Joint Budget Committee

Staff Figure Setting
FY 2026-27

Health Care Policy and Financing
Behavioral Health Community Programs

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March 10, 2026

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Contents

How to Use this Document

The Department Overview contains a table summarizing the staff recommended incremental changes followed by brief explanations of each incremental change. A similar overview table is provided for each division, but the description of incremental changes is not repeated, since it is available under the Department Overview. More details about the incremental changes are provided in the sections following the Department Overview and the division summary tables.

Decision items, both department-requested items and staff-initiated items, are discussed either in the Decision Items Affecting Multiple Divisions or at the beginning of the most relevant division. Within a section, decision items are listed in the requested priority order, if applicable.

Department Overview

The Department pays health and long-term care expenses for low-income and vulnerable populations. Federal matching funds assist with most of these costs. In return for the federal funds, the Department must follow federal rules governing eligibility, benefits, and other features.

This document is primarily focused on behavioral health. The document includes figure setting recommendations for line items in the Behavioral Health Community Programs and Transfers to Other State Department Medicaid-funded Programs subdivisions. The document also includes recommendations for requests that are not in these subdivisions, and may not be directly related to behavioral health.

Behavioral health includes mental health and substance use treatment. The Behavioral Health Community Programs subdivision includes two line items for behavioral health capitation and fee-for-service payments. The Department negotiates rates with Regional Accountability Entities (RAEs) for the provision of behavioral health services in each region under behavioral health capitation. Fee-for-service payments support services that are not included in RAE capitation contracts.

Summary of Staff Recommendations

Health Care Policy and Financing

Item	Total Funds	General Funds	Cash Funds	Reapprop. Funds	Federal Funds	FTE
R2 Behavioral health	$232,326,516	$45,066,026	$24,526,594	$0	$162,733,896	0.0
R6.02 Behavioral health incentives	-7,974,052	-1,891,927	-2,095,099	0	-3,987,026	0.0
R6.06 SBIRT training grants	-1,000,000	0	-1,000,000	0	0	0.0
R6.09 Outpatient psychotherapy	0	0	0	0	0	0.0
R6.10 PBT reviews	0	0	0	0	0	0.0
R6.15 PBT rate	-13,057,068	-6,528,534	0	0	-6,528,534	0.0
R6.35/BA7p Movement therapy	0	0	0	0	0	0.0
R14.1 Chronic pain	0	0	0	0	0	0.0
R14.2 IV nutrition	307,660	101,814	12,227	0	193,620	0.0
R16 Unspent grant admin	0	0	0	0	0	0.0
BA11 CCBHC implementation	1,304,760	652,380	0	0	652,380	0.9
Total	$211,907,816	$37,399,759	$21,443,722	$0	$153,064,336	0.9
FY 2026-27 Executive Request	$157,888,417	$5,776,130	$20,932,740	$0	$131,179,547	4.7
Staff Rec. Above/-Below Request	$54,019,399	$31,623,629	$510,982	$0	$21,884,789	-3.8

The table only reflects decisions items addressed in this document. Other decision items are discussed in separate staff presentations.

R2 Behavioral health: Staff recommends approval of the Department's request for the February forecast.

- Current year: -$8.2 million total funds, including a decrease of $365,947 General Fund.
- Year 1 and ongoing: $232.3 million total funds, including $45.1 million General Fund.

R6.02 Behavioral health incentives: Staff recommends a 30.0 percent reduction for behavioral health incentive payments to RAEs.

Year 1 and ongoing: -$8.0 million total funds, including a reduction of $1.9 million General Fund.

The request is a reduction of $12.0 million total funds. Staff does not recommend the full reduction based on an assumption that the reduction is more severe than initially anticipated by the request.

R6.06 SBIRT training grants: Staff recommends a reduction of $1.0 million Marijuana Tax Cash Fund for SBIRT training grants. Staff does not recommend a General Fund refinance of Medical Services Premiums proposed by the request.

R6.09 Outpatient psychotherapy PAR [legislation]: Staff recommends denial of the Department's request for the Committee to sponsor legislation to implement PARs for outpatient psychotherapy. The Department anticipated a reduction of $31.3 million total funds, including $12.2 million General Fund, from the request.

R6.10 PBT reviews: Staff recommends denial of the request. Staff and the Department agree that the savings assumed by the request were already included during figure setting for FY 2025-26.

R6.15 PBT rate: Staff recommends approval of the Department's request to reduce PBT rates to 95.0 percent of a new benchmark.

- Year 1 and ongoing: $5.4 million total funds, including $2.7 million General Fund.

R6.35/BA7p Movement therapy: Staff recommends the Committee take no action on movement therapy rates. The January request (BA7p) withdrew the request for a rate reduction submitted in November (R6.35).

R14.1 Chronic pain: Staff recommends denial of the Department request to continue a term-limited chronic pain program.

R14.2 IV nutrition: Staff recommends increasing the rate for IV nutrition beginning in January 2027. The request asks to implement a rate increase beginning July 2026. Legislation is required to implement the request, but not the staff recommendation, because there is a statutory cap on the rate for 2026 only.

- Year 1: $307,660 total funds, including $101,814 General Fund.
- Year 2 and ongoing: $615,320 total funds, including $203,628 General Fund.

R16 Unspent grant admin [legislation]: Staff recommends the Committee include a transfer of $800,000 from the Behavioral and Mental Health Cash Fund to the General Fund in legislation for ARPA funding that has already been approved.

- One-time increase of $800,000 General Fund revenue.

The request asks the Committee to sponsor legislation to make Medical Services Premiums an allowable use of an ARPA cash fund to offset a General Fund reduction. The recommendation has the same net General Fund impact as the request, but does not expand the allowable use of the cash fund as proposed by the Department.

BA11 CCBHC implementation: Staff recommends an increase for additional staff and contract resources to implement a CCBHC demonstration grant. Staff does not recommend approval of federal funds savings assumed in the request prior to the grant award.

- Year 1: $1.3 million total funds, including an increase of $652,380 General Fund and 0.9 FTE.
- Year 2: $2.7 million total funds, including a decrease of $13.5 million General Fund.
- Year 5: $0

Major Differences from The Request

- The staff recommendation incorporates the February forecast.
- Staff recommends denial of requests for outpatient psychotherapy PARs, PBT reviews, and chronic pain.
- Staff recommends a larger decrease for SBIRT training grants than the request.
- Staff does not recommend General Fund refinances for Medical Services Premiums proposed by requests for SBIRT training grants and unspent APRA grant administration.
- Staff recommends delayed implementation of the request for increased IV nutrition rates.
- Staff does not recommend assuming federal funds savings from a CCBHC demonstration grant prior to the grant award.

Decision Items Affecting Other Divisions

→ R6.06 SBIRT Training grants

Request

The Department asks for a reduction for Screening, Brief Intervention and Referral to Treatment (SBIRT) training grants to use the Marijuana Tax Cash Fund to refinance a General Fund reduction to Medical Services Premiums.

- Year 1: -$500,000 General Fund and net-zero changes for the Marijuana Tax Cash Fund.

Recommendation

Staff recommends a $1.0 million reduction of Marijuana Tax Cash Fund for SBIRT training grants without the General Fund refinance proposed by the request.

Analysis

The Screening, Brief Intervention and Referral to Treatment (SBIRT) program is intended to prevent and treat substance use disorders through screening, treatment, and referrals. Providers must complete trainings to receive Medicaid reimbursement for SBIRT services. The Department has a $1.5 million appropriation from the Marijuana Tax Cash Fund (MTCF) to support a contract for SBIRT trainings.

The contractor provides training and technical assistance for healthcare providers and schools statewide. Trainings are expected to help providers identify, intervene, and refer patients for substance use treatment. The $1.5 million appropriation specifically supports provider trainings, and does not support direct services or receive a federal match.

The current appropriation is expected to support 150 trainings a year, or an average of about 3 trainings a week. The program provided 150 trainings to 1,082 providers in FY 2024-25. A total of 3,447 members received SBIRT screenings. Trainings may occur in person or online.

Federal resources for SBIRT training are available through SAMHSA and NIH. Resources similar to SBIRT are also available through several federal agencies, including the CDC. These federal trainings and additional resources are available on demand and free of cost to providers. The Department does not have data to know if federal resources are widely utilized. The Department indicates that federal trainings do not offer the in-person and technical assistance available through the state funded trainings.

The grants were originally created by H.B. 15-1367 (Retail Marijuana Taxes) with a $500,000 appropriation from the Marijuana Tax Cash Fund (MTCF). The appropriation was increased to $1.5 million on an ongoing basis by H.B. 18-1003 (Opioid Misuse Prevention). The appropriation was reduced to $500,000 in 2020, but funding was restored to $1.5 million by 2022 through Long Bill amendments and JBC action.

The Committee denied a staff recommendation to eliminate grants and support Medical Services Premiums for FY 2025-26 during figure setting. The Department has implemented a $500,000 reduction as part of the Governor's Executive Order and supplemental action. The SBIRT training contract was reduced in the current fiscal year prior to supplemental action as a result of the Executive Order.

Request

The request reduces the SBIRT training appropriation by $500,000 cash funds, and increases the appropriation for Medical Services Premiums (MSP) by the same amount. The MSP appropriation is then reduced by $500,000 General Fund for a net-zero change to the total appropriation for MSP, but a net reduction in General Fund appropriations.

R6.06 Request Impact by Line Item

Line Item	Total Funds	General Fund	MTCF
SBIRT training	-$500,000	$0	-$500,000
Medical Services Premiums	0	-500,000	500,000
Total	-$500,000	-$500,000	$0

The current MSP appropriation does not include cash funds from the Marijuana Tax Cash Fund (MTCF). SBIRT training is the only line item in the Department's budget that currently receives an MTCF appropriation.

Statute requires the Department to grant $1.5 million to one or more organizations to operate a screening, brief intervention, and referral to treatment practice on or after July 1, 2018.[1] The program must require evidence-based trainings statewide for healthcare professionals who serve women of childbearing age and adolescents. Trainings must include Medicaid billing instructions.

The Department indicates that the request requires legislation to reduce the appropriation because of the statutory requirement. However, JBC Staff and the Office of Legislative Legal Services agree that statute only requires that one grant be made after July 1, 2018, not annual ongoing grants. Therefore, the statutory requirement has been satisfied and legislation is not required to implement a reduction.

Supplemental Action

The Committee and General Assembly approved a $500,000 reduction for SBIRT training during the supplemental process. The reduction was used to offset a General Fund decrease for behavioral health capitation rather than MSP. The behavioral health refinance was based on the current allowable uses of MTCF.

The allowable uses of MTCF in statute are specific to education, prevention, treatment, study, and enforcement of substance use. Allowable uses include "To treat and provide related services to people with any type of substance use or mental health disorder, including those with co-occurring disorders."[2] Staff therefore finds that behavioral health capitation is an allowable use of the MTCF, but physical health services provided under MSP are not.

[1] Section 25.5-5-208, C.R.S.
[2] Section 39-28.8-501 (2)(b)(IV)(C), C.R.S.

Marijuana Tax Cash Fund Forecasts

Staff assumes that the Committee may need to consider MTCF reductions for balancing based on the Legislative Council Staff December forecast. It is staff's understanding that the OSPB December forecast is $6.4 million above the MTCF reserve requirement, while the LCS December forecast is $14.2 million below the reserve requirement.

Recommendation

Staff recommends a decrease of $1.0 million MTCF for SBIRT training grants for budget balancing. Staff finds that the state grants are Colorado specific resources beyond existing federal programs that may increase access to substance use treatment. However, staff assumes that reductions to MTCF programs are necessary based on the December LCS forecast and reductions to SBIRT may be less impactful than other reductions to direct services. The Committee may choose to reduce the appropriation by higher or lower amounts based on the March forecasts.

S6.06 Recommendation Impact by Line Item

Line item	Total Funds	General Fund	MTCF
Medical Services Premiums	$0	$0	$0
SBIRT training	-1,000,000	0	-1,000,000
Total	-$1,000,000	$0	-$1,000,000

Staff does not recommend that the Committee sponsor legislation to change the SBIRT training grant amount specified in statue. The statutory requirement has been met, and reductions have been made in the past without a statutory change. Legislation may be recommended, but not required, if the Committee chose to eliminate grants.

Evidence Designation

The Department indicates that a level of evidence is not applicable because the request does not meet the statutory definition of a program or practice. Staff agrees that an evidence designation is not applicable.

→ R6.09 Outpatient psychotherapy PAR [legislation]

Request

The Department asks for the Committee to sponsor legislation to eliminate the statutory prohibition on PARs for outpatient psychotherapy. The request assumes savings of $31.3 million total funds, including $12.2 million General Fund.

Recommendation

Staff recommends denial of the request. The Committee denied the current year impact of the request as part of the supplemental process.

Analysis

Senate Bill 22-156 (Medicaid Prior Authorization and Recovery of Payment) prohibited PARs for outpatient psychotherapy. PARs are a third-party assessment mandated to access services. The request is for legislation to reinstate the PAR for outpatient psychotherapy services after 24 sessions in a calendar year. PARs would not be required for initial access to services.

The fiscal note for S.B. 22-156 assumed no fiscal impact from the bill because almost all PARs requested were approved at the time. Providers and the department assumed that the change would simply decrease administrative burden without significantly impacting utilization.

However, a third-party actuarial analysis determined that the bill resulted in a 16.9 percent increase in outpatient psychotherapy utilization. The Department estimates that the change has increased expenditures by $31.3 million total funds annually. The analysis also demonstrated a significant increase in visits above 26 per year.

Change in Utilization Above 26 Sessions

Annual Sessions	FY 21-22	FY 23-24	% Change
26-35	4,237	6,836	61%
36-45	2,121	3,569	68%
46-55	764	1,221	60%
56+	447	886	98%

The analysis demonstrates a 98.0 percent increase in the number of members receiving outpatient psychotherapy by an average of more than once a week. The analysis also determined that increased psychotherapy did not decrease utilization of other services. Therefore, there is no assumed offsetting impact from decreased hospitalization or other, more expensive services. The Department indicates that a twenty-four session limit is based on clinical best practice and where data is showing alarming utilization increases.[3]

The PAR includes multiple individual, group, and family therapy billing codes. The PAR applies to the total sessions a member receives, even if services are received from different providers. Providers are therefore expected to collaborate to know what services the member is receiving elsewhere.

PARs require additional documentation, which is an administrative increase for the provider. The Department emphasizes that there is no limit to the number of medically necessary services a member can receive if PARs were implemented. Medical necessity is defined to mean a service:[4]

1. Will, or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability. This may include a course of treatment that includes observation or no treatment at all.

[3] HCPF Prior Authorization and Retrospective Reviews for Outpatient Psychotherapy Frequently Asked Questions.
[4] 10 CCR 2505-10 8.076.1.8

2. Is provided in accordance with generally accepted professional standards for health care in the United States.
3. Is clinically appropriate in terms of type, frequency, extent, site, and duration.
4. Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider.
5. Is delivered in the most appropriate setting required by the client's condition.
6. Is not experimental or investigational.
7. Is not more costly than other equally effective treatment options.

Federal and State law require that health insurance carriers cover services for mental and behavioral health in the same way physical health is covered. Parity includes what individuals pay out of pocket, limitations on use of services, use of management tools like pre-authorization, which doctors the patient can see, and what the insurance company uses to determine medical necessity. The Division of Insurance specifically notes that a limit on the number of visits or days of behavioral health treatment is a "red flag" for potential parity violations.[5]

The Department states that PARs and payment reviews do not inherently create a parity violation. PARs and payment reviews are not a cap on services if additional services are medically necessary. During the hearing, the Department indicated that PARs and payment reviews are also in place for outpatient physical therapies.

