

Behavioral Health Accountability Map

Medicaid Commission, October 7, 2026

Purpose. This fact sheet shows who is responsible for behavioral health across HCPF, the Behavioral Health Administration (BHA), the Regional Accountable Entities (RAEs), and the Behavioral Health Administrative Service Organizations (BHASOs); where their responsibilities meet; and the people each one serves.

Behavioral Health Landscape in Colorado

Statewide need. About 1 in 4 Colorado adults (24.6%) had a mental illness in the past year, and 7.0% had a serious mental illness (2023-2024 NSDUH estimates). There were 1,293 deaths by suicide in 2025 (CDPHE). In 2025, across all age groups except 18-29 year olds, access to care improved, with fewer people reporting they could not access the care they needed (CHAS 2025).

Medicaid members served. In FY 2024-25, 241,345 Health First Colorado members used behavioral health services, or 23.8% of members, up from 18-19% in the prior four years. 88% had a primary mental health diagnosis and 23% had a primary substance use diagnosis. There are 36,023 Medicaid members with chronic and severe needs with a diagnosis of serious mental illness. This fact sheet focuses on the BH Capitated benefit, it does not include information regarding individuals served through the Child Health Plan (CHP+), through Home and Community Based Services (HCBS), or paid fee-for-service outside the capitation.

BHASO delivered safety-net services. Provider capacity (276 provider organizations) and targeted safety-net services for people in Colorado who do not have the service paid for by Medicaid or private insurance.

Top Five Most common Medicaid diagnosis codes. Generalized anxiety disorder; Post-Traumatic Stress Disorder; Adjustment Disorder; Major Depressive Disorder, Recurrent, Moderate; and Opioid Dependence

Top safety-net services provided by BHASOs (determined by dollars spent on capacity or fee-for-service funding from BHA): Emergency and Crisis Services (\$46,160,302); Outpatient Services (\$41,231,431); Residential Treatment (\$23,145,490); Recovery Support Services (\$16,242,621).

HCPF and BHA Mandates

Table 1. The State Agencies

	HCPF	BHA
Role	Designs and administers Colorado Medicaid's behavioral health benefits.	Leads and develops the state's vision and strategy for behavioral health. Every state agency that administers a behavioral health program must collaborate with BHA to achieve its goals.
How it pays for services	Pays for behavioral health services for members through capitation payments	Provides capacity and limited fee for service funding to the BHASOs to pay providers for

	HCPF	BHA
	to the RAEs, Managed Care Plans and some fee for service payments directly to providers. HCPF is the largest payer of behavioral health services in the state.	uninsured individuals or services Medicaid does not cover (e.g., recovery residence costs).
Behavioral Health Provider oversight	Enrolls providers in Medicaid and CHP+ based on BHA licensing and approval.	Licenses providers for community-based behavioral health services. Designates facilities to provide court-ordered involuntary mental health services. Defines and approves safety-net providers for eligibility to receive enhanced payments.
Funded by	State general and federal Medicaid funds, including CHASE fees.	State General, State Cash and federal funds
Accountable to	CMS; General Assembly	HHS (SAMHSA); General Assembly
Statute	C.R.S. Title 25.5	C.R.S. Title 27, Art. 50 (HB22-1278)
Share of funding spent on services	Requires that at least 85% of funds paid to the RAEs must go directly to behavioral health services. In FY24-25, all of the MCEs in the ACC program exceeded that minimum amount, some even reaching 99%.	93.1% of funds paid to the BHASOs go directly to behavioral health services (cumulative 6.9% BHASO administrative rate).

