Joint Budget Committee

Staff Budget Briefing
FY 2026-27

Health Care Policy and Financing
Behavioral Health Community Programs

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Contents

Additional Resources

To find the online version of the briefing document search the General Assembly's website for budget documents (leg.colorado.gov/content/budget/budget-documents).

Overview of Health Care Policy and Financing

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 limited to Behavioral Health Community Programs.

Behavioral health refers treatment for mental health and substance use disorders. The Behavioral Health Community Programs division only consists of two line items. Appropriations for FY 2025-26 include $1.5 billion total funds for capitated payments and $11.3 million for fee-for-service payments for behavioral health services.

Funding related to behavioral health can be appropriated throughout the Department outside of this division. Funding for pharmacy and long-term care is appropriated to Medical Services Premiums. Funding for youth with disabilities and serious emotional disturbance is appropriated to the Office of Community Living. Staffing costs for the Behavioral Health Initiatives and Coverage Office (BHIC) are appropriated in the Executive Director's Office. Medicaid funding for programs in the Department of Human Services such as child welfare and the state hospitals is appropriated in the Transfers to Other Departments section of the Department's Long Bill.

Recent Appropriations

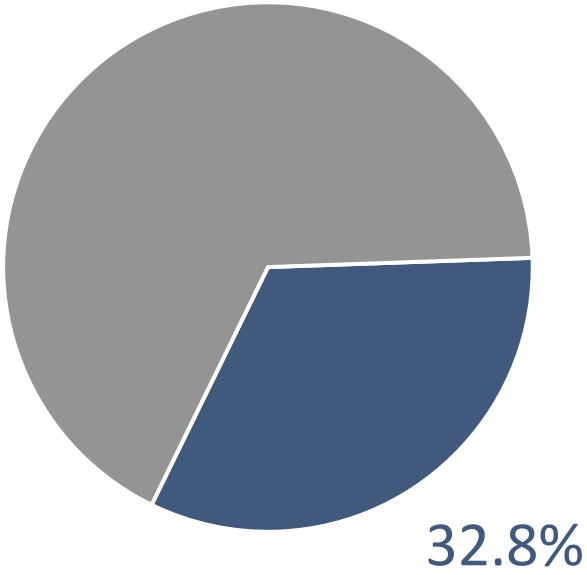
Behavioral Health Community Programs

Funding Source	FY 2023-24	FY 2024-25	FY 2025-26	FY 2026-27 [1]
General Fund	$283,497,693	$313,997,916	$352,571,292	$419,455,115
Cash Funds	86,656,628	108,885,124	122,653,551	149,612,088
Reappropriated Funds	0	0	0	0
Federal Funds	768,244,816	845,780,497	987,796,933	1,227,213,080
Total Funds	$1,138,399,137	$1,268,663,537	$1,463,021,776	$1,796,280,283
Full Time Equivalent Staff	0.0	0.0	0.0	0.0

[1] Requested appropriation.

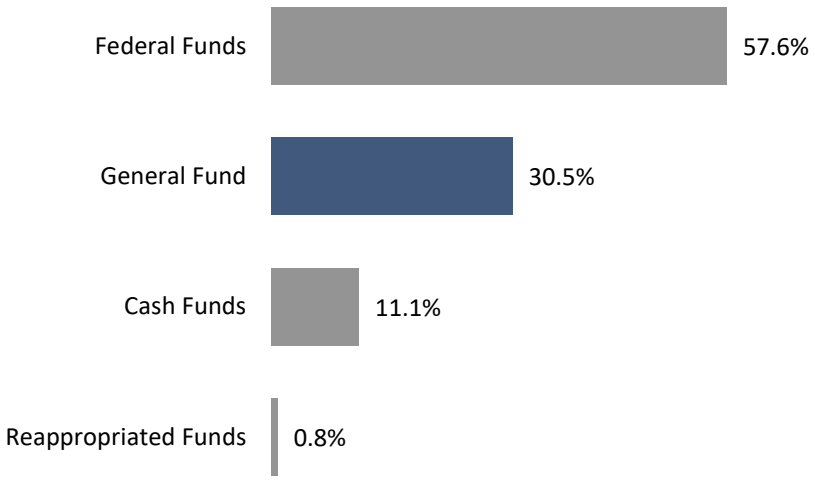
Graphic Overview

Department's Share of Statewide General Fund



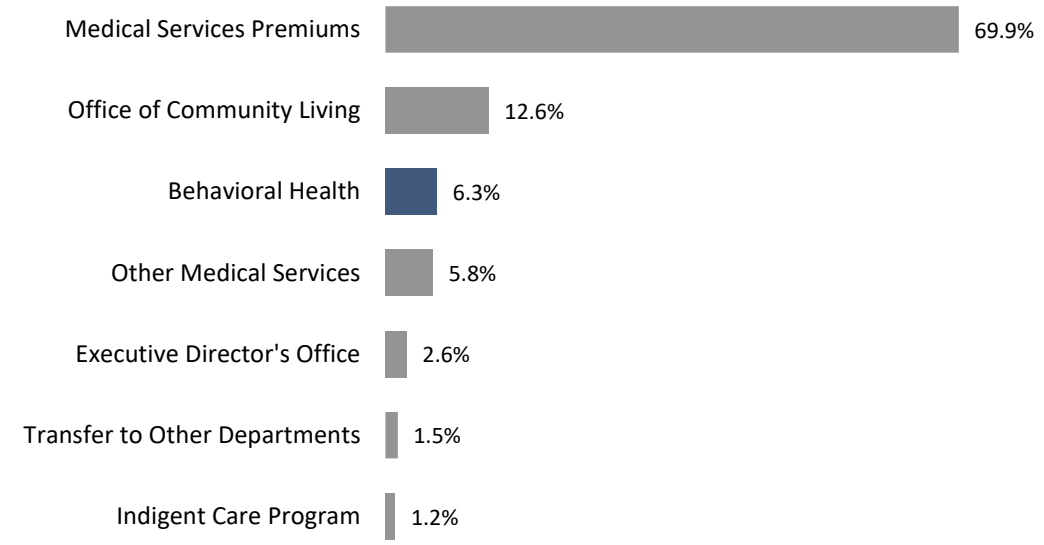
Based on the FY 2025-26 appropriation.

Department Funding Sources



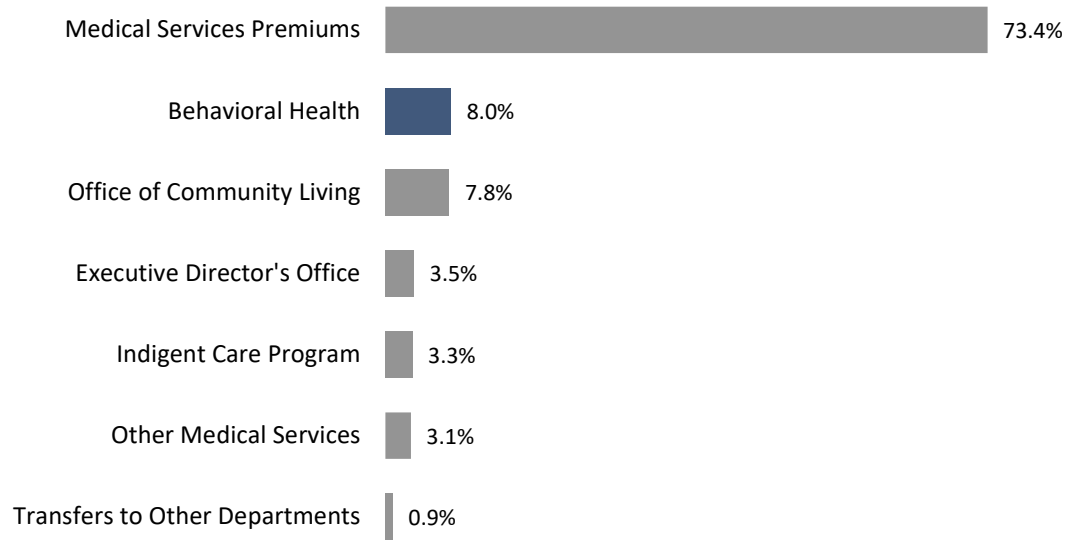
Based on the FY 2025-26 appropriation.

Distribution of General Fund by Division



Based on the FY 2025-26 Appropriation

Distribution of Total Funds by Division



Based on the FY 2025-26 Appropriation

Cash Funds Detail

Behavioral Health Community Programs Cash Funds Detail

Fund Name	FY 2025-26 Approp.	Note	Primary Revenue Sources	Primary Uses in Dept.
Hospital provider fee CF	$122,607,105	[1]	Hospital fees	Behavioral health capitation payments ($121.9 million); Fee-for-service payments ($672,498)
Breast and Cervical Cancer Prevention and Treatment Fund	46,446		Tobacco settlement and special license plate revenues	Behavioral health services for breast and cervical cancer patients.
Total	$122,607,105			

[1] TABOR exempt.