Outpatient psychotherapy clinical guidelines from the American Psychoanalytic Association include, but are not limited to:[6]

- Clinical expertise and research identify significant populations of psychiatric patients who need ongoing availability of open-ended psychotherapy.
- Insurance companies block access to psychotherapy of adequate duration and frequency for the large group of more chronic patients who need more than brief therapy to ameliorate ongoing vulnerability and decrease disability, morbidity, mortality, relapse, and expenses in other medical care.
- Patients with a single diagnosis are highly atypical of real-world clinical populations.
- Large patient groups with recurrent and chronic illness improve substantially with ongoing access to psychotherapy.
- Clinical necessity guidelines should support access to psychotherapy as prescribed by the clinician without arbitrary limitations in duration or frequency.

Statutory Authority

In October, the Department distributed a memo permitting RAEs to reinstate PARs January 1, 2026. The instruction followed the Executive Order to reduce expenditures. The change permitted PARs even though the prohibition remained in statute.[7] The Department indicates that the change is authorized by S.B. 25B-001 (Processes to Reduce Spending During Shortfall), which clarified the process for a Governor to suspend or discontinue discretionary spending by executive order when there are not sufficient revenues available.

JBC Staff and the Office of Legislative Legal Services agree that limiting expenditures allows the Executive Branch to *stop* performing functions that are *permitted* in statute, but does not grant the Executive Branch authority to

[5] Division of Insurance Mental/Behavioral Health Parity.
[6] American Psychoanalytic Association (2017). The Coalition for Psychotherapy Parity Executive Summary.
[7] Section 25.5-5-406.1 (1)(j)(II), C.R.S.

start performing activities that are *prohibited* in statute. The Office of State Planning and Budgeting indicated that the Executive Branch does not agree with this interpretation during the supplemental comeback process.

Recommendation

Staff recommends denial of the request because staff does not agree that reinstating PARs is in the best interest of patients, providers, or RAEs. Staff agrees that outpatient psychotherapy PARs are less impactful that other high expenditure reduction options for behavioral health. However, Staff is concerned that implementing PARs reduces access to medically necessary services simply due to additional administrative burden.

Technical difference

Staff is concerned that the request places the reduction in the incorrect line item. Request documents from the Department place the reduction in Medical Services Premiums. Hearing documents from the Department for the last two years indicate that the prohibition on outpatient psychotherapy PARs is a major factor driving increased costs for behavioral health capitation. RAEs also indicate that outpatient psychotherapy is part of behavioral health capitation contracts. Staff therefore assumes that the reduction should be in behavioral health capitation if approved by the Committee.

Evidence Designation

The request includes limited information regarding evidence designations given the number of components included in R6. The request states that an uncited white paper from the American Academy of Nursing on Policy, "highlighted the importance of care coordination as foundational to the health care reform goals of improving the quality of care for individuals and populations via the efficient and effective use of resources." It is unclear to staff how the quote is relevant to the evidence designation for the request.

Staff finds that the request is Harmful based on research that indicates PARs reduce utilization of outpatient psychotherapy that would otherwise be medically appropriate.

Liu X, Sturm R, Cuffel BJ. The Impact of Prior Authorization on Outpatient Utilization in Managed Behavioral Health Plans. Medical Care Research and Review. 2000;57(2):182-195. doi:10.1177/107755870005700203.

- **Article summary:** A comparison of behavioral health managed care plans that required PARs after 5 and 10 visits found that patients with PARs required after 5 visits were nearly 3 times more likely to terminate treatment after 5 visits.
- **Staff finding:** The article was published in 2000, but finds statistically significant evidence that the administrative burden of PARs artificially limits access to outpatient psychotherapy in managed care systems.

Lazar, Susan G. MD; Bendat, Meiram JD, PhD; Gabbard, Glen MD; Levy, Kenneth PhD; McWilliams, Nancy PhD; Plakun, Eric M. MD; Shedler, Jonathan PhD; Yeomans, Frank MD, PhD. Clinical Necessity Guidelines for Psychotherapy, Insurance Medical Necessity and Utilization Review Protocols, and Mental Health Parity. Journal of Psychiatric Practice 24(3):p 179-193, May 2018. | DOI: 10.1097/PRA.0000000000000309

- **Article summary:** Review of psychotherapy utilization guidelines by the founding members of the Coalition for Psychotherapy Parity. Argues that the clinical trials used by insurance companies to justify brief treatment are highly selected, atypical populations and do not represent the typical population of patients

with chronic, recurring symptoms who require ongoing treatment. The standard for physical health is continuation of effective treatment until meaningful recovery, which is therefore the standard for mental health services required by the Mental Health Parity and Addiction Equity Act.

- **Staff finding:** The article is from a biased source, but indicates that restrictions on outpatient psychotherapy are motivated by cost controls rather than clinical best practice and parity laws.

Wickizer, Thomas M. PhD, MPH[*]; Lessler, Daniel MD, MHA[†]. Do Treatment Restrictions Imposed by Utilization Management Increase the Likelihood of Readmission for Psychiatric Patients?. Medical Care 36(6):p 844-850, June 1998.

- **Article summary:** Logistic regression of privately insured inpatient psychiatric patients. The study found that patients whose length of stay was restricted by utilization management were more likely to be readmitted within 60 days.
- **Staff finding:** The article was published in 1998 and is specific to inpatient admissions. However, the study indicates that patients who loose access to care due to utilization management restrictions are more likely to re-enter care later.

→ R6.10 PBT reviews

Request

The request assumes savings of $20.0 million total funds, including $10.0 million General Fund, based on federal audit findings of Pediatric Behavioral Therapies.

Recommendation

Staff recommends denial of the request because savings were already assumed during figure setting for FY 2025-26.

Analysis

The budget request is based on assumed savings for pre- and post-payment reviews for Pediatric Behavioral Therapy (PBT). PBT is the Medicaid payment for therapies like Applied Behavioral Analysis (ABA) for Autism Spectrum Disorder (ASD). PBT is paid fee-for-service by the Department, and does not involve the RAEs. The Department has also submitted requests for pre-payment reviews of PBT (BA7a), post-payment RAC audits of PBT (BA7c), and assumed pre- and post-payment review savings during figure setting for FY 2025-26.

Total Medicaid spending for PBT was $287 million in FY 2024-25. Expenditures for PBT have increased 436 percent from FY 2018-19 to FY 2024-25. Spending on PBT makes up approximately 2.0 percent of total Medicaid spending. The growth in expenditures has significantly outpaced the growth in utilization, leading to reviews by the Office of the Inspector General and Manatt.

Office of the Inspector General Audit

The savings assumed by this request were based on a federal audit of PBT from the Office of the Inspector General (OIG) that was ongoing when the request was submitted and when the Committee considered the supplemental requests. Audit findings were published on March 2.[8] The audit found that HCPF made at least $77.8 million in improper PBT payments in 2022 and 2023.

The audit makes five recommendations for HCPF, including:

1. Refund $42.6 million to the federal government for payments that did not comply with federal and state requirements.
2. Provide additional guidance to ABA facilities on documentation, billing, and credentialing requirements.
3. Periodically perform statewide post-payment reviews.
4. Periodically review prior authorization procedures for verifying facility compliance with requirements for state diagnostic evaluations.
5. Exercise reasonable diligence to review and determine whether any of the estimated $112.5 million in potentially improper payments complied with federal and state requirements and refund the federal share of any identified improper payments.

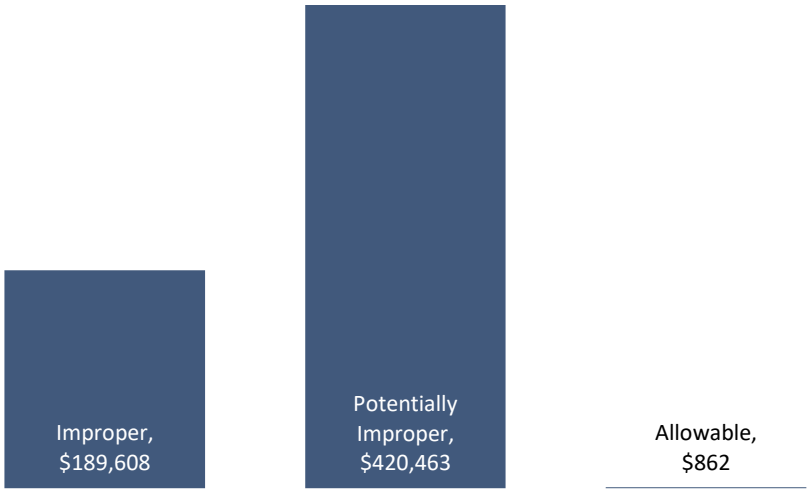
The Department agreed to the second through fourth recommendations, but does not agree with the methodology used to determine the amount of improper payments. The report indicates that the audit was completed in accordance with generally accepted government auditing standards.

The audit reviewed services from January 2022 through December 2023. A random sample of payments totaling $610,933 were evaluated. The sample consisted of 47 facilities and 96 enrollees. The audit reviewed prior authorizations, diagnostic evaluations, individual treatment plans, and session notes.

The audit found that $189,608 of the payments in the sample were improper, $420,463 were potentially improper, and only $862 was allowable. All sampled enrollee-months included payments for 1 or more claim lines that were improper or potentially improper. The audit extrapolates those amounts to assume that a total of $77.8 million in expenditures were improper, and $112.5 million were potentially improper.

[8] OIG Colorado PBT audit.

Only $862 in payments from a $610,933 sample were found to be allowable.



Payments are found to be improper when state or federal guidelines are clearly violated. Examples of improper payments include a lack of required documentation, services by staff who did not meet appropriate credentials, or treatment without evaluations or referrals.

Payments are potentially improper when documentation or guidelines were unclear. Examples included documentation that did not adequately describe the ABA techniques used, notes did not meet signature requirements, billing for individual therapies when documentation reflected group activities, and notes referring to non-ABA activities like day care, custodial care, meals, breaks, and naps.

The audit includes the following statement:

> "The State agency made improper and potentially improper payments because it did not provide effective oversight of fee-for-service Medicaid ABA payments."

The report specifically states that HCPF had not performed a statewide post-payment review, did not provide sufficient guidance to providers, and did not review its prior authorization contractor's procedures for verifying compliance with state and federal requirements.

Documentation

Medicaid records are required to fully disclose the extent of services provided for payment. Records must be complete, accurate, and fully disclose the basis for the type, frequency, extent, duration, and delivery of services. The audit could not determine if many documentation errors were improper because HCPF does not have clear documentation standards.

The audit found that 96 samples from 44 facilities did not fully describe the services provided. Most session notes were found to be insufficient because basic information about the location, type, and duration of treatment used was omitted. Some notes only indicated the start and end time of sessions.

Many samples included session notes with text that appeared to be from a template or copied from another session. Some notes showed the wrong child's name, wrong therapist name, or incorrect dates and times. Specific examples included:

- HCPF paid for services when the session notes did not match the billed code for 72 samples from 38 facilities.
- HCPF paid for time that was not supported by session notes for 63 samples from 30 facilities. This was both because the notes indicated less time than was billed or the billed time included non-billable services.
- HCPF paid for services that did not have notes with required signatures for 22 samples from 17 facilities.
- HCPF paid for services on one or more dates of service that the facilities were unable to provide documentation for 26 samples from 17 facilities.

Prior Authorizations

The audit states that HCPF never reviewed prior authorization procedures. The audit found that the prior authorization contractor approved requests even though required documentation, such as a diagnostic evaluation or treatment referral, was not provided. Some facilities were not aware that they were submitting incorrect documentation because their prior authorization requests were being approved.

Credentials

ABA providers are not licensed by the state, but may seek national certification. Some billing codes require that services are provided or supervised by a graduate level or certified paraprofessional. The audit found that HCPF paid claims for services billed by noncredentialled technicians that should have been provided by credentialled staff.

The audit states that HCPF told the OIG that credentials were required to provide ABA to Medicaid enrollees, but that requirement was not documented. Of the sample, 30 facilities permitted billing from uncredentialled staff. The audit did not consider these payments to be improper because state requirements were not clear. However, the audit identifies that this practice does not align with private health insurance and may have affected the quality of care that children received.

HCPF issued accreditation guidance in December. Providers have requested a grace period and expect that the guidance will create a national backlog.

Manatt

The Colorado Medicaid Landscape Analysis presented to the Committee by Manatt in January also included several PBT findings, listed below.

1. PBT spending increased 650 percent from FY 2017-18 to FY 2024-25, compared to a 164 percent increase in enrollment.
2. PBT utilization is not evenly distributed across providers, raising concerns about consistency in medical necessity.
3. PBT spending is driven by increased rates and the average number of hours utilized per week.

Manatt recommended standardized assessments for PBT to support clinically-informed individual treatment planning and appropriate levels of service. According to the presentation, there are currently a variety of assessments used. Medical necessity determinations could be more consistent with a standardized assessment. However, presentation indicates that clinical best practices have not coalesced around a single standardized assessment for PBT.

Staff Concerns

Staff is concerned that the audit identified a lack of oversight at HCPF for PBT. Many of the findings indicate that HCPF has provided insufficient guidance to providers. Poor documentation may be the result of facilities not assuring appropriate utilization and training. However, some providers may be acting in good faith without knowing that documentation has been insufficient because HCPF has not conducted reviews and clarified guidance accordingly.

Staff is also concerned that HCPF has not reviewed the work of a prior authorization contractor according to the audit. It is also concerning that the Department has not previously identified the risk of a lack of reviews given the sharp increase in expenditures in recent years. Staff is concerned about the Department's capacity and ability to identify risk and growth trends in fee-for-service programs, and the impact a lack of review has on vulnerable children.

Staff expects that the Department will continue to negotiate refunds to the federal government for many years. The Department is expected to recoup payments from providers. Half would be recouped to the state, and half to the federal government. Some General Fund savings should be realized if the Department is able to recoup improper payments from providers. However, staff also anticipates that there will be increased costs to fully review payments and negotiate with the OIG.

Staff is also concerned that the Department may be required to recoup payments from providers that did not know that they were not meeting requirements because guidance has been lacking. It is also anticipated that many providers have been sold or closed, making recoupment more challenging or impossible. Finally, the audit only considered payments from 2022 to 2023. PBT payments increased significantly in 2024 and 2025.

Staff agrees that General Fund savings may be realized in FY 2026-27. However, the savings provided in this request were already included in figure setting for FY 2025-26. The Department indicates that they're most recent costs and savings estimates are provided in BA7a and BA7c, which are discussed in a separate staff presentation. Therefore, staff recommends denial of the request.

→ R6.15 PBT rate

Request

The Department has reduced the rate for pediatric behavioral therapy to 95.0 percent of a new benchmark.

- Year 1 and ongoing: $5.4 million total funds, including $2.7 million General Fund.

Recommendation

Staff recommends approval of the request. The Committee and General Assembly approved the current year impact of the request as part of the supplemental process.

Analysis

The Department reduced rates for Pediatric Behavioral Therapies (PBT) October 1, 2025. PBT covers services that treat maladaptive behaviors, including Applied Behavior Analysis (ABA). All PBT services must be pre-approved through prior authorization. Services may occur in a school, office, home, community-based, or telehealth setting.[9]

In 2023, Colorado PBT rates were assessed as 78.7 percent of benchmark states. The Department request for FY 2024-25 reflected an increase to 100.0 percent of the benchmark *excluding* Nebraska. Nebraska was excluded because it was identified as an "extreme outlier" with rates 41-508 percent above other states. The request cost $13.0 million total funds, including $6.5 million General Fund.[10] The Committee and General Assembly approved a rate increase to 100.0 percent *including* Nebraska, for a General Fund increase of $17.1 million beginning in FY 2024-25.

