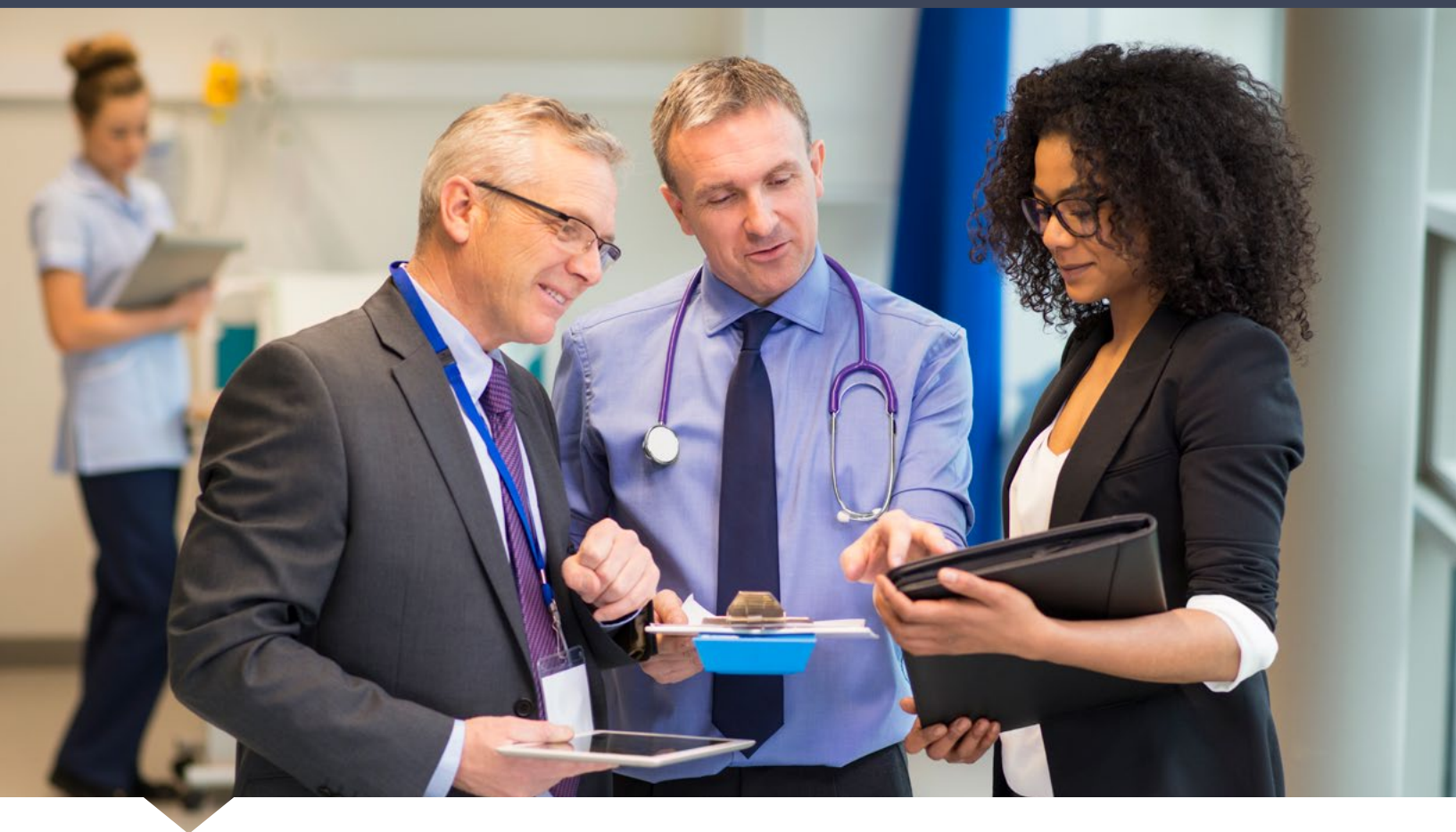


Health First Colorado's Experience Implementing a Short-Term Behavioral Health Benefit



Acknowledgements

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About the Authors

The University of Colorado Anschutz Farley Health Policy Center strives to advance policy that overcomes fragmented systems and addresses the wholeness of a person — physical, behavioral, and social health in the context of family, community, and the health care system. The FHPC works with state agencies and policymakers to understand and inform achievable policy actions to improve the integration of behavioral health across health and health care systems.

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Executive Summary

Since 1995, most behavioral health (BH) services for Health First Colorado (Colorado's Medicaid program) have been delivered through a capitated managed care system. In July 2018, the Department of Health Care Policy and Financing (HCPF) created a Short Term Behavioral Health (STBH) benefit to improve access to behavioral health services for low-acuity conditions. This benefit allows members to receive up to six psychotherapy visits per fiscal year from licensed behavioral health clinicians on primary care teams, billed through fee-for-service, and without needing a formal behavioral health diagnosis. This report describes Colorado's experience implementing this benefit.

The Farley Health Policy Center (FHPC) reviewed five years of data (2019–2023) and interviewed six of the seven Regional Accountable Entities (RAEs). The study looked at service use, provider participation, and how the benefit was implemented. Major findings include:

■ Utilization Trends

Use of the STBH benefit was low. Less than 2% of Health First Colorado members used these services each year from 2019 to 2023, even as total Medicaid enrollment increased by 35%. Most members who used the benefit had only one visit in a calendar year, and only about 7% used six visits. More than half of STBH users also received capitated behavioral health services, often from the same provider. This suggests that the benefit added to existing care rather than replacing it.

■ Population Differences

Certain groups were more likely to use STBH services. Pregnant individuals and youth in foster care used the benefit at higher rates than other members. American Indian/Alaska Native members had the highest use of STBH services overall, while Asian and Native Hawaiian/Other Pacific Islander members had the lowest use of behavioral health services in general. These differences highlight the need to better understand and address barriers to care.

■ Provider Patterns

Federally Qualified Health Centers (FQHCs) were much more likely than other practices to provide STBH services. Each year, more than 75% of FQHC locations offered STBH services, compared with only 14–18% of non-FQHC clinics. Although FQHCs made up less than 20% of primary care locations, they delivered about two thirds of all STBH visits. Larger clinics were also more likely to offer the benefit, likely because they have more staff and existing integrated care structures. Smaller and rural practices faced challenges such as workforce shortages, limited space, and administrative complexity.

