

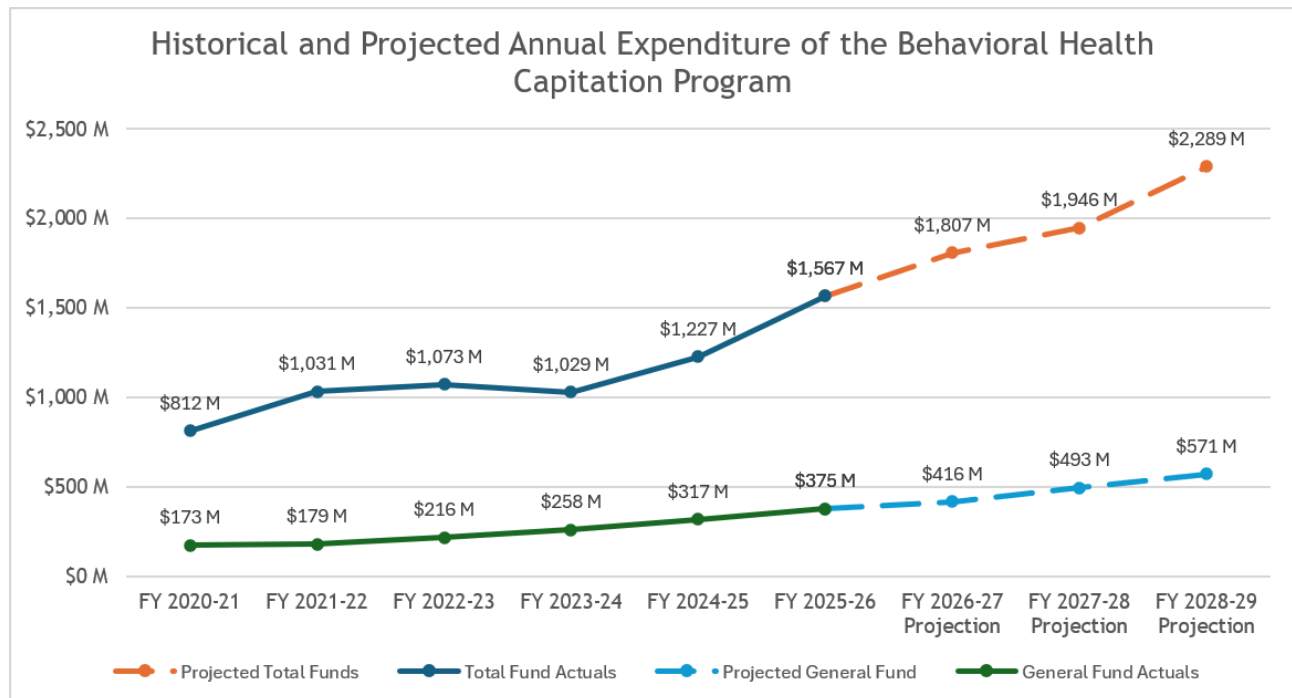


Behavioral Health Cost Growth

Medicaid spending on behavioral health services has grown over recent years as a result of intentional efforts to expand access to a full continuum of behavioral health services across the member lifespan. Behavioral health services include mental health and substance use disorder (SUD) services such as individual, family and group psychotherapy; crisis and high intensity outpatient services; residential and inpatient care; medication assisted treatment; and support services such as case management, outreach, life skills, education, and housing supports.

Figure 1 shows the historical and forecasted growth of the Behavioral Health Capitation program through FY 2028-2029, with a projected spend of \$2.289 billion total fund by 2029, if no action is taken.

Figure 1. Historical and Projected Annual Expenditure of the Behavioral Health Capitation Program



The majority of behavioral health services are provided through the Accountable Care Collaborative. The Department of Health Care Policy and Financing (HCPF) contracts with four Regional Accountable Entities (RAEs) that contract with a statewide network of behavioral health providers that provide mental health and SUD services for members. HCPF pays RAEs a capitated rate for each enrolled member to manage the Medicaid behavioral health benefit. The rates paid to the RAEs for the covered behavioral health services are based on historic utilization patterns and unique regional variations that affect pricing. RAEs accept financial risk under this arrangement and are responsible for paying behavioral health providers.