Nebraska reduced rates in the summer of 2025 after Medicaid payments for ABA services increased nearly 2,000 percent in four years.[11] The new HCPF rate therefore reflects 95.0 of the new benchmark, including Nebraska's reduced rates. PBT rates are not subject to the requested 1.6 percent across the board rate decrease in addition to this request. Rate reductions vary by service type. PBT providers indicate that the change reflects a 5-6 percent reduction on average.

PBT Rate Reductions by Service

Rate	Current rate	Reduced rate	% Change	Total Impact
Assessment	$27.59	$27.12	-1.7%	-$70,800
Adaptive behavior (tech)	$18.17	$17.22	-5.2%	-$11,363,149
Group adaptive behavior (tech)	$11.51	$8.81	-23.5%	-$56,061
Adaptive behavior (phys)	$26.62	$25.84	-2.9%	-$1,537,437
Group adaptive behavior (phys)	$17.83	$9.34	-47.6%	-$29,622
Total				-$13,057,069

The Committee questioned the overall impact of PBT and ABA requests during the briefing. The Department's hearing response states that state agencies have been working together to identify and respond to reports of problematic providers and activities. The response indicates that it is important to address issues from multiple perspectives, including payments, reviews, and licensing. Staff agrees that PBT expeniture trends are concerning. However, Staff is concerned about the overall impact to providers and patients of the requested reductions, and a lack of accounting for compounding impacts in request calculations.

Evidence Designation

The Department indicates that a level of evidence is not applicable because the request does not meet the statutory definition of a program or practice. Staff agrees that an evidence designation is not applicable.

[9] HCPF PBT Billing Manual.
[10] HCPF JBC 2023 MPRRAC Report Presentation.
[11] Nebraska DHHS Explains Medicaid Rate Adjustment (July, 2025).

→ R6.35/BA7p Movement therapy

Request

The November request included a rate reduction for movement therapy. The January request withdrew the reduction following stakeholder feedback about the education requirements for movement therapists.

Recommendation

Staff recommends that the Committee take no action, which will have the same effect as approving both requests.

Analysis

The Department submitted a request in November to reduce rates for movement therapy. The request reflected a reduction of $59,709 General Fund in the current fiscal year, and $358,234 General Fund on an ongoing basis.

Staff received outreach from impacted providers following the November budget submission. Providers indicated that the Department was not accurately describing the services offered, the educational requirements of providers, or the impact the rate reduction would have.

The Department withdrew the request as part of the January supplemental submission after receiving materials from stakeholders. The narrative submitted by the Department states:

> "… the Department recognizes that the methodology originally used to support a potential rate reduction does not adequately reflect the level of professional preparation or the clinical value inherent in Movement Therapy services."

Staff agrees that the potential General Fund savings are not sufficient to justify a potential loss in providers from the rate decrease. Staff recommends the Committee take no action on the requests, which has the same effect as approving both requests.

→ R14.1 Chronic pain

Request

The Department asks to continue a term-limited program that conducts chronic pain training for providers.

- Year 1 and ongoing: $290,738 total funds, including $94,867 General Fund and 1.0 FTE.

Recommendation

Staff recommends denial of the request.

Analysis

The Chronic Pain Centers of Excellence was initiated by the Department in FY 2021-22 using federal stimulus funds from the American Rescue Plan Act of 2021 (ARPA). The program was continued for two years using General Fund from a FY 2024-25 budget request. The request was intended to allow additional data collection to determine if the program was effective. This request continues the program on an ongoing basis.

The program was intended to address gaps in pain management care for Medicaid clients with chronic pain. The Center offers accredited education for providers, patient consults, and care coordination. The Department indicates that the program has offered live and on-demand educational sessions for over 100 Medicaid providers and connected dozens of patients to resources.

Educational opportunities are provided through a contract with the University of Colorado School of Pharmacy. There is also one administrative FTE in the Department to provide care coordination. The position within the Department connects Medicaid patients with eligible treatment resources, sets up peer-to-peer consults between primary care providers, and recruits providers for educational opportunities.

The Department indicates that the program was initially intended to create a network of pain specialists to refer members to. However, the Department was not successful in recruiting pain specialists into the program. Therefore, the program was adapted to training and supporting existing Medicaid primary care providers.

Program Effectiveness

The Department has conducted provider surveys to determine if the program is effective. However, the request indicates that it is difficult to gather conclusive data on program effectiveness due to the nature of the program. Intervention may occur at different times for each member, and it is difficult to measure the prescribing habits of hundreds of individual providers, or whether providers are accepting new chronic pain patients as a result of the training.

Survey results found that 76.0 percent of providers surveyed were comfortable incorporating skills learned into their everyday work, and 96.0 percent found the information useful. The Department expects that continuing the program will allow meaningful data collection in the next two years if the request is approved, which was the same justification used for the FY 2024-25 request.

The Department hopes to evaluate claims one year prior to intervention and one-year after intervention if the request is approved. This analysis hasn't been possible in the four years the program has operated because medical claims may be submitted 12 months after the date of service. Program uptake was slow at the beginning, and the Department is only now seeing a sufficient amount of members with 2 years of claims data to provide meaningful analysis in future years.

Evidence Designation

The Department indicates that this is a Proven request. The narrative cites a randomized control trial to support this claim.

Dobscha SK, Corson K, Perrin NA, et al. Collaborative Care for Chronic Pain in Primary Care: A Cluster Randomized Trial. JAMA. 2009;301(12):1242–1252. doi:10.1001/jama.2009.377

- **Article summary:** RCT of 42 clinicians and 401 patients with chronic pain. Half of clinicians received a two chronic pain education sessions, patient assessment, symptom monitoring, feedback and recommendations, and facilitation of specialty care. The study measured changes in pain-related disability, pain intensity, and depression over 12 months and found modest but statistically significant improvement for patients treated by clinicians with interventions.
- **Staff finding:** Staff agrees that the study shows modest statistically significant improvement for the measured chronic pain interventions.

Staff is unsure if the request meets the statutory definition for a program or practice. The definition requires defined and replicable elements, and the request indicates that evaluation is difficult because intervention occurs at different times. Staff agrees that the cited RCT trial shows favorable outcomes, but staff is unsure how the chronic pain activities measured in the study compare to the program implemented by the Department.

Staff finds that an evidence designation is not applicable assuming that the Department's implementation of the program does not have defined, replicable elements.

Recommendation

Staff recommends denial of the request for budget balancing because the Department has not been able to demonstrate effectiveness. The program was initiated by the Department on a term-limited basis using APRA funds. The program would become an ongoing General Fund obligation if the request was approved. If the Committee chooses to approve the request, staff recommends that the Committee approve the amounts on a term-limited basis of two years for the Department to report on effectiveness before establishing an ongoing program.

Impact if not approved

The Department indicates that if the request is not approved, members suffering from chronic pain would be more likely to receive inadequate care and providers would have no state-supported resources available. Federal chronic pain resources are available through the CDC and FDA. These programs would not provide the same outreach and care coordination activities as the state program, but do make resources available for providers.

→ R14.2 IV nutrition

Request

The Department asks to increase the pharmacy rate for intravenous (IV) nutrition.

- Year 1 and ongoing: $615,320 total funds, including $203,628 General Fund.

Recommendation

Staff recommends implementation of the requested rate increase beginning in January 2027, rather than July 2026 as requested.

- Year 1: $307,660 total funds, including $101,814 General Fund.
- Year 2 and ongoing: $615,320 total funds, including $203,628 General Fund.

If the Committee approves the request, staff recommends legislation to eliminate the current statutory cap on the reimbursement rate in 2026.

Analysis

Total Parenteral Nutritional (TPN) is nutrition that is received through an IV for people who are unable to consume food. The Department indicates that there is currently only one pharmacy in the state that provides TPN to Medicaid members due to the low reimbursement rate. This places strain on the pharmacy, inadequate geographic coverage, and severe risk of access disruption. Reporting indicates that the number of participating pharmacies has gradually dropped from six to one over the last several years.[12]

The Department currently assumes that the actual cost of administering TPN is $238.86 per claim. The cost is based on a third-party analysis contracted by the Department. The analysis collected data from 87 specialized pharmacies on the average cost of custom preprepared intravenous products.

Reimbursement rates are tiered, but averaged $11.91 per claim in 2025. Senate Bill 25-084 (Medicaid Access to Parenteral Nutrition) required the Department to establish rates to encourage pharmacy participation in IV nutrition by January 2026. The bill included an ongoing appropriation of $219,326 total funds to cap reimbursement at 30.0 percent of cost, or $70.76 per claim. The fiscal note indicates that the cap was expected to be in place until participation could be assessed and future legislation or budget action adjusts the rate.

When the bill was introduced, S.B. 25-084 required the Department to implement a reimbursement rate sufficient to encourage an adequate level of market participation. The fiscal note assumed the bill would implement a $238.86 reimbursement rate. However, an amendment to cap the dispensing fee to thirty percent of cost in 2026 was adopted in Senate Appropriations.

Staff assumes that the appropriation was reduced for General Fund balancing. Staff is therefore unsure if TPN is a General Fund priority for FY 2026-27. The request states concern that CMS would reject the $70.76 rate provided by S.B. 25-084 because the rate was known to cause access and adequacy issues. However, the rate was approved by CMS in October and implemented by the Department in January.

The Department assumes that implementing a rate increase will not increase utilization because TPN services are needed to survive. Therefore, all Medicaid members that need TPN are expected to already be utilizing the service. The request is expected to increase the number of pharmacies providing the service. The Department is concerned that a single pharmacy leads to a high risk if staffing shortages, natural disaster, or any logistical delay temporarily interrupts service for the entire state.

[12] Colorado Sun (2025). Colorado legislature steps in to help kids who need IV nutrition and are down to one pharmacy.

Legislation

The request does not indicate that legislation is required. However, the reimbursement rate is capped in statute at 30.0 percent of cost for 2026. Staff therefore assumes that approval of the request would require legislation, but increasing the rate in 2027 or any later year would not.

Senate Bill 25-084 also required an annual report from the Department to the Committee and during SMART Act hearings to provide the number of pharmacies that provide the service throughout the state beginning in 2026. Staff assumes that this report will be informative for a few years, but may not be necessary on an ongoing basis. If the Committee chooses to sponsor legislation related to the request, staff would recommend repealing this requirement after a few years.

Recommendation

Staff recommends that the Committee approve the rate increase proposed by the request beginning January 2027. Staff agrees that there is a high risk for only providing vital services through a single pharmacy. However, staff recommends implementing the increase for half of the fiscal year for budget balancing. Implementing the increase beginning in 2027 will reduce the cost of the request, and not require the Committee to sponsor an additional bill.

If the Committee approves the request, staff recommends legislation to remove the 30.0 percent statutory cap and add a repeal date for reporting requirements. The Long Bill would continue to reflect the 30.0 percent cap in current law, and additional appropriations would be included in the separate legislation.

Evidence Designation

The Department indicates that a level of evidence is not applicable because the request does not meet the statutory definition of a program or practice. Staff agrees that an evidence designation is not applicable.

→ R16 Unspent grant admin [legislation]

Request

The Department asks the Committee to sponsor legislation to make Medical Services Premiums an allowable use of the Behavioral and Mental Health ARPA cash fund. The request is a one-time General Fund refinance with ARPA cash funds.

- Year 1: $0, including a reduction of $800,000 General Fund and an increase of $800,000 cash funds.

Recommendation

Staff recommends that the Committee include a reduction of $800,000 from the Behavioral and Mental Health cash fund in legislation to recapture ARPA funds that has already been approved by the Committee.

Analysis

The Department has identified an under-expenditure of appropriations that originated as federal stimulus funds from the American Rescue Plan Act of 2021 (ARPA). House Bill 22-1302 (Health-care Practice Transformation) appropriated $33.8 million from the cash fund to the Department for provider grants to integrate behavioral and health into primary care visits.

The Department expects $800,000 of $3.0 million appropriated for grant administration to revert. Under current law, any funds that are unspent by December 31, 2026 will revert to the General Fund.[13] The request asks the Committee to sponsor legislation to allow the Department to use the unspent funds for Medical Services Premiums instead of allowing funds to revert.

Staff finds that the request is unnecessary because funds will revert to the General Fund in the budget year if the Committee takes no action. However, staff recommends recapturing this amount if the Committee takes action to extend the spending authority of the ARPA cash funds. The Committee may choose to transfer funds to the General Fund in FY 2025-26 or FY 2026-27 depending on the March General Fund forecasts.

Evidence Designation

The Department indicates that a level of evidence is not applicable because the request does not meet the statutory definition of a program or practice. Staff agrees that an evidence designation is not applicable.

[13] Section 24-75-230 (4.8) and Section 24-75-226.5 (7), C.R.S.

(3) Behavioral Health Community Programs

This section provides funding for Medicaid clients' behavioral health care. Most mental health and substance use disorder services are provided to Medicaid-eligible clients through a statewide managed care or "capitated" program. The Department contracts with Regional Accountable Entities (RAEs) to provide or arrange for medically necessary behavioral health services to Medicaid-eligible clients. Each RAE receives a pre-determined monthly amount for each client who is eligible for Medicaid behavioral health services and enrolled with that RAE.

In addition to funding for capitation payments to RAEs, a separate appropriation covers fee-for-service payments for certain behavioral health services that are not covered by the capitation program. Behavioral health services are primarily supported by General Fund and federal funds. Cash fund sources include the Hospital Provider Fee Cash Fund and the Breast and Cervical Cancer Prevention and Treatment Fund.

Behavioral Health Community Programs

Item	Total Funds	General Fund	Cash Funds	Federal Funds	FTE
FY 2025-26 Appropriation					
FY 2025-26 Appropriation	$1,586,714,004	$369,123,420	$128,283,634	$1,089,306,950	0.0
Total FY 2025-26	$1,586,714,004	$369,123,420	$128,283,634	$1,089,306,950	0.0
FY 2026-27 Recommended Appropriation					
FY 2025-26 Appropriation	$1,586,714,004	$369,123,420	$128,283,634	$1,089,306,950	0.0
Medical forecast	232,326,516	45,066,026	24,526,594	162,733,896	0.0
Prior year actions	11,459,606	4,727,807	999,238	5,732,561	0.0
Provider rates	-7,974,052	-1,891,927	-2,095,099	-3,987,026	0.0
Administration	0	0	0	0	0.0
Continuation of supplemental actions	-58,801	-14,129	-3,488	-41,184	0.0
Total FY 2026-27	$1,822,467,273	$417,011,197	$151,710,879	$1,253,745,197	0.0
Changes from FY 2025-26	$235,753,269	$47,887,777	$23,427,245	$164,438,247	0.0
Percentage Change	14.9%	13.0%	18.3%	15.1%	0.0%
FY 2026-27 Executive Request	$1,796,716,973	$412,081,281	$149,419,977	$1,235,215,715	0.0
Staff Rec. Above/-Below Request	$25,750,300	$4,929,916	$2,290,902	$18,529,482	0.0

→ R2 Behavioral Health

Request

The Department requests an increase for the Behavioral Health forecast.

- Current year: Decrease of $8.2 million total funds, including a decrease of $365,947 General Fund.
- Year 1 and ongoing: $232.3 million total funds, including $45.1 million General Fund.

Recommendation

Staff recommends approval of the February forecast.