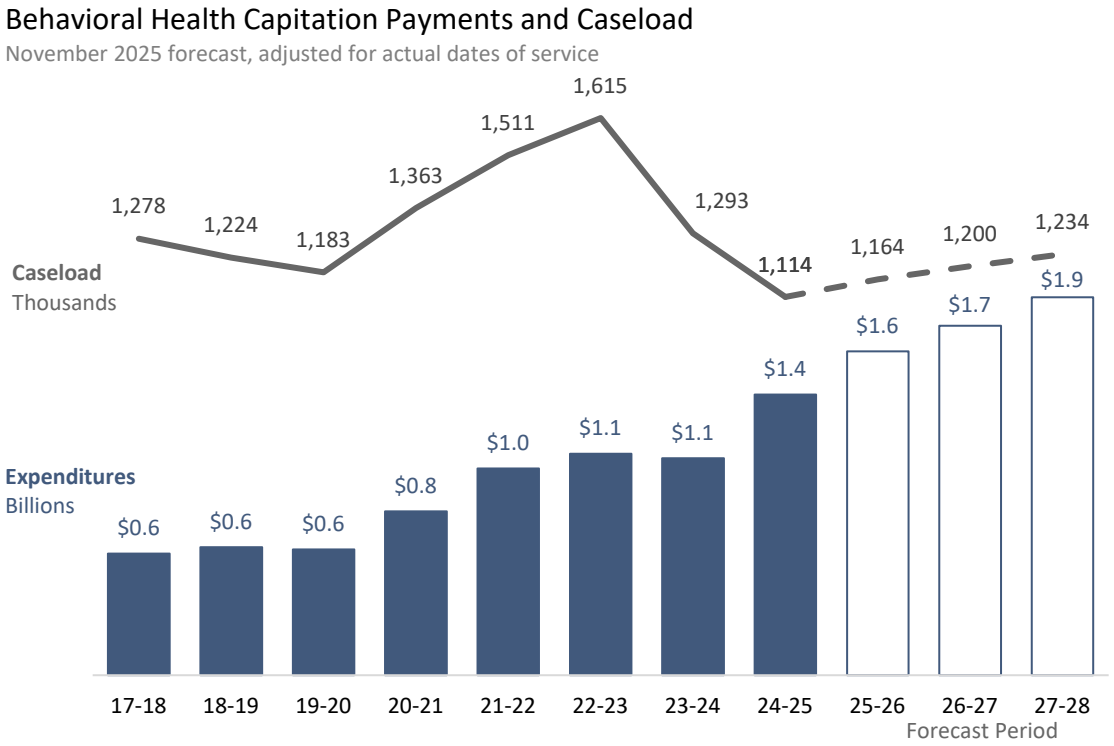
General Factors Driving the Budget

Behavioral health services are provided to Medicaid clients through a statewide managed care or "capitated" program. The Department contracts with Regional Accountable Entities (RAEs) to provide behavioral health services for clients enrolled with each RAE.

Monthly funding is provided to RAEs based on the number of eligible Medicaid behavioral health clients and Department contracts (per-member per-month rates). Each RAE subcontracts with providers to establish regional access to care. RAEs are able to pay variable rates to providers based on specific regional need for services.

Behavioral health expenditures are driven by changes to caseload, negotiated rates, and services eligible for coverage. The Department reports that 23.8 percent of Medicaid members accessed capitated behavioral health services in FY 2023-24. Of the members who accessed services, 66.7 percent used mental health services, 54.9 percent used wraparound services, and 16.2 percent used substance use services.[1] Additional information on recent cost drivers is provided in the Budget Reductions issue brief in this document.

Behavioral health services are primarily supported by the General Fund and federal funds. The state receives a 90 percent federal match for adults who are “newly eligible” pursuant to the federal Affordable Care Act (ACA). ACA expansion adults represent a significant portion of caseload, but expenditures tend to be driven by higher cost populations such as children and people with disabilities. Therefore, caseload and expenditures may change at different rates.



[1] 2025 HCPF RFI 2, page 6.

Summary of Request

Department of Health Care Policy and Financing

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 2025-26 Appropriation						
FY 2025-26 Appropriation	$18,217,290,946	$5,554,316,022	$2,030,279,577	$144,020,883	$10,488,674,464	843.2
Total	$18,217,290,946	$5,554,316,022	$2,030,279,577	$144,020,883	$10,488,674,464	843.2
FY 2026-27 Requested Appropriation						
FY 2025-26 Appropriation	$18,217,290,946	$5,554,316,022	$2,030,279,577	$144,020,883	$10,488,674,464	843.2
Medical forecast [1]	2,841,332,450	630,860,236	477,749,914	0	1,732,722,300	0.0
Employee compensation common policies	8,693,320	2,544,524	1,436,917	0	4,711,879	0.0
Operating common policies	4,277,298	1,280,829	473,422	-13,427	2,536,474	0.0
Impacts driven by other agencies	1,890,335	852,076	93,091	0	945,168	1.8
Eligibility & benefit changes [1]	-203,585,062	-82,866,991	-5,345,281	0	-115,372,790	7.0
Provider rates [1]	-341,182,268	-126,227,926	-17,665,178	0	-197,289,164	1.0
Administration [1]	8,655,095	-7,133,048	2,291,649	2,455,447	11,041,047	11.3
Prior year actions [1]	37,382,050	15,219,353	-4,075,326	-1,652,006	27,890,029	-2.6
Total	$20,574,754,164	$5,988,845,075	$2,485,238,785	$144,810,897	$11,955,859,407	861.7
Increase/-Decrease	$2,357,463,218	$434,529,053	$454,959,208	$790,014	$1,467,184,943	18.5
Percentage Change	12.9%	7.8%	22.4%	0.5%	14.0%	2.2%

[1] Only the highlighted items are discussed in this document. Other items are discussed in separate staff briefings.

Changes are assumed to be ongoing unless otherwise noted.

Medical forecast

The Department requests an increase for projected behavioral health expenditures under current law and policy. The cost is $343.8 million total funds in FY 2026-27, including $68.2 million General Fund.

Medical forecast

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE	JBC Lead
R1 Medical Services Premiums	$2,282,305,964	$431,286,496	$443,437,319	$0	$1,407,582,149	0.0	EK
R2 Behavioral health [1]	343,831,232	68,242,986	30,852,643	0	244,735,603	0.0	EP
R5 Office of Community Living	136,855,181	72,893,346	-1,713,868	0	65,675,703	0.0	TD
R4 Other programs & services	56,180,311	56,180,311	0	0	0	0.0	EK
R3 Child Health Plan Plus	22,659,762	2,757,097	5,173,820	0	14,728,845	0.0	EK
R6.05 Immigrant family planning	-500,000	-500,000	0	0	0	0.0	EK
Total	$2,841,332,450	$630,860,236	$477,749,914	$0	$1,732,722,300	0.0	

[1] Only the highlighted items are discussed in this document. Other items are discussed in separate staff briefings.

The forecasts do not account for impacts from the Governor's Executive Order or H.R. 1. Impacts from the Executive Order are included in R6. The forecast is based on enrollment and expenditure data through June 2025. The Committee will receive an updated forecast based on enrollment and expenditure data through December 2025 in February to consider for figure setting.

Increased costs for behavioral health are driven by increases in patient acuity, utilization, and eligible services. The Department's response to RFI 2 provides the following data:

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

Eligibility and benefit changes

The Department requests 18 eligibility and benefit changes across 3 prioritized requests. Two changes are discussed in this document. Additional changes are discussed in separate staff briefings.

Eligibility and benefit changes

Item	Total Funds	General Fund	Cash Funds	Federal Funds	FTE	JBC Lead
R18 3D mammograms	$635,758	$128,456	$37,885	$469,417	0.0	EK
R6.09 Outpatient psychotherapy prior auth [1]	-31,330,942	-12,241,619	-959,135	-18,130,188	0.0	EP
R6.04 Continuous coverage	-27,209,010	-11,226,343	-716,877	-15,265,790	0.0	EK
R6.10 Pediatric behavioral therapy reviews [1]	-20,000,000	-10,000,000	0	-10,000,000	0.0	EP
R6.17 IDD youth transitions	-15,261,376	-7,630,688	0	-7,630,688	1.0	TD
R6.34 Community connector units	-15,092,224	-7,546,112	0	-7,546,112	1.0	TD
R6.08 Tests for specific drugs	-14,106,232	-1,876,129	-1,035,397	-11,194,706	0.0	EK
R6.30 HCBS hours soft cap	-13,891,297	-6,945,648	0	-6,945,649	3.0	TD
R6.20 Community health workers	-13,385,549	-3,196,962	-803,013	-9,385,574	0.0	EK
R6.36 IDD cost share	-12,641,818	-6,320,909	0	-6,320,909	0.0	TD
R6.25 Biosimilars	-12,316,324	-2,357,591	-1,240,468	-8,718,265	0.0	EK
R6.26 3rd party pay for drugs	-9,770,846	-2,944,176	-645,423	-6,181,247	0.0	EK
R6.18 IDD waitlist	-6,497,170	-3,248,585	0	-3,248,585	1.0	TD
R17 Community connector age limit	-5,229,310	-2,632,702	17,147	-2,613,755	0.0	TD
R6.29 LTSS presumptive eligibility	-2,775,871	-1,471,558	0	-1,304,313	0.0	TD
R6.31 Caregiving hours soft cap	-2,266,749	-1,133,374	0	-1,133,375	1.0	TD
R6.19 Senior dental grants	-2,000,000	-2,000,000	0	0	0.0	EK
R6.32 Homemaker hours soft cap	-446,102	-223,051	0	-223,051	0.0	TD
Total	-$203,585,062	-$82,866,991	-$5,345,281	-$115,372,790	7.0	

[1] Only the highlighted items are discussed in this document. Other items are discussed in separate staff briefings.

R6.09 Outpatient psychotherapy prior authorization [legislation]: The Department is undoing the statutory prohibition on prior authorization for outpatient psychotherapy from S.B. 22-156 (Medicaid Prior Authorization and Recovery of Payment).

The Department began implementing the change October 10, 2025. The change reduces the Department's forecast by:

- Current year: $15.7 million total funds, including $6.1 million General Fund.
- Year 1: $31.3 million total funds, including $12.2 million General Fund.

Senate Bill 22-156 prohibited prior authorization requirements (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 that exceed clinical standard best practices.

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

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 request will reinstate PARs for providers claiming more than 24 sessions per patient in a calendar year. A PAR would not be required for initial access to therapy sessions. The Department began implementing the change into RAE contracts in October to allow RAEs to reinstate PARs by January 1, 2026.[2] However, the prohibition on PARs remains in statute.[3]

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. Nonpartisan legislative staff agree that it is within the Governor's authority to reduce expenditures, but find that allowing outpatient psychotherapy PARs prior to legislative change is in conflict with state law.

R6.10 Pediatric behavioral therapy reviews: The Department estimates savings from a pending review of pediatric behavioral therapy utilization.

The Department estimates savings of:

- Current year: $14.0 million total funds, including $7.0 million General Fund.
- Year 1: $20.0 million total funds, including $10.0 million General Fund.