Figure 2 shows two trends over the same period. Medicaid enrollment rose sharply during the continuous coverage period created during the national Public Health Emergency and has since fallen back and flattened. At the same time, the average per member per month weighted rate paid to the RAEs to cover the cost of services has risen to \$112.00 in FY 2025-26 and is projected to reach \$171.48 by FY 2028-29. Spending increases in this benefit is largely attributed to rising costs to cover behavioral health services, and increased utilization per person, rather than the total Medicaid population count. In FY 2024-25, 241,345 Medicaid members accessed capitation behavioral health services. Figure 3 shows that the total number of Medicaid members receiving services increased in both volume and percent of total members, from 14% to 20%, which explains some growth but is not as significant a factor in total costs.

Figure 2. Average Caseload and Average Weighted Rate by Fiscal Year

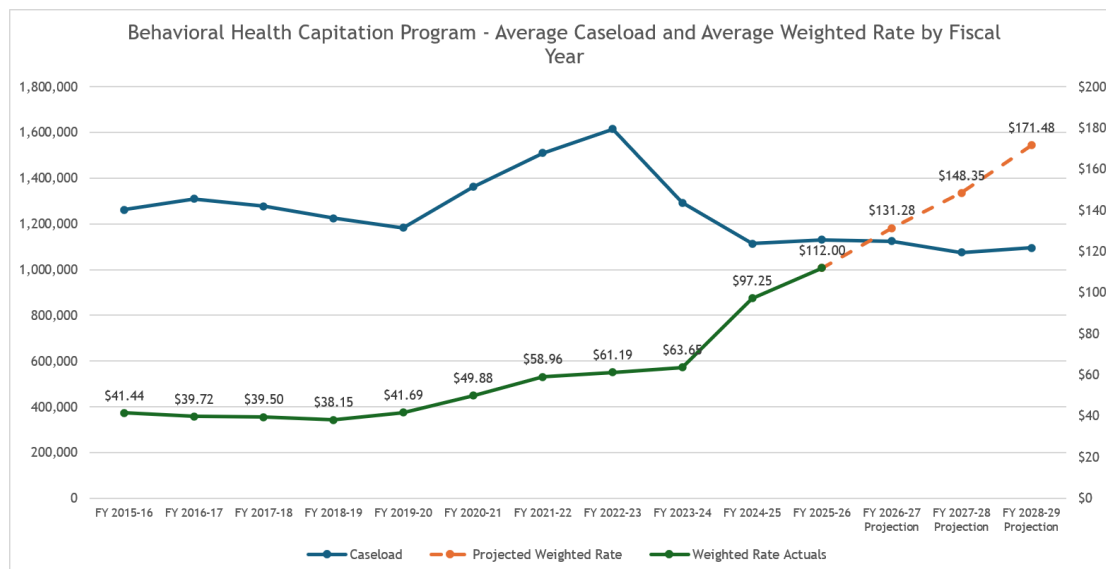
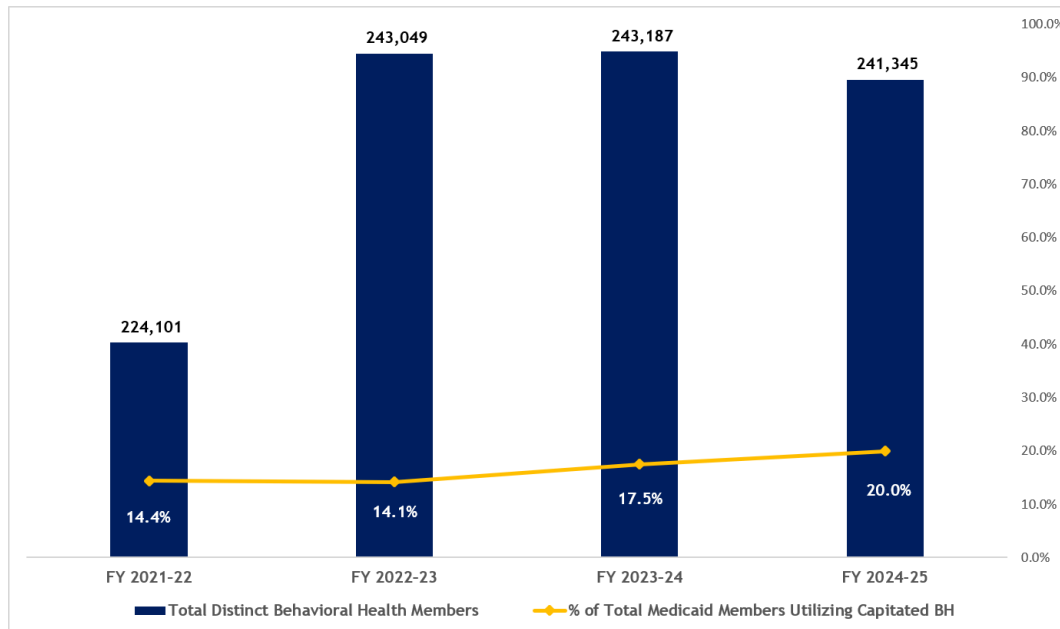