Analysis

The request is the Department's most recent estimate of expenditures for behavioral health under current law and policy. The forecast is based on expenditure data through December 2025. The February forecast includes a reduction of $21.4 million General Fund for caseload, but an increase of $16.5 million General Fund for per capita rates.

The forecast is primarily driven by a $20.0 million rate renegotiation with the region 3 RAE, which serves Boulder, Broomfield, Jefferson, Gilpin, Clear Creek, Park, Teller, and El Paso counties. The renegotiation is the result of utilization changes that brought the agreed upon rate below the actuarially sound range.

Federal law triggers rate renegotiations if the actual rate varies by more than 1.5 percent from agreed upon rates.[14] During the supplemental, it was identified that the Region 3 RAE had the lowest administrative and average per-member-per-month rates.

During the briefing, the Committee asked the Department for detailed information about how rates are set. Rates are set with contracted actuaries using historical data for claims, enrollment, utilization trends, and policy changes. Actuaries align rate-setting to yearly guidelines published by CMS. Actuaries create a lower and upper bound for trend factors and administrative costs. A rate within the range is negotiated with each RAE and certified by the actuaries.

Administrative costs are reviewed by contracted auditors. Administrative costs are weighed against anticipated needs and efficiencies to produce an adjustment as part of the rate-setting process. A 1.0 percent risk margin is added for population-based administrative costs.

The Department also reviews the RAE's Medical Loss Ratio (MLR). The MLR measures how much of the revenue paid to the RAEs was spent on medical services rather than administrative costs. Contracts and federal regulations require recoupment for an MLR below 85.0 percent.

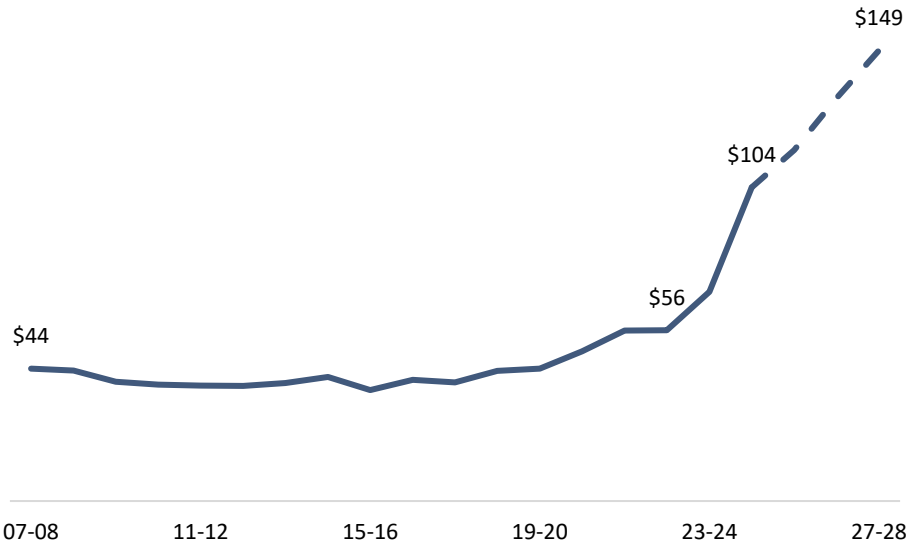
Each RAE may contract with providers to pay different rates for the same service. Variable rates are intended to be sensitive to regional need for the service, as well as cost of living. A RAE may offer a higher rate for a service that is not available in their region compared to a RAE where the service is readily available.

Expenses for behavioral health have increased significantly in recent years as patient acuity, benefits, and provider payments have increased. Data provided by the Department includes:

- The number of unique providers increased 95.2 percent from FY 2018-19 to FY 2023-24.
- The number of unique members accessing behavioral health increased 41.0 percent from 2019 to 2024.
- The percent of Medicaid members accessing behavioral health in FY 2023-24 was 25.0 percent higher than the previous four fiscal years.

[14] 42 CFR 438.7

The chart below provides the average per-member-per-month expenditures and forecasts since FY 2007-08. The per-member-per-month expenditure increased 83.5 percent from FY 2022-23 to FY 2024-25.



→ R6.02 Behavioral health incentives

Request

The Department asks for a reduction in behavioral health incentive payments to RAEs.

- Year 1 and ongoing: $12.6 million total funds, including $3.0 million General Fund.

Recommendation

Staff recommends an estimated 30.0 percent reduction for incentive payments.

- Year 1 and ongoing: $8.0 million total funds, including $1.9 million General Fund.

Analysis

The Committee approved a reduction of $1.5 million General Fund in the current year as part of the supplemental process. The amount was based on an assumption that reductions are necessary for budget balancing, but that the proposed reduction was more severe than initially anticipated by the Department.

RAEs are eligible to earn incentive payments based on performance metrics. Payments can be up to an additional 5.0 percent of the behavioral health capitation rate. Payment is based on annual performance and is not finalized until six to nine months following the end of the fiscal year. Examples of performance measures include:

- Engagement in outpatient substance use treatment
- Follow up within 7 days after discharge of hospitalization for mental illness or self-harm

- Follow up within 7 days after discharge from emergency room for substance use
- Follow up within 30 days after positive depression screen
- Percent of foster children who received a behavioral health screening within 30 days

The request states that the requested reduction reflects a 31.0 percent reduction to estimated incentive payments. However, hearing documents indicate that the FY 2025-26 behavioral health incentive payments are $26.6 million. The request therefore reflects a reduction of 54.9 percent.

Payments are distributed annually with 66-90.0 percent of awards passed through to providers. RAEs often indicate that costs are not covered without incentive payments. Staff therefore assumes that the impact of the reduction could be passed on to providers, decrease provider and RAE performance, or simply result in RAEs negotiating higher rates.

Staff agrees that reducing incentive payments may be preferable to reducing direct services. However, staff is concerned about the long-term performance and cost implications of the reduction. Staff also assumes that the requested reduction is more severe than the Department originally intended.

Staff recommends a reduction of $1.9 million General Fund. The reduction reflects an estimated 30.0 percent reduction from the FY 2025-26 budgeted amounts prior to the implemented reduction, which aligns with the intent of the Department request. Staff does not recommend approval of the request assuming that the requested amounts are a more significant reduction than initially assumed by the Department.

Request and Recommendation Amounts

Item	Total Funds	General Fund	Cash Funds	Federal Funds
FY 25-26 Base Incentives	$26,580,173	$6,306,424	$6,983,662	$13,290,087
Request	-12,644,332	-3,000,000	-3,322,166	-6,322,166
Recommendation	-7,974,052	-1,891,927	-2,095,099	-3,987,026

Evidence Designation

The Department indicates that a level of evidence is not applicable because the request does not meet the statutory definition of a program or practice. Staff agrees that an evidence designation is not applicable.

→ BA11 CCBHC implementation

Request

The Department requests funding adjustments to implement CCBHC demonstration.

- Year 1: $2.2 million total funds, including a decrease of $6.5 million General Fund more than offset by an increase of $8.9 million federal funds and 4.0 FTE.
- Year 5: $138,262 total funds, including $69,131 General Fund and 1.0 FTE.

Recommendation

Staff recommends approval of portions of the request without assuming General Fund savings prior to the award of the demonstration grant.

- Year 1: $1.3 million total funds, including an increase of $652,380 General Fund and 0.9 FTE.
- Year 2: $2.7 million total funds, including a decrease of $13.5 million General Fund.
- Year 5: $0

Analysis

The Certified Community Behavioral Health Clinic (CCBHC) model was established by the Protecting Access to Medicare Act (PAMA) in 2014.[15] The model is jointly implemented by the Substance Abuse and Mental Health Services Administration (SAMHSA), Centers for Medicare and Medicaid Services (CMS), and the Office of the Assistant Secretary for Planning and Evaluation (ASPE).

CCBHCs are clinics that receive additional federal funds for meeting certain requirements. CCBHCs must provide services to all people regardless of payer, meet rigorous data reporting standards, and provide the following services:

- 24/7 crisis stabilization
- Outpatient mental health and substance use treatment
- Person and family centered treatment planning
- Community-based mental health care for veterans
- Peer family support and counselor services
- Targeted care management
- Outpatient primary care screening and monitoring
- Psychiatric rehabilitation services
- Screening, diagnosis, and risk assessment

CCBHCs may receive enhanced federal funds from SAMHSA grants or adoption of the CCBHC model into the state Medicaid program. States may adopt the CCBHC model by receiving planning and demonstration grant awards from SAMHSA. State CCBHC implementation includes an enhanced federal match of 65.0 percent for eligible services and Prospective Payment Systems (PPS) for certified providers.

The Committee sponsored H.B. 24-1384 (CCBHC) to require the Department to apply for a CCBHC planning grant. The Department partnered with the BHA to apply, and was awarded a $1.0 million one-year planning grant in December 2024. The Department intends to apply for a demonstration grant in April 2026.

The state previously applied for a demonstration grant, but the grant was not awarded. The comprehensive provider system implemented by HCPF and the BHA is intended to align with the CCBHC system and promote a successful application this cycle.

[15] SAMHSA CCBHCs.

Request

The request reflects the enhanced federal funds the Department expects to receive from CCBHC demonstration, as well as costs for additional staff and contracts to manage implementation. Most funding is term-limited to the four years of demonstration, but one management staff position is ongoing. The request is a net increase in total funds, but a reduction in General Fund.

Request Total Funds Impact by Fiscal Year

Item	2026-27	2027-28	2028-29	2029-30	2030-31
4.0 FTE	$487,701	$503,079	$503,079	$503,079	$138,262
Provider system alignment contract	800,000	800,000	800,000	800,000	0
Cost report reviews and auditing contract	286,357	286,357	286,357	286,357	0
Quality strategy and reporting contract	99,840	99,840	99,840	99,840	0
CCBHC demonstration	514,287	989,587	1,068,227	1,153,140	0
Total	$2,188,185	$2,678,863	$2,757,503	$2,842,416	$138,262

Request General Fund Impact by Fiscal Year

Item	2026-27	2027-28	2028-29	2029-30	2030-31
4.0 FTE	$243,851	$251,540	$251,540	$251,540	$69,131
Provider system alignment contract	400,000	400,000	400,000	400,000	0
Cost report reviews and auditing contract	143,179	143,179	143,179	143,179	0
Quality strategy and reporting contract	49,920	49,920	49,920	49,920	0
CCBHC demonstration	-7,355,189	-14,151,485	-15,276,054	-16,490,349	0
Total	-$6,518,240	-$13,306,847	-$14,431,416	-$15,645,711	$69,131

Staffing costs include an ongoing program manager, one policy advisor, one rate analyst, and one statistical analyst. Positions are expected to allow the Department to implement and comply with federal requirements for rate setting and data reporting for the demonstration grant. All positions are term-limited to the four years of the demonstration grant except the program manager.

The Department assumes that three separate contracts are necessary to facilitate the requirements of the demonstration grant. Contracting costs are based on similar historic contracts. The contracts include the following components and costs:

- **$800,000 Provider system alignment contract:** The contractor is expected to work with clinics to align internal data systems with state and federal requirements.
- **$286,357 Cost report reviews and auditing contract:** The contractor is expected to develop and maintain annual rates, audit cost reports, provide technical assistance, and conduct provider trainings.
- **$99,840 Quality strategy and reporting contract:** The contractor is expected to support federally required reporting, data alignment, rate setting, and fidelity activities.

The Department anticipates that the demonstration grant cannot be supported without the requested resources beginning July 2026.

Recommendation

Staff is concerned that the request assumes General Fund savings before the demonstration grant is awarded. However, staff agrees that implementation of the demonstration grant likely requires additional resources to be

successful. Therefore, staff recommends approval of contractor funding, one term-limited program manager, and no assumed changes to federal fund savings until the grant is awarded.

The staff recommendation is based on an assumption that it would be easier for the Committee to assume General Fund savings during the supplemental or figure setting process next year if the grant is awarded, rather than making a mid-year increase if the demonstration grant is not awarded.

Staff does not agree with approving a program manager on an ongoing basis when all other costs are assumed to be term-limited to the demonstration period. The staff recommendation assumes that the Department will be able to implement the demonstration grant without all of the requested staffing resources. However, staff is concerned that the demonstration may not be successful if the Department is not adequately resourced to fully invest in the demonstration.

Staff Recommendation: General Fund Impact

Item	2026-27	2027-28	2028-29	2029-30	2030-31
1.0 Program Manager FTE	$59,281	$128,670	$128,670	$128,670	$0
Cost report reviews and auditing contract	143,179	143,179	143,179	143,179	0
Quality strategy and reporting contract	49,920	49,920	49,920	49,920	0
Provider system alignment contract	400,000	400,000	400,000	400,000	0
CCBHC demonstration	0	-14,151,485	-15,276,054	-16,490,349	0
Total	$652,380	-$13,429,717	-$14,554,286	-$15,768,581	$0

Staff Recommendation: Total Funds Impact

Item	2026-27	2027-28	2028-29	2029-30	2030-31
4.0 FTE	$118,562	$503,079	$503,079	$503,079	$138,262
Cost report reviews and auditing contract	$286,357	286,357	286,357	286,357	0
Quality strategy and reporting contract	$99,840	99,840	99,840	99,840	0
Provider system alignment contract	$800,000	800,000	800,000	800,000	0
CCBHC demonstration	0	989,587	1,068,227	1,153,140	0
Total	$1,304,759	$2,678,863	$2,757,503	$2,842,416	$138,262

If the Committee prefers to approve the Department request, staff recommends slightly reduced amounts for standard FTE calculations.

Option 2: General Fund Request with Standard FTE Adjustments

Item	2026-27	2027-28	2028-29	2029-30	2030-31
4.0 FTE	$182,022	$232,819	$232,819	$232,819	$0
Cost report reviews and auditing contract	143,179	143,179	143,179	143,179	0
Quality strategy and reporting contract	49,920	49,920	49,920	49,920	0
Provider system alignment contract	400,000	400,000	400,000	400,000	0
CCBHC demonstration	-7,355,189	-14,151,485	-15,276,054	-16,490,349	0
Total	-$6,518,240	-$13,306,847	-$14,431,416	-$15,645,711	$69,131

Option 2: Total Funds Request with Standard FTE Adjustments

Item	2026-27	2027-28	2028-29	2029-30	2030-31
4.0 FTE	$364,044	$465,637	$465,637	$465,637	$0
Cost report reviews and auditing contract	286,357	286,357	286,357	286,357	0
Quality strategy and reporting contract	99,840	99,840	99,840	99,840	0
Provider system alignment contract	800,000	800,000	800,000	800,000	0

Item	2026-27	2027-28	2028-29	2029-30	2030-31
CCBHC demonstration	514,287	989,587	1,068,227	1,153,140	0
Total	$2,064,528	$2,641,421	$2,720,061	$2,804,974	$0

Evidence Designation

The Department indicates that the request is Promising. The request does not provide evidence citations, but indicates that evaluations of early demonstration states found that wait times decreased and more clients were seen within ten days, and stakeholders credited the model with expanded same-day appointments and peer support.

Staff identified three reviews of the CCBHC model, discussed below.

Smith, A. P., & Talbert, J. Rural Access to Certified Community Behavioral Health Clinics (CCBHCs).

- **Article summary:** Year-over-year comparison of the number of CCBHCs in urban and rural areas of the country, and services provided. The study found that the number of CCBHCs has grown more in rural areas than urban areas and CCBHCs offer more services than other mental health clinics. The study concludes that growth in the number of CCBHCs shows promise for increasing the availability of integrated treatment.
- **Staff finding:** The article concludes that the CCBHC model increases access to services, but is not a quality evaluation with strong comparison groups that shows statistically significant favorable outcomes.