[2] HCPF Prior Authorization and Retrospective Reviews for Outpatient Psychotherapy Frequently Asked Questions.
[3] Section 25.5-5-406.1 (1)(j)(II), C.R.S.

The Department has contracted with an auditing firm to review claims for pediatric behavioral therapy (PBT). PBT covers behavioral therapy for youth under the age of 21, including but not limited to treatments for autism spectrum disorder like applied behavior analysis (ABA).

The audit is expected to be complete by the end of 2025. The Department estimates that the implementation of preliminary audit findings, including pre- and post-payment reviews, could result in General Fund savings based on similar audits in other states.

The U.S. Department of Health and Human Services Office of the Inspector General (OIG) has released similar audits of Indiana and Wisconsin. The audits found that Indiana made at least $56.5 million in improper payments for ABA services.[4] OIG found at least $18.5 million in improper payments, and $94.3 million in potentially improper payments, in Wisconsin.[5]

Improper payments were the result of documentation requirements not met, no appropriate credentials, and no diagnosis or treatment referral. Potentially improper payments include lack of detail in session notes, nontherapy time, recreational or academic activities, and group activities. Recommendations to other states included a refund of federal money for payments that were not in compliance with federal and state standards, increased state guidance to providers, increased payment reviews, and a review of PAR procedures.

The Department issued emergency guidance for PBT providers in September 2025.[6] The rule indicates that the OIG reviewed PBT services in Colorado and found some ABA providers were not meeting national standards for training and supervision and risked repayment of federal funding.

Provider rates

The Department requests 18 provider rate changes across 4 prioritized requests. Four changes are discussed in this document. Additional changes are discussed in separate staff briefings.

Provider rates

Item	Total Funds	General Fund	Cash Funds	Federal Funds	FTE	JBC Lead
R13 Denver Health fed funds	$11,331,455	$0	$3,527,482	$7,803,973	0.0	EK
R14.2 IV nutrition rates [1]	615,320	203,628	24,453	387,239	0.0	EP
R6.03 Primary care stabilization	0	0	0	0	0.0	EK
R6.11 Provider rates -1.6%	-160,972,816	-56,992,200	-8,810,550	-95,170,066	0.0	EK
R6.23 Rates above 85% Medicare	-53,241,533	-15,046,057	-3,780,149	-34,415,327	0.0	EK
R15 Home health/nurse rates	-26,582,980	-13,670,319	160,503	-13,073,164	1.0	TD
R6.16 Dental rates	-20,668,949	-3,774,150	-3,121,011	-13,773,788	0.0	EK
R6.33 Community connector -23%	-18,331,864	-9,165,932	0	-9,165,932	0.0	TD
R6.24 Outpatient drug rates	-15,805,934	-3,772,279	-1,178,513	-10,855,142	0.0	EK
R6.15 Pediatric behavioral therapy rates [1]	-13,057,068	-6,528,534	0	-6,528,534	0.0	EP
R6.02 Behavioral health incentives [1]	-12,644,332	-3,000,000	-3,322,166	-6,322,166	0.0	EP
R6.12 Community connector -15%	-12,052,939	-6,026,469	0	-6,026,470	0.0	TD
R6.13 Nursing minimum wage	-8,719,922	-4,359,961	0	-4,359,961	0.0	EK
R6.14 Individual residential srvcs & supports	-5,801,116	-2,284,479	-616,079	-2,900,558	0.0	TD
R6.01 Accountable care incentives	-2,325,290	-750,000	-412,645	-1,162,645	0.0	EK

[4] OIG Indianna ABA Audit.
[5] OIG Wisconsin ABA Audit.
[6] Emergency Rule: PBT Providers Stakeholder Meeting.

Item	Total Funds	General Fund	Cash Funds	Federal Funds	FTE	JBC Lead
R6.28 Drug dispensing fees	-1,690,905	-509,509	-111,694	-1,069,702	0.0	EK
R6.35 Movement therapy rates [1]	-716,467	-358,234	0	-358,233	0.0	EP
R6.27 Specialty drug rates	-516,928	-193,431	-24,809	-298,688	0.0	EK
Total	-$341,182,268	-$126,227,926	-$17,665,178	-$197,289,164	1.0	

[1] Only the highlighted items are discussed in this document. Other items are discussed in separate staff briefings.

R14.2 IV nutrition rates [legislation]: The Department asks to increase the pharmacy rate for intravenous (IV) nutrition.

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

Total Parenteral Nutrition (TPN) is provided for Medicaid members who can only receive nutrition by IV. The current pharmacy reimbursement is $11.91 per claim. However, a contracted analysis found that the true cost of service is $235.86 per claim. The request would increase the rate to $235.86 per claim.

Only one pharmacy currently provides IV nutrition services in the state. The Department expects that the request will increase the number of pharmacies providing IV nutrition. Increased funding is expected to improve access for Medicaid clients who require IV nutrition to survive. However, the Department does not anticipate that the increased rate will increase utilization because anyone in the state who needs the service is already utilizing the service.

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.

The Department has submitted a State Plan Amendment to the Centers for Medicare and Medicaid Services (CMS) to implement S.B. 25-084. CMS requires the rate to be data informed. The Department is concerned that the amendment will be rejected because the current rate is known to be insufficient.

The Department does not identify that the request requires legislation. However, S.B. 25-084 enacted a statutory rate cap for 2026.[7] Staff therefore assumes that the request requires legislation to approve any rate above $70.76. The bill also required the Department to report the number of participating pharmacies to the JBC during the 2026 Department hearing.

R6.15 Pediatric behavioral therapy rates: The Department is reducing the rate for pediatric behavioral therapy (PBT) to 95.0 percent of a new benchmark.

The Department implemented the new rate October 1, 2025. The rate decrease reduces the Department's forecast by:

- Current year: $5.4 million total funds, including $2.7 million General Fund.
- Year 1: $13.1 million total funds, including $6.5 million General Fund.

The Committee approved a PBT rate increase to 100.0 percent of the benchmark with other states in FY 2024-25. The increase cost $34.3 million total funds, including $17.1 million General Fund. The rate included Nebraska, which was considered a significant outlier at the time.

[7] Section 25.5-5-519 (2)(b), C.R.S.

The new benchmark still includes Nebraska. However, Nebraska reduced PBT rates beginning October 1, 2025. PBT rates are not included in the 1.6 percent across the board provider rate decrease. Rates vary by service and provider type. Proposed rate reductions are provided in the table below.

PBT Rate Reductions

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

R6.02 Behavioral health incentives: The Department is reducing incentive payments to RAEs for behavioral health capitation.

The Department expects to implement the decrease in Spring 2026. The decrease reduces the Department's forecast by:

- Current year: $12.0 million total funds, including $3.0 million General Fund.
- Year 1: $12.6 million total funds, including $3.0 million General Fund.

RAEs are eligible to earn up to an additional 5.0 percent of their behavioral health capitation rate by meeting performance metrics. Payments are distributed annually with 66-90.0 percent of awards passed through to providers. The request reflects a 31.0 percent reduction to estimated incentive payments.

RAEs and providers often indicate that incentive payments are essential to maintaining business operations. However, reductions to incentive payments prevent additional direct reductions to services.

R6.35 Movement therapy rates: The Department is reducing rates for movement therapy to align with statewide rate review methodologies.

The Department expects to implement the decrease April 1, 2026. The decrease reduces the Department's forecast by:

- Current year: $119,412 total funds, including $59,706 General Fund.
- Year 1: $716,467 total funds, including $358,234 General Fund.

Movement therapy includes services such as music and dance therapy to support behavioral, developmental, and physical skills. Movement therapy is available under the Children's Extensive Support (CES), Children's Habilitative Residential Program (CHRP), and Supported Living Services (SLS) waivers.

The Department identified irregularities with the rate methodologies compared to Department standards. The reduction aligns movement therapy rates across waivers and establishes parity with comparable therapies. Rates vary by waiver and provider type, described in the table below.

Movement Therapy Rate Reductions

Type	Current Rate	Reduced Rate	% Change	Total Impact
CES, SLS (Bachelors)	$17.50	$16.11	-7.9%	-$94,222
CHRP (Bachelors)	$17.68	$16.11	-8.9%	-$7,630
CES, SLS (Masters)	$25.63	$18.61	-27.4%	-$590,407

Type	Current Rate	Reduced Rate	% Change	Total Impact
CHRP (Masters)	$25.91	$18.61	-28.2%	-$24,208
Total				-$716,467

The Department indicates that movement therapy is not explicitly identified in the 2025 MPRRAC report. However, the rate is included in the Professional Services category of HCBS. The 2024 MPRRAC found that Colorado payments for HCBS professional services were 109.7 percent of the benchmark. One recommendation of the 2024 review was to standardize uneven rates for the same service across different programs.

Administration

The Department requests 15 administrative changes across 11 prioritized requests. Three changes are discussed in this document. Additional changes are discussed in separate staff briefings.

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE	JBC Lead
R7 Eligibility administration	$16,626,704	$1,503,264	$1,560,567	$2,455,447	$11,107,426	3.0	TD
R9 Provider directory	5,955,875	451,455	248,360	0	5,256,060	0.0	EK
R10.1 Disability determinations	1,381,020	837,000	-146,491	0	690,511	0.0	TD
R11 Salesforce support	700,172	223,727	120,059	0	356,386	1.8	EK
R14.1 Chronic pain manage [1]	290,738	94,867	50,502	0	145,369	1.0	EP
R12 Home health administration	95,738	31,237	16,631	0	47,870	1.0	EK
R10.2 3rd party insurance	0	-781,598	-418,965	0	1,200,563	1.8	EK
R6.22 Provider credential ACC	0	0	0	0	0	0.0	EK
R16 Unspent grant admin [1]	0	-800,000	800,000	0	0	0.0	EP
R19 Line item consolidation	0	0	0	0	0	0.0	TD
R20 CHP+ Trust consolidation	0	0	0	0	0	0.0	EK
R8 Single assessment	-11,668,682	-6,192,265	60,986	0	-5,537,403	2.7	TD
R6.21 Children in Rocky PRIME	-3,476,470	-1,738,235	0	0	-1,738,235	0.0	EK
R6.07 Immigrant services outreach	-750,000	-262,500	0	0	-487,500	0.0	EK
R6.06 SBIRT training grants [1]	-500,000	-500,000	0	0	0	0.0	EP
Total	$8,655,095	-$7,133,048	$2,291,649	$2,455,447	$11,041,047	11.3	

[1] Only the highlighted items are discussed in this document. Other items are discussed in separate staff briefings.

