COLORADO
Department of Health Care Policy & Financing

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Medicaid Sustainability: Behavioral Health and Managed Care Actions

Memo to Regional Accountable Entities (RAEs) - June 2025

In recent years, Colorado has benefited from an unprecedented amount of state and federal investment dollars to reform the Colorado behavioral health safety net system. These dollars, in combination with state agency focus, updated policies, increased reimbursements, new alternative payment methodologies, and stakeholder engagement have resulted in increased access across the continuum of care, more behavioral health providers enrolled in the Medicaid network than ever before, improved provider accountability, better whole person care, and improved Medicaid benefits.

Following this period of rapid growth and change, and recognizing Colorado's fiscal challenges as well as the evolving Federal Medicaid funding threats, it is critical that we evaluate and monitor the impact of the implemented changes on Medicaid behavioral health cost trends and the shared Medicaid Sustainability framework and goals. This memo was prepared by the Department of Health Care Policy and Financing (HCPF) to transparently share with Regional Accountable Entity managed care entities expectations for the coming 2025-26 fiscal year to maintain alignment with the Medicaid Sustainability Framework.

Medicaid Sustainability Framework

1. **Address Drivers of Trend:** Better address all the controllable factors that drive Medicaid cost trends
2. **Maximize Federal Funding:** Leverage and maximize HCPF's ability to draw down additional federal dollars
3. **Invest in Coloradans:** Continue investing in initiatives to drive a Colorado economy and educational system to reduce the demand for Medicaid over the long term as Coloradans rise and thrive
4. **Make Reasonable Medicaid Cuts or Adjustments:** Identify where programs, benefits, and reimbursements are comparative outliers or designed in such a way that we are seeing - or will experience - higher than intended trends or unintended consequences
5. **Reassess New Policies:** Consider pausing or adjusting recently passed policies

not yet implemented

6. **Exercise Caution in Crafting Increases** to the Medicaid program going forward

Overview

The end of the COVID-19 Public Health Emergency marked the end of the continuous coverage requirement and resulted in a sharp, predicted decline in Medicaid membership returning to just above pre-pandemic numbers. Additionally, with cuts to the State budget, the Colorado State Legislature passed legislation that impacts the Medicaid behavioral health benefit. HCPF's Medicaid Sustainability Framework is an outline to HCPF's approach to addressing fiscal challenges and mitigate additional cuts, with new information regularly added to the Federal Resources section of the Legislator Resource Center webpage. RAEs will continue to be key partners in exploring and implementing trend management activities and monitoring and enforcing policies that reduce or eliminate fraud, waste, and abuse.

This memo and framework outlines agency's values, priorities and direction for RAEs to identify the serious risk that comes without action, ensures clarity for the purposes of planning and lays out 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.

Upcoming Changes to Covered Services and Providers	Planning for the Future
Limiting Peer Support Scope	Reduce / Adjust Available B3 Codes, H-Codes
Removing 988 Billing and Associated Funds	Certified Community Behavioral Health Clinics Demonstration
Treatment for Youth Without a Covered Diagnosis	Implementation of ASAM 4th Edition Requirements
Monitoring and Retroactive Review of Outpatient Rates	Stabilize Inpatient Behavioral Health Payment Across Settings
National Correct Coding Initiative (NCCI) Edits	Prospective Payment System Guardrails for Comprehensive Providers
Directed Payment Policy Review	

As we align with the Medicaid Sustainability Framework, quality care remains a priority. HCPF plans to use cost and quality metrics to support continued development of quality provider networks. HCPF will continue to work with RAEs to support

network access and quality standards for providers. That includes supporting quality credentialing for new or existing providers. As RAEs determine which providers are part of their regional network, prioritizing providers that are able to demonstrate quality outcomes is a reasonable practice.

Upcoming Changes to Covered Services and Providers

Outlined in this section are a series of changes to services including who may deliver the service, in what setting, for what period of time and if a directed payment will be required. These changes may align with the transition to ACC Phase III effective July 1, 2025, legislative directives, budget actions, and/or the quest to drive behavioral health quality and affordability.

Peer Support Scope

In response to budget challenges and adjustments authorized by the state legislature, HCPF is limiting the providers that can bill for services performed by a Peer Support Professional, in addition to updating the services that can be billed for when performed by a Peer Support Professional. These changes will be effective July 1, 2025, with the goal of prioritizing SUD and team-based care. In the next phase, by January 1, 2026, additional documentation of peer credentialing through a nationally recognized organization for all Peer Support Professionals delivering peer services will be required.