■ Regional Variation

Use of the STBH benefit varied across the seven RAEs. RAE 5 (Denver) had the highest use, while RAE 2 (northeast Colorado) had the lowest use of both STBH and capitated behavioral health services. These differences likely reflect variation in the number of FQHCs, available behavioral health providers, and other local factors.

■ Implementation Insights

RAE representatives said the STBH benefit supported integrated care but also created some disruptions to previous care models. Providers sometimes experienced confusion about billing and coding. RAEs played a key role in providing training, workforce support, and financial strategies to help clinics adopt the benefit. However, limited billing codes, unclear guidelines, and behavioral health workforce shortages made implementation difficult. RAEs emphasized the need for expanded billing codes, clearer instructions, and sustainable funding approaches.

■ Implications

Although the STBH benefit was not widely used, it increased access for some priority groups and offered important lessons for integrating behavioral health into primary care. Colorado's experience can inform future policy efforts, such as the next phase of the Accountable Care Collaborative (ACC Phase 3) or similar models in other states. Policymakers should consider flexible billing code options, sustainable financing, and workforce development. Finally, health systems should take into account the social structures where patients live, work, and play to enhance access to BH care.

Introduction

Since 1995, most behavioral health (BH) care for Health First Colorado (Colorado's Medicaid Program) members has been provided through a capitated managed care system. In this system, the Department of Health Care Policy and Financing (HCPF) makes a per member per month (PMPM) payment to the Regional Accountable Entities (RAEs) (or their predecessors) to deliver a designated set of BH services for members who have a covered BH diagnosis.

In July 2018, HCPF implemented a new policy that allowed Health First Colorado members to receive short-term behavioral health (STBH) services provided outside of the capitated BH structure.¹ These services must be provided by a licensed behavioral health clinician working as part of a primary care medical provider (PCMP) care team. The STBH benefit included six Current Procedural Terminology (CPT®) codes for which PCMPs receive fee-for-service (FFS) payment directly from HCPF. Members do not need a covered BH diagnosis and are limited to six visits per fiscal year (July 1–June 30).

With this change, HCPF intended to provide additional access to BH services for short-term episodes of care for low-acuity BH conditions. HCPF did not establish a specific utilization goal as this was a new benefit without historical utilization information. Rather, the objective was to prevent the exacerbation of both medical and behavioral conditions by supporting the delivery of early interventions in a convenient location for members.

To assess whether the STBH policy change realized its objective and to help inform future benefits designed to increase access to BH services, the Farley Health Policy Center (FHPC) at the University of Colorado School of Medicine (CUSOM) collaborated with HCPF to analyze:

1. Who received these services and how they were being used;
2. Who provided them; and
3. The RAEs' experiences in supporting the implementation of these services.

¹ Colorado Department of Health Care Policy and Financing. Short-term Behavioral Health Services in the Primary Care Setting. <https://hcpf.colorado.gov/sites/hcpf/files/Short-term%20Behavioral%20Health%20Services%20in%20Primary%20Care%20Fact%20Sheet%20Jan%202019.pdf>

Assessment and Research Questions

To assess these dimensions of Colorado's experiences implementing a STBH benefit, the Farley Center used two sources of information. First, in collaboration with HCPF, the CUSOM has developed a data warehouse that includes Health First Colorado FFS claims, capitated BH encounters, and member and provider eligibility data. For this analysis, we examined five calendar years of data (2019–2023). In addition, we excluded the six months from July to December 2018 when the STBH benefit was just being implemented and stakeholders were adjusting to its availability. Second, to understand how the RAEs and PCMPs adjusted to the introduction and implementation of the STBH benefits, we conducted key informant interviews (KIIs) with representatives from six of the seven RAEs.²

The STBH benefit was envisioned to increase access to BH services as a complement to the existing capitated benefit and services rather than a substitute for these services. To examine the interrelationships with BH services provided under the capitated benefit, we examined utilization of both STBH services and a sub-set of capitated BH services. As noted above, STBH services were developed to address low-acuity BH needs, and to focus the analysis on the most relevant capitated services we excluded emergency department services and inpatient hospitalizations that were paid for by the RAEs under the capitated benefit. We refer to these non-emergency, non-hospital capitated BH services as “selected capitated BH services” throughout this report. To isolate STBH services from other FFS benefits that use the same six CPT® codes, we excluded FFS claims with these procedure codes that were delivered by licensed providers outside of a PCMP setting. In addition, our analysis also excluded:

1. Services provided by the two physical health managed care programs, Denver Health Medical Plan and Rocky Mountain Health Plans Prime, because these encounter claims are not in the FFS claims data warehouse used for this analysis.
2. Substance use disorder services because these claims are removed from the data HCPF provides to the CUSOM in compliance with Title 42 of the Code of Federal Regulations (CFR) Part 2.

To summarize Colorado's experiences in implementing a STBH benefit in primary care settings, we answer the following questions from the perspective of members who utilized BH services, providers delivering STBH services, and the RAEs responsible for coordinating BH services.

MEMBERS:

1. To what extent did members use STBH and selected capitated BH services?
2. Were there differences across member characteristics in the utilization of these services?
3. What percent of members received one STBH service compared to using all six available visits?
4. Were there differences in usage patterns of BH services across RAE regions?
5. Which STBH CPT® codes were the most used and what were the most common diagnoses?

² One RAE indicated that all of the personnel involved in supporting the implementation of the STBH benefit were no longer employed by the RAE and the remaining staff were not able to provide informed responses to our interview questions.

PROVIDERS:

1. Which PCMPs provided STBH services and how many services were provided?
2. What practice characteristics were associated with the provision of STBH services and did these characteristics change over the five years?
3. Were there different patterns in PCMPs provision of STBH services across RAE regions?

RAES:

1. How did the implementation of the STBH benefit affect the RAEs coordination of BH services in their regions? To what extent did the RAEs' coordination activities differ for Federally Qualified Health Centers (FQHCs) compared to other PCMPs?
2. What factors facilitated the delivery and receipt of STBH services in the region? Did these factors differ for FQHCs compared to other PCMPs?
3. What factors were a barrier to the delivery and receipt of STBH services in the region? Did these factors differ for FQHCs compared to other PCMPs?

