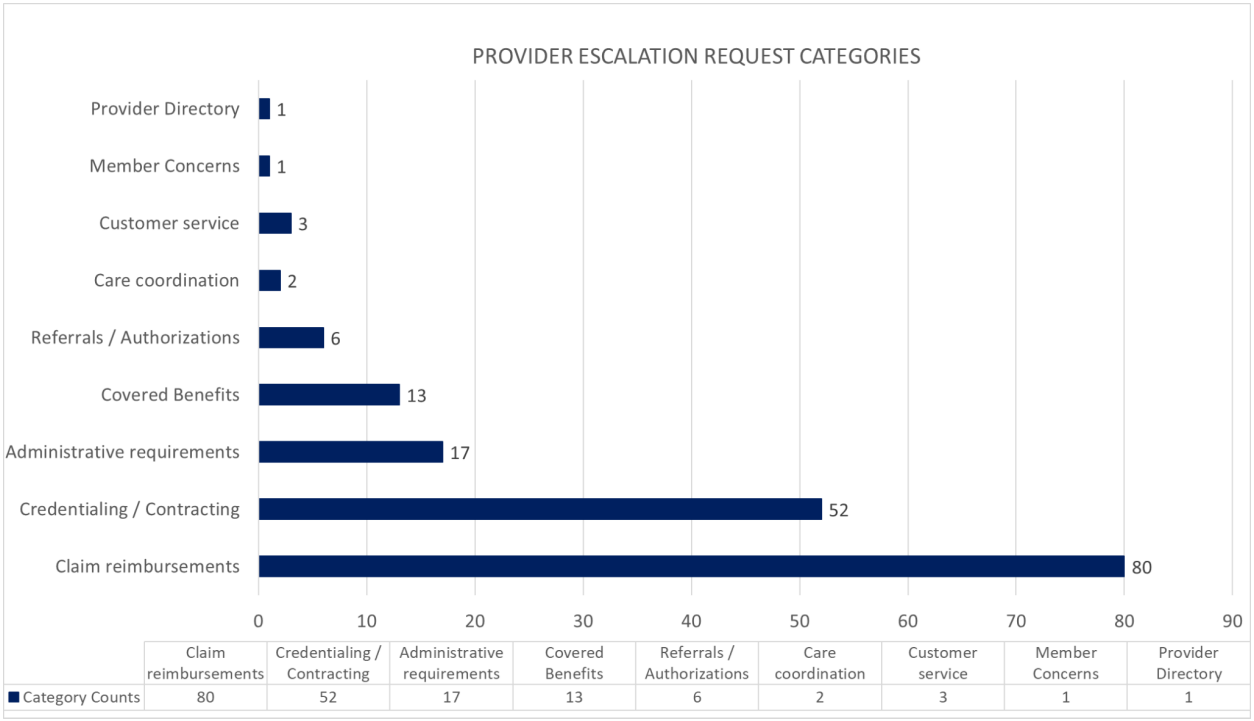
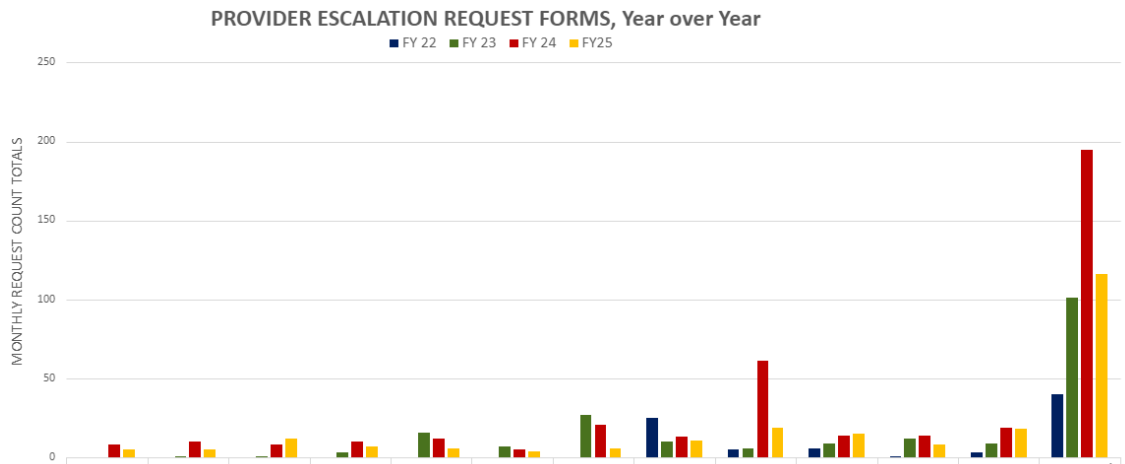


