Commission 10/7 follow up questions

Part A – Behavioral health: what the October 7 discussion left open

Q1. Peer and supportive services

Total spending by year, reconciled (the meeting cited both $145M and about $300M)

The mislabeling on the slide has been corrected, and slides and fact sheet both correctly reflect the $293M in FY25 spending on peer and supportive services.

The share billed with no connected clinical care

Supportive services include services like Peer Support, Skills Training, Psychoeducation, and Medication Training. These services are provided by unlicensed and sometimes uncredentialed staff.

When looking at Skills Training and Peer Support as a subset of these supportive services, about 1,200 members received these services in FY25, and had *exactly zero* other behavioral health services.

Over 2,400 additional members received Skills Training or Peer Support, and *nearly zero* other BH services, meaning they had five days or less of other behavioral health services within the fiscal year.

Combined, this represents 3600 members, approximately 15% of the unique members that received Skills Training or Peer Support, with zero or *nearly zero* other behavioral health services.

Broadening out to a larger set of supportive services codes, including services such as Psychoeducation, and Medication Training, more than 3000 members received supportive services and *zero* other BH services.

An additional 3700+ received supportive services and *nearly zero* other behavioral health services. Among all members that received any supportive service in FY 25, approximately 11% received nearly zero other services.

The share billed by uncredentialed staff or asked differently, can we pull out peers only, excluding care coordination and case managers?

The department cannot determine the share of these services delivered by unlicensed or uncredentialed staff, or separate out current service delivery by specific types of uncredentialed staff (i.e. peers vs qualified behavioral health assistants). This is because unlicensed practitioners are unable to bill Medicaid directly. Services provided by unlicensed practitioners are billed under a Medicaid enrolled licensed practitioner, meaning that the claims data does not

distinguish between the type of unlicensed staff providing the service under the Medicaid enrolled licensed practitioner.

Whether billing is shifting to the qualified behavioral health assistant credential, which would offset savings;

We cannot evaluate whether billing today is shifting from one uncredentialed staff type to another, for the reasons discussed above. However, actions the department is considering in response to the cost growth trends are focused on when and where supportive services are allowable, regardless of who is delivering the services. These actions would apply to services delivered by peers in the same way that they would apply to services delivered by qualified behavioral health assistants. The intent of these changes is to address the cost growth holistically, by connecting support services to clinical care, and not just shifting these services from being delivered by peers to being delivered by other unlicensed practitioners such as qualified behavioral health assistants.

Q2. Comprehensive safety net providers:

the average indirect cost rate from the most recent cost reports and the range across providers;

For Comprehensive Safety Net Providers, “indirect costs” are defined in the cost reports as costs that cannot be attributed to a single program, department, or unit (often referred to as a cost center). These costs often include but are not limited to typical overhead/administrative expenses such as executive compensation, legal fees, human resources, and clinical staff that work across multiple programs. The indirect cost rate represents the ratio of indirect costs to direct costs, which is different from the percent of total expenses going to indirect costs. The average indirect cost rate was 30.3% for the FY24-25 cost report period, with the range of 12.2% to 46.2%. For comparison in cost-based physical health safety net programs, the average indirect costs for FQHCs is 52% and ranges from 28-85%.

the increase in prospective payment spending since July 2024, in general fund dollars;

The Department does not pay prospective payment system (PPS) rates directly to Comprehensive Safety Net Providers (CSNPs). Rather, PPS rates are established for each CSNP and incorporated into behavioral health capitation rates based on historical utilization, with a trend factor applied to reflect the applicable capitation period.

As a result, increases in PPS rates do not translate directly into corresponding increases in General Fund expenditures. The General Fund impact is reflected within overall behavioral health capitation payments and depends on the number of member-months paid, the applicable capitation rates, and the General Fund share of those payments.

Using the capitations paid or projected, and the amounts within each capitation that was attributed to PPS services when the capitation was built, we can estimate a value for General

Fund spend attributable to the PPS. This will not tie to actual utilization at all, especially for the FY 2024-25 and FY2025-26 time periods, as they have reconciliations associated. The General Fund estimates are as follows: FY 2024-25 - $149,765,926.51; FY 2025-26 - $163,723,744.20; FY2026-27 - $155,186,454.75.

the expected general fund effect of the July 2025 limits on allowable costs and the October 2026 value-based payment change.

The July 2025 allowable cost changes had very little impact on allowable costs, and there is no assumed impact from the value-based payment change, since the PPS rates are accounted for within the capitated rate.

Q4. The federal match on behavioral health spending: the share of capitated behavioral health spending for expansion members (90 percent federal) against other members, so the Commission can see what a dollar of reduction returns to the general fund.

Per the November 1, 2026 forecast, the Department requests in FY27-28 R-02 to spend $1,771,709,774 on behavioral health capitations for all populations in FY 2026-27. Of this total, $414,774,182 is General Fund, $140,509,332 is Cash Funds, and $1,216,426,260 is Federal Funds.

Of the $1,771,709,774 total funds requested, $784,215,149 is requested for the expansion adult population, meaning that **44% of the total behavioral health capitated funds request is for expansion adults**. Of the $1,216,426,260 Federal Funds, $704,773,657 is requested for the Expansion Adult population, **meaning that 58% of the federal funds capitation expenditure is for expansion adults**.