Olgac, T., McCann, E., Riske-Morris, M., & Hussey, D. L. (2026). A Critical Examination of the Certified Community Behavioral Health Clinic Model: Provider Perceptions and Themes. *Health Services Research*, *61*(1), e70041.

- **Article summary:** Qualitative analysis of two community-based health agencies using focus group discussions that included 91 participants. Providers reported improvements in service accessibility and care coordination, but indicated that a lack of community resources like housing and transportation continued to restrict the ability of clinics to address the basic needs of clients. Program sustainability was also a concern since the CCBHC model is implemented through temporary grants.
- **Staff finding:** The article notes some positive outcomes and concerns from providers about the CCBHC model, but is not a quality evaluation with strong comparison groups that shows statistically significant favorable outcomes.

U.S. Department of Health and Human Services, "Implementation Findings From the National Evaluation of the Certified Community Behavioral Health Clinic Demonstration," 2020, https://aspe.hhs.gov/sites/default/files/private/pdf/263986/CCBHCImpFind.pdf

- **Article summary:** Evaluation by the US Department of Health and Human Services on the outcomes for CCBHC demonstration states. The report found:
  - Most CCBHCs hired additional staff.
  - The ability to retain staff varied by staff type. There was no difference in staffing in the first and second year of demonstration for several positions, but the number of psychiatrists and linguistic counselors declined. Clinics indicated funding uncertainty and burnout from increased demand for services as reasons for declined staff.
  - Uncertainty around the future of the demonstration was cited as the most significant staffing challenge by all but one state.

    - CCBHCs increased access to services outside of the clinic, including telehealth, providing services at third-party locations, and adding new services.
    - Most CCBHCs expended their scope of service to meet certification requirements.
    - CCBHCs were able to add and sustain a range of evidence-based practices across demonstration years.
    - CCBHCs increased access to care coordination services.
- **Staff finding:** The report provides survey results of implemented and sustained programs during CCBHC demonstration. The report identifies increased services but concerns with funding sustainability, which aligns with other articles. However, the report is not a quality evaluation with strong comparison groups that shows statistically significant favorable outcomes.

Staff was not able to quickly identify a quality evaluation of the CCBHC model. Therefore, staff finds that the evidence level is Ineligible. However, staff agrees that federal funding from the CCBHC demonstration is expected to increase access to services and data reporting that would be excepted to improve patient outcomes if sustained.

Line Item Detail – Behavioral Health Community Programs

Behavioral Health Capitation Payments

This line item supports the provision of most behavioral health services to Medicaid clients. Behavioral health services, which include both mental health and substance use-related services, are provided to Medicaid clients through a statewide managed care or "capitated" program. The Department contracts with “regional accountable entities” (RAEs) to provide or arrange for behavioral health services for clients enrolled with each RAE. The Department used a competitive bid process to award RAE contracts for each region.

In order to receive services through behavioral health capitation, a client must have a covered diagnosis and receive a covered service or procedure that is medically necessary. Services for Medicaid clients that are managed by RAEs are listed below, with the first group including services that are covered by the State Medicaid Plan, and the second group including services that are authorized under a federal waiver.

Covered State Plan Services

- School-based behavioral health services
- Targeted case management
- Drug screening and monitoring
- Outpatient services, including:
    - Physician services (including psychiatric care)
    - Rehabilitative services (including: individual, group, and family behavioral health therapy; behavioral health assessment; pharmacologic management; day treatment; and emergency/crisis services)
- Detoxification services
- Medication-assisted treatment

Alternate Services Covered by the Federal “1915 (b)(3)” Waiver

- Prevention/early intervention services
- Vocational services
- Drop-in center services

- Assertive community treatment
- Intensive case management
- Residential services (24-hour psychiatric care provided in a non-hospital, non-nursing home setting; excludes room and board), except that these services are not covered for a client for whom the primary diagnosis is a substance use disorder (SUD).
- Respite care
- Recovery services
- New: Inpatient psychiatric hospitalization, or “Institution for Mental Disease” (IMD) stays up to 60 days, as long as the average stay does not exceed 30 days.
    - The federal Social Security Act bars states from receiving federal Medicaid funding for any services (medical or behavioral health) provided to individuals ages 21 through 64 who are patients in an IMD. However, if a state has implemented a managed care plan for behavioral health services, it is allowed to use Medicaid funding to pay for inpatient psychiatric services provided for those ages 21 through 64 who reside in an IMD as an “in lieu of” State Plan service. Recent revisions to federal managed care regulations limit these services to 15 days in a calendar month. The Department applied for and received a waiver to cover the first 15 days of an IMD stay if the total stay exceeds 15 days as part of a FY 2024-25 budget request.
    - For individuals under age 21 and over age 64 who reside in an IMD, Medicaid covers inpatient psychiatric care without any limitation on the number of days of care .

Each RAE receives a pre-determined monthly amount for each Medicaid client who is eligible for behavioral health services and enrolled with the RAE. The "per-member-per-month" rates paid to each RAE are unique for each Medicaid eligibility category in each geographic region. The Department re-negotiates these rates periodically based on historical rate experience and data concerning client service utilization. The Department divides the state into four geographic regions for the provision of behavioral health services to the following Medicaid eligibility categories :

- Adults age 65 and older;
- Children and adults with disabilities under age 65;
- Parents and caretakers;
- Pregnant adults;
- Adults without dependent children;
- Children;
- Children and young adults in or formerly in foster care (through age 26); and
- Adults served through the Breast and Cervical Cancer Treatment and Prevention Program.

Two Medicaid populations that are eligible for certain medical benefits are not eligible for behavioral health services through the Medicaid program: (1) Non-citizens; and (2) Partial dual-eligible individuals (i.e., individuals who are eligible for both Medicare and Medicaid benefits, but for whom the Medicaid benefit is limited to payment of Medicare premiums and co-insurance payments).

In addition, Medicaid-eligible clients who are enrolled in a Program of All-inclusive Care for the Elderly (PACE Program) are excluded from enrollment in a RAE.

Finally, in some instances certain behavioral health services for Medicaid clients are not covered by Capitation, and are instead covered through other appropriations to the Department of Health Care Policy and Financing (HCPF):

- Services Provided Through Primary Care. The Medical Service Premiums line item appropriation to HCPF covers short-term behavioral health services that a RAE-enrolled client receives by a licensed behavioral health clinician at their primary care medical provider's office. These expenditures are limited to six visits per client per state fiscal year. The services include:
  - Diagnostic evaluation without medical services;
  - Individual psychotherapy for up to 60 minutes; and
  - Family psychotherapy.
- Services for Children and Youth in the Custody of the Department of Human Services (DHS). Children and youth in the custody of Child Welfare or the DHS Division of Youth Services are enrolled in RAEs, and each RAE receives per-member-per-month payments for these individuals. However, if one of these children or youth is placed in a psychiatric residential treatment facility (PRTF) or a residential childcare facility (RCCF), the behavioral health services provided by that facility are not covered by the RAE and these costs are not considered as part of the associated per-member-per-month capitation rate. Instead, these costs are covered by appropriations of Medicaid funds to HCPF that are transferred to the DHS Division of Child Welfare and the Division of Youth Services.
- Services for Individuals with Intellectual and Developmental Disabilities (IDD). Individuals with IDD are enrolled in RAEs, and each RAE receives per-member-per-month payments for these individuals. However, for individuals who reside in a facility that is licensed as an "intermediate care facility" for individuals with IDD, the behavioral health services provided by that facility are not covered by the RAE and these costs are not considered as part of the associated per-member-per-month capitation rate. Instead, these costs are billed on a fee-for-service basis and are covered by other appropriations. Specifically:
  - For the Wheat Ridge Regional Center and for some beds within the Grand Junction Regional Center that are also licensed as an intermediate care facility, residents' behavioral health care services are covered by appropriations of Medicaid funds to HCPF that are transferred to DHS for these Regional Centers. In contrast, for individuals with IDD who reside in "adult comprehensive waiver homes" connected with the Grand Junction or Pueblo Regional Centers, these services are covered by the Capitation program.
  - For individuals with IDD who reside in a private intermediate care facility (e.g., Bethesda Lutheran), the behavioral health services are included in the Medicaid per diem rate paid to that facility, similar to the Regional Centers. These costs are covered by the Medical Service Premiums line item appropriation to HCPF.

Statutory Authority: Articles 4, 5, and 6 of Title 25.5 [Colorado Medical Assistance Act]; C.R.S. Sections: 25.5-4-401.2 [Performance-based payments]; 25.5-4-403 [Reimbursement for community mental health centers and clinics]; 25.5-4-405 [Mental health managed care service providers]; 25.5-5-325 [Residential and inpatient substance use disorder treatment]; 25.5-5-402 to 410 [Statewide managed care system]; 25.5-5-415 [Medicaid payment reform and innovation pilot program]; 25.5-5-419 [Accountable Care Collaborative]

Request: The Department requests an appropriation of $1.8 billion total funds, which reflects the November forecast.

Recommendation: The staff recommendation is provided in the table below and is updated from the request to reflect the February forecast.

Behavioral Health Capitation Programs

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 2025-26 Appropriation						
FY 2025-26 Appropriation	$1,576,377,067	$366,639,665	$127,670,433	$0	$1,082,066,969	0.0
Total FY 2025-26	$1,576,377,067	$366,639,665	$127,670,433	$0	$1,082,066,969	0.0
FY 2026-27 Recommended Appropriation						
FY 2025-26 Appropriation	$1,576,377,067	$366,639,665	$127,670,433	$0	$1,082,066,969	0.0
Medical forecast	232,297,819	45,059,130	24,524,892	0	162,713,797	0.0
Prior year actions	11,445,844	4,724,500	998,422	0	5,722,922	0.0
Administration	0	0	0	0	0	0.0
Provider rates	-7,974,052	-1,891,927	-2,095,099	0	-3,987,026	0.0
Total FY 2026-27	$1,812,146,678	$414,531,368	$151,098,648	$0	$1,246,516,662	0.0
Changes from FY 2025-26	$235,769,611	$47,891,703	$23,428,215	$0	$164,449,693	0.0
Percentage Change	15.0%	13.1%	18.4%	n/a	15.2%	n/a
FY 2026-27 Executive Request	$1,789,389,555	$410,592,797	$149,356,892	$0	$1,229,439,866	0.0
Staff Rec. Above/-Below Request	$22,757,123	$3,938,571	$1,741,756	$0	$17,076,796	0.0

Behavioral Health Fee-for-Service Payments

This line item supports certain "fee-for-service" payments for a limited set of behavioral health services to treat mental health conditions and diagnoses that are not covered by the behavioral health capitation program, including autism spectrum disorder. In addition, if “partial dual-eligible” individuals receive mental health services under their Medicare benefits package, this line item covers that portion of expenditures that would have been the responsibility of the client.

While the fee-for-service program does cover all Medicaid State Plan mental health and substance use disorder services, it does not cover services approved through the Department’s federal 1915 (b)(3) waiver.

Statutory authority: Articles 4, 5, and 6 of Title 25.5 [Colorado Medical Assistance Act]

Request: The Department requests an appropriation of $7.3 million total funds, which reflects the November forecast.

Recommendation: The staff recommendation is provided in the table below and reflects the February forecast. The recommendation is pending Committee action on provider rate reductions presented in separate staff presentations.

Fee-for-service Payments

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 2025-26 Appropriation						
FY 2025-26 Appropriation	$10,336,937	$2,483,755	$613,201	$0	$7,239,981	0.0
Total FY 2025-26	$10,336,937	$2,483,755	$613,201	$0	$7,239,981	0.0

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 2026-27 Recommended Appropriation						
FY 2025-26 Appropriation	$10,336,937	$2,483,755	$613,201	$0	$7,239,981	0.0
Medical forecast	28,697	6,896	1,702	0	20,099	0.0
Prior year actions	13,762	3,307	816	0	9,639	0.0
Continuation of supplemental actions	-58,801	-14,129	-3,488	0	-41,184	0.0
Total FY 2026-27	$10,320,595	$2,479,829	$612,231	$0	$7,228,535	0.0
Changes from FY 2025-26	-$16,342	-$3,926	-$970	$0	-$11,446	0.0
Percentage Change	-0.2%	-0.2%	-0.2%	n/a	-0.2%	n/a
FY 2026-27 Executive Request	$7,327,418	$1,488,484	$63,085	$0	$5,775,849	0.0
Staff Rec. Above/-Below Request	$2,993,177	$991,345	$549,146	$0	$1,452,686	0.0

(7) Transfers to Other State Department Medicaid-funded Programs

This section contains funding for programs administered by other departments that are funded with Medicaid dollars. General Fund is appropriated in this section, matched with anticipated federal funds, and then transferred to the other departments, where the Medicaid funds are reflected as reappropriated funds. The majority of the money goes to the Department of Human Services.

This document only discusses line items that transfer funding to the Executive Director's Office, Administration and Finance, Office of Children, Youth and Families, Behavioral Health Administration, and Office of Civil and Forensic Mental Health in the Department of Human Services. Other line items in this division are discussed in separate staff presentations. Staff requests permission to adjust the appropriations as necessary to align with Committee final action on the Department of Human Services.

Transfers to Other State Department Medicaid-funded Programs

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 2025-26 Appropriation						
FY 2025-26 Appropriation	$175,053,052	$86,176,582	$2,395,303	$14,652	$86,466,515	0.0
Total FY 2025-26	$175,053,052	$86,176,582	$2,395,303	$14,652	$86,466,515	0.0
FY 2026-27 Recommended Appropriation						
FY 2025-26 Appropriation	$175,053,052	$86,176,582	$2,395,303	$14,652	$86,466,515	0.0
Impacts driven by other agencies	1,910,580	987,290	-32,000	0	955,290	0.0
Prior year actions	997,298	539,874	-41,225	0	498,649	0.0
Total FY 2026-27	$177,960,930	$87,703,746	$2,322,078	$14,652	$87,920,454	0.0
Changes from FY 2025-26	$2,907,878	$1,527,164	-$73,225	$0	$1,453,939	0.0
Percentage Change	1.7%	1.8%	-3.1%	0.0%	1.7%	0.0%
FY 2026-27 Executive Request	$177,967,664	$87,707,113	$2,322,078	$14,652	$87,923,821	0.0
Staff Rec. Above/-Below Request	-$6,734	-$3,367	$0	$0	-$3,367	0.0

→ Informational: FY 2024-25 Overexpenditures

Two of the line items that transfer funding to the Department of Human Services (CDHS) overspent in FY 2024-25. The appropriations and expenditures are provided in the table below.

FY 2024-25 General Fund Appropriations and Expenditures

Line Item	Appropriation	Expenditure	Over-expenditure
Child Welfare Services	$7,191,615	$10,591,900	$3,400,285
Mental Health Institutes	4,160,099	6,633,122	2,473,023

Line Item	Appropriation	Expenditure	Over-expenditure
Total	$11,351,714	$17,225,022	$5,873,308

The Department indicates that the over-expenditures occurred because the number of patients served at the State Mental Health Hospitals has increased, and expenditures for Psychiatric Residential Treatment Facilities (PRTF) were previously being attributed to the wrong line item. The Committee and General Assembly released the over-expenditures as part of the supplemental process.

Child Welfare Services

The Child Welfare Services line item is expected to pay for PRTF placements for youth who are in county custody. Statute allows HCPF and CDHS to transfer corresponding appropriations between the departments.[16] Therefore, unexpended General Fund in this line item is typically transferred to CDHS rather than reverting. The transfer can make additional General Fund available for the county child welfare close-out process.