Figure 3. Colorado Medicaid Members Accessing Behavioral Health Services, by Individual and by Percentage of all Medicaid Members



Much of the rate growth reflects deliberate policy choices. Colorado made significant efforts to expand behavioral health access and services over the past 5-7 years including:

- Increased providers accepting Medicaid from ~6,000 to over 14,000 between 2018 and 2025.
- Expanded coverage through a 1115 Demonstration Waiver including
 - Residential, inpatient services and IOP SUD beginning 2021 and Partial Hospitalization in 2024;
 - Expanded inpatient mental health for adults in October 2025;
 - Housing navigation and support services in July 2025; and
 - Coverage for some services in prisons 90 days prior to reentry in 2026.
- Expanded coverage for supportive services in 2021, 2022, and 2025.
- Removed prior authorization for outpatient psychotherapy services via [SB22-156](#) in 2022
- Established new safety net provider standards and public provider expansion in partnership with the Behavioral Health Administration from 2021 to 2023.
- Developed services for youth with complex needs and high-acuity youth through the Colorado System of Care from 2024 to present.
- Created a more stable cost-based payment (the Prospective Payment System or PPS) for safety net providers.

Service Areas with Concentrated Growth

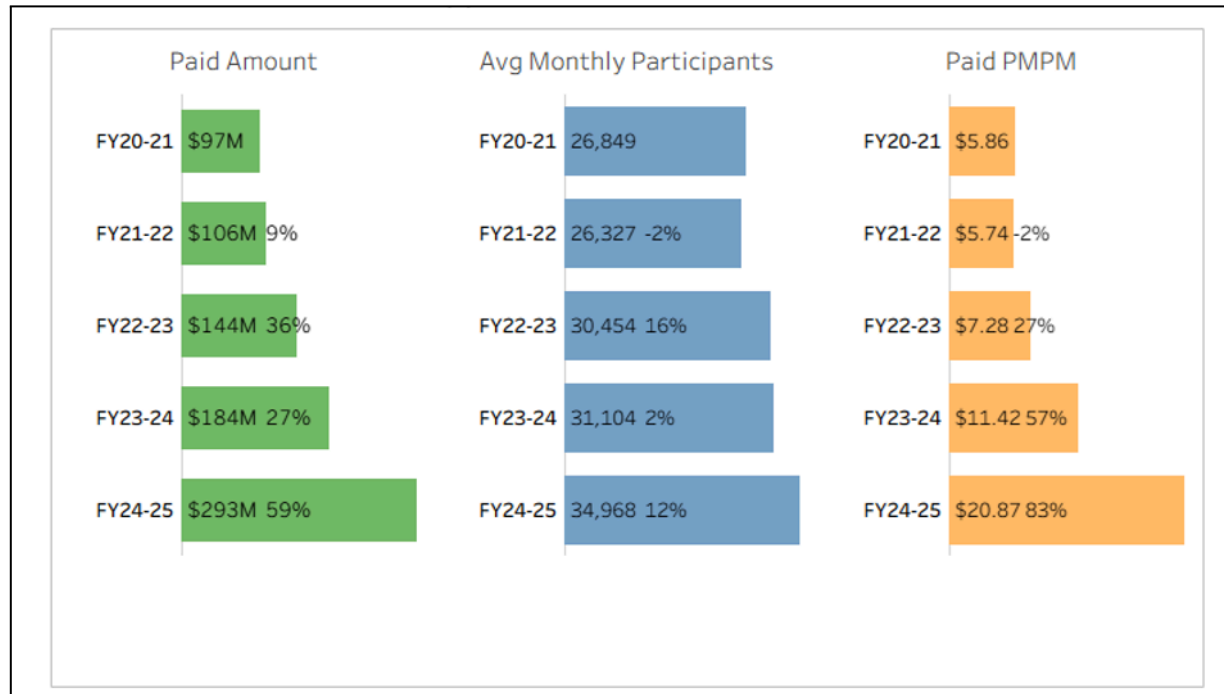
Member utilization of peer and support services, SUD related services and outpatient psychotherapy has grown significantly in the last few years. Figures 4-10 show the paid amount



for these services, the average monthly participants and the amount paid per member per month for each year. The percentages on each bar represent the percent increase year over year.