R14.1 Chronic pain management: The Department asks to continue chronic pain training for providers.

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

The Chronic Pain Centers of Excellence was initially created from the federal American Rescue Plan Act of 2021 (ARPA). Funding was continued through a budget request to continue the program through FY 2025-26 using General Fund. The request would continue the program on an ongoing basis.

The program offers live an on-demand training for Medicaid providers, pain consultations, and connects individuals with chronic pain to appropriate care resources. The intent of the program is to connect people with chronic pain to care, and reduce over-prescription of narcotics. The program is operated through a contract with the University of Colorado's School of Pharmacy.

R16 Unspent grant admin [legislation]: The Department asks for the Committee sponsor legislation to allow the Behavioral and Mental Health Cash Fund to support Medical Services Premiums.

Year 1: The total cost is net-zero, including a one-time reduction of $800,000 General Fund offset by an equal increase of cash funds.

The Behavioral and Mental Health Cash Fund consists of funding that originated as federal ARPA funds. House Bill 22-1302 (Health-care Practice Transformation) appropriated $33.8 million from the cash fund to the Department for integrated care grants. Grant awards were intended to support the integration of behavioral health into primary care visits.

The Department expects $800,000 of $3.0 million appropriated for grant administration to revert in December 2026. The request would allow the Department to use the unspent funds to support the Medical Services Premiums forecast.

The Committee sponsored legislation in the last two legislative sessions to transfer ARPA funds to the General Fund to capture expected reversions. Staff anticipates that the Committee would sponsor similar legislation in 2026 rather than changing the allowable use of the cash fund. Funds could be transferred to the General Fund for FY 2025-26 or FY 2026-27. Funds will revert to the General Fund in FY 2026-27 if the Committee or General Assembly take no action.

R6.06 SBIRT training grants: The Department asks for a reduction for Screening, Brief Intervention and Referral to Treatment (SBIRT) provider training grants.

The Department implemented a reduction on October 1, 2025. The change impacts current appropriations by:

- Current year: $500,000 cash funds reduction from the Marijuana Tax Cash Fund (MTCF).
- Year 1: Decrease of $500,000 General Fund and net-zero change from the MTCF.

The SBIRT appropriation is $1.5 million cash funds from the MTCF for FY 2025-26. The appropriation supports provider training to screen, intervene, and refer individuals for substance use treatment. The Department is statutorily required to support SBIRT training and technical assistance.[8] The reduction is expected to decrease trainings from 150 to 100 per year, from an average of about 3 per week to 2. The appropriation does not support direct services.

The request is a simple reduction of the MTCF appropriation for SBIRT training grants in the current fiscal year. However, the MTCF reduction is used to offset General Fund for Medical Services Premiums (MSP) in FY 2026-27 and ongoing. The budget year impact of the request by line item is provided in the table below.

R6.06 Ongoing SBIRT training grants impact by line item

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 Department indicates that there are federal training opportunities available, but they do not include the in-person and on-demand options available through the state grant. The Committee did not approve a staff recommendation to eliminate SBIRT training grants and refinance MSP as part of FY 2025-26 Figure Setting.

[8] Section 25.5-5-208, C.R.S.

Prior year actions

The request includes a net increase of $5.5 million total funds for the impact of prior year budget decisions and legislation for the Behavioral Health Community Programs division. The table below only reflects impacts for the division rather than the entire Department.

Prior year actions

Item	Total Funds	General Fund	Cash Funds	Federal Funds	FTE
FY 25-26 BA10 System of care	$2,949,000	$1,474,500	$0	$1,474,500	0.0
HB 24-1038 High acuity youth	2,500,000	1,250,000	0	1,250,000	0.0
FY 25-26 Provider rates 1.6% adjustment	13,762	3,307	816	9,639	0.0
Total	$5,462,762	$2,727,807	$816	$2,734,139	0.0

The increase from FY 2025-26 BA10 System of care is for high fidelity wraparound services. The increase from H.B. 24-1038 is for youth assessments. Additional information is provided in the last issue brief.

Budget Reduction Options

The Executive Budget Request includes reductions of $4.1 million General Fund for Behavioral Health Community Programs representing 1.2 percent of the current General Fund appropriations in this section of the budget.[9] This issue brief reviews these proposals and additional options identified by staff.

Summary

Behavioral Health Community Programs represents 2.1 percent of total state General Fund appropriations in FY 2025-26. The Executive budget request includes proposed reductions of $4.1 million, representing 1.2 percent of the General Fund appropriations in this section of the budget. These reductions are offset by proposed increases, so that the Division's total General Fund is requested to increase by 19.0 percent.

There are multiple requested reductions that impact behavioral health services, but do not directly impact requested appropriations for the Behavioral Health Community Programs division.

Discussion

Funding History FY 2018-19 to FY 2025-26

Behavioral Health Community Programs represents 2.1 percent of total state General Fund appropriations in FY 2025-26. As reflected in the table below, General Fund in this section of the budget has increased by 43.6 percent since FY 2018-19 after adjusting for inflation. This is more than the statewide increase of 13.6 percent over the same period.[10]

FY 2018-19 to FY 2025-26 Appropriations Comparison - Adjusted for Inflation

Fund	FY 2018-19 Nominal	FY 2018-19 Adjusted	FY 2025-26	$ Change from FY 2018-19 Adjusted	% Change from FY 2018-19 Adjusted
General Fund	$188,611,425	$245,452,978	$352,571,292	$107,118,314	43.6%
Total Funds	$663,729,374	$863,756,539	$1,463,021,776	$599,265,237	69.4%

The Committee asked the Department to provide information on cost drivers for behavioral health as part of the FY 2025-26 hearing. The Department indicated that increases in expenditures can be attributed to increases in the number of providers, eligible services, utilization, and reimbursement rates.

The number of providers increased from 6,391 to 12,478 from FY 2018-19 to FY 2023-24, reflecting a 95.2 percent increase. The number of unique members accessing behavioral healthcare increased 41.0 percent from 2019 to 2024. The number of unique members receiving at least one psychotherapy session increased 64.0 percent in the same time period.

[9] Current FY 2025-26 appropriations do not include mid-year reductions in executive orders.

[10] Fiscal year 2018-19 appropriations are adjusted for inflation, calculated based on the Legislative Council Staff September 2025 forecast, which reflects an increase in the Denver-Aurora-Lakewood consumer price index of 30.1 percent between FY 2018-19 and FY 2025-26.

The Department provided a list of bills that have increased costs for behavioral health by expanding eligible services as part of the hearing response. The actual cost of the bills may be higher or lower than the amounts assumed in the fiscal note when the General Assembly approved the service. The estimated impact for FY 2025-26 provided by the Department by bill is in the table below.

Estimated Impact of Recent Legislation Identified by Department

Bill	Service	Total Funds (millions)	Fiscal Note
HB 18-1136	SUD Residential and inpatient	$110.0	$180.0
SB 22-156	Prohibit outpatient psychotherapy PAR	38.8	0.0
HB 22-1303	Mental Health Transitional Living homes	3.8	6.4
SB 17-207 and HB 22-1214	Mobile crisis	1.3	0.0
HB 21-1085	Secure transport	1.0	0.2
SB 22-231	Supportive housing	0.9	0.0
Total		$155.7	$186.6

Staff also considers additional bills related to high acuity youth and prior authorization requirements as significant cost drivers. The actual cost of these bills is not assumed to exceed the costs identified in the fiscal note.

FY 2026-27 Impact of Additional Legislation

Bill	Service	General Fund
SB 19-195	Youth high fidelity wraparound	$3,300,000
HB 24-1038	Youth assessments	3,750,000
HB 24-1038	Youth intensive care coord	2,664,000
HB 24-1038	CHRP emotional disturbance expansion	1,480,139
HB 24-1038	PRTF actuarial	0
SB 24-110	Antipsychotic drug PAR limit	974,301
Total		$12,168,440

The estimates for S.B. 19-195 include implementation delays and caseload decreases from budget actions, including a FY 2025-26 request. The Committee and General Assembly have also approved budget requests to increase eligible behavioral health services. Recent budget actions are provided in the table below.

FY 2026-27 Impact of Recent Budget Actions

Item	Total Funds	General Fund	FTE
FY 24-25 IMD waiver	$7,205,882	$1,713,811	0.0
FY 23-24 CHRP and CES respite	3,538,858	1,769,429	0.0
FY 25-26 Integrated care	2,939,474	686,967	0.0
FY 25-26 Workforce capacity center	1,607,894	803,947	1.0
FY 24-25 Partial hospitalization	775,500	118,900	0.0
FY 24-25 Permanent supportive housing	765,201	41,467	1.0
FY 23-24 Complex youth staff	389,680	194,840	4.0
Total	$17,222,489	$5,329,361	6.0

Prior Year Reductions

The Committee and General Assembly approved the following reductions for this section of the budget in the FY 2025-26 Long Bill.

- $4.2 million General Fund to limit peer services to substance use recovery and comprehensive providers.
- $300,000 General Fund to capture unutilized funds in RAE contracts for the 988 crisis hotline because the hotline does not bill for calls or collect insurance information.

Budget Requests for General Fund Relief

For this section of the budget, the budget request includes proposals for General Fund relief totaling $4.1 million, representing 1.2 percent of the General Fund appropriations. These reductions are offset by proposed increases, so that the Division's total General Fund is requested to increase by 19.0 percent. The proposals for General Fund relief are summarized in the table below.