Of the total estimated behavioral health capitated caseload, 1,124,556, the Department estimates an expansion adult caseload of 352,480 for FY 2026-27, representing about 31% of the total.

Part B – What the Commission needs to decide on November 10 and 18

Q8. Medical Services Board: any benefit or rule changes the Department expects to bring to the Board before December 11, 2026.

Rule Title	MSB Date	Rulemaking Step
Rural Health Center Remote Patient Monitoring Reimbursement	11/13/2026	Initial
Cover All Coloradans Service Limits HB 26-1411	11/13/2026	Initial

Rule Title	MSB Date	Rulemaking Step
Parenteral Nutrition Enhanced Dispensing Fee Increase	11/13/2026	Final on Consent
Creation of Access-Based Specialty Drug Rate	11/13/2026	Final on Consent
Nursing Facility Pathways	11/13/2026	Final on Consent
Electronic Visit Verification in a School-Based Setting	12/11/2026	Initial
H.R. 1 Work Requirements for Medical Assistance	12/11/2026	Emergency
Service Unit Durations for Long-Term Home Health	12/11/2026	Emergency
Pediatric Behavioral Therapy Rule	12/11/2026	Initial
Repeal of § 8.761 Targeted Case Management Services for Persons with Developmental Disabilities	12/11/2026	Initial

Agendas, proposed rule text, and supporting materials will be posted to the Department's Medical Services Board website the Friday before the Board meeting (or November 6 and December 4, respectively) at https://hcpf.colorado.gov/medical-services-board.

Q12. Outpatient psychotherapy: the general fund value of lifting the SB22-156 prohibition on prior authorization, and the expected effect on members' access to therapy. Not yet a docket line.

The Department's Nov. 1, 2026 budget includes FY 2027-28, R-06.I., which is a decision item to remove the prohibition on Prior Authorization Requests (PARs) for outpatient psychotherapy services. The Department estimates savings of $64.9 million total funds including $14.5 million in general fund in FY 2027-28 and ongoing if this proposal is adopted. The Department anticipates no adverse impact on members' access to clinically appropriate care.

Part C – Facts that change a saving or a risk to members

Q15. Confirmation that the Department will pursue the hospital payment methodology prospectively, and why the $569M and $270M figures differ.

Yes, the Department intends to continue collaborating with the Colorado Hospital Association (CHA) and Colorado hospitals to evaluate opportunities to increase the Upper Payment Limit (UPL) and maximize federal funding. Various proposals developed over the past year have produced differing estimates of the potential financial benefit to hospitals, and the actual amount

of additional federal funding would depend on the specific methodology and financing arrangements ultimately approved by CMS.

Q18. Whether ending behavioral health capitation would forfeit federal financing that runs through managed care, including state-directed payments under H.R. 1.

Eliminating behavioral health capitation would not result in a loss of federal funding for services, as many of the services currently provided through managed care could instead be paid through fee-for-service.

State-directed payments are a financing mechanism available only through managed care, and eliminating the use of managed care to deliver behavioral health services would therefore eliminate the ability to use these payments to increase provider payments.

However, other financing opportunities, such as potentially increasing upper payment limits under fee-for-service, could offset some or all of the associated federal funding losses.

Ultimately, the net fiscal impact would depend heavily on the structure of any replacement payment system and the policy choices made during the transition. Moving to fee for service does change the kinds of behavioral health services that can be provided because there are some services we are able to cover under capitation that are not covered services in fee for services, such as residential mental health services. Paying for behavioral health services through fee for service would also require HCPF to contract with any willing provider and use standard rates, so there would no longer be an option for prioritizing quality providers, many value based payment and tiered programs, or the ability to end a provider contract without litigation.

Q19. Spending on ACC primary care case management (PCCM) and the children's share

The Regional Accountable Entities (RAEs) received $236,802,371 from the Department in per member per month Care Management payments in FY 2025-26. Of that total amount paid to the RAEs, 43%, or $100,524,463, was for members that were under 21 years of age.

Additional information on overall spending is addressed in HCPF's Assessment of the Accountable Care Collaborative data request delivered for August 27.
Advance Deliverable_ HCPF's Assessment of the ACC.pdf

PCCM funding only goes to the RAEs. PRIME and Denver Health Medical Plans only receive MCO capitation funding.

Q21. Which federal eligibility group the Buy-In uses and its premium ceiling; members in each tier after the earned-income disregard.