Figure 4. Total count of provider concerns by month, year over year, from FY 2021-22 to FY 2024-25



	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	SFY Total
FY 22								25	5	6	1	3	40
FY 23	0	1	1	3	16	7	27	10	6	9	12	9	101
FY 24	8	10	8	10	12	5	21	13	61	14	14	19	195
FY25	5	5	12	7	6	4	6	11	19	15	8	18	116

As more providers become aware of this form, an increase in provider outreach to HCPF may be expected and show progress in HCPF support and oversight support. Trends and patterns of concern are identified, monitored and addressed by HCPF with MCEs. This is a valuable indicator of provider experience and informs where areas of opportunities exist for continued program improvement.

B. Healthy Colorado for All

As regional entities, MCEs continue to be an important partner in the commitment to meaningfully address and eliminate health disparities, referred to as Healthy Colorado For All (HCFA), for the communities they serve. In FY 2024-25, MCEs submitted their first annual HCFA reports which illustrate current strategies, identified priority populations, achievements, challenges, data collection methodologies and future strategies to address the focus areas outlined in their FY 2023-24 HCFA plans. Areas of focus include vaccinations, maternity and perinatal health, behavioral health and prevention. HCPF continues to send each MCE member-level data files, by indicator, with demographic fields (age, county, disability, gender, language and race/ethnicity) that can be used to identify priority populations.

C. House Bill 23-1243 Hospital Community Benefit

Many Colorado hospitals are considered non-profit or are tax-exempt through state law. As such, hospital community benefit spending is intended to supplement waived tax revenues for the betterment of the community since these hospitals do not pay taxes. Colorado hospitals invested $1.22 billion in community investments in the FY 2022-23 reporting year, which is an increase of $129.8 million or 11.9% above the community benefit spending reported for the prior year. A total of $43.4 million was allocated for hospitals' community investment in behavioral health. **HCPF's 2025 Colorado Hospital Community Benefit Annual Report found that behavioral health-related needs were the top prioritized community-identified need overall in reporting hospitals' community benefit implementation plans (84.8%, or 39 hospitals, prioritized behavioral health as a need).**

HCPF reviewed hospitals' Community Health Needs Assessments (CHNA) to see how many hospitals allocated investment dollars into the behavioral health category since communities and hospitals cited behavioral health as the most prioritized need. HCPF found that 28 out of 46 reporting hospitals had allocated their investment into the behavioral health category. However, 18 hospitals did not report investment dollars in the behavioral health category. Additionally, HCPF found that 15 of these 18 hospitals prioritized behavioral health in their CHNA but did not report parallel investments in behavioral health. **This indicates that 38.5% of the 39 hospitals that stated they prioritized behavioral health did not allocate any investment dollars into the behavioral health category.**

The goal of House Bill 23-1243[13] was to ensure that hospitals' community benefit investment dollars are far more aligned with the actual needs of the community, and that the hundreds of millions of community benefit dollars are directly impacting the changing needs of the community to the betterment of Coloradans for years to come. Communities have robust and differing needs, such as food insecurity, housing insecurity, or behavioral health access gaps. Meeting those needs more directly is a key objective of this bill — through sustainable, year-over-year funding. As state and federal funding constraints persist, local community partnerships can help bridge the gaps.

[13] https://leg.colorado.gov/bills/hb23-1243

D. Certified Community Behavioral Health Clinics Planning Grant

HCPF partnered with the BHA to lead Colorado's participation in the 2025 Colorado Certified Community Behavioral Health Clinics (CCBHC) Planning Grant, as directed by House Bill 24-1284[14]. CCBHC related work began in August of 2024 with the submission of a CCBHC Planning Grant Application submitted to Substance Abuse and Mental Health Services Administration (SAMHSA) in September 2024. The application project also launched Colorado's CCBHC stakeholder engagement efforts, which have continued and expanded through calendar year 2025.