The line item has historically underspent, and transferred $5.7 million in FY 2023-24 and $4.5 million in FY 2022-23 for child welfare county close-out. HCPF indicates that the line over-spent in FY 2024-25 because PRTF expenditures were being attributed to Medical Services Premiums rather than this line in prior years.

PRTF expenses for child welfare youth are expected to move to behavioral health capitation in FY 2026-27. The Committee sponsored S.B. 25-294 to delay the transition initiated by the Department by one year. The intent of the delay was to allow additional time for the Department to provide guidance to RAEs and providers, and increase availability of step-down services through the implementation of a Workforce Capacity Center.

The Department request does not appear to account for the transition of these services to behavioral health capitation. Last year, the Department indicated that the adjustment was not incorporated into the request because the Child Welfare Services line will continue to pay for prior dates of service, and the cost is assumed to be within forecasted trends for behavioral health capitation.

Staff is concerned that the appropriation will continue to over-expend in FY 2025-26. However, medical necessity determinations began in December. Providers have also indicated that more youth are being placed by RAEs, and fewer youth are being placed by county departments of human services. Therefore, costs may decline. Staff is also concerned that the Department was attributing expenditures to the wrong line item and has not transparently accounted for shifting the costs for these expenditures.

Workforce Capacity Center Updates

The Committee required quarterly reporting on development of the Workforce Capacity Center in S.B. 25-292. The most recent report from January 2026 indicates that contracts are in place with five agencies through the RAEs to begin delivering high fidelity wraparound services in November 2025. CSU is operating the Workforce Capacity Center. CSU is conducting a landscape analysis to assess the current skills and knowledge of providers and expectations for graduates.

A subaward was made between CSU and the National Wraparound Implementation Center (NWIC) to deliver high fidelity wraparound trainings. The Center will offer 1, 2, and 3 day trainings depending on provider

[16] Section 24-75-106.5

experience. The report indicates that NWIC has hosted six virtual Introduction to Wraparound trainings as of January 2026. A total of 17 providers have completed at least one high fidelity wraparound training.

Mental Health Institutes

The increase in expenditures from the Mental Health Institutes is addressed in the R4 Patient revenues request from the Department of Human Services. The request increases the appropriation to $5.0 million General Fund, which is $1.6 million below FY 2024-25 expenditures. Staff therefore assumes the CDHS request does not sufficiently address increased costs. Staff is working with CDHS to align patient revenues with anticipated expenditures. Staff assumes that additional General Fund appropriations above the request may be necessary to address anticipated costs.

Line Item Detail – Transfers to Human Services

(1) Executive Director's Office

The Executive Director's Office is responsible for the general policy of the Department of Human Services (DHS) and contains staff and associated resources for implementing policy. In DHS, the General Administration section includes the DHS Executive Director and associated administrative staff, including the department's budget staff, the Public Information Office, the Legislative Liaison, and the Division of Field Administration that includes the County Commissioner Liaison. These staff members are FTE at DHS, but several of them also perform services related to Medicaid, so part of their salaries and related expenses are reimbursed by the Department of Health Care Policy and Financing.

Statutory Authority: Sections 24-1-120, C.R.S.

Request and Recommendation: The staff recommendation is pending Committee action on compensation common policies. The table below reflects the Department request.

Executive Director's Office

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 2025-26 Appropriation						
FY 2025-26 Appropriation	$18,242,507	$9,102,264	$18,990	$0	$9,121,253	0.0
Total FY 2025-26	$18,242,507	$9,102,264	$18,990	$0	$9,121,253	0.0
FY 2026-27 Recommended Appropriation						
FY 2025-26 Appropriation	$18,242,507	$9,102,264	$18,990	$0	$9,121,253	0.0
Impacts driven by other agencies	6,570,052	3,285,026	0	0	3,285,026	0.0
Prior year actions	-262,370	-131,185	0	0	-131,185	0.0
Total FY 2026-27	$24,550,189	$12,256,105	$18,990	$0	$12,275,094	0.0
Changes from FY 2025-26	$6,307,682	$3,153,841	$0	$0	$3,153,841	0.0
Percentage Change	34.6%	34.6%	0.0%	n/a	34.6%	n/a
FY 2026-27 Executive Request	$24,550,189	$12,256,105	$18,990	$0	$12,275,094	0.0
Staff Rec. Above/-Below Request	$0	$0	$0	$0	$0	0.0

(2) Child Welfare

Child Welfare Administration

This line item reflects the amount of Medicaid funds appropriated to the Administration line item in the Division of Child Welfare in the Department of Human Services.

Statutory Authority: Section 26-1-109 (2)(a) and (3), C.R.S.

Request: The Department requests an appropriation of $356,177 total funds.

Recommendation: Staff recommends approval of the request.

Child Welfare Administration

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 2025-26 Appropriation						
FY 2025-26 Appropriation	$352,543	$145,627	$0	$0	$206,916	0.0
Total FY 2025-26	$352,543	$145,627	$0	$0	$206,916	0.0
FY 2026-27 Recommended Appropriation						
FY 2025-26 Appropriation	$352,543	$145,627	$0	$0	$206,916	0.0
Impacts driven by other agencies	3,574	1,787	0	0	1,787	0.0
Total FY 2026-27	$356,117	$147,414	$0	$0	$208,703	0.0
Changes from FY 2025-26	$3,574	$1,787	$0	$0	$1,787	0.0
Percentage Change	1.0%	1.2%	n/a	n/a	0.9%	n/a
FY 2026-27 Executive Request	$356,117	$147,414	$0	$0	$208,703	0.0
Staff Rec. Above/-Below Request	$0	$0	$0	$0	$0	0.0

Child Welfare Services

This line item reflects the amount of Medicaid funds appropriated to the Child Welfare Services line item in the Division of Child Welfare in the Department of Human Services (the Block). The Child Welfare Services line item is more commonly referred to as the Block, and accounts for the majority of Child Welfare funding in the state.

Statutory authority: Section 26-5-101, C.R.S.

Request: The Department requests a continuation appropriation of $14,383,230 total funds split equally between General Fund and federal funds.

Recommendation: Staff recommends approval of the request.

Division of Youth Services

This line item reflects the amount of Medicaid funds appropriated to the Community Programs subdivision of the Division of Youth Services in the Department of Human Services. Line items with reappropriated Medicaid funds in DYS include Program Administration, Purchase of Contract Placements, and the Managed Care Project.

Statutory authority: Section 26-5-101, C.R.S.

Request: The Department requests an appropriation of $762,131 total funds.

Recommendation: Staff recommends approval of the request.

Division of Youth Services

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 2025-26 Appropriation						
FY 2025-26 Appropriation	$758,785	$379,394	$0	$0	$379,391	0.0
Total FY 2025-26	$758,785	$379,394	$0	$0	$379,391	0.0
FY 2026-27 Recommended Appropriation						
FY 2025-26 Appropriation	$758,785	$379,394	$0	$0	$379,391	0.0
Impacts driven by other agencies	3,346	1,673	0	0	1,673	0.0
Total FY 2026-27	$762,131	$381,067	$0	$0	$381,064	0.0
Changes from FY 2025-26	$3,346	$1,673	$0	$0	$1,673	0.0
Percentage Change	0.4%	0.4%	n/a	n/a	0.4%	n/a
FY 2026-27 Executive Request	$762,131	$381,067	$0	$0	$381,064	0.0
Staff Rec. Above/-Below Request	$0	$0	$0	$0	$0	0.0

Health-Related Social Needs

This line item This line item was created by S.B. 25-308 and reflects the amount of Medicaid funds appropriated for the Preventing Youth Homelessness program. The program includes housing and case management support for youth transitioning from commitment in the Division of Youth Services.

Statutory authority: Section 25-5-339 (10), C.R.S.

Request: The Department requests a continuation appropriation of $1,142,323 total funds, including $761,549 General Fund and $380,774 federal funds.

Recommendation: Staff recommends approval of the request.

Reentry Services

This line item was created by S.B. 25-308 and reflects the amount of Medicaid funds appropriated for eligible personal services, operating expenses, and medical services in the Division of Youth Services (DYS) and Administration and Finance Division of for DYS reentry services.

Statutory authority: Section 25-5-339 (10), C.R.S.

Request: The Department requests a continuation appropriation of $84,352 total funds, including $56,235 General Fund and $28,117 federal funds.

Recommendation: Staff recommends approval of the request.

(4) Behavioral Health Administration

Program Administration [updated name]

This line item reflects the amount of Medicaid funds appropriated for the personal services and operating expenses for the Behavioral Health Administration (BHA). Staff recommends renaming the line item to align with the line item name in the BHA.

Statutory authority: Section 26-5-101, C.R.S.

Request: The Department requests an appropriation of $952,468 total funds.

Recommendation: Staff recommends approval of the request.

Program Administration

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 2025-26 Appropriation						
FY 2025-26 Appropriation	$926,843	$463,421	$0	$0	$463,422	0.0
Total FY 2025-26	$926,843	$463,421	$0	$0	$463,422	0.0
FY 2026-27 Recommended Appropriation						
FY 2025-26 Appropriation	$926,843	$463,421	$0	$0	$463,422	0.0
Impacts driven by other agencies	25,625	12,812	0	0	12,813	0.0
Total FY 2026-27	$952,468	$476,233	$0	$0	$476,235	0.0
Changes from FY 2025-26	$25,625	$12,812	$0	$0	$12,813	0.0
Percentage Change	2.8%	2.8%	n/a	n/a	2.8%	n/a
FY 2026-27 Executive Request	$952,468	$476,233	$0	$0	$476,235	0.0
Staff Rec. Above/-Below Request	$0	$0	$0	$0	$0	0.0

Children and Youth Mental Health Treatment Act

This line item reflects the amount of Medicaid funds appropriated for the Children and Youth Mental Health Treatment Act. This program is administered by DHS, and it provides funding for mental health treatment services for children and youth under age 21 . The program is designed to make services available for children and youth who are at risk of out-of-home placement, but a dependency and neglect action is neither appropriate nor warranted. Services may include mental health treatment services and care management, including any residential treatment, community-based care, or any post-residential follow-up services that may be appropriate.

The CYMHTA applies to two groups of children, with different application and payment processes for each group.

- Children who are categorically Medicaid-eligible and have a covered mental health diagnosis. A parent or guardian of a Medicaid-eligible child may apply for residential treatment through the local regional accountable entity (RAE). If the child is determined to require a residential level of care, the RAE is responsible for covering the residential treatment costs.

- Children Who Are NOT Categorically Eligible for Medicaid. If a child is at risk of being placed out of the home because they have a mental illness and they require a residential treatment level of care or equivalent community-based services, the parent or guardian may apply for such services through the local community mental health center (Center) or another mental health agency. The Center or mental health agency is required to evaluate the child or youth and clinically assess their need for mental health services.

When a child or youth is approved for funding through this program and the child or youth requires residential treatment, the child or youth may become eligible for Medicaid funding through the federal supplemental security income (SSI) eligibility process. If a child has been in residential services for more than 30 days, or is expected to remain in residential services for more than 30 days, the child can qualify for SSI due to being considered a "household of one" per the federal Social Security Administration. Once a child obtains SSI, the child automatically acquires fee-for-service Medicaid. Medicaid funding pays for the treatment costs of residential services, but does not fund room and board costs.

Due to federal regulations, the SSI benefit is paid directly to the child or payee (typically the parent) to fund a portion of the residential room and board rate. The parent will then give all but $30 of the SSI award to the residential provider. SSI awards vary based on the child's treatment location and family income, ranging from $30 to $700 per month.

Private insurance benefits must be exhausted prior to accessing any public benefits. In addition, the parents are responsible for paying a portion of the cost of services that is not covered by private insurance or by Medicaid funding; the parent share is based on a sliding fee scale that is based on child support guidelines.

When and if the child is in residential care and funded by the CYMHTA, expenses are covered by parental fees, SSI benefits (if benefits are approved), and CYMHTA funds. If the child or youth is placed in a psychiatric residential treatment facility, treatment expenses are covered by a Medicaid per diem rate and "room and board" expenses are covered by parental fees and CYMHTA funds. If the child is in non-residential care, expenses are covered by SSI benefits, parental fees, and CYMHTA funds.

Statutory authority: Section 25.5-5-307, C.R.S. [Child mental health treatment and family support program]; Section 27-67-101 et seq., C.R.S. [Children and Youth Mental Health Treatment Act]

Request: The Department requests a continuation appropriation of $137,680 split equally between General Fund and federal funds.

Recommendation: Staff recommends approval of the request.

(5) Office of Civil and Forensic Mental Health

Mental Health Hospitals

This line item reflects the amount of Medicaid funds appropriated for fee-for-service payments to the Colorado Mental Health Hospitals. These Medicaid funds support personal services, operating expenses, and pharmaceutical expenses associated with inpatient psychiatric services for Medicaid-eligible "forensic" patients (i.e., individuals who are admitted to the Institutes through the criminal or juvenile justice system) who are under the age of 21 or over the age of 64.

Services not covered by this line item:

- The state hospitals bill regional accountable entities (RAEs) for services provided to Medicaid-eligible patients who are under the age of 21 or over the age of 64, and who are referred to the Institutes from a community mental health center or another health care provider (and are thus classified as "civil" patients).
- For Medicaid-eligible patients age 21 through 64, Colorado Medicaid rules do not allow the state hospitals to receive any Medicaid funding, whether the patient is classified as civil or forensic.

Statutory authority: Section 25.5-5-202 (1)(a), (i), and (j), C.R.S.; 10 CCR 2505-10 8.212.4.A1. [Medical Services Board rules concerning the inpatient psychiatric hospital services benefit, which excludes services to adults ages 21 through 64 who receive services through a State Institute of Mental Disease]

Request and Recommendation: The recommendation is pending Committee action on the Department of Human Services. The table reflects the Department request.

Mental Health Institutes

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 2025-26 Appropriation						
FY 2025-26 Appropriation	$11,014,933	$5,507,466	$0	$0	$5,507,467	0.0
Total FY 2025-26	$11,014,933	$5,507,466	$0	$0	$5,507,467	0.0
FY 2026-27 Recommended Appropriation						
FY 2025-26 Appropriation	$11,014,933	$5,507,466	$0	$0	$5,507,467	0.0
Impacts driven by other agencies	1,283,970	641,985	0	0	641,985	0.0
Total FY 2026-27	$12,298,903	$6,149,451	$0	$0	$6,149,452	0.0
Changes from FY 2025-26	$1,283,970	$641,985	$0	$0	$641,985	0.0
Percentage Change	11.7%	11.7%	n/a	n/a	11.7%	n/a
FY 2026-27 Executive Request	$10,046,849	$5,023,424	$0	$0	$5,023,425	0.0
Staff Rec. Above/-Below Request	$2,252,054	$1,126,027	$0	$0	$1,126,027	0.0

State Operated Mental Health Transitional Living Homes [updated name]

This line item reflects the amount of Medicaid funds appropriated for state-operated Mental Health Transitional Living Homes. The homes were created by H.B. 22-1303, and the line item was first added to the FY 2024-25 Long Bill to align appropriations between the two Department. Transitional living homes may be state-operated or contracted. Beds contracted by DHS are billed directly to the RAEs by the provider and are therefore included in behavioral health capitation.

Statutory authority: Section 27-71-103 (1)(c), C.R.S.

Request: The Department requests a continuation appropriation of $5,165,032 total funds split equally between General Fund and federal funds.

Recommendation: Staff recommends approval of the request.

(7) Indirect Cost Assessment

This line item funds the indirect costs associated with the operation of the Department of Human Services.