988 Billing

Prior to July 2024, HCPF supported the development of the 988 crisis line using administrative funding of 988 services through the RAEs (through per member payment). Effective July 2024, the new 988 vendor was required to contract with RAEs as a provider while the RAEs were required to cover eligible billable encounters for services. This approach of the 988 service provider enrolling as a Medicaid provider and billing through the RAEs has been unsuccessful due to data collection and sharing limitations and programmatic standards from the national 988 organization. As a result of underutilized funds, the Joint Budget Committee, given budget challenges, has eliminated this funding. Therefore, HCPF is removing the 988 crisis services funding from the RAE contracts, and removed the expectation to contract with the 988 service provider from RAE expectations in tandem.

Treatment for Youth Without a Covered Diagnosis

In 2023, Colorado passed Senate Bill 23-174, Access to Certain Behavioral Health Services. HCPF engaged stakeholders and identified specific service codes allowed for treatment without a diagnosis for members under age 21; this coverage policy went into effect July 1, 2024. HCPF is reviewing this policy and analyzing data from the last year to establish a monitoring strategy. HCPF plans to develop recommendations for limiting the number of services that may be delivered to members under the age of 21 without a behavioral health diagnosis in July 2025; if recommendations are approved, implementation is targeted for October 1, 2025. System changes for the RAEs would

be required to support this policy change. Proposed code limits will be discussed in collaboration with the RAEs by July 2025 for planning purposes.

Monitoring and Retroactive Review of Outpatient Rates

Beginning with a review of current RAE service rates in March 2025, HCPF has initiated the exploration of the process to monitor and perform retroactive review of outpatient rates. Next, HCPF looks to set up a dashboard to monitor highly utilized rates across RAEs, and work with the RAEs to implement retroactive review of outpatient psychotherapy sessions beyond 26 visits by October 1, 2026. With this effort, HCPF aims to collaborate with RAEs to identify where RAEs are paying providers reasonable/marketable rates and where they may be overpaying or underpaying rates for needed Q1 FY2025/26 adjustment.

National Correct Coding Initiative (NCCI) Edits

Beginning July 1, 2025, RAEs are required to implement all National Correct Coding Initiative (NCCI) edits. CMS created the NCCI to reduce improper payments stemming from incorrect coding and billing practices. NCCI prevents reimbursement for inappropriate combinations of Current Procedural Terminology (CPT) codes. The following are the three types of NCCI Edits:

- **Add-on Code (AOC)** edits ensure add-on codes are not billed without a primary procedure code.
- **Medically Unlikely Edits (MUEs)** prevent inappropriate payments when services are reported with an unusually high number of units of service.
- **Procedure to Procedure (PTP)** edits prevent code pairs that should not be reported together on the same date of service.

For example, for a 45 minute psychotherapy session with a member (procedure code 90834) the Practitioner Services' MUE value is 2. This means providing two services on the same date, to the same member is allowed, but anything over two is denied. The MUE Adjudication indicator is 3, meaning it is a Date of Service Edit. The edit looks at how many of the same services were furnished on the same date. HCPF is looking into creating tailored B3 edits with a goal of a January 1, 2026, implementation date.

Directed Payment Policy Review

Effective July 1, 2025, HCPF will no longer set directed payments for outpatient behavioral health essential safety net services, except for the limited list of services noted below. Directed payments for Essential Safety Net Services in a bedded facility will remain in place until June 30, 2026.

Directed payments for behavioral health services as of July 1, 2025, include:

- Essential Safety Net Providers
    - Mobile Crisis Response (MCR) services
    - Opioid Treatment Program services (OTPs)
    - Services in a bedded facility (Until June 30, 2026)
- Comprehensive Safety Net Providers

    - Prospective Payment System (PPS)
- For all provider types
    - Functional Family Therapy (FFT)
    - Multisystemic Therapy (MST)

When launching the safety net in 2024, directed payments 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. Directed payments are reviewed on a regular basis to monitor their effectiveness and are not a sustainable funding mechanism within a managed care model.

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.

As a Directed Payment is phased out, Regional Accountable Entities (RAEs) may negotiate provider rates based on quality and network needs. RAE expectations include maintaining adequate networks, including specialty and intensive services provided by essential providers. We expect RAEs to negotiate with Essential Safety Net Providers to establish fair rates for meeting a higher level of care and service delivery, while assuring fiscal responsibility.