Peer & Supportive Services

Figure 4. Peer & Supportive Services



HCPF's internal analysis over the past two years shows growth in supportive services exceeding expectations in both pace and scale. Supportive services are non-clinical services, often provided by peers, case managers, or other unlicensed professionals. Examples include skills training, peer recovery supports, outreach, wraparound care, activity therapy and stress management. Utilization of outpatient supportive services has grown faster than the benefit overall, from 9.25 hours per person getting support services per year in FY 2022-23 to 24.75 hours in FY 2025-26. Services billed under Self-Help Peer Services (H0038), Behavioral Health Outreach (H0023), and Skills Training and Development (H2014) grew 286% between FY2022 and FY2024, and H0038 alone rose from \$8.8 million in FY2022 to \$51.8 million in FY2025. Part of this reflects the intended results of workforce expansion, new providers, new models of care, and federal ARPA investment in peer support training. Recent analysis into the unprecedented growth however indicates these services are being delivered without appropriate oversight from a clinical team, and concentrated among newer providers whose programs rely heavily on unlicensed staff, raising quality-of-care concerns alongside the question of sustainability.



Substance Use Disorder Related Services

Figure 5. Behavioral Health Services - Substance Use Disorder

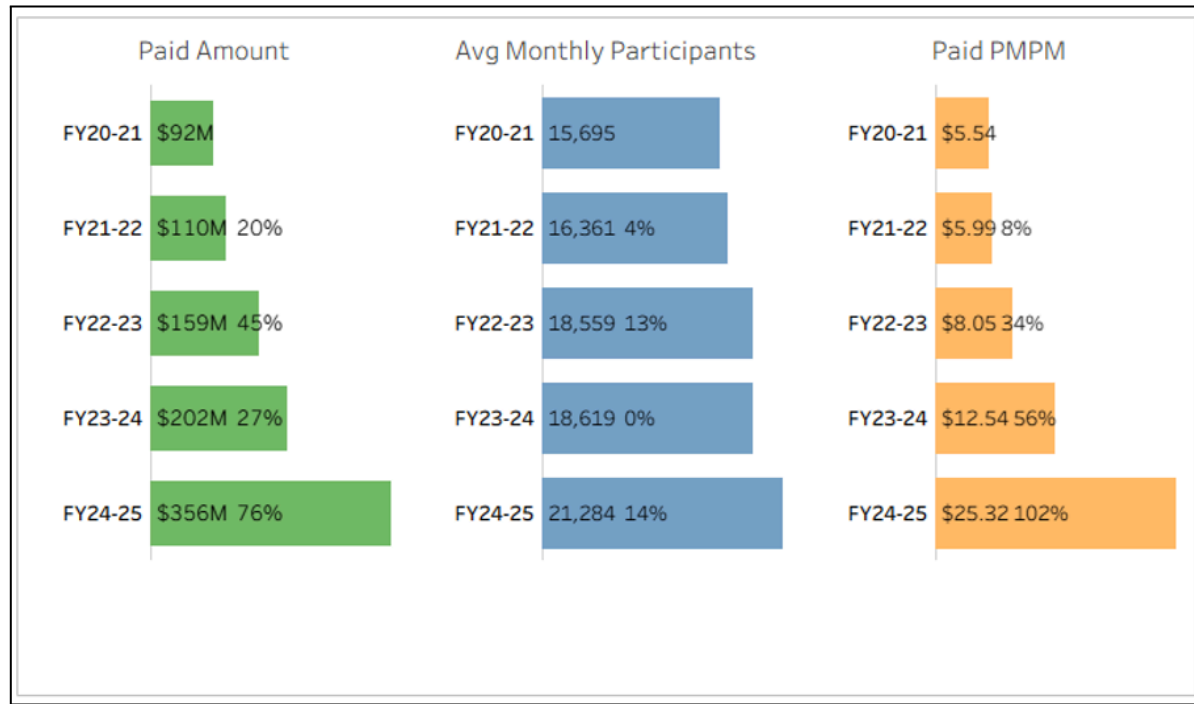
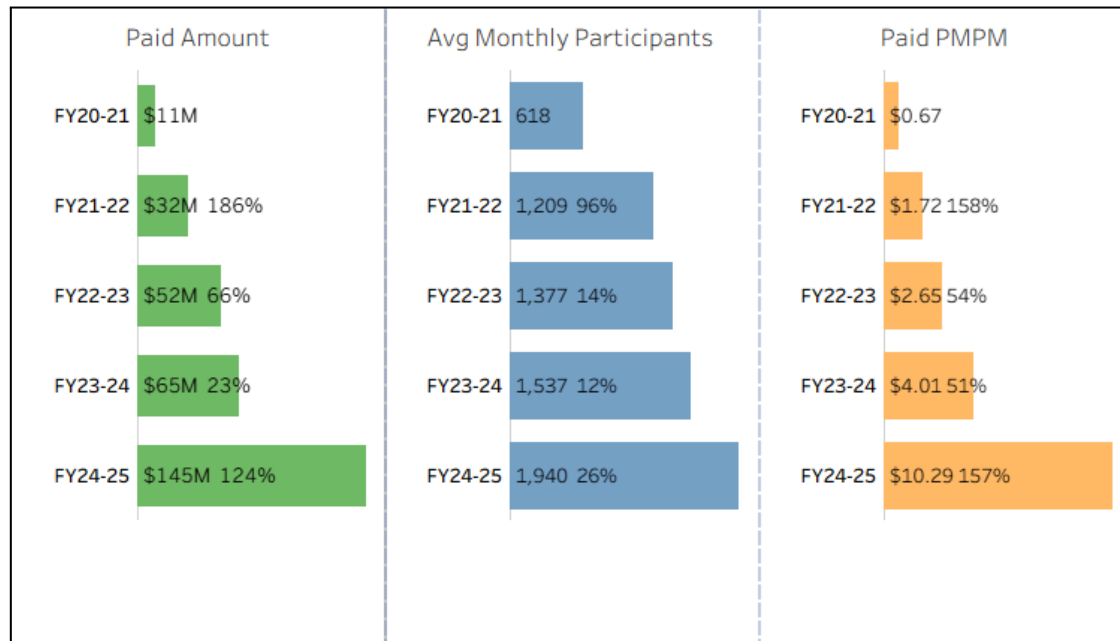