The Layers at a Glance

Table 2. Regional Contractors

	RAEs	BHASOs
Contracted by	HCPF	BHA
Serves	Medicaid members	Provider capacity and targeted safety-net services for people in Colorado who do not have the service paid for by Medicaid or private insurance.
Entities	Region 1 Rocky Mountain Health Plans; Region 2 Northeast Health Partners; Region 3 Colorado Community Health Alliance; Region 4 Colorado Access	Region 1 Rocky Mountain Health Plans; Regions 2-4 Signal Behavioral Health Network
Paid by	Capitation	Capacity funding and fee-for-service
Accountable to	HCPF, by contract	BHA, by contract
Regions	Aligned regional map for RAEs and BHASOs	Same
Provider requirement	Providers must be Medicaid enrolled. RAEs credential and contract with all behavioral health providers and pay claims under the capitation.	BHASO providers must also be enrolled in Medicaid

Services and People Served

Table 3. Services and People Served

Service line	Medicaid members served	People receiving BHASO delivered safety net services [^]
Crisis and emergency	32,427	24,306
Outpatient treatment	238,931*	135,669
High-Intensity outpatient treatment	7,154	3,094
Mental Health Inpatient	8,923	0
Mental health residential	604	899
Withdrawal management	18,369**	13,851
Substance use residential and inpatient	12,901	3,802
Recovery and supportive services	107,458	34,708
Care Coordination	76,238***	19,199
Children and youth (included in services above)	62,894	34,058

*Medicaid outpatient treatment is all outpatient treatment inclusive of high intensity.

**Medicaid withdrawal management includes both outpatient withdrawal management and residential/inpatient withdrawal management.

***Care coordination for Medicaid is defined as outreach and case management.

[^]Note, individuals may be counted in more than one contracted service if they participate in multiple services

Agency Accountability

Table 4. Who is Accountable for What

Function	HCPF	BHA
Behavioral health strategy	Identifies services that are eligible for coverage under Medicaid and develops policy for oversight of those benefits.	Leads and develops Colorado's vision and strategy for behavioral health for children, youth, and adults.
Service and provider definitions	Defines covered services eligible for reimbursement and provider types allowed to deliver services based on BHA, CDHPE, CDHS, and DORA licensing requirements.	Defines, regulates and monitors behavioral health services accessibility and quality.
Provider monitoring	Defines monitoring requirements for RAEs to ensure compliance with Medicaid regulations, submits complaints to regulatory agencies. Receives regulatory	Licenses, regulates and monitors. (Sends HCPF a monthly report of all licensed and approved providers at every level).

Function	HCPF	BHA
	compliance reports from the BHA to track any areas of concern for follow up.	
Care coordination	Defines requirements for RAEs to provider tiered care coordination for members based on member acuity.	Endorsement through the BHE license, joint expectations and definitions.
Data definitions	MMIS data dictionary	Performance Hub
Duplicate billing prevention	Non-Medicaid state ID for BHA clients, used for BHA data and reporting.	Providers demonstrate Medicaid offset with remittance data.
Crisis services	Provide reimbursement for walk-in, mobile crisis, in-home follow up, outpatient and short term residential crisis services delivered to members in accordance with BHA established licensure requirements.	Statewide behavioral health crisis response system. Licenses, regulates, and monitors crisis providers. BHASOs contract for crisis services.
Network adequacy	Establishes services and access to care standards for RAEs who are required to comply with Managed Care Federal Regulations. Monitor network adequacy by RAE region.	Creates community-based networks and provider standards.
Quality and outcomes measurement	Collects and reports CMS core measures, collects and pays on national metrics to the RAEs through the use of incentive programs.	Community-based behavioral health provider licensing. Performance Hub.
Program integrity and provider oversight	Ensures through collaboration between program integrity and RAEs that providers meet benefit expectations in the delivery of services. Reports complaints to the Medicaid Fraud, Abuse & Neglect Unit with the Atty. General's Office. Monitor statewide and regional unitization and program integrity through claims data.	BHA provider oversight through licensing and regulating. Program integrity through BHASOs and BHA.

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BHASOs As Contractors

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BHASOs as Contractors: General Description

What a BHASO is. BHA contracts with Behavioral Health Administrative Service Organizations (BHASOs) to manage and monitor behavioral health services by funding provider capacity and targeted safety-net services for people in Colorado who do not have the service paid for by Medicaid or private insurance. The BHASOs launched July 1, 2025 to deliver mental health, crisis, and substance use services.