Federal authorities:/
The Health First Colorado Buy-In Program For Working Adults With Disabilities uses the following federal authorities:

- Ages 16-65 federal eligibility: §1902 (a)(10)(A)(ii)(XV)TWWIIA, Basic Coverage Group
- Age 65+ federal eligibility: §1902(a)(10)(A)(ii)(XIII) Balanced Budget Act, Work Incentives Eligibility Group

The Health First Colorado Buy-In Program For Children With Disabilities uses the following federal authorities:

- Ages 18 or younger federal eligibility: §1902 (a)(10)(A)(ii)(XIX), Family Opportunity Act

Premiums limitations:
Per CRS 25.5-6-1404.(3)(b), any premium changes require an actuarial study. Current premiums, effective April 1, 2026 based on 2026 FPL amounts are:

Table 1. Working Adults With Disabilities Buy-In Premiums

Federal Poverty Level (FPL)	Monthly Income for an Individual	You Pay Each Month
0-40%	$0 - $532*	$0
41-133%	$533 - $1,769*	$25
134-200%	$1,770 - $2,660*	$90
201-300%	$2,661 - $3,990*	$130
301-450%	$3,991 - $5,985*	$200

*Some people earning more may still qualify.

Federal requirements: For any individual whose annual family income is less than 450 percent of the Federal poverty level, states can require payment of premiums only to the extent that the amount of the premiums does not exceed 7.5 percent of the individual's income.

Table 2. Working Adults With Disabilities Buy-In Enrollments and Premiums Paid, Fiscal Year 2025-2026

FPL	Member Months	Avg Monthly Enrollment	Paid Amount
0-40%	40,156	3,346	$199,964,682.49
41% - 133%	125,144	10,429	$245,358,889.65
134% - 200%	74,745	6,229	$119,749,510.49

FPL	Member Months	Avg Monthly Enrollment	Paid Amount
201% - 300%	26,084	2,174	$46,971,061.89
301% and Over	5,763	480	$10,876,318.58
Total	**271,892**	**22,658**	**$622,920,463.10**

Table 3. Children With Disabilities Buy-In Premiums

FPL	0% - 133%	134% - 185%	186% - 250%	251% - 300%
Monthly Income Family Size: 1	$0 - $1,769	$1,770 - $2,461	$2,462 - $3,325	$3,326 - $3,990
2	$0 - $2,399	$2,400 - $3,337	$3,338 - $4,509	$4,510 - $5,410
3	$0 - $3,028	$3,029 - $4,212	$4,213 - $5,692	$5,693 - $6,830
4	$0 - $3,658	$3,659 - $5,088	$5,089 - $6,875	$6,876 - $8,250
5	$0 - $4,288	$4,289 - $5,964	$5,965 - $8,059	$8,060 - $9,670
6	$0 - $4,917	$4,918 - $6,839	$6,840 - $9,242	$9,243 - $11,090
7	$0 - $5,547	$5,548 - $7,715	$7,716 - $10,425	$10,426 - $12,510
8	$0 - $6,176	$6,177- $8,591	$8,592 - $11,609	$11,610 - $13,930

FPL	0% - 133%	134% - 185%	186% - 250%	251% - 300%
Monthly Premium	**$0**	**$70**	**$90**	**$120**

Federal requirements for children with disabilities outlined within 42 CFR 447.55 require that the premium amount for children up to 200% FPL do not exceed more than 5% of their family income and no more than 7.5% family income for those between 200-300% FPL.

Table 4. Children With Disabilities Buy-In **Enrollments and Premiums Paid, June 2025-May 2026**

FPL	Member Months	Avg Monthly Enrollment	Paid Amount
Under 100%	8121	677	$20,116,710.96
100%-199%	12438	1037	$26,321,998.35
200%-300%	4130	343	$7,468,823.71
Total	**24689**	**2057**	**$53,907,533.02**

Q22. Whether Colorado may charge a fee based on parents' income for a child whose waiver or CFC eligibility disregards it, and under what federal authority.

For a brief background, under State Plan Medicaid, household income is counted towards Medicaid eligibility for children. Community First Choice (CFC) is a State Plan program and household/parental income is counted for children only enrolled in CFC and State Plan Medicaid. If a child is enrolled in a 1915(c) HCBS waiver (alone or in addition to CFC), parental/household income is disregarded as they qualify through institutional eligibility rules.

1915(c) Waivers

The Department attempted to implement fees based on parental income for the Children's Home and Community Based waiver, which was initiated by FY18 R-8. This project was ultimately scrapped for several reasons, including stakeholder feedback and concerns with conflicting federal guidelines. For example:

- Implementing a parental fee created a conflict with Social Security Income (SSI)-based eligibility rules, which do not allow parental income to be considered.
- Colorado is a Section 1634 state, which means that the Social Security Administration conducts Medicaid eligibility determinations for SSI recipients - thus Colorado follows SSI financial eligibility SSI rules.

- Under SSI rules, children receiving institutional-level of care are treated as a household of one, and parental income is not considered.
- 1915 (c) HCBS waivers require an institutional level of care.

1915(k) Community First Choice

Since Community First Choice is part of the Medicaid State Plan, it is considered an entitlement program and according to 42 CFR Part 447 Subpart A § 447.55 Premiums, states generally cannot charge premiums to Medicaid enrollees with incomes below 150% of the FPL. Children and families on CFC-only (not also enrolled in a waiver) would be below 150% of the FPL and therefore premiums are not allowed.

Q25. The share of private duty nursing, long-term home health and LTSS authorizations changed on appeal or exception.

On average across all benefit appeals, about 25% of appeals are resolved in favor of the member. We do not track appeals outcomes data at the level requested in this question.