Figure 5 shows the total cost of all substance use treatment services including outpatient services and bedded facilities. Figures 6-9 break this total cost of SUD services into four distinct service categories.



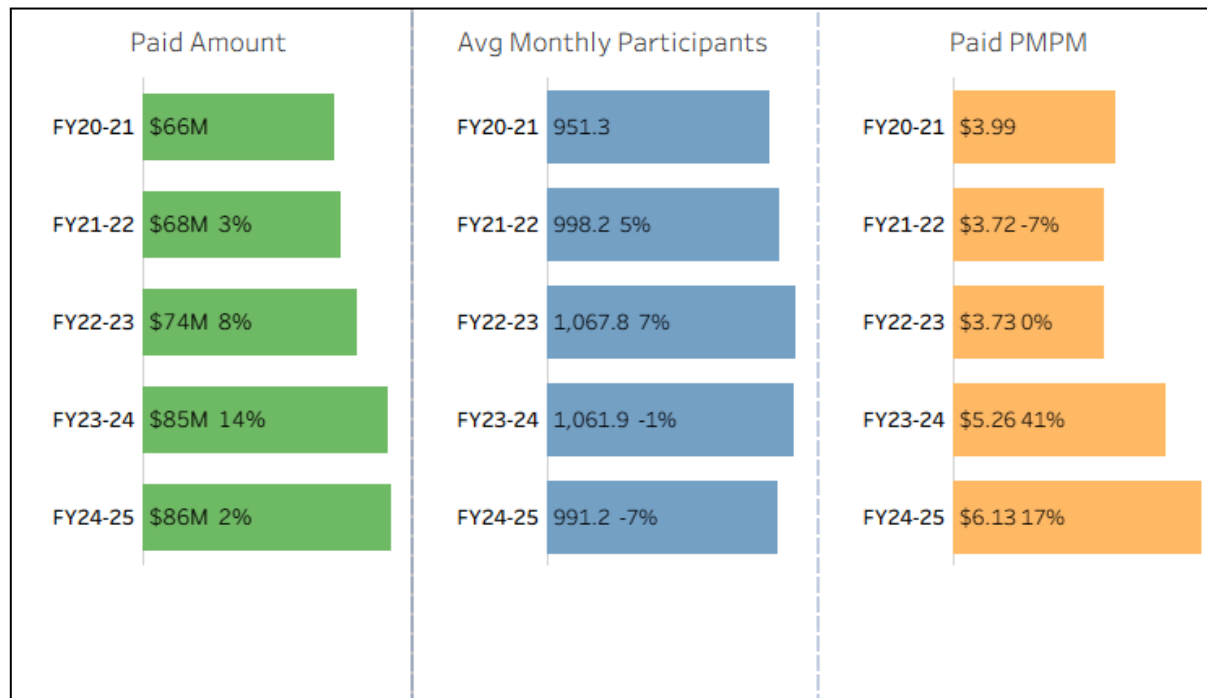
Figure 6. Substance Use ASAM Residential (Capitation, all diagnoses)



SUD residential and inpatient services became a [covered benefit in 2021](#) under the federal 1115 Demonstration Waiver, so some growth in this area was planned and reflects a new benefit reaching members who previously had no coverage for it. The scale and pace warrant continued attention as the rate of growth has accelerated instead of stabilizing. This shows a need for better oversight and control of the benefit. Areas HCPF has identified of overspend here is standalone withdrawal management with high rates of readmission, and for diagnosis that may be more effectively treated in an outpatient setting.