Colorado was awarded a one-year CCBHC Planning Grant for calendar year 2025 with a grant period of December 31, 2024, through December 30, 2025. Through the second half of FY 2024-25, joint BHA and HCPF teams partnered with external stakeholders, community, and provider partners, to explore how the CCBHC model compares to, and may expand upon, the existing Colorado Safety Net System to promote Colorado's overall goal of integrated and accessible behavioral health care through sustainable funding practices. Required grant objectives completed through FY 2024-25 include determining a CCBHC PPS methodology necessary for building reimbursement rates, establishing a scope of service to meet statewide needs, finalizing a sub-regulatory certification strategy to balance the state's goal of increasing access for all Coloradans seeking behavioral health support with the need for fiscal sustainability, and establishing an implementation plan for the collection of CCBHC quality measures as required by federal standards.

CCBHC Planning Grant work continues in an effort to establish a realistic CCBHC model implementation infrastructure and policy while understanding the cost and timeline ramifications of such changes at a state and provider level. A proposal for Colorado's participation in the 2026 CCBHC Demonstration Program is planned for submission in April 2026. Participation in the demonstration must then be approved by SAMHSA and Colorado's state legislature.

VIII. Improving Behavioral Health Services Statewide

A. Cost Report to improve the behavioral health rate structure

In order to determine the rates for Comprehensive Safety Net Providers, HCPF audits cost reports submitted by providers. To increase transparency of rate setting for the new Comprehensive Providers, and to bring reimbursement for these providers in alignment with how FQHCs are reimbursed, HCPF released new Cost Report templates

[14] https://leg.colorado.gov/bills/hb24-1384

for the Comprehensive Providers in June of 2024. Starting November 2024, all Comprehensive Providers must submit their cost information to HCPF using these new templates. The new cost report structure creates better alignment for the PPS payment methodology. Cost report templates and audited cost reports are posted publicly on HCPF's Behavioral Health Rate Reform webpage.

B. Evaluation of Directed Payments

A key aspect of behavioral health system reform has been the expansion of the behavioral health safety net, with the goal of expanding access to care and enhancing the quality of care delivered to all people in Colorado. When launching the safety net in 2024, Directed Payments for ESNPs were utilized as a time-limited method to infuse funds into the behavioral health safety net system to support providers through the transition to the new system, support network access, and create growth for specific services. The factors that inform when a Directed Payment is considered include:

- When a service is new or is being underutilized across the state.
- When there are identified access issues related to a specific service.

All Directed Payments are reviewed on a regular basis to monitor effectiveness and are not a sustainable funding mechanism within a managed care model. As Directed Payments are phased out, RAEs may negotiate provider rates based on quality and network needs.

By December 2024, 49% (97 out of 195 enrollments) of all ESNP provider enrollments were SUD providers, of which 76% (74 out of 97 enrollments) provided outpatient services only. While these providers represent a critical component of the safety net, their dominance within the network raised concern since the majority (60 enrollments) used an unspecified specialty and were not delivering broad based supportive services aligned with safety net intentions. Geographic analysis further demonstrated that 81% of ESNP enrollments serviced only areas in the Front Range, with half of all enrollments being concentrated in the Denver-metro area. This concentration results in an overrepresentation of safety net providers in already well-served and densely populated regions of the state. Conversely, rural and frontier communities remain underserved, with limited access to certain essential behavioral health services.

By March 2025, it became evident that some providers continued to only have provisional safety net approvals, meaning they were not meeting the full definition and requirements of the safety net but yet were still seeking enhanced payments. In

response, HCPF adjusted policy to ensure that enhanced payments were reserved only for fully approved safety net providers.

In summary, HCPF recognized that ESNPs were concentrated along the Front Range and not broadly dispersed across Colorado. By evaluating enrollment, service type, and geographic data, HCPF implemented the July 2025 policy changes as a deliberate step toward a **more accessible, accountable, and sustainable behavioral health system**.

Effective July 1, 2025, HCPF removed Directed Payments for outpatient behavioral health essential safety net services, except for the limited list of services (Mobile Crisis Response services, Opioid Treatment Program services, Services in a bedded facility). Directed Payments for Essential Safety Net Services in bedded facilities will remain in place until June 30, 2026.