Planning for the Future

As we plan for the future, HCPF will work with the RAEs and continue to utilize data to inform policy decisions and view potential policy changes through an analytical lens, researching opportunities to identify cost savings and to develop systemic efficiencies. The following longer term plans are areas where HCPF is focusing further research in consideration of additional policy and operational changes beyond those planned for FY2025-26.

Reduce / Adjust Available B3 Codes, H-Codes

HCPF is exploring opportunities to either reduce or adjust the current available B3 codes and H-Codes. HCPF is continuing to research and analyze utilization of codes and code limits under MUEs with a goal of creating recommendations for modification by January 1, 2026. RAEs will need to support HCPF in drafting recommendations by participating in reviews of code utilization by provider types and analyze utilization within their regions. Following approval of recommendations, implementation of adjustments to codes and systems modification to support those changes will be completed by July 1, 2026.

Certified Community Behavioral Health Clinics Demonstration

HCPF has partnered with the Behavioral Health Administration (BHA) to lead Colorado's participation in the 2025 Certified Community Behavioral Health Clinics (CCBHC) Planning Grant, as directed by Colorado House Bill 24-1284. This is part of a

state-wide, multi-agency effort to build and expand Colorado's behavioral health system of care. This one year planning grant provides federal funds to develop a model to benefit communities around the state, provide needed behavioral health services and strengthen the provider network. The grant also supports preparation of an application for a four-year CCBHC Demonstration program beginning in 2026. Participation in the CCBHC Demonstration would mean an increase in federal matching funds to support Colorado's efforts to improve the availability, quality, and outcomes of outpatient services provided in these clinics. However, the enhanced match is time limited, and after four years, the state would be responsible for sustaining grant activities and the resulting budget impacts. HCPF plans to complete all CCBHC Planning Grant activities, identify potential federal match opportunities, and submit Colorado's CCBHC Demonstration application by April 1, 2026.

ASAM 4th Edition Requirements

Colorado is preparing to transition into alignment with the American Society of Addiction Medicine (ASAM) Criteria 4th Edition Standards, effective July 1, 2026. HCPF is working in collaboration with the Behavioral Health Administration (BHA) to align licensing requirements being developed with modifications that will be required to reflect Medicaid rules, policies and standards. HCPF is reviewing existing policies to determine what changes are needed to align with the new standards. Transitioning to ASAM 4th Edition also creates an opportunity for HCPF to explore options for current withdrawal management facilities to expand care to treatment, adjustments to the model for crisis stabilization, establishing new provider types, and reducing rate variations across hospital and hospital alternatives.

Additionally, HCPF and BHA are supporting SUD providers through this transition by offering a Provider Ambassador Program for SUD providers who currently deliver ASAM 3.2 withdrawal management (WM) services. HCPF contracted with Health Management Associates (HMA) to provide resources and direct technical assistance to 3.2-WM providers in preparing for the ASAM 4th Edition transition. Each 3.2-WM provider has been invited to engage in this program. If providers reach out to RAEs, they should be directed to complete this Feedback and Technical Assistance Form.

Stabilize Inpatient Behavioral Health Payment Across Settings

HCPF is exploring strategies to stabilize payments for inpatient behavioral health across settings, including researching hospital and hospital alternative cost systems and potentially implementing an All Patient Refined-Diagnosis Related Group (APR-DRG) payment system. The APR-DRG payment system allows for standardization of payments to providers and reimburses for the level of services rendered. Variances in length of stay, population and service provision are accounted for and addressed in an APR-DRG model.

For HCPF to finalize recommendations regarding implementation of the APR-DRG model for free standing psychiatric hospitals, Crisis Stabilization Units (CSUs), Acute Treatment Units (ATUs), and inpatient hospitals, by October 1,2025, the RAEs will

need to assess the changes required to incorporate an APR- DRG model into their systems. Once an implementation plan is approved, collaboration with HCPF to establish timelines and processes for stakeholdering with providers is necessary.