Budget Requests 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				
R6.02 Behavioral health incentives	-$3,000,000	-$12,644,332	N	Reduce behavioral health incentive payments to RAEs
R10.2 3rd party insurance	-1,043,983	-3,212,252	N	Shift from post-payment reviews to IT systems that stop pay when there is a 3rd party insurer
R6.11 Provider rates -1.6%	-42,987	-178,903	N	Undo the 1.6 percent provider rate increase
Subtotal - Expenditures	-$4,086,970	-$16,035,487		
Net General Fund Relief	$4,086,970			

Additional Options for JBC Consideration

The table below summarizes options identified by the JBC staff that the Committee could consider in addition to or instead of the options presented in the budget request. A General Fund reduction of 5.0 percent to the sections of the budget covered in this briefing would require a reduction of $17.6 million.

The staff options reverse all significant budget actions and legislation that have increased behavioral health services in recent years. In general, significant budget reductions for behavioral health would require reducing or eliminating services for high acuity youth or inpatient and residential substance use treatment.

Some options may take multiple fiscal years to implement and/or require federal approval. Amounts are estimates based on the most recent information available to staff. Actual costs may be higher or lower. Several reductions impact other sections of the Department's budget rather than behavioral health capitation.

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	5% BH office reduction
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 Initiatives and Coverage (BHIC) Office 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.

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.[11]

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.

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.

[11] 2025 HCPF RFI 2, page 41.

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.[12]

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.

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.

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

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

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.[13]

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.

[13] 2025 HCPF RFI 2, pages 19 and 40-41.

High Acuity Youth

The JBC sponsored S.B. 25-292 (Workforce Capacity Center) and S.B. 25-294 (Behavioral Health Services for Medicaid Members) to address concerns with the continuum of care for high acuity youth. This issue brief provides an update on the Department's implementation of a system of care for Medicaid youth and movement of child welfare residential treatment placements to behavioral health capitation.

Summary

- The Department is operating under a settlement agreement that requires the implementation of a comprehensive system of care for Medicaid youth.
- The General Assembly has implemented several bills and budget actions in recent years related to high acuity youth and the development of a system of care.
- Multiple departments have provided data related to high acuity youth through statutory reports and requests for information, summarized in this issue brief.

Discussion

A system of care ensures that necessary and timely treatment options across the service continuum are available to anyone in need, regardless of payer and system involvement. Three bills have charged HCPF with implementing a system of care for children and youth in partnership with the Behavioral Health Administration (BHA) and Department of Public Health and Environment (CDHPE).

- Senate Bill 19-195 (Child and Youth Behavioral Health System) included $4.8 million General Fund to provide wraparound services for Medicaid youth.
- House Bill 22-1278 (Behavioral Health Administration) included an additional 5.0 FTE for HCPF, including one position to coordinate youth care.
- House Bill 24-1038 (High Acuity Youth) included $6.8 million General Fund to establish a system of care for high acuity youth.

A federal class action lawsuit was filed against HCPF on behalf of three youth plaintiffs in September 2021, *G.A. v. Bimestefer*. The three plaintiffs were Colorado teenagers diagnosed with mental illness who alleged harm from not receiving services. A settlement agreement was reached in February 2024. The agreement requires HCPF to develop and implement a system of care that delivers intensive behavioral health services to all Medicaid members ages 0-21.

Prior Year Action

The Committee and General Assembly took several actions related to the system of care and services for Medicaid high acuity youth during the 2025 legislative session.

1. Approved a budget request to decrease funding for high fidelity wraparound (HFW) services to align with anticipated caseload, and move HFW from medical services premiums to behavioral health capitation.
2. Approved a budget request to create a workforce capacity center for HFW.

3. Sponsored S.B. 25-292 (Workforce Capacity Center) to provide statutory requirements for the workforce capacity center, including a quarterly statutory report for implementation updates.
4. Sponsored S.B. 25-294 (Behavioral Health Services for Medicaid Members) to delay the movement of residential treatment for child welfare youth payments to behavioral health capitation from FY 2025-26 to FY 2026-27.
5. Approved two requests for information (RFIs) for the Department to report on the implementation of the youth system of care and child welfare residential treatment payments.

The following sections provide updates on the implementation of the youth system of care, workforce capacity center, and child welfare residential treatment from statutory reports and RFIs.

System of Care Updates

The Committee approved an RFI for the Department to report on the implementation of the youth system of care and response to the *G.A. v. Bimestefer* settlement agreement. The RFI asked for details on the system of care implementation plan as approved by the plaintiffs, implementation phases, the estimated number of youth served, and the estimated total cost.[14]

Implementation Plan

The settlement agreement requires the Department to create an implementation plan to expand access to intensive behavioral health services and reduce reliance on residential placements.[15] The plan includes the following components:

1. **Identification tool:** Identify members in need of system of care services.
2. **Enhanced Standardized Assessment:** Highlights member's strengths and needs.
3. **Intensive Care Coordination:** Provided by a designated professional who works with the family to coordinate care across providers and child agencies.
4. **Mobile Crisis Stabilization:** Address needs in the home during a crisis to mitigate the need for emergency room, residential, and inpatient hospitalization care.
5. **Intensive home-based treatment:** Clinical interventions provided to members and family in home to reduce the need for inpatient care.
6. **Support services:** Supplement clinical interventions for the member and family to successfully engage in treatment.
7. **Behavioral Consultation Services:** Advise treatment team on best practices.

Implementation Phases

Implementation will occur over seven years from FY 2024-25 to FY 2030-31. The response states that FY 2024-25 was a planning year and FY 2025-26 is the first year of services. The first year of services will include:

- Development of the Workforce Capacity Center.
- Enhanced RAE contracts for oversight responsibilities to ensure access to services.

[14] 2025 HCPF RFI 5.
[15] HCPF Colorado System of Care Resources.

- Enhanced Standardized Assessment, intensive care coordination through high fidelity wraparound, and intensive home-based treatment through multisystemic therapy or functional family therapy models added to RAE contract language.

Future years will include:

- Additional intensive care coordination models in addition to high fidelity wraparound.
- Development and implementation of home-based treatment models such as support services, family peer supports, therapeutic mentoring, respite, behavioral consultations, and crisis services.

Number of Youth Served

At of the time of the report, no children had been served by the system of care because implementation had not begun. There were no youth served by high fidelity wraparound or intensive care coordination, and no providers trained in high fidelity wraparound. The Department anticipates that 750 youth will be served in the first year and more than 10,500 youth will be served annually once fully implemented in FY 2030-31.

Table 1. Estimated Youth Served

Fiscal Year	Youth Served
2025-26	<750
2026-27	1,500
2027-28	2,500
2028-29	5,000
2029-30	8,000
2030-31	10,500+

Cost

The cost of implementing the system of care is currently estimated at $273.7 million total funds split equally between General Fund and federal funds. Of that amount, $258.5 million is for services and $15.3 million is for operations. Costs by service are provided in the table below.

Table 2. Estimated System of Care Cost by Service (total funds)

Service	Cost per unit	Units per year	Members	Funding
Assessment	$950	1	12,600	$11,970,000
High Fidelity Wraparound	$1,172	12	5,250	$73,836,000
FOCUS Wraparound	$622	12	5,250	$39,186,000
Crisis initial	$500	1	3,465	$1,732,500
Crisis ongoing (up to 4 weeks)	$139	8	3,465	$3,853,080
Mobile response initial	$500	1	1,260	$630,000
Mobile response ongoing	$139	8	1,260	$1,401,120
Intensive in-home (monthly)	$2,800	4	8,925	$99,960,000
BH consultation	$150	2	1,050	$315,000
Respite	$60	120	2,625	$18,900,000
Mentoring	$75	66	1,050	$5,197,500
Therapeutic support	$600	1	2,625	$1,575,000
Total				$258,556,200

Estimated operating costs are described in the table below.

Table 3. Est. System of Care Operating Costs (total funds)

Item	Annual cost
Workforce Capacity Development	$13,000,000
Oversight	$1,250,000
Provider outreach and education	$500,000
Info exchange and data licensing	TBD
Quality improvement	$500,000
Total	$15,250,000

The report indicates that funding for workforce development includes credentialing, training, and technical assistance for providers for assessment, high fidelity wraparound, stabilization, in-home treatment, and therapeutic mentoring. The Workforce Capacity Center approved by the Committee and General Assembly was specific to high fidelity wraparound and cost $1.6 million General Fund annually.

Staff assumes that costs associated with legislatively approved services could be included in the forecast without additional budget requests. Approved services include assessments, high fidelity wraparound, and intensive care coordination. Other services should be subject to approval by the General Assembly through budget requests or legislation.

The Department estimates that $110.0 million total funds was spent on behavioral health for youth under 21 in FY 2023-24. Increased funding for home and community-based services is expected to result in cost savings from reduced reliance on hospitalization and inpatient care. The average cost for system of care services is estimated at $71 per member per day, compared to $736 average for inpatient care. The Department is tracking claims to determine if system of care resources are reducing utilization of inpatient services, but financial offsets are not estimated at this time.

High Fidelity Wraparound

High fidelity wraparound (HFW) is a team-based, collaborative planning process for developing and implementing individualized care plans for youth with intensive behavioral health needs and their families.[16] One form of HFW is intensive care coordination (ICC). ICC is a tier of care coordination used when patient needs exceed the general population.

FY 2025-26 Budget Action

A total of $6.6 million was appropriated for HFW and ICC from S.B. 19-195 and H.B. 24-1038. The Department submitted a budget request to consolidate HFW and ICC payments into behavioral health capitation, and reduce the appropriation by $2.0 million General Fund on an ongoing basis. The FY 2026-27 request for HFW and ICC is $6.0 million General Fund.

The request used the funding reduction to develop a Workforce Capacity Center to develop HFW through a contract with an institution of Higher Education. The Committee initially denied the Workforce Capacity Center portion of the request. The Committee approved the center after a hearing with HCPF and the BHA, but sponsored legislation to establish statutory requirements for the center.