Member Experiences

To examine the experiences of Health First Colorado members, we analyzed the STBH FFS claims and the selected capitated BH services for all members who were not enrolled in a physical health managed care plan and for various subgroups of these members. Subgroups examined members based on their race/ethnicity, sex, budget group, and the RAE they were attributed to for the most months in a calendar year.

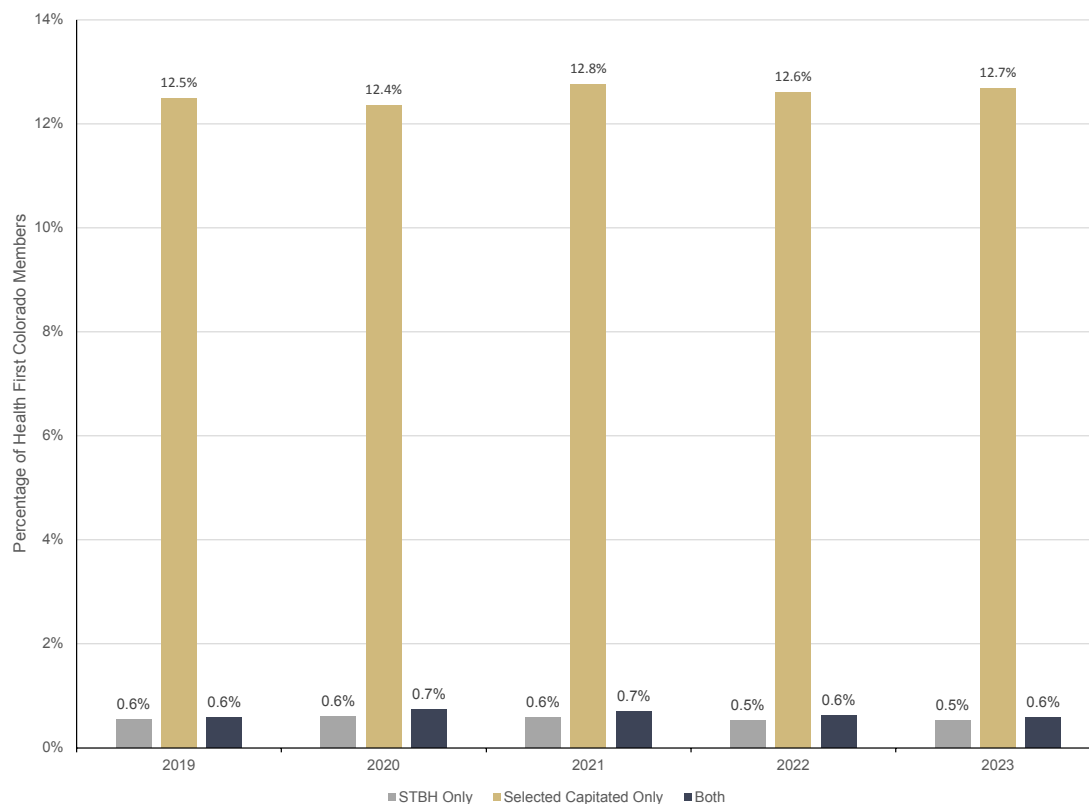
To what extent did members use STBH and selected capitated BH services?

Figure 1 presents the percentage of Health First Colorado members that utilized at least one STBH service and/or at least one selected capitated BH service in a calendar year. This figure distinguishes between members that received only STBH services, only selected capitated BH services, or both categories of services in calendar years 2019–2023.

A small percentage of Health First Colorado members utilized any STBH services in a year and there was little change year to year. The utilization percentages were also similar each year for the selected capitated BH services. It is worth noting, however, that over the five-year review period the number of Coloradans enrolled in Health First Colorado increased about 35% from an average of just over 1.2 million in 2019 to more than 1.6 million in 2023. Thus, while the rates of utilization of these services were stable, the number of Coloradans receiving BH services through Health First Colorado increased, particularly during the COVID-19 public health emergency years, as shown in Table 1.

As shown in Figure 1 and Table 1, of the members that received any STBH services in a year somewhat less than half of these members only utilized STBH BH services. This stable pattern suggests that even though utilization was low overall, the implementation of the STBH benefit likely improved access for individuals when they had lower acuity BH needs.

Figure 1. Percentage of Health First Colorado Members with Behavioral Health Visits by Year



These percentages, as well as all other measures presented in this report, are calculated using the entire population of Health First Colorado Members not enrolled in a physical health managed care plan and standard statistical tests are not applicable.

Table 1. Number of Health First Colorado Members with Behavioral Health Visits by Year

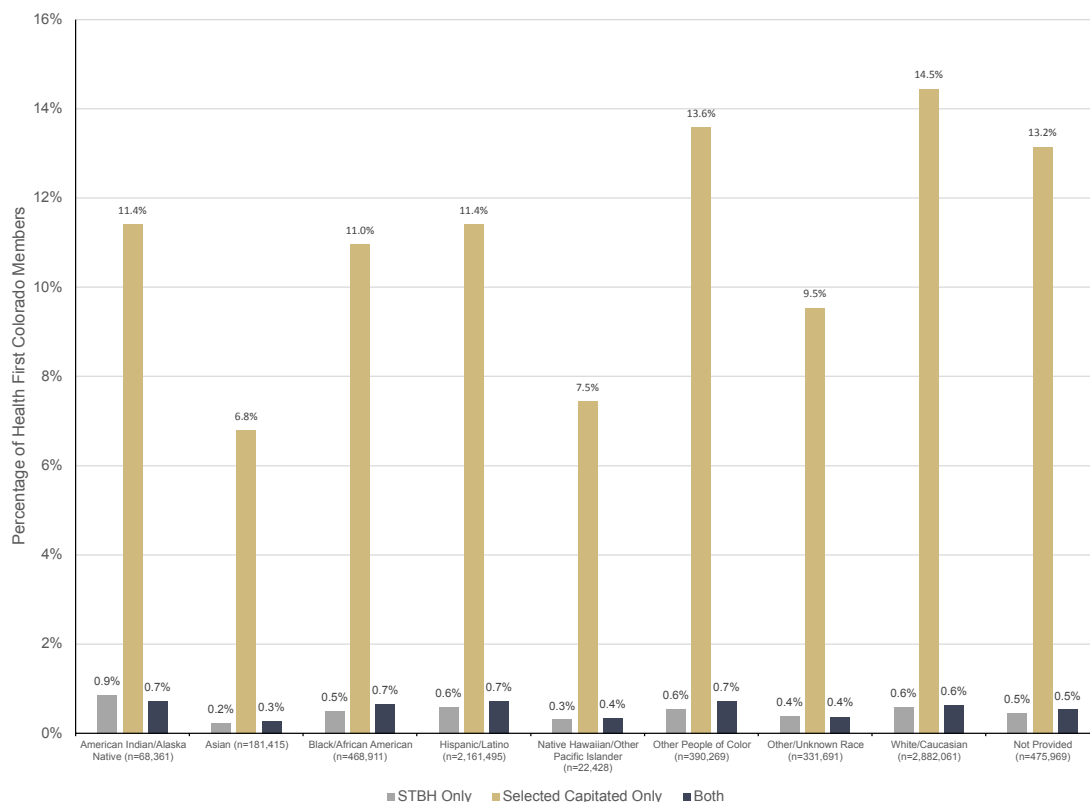
Year	STBH Only	Selected Capitated Only	Both
2019	7,015	159,865	7,462
2020	7,673	155,519	9,284
2021	7,975	174,750	9,446
2022	7,798	187,471	9,333
2023	8,380	201,099	9,188