Where they came from. BHASOs were mandated by House Bill 22-1278 and were a key recommendation of the Behavioral Health Task Force. They merged the functions of the substance use disorder Managed Service Organizations and the crisis services Administrative Service Organizations, and also took on the responsibility of contracting for mental health services, which was previously managed directly by the State.

What they do. BHASOs establish, administer, and maintain regional networks of behavioral health providers. They offer care coordination to community members and handle administrative functions: network development, contracting, payment, data collection, and quality improvement. Their networks provide mental health treatment, substance use treatment and recovery supports, crisis services, and care coordination. BHA's combined network under these contracts is called Colorado LIFTS.

Who holds the contracts. Two organizations manage the services across four regions: Rocky Mountain Health Plans (Region 1) and Signal Behavioral Health Network (Regions 2, 3, and 4). The four BHASO regions are identical to the Medicaid RAE regions, to keep care coordination aligned across payers.

How they relate to Medicaid. BHASOs provide capacity funding to providers to cover costs associated with care for uninsured individuals or for services Medicaid does not cover such as room and board. BHASO providers must be enrolled in Medicaid for Medicaid covered services.

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COLORADO

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1115 Waiver Demonstrations

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Section 1115 waivers provide states with the flexibility to test different innovations or pilots by waiving portions of federal Medicaid law that would otherwise prohibit Medicaid funding to be used for these purposes. These are called 1115 waivers because they are established under Section 1115 of the Social Security Act. Colorado's current 1115 Demonstration Waiver includes coverage for:

- Residential Substance Use Disorder (SUD) Treatment
- Inpatient Hospitalization for Mental Health for Individuals with Serious Mental Illness (SMI)
- Health Related Social Needs (HRSN) including housing navigation and tenancy support services
- Criminal Justice (CJ) Re-entry supports for 90 days prior to release for care coordination, medication assisted treatment (MAT) for SUD, and 30 days of pharmacy
- CMS denied Continuous eligibility for youth and re-entry populations, a request made by the Colorado Legislature via [HB 23-1300](#), but not carried out due to being contingent on receiving approval by CMS granting 1115 authority.
- CMS has indicated verbally that presumptive eligibility for individuals that need Long Term Services and Supports will not receive approval. Although requested by the legislature via [HB 24-1229](#), this cannot be implemented without 1115 authority.

While the SUD and SMI waiver elements required new general fund to be implemented, the CJ Re-entry and HRSN were implemented without additional general fund, drawing down new federal funds using existing general fund state investments as the state match.

Colorado's 1115 Waiver Demonstration Overview

Colorado's application for a section 1115(a) demonstration waiver titled "[Expanding the Substance Use Disorder Continuum of Care](#)" was approved by the Centers for Medicare & Medicaid Services (CMS) on November, 13, 2020. The initial approval was effective from January 1, 2021 through December 31, 2025 and allowed for the state to receive Federal Financial Participation (FFP) for services provided to Medicaid members while residing in institutions for mental disease (IMD) for a primary diagnosis of substance use disorder (SUD). Beneficiaries have access to high quality, evidence-based Opioid use disorder (OUD) and SUD treatment services across a comprehensive continuum of care, ranging from residential and inpatient treatment to ongoing chronic care for these conditions in cost-effective community-based settings.

Goals of SUD Demonstration: [SUD Demonstration STCs](#)

- Increased engagement and adherence to treatment
- Reduced overdoses, emergency department and inpatient treatment through improved access to residential and outpatient treatment
- Reduced readmissions from withdrawal management and hospitalizations; and
- Better physical health access and outcomes.