[16] Virginia Office of Children's Services, High Fidelity Wraparound.

Senate Bill 25-292 (Workforce Capacity Center)

The bill created statutory requirements for the HFW Workforce Capacity Center. The bill required HCPF to work with the BHA and providers to develop the center. The center is responsible for developing and conducting trainings, as well as covering the costs and providing technical assistance to providers participating in trainings.

The bill requires the Department to report to the Committee on a quarterly basis as part of an existing report from H.B. 24-1038. The most recent report from September 2025 states that HCPF entered into an interagency agreement with the Kempe Center at Colorado State University in August to implement the center.[17]

The January 2027 report is required to provide an analysis of the workforce capacity center that includes an overview of the impact of the center and a recommendation on the continuation, reduction, or closure of the center based on outcomes.[18] The report must also describe the type and number of trainings provided each month, the number and type of certifications earned, the number of certified providers enrolled as Medicaid providers, and the location certified providers practice.

Child Welfare Residential Payment Updates

Currently, children in the custody of county departments of human services are enrolled in RAEs, and each RAE receives per-member-per-month payments for these individuals. However, psychiatric residential treatment for foster youth is not covered by the RAE and those costs are not part of the per-member-per-month behavioral health capitation rate. Payments for youth who are not in the child welfare system are paid out of capitation.

These payments are made from the child welfare services line item in the Transfers to Other Agencies section of the HCPF Long Bill. Any General Fund remaining at the end of the fiscal year is transferred to the Department of Human Services to backfill the Child Welfare Block as part of the county close process. This funding is commonly referred to as the "child welfare carve out."

Funding for FY 2024-25 included $7.2 million General Fund and an equal amount of federal funds. No transfers were made to the Child Welfare Block in FY 2024-25 because the line item overspent by $3.4 million General Fund. However, transfers of $5.7 million General Fund were made in FY 2023-24 and $4.5 million in FY 2022-23.

Movement to capitation

In 2024, the Department announced that child welfare residential treatment payments would move to capitation July 1, 2025. Under the change, RAEs would make medical necessity determinations after a 30 day stay. If the RAE determines that a residential level of treatment is not medically necessary, the county would have 10 days to find an alternative placement or begin to cover the cost of care ($817/day).[19]

County departments of human services, residential providers, and hospitals had several concerns with the change:

1. Appropriate step-down placements are often unavailable or time consuming to arrange. The proposed medical necessity process could lead to an increase in youth spending the night in county offices or in hotels while appropriate arrangements are made.

[17] H.B. 24-1038 System of Care Quarterly State Update, September 2025.
[18] Section 25.5-6-2001 (7.5)(d)(II), C.R.S.
[19] HCPF youth psychiatric residential treatment facility rate for FY 2025-26.

2. Costs would increase for counties when expenditures for the Child Welfare Block are already expected to exceed appropriations by $19.8 million General Fund.[20]
3. Transitioning youth out of residential care without appropriate transition resources for families could increase emergency room visits. Investments in HFW proposed by HCPF were not seen as sufficient to meet step-down needs.

HCPF's concerns with the current system include:

1. Youth may be staying in residential settings longer than is medically necessary.
2. Maintaining the current system opens the state to legal risk under the *G.A. v. Bimestefer* settlement agreement.
3. The state does not have necessary rule and residential placement criteria required by CMS.
4. Statutory authority for the child welfare carve-out was eliminated by a JBC bill in 2021.

Senate Bill 25-294 (Behavioral Services for Medicaid Members)

The Committee sponsored legislation to delay implementation of the movement of residential treatment for child welfare payments to capitation from July 2025 to July 2026. The intent of the delay was to allow additional time for HCPF to build out high fidelity wraparound services, explain the implementation plan, and address concerns from other partners.

Payments are not expected to move to capitation until FY 2026-27 as required by statute. However, medical necessity determinations begin December 15, 2025 for the state to come into compliance with CMS standards.[21]

Request for Information

The Committee approved an RFI for the Department to provide implementation updates and data. The RFI required information on current utilization, step-down services, expectations for medical necessity determinations, expected practice and available services for transition planning, and financing.

The RFI requested a large amount of detail, described in the following sections.[22,23] All data is noted as preliminary and based on FY 2023-24 since the response was due to the Committee in June 2025 (prior to the close of FY 2024-25).

Current utilization data

The RFI asked for the number of child welfare and non-child welfare youth in Qualified Residential Treatment Programs (QRTP) and Psychiatric Residential Facilities (PRTF). PRTF is the highest level of youth inpatient care. The most recent report from DHS indicates that there were 156 QRTP beds and 126 PRTF beds in June 2024.

The response indicates that the average length of stay is higher for child welfare youth for both placement types.

[20] Child Welfare Allocation Committee Child Welfare Block report through September 2025.
[21] HCPF Operational Memo, Utilization Management and Assessment Requirements for Qualified Residential Treatment Providers and Psychiatric Residential Treatment Facilities.
[22] 2025 HCPF RFI 6.
[23] 2025 HCPF RFI 6 update.

FY 2023-24 Qualified Residential Treatment (QRTP) Placement Data

Item	Child Welfare	Non-child Welfare	CW higher/-lower
Total number of youth	137	50	87
Average length of stay (days)	105	95	10

FY 2023-24 Psychiatric Residential Treatment (PRTF) Placement Data

Item	Child Welfare	Non-child Welfare	CW higher/-lower
Total number of youth	96	193	-97
Average length of stay (days)	139	101	38

RAEs reported 25 youth were determined to not meet medical necessity for admission or continuation of care but no step-down services were accessed. Approximately 74 youth out of 390 discharged from QRTP or PRTF placements re-entered hospital or emergency services within 3 months of discharge (19.0 percent).

Available step down services

The RFI asked the Department to describe available step-down services from residential treatment. The response states that there are a number of supportive and step-down services available for Medicaid and CHP+ youth. Examples include:

- Care coordination delivered by RAEs
- Outpatient therapy
- Intensive community-based treatment
- Intensive outpatient treatment
- Day treatment
- Partial hospitalization
- Psychiatric medication services

The response also describes HCPF's work with the BHA to implement a system of care and develop HFW. Treatment foster care is a gap in the care continuum most often cited to staff. Treatment foster care is included in the system of care plan, and DHS indicates that treatment foster care beds increased from 124 in July 2023 to 226 in June 2024.

Medical necessity

The RFI asked the Department to describe the process for determining medical necessity. The response provides the federal requirements for medical necessity. To summarize, the intensity of service must meet the needs of the child in the least restrictive environment possible.

The response states that if a continued stay is not medically necessary, the RAE is still responsible for ensuring services are provided at the assessed step-down level as a requirement of RAE contracts. The RAE will not pay if appropriate services are identified, but the family will not allow the child to return home or the county has not identified a living arrangement. The RAE will continue to pay while a resolution is determined if an appeal is made.

Discharge and transition planning

The RFI asked the Department to describe the anticipated process for discharge, transition, and aftercare planning. The response indicates that RAEs have dedicated care managers that participate in discharge planning.

At a minimum, RAEs coordinate support services with youth and families at least 30 days prior to the proposed discharge date. Contractual obligations include HFW coordinators to assist youth, families, providers, and any other vested parties.

Financing structure

The RFI asked the Department to outline the anticipated financing structure, including the timing of payments from RAEs and efforts to ensure sustainable funding for child welfare youth. Current contracts require 90.0 percent of clean payments to be made within 30 days, and 99.0 percent within 90 days. The response indicates that the Department will tighten requirements to 90.0 percent within 20 days and 99.0 percent within 45 days beginning FY 2025-26. RAEs typically pay more than 90.0 percent of clean claims within 14 days.

The report lists the following efforts to increase sustainable funding for child welfare youth:

1. H.B. 24-1038 added social emotional disturbance as a disability included in the Child Habilitative Residential Program (CHRP), expected to reduce the number of children requiring child welfare involvement for access to Medicaid (effective January 2025).
2. HCPF is developing a system of care that will offer more intensive in-home services as a step-down from residential treatment in partnership with the BHA, DHS, and stakeholder committees.
3. HCPF has contracted for an actuarial analysis of PRTF rates as required by H.B. 24-1038 completed June 2025.
4. HCPF created QRTP rates for children under the age of 13 to increase the number of facilities serving this age group. HCPF is working to finalize an agreement with two facilities.
5. HCPF obtained an agreement with CMS to negotiate in-state and out-of-state rates for members who are able to access medically necessary services to allow HCPF to serve youth who are in need of residential care.

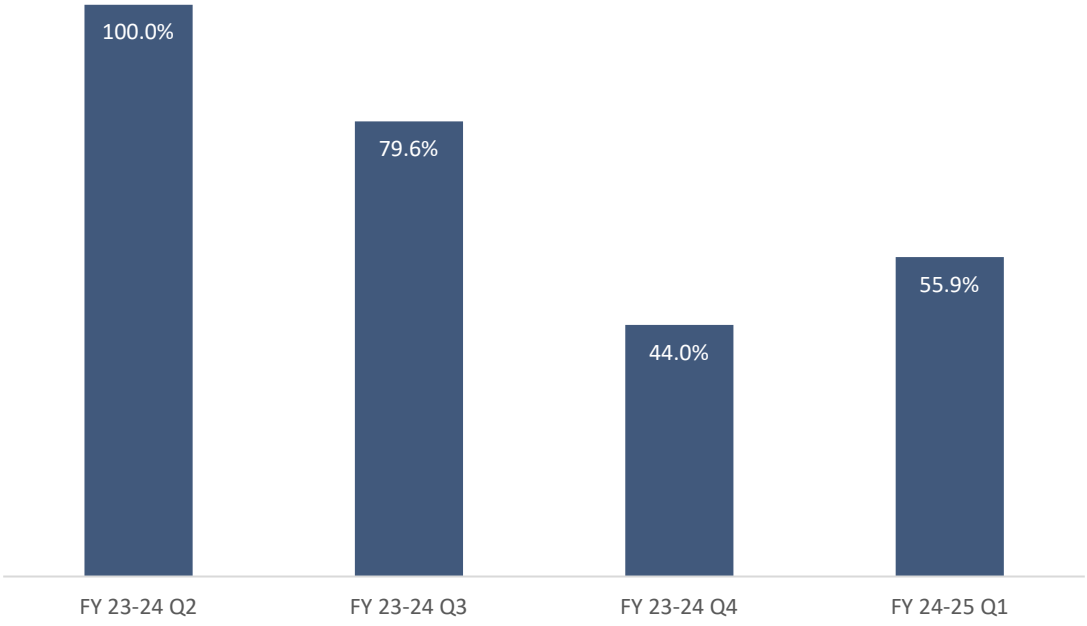
Additional High Acuity Data

The Department of Human Services has been leading a High Acuity Youth Summit that includes HCPF, the BHA, hospitals, residential providers, counties, and other stakeholders to address high acuity youth concerns, including but not limited to the implementation of H.B. 24-1038 and the transition of child welfare residential payments to capitation.