Were there differences across member characteristics and utilization of these services?

With policymakers' and the public's expanded focus on health equity amid growing awareness of the disparate effects of the COVID-19 pandemic on historically underserved communities, Figure 2 examines the utilization of STBH and selected capitated BH services by the following racial and ethnic categories:

1. **American Indian/Alaska Native:** Non-Hispanic, Non-multiracial, American Indian/Alaska Native
2. **Asian:** Non-Hispanic, Non-multiracial, Asian
3. **Black/African American:** Non-Hispanic, Non-multiracial, Black/African American
4. **Hispanic/Latino:** Hispanic, also includes members who selected "White/Caucasian" and/or "Other/Unknown" in addition to the "Hispanic/Latino" option
5. **Native Hawaiian/Other Pacific Islander:** Non-Hispanic, Non-multiracial, Native Hawaiian/Other Pacific Islander
6. **Other People of Color:** Multiracial; or Hispanic, American Indian/Alaska Native; or Hispanic, Asian; or Hispanic, Black/African American; or Hispanic, Native Hawaiian/Other Pacific Islander
7. **Other Unknown Race:** Non-Hispanic, Other unknown race, with or without White/Caucasian.
8. **White/Caucasian:** Non-Hispanic, Non-multiracial, White/Caucasian
9. **Not Provided:** Race and Ethnicity not provided or not available

Figure 2. Percentage of Health First Colorado Members with BH Visits, by Race/Ethnicity Categories (2019–2023)



The numbers in parentheses (n) represent the number of member-years across all five calendar years.

Among different racial and ethnic groups, American Indian/Alaska Native were the most likely to use the STBH visit benefit while Asians were the least likely. White/Caucasian and Other People of Color were the most likely to use selected capitated benefits while Asian and Native Hawaiian/Other Pacific Islander members had the lowest usage rates. In fact, Asians and Native Hawaiian/Other Pacific Islanders were the least likely to access any BH services. Utilization was higher among Black/African American and Hispanic/Latino populations than among some of the other groups. However, access to any BH services for all of the non-White groups were not on par with White/Caucasian populations suggesting that these cohorts may have faced barriers to accessing these services, which merits further research.

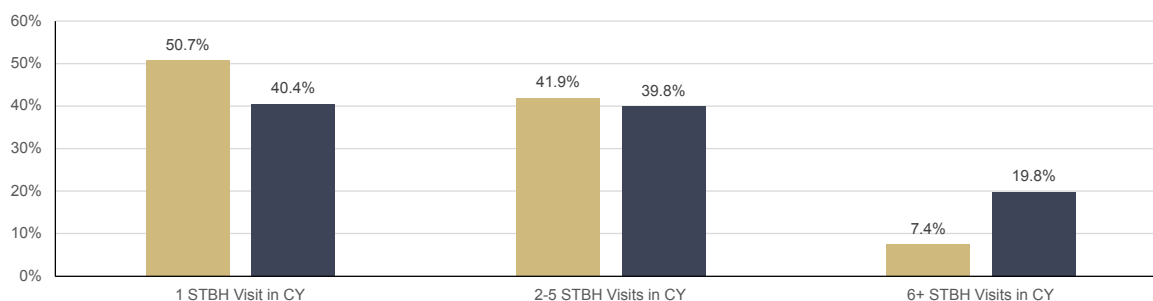
Among other historically underserved communities, individuals with disabilities and foster care members were by far the most likely to have received selected capitated services compared to other Health First Colorado members (not presented graphically). Pregnant adults were the most likely to use the STBH benefit (1.1% had a STBH visit only and an additional 1.1% had both). Older adults had the lowest rates. Women had somewhat higher rates than men for utilization of both selected capitated services and STBH. Specifically, 1.5% had a STBH visit (with or without a selected capitated visit) and 14.1% had a selected capitated BH visit only, compared to 0.9% and 10.9% of males.

Overall, the take-up rate for the STBH benefit was low. However, there is some evidence that the STBH benefit increased access to BH services for some groups of Health First Colorado members, particularly for individuals who are pregnant. In addition, 53.5% of people who had a STBH visit also had a capitated visit and, of that group, 51.6% received at least one visit for both types of services from the same provider suggesting the STBH benefit also provided improved access to more intensive BH services.

What percent of members received one STBH service compared to using all six?

As shown in Figure 1, only a small percentage of Health First Colorado members accessed STBH services in a calendar year (CY). Among members who received any STBH services in a CY, Figure 3 presents the percentage of these members with only 1 visit in a CY, the percentage with 2-5 visits in a CY, and the percentage with 6 or more visits in a CY³ across all 5 years (2019–2023). This figure distinguishes between members that only utilized STBH visits in a CY and members that utilized both STBH and selected capitated services in a CY. As shown in Figure 3, more than half of members that only utilized STBH services had only 1 visit and about 7% had 6 or more visits during the calendar year. In contrast, almost 1 out of every 5 members that utilized both STBH and selected capitated services in a CY had 6 or more STBH visits in that CY.