Directed Payments for services for Targeted Populations (non-Safety Net) are limited unique situations where targeted action is necessary to support network access and growth for specific services.

Current Directed Payments for Targeted Populations serve youth receiving the following services:

- Functional Family Therapy
- Multisystemic Therapy
- Wraparound Services
- Community Support Services

More information on Directed Payments for behavioral health services, can be found on the Behavioral Health Policies, Standards, and Billing References webpage here.

C. SB23-174 Treatment for Youth Without a Covered Diagnosis

In 2023, the Colorado Legislature passed Senate Bill 23-174[15] that required HCPF to provide access to a limited set of behavioral health services to members under the age of 21 without a covered diagnosis. The legislation detailed service categories that must be included under this coverage, and HCPF engaged stakeholders to identify the specific service codes that are included. This coverage policy went into effect July 1, 2024. There are eighteen services covered under the 174 Coverage Policy. HCPF is reviewing this policy and analyzing data from the last year to establish a monitoring strategy. HCPF is developing recommendations for limiting the number of services that may be delivered to members under the age of 21 without a behavioral health

[15] https://leg.colorado.gov/bills/sb23-174

diagnosis in July 2025. HCPF will implement changes as necessary following the completion of this evaluation. More information about the 174 Coverage Policy can be found on the webpage or in the annual legislative report available in November 2025.

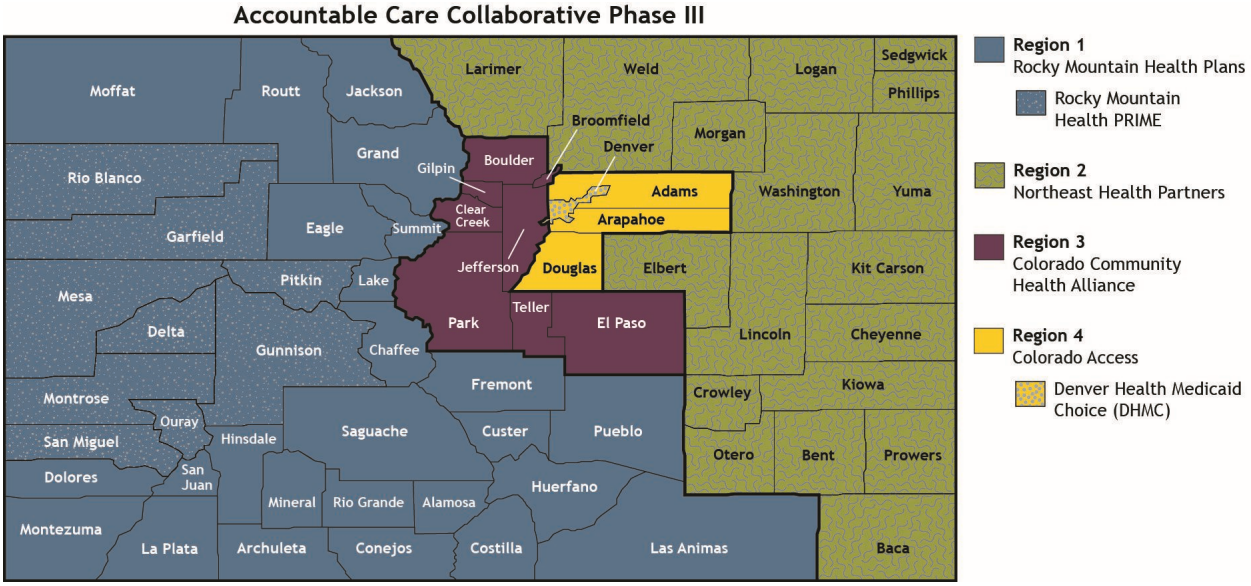
IX. New and Changing Behavioral Health Benefits

A. ACC 3.0 and Changes In Payment Delivery

Beginning July 1, 2025, the transition of benefits between FFS and the behavioral health capitation include the following:

1. Short-term Behavioral Health (STBH) benefit moved to the capitation to build a sustainable reimbursement model for primary care providers who are incorporating behavioral health services into their practices. STBH is a benefit for members to receive up to six visits for low-acuity behavioral health needs at the member's primary care medical provider site. More information on this move can be found in the Integrated Care Sustainability Policy section in this report.
2. Behavioral Health Secure Transportation (BHST) moved to the capitation for RAE oversight of BH services providers as it is an established benefit. BHST is a benefit for members who are experiencing a behavioral health crisis and require urgent transportation for behavioral health stabilization and treatment
3. Permanent Supportive Housing (PSH) moved to FFS as part of the 1115 alignment including services by providers - not limited to behavioral health members - and alignment with reimbursement for housing which is also not specific to behavioral health. PSH is an intervention that combines housing and support services for individuals with a disability, including those whose disability is related to a behavioral health diagnosis and a history of homelessness
4. New contracts with the newly selected RAEs, referred to as ACC Phase III, launched on July 1, 2025. Because the ACC is Health First Colorado's delivery system, Phase III is a critical part of efforts to improve care quality, service, equity and affordability. The following organizations will serve as RAEs in each region of the state:

   Regions of the Accountable Care Collaborative (ACC) Phase III



ACC Phase III takes important steps to modernize our delivery system, including:

- A reduction in the number of regions from seven to four to ensure sustainable investment in regional infrastructure and better leverage RAEs' efficiencies.
- Increased care coordination requirements with an emphasis on supporting members' care transitions, especially from inpatient or residential settings. RAEs will have additional resources in Phase III to ensure these members receive follow-up care and prevent avoidable readmissions thanks to the legislature's approval of our FY 2025-26 budget request.
- Supporting A Healthy Colorado for All by requiring dedicated personnel, staff training and a regional committee.
- Improved processes for children and youth accessing behavioral health care services by supporting the implementation of CO-SOC.

These advances will build on the foundation set over the past 14 years of the program. HCPF will continue the capitated behavioral health benefit to encourage the effective utilization of the full continuum of behavioral health services and provide avenues for addressing HRSNs. RAEs will continue to receive a care management payment from HCPF for providing care coordination, provider support and management of whole-person care. Incentive payments will continue to tie a portion of RAE funding to achieving established outcome targets.

B. Colorado System of Care

The Colorado System of Care (CO-SOC) is the designated framework developed collaboratively by HCPF and the Behavioral Health Administration (BHA) to serve children and youth with complex or high acuity behavioral health needs. In February

2024, Health Care Policy and Financing (HCPF) entered into a Settlement Agreement (Agreement) with the Center for Legal Advocacy, d/b/a Disability Law Colorado, and three children and youth with complex behavioral health needs (Plaintiffs) who filed a class action lawsuit on behalf of similarly situated Medicaid-eligible children and youth. A key requirement of the Agreement is for HCPF to create an Implementation Plan (Plan) that demonstrates how it will build a systematic approach to providing Medicaid members, who are under the age of 21, with intensive behavioral health services in their homes and communities.

The vision for CO-SOC is to create an array of services that meet the needs of Medicaid members and families so that, as appropriate, Members can remain in their homes or communities instead of requiring services to be obtained in residential or inpatient settings. In addition, the CO-SOC is structured to incorporate the voices of families in the design of services and development of program policies. In cases where families interact with multiple systems, CO-SOC helps Members and families navigate between systems, such as juvenile justice, child protection, developmental disabilities, mental health and addiction, education, and others. The CO-SOC will provide an evidence-based approach to delivering services in a well-designed manner to address the needs of the Medicaid Members receiving services.

HCPF is on target to meet all its statutory obligations as outlined C.R.S. 25.5-6-2001 Section 1. HCPF continues to overlap the requirements of C.R.S. 25.5-6-2001 system of care with the work being completed for its Settlement Agreement stemming from GA v. Bimestefer. More information about CO-SOC and the implementation plan can be found on the Colorado System of Care (CO-SOC) webpage.

HCPF's progress on implementation efforts includes:

- Submission of the Implementation Plan, per the Agreement
- Execution of the Accountable Care Collaborative (ACC) 3.0 Regional Accountable Entity (RAE) contracts, with a July 1, 2025 effective date
- Convening the Statewide Leadership Committee, as required under C.R.S. 25.5-6-2001(2)(a)
- Convening the Implementation Advisory Committee, as required under C.R.S. 25.5-6-2001(3)(a)

HCPF is on target to meet all its statutory obligations as outlined in C.R.S. 25.5-6-2001(1). To stay up-to-date on HCPF's continued implementation efforts, the most recent quarterly reports can be found on the Legislator Resource Center webpage.