BHA Hospital Extended Stay Data

The BHA has reported data related to high acuity youth placements related to H.B. 23-1269 (Extended Stay and Boarding Patients). Data includes information on the number of hospitals with youth in extended stay and the reason preventing discharge.

Percent of reporting hospitals with youth in extended stay.



The number of hospitals reporting declined from 53 to 34 in the reported time period. Based on hospital reports, the number of youth in hospital boarding varied from 196 to 518 from the winter of 2023 to the summer of 2024. The number of reported youth in extended hospital stay varied from 9 to 51 in the same time period.

Of youth awaiting discharge, 40.1-54.1 percent were awaiting discharge to home. The reported reason for hospital boarding or extended stay from the third quarter of FY 2023-24 to the first quarter of FY 2024-25 is provided in the table below.

Number of Youth by Reason for Extended Stay

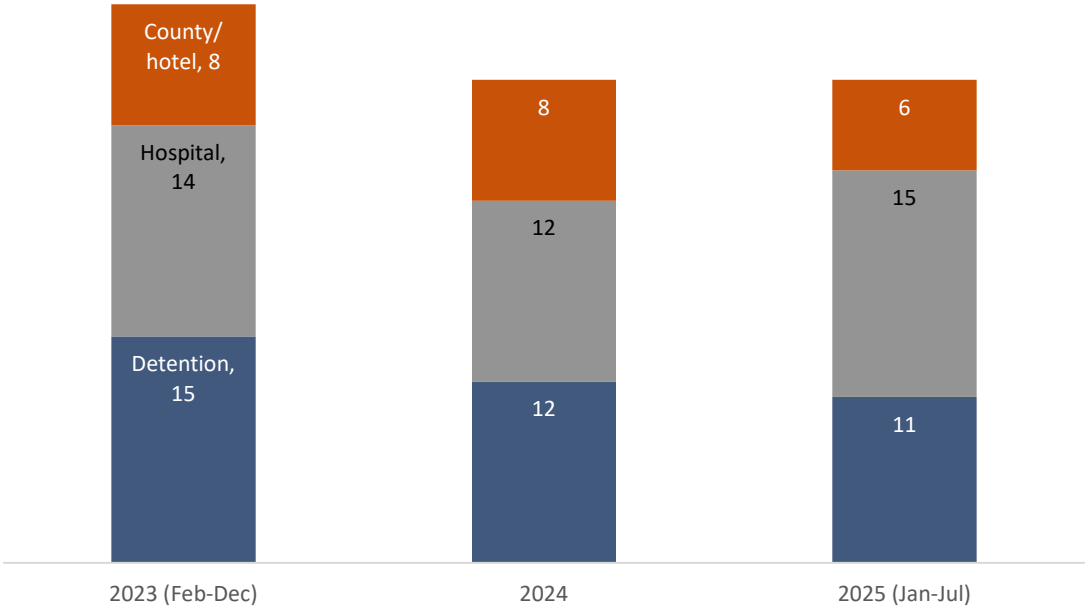
Reason for extended stay	Child Welfare	Non-child Welfare
No placement	7	20
Aggression	4	16
Inadequate community support	4	15
Substance use	2	11
Under 13	3	10
No secure transport	2	10
No caregiver response	3	9
Self injury	4	9
Medical need	2	8
Personality disorder	0	7
No county response	3	4

CHSDA Stopgap Stay Data

The Colorado Human Services Directors Association (CHSDA) began collecting data on the number of youth counties are supporting in stopgap settings in 2022. Stopgap settings may be utilized when a county department cannot locate appropriate living arrangements for youth in county custody. Stopgap settings include overnight

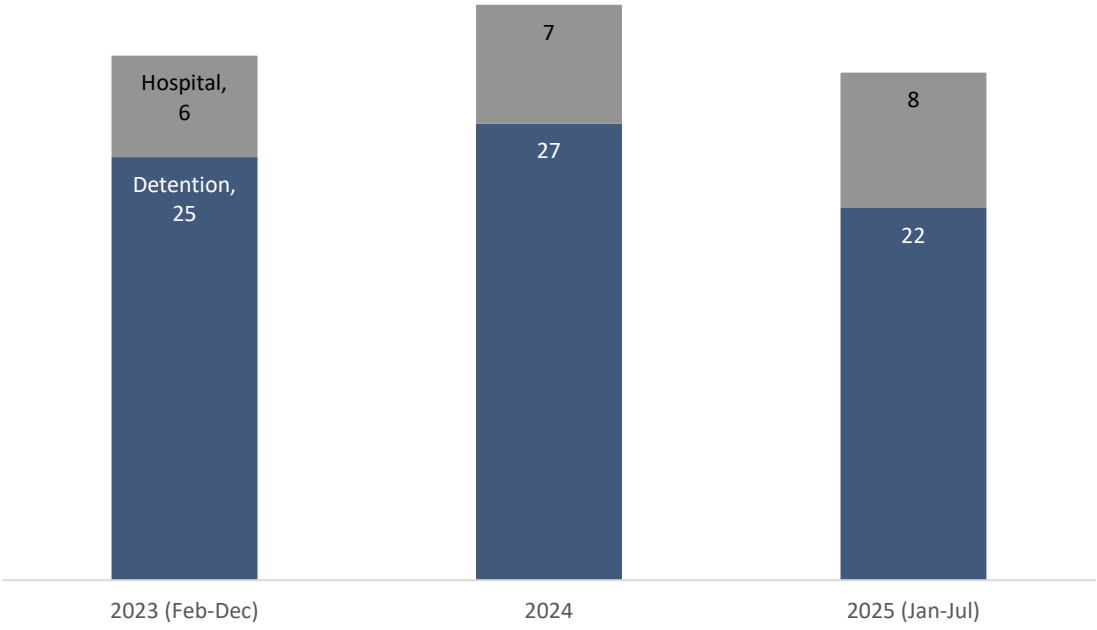
stay in a county department of human services office or hotel, hospital stay beyond medical necessity, and detention stay after ruled releasable by the court.

Monthly average youth in county custody utilizating stopgap services due to a lack of appropriate placement.



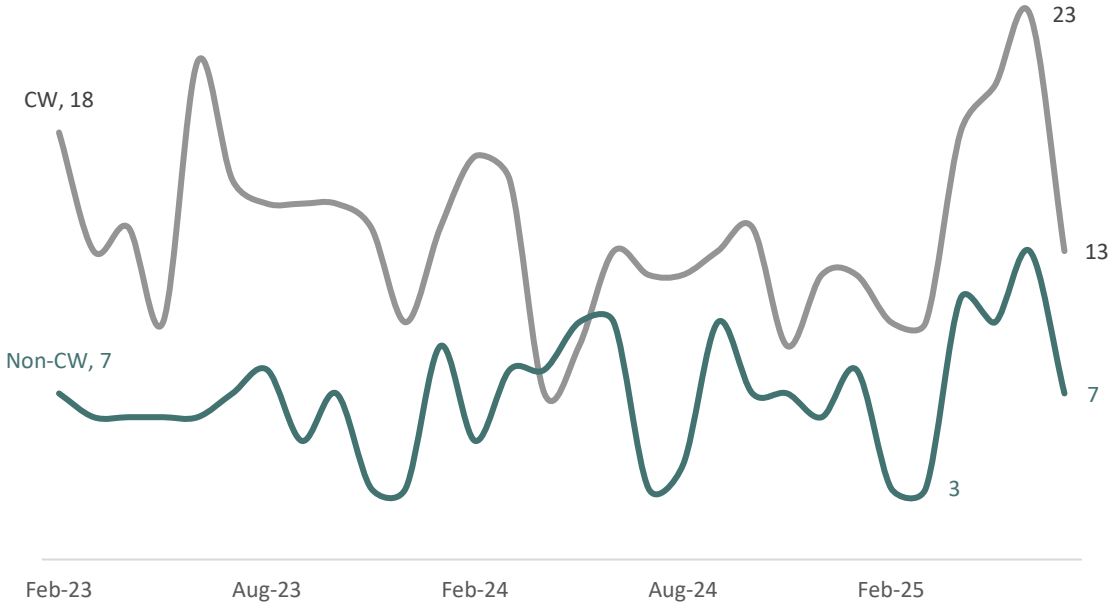
CHSDA has also collected information on the number of youth who are not in county custody, but are in hospitalization beyond medical necessity or detention beyond court release.

Monthly average youth in **not** in county custody in hospitalization or detention beyond necessity.