Figure 3: Percentage of Members with a STBH Visit in a Calendar Year, By Number of Visits in a Calendar Year and Utilization of Selected Capitated Services (2019–2023)

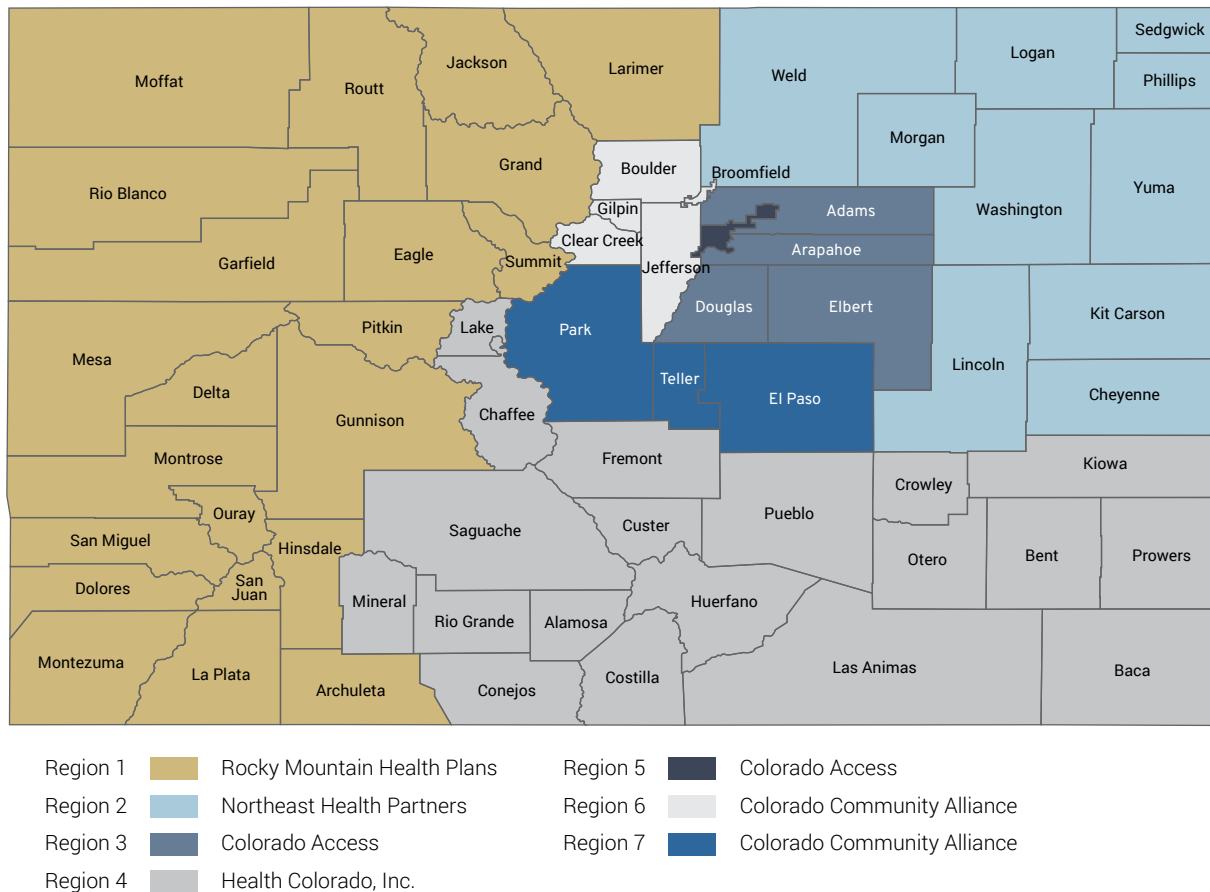


³ While the STBH benefit is limited to six visits per fiscal year, because this analysis used calendar year it is feasible for a small percentage to have seven or more visits in a calendar year.

Were there different member usage patterns across RAE regions?

During the first two phases of the Accountable Care Collaborative (ACC), HCPF divided the state into seven regions (as shown in Figure 4).

Figure 4: RAE Regions During the Analysis Period

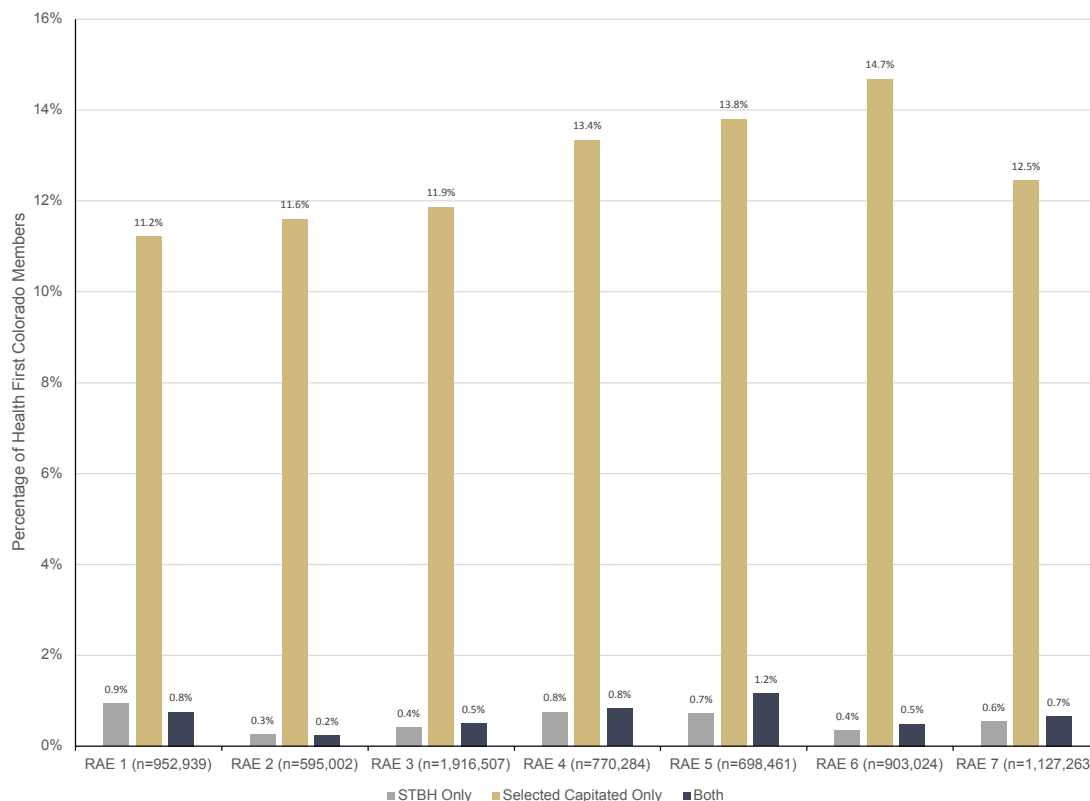


Each region is served by a RAE that was responsible for ensuring appropriate primary and BH care for Health First Colorado members. Specifically, RAEs were tasked with developing and supporting a network of primary care physical health providers designated as a PCMP (the Appendix describes the criteria), and for developing a network and reimbursing capitated BH services for members attributed to their RAE. While all seven RAEs had the same contractual requirements, each RAE had flexibility in:

- how they supported PCMPs to ensure they were successful medical homes;
- how they developed and implemented special programs; and
- how and what they paid providers delivering capitated BH services (some PCMPs are also part of the capitated network).

It is possible that any differences in approaches to these requirements resulted in variation across RAEs in utilization of both STBH and selected capitated BH services. In addition, any variation could have reflected differences in member characteristics and/or the extent PCMPs in a region implemented an integrated care model. Figure 5 presents the five-year average of the percentage of members attributed to a RAE who received a BH service in a calendar year, again distinguishing between members accessing only STBH services, only selected capitated services, and both types of services.

Figure 5: Five-Year Average Percentages of Health First Colorado Members who had BH Visits, by RAE



The numbers in parentheses (n) represent the number of member-years across all five calendar years.

Across the RAEs, the percentage of members that had only STBH visits ranged from a low of 0.3% in RAE 2 to a high of 0.9% in RAE 1 (a three-fold difference). The difference across RAEs in the percentage of members receiving both STBH and selected capitated services was even more pronounced ranging from a low of 0.2% in RAE 2 to a high of 1.2% in RAE 5. The pattern for those who had only selected capitated services ranged from a low of 11.2% in RAE 1 to a high of 14.7% in RAE 6. Overall, individuals assigned to RAE 2 were the least likely to receive any BH services included in this analysis with 12.1% accessing care and members in RAE 5 were the most likely with 15.7% having received any BH service. Finally, although not shown in this figure, among members that received both types of benefits, over 60% in RAEs 6 and 7 received both a STBH service and a selected capitated service from the same provider, whereas in RAE 2 only 33.5% of members receiving both types of services received each type of service from the same provider.

Which CPT® codes were the most used and what were the most common diagnoses?

The six CPT® codes that were part of the STBH benefit are:

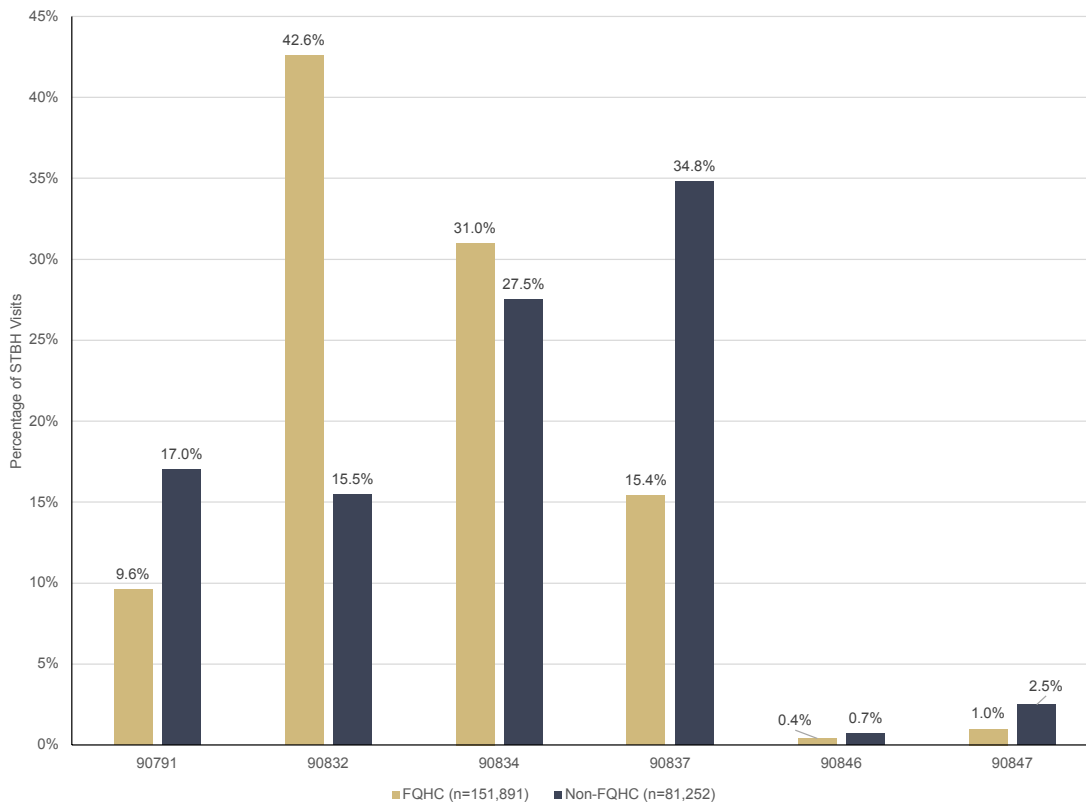
1. Diagnostic evaluation without medical services (90791)
2. Psychotherapy – 30 minutes (90832)
3. Psychotherapy – 45 minutes (90834)
4. Psychotherapy – 60 minutes (90837)
5. Family psychotherapy without patient (90846)
6. Family psychotherapy with patient (90847)

For the remainder of the member focused section and the provider focused section we report our findings separately for FQHCs and non-FQHCs. We do so because payments to FQHCs differed from the procedure specific FFS payments that most other PCMPs received for delivering STBH services. Specifically, FQHC PCMPs received payments based on encounter rates that were established by HCPF as a prospective payment. Encounter rates for the STBH services for FQHC PCMPs were paid at the behavioral health rate for each clinic. For example, in CY 2023 the mean plan paid amount across all members receiving diagnostic evaluation without medical services (90791) was \$232 among FQHC PCMPs compared to \$144 among non-FQHC PCMPs.

