COLORADO
Department of Health Care Policy & Financing

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Policy Statement: Enhancing Regional Accountable Entity Care Coordination for Members Admitted to a Psychiatric Residential Treatment Facility, Qualified Residential Treatment Program, or Out-of-State High-Intensity Residential Treatment

Division or Office Name: Behavioral Health Initiatives and Coverage Office (BHIC)
Subject: Enhancing RAE Care Coordination for Health First Colorado Members in Residential Behavioral Health Treatment
Effective Date: December 8, 2025

Purpose

The purpose of this policy guidance is to identify the expectations of Regional Accountable Entity (RAE) Care Coordination engagement and participation with and for pediatric Members under 21 years of age admitted to residential behavioral health treatment facilities[1]. These expectations will ensure appropriate and timely care is supported by the Health First Colorado Member's care team and enhance access to the full spectrum of Medicaid-covered behavioral health treatment services for Members with high-acuity behavioral health needs during and following residential treatment (e.g., Colorado System of Care identification & referrals). (Note: Care Coordinator, RAE Subcontracted Care Coordinator, and RAE Delegated Care Coordinator are synonymous for the purposes of this guidance.)

Policy: Care Coordination (CC) & Discharge Planning for Members admitted to a Psychiatric Residential Treatment Facility (PRTF), Qualified Residential Treatment Program (QRTP), or Out-of-State High Intensity Residential Treatment (OHIRT).

- RAE & Provider Collaboration

[1] For the purposes of this policy statement, residential treatment facilities include all in-state QRTP, all in-state PRTF, and OHIRT providers contracted with RAEs and/or HCPF

- The RAE should establish an outreach and engagement plan with all contracted PRTF and QRTP providers, which may be outlined in an MOU/BAA, to ensure the RAE & RAE Care Coordinator is involved in Members' full treatment course.

- RAE involvement and Care Coordination must occur for all RAE enrolled members utilizing PRTF & QRTP, regardless of payor. Potential payors for QRTP and PRTF services, for Health First Colorado Members may include other state agencies, private insurance, HCPF Fee-for-Service (FFS), or the RAE.

- Care Coordination for Members in PRTF and QRTP

  - Due to the acuity and clinical needs of Members utilizing QRTP & PRTF, Members must be offered at least monthly Care Coordination engagement. This may require scheduling with the QRTP or PRTF provider directly.

  - "Care Coordinators shall participate in multi-Provider care teams and, as appropriate, multi-agency care teams for Members with co-occurring physical and/or Behavioral Health conditions and/or Members who receive services from various state agencies" (RAE Contract: 8.2.3.1.7.1.).

  - Care Coordinators should request to attend multidisciplinary team and interdisciplinary team meetings (MDTs and IDTs), including while the member is in QRTP & PRTF; this may also meet the above additional requirement for monthly CC engagement for members admitted to residential treatment.

  - While the Member is admitted to QRTP or PRTF the Care Coordinator is to conduct the following communication with the residential provider:

    - Request the provider notify the RAE of the admission by close of business on the day[2] following admission.

    - Request documentation of treatment/care plans:

[2] 10 CCR 2505-8.765.5.O.1, 8.765.11.O.1 & 8.765.21.C.3.a

- Additional requests of QRTP & PRTF providers to support utilization management reviews, discharge planning, etc. may include (these may be outlined in an MOU/BAA):
    - Weekly written progress updates with clinical progress or barriers.
    - Medication changes.
    - Family/caregiver engagement status.
    - Discharge planning activities, including a draft discharge plan within 30 days of admission, at the time of any significant status changes, and then a minimum of monthly updates to follow.
    - Notification of any critical incident within 24 hours with a written report to follow.
    - Invitations for the care coordinator to participate in any treatment team meetings regarding the Member due to significant status changes; this may also meet the aforementioned requirement for monthly CC engagement for members admitted to residential treatment. Likewise, the care coordinator will notify and request that the clinical lead of the Member's treatment team attend and participate in any IDTs/MDTs, creative solutions meetings, elevated solutions meetings, etc. facilitated by the care coordinator/care management.
    - Updates/changes to the Member's family engagement status including if engagement becomes impossible or contraindicated.
    - Notification when Acentra (Fee-for-Service [FFS] Utilization Management vendor) authorization ends to ensure RAE Care Coordination activities occur during the 14 days of "transition time" allowed by Acentra/FFS).[3]

[3] Information regarding the 14 day "transition time" can be found in the Acentra Health PRTF/OHIRT and QRTP Benefit Specific Training on slide 14

- Notification of emergent transfers or changes of placement of any member by close of business on the day following transfer.[4]

- Notification of any plans to transfer the member to another placement or facility as soon as possible.[5]

  - Finally, if a member is awaiting admission into a QRTP or PRTF, including if the member is in a hospital setting, the RAE care coordination process must begin at the time the RAE is notified of the member's status.

  - If the member does not or is unable to consent to CC, the above requests of the provider are still appropriate.

- Discharge Planning for Members in QRTP & PRTF

  - Discharge planning is initiated by the provider upon admission and includes collaboration with the provider and the Member and/or the Member's caregivers as soon as possible to prepare for successful transition planning. If a county department of child welfare/human services has an open case with the member, the Department of Human Services/Child Welfare (DHS/CW) caseworker should be included in collaborative transition planning.

  - By aligning care coordination encounters with existing treatment team meetings, the Care Coordinator will gain enhanced awareness of ongoing discharge planning and be able to coordinate services for step-down/Colorado System of Care (CO-SOC) referral (RAE Contract: 8.3.6.1.)

  - This level of CC engagement should mitigate potential scenarios where a member is unexpectedly given a discharge notice from the facility.

  - If, at discharge, the member is appropriate for CO-SOC, the RAE will make a referral to Enhanced High Fidelity Wraparound (EHFW). EHFW can begin up to 30 days in advance of discharge. The RAE Care Coordinator continues to stay involved through the duration of QRTP/PRTF and CO-SOC for continuity of care. If the member is not appropriate for CO-SOC, the RAE Care Coordinator will assist in referrals

[4] 10 CCR 8.765.5.O.2, 8.765.11.O.2, & 8.765.21.C.3.b

[5] 10 CCR 8.765.5.O.3, 8.765.11.O.3, & 8.765.21.C.3.c

for ongoing medically necessary services to support transition from residential treatment.

References:

Acentra Health PRTF/OHIRT and QRTP Benefit Specific Training

Colorado Statewide Standardized UM (SSUM) Guidelines

Fee for service QRTP Billing manual

Fee for service Operational memo - Utilization Management and Assessment Requirements for Qualified Residential Treatment Providers (QRTP) and Psychiatric Residential Treatment Facilities (PRTF)

Fee for service PRTF Billing manual

10 CCR 8.765 PRTF, QRTP, & OHIRT regulations