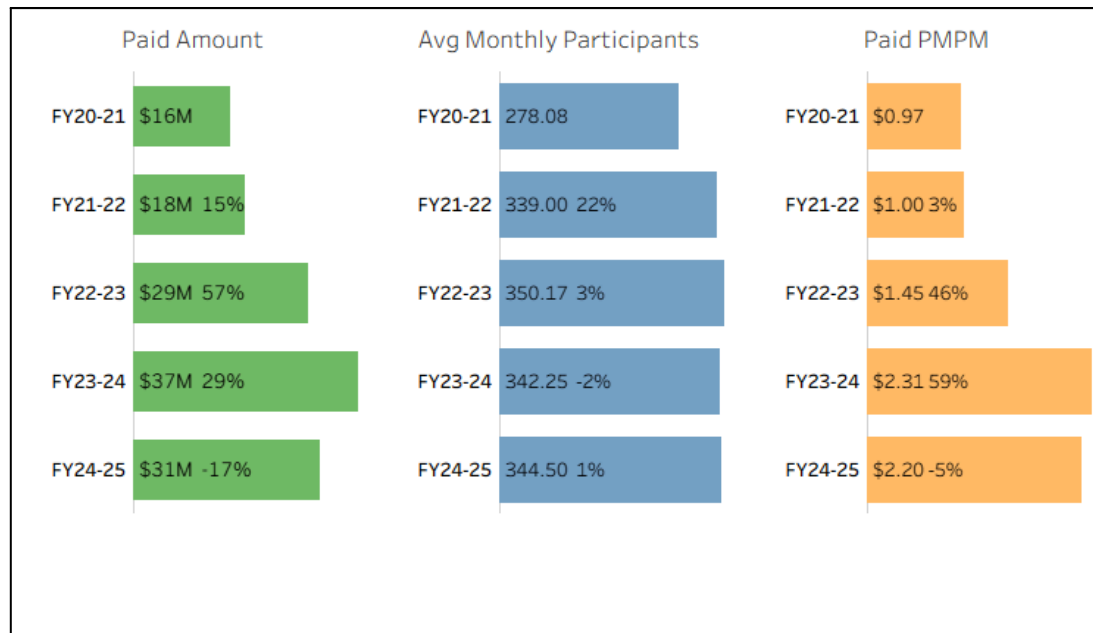
Figure 7. Inpatient hospital - 01 and 02 hospitals (Capitation, all diagnoses)



Inpatient hospitalization includes services in general hospitals, in psychiatric units of general hospitals, and in free-standing psychiatric hospitals. From FY2024-25 to FY25-26, HCPF implemented an expanded inpatient mental health benefit, allowing reimbursement for stays up to 60 days for those with serious mental illness, up from the previous limit of 15. This would influence the per member per month costs, with members with higher needs staying longer in inpatient care.