FQHCs also received funds from the U.S. Department of Health and Human Services Health Resources and Services Administration (HRSA) and were required to provide services to individuals regardless of their ability to pay, charge for services on a sliding fee scale, and operate under the direction of a patient-majority governing board. Non-FQHCs included provider types of Physician, Osteopath, Rural Health Clinic, School Health Clinic, Family/Pediatric Nurse Practitioner, Clinic-Practitioner Group, and Non-Physician Practitioner Group. Like FQHCs, Rural Health Clinics received individual cost-based encounter rate payments, however, they did not receive the additional HRSA funding and tended to be smaller practices. Therefore, they have been categorized as non-FQHC PCMPs for this analysis.

Figure 6 presents the percentage of STBH visits that included each of the six CPT codes for FQHC and non-FQHC PCMPs across all five years of FFS claims (2019–2023). As shown in this figure, FQHCs were nearly three times as likely to use CPT® code 90832 (30-minute psychotherapy), while non-FQHCs were more than twice as likely to use 90837 (60-minute psychotherapy). Both types of practices had low rates of family psychotherapy. In terms of year-over-year changes, there were fluctuations for both practice types but no discernable trends.

Figure 6: Percentage of STBH Visits with Billed CPT Codes by Provider Type (2019–2023)



n represents the number of STBH visits across all five calendar years.

The different CPT® code patterns and the underlying payment differences between FQHCs and non-FQHCs suggest the STBH benefit was operationalized differently. Therefore, we examined the top diagnoses (when provided on the claim) for each provider type for diagnoses that were covered under the capitated BH benefit (Table 2) and those that are not-covered (Table 3), distinguishing between FQHC and non-FQHC PCMPs.

Overall, 83.2% of STBH visits with one or more diagnoses provided as part of the claim included at least one diagnosis covered by the capitated BH benefit. Among the claims that included a capitated covered diagnosis, both clinic types had the same top diagnosis, as shown in Table 2. They also shared the next three most commonly cited diagnoses, though they were in a different order. The fifth diagnosis differed across the two provider types. For both types, the top five accounted for more than half of all visits that had a diagnosis on the claim.

Table 2: Most Prevalent Diagnoses from STBH Claims with at Least One Capitated Services Covered ICD-10-CM Diagnosis by Provider Type (2019–2023)

FQHCs		Non-FQHCs	
Diagnosis Code and Description	% of Claims	Diagnosis Code and Description	% of Claims
F41.1 - Generalized Anxiety Disorder	12.4%	F41.1 - Generalized Anxiety Disorder	17.2%
F33.1 - Major Depressive Disorder, Recurrent, Moderate	11.4%	F41.9 - Anxiety Disorder, Unspecified	15.6%
F43.10 - Post-traumatic Stress Disorder, Unspecified	10.5%	F33.1 - Major Depressive Disorder, Recurrent, Moderate	13.1%
F41.9 - Anxiety Disorder, Unspecified	10.5%	F43.10 - Post-traumatic Stress Disorder, Unspecified	7.8%
F43.23 - Adjustment Disorder with Mixed Anxiety and Depressed Mood	9.3%	F32.9 - Major Depressive Order, Single Episode, Unspecified	6.0%

As shown in Table 3, the most common diagnoses for STBH claims that did not include a capitated BH benefit covered diagnosis were also similar across FQHCs and non-FQHCs. Three of the top five diagnoses for each type of provider were the same, although the order in which they appear differs. The most common diagnoses for each type of provider (R69 and Z03.89) do not appear in the top five of the other provider type. The fourth most common diagnosis also differed between FQHC and non-FQHC, with non-FQHCs including diagnoses for autistic disorders.

Table 3: Most Prevalent Diagnoses from STBH Claims without a Capitated Services ICD-10-CM Covered Diagnosis by Provider Type (2019–2023)

FQHCs		Non-FQHCs	
Diagnosis Code and Description	% of Claims	Diagnosis Code and Description	% of Claims
R69 – Illness, Unspecified	28.5%	Z03.89 – Encounter for Observation for Other Suspected Diseases and Conditions Ruled Out	22.7%
Z71.89 – Other Specified Counseling	18.4%	R46.89 – Other Symptoms and Signs Involving Appearance and Behavior	12.4%
R46.89 – Other Symptoms and Signs Involving Appearance and Behavior	9.6%	Z71.89 – Other Specified Counseling	10.0%
Z13.31 – Encounter Screen Exam for Mental Health and Behavioral Disorder, Unspecified	6.9%	F84.0 – Autistic Disorder	8.4%
Z71.9 – Counseling, Unspecified	5.8%	Z71.9 – Counseling, Unspecified	6.9%

Provider Focused Experiences

To examine experiences with the STBH benefit from a provider perspective, we identified all unique PCMP locations that had at least one attributed (assigned) Health First Colorado member between January 1, 2019 through December 21, 2023. PCMP locations were identified using the unique clinic billing identification number (location ID) generated by HCPF during provider enrollment or revalidation.⁴ PCMP locations are categorized as having provided STBH services if the PCMP location submitted a claim to HCPF for at least one STBH service in a given calendar year. PCMP locations that have only billed STBH visits to one or both of the two managed care plans (Denver Health Medical Plan or Rocky Mountain Health Plans Prime) have been categorized as not providing STBH services as the claims data used for this analysis does not include managed care encounter data.

Table 4 provides information on the number of PCMP locations included in the analysis – that is those who had at least one attributed member in a calendar year. This table presents the number of FQHC PCMP locations with at least one attributed member, the number of non-FQHC PCMP locations with at least one attributed member, the total number of PCMP locations in the counties within each RAE's geographic boundaries, and the number of PCMP locations that are FQHCs and non-FQHCs by the average monthly number of attributed members in a calendar year. The size measures were developed separately for FQHC and non-FQHC PCMP locations around the 25th, 50th and 75th percentiles (quartiles) of the distribution of the five-year average monthly number of attributed members to each PCMP location. PCMP locations with attributed members below the 25th percentile were categorized as “small,” PCMP locations between the 25th and 75th percentile were categorized as “medium,” and PCMP locations above the 75th percentile were categorized as “large.”