Statutory Authority: Section 24-75-1401, C.R.S.

Request and Recommendation: The recommendation is pending Committee action on compensation common policies. The table below reflects the Department request.

Indirect Cost Assessment

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 2025-26 Appropriation						
FY 2025-26 Appropriation	$24,523,468	$12,261,734	$0	$0	$12,261,734	0.0
Total FY 2025-26	$24,523,468	$12,261,734	$0	$0	$12,261,734	0.0
FY 2026-27 Recommended Appropriation						
FY 2025-26 Appropriation	$24,523,468	$12,261,734	$0	$0	$12,261,734	0.0
Impacts driven by other agencies	-2,933,499	-1,466,749	0	0	-1,466,750	0.0
Prior year actions	-405,828	-202,914	0	0	-202,914	0.0
Total FY 2026-27	$21,184,141	$10,592,071	$0	$0	$10,592,070	0.0
Changes from FY 2025-26	-$3,339,327	-$1,669,663	$0	$0	-$1,669,664	0.0
Percentage Change	-13.6%	-13.6%	n/a	n/a	-13.6%	n/a
FY 2026-27 Executive Request	$21,184,141	$10,592,071	$0	$0	$10,592,070	0.0
Staff Rec. Above/-Below Request	$0	$0	$0	$0	$0	0.0

Long Bill Footnotes and Requests for Information

Long Bill Footnotes

The FY 2025-26 Long Bill did not include any footnotes specific to the behavioral health community programs. Staff does not recommend adding any footnotes to this section.

Requests For Information

Staff recommends continuing and **CONTINUING AND MODIFYING** the following request for information:

1 Department of Health Care Policy and Financing, Behavioral Health Community Programs –The Department is requested to submit a report by November 1, discussing member utilization of capitated behavioral health services in the prior fiscal year and the Regional Accountable Entity's (RAE's) performance on network provider expansion, timeliness of processing provider claims within contract requirements, and timeliness of credentialing and contracting network providers. The report should include aggregated data on the number of members accessing inpatient and residential mental health treatment, inpatient and residential substance use disorder treatment, outpatient mental health and substance use disorder services, and alternative services allowed under the Department's waiver with the Centers for Medicare and Medicaid Services. ~~For Calendar Year 2023, t~~The Department shall report aggregated provider data by quarter showing changes in the number of providers contracted, monthly claims processing timeframes by each RAE, and timeliness of provider credentialing and contracting by each RAE. Also, please discuss differences in the performance of the RAEs, how the Department monitors these performance measures, and any actions the Department has taken to improve RAE performance and client behavioral health outcomes.

Comment: This request provides information about overall Medicaid Behavioral Health funding distributions.

2 Department of Health Care Policy and Financing, Behavioral Health Community Programs – The Department is requested to provide, by November 1, a report on implementation of the youth system of care pursuant to GA v Bimestefer. The report should include, but is not limited to, the following information:

- A description of ANY CHANGES TO the implementation plan as approved by the plaintiffs SINCE THE MOST RECENT RFI RESPONSE. The description should include the services included in the plan, implementation phases, and the services included in each phase.
- The number of youth expected to be served in each implementation phase.
- Estimated funding required to fully implement the system of care plan.
- The number of high fidelity wraparound and intensive care coordination providers, and the number of youth that received these services in ~~FY 2024-25.~~ THE LAST FISCAL YEAR.

Comment: This request was added in 2025 to provide information on the implementation of high fidelity wraparound services as a response to the GA V Bimestefer.

3 Department of Health Care Policy and Financing, Behavioral Health Community Programs – The Department is requested to provide, ~~by June 6, 2025~~ BY NOVEMBER 1, a description of efforts to implement Section 25.5-5.202, C.R.S., related to the transition of residential treatment for child welfare youth to behavioral health capitation. The Department is requested to collaborate with other state departments and stakeholders as necessary to develop responses. The report should include the following information.

- Information regarding the current utilization of youth residential treatment, including:
  - The total number of child welfare and non-child welfare youth in QRTP and PRTF placements in the prior fiscal year;
  - The average length of stay for child welfare and non-child welfare youth in QRTP and PRTF placements in the prior fiscal year;
  - The number of youth who were determined to not meet medical necessity, but no step-down service was available in the prior fiscal year;
  - The number of youth who re-entered the hospital or emergency services within 3 months of discharge from a QRTP or PRTF in the prior fiscal year;
  - A description of the availability of step-down services across the state.
- The process for determining medical necessity, including but not limited to:
  - A description of the factors considered for determining medical necessity;
  - How the availability of appropriate step-down services factors into medical necessity determinations;
  - The anticipated length of time from medical necessity determination to discharge;
  - The Department's efforts to collaborate with QRTP and PRTF providers, hospitals, county departments of human services, and families to determine medical necessity procedures.
- The anticipated process for discharge, transition, and aftercare planning, including but not limited to:
  - How and when discharge, transition, and aftercare plans will be developed; and
  - Efforts to include families, providers, hospitals, and counties in collaborative treatment teams, transition, discharge, and aftercare planning.
- The anticipated financing structure, including but not limited to:
  - The anticipated timing of payments and authorizations from RAEs to residential providers;
  - Efforts to assist providers, counties, and families in connecting with RAEs to ensure access to benefits;
  - Efforts to ensure sustainable, long-term funding for child welfare youth in need of residential treatment.

Comment: This request was added in 2025 to provide information on the transition of payments for residential treatment for child welfare youth to behavioral health capitation.

Additional Balancing Options

As part of staff budget briefings in November and December 2025, staff identified budget reduction options for each department that the JBC could consider in addition to or instead of the options presented in the budget request**. Items staff recommends and items that agencies have requested formally are addressed earlier in this packet**. Other items that could be considered, if needed to bring the budget into balance, are listed below.

A General Fund reduction of 5.0 percent to the sections of the budget covered in this figure setting packet equates to reduction of $18.4 million. Options from the table below, if adopted, increase that amount. Items in the table are ordered from lowest impact on program operations to highest, based on staff's understanding of the impact of the change.

Additional Options for General Fund Relief

Option	General Fund	Other Funds	Bill? Y/N	Description
Revenue Enhancements				
None	$0	$0	NA	NA
Subtotal - Revenue	$0	$0		
Expenditure Reductions				
BHIC admin	-$118,091	-$118,091	N	1% BH office reduction
Approve outpatient psych PAR	-12,241,619	-19,089,323	Y	Request not recommended
Approve BH incentive request	-1,108,073	-3,562,207	N	Amount not included in recommendation
Approve CCBHC request	-7,355,189	7,869,476	N	Savings not included in recommendation
PPS guardrails	TBD	TBD	N	Assume cost savings from policy changes
Reduce peer services	-4,249,746	-16,218,017	N	Doubles FY 25-26 reduction
PBT Policy changes	TBD	TBD	N	Assume cost savings from policy changes
Collab care management	-686,967	-2,252,507	N	FY 25-26 Integrated care request
Workforce capacity center	-1,553,947	-1,553,947	Y	FY 25-26 System of care and SB 25-292
Complex youth staff (4.0 FTE)	-194,840	-194,840	N	FY 23-24 Complex youth request
Secure transport benefit	-461,008	-538,992	Y	HB 21-1085
Partial hospitalization	-118,900	-656,600	Y	FY 24-25 BH continuum and HB 24-1045
High fidelity wrap and intensive care coord	-5,964,000	-5,964,000	Y	HB 24-1038, SB 19-195 and budget actions
Mobile crisis	-585,000	-715,000	Y	SB 17-207 and HB 22-1214
Antipsychotic drug PAR	-974,301	-2,739,898	Y	Reinstate PAR for drugs from SB 24-110
Child welfare PRTF utilization management	-1,489,424	-1,489,424	N	Reduce child welfare for reduced inpatient care from medical necessity determinations
CHRP emotion disturbance expansion	-1,480,139	-1,480,139	Y	HB 22-1038
Reduce PRTF rate	-211,142	-211,142	N	HB 22-1038
MHTLH beds	-614,135	-614,135	N	HB 22-1303 reduce transitional living homes to statutory minimum
IMD waiver	-1,713,811	-5,492,071	Y	FY 24-25 BH continuum request and SB 25-042
SUD residential and inpatient	-30,293,632	-108,423,690	Y	HB 18-1136
Youth behavioral health assessments	-3,750,000	-3,750,000	Y	HB 24-1038
Subtotal - Expenditures	-$50,209,337	-$136,194,476		
Net General Fund Relief	$50,209,337			

Revenue Enhancements

There are no revenue enhancement options for this section of the budget.

Expenditure Reductions

5% Behavioral Health administrative reduction

Description: Reduces administrative funding for the BHIC office for a reduction of $118,091 General Fund.

Health/Life/Safety Impact: Low

Additional Information: Most appropriations for FTE costs in the Department are included in a single line item in the Executive Director's Office. Staff does not have transparency into the cost of staffing for individual offices and programs other than the Office of Community Living and IT projects. The reduction is based on the General Fund appropriation for the BHIC office in FY 2024-25 provided during the Department's FY 2024-25 hearing ($2,361,826).

The FY 2024-25 appropriation included term-limited FTE that administer ARPA programs. The Department indicated that the FY 2024-25 appropriation included 46.3 FTE at the beginning of FY 2024-25, reduced to 35.2 beginning January 2025.

The reduction is based on similar administrative reduction options presented for the Department of Human Services (DHS) and is not informed by actual vacancy, turnover, or reversion data. Staff assumes that the administrative burden for HCPF will increase due to the implementation of H.R. 1 and reductions could impact capacity to implement federal requirements.

Expenditure Reductions based on denied requests

The following sections provide the General Fund savings if the Committee chose to approve the Department request for General Fund reductions that are not recommended by staff.

R6.09 Outpatient psychotherapy PAR

Description: Staff recommends denial of the Department request to implement PARs for outpatient psychotherapy. The Department assumes the policy change would save $2.2 million General Fund.

Health/Life/Safety Impact: Moderate

R6.02 Behavioral health incentives

Description: Staff recommends partial approval of the Department request to reduce incentive payments to RAEs. The request is assumed to reduce payments by 54.9 percent and increase future rate negotiations. Approval of the request would save an additional $1.1 million General Fund.

Health/Life/Safety Impact: Moderate

BA11 CCBHC Implementation

Description: Staff recommends denial of General Fund savings assumed for CCBHC implementation before the demonstration grant is awarded. Approval of the request would save an additional $7.4 million General Fund.

Health/Life/Safety Impact: Moderate

Expenditure reductions based on recent policy changes

The following sections presume that additional savings may be recognized from policy changes implemented by the Department. Policy changes for PPS and PBT are under consideration by the Department, and it may be premature to assume savings in this budget cycle.

Prospective payment guardrails

Description: The Department has implemented guardrails for the payment system to comprehensive providers, but has not assumed savings from those policy changes.

Health/Life/Safety impact: Low

Additional Information: The Department is in the process of developing guardrails for PPS. The Department has also ended directed payments to essential providers. Staff has asked the Department for additional information on cost savings from PPS guardrails. Savings may already be assumed in the behavioral health forecast. Guardrails include

Peer Support

Description: Doubles a reduction for peer support services approved by the Committee in FY 2025-26.

Health/Life/Safety Impact: Moderate

Additional Information: The Committee and General Assembly approved a reduction of $4.2 million General Fund for peer support services in FY 2025-26. The reduction was based on an assumption that peer services would be limited to comprehensive providers. Staff continues to hear that peer services may be over-utilized even after the implemented reduction. Staff has asked the Department to consider possible reductions for peer support and the impact of further reductions.

PBT Policy changes

Description: Staff anticipates that payments for PBT should decrease as the Department implements clearer policies and oversight for providers, and the General Assembly considers licensing requirements.

Health/Life/Safety Impact: Moderate

Additional Information: It is unclear at this time what savings may be assumed from policy changes for PBT. HCPF has already implemented certification requirements that may reduce billing. Savings from the policy change are not assumed in the request.

Expenditure Reductions Based on Recent Increases

The following sections eliminate the appropriations for recent increases to behavioral health and related programs from legislation and budget actions.

Collaborative care management

Description: Eliminates funding for collaborative care management from a FY 2025-26 budget request for a $686,967 General Fund reduction.

Health/Life/Safety Risk: Moderate

Additional Information: Collaborative care management is a Medicaid benefit to embed behavioral health clinicians within primary care clinics. The benefit is expected to improve health outcomes and reduce hospitalization. The Committee initially denied the request, but approved the increase as part of the comeback process. The Department's response to RFI 2 indicates that the increase was the result of requests from providers to improve resources for integrated care.[17]

Workforce capacity center

Description: Repeals the Workforce Capacity Center from a FY 2025-26 budget request and enacted by S.B. 25-292 (Workforce Capacity Center) for a reduction of $1.6 million General Fund and 1.0 FTE.

Health/Life/Safety Risk*:* Moderate

Additional Information: The Workforce Capacity Center was established to train and certify providers for high fidelity wraparound services. The center is intended to address a lack of available home-based services to reduce hospitalization for high acuity youth. The Committee initially denied the request, but approved the increase as part of the comeback process. Additional information is provided in the next issue brief.

Complex youth staff (4.0 FTE)

Description: Eliminates funding for four staff positions approved as part of a FY 2023-24 budget request to coordinate care and coverage for high acuity youth for a reduction of $194,840 General Fund.

Health/Life/Safety Risk: Moderate

Additional Information: The positions included an administrator, two nurses, and a compliance specialist to create a multi-disciplinary team in response to a lawsuit that alleged violations of federal assessment standards. The positions would focus on clinical, policy, benefits, and legal issues for children with complex needs.

The reduction would eliminate current staff and care coordination resources for high acuity youth. However, reducing these services could prevent further reductions to direct services. The reduction would be to the Executive Director's Office rather than behavioral health capitation.

[17] 2025 HCPF RFI 2, page 41.

Secure transportation benefit

Description: Repeals the secure transportation benefit created by H.B. 21-1085 (Secure Transportation Behavioral Health Crisis) for an estimated General Fund reduction of $461,008.

Health/Life/Safety Risk: Moderate

Additional Information: The bill required the Department to create a benefit for secure transportation services. Secure transportation provides urgent transport to emergency, mental health, substance use, or walk-in crisis facilities. Estimated current costs are twice as high as the estimates provided in the fiscal note for the bill.

Partial hospitalization

Description: Repeals partial hospitalization benefit required by H.B. 24-1045 (Treatment for Substance Use) and approved as part of a FY 2024-25 budget request for a reduction of $118,900 General Fund.

Health/Life/Safety Risk: High

Additional Information: The bill required the Department to seek federal approval for a partial hospitalization benefit. Partial hospitalization provides clinical outpatient support for 20 hours per week, 5 days a week. Elimination of the benefit is expected to increase rates of hospitalization, but that offset is accounted for in the reduction amount. The estimated cost of partial hospitalization without the hospitalization offset is $6.4 million total funds.

High fidelity wraparound and intensive care coordination

Description: Eliminates funding for high fidelity wraparound and intensive care coordination from S.B. 19-195 (Child and Youth Behavioral Health System Enhancements) and H.B. 24-1038 (High Acuity Youth) and a FY 2025-26 budget request.

Health/Life/Safety Risk: High

Additional Information: Funding has been provided in several bills and budget requests to increase in-home and community-based services for high acuity youth. Funding is intended to be responsive to a settlement agreement and statutory requirements to create a system of care for high acuity youth. Additional information is provided in the last issue brief.