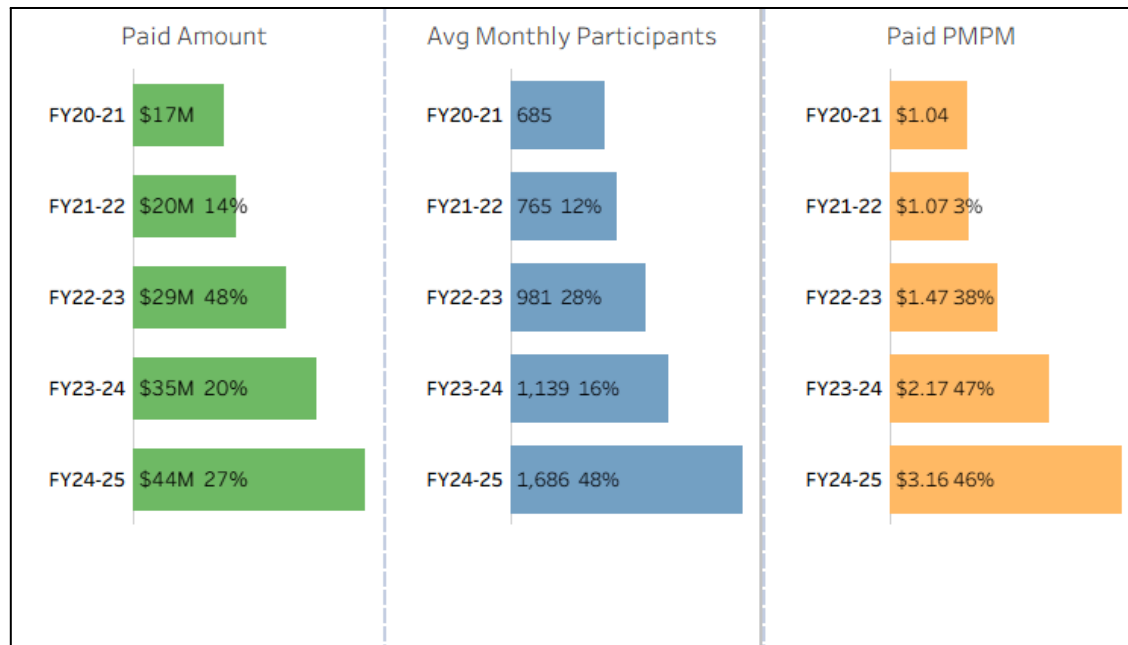
**Figure 8. Bedded Crisis - Acute Treatment Units (ATU) and Crisis Stabilization Units (CSU)
(Capitation, all diagnoses)**



Acute Treatment Units (ATU) and Crisis Stabilization Units (CSU) are able to serve individuals for short term 24/7 mental health, substance use, or co-occurring stabilization services. Prior to July 2024 any Essential Safety Net provider that provided this level of care was able to receive cost based rates, with the average rate growing to approximately twice a hospital daily rate. As of FY 2025-26, HCPF no longer enforced a minimum for CSU/ATU rates to be paid by the RAEs based on cost reports. HCPF does use the cost reports to inform the CSU/ATU rates to be used in rate-setting for the RAEs. These cost informed rates are moving to a cost informed fee schedule.



Figure 9. High intensity (team based) Clinical SUD services - IOP, PHP, ACT, Day treatment (Capitation, all diagnoses)

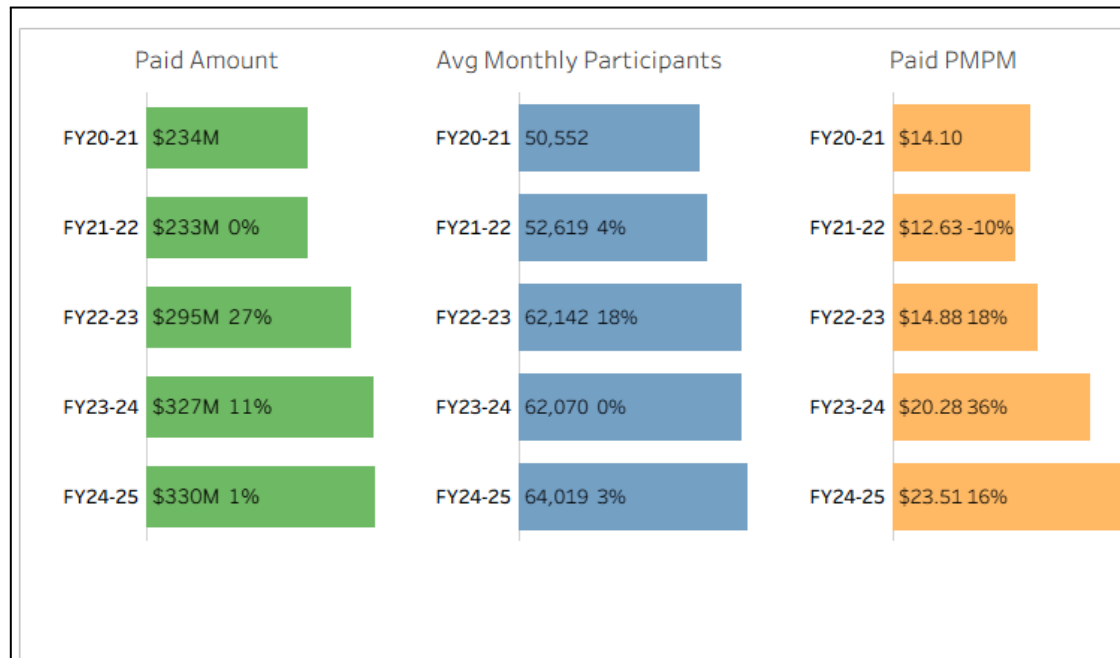


Outpatient Psychotherapy

Outpatient psychotherapy is the most commonly billed behavioral health service. The State prohibited prior authorization for these services under SB22-156 in 2022, which limits HCPF's ability to manage utilization through prior authorization for services. HCPF continues to monitor this service area given its size and the absence of prior authorization as a management tool.