Amendments to Colorado's 1115 Waiver Demonstration

CMS approved Colorado's request for an [amendment](#) to the 1115 waiver on January 13, 2025. The amendment expanded the waiver to include three additional demonstrations: Health Related Social Needs (HRSN), Serious Mental Illness/Serious Emotional Disturbance (SMI/SED) and Reentry.

HRSN Demonstration

Colorado's [HRSN amendment](#) to the SUD demonstration 1115 waiver went live on July 1, 2025, allowing the state to claim FFP for expenditures related to certain qualifying HRSN services. These expenditures are limited items and services not otherwise covered under Title XIX, but that are consistent with Medicaid demonstration objectives and enable the state to continue to increase the efficiency and quality of care. All HRSN interventions must be evidence-based and medically appropriate based on clinical and social risk factors. The state is authorized to cover the following HRSN services:

- Case management services for access to housing supports
- Housing Interventions, including:
 - Housing supports without room and board, including:
 - Pre-tenancy navigation services
 - One-time transition and moving costs other than rent, to assist with identifying, coordinating, securing, or funding one-time necessary services and modifications to help a person establish a basic household
 - Tenancy and sustaining services.
 - Utility assistance
 - Episodic housing interventions with clinical services

The state may claim FFP for expenditures for infrastructure investments, that are separate and distinct from delivery of services, to support the development and implementation of HRSN services for the following activities:

- Technology
- Development of business or operational practices
- Workforce development
- Outreach, education, and interested parties convening

Goals of HRSN Demonstration:

- Improve the health outcomes, reduced total cost of care, and reduced hospital readmissions for Medicaid beneficiaries by removing social barriers to health; and
- Improve prevention and connections between Medicaid beneficiaries and community services to address physical health, behavioral health, and HRSN.

State requirements outlined in the approved demonstration include maintenance of effort provisions ([HRSN MOE Data 2-26](#)). Specifically, the state must maintain a baseline level of state funding for ongoing social services related to housing and housing transition supports and nutrition supports for the duration of the demonstration, not including one-time or non-recurring funding.

Changes to HRSN as of August 2026

CMS rescinded Health-Related Social Needs (HRSN) guidance in March 2025 that was previously used to approve Housing interventions with Room and Board in this demonstration, indicating that

Medicaid reimbursement of Housing interventions with Room and Board provided through this demonstration is unlikely to be renewed. Colorado anticipates that reimbursement authority for Housing interventions with Room and Board under Medicaid will expire at the end of the current demonstration period and will not be part of a CMS approved renewal, December 31, 2026. Colorado will phase out paying for the cost of up to six months of rental assistance as a Medicaid covered benefit for members newly matched with a housing voucher.

SMI/SED Demonstration

Colorado's SMI demonstration went live on October 1, 2025 authorizing the state to receive federal financial participation (FFP) for delivering high-quality, clinically appropriate treatment to beneficiaries diagnosed with serious mental illness (SMI) and/or serious emotional disturbance (SED) and receiving treatment while they are short-term residents in settings that qualify as IMDs. Beneficiaries may receive services in IMD settings for up to 60 days, provided the statewide average length of stay is no more than 30 days.

Goals of SMI Demonstration:

- Reduced ED visits, lengths of stay, and readmissions to hospitals for Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings;
- Improved access to crisis stabilization services including 988, mobile crisis units, intensive outpatient services, short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the state; and
- Increased access to community based services, primary care, and behavioral health services;
- Improved coordination and integration of physical, behavioral, and social services for beneficiaries who have complex health and social needs.