Standardized Utilization Management Requirements

It is clear that Utilization Management (UM) is a central component to cost trend control. HCPF is performing policy review and data analysis to determine what revisions to existing policies will help us reach our goals. This process will include reviewing current required authorization timeframes and making necessary adjustments by January 1, 2026. HCPF will determine where having standardized UM policies are appropriate, when it makes sense to automate approval, and where soft caps on those services that do not require a behavioral health diagnosis are needed. HCPF will also look to create a monitoring strategy by July 1, 2026, to ensure the changes made are accomplishing the desired outcomes. HCPF will also set standard service limits before RAEs must require an authorization with a policy go-live date of January 1, 2026. Where prospective utilization management is prohibited, retrospective utilization review must be performed. HCPF will require the RAEs to begin mandatory retrospective and fiscal monitoring activities. All UM activities must align with CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F) which goes into effect January 1, 2026.

Prospective Payment System Guardrails

HCPF will be performing analyses of the Prospective Payment System (PPS) to explore options for guardrails to ensure appropriate payment and access of services. This includes revising billing policies and updating cost reporting structures to properly incentivize Comprehensive Providers. HCPF is also creating a monitoring strategy to evaluate appropriate utilization of services under the PPS model after July 2025 when there will be a year of data available.

HCPF is also collaborating with the BHA to establish a decertification process. This will allow the State to decertify a Comprehensive Provider in the case that the provider is unable to meet the standards outlined for a Comprehensive Provider under licensure requirements.

The final change that HCPF will be considering is stratification of the PPS rates. The initial PPS rate was built with a general structure to make the transition as smooth as possible. Once two years of data are available, HCPF may shift the structure of the PPS to incentivize serving priority populations or providing specific services.

The timeframes for this work include research on the topics and recommendations proposed by January 1, 2027, with implementation of the recommendations by July 1, 2027.

Appendix A - Medicaid Sustainability Policy Timeline

Activity	Sub-activities / Detail	Due Date
SB23-174 - Allows for services w/o diagnosis: Policy review, data analysis, revision, monitoring strategy	Part I: Research and analysis on limiting number of services w/o BH Diagnosis, make decision on policy.	7/1/2025
	Part II: Implement updated policy.	10/1/2025
Monitoring and Retroactive Review of Outpatient Rates	Part I: Review of current service rates by RAE.	3/31/2025
	Part II: Set up a dashboard to monitor highly utilized rates across RAEs. Work with RAEs to implement retroactive review of 26+ visits.	10/1/2026
NCCI Edits	Part I: Apply all NCCI Edits	7/1/2025
	Part II: Look at creating tailored B3 edits	1/1/2026
Standardized UM requirements: Policy review, data analysis, revision, monitoring strategy	Part I: Review current required authorization timeframes and adjust appropriately; policy go live	1/1/2026
	Part II: Create monitoring strategy	7/1/2026
	Part III: Set standard service limits before RAEs must require an authorization; policy go live	1/1/2026
	Part IV: Begin mandatory audit activities	10/1/2026
Directed Payment Policy Review	Part I: Limit directed payments for outpatient ESNP services	7/1/2025
	Part II: Limit directed payments for bedded ESNP services and others as needed	7/1/2026
Scoping services provided by peers and billing providers	Part I: Limit peer service codes and allowable settings, prioritize SUD and team-based care	7/1/2025
	Part II: Require additional credentialing; policy go live	1/1/2026
988 Billing	Remove 988 billing as an allowable service	7/1/2025
Explore DRG as a way to stabilize payment for inpatient BH across settings	Part I: Research and create recommendations	10/1/2025
	Part II: Implement recommendations	7/1/2026

PPS Guardrails: data analysis, revision, monitoring strategy, decertification process, stratification of rate	Part I: Research and create recommendations	1/1/2027
	Part II: Implement recommendations	7/1/2027
Reduce / adjust available B3 codes, H-Codes	Part I: Research and create recommendations	10/1/2025
	Part II: Implement recommendations	1/1/2026
Use cost and quality metrics to support quality provider networks	Work with RAEs to support network access and quality standards for providers, prioritize access with demonstrated quality and safety net providers.	Ongoing
Implement CCBHC Demonstration	Complete all planning activities, identify potential federal match opportunity, submit CCBHC Demonstration application	4/1/26
ASAM 4th Edition requirements, researching changes in SUD and crisis care trends	Identify opportunity for withdrawal management facilities to expand care to treatment, adjust model for crisis stabilization, or a new provider option to be determined. Research rate variations across hospital and hospital alternatives.	7/1/26

All preservation activities related to utilization management will comply with CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F) which goes into effect January 1, 2026.

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