Figure 10. Individual and Group Psychotherapy (Capitation, all diagnoses)



Note: Utilization data is pulled from behavioral health encounter data submitted by the RAEs detailing out the services utilized under the capitated behavioral health benefit and the percent growth year over year. HCPF will have reliable FY2025/26 data to share later in the fall.

What HCPF is Doing to Sustain Services

Following this period of rapid growth and change, HCPF has evaluated the impact of these increased costs to establish a Medicaid Sustainability strategy to preserve necessary services for vulnerable members in fiscally responsible ways. HCPF has leaned heavily on data and stakeholder input to identify opportunities with particular attention to the three service areas above given their outsized impact on total cost trends.

Since January 2025, HCPF has implemented and planned a series of actions to improve the sustainability of the behavioral health benefit, strengthen program integrity, and better align Medicaid payments with appropriate service delivery. Due to the process and time required for policy and contract changes, some of these actions are only just now showing results.

HCPF Actions, January 2025 to Present:

- **Limited the scope of peer and supportive services.**
 - Effective July 1, 2025, HCPF limited the providers that can bill for services delivered by a Peer Support Professional, updated the codes that can be billed for services delivered by a Peer Support Professional, and implemented all National Correct Coding Initiative (NCCI) edits into claims.



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- Effective January 1, 2026, required additional documentation of peer credentialing, required all behavioral health Peer Support Professionals must be certified or be in the process of becoming certified, Behavioral Health Peer Support Professionals are required to deliver services under the oversight of a Rendering Provider. Health First Colorado Behavioral Health Rendering Provider Oversight (RPO) Policy.
 - Effective May 15, 2026, HCPF clarified the scope of behavioral health Peer Recovery Groups and listed criteria in a group setting.
 - Effective October 1, 2026, implemented new Daily limits (CO MUEs) and same day billing limits (PTPs) on supportive services.
- **Limited directed payments for essential safety net services.** Effective July 1, 2026, HCPF no longer sets a minimum rate that RAEs must meet or exceed for payment for behavioral health essential safety net services in a bedded facility. HCPF continues to direct payment rates for child and youth services, CSNPs, Mobile Crisis Response (MCR) services, and Opioid Treatment Program (OTP) services.
- **Updated the CSNP prospective payment system (PPS) state directed payment policy** beginning July 2025, creating more transparency in cost of services and indirect costs, and limiting allowable costs. In October 2026, HCPF incorporated value based payments into the PPS.
- **Strengthened the monitoring and retroactive review of outpatient psychotherapy.** With the prohibition on psychotherapy prior authorization review (PARs) through SB22-156, HCPF directed RAEs to explore utilization management strategies that address inappropriate and outlier billing practices for therapy.
- **Secured a Certified Community Behavioral Health Clinics (CCBHC) Demonstration** that increases the federal payments for safety net services provided by certified clinics, increasing federal funds to Colorado.
- **Stabilizing inpatient behavioral health payment across settings.** HCPF stopped directing cost-based payments for CSU/ATUs (July 1, 2026).
- **Implementing ASAM 4th Edition Requirements**, ending free-standing Withdrawal Management (July 1, 2027). High rates of readmissions in WM are driving SUD costs and do not support individuals in reaching and sustaining recovery.

RAE Actions in FY 2026-27

- **Provider contracting and network management:** Renegotiate provider rates and contract terms, restructure fee schedules, and terminate or modify contracts with providers demonstrating concerning utilization or billing patterns.
- **Utilization and level-of-care management:** Strengthen reviews of service utilization, duration, medical necessity, and appropriate level of care, including targeted prior authorization and clinical review where applicable.



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- **Payment and service controls:** Reduce or modify reimbursement for selected services, restrict certain services to designated providers, and implement alternative payment approaches such as capitated CSNP arrangements.
- **Billing and coding oversight:** Strengthen billing controls through procedure-code changes, encounter limits, audits, coding reviews, and targeted monitoring of inappropriate or excessive billing.
- **Ongoing monitoring and accountability:** Track implementation, utilization, provider behavior, and actual financial results to confirm that the initiatives are producing the expected savings and identify areas requiring further action.