Mobile crisis

Description: Repeals mobile crisis from S.B. 17-207 (Strengthen Behavioral Health Crisis) and H.B. 22-1214 (Behavioral Health Crisis Response System)for an estimated reduction of $585,000 General Fund.

Health/Life/Safety Impact: High

Additional Information: Senate Bill 17-207 required crisis walk-in centers to be equipped to accept mobile response units. The fiscal note indicates that the bill may drive increased costs for Medicaid behavioral health services that could be used to negotiate increased costs in the future. The fiscal note did not estimate a specific fiscal impact to the Department.

House Bill 22-1214 required DHS to update contracts for crisis services to ensure minimum regulatory standards. The fiscal note estimated no fiscal impact.

Prior year hearing documents indicate that the Department assumes an increased cost of $1.3 million total funds for mobile crisis services from the two bills. Staff is unsure what aspect of the bills is driving the cost, and the General Fund impact to behavioral health capitation of repealing either bill.

Antipsychotic drug PAR

Description: Repeals S.B. 24-110 (Medicaid Prior Authorization Prohibition) for an estimated General Fund reduction of $974,301.

Health/Life/Safety Risk: High

Additional Information: Prior to the bill, prior authorization requirements (PAR) mandated that patients failed two preferred antipsychotic drugs before receiving coverage for a non-preferred drug. The bill limited the PAR to one failure. The reduction would be to the Medical Services Premiums line item rather than behavioral health capitation.

Child welfare PRTF utilization management

Description: Reduces funding for child welfare youth in psychiatric residential treatment facilities (PRTF) for an estimated reduction of $1.5 million General Fund.

Health/Life/Safety Risk: High

Additional Information: The reduction is associated with the movement of child welfare residential payments to behavioral health capitation beginning in FY 2026-27. Medicaid will no longer pay for placements beyond medical necessity, and is expected to reduce utilization of inpatient care.

The change is not transparently reflected in the Department's budget request. The Department has previously indicated that reductions are not assumed in the first year of the policy change as the impact is unknown. The amount estimated by staff is the difference in cost between the average length of stay for child welfare and non-child welfare youth. Any reduction in HCPF will be imposed on the Child Welfare Block in the Department of Human Services where estimated county expenditures are estimated to exceed the General Fund appropriation by $19.8 million. Additional information is provided in the last issue brief.

Children's Habilitation Residential Program (CHRP) serious emotional disturbance expansion

Description: Repeals CHRP expansion from H.B. 24-1038 for a reduction of $1.5 million General Fund.

Health/Life/Safety Risk: High

Additional Information: CHRP supports youth who are at risk for out-of-home placement and was limited to youth with intellectual and developmental disabilities (IDD) prior to H.B. 24-1038. The bill required HCPF to apply for federal approval to include youth with serious emotional disturbance.

Reduce Youth Psychiatric Residential Treatment Facility (PRTF) rate

Description: Reduces the daily rate for youth psychiatric residential treatment facilities (PRTF) from $817 to $803 for an estimated reduction of $211,142 General Fund.

Health/Life/Safety Risk: High

Additional Information: This option reduces the FY 2025-26 PRFT rate to the FY 2024-25 rate. The amount is estimated based on utilization data provided by the Department in RFI 5. Actual amounts may be higher or lower.

House Bill 24-1038 (High Acuity Youth) required the Department to contract for an actuarial analysis of the PRTF rate. The analysis recommended a rate of $815, and found that rates in other states ranged from $643 in Oklahoma to $1,027 in Minnesota.[18]

Reduce Mental Health Transitional Living Homes from 164 to 125

Description: Reduces Medicaid payments for Mental Health Transitional Living Homes in DHS to the statutorily required minimum for an estimated reduction of $614,135 General Fund.

Health/Life/Safety Impact: High

Additional Information: House Bill 22-1303 (Increase Residential Behavioral Health Beds) appropriated federal stimulus funds that originated from the American Rescue Plan Act of 2021 (ARPA) to create Mental Health Transitional Living Homes (MHTLH) in DHS. The Department was required to create a minimum of 125 beds. There are currently 164 beds in operation.

MHTLHs are intended to be a step-down from the state hospitals and step-up from community-based services. The beds are essential for managing capacity at the state hospitals. Any decrease is expected to impact the waitlist for inpatient competency restoration services.

The beds receive $5.2 million total funds in HCPF for eligible clients, and an additional $12.0 million General Fund in DHS. The reduction is estimated based on the current appropriation. Actual impact may be higher or lower. DHS assumes there would be no General Fund savings from reducing to 125 beds because the current appropriation is not sufficient to cover 164 beds.

Institute of Mental Disease (IMD) waiver

Description: Repeals IMD waiver expansion from S.B. 25-042 (Behavioral Health Crisis Response Recommendations) and a FY 2024-25 budget request for a reduction of $1.7 million General Fund.

Health/Life/Safety Risk: High

Additional Information: A facility with 16 or more beds primarily engaged in behavioral healthcare is federally referred to as an Institute of Mental Disease (IMD). The IMD rule prohibits reimbursement for IMD stays that exceed 15 days per calendar month.

[18] CBIZ Optumas HCPF PRTF actuarial rate analysis, September 2025.

The Department applied for an IMD waiver as part of a FY 2024-25 budget request to allow reimbursements for IMD stays up to 60 days as long as the average length of stay does not exceed 30 days. S.B. 25-042 statutorily required the Department reimburse stays to the extent permitted by federal approval.

Substance Use Disorder (SUD) residential and inpatient

Description: Repeals residential and inpatient substance use from H.B. 18-1136 (Substance Use Disorder Treatment) for an estimated reduction of $30.3 million General Fund.

Health/Life/Safety Impact: High

Additional Information: The bill required HCPF to seek federal approval for inpatient and residential substance use treatment. The fiscal note assumed an annual cost of $174.2 million total funds for treatment and associated staff, outreach, and actuarial services. Budget requests in FY 2020-21 and FY 2021-22 had a net effect of reducing funding by $35.4 million total funds. The Department's response to RFI 2 indicates that 14,632 Medicaid members accessed inpatient or residential substance use treatment in FY 2023-24. This reflects 29.8 percent of Medicaid substance use treatment and 3.5 percent of total behavioral health services.

The Department's response to RFI 2 indicates that the Department applied for a continuation of the Substance Use Continuum of Care waiver in December 2024. The extension continued current services and added presumptive eligibility for long-term services and supports. CMS delayed approval of a five-year extension, but granted a one year approval of the existing waiver without presumptive eligibility.[19]

Youth behavioral health assessments

Description: Eliminates funding for youth behavioral health assessments from H.B. 24-1038 for a reduction of $3.8 million General Fund.

Health/Life/Safety Impact: High

Additional Information: The bill included funding for behavioral health assessments for 3,000 youth as part of a requirement to develop a youth system of care. A FY 2023-24 budget request indicates that a lawsuit alleged the Department was not in compliance with federal screening and assessment standards.

Staff therefore assumes that eliminating funding for assessments may be a violation of federal law and the Department's response to a settlement agreement discussed in the last issue brief. The resources for assessments prior to the bill, whether the appropriation is fully utilized, and the impact of a reduction are currently unknown.

[19] 2025 HCPF RFI 2, pages 19 and 40-41.

Appendix A: Numbers Pages

Appendix A details the actual expenditures for the last two state fiscal years, the appropriation for the current fiscal year, the requested appropriation for next fiscal year, and the staff recommendation. Appendix A organizes this information by line item and fund source.

Appendix A: Numbers Pages

	FY 2023-24 Actual	FY 2024-25 Actual	FY 2025-26 Appropriation	FY 2026-27 Request	FY 2026-27 Recommendation	
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING **Kim Bimestefer, Executive Director**						
(3) BEHAVIORAL HEALTH COMMUNITY PROGRAMS						
Healthcare Affordability and Sustainability Cash Fund.						
Behavioral Health Capitation Payments	1,028,527,782	1,226,649,604	1,564,776,395	1,789,389,555	1,800,546,006	*
General Fund	257,694,490	316,708,617	365,457,319	410,592,797	413,349,022	
Cash Funds	75,710,138	99,160,135	123,502,054	149,356,892	146,930,269	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	695,123,154	810,780,852	1,075,817,022	1,229,439,866	1,240,266,715	
Behavioral Health Fee-for-service Payments	10,956,804	3,717,365	13,734,646	7,327,418	13,640,707	*
General Fund	2,563,728	2,453,203	3,300,154	1,488,484	3,277,583	
Cash Funds	665,268	593,173	814,759	63,085	809,186	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	7,727,808	670,989	9,619,733	5,775,849	9,553,938	
TOTAL - (3) Behavioral Health Community Programs	1,039,484,586	1,230,366,969	1,578,511,041	1,796,716,973	1,814,186,713	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	260,258,218	319,161,820	368,757,473	412,081,281	416,626,605	
Cash Funds	76,375,406	99,753,308	124,316,813	149,419,977	147,739,455	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	702,850,962	811,451,841	1,085,436,755	1,235,215,715	1,249,820,653	

	FY 2023-24 Actual	FY 2024-25 Actual	FY 2025-26 Appropriation	FY 2026-27 Request	FY 2026-27 Recommendation	
(D) Human Services						
(I) Executive Director's Office						
Executive Director's Office	17,003,357	18,242,507	24,550,189	24,543,455		*
General Fund	8,501,679	9,102,264	12,256,105	12,252,738		
Cash Funds	0	18,990	18,990	18,990		
Reappropriated Funds	0	0	0	0		
Federal Funds	8,501,678	9,121,253	12,275,094	12,271,727		
SUBTOTAL - (I) Executive Director's Office	17,003,357	18,242,507	24,550,189	24,543,455		
FTE	0.0	0.0	0.0	0.0		
General Fund	8,501,679	9,102,264	12,256,105	12,252,738		
Cash Funds	0	18,990	18,990	18,990		
Reappropriated Funds	0	0	0	0		
Federal Funds	8,501,678	9,121,253	12,275,094	12,271,727		

	FY 2023-24 Actual	FY 2024-25 Actual	FY 2025-26 Appropriation	FY 2026-27 Request	FY 2026-27 Recommendation
(II) Office of Children, Youth, and Families					
Child Welfare Administration	137,326	352,543	356,117	356,117	
General Fund	68,663	145,627	147,414	147,414	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	68,663	206,916	208,703	208,703	
Child Welfare Services	21,187,188	14,383,230	14,383,230	14,383,230	
General Fund	10,591,900	7,191,615	7,191,615	7,191,615	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	10,595,288	7,191,615	7,191,615	7,191,615	
Division of Youth Services	736,945	758,785	762,131	762,131	
General Fund	368,472	379,394	381,067	381,067	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	368,473	379,391	381,064	381,064	
Health-Related Social Needs	0	1,142,323	1,142,323	1,142,323	
General Fund	0	761,549	761,549	761,549	
Federal Funds	0	380,774	380,774	380,774	

	FY 2023-24 Actual	FY 2024-25 Actual	FY 2025-26 Appropriation	FY 2026-27 Request	FY 2026-27 Recommendation
Reentry Services	0	84,352	84,352	84,352	
General Fund	0	56,235	56,235	56,235	
Federal Funds	0	28,117	28,117	28,117	
SUBTOTAL - (II) Office of Children, Youth, and Families	22,061,459	16,721,233	16,728,153	16,728,153	
FTE	0.0	0.0	0.0	0.0	
General Fund	11,029,035	8,534,420	8,537,880	8,537,880	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	11,032,424	8,186,813	8,190,273	8,190,273	
(IV) Behavioral Health Administration					
Community Behavioral Health Administration	503,686	926,843	952,468	952,468	
General Fund	251,843	463,421	476,233	476,233	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	251,843	463,422	476,235	476,235	
Children and Youth Mental Health Treatment Act	0	137,680	137,680	137,680	
General Fund	0	68,840	68,840	68,840	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	68,840	68,840	68,840	
SUBTOTAL - (IV) Behavioral Health Administration	503,686	1,064,523	1,090,148	1,090,148	
FTE	0.0	0.0	0.0	0.0	
General Fund	251,843	532,261	545,073	545,073	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	251,843	532,262	545,075	545,075	

	FY 2023-24 Actual	FY 2024-25 Actual	FY 2025-26 Appropriation	FY 2026-27 Request	FY 2026-27 Recommendation
(V) Office of Behavioral Health					
Mental Health Institutes	13,266,244	11,014,933	10,046,849	10,046,849	*
General Fund	6,633,122	5,507,466	5,023,424	5,023,424	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	6,633,122	5,507,467	5,023,425	5,023,425	
Mental Health Transitional Living Homes	0	5,165,032	5,165,032	5,165,032	
General Fund	0	2,582,516	2,582,516	2,582,516	
Federal Funds	0	2,582,516	2,582,516	2,582,516	
Mental Health Transitional Living Homes	2,582,515	0	0	0	
General Fund	1,291,257	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	1,291,258	0	0	0	
SUBTOTAL - (V) Office of Behavioral Health	15,848,759	16,179,965	15,211,881	15,211,881	
FTE	0.0	0.0	0.0	0.0	
General Fund	7,924,379	8,089,982	7,605,940	7,605,940	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	7,924,380	8,089,983	7,605,941	7,605,941	

	FY 2023-24 Actual	FY 2024-25 Actual	FY 2025-26 Appropriation	FY 2026-27 Request	FY 2026-27 Recommendation	
Department of Human Services Indirect Cost Assessment	16,969,736	24,523,468	21,184,141	21,184,141		*
General Fund	8,484,868	12,261,734	10,592,071	10,592,071		
Cash Funds	0	0	0	0		
Reappropriated Funds	0	0	0	0		
Federal Funds	8,484,868	12,261,734	10,592,070	10,592,070		
SUBTOTAL - (VII) Other	18,564,747	24,523,468	21,184,141	21,184,141		
FTE	0.0	0.0	0.0	0.0		
General Fund	8,484,868	12,261,734	10,592,071	10,592,071		
Cash Funds	0	0	0	0		
Reappropriated Funds	0	0	0	0		
Federal Funds	10,079,879	12,261,734	10,592,070	10,592,070		
SUBTOTAL - (D) Human Services	129,519,998	138,354,207	141,351,269	141,344,535		
FTE	0.0	0.0	0.0	0.0		
General Fund	62,128,970	67,395,195	68,925,726	68,922,359		
Cash Funds	1,888,903	1,955,713	1,923,713	1,923,713		
Reappropriated Funds	0	0	0	0		
Federal Funds	65,502,125	69,003,299	70,501,830	70,498,463		

	FY 2023-24 Actual	FY 2024-25 Actual	FY 2025-26 Appropriation	FY 2026-27 Request	FY 2026-27 Recommendation
TOTAL - (1) Transfers to Other State Department Medicaid-Funded Programs	142,773,688	175,053,052	177,967,664	177,960,930	
FTE	0.0	0.0	0.0	0.0	
General Fund	67,743,634	86,176,582	87,707,113	87,703,746	
Cash Funds	1,938,903	2,395,303	2,322,078	2,322,078	
Reappropriated Funds	0	14,652	14,652	14,652	
Federal Funds	73,091,151	86,466,515	87,923,821	87,920,454	
TOTAL - Department of Health Care Policy and Financing	1,039,484,586	1,373,140,657	1,753,564,093	1,974,684,637	1,992,147,643
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	260,258,218	386,905,454	454,934,055	499,788,394	504,330,351
Cash Funds	76,375,406	101,692,211	126,712,116	151,742,055	150,061,533
Reappropriated Funds	0	0	14,652	14,652	14,652
Federal Funds	702,850,962	884,542,992	1,171,903,270	1,323,139,536	1,337,741,107