State requirements outlined in the approved demonstration include maintenance of effort provisions. Specifically, the state must maintain a level of state and local funding for outpatient community-based mental health services for Medicaid beneficiaries for the duration of the demonstration that is no less than the amount of funding provided at the beginning of the demonstration. [SMI MOE Data](#)

Reentry Demonstration

In 2022, the Colorado General Assembly passed [SB22-196](#), requiring HCPF to evaluate and decide if the state should seek additional federal authority to provide certain reentry services through Health First Colorado (Colorado Medicaid). In 2024, the Colorado General Assembly passed [HB24-1045](#), authorizing HCPF to request federal authority for and to implement a limited set of reentry services. The Reentry Demonstration Initiative went live on July 1, 2026, allowing certain incarcerated individuals residing in state prisons, local jails, Tribal jails, and youth correctional facilities access to a defined set of pre-release services. To qualify for pre-release services, individuals must be determined eligible for Medicaid or the Children's Health Insurance Program (CHIP), except for their incarceration status, either prior to or during incarceration and have an expected release date within 90 days. If eligible for Medicaid or CHIP prior to incarceration, Medicaid or CHIP eligibility is suspended instead of terminated.

Goals of Reentry Demonstration:

- Increase coverage, continuity of care, coordination and communication between correctional systems, Medicaid and CHIP systems, managed care plans (as applicable), and community-based providers;

- Improve access to services prior to release and improve transitions and continuity of care into the community upon release and during reentry;
- Increase use of stabilizing medications like long-acting injectable antipsychotics and medication for addiction treatment for SUDs where appropriate.
- Reduced overdose, all-cause death, ED visits and hospitalizations post-release; and
- Increase additional investments in health care and care quality in correctional facility settings, and successful reentry post-release.

Covered pre-release services for eligible individuals include:

- **Case management** to assess and address physical and behavioral health needs and health-related social needs;
- **Medication-assisted treatment (MAT)** for all types of substance use disorders (SUDs), as clinically appropriate, including coverage for medications in combination with counseling and behavioral therapies; and
- **A 30-day supply of prescription and over the counter medications** provided to the individual immediately upon release from the correctional facility, consistent with approved Medicaid and CHIP State Plan coverage authorities and policies.

Reinvestment Fund

To the extent that the reentry demonstration initiative covers services that are the responsibility of and were previously provided or paid by the correctional facility, the state must reinvest all new federal dollars, equivalent to the amount of FFP projected to be expended for such services. The reinvestment fund will hold General funds from state-only programs that under the 1115 demonstration waiver are eligible to receive a federal Medicaid match. The reinvestment fund will be used to expand services to Medicaid members as authorized by CMS under the 1115 authority. Rules governing use of funds will provide a mechanism to document required maintenance of effort for the HRSN demonstration. State agencies will collectively agree upon a process of depositing funds into the account, tracking the demonstration the funds are allocated to support and developing the rules and governance structure for requesting use of funds which will be determined on an annual basis in accordance with 1115 federal requirements.

Reinvestment Fund Requirements

- For Re-entry demonstrations the state is required to reinvest the total amount of federal matching dollars received to fund health care services currently funded with state and/or local dollars.
- States must ensure the year over year state funds continue to be allocated to the same populations and service areas and at the same level. The increase of funds from federal matching must also be used to serve the same purposes.
- The scope of activities these funds may be used to support include improving community-based physical and behavioral health services, health information technology and data sharing, and community-based provider capacity.

Reentry Reinvestment

- The state share of funding associated with new services covered under the reentry demonstration initiative;
- Improved access to behavioral and physical community-based health care services and capacity focused on meeting the health care needs of individuals who are incarcerated (including those who are soon to-be released), those who have recently been released, and

those who may be at higher risk of criminal justice involvement due to untreated behavioral health conditions;

- Improved access to or quality of carceral health care services, including covering new, enhanced, or expanded pre-release services;
- Improved health information technology (IT) and data sharing;
- Increased community-based provider capacity that is particularly attuned to the specific needs of, and able to serve, justice-involved individuals or individuals at risk of justice involvement;
- Any other investments that aim to support reentry, smooth transitions into the community, divert individuals from incarceration or re-incarceration, or better the health of the justice-involved population;
- Reinvestment funds cannot be used to build prisons, jails, or other carceral facilities or pay for prison or jail-related improvements other than those for direct and primary use in meeting the health care needs of individuals who are incarcerated or to support for-profit carceral settings.

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