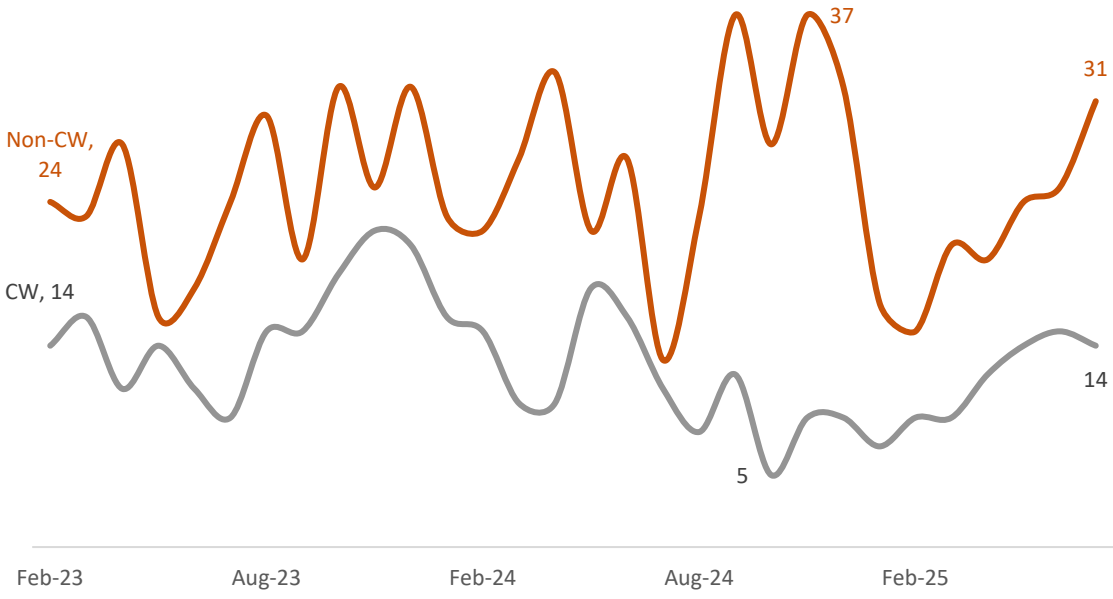
More child welfare youth are typically in hospitalization beyond medical necessity than non-child welfare youth.

Monthly child welfare and non-child weflare youth in hospitalization beyond medical necessity.



However, more non-child welfare youth are typically in detention beyond court release than child welfare youth.

Monthly child welfare and non-child weflare youth in detention beyond court release.



Complete monthly stopgap data is provided in the table below.

Monthly Youth in Stopgap Services

Month	County/hotel (child welfare)	Hospital (Child Welfare)	Detention (Child Welfare)	Hospital (Non-child Welfare)	Detention (Non-child Welfare)	Total
Feb-23	5	18	14	7	24	68
Mar-23	15	13	16	6	23	73
Apr-23	7	14	11	6	28	66
May-23	9	10	14	6	16	55
Jun-23	8	21	11	6	18	64
Jul-23	7	16	9	7	24	63
Aug-23	8	15	15	8	30	76
Sep-23	4	15	15	5	20	59
Oct-23	4	15	19	7	32	77
Nov-23	12	14	22	3	25	76
Dec-23	15	10	21	3	32	81
Jan-24	7	14	16	9	23	69
Feb-24	15	17	15	5	22	74
Mar-24	12	16	10	8	27	73
Apr-24	11	7	10	8	33	69
May-24	7	9	18	10	22	66
Jun-24	9	13	16	10	27	75
Jul-24	5	12	11	3	13	44
Aug-24	4	12	8	4	23	51
Sep-24	9	13	12	10	37	81
Oct-24	12	14	5	7	28	66
Nov-24	5	9	9	7	37	67
Dec-24	2	12	9	6	32	61
Jan-25	2	12	7	8	17	46
Feb-25	7	10	9	3	15	44
Mar-25	2	10	9	3	21	45
Apr-25	4	18	12	11	20	65
May-25	8	20	14	10	24	76
Jun-25	7	23	15	13	25	83
Jul-25	11	13	14	7	31	76

FY 2025-26 Executive Order Budget Adjustments

Budget Reductions

Executive Order D 2025 014, as amended, identifies the following plans for FY 2025-26 spending reductions in this division.

Title	General Fund	Description
Behavioral health incentive reduction	-$3,000,000	Reduces payments to providers and RAEs for meeting performance outcomes for behavioral health.
Rollback FY 24-25 1.6% provider rate increase	-42,987	Maintains provider rates at FY 24-25 level by rolling back the 1.6% increase.
Total - HCPF	-$3,042,987	

Footnotes and Requests for Information

Update on Long Bill Footnotes

The General Assembly includes footnotes in the Long Bill to:

6. set forth purposes, conditions, or limitations;
7. explain assumptions; or
8. express legislative intent.

There are no footnotes for this section of the budget. For a full list of footnotes, see the end of each departmental section of the 2026 Long Bill (https://leg.colorado.gov/bills/sb25-206).

Update on Requests for Information

The Joint Budget Committee may submit requests for information (RFIs) to departments. The Joint Budget Committee must prioritize the requests per Section 2-3-203 (3), C.R.S.

This section discusses a subset of the RFIs relevant to the divisions covered in the briefing. For a full list of RFIs, see the letters requesting information (https://leg.colorado.gov/sites/default/files/rfi_fy_2025-26.pdf).

Requests Affecting Multiple Departments

None.

Health Care Policy and Financing Requests

2 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, 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: The response includes the requested information. Key data points identified by staff are provided below. Data is based on FY 2023-24.

Access to behavioral health services has increased by 41.0 percent from 2018 to 2025. Paid behavioral health services increased 115.0 percent from FY 2018-19 to FY 2024-25 due to an increased provider network, increased rates, and new benefits.

23.8 percent of Medicaid members accessed capitated behavioral health services. The percent of Medicaid members accessing behavioral health services has increased 25.0 percent compared to the prior four years.

- 201,766 members used mental health services.
  - 201,327 (99.8 percent) accessed outpatient services.
  - 11,534 (5.7 percent) accessed inpatient services.
  - 3,499 (1.7 percent) accessed residential services.
- 49,077 members used substance use services.
  - 44,574 (90.8 percent) accessed outpatient services.
  - 10,687 (21.8 percent) accessed inpatient services.
  - 3,945 (8.0 percent) accessed residential services.
- 166,564 members used wraparound services for co-occurring disorders like prevention, early intervention, respite, recovery, and peer support. The response highlights that the capitated benefit allows better access for federally approved wraparound services that are more difficult to bill on a fee-for-service basis.
- The largest utilization increase was for outpatient mental health services.

Payments to Community Mental Health Centers (CMHCs) made up 26.9 percent of payments for capitated behavioral health.

- CMHCs made up 33.7 percent of payments for mental health services.
- CMHCs made up 14.2 percent of payments for substance use services.
- CMHCs made up 34.6 percent of payments for wraparound services.

The state was awarded a **CCBHC** planning grant in December 2024 and expects to apply for a demonstration grant in early 2026. If demonstration is granted, the plan must be approved by the General Assembly.

Directed payments for **essential safety net providers** (ESNPs) designated by the BHA are described as a time-limited method to infuse funds into the safety net system, but was determined to be an unsustainable funding model. RAEs may still negotiate enhanced rates, but are not required.

- 49.0 percent of all ENSP provider were SUD providers. 76.0 percent of those providers were outpatient.
- 81.0 percent of ESNP enrollments only served the Front Range, with half concentrated in the Denver area.
- Enhanced payments are still required for targeted services such as mobile crisis, opioid treatment, and services in bedded facilities.

5 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 the implementation plan as approved by the plaintiffs. 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.

Comment: A summary of the Department's response is provided in the last issue brief.

6 Department of Health Care Policy and Financing, Behavioral Health Community Programs – The Department is requested to provide, by June 6, 2025, 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, 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: A summary of the Department's response is provided in the last issue brief.

Department Annual Performance Report

Departments must publish an **Annual Performance Report**[24] for the *previous state fiscal year* by November 1 of each year. This report summarizes the Department's performance plan and most recent performance evaluation. In addition, departments develop and submit a **Performance Plan**[25] for the *current fiscal year* to the Joint Budget Committee and the relevant Joint Committee of Reference by July 1 of each year.

Per statute[26], the Joint Budget Committee must consider performance plans submitted by departments and may prioritize budget requests intended to enhance productivity, improve efficiency, reduce costs, and eliminate waste. To find the performance plans, search the Office of State Planning and Budgeting website and select the performance plan (www.colorado.gov/pacific/performancemanagement/department-performance-plans).

[24] Section 2-7-205, C.R.S.
[25] Section 2-7-204 (3)(a), C.R.S.
[26] Section 2-7-204 (6), C.R.S.

Appendix A: Numbers Pages

Appendix A details the actual expenditures for the last two state fiscal years, the appropriation for the current fiscal year, and the requested appropriation for next fiscal year. 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		Request vs. Appropriation
(3) Behavioral Health Community Programs						
Healthcare Affordability and Sustainability Cash Fund.						
Behavioral Health Capitation Payments	1,028,527,782	1,226,649,604	1,451,675,162	1,788,875,268	*	
FTE	0.0	0.0	0.0	0.0		
General Fund	257,694,490	316,708,617	349,844,933	417,947,986		
Cash Funds	75,710,138	99,160,135	121,980,456	149,544,400		
Reappropriated Funds	0	0	0	0		
Federal Funds	695,123,154	810,780,852	979,849,773	1,221,382,882		
Behavioral Health Fee-for-service Payments	10,956,804	3,717,365	11,346,614	7,405,015	*	
FTE	0.0	0.0	0.0	0.0		
General Fund	2,563,728	2,453,203	2,726,359	1,507,129		
Cash Funds	665,268	593,173	673,095	67,688		
Reappropriated Funds	0	0	0	0		
Federal Funds	7,727,808	670,989	7,947,160	5,830,198		
TOTAL - (3) Behavioral Health Community Programs	1,039,484,586	1,230,366,969	1,463,021,776	1,796,280,283		22.8%
FTE	0.0	0.0	0.0	0.0		0.0%
General Fund	260,258,218	319,161,820	352,571,292	419,455,115		19.0%
Cash Funds	76,375,406	99,753,308	122,653,551	149,612,088		22.0%
Reappropriated Funds	0	0	0	0		0.0%
Federal Funds	702,850,962	811,451,841	987,796,933	1,227,213,080		24.2%

NOTE: An asterisk (*) indicates that the FY 2026-27 request for a line item is affected by one or more decision items.