C. 1115 Waiver Approvals and Implementations

On January 13, 2025, HCPF received approval from the Centers of Medicare and Medicaid Services (CMS) for the following 1115 Waiver Demonstrations submitted as amendments to the current 1115 Waiver SUD Demonstration "Expanding the Substance Use Disorder (SUD) Continuum of Care":

- HRSN Demonstration - covering housing and nutrition interventions through a partnership with the Colorado Department of Local Affairs (DOLA) for members who meet certain social and clinical criteria.
    - Housing services including pre-tenancy and housing navigation services, tenancy sustaining services, rent/temporary housing for up to 6 months (including utilities), and one-time transition and moving costs; and
    - Nutrition services including meals or pantry stocking, medically-tailored meals, and nutrition counseling/education.
- SMI/SED Demonstration - covering reimbursement for acute inpatient and residential stays in Institutes for Mental Disease (IMD) for individuals diagnosed with a serious mental illness (SMI) or serious emotional disturbance (SED). Through the SMI/SED demonstration this will allow HCPF to reimburse for up to 60 days while maintaining an average length of stay of 30 days per episode for each member staying in an IMD.
- Reentry Demonstration - covering prerelease services for individuals transitioning from correctional facilities. Coverage under the reentry demonstration will include case management services and medication-assisted treatment (MAT) for SUD 90 days prior to release, and a 30-day supply of medications upon release from Department of Corrections and Division of Youth Services facilities.

HCPF must also receive approval for implementation plans to go live with benefits:

- Approval for Implementation of the HRSN demonstration occurred in January 2025 and this benefit went live as requested to CMS July 1, 2025.
- Approval for Implementation of the SMI/SED Demonstration was received September 2, 2025 and benefit go-live is targeted for October 1, 2025.
- Reentry Implementation plan is under review with CMS with anticipated approval and targeted benefit go live January 2026.

Colorado requested CMS to extend the current 1115 "Expanding the Substance Use Disorder (SUD) Continuum of Care" Waiver on December 23, 2024. Colorado's current demonstration was approved for January 1, 2021-December 31, 2025. HCPF proposed an extension to the current SUD demonstration with the addition of presumptive

eligibility for long term services and supports. CMS has delayed the approval of the five-year extension and instead granted Colorado an additional year of approval authority through the existing waiver. This means everything approved under the existing waiver can continue, but the new presumptive eligibility provisions will not be approved at this time.

D. Integrated Care Sustainability Policy

Starting July 1, 2025, HCPF implemented the Integrated Care Sustainability Policy transitioned to be covered by the behavioral health capitation through the RAEs. This change should improve member health by increasing access to integrated care services for Medicaid members and building a sustainable reimbursement model for primary care providers who are incorporating behavioral health services into their practices.

The Integrated Care Sustainability Policy allows Primary Care Medical Providers (PCMPs) to bill Health Behavior Assessment and Intervention (HBAI) codes and Collaborative Care Model (CoCM) codes and be reimbursed fee-for-service (FFS). HCPF is subsequently transitioning the STBH benefit from FFS to the behavioral health capitation. The standard psychotherapy services that were billable under the STBH benefit will continue to be covered by Medicaid when provided in a PCMP setting, however, these services must be billed to the member's RAE effective July 1, 2025. Since July 1, 2018, Medicaid Members have been able to receive STBH (up to six visits) for low-acuity behavioral health needs at the member's primary care medical provider site reimbursed under fee-for-service. In FY 2023-24, about 1.34% (17,132) eligible members used the STBH benefit. Of these 17,132 members, 44.10% (7,556) had not previously accessed behavioral health services.

Stakeholders spoke strongly about shortcomings in the current state of integrated care. The six STBH benefit implemented by HCPF in 2018 did not offer codes short enough to cover briefer interventions (e.g. a 15-minute intervention or encounter) and more complex patients often need more than six visits that are reimbursed FFS. Ultimately, there was clear feedback that current codes will not sustain integrated care and any new payment model will be irrelevant if funding is not adequate. Stakeholders also felt strongly that using psychotherapy codes under the current STBH benefit promotes a reactive approach to care, providing services after there is a significant problem rather than focusing on proactive, preventative approaches such as brief interventions earlier in the scope of care.