Table 4: Number of PCMP locations with at Least One Attributed Member by Year

	Calendar Year				
	2019	2020	2021	2022	2023
Number of FQHC PCMPs with at least one attributed member	158	165	175	180	174
Number of non-FQHC PCMPs with at least one attributed member	797	775	751	761	748
RAE					
1	214	205	209	208	208
2	69	64	57	62	60
3	196	199	183	184	178
4	121	118	124	120	120
5	97	95	95	104	101
6	146	139	138	142	139
7	107	115	113	114	109

⁴ The number of PCMP locations included in this analysis may exceed the number of PCMP contracts reported by HCPF as a single contract with a RAE may include more than one clinic location.

	Calendar Year				
	2019	2020	2021	2022	2023
FQHC and Size					
FQHC Small (1-450)	35	36	44	50	52
FQHC Medium (451-4,060)	81	87	86	87	82
FQHC Large (4,061-17,000)	42	42	43	43	40
Non-FQHC Small (1-235)	225	197	178	176	183
Non-FQHC Medium (236-1,360)	384	388	381	386	380
Non-FQHC Large (1,361-11,200)	188	190	192	199	185

Of the more than 900 PCMP locations included in the analysis, not quite one in five are FQHCs. Table 4 also shows that the number of PCMP locations in a RAE ranged from over 200 in Region 1 (western region of the state) to less than 70 in Region 2 (northeastern region of the state). The bottom section of Table 4 shows that overall FQHC PCMP locations have more attributed members per PCMP location. Overall, approximately one out of every three Health First Colorado members are attributed to a FQHC PCMP location even though less than one in five PCMP locations are an FQHC.

Which PCMP locations provided STBH services and how many services were provided?

Each year, a higher percentage of PCMP locations that had at least one attributed member in a calendar year billed for STBH services in that calendar year (Table 5). Among the PCMP locations providing at least one billed STBH service in a calendar year, we also examined the number of STBH claims submitted by each PCMP location.

Table 5: Number of PCMP locations with at Least One Attributed Member with One or More STBH claims in a Calendar Year

Year	Percent Providing Any STBH Service
2019	24.5%
2020	26.5%
2021	28.5%
2022	28.9%
2023	29.5%

What practice characteristics were associated with the provision of STBH services and did these characteristics change over the five years?

As described above, payments to FQHCs differ from the procedure specific FFS payments that most other PCMP locations received for delivering STBH services. In addition, as demonstrated in Table 4, FQHC PCMP locations tend to be larger and have more Health First Colorado members attributed to them. The upper bound of small FQHC locations was about three times higher than the upper bound for small non-FQHC locations. Given these differences, we examined the extent to which FQHC PCMP locations delivered STBH services compared to non-FQHC PCMP locations (Table 6).

Table 6: Percentage of PCMP locations with at Least One Attributed Member with One or More STBH Claims by FQHC and non-FQHC location in a Calendar Year

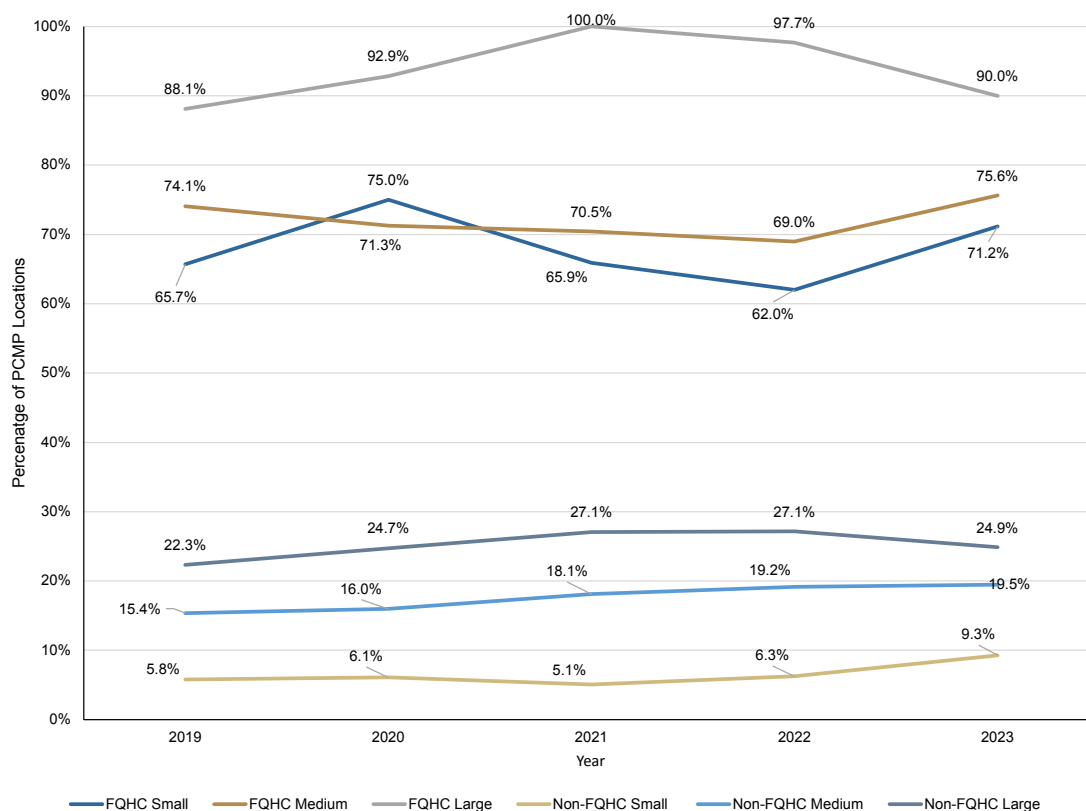
PCMP location Type	2019	2020	2021	2022	2023
FQHC	76.0%	77.6%	76.6%	73.9%	77.6%
Non-FQHC	14.3%	15.6%	14.0%	18.3%	18.3%

As shown in Table 6, FQHC locations were much more likely to have delivered STBH services than non-FQHC locations. While the gap between the two types of PCMP locations was smaller in the later years than in the first year, it is clear that FQHCs were able to provide STBH services to their Health First Colorado members compared to non-FQHC locations. The higher percentage of FQHC PCMP locations delivering STBH services and their larger number of attributed members meant that almost two out of every three members receiving a STBH service were attributed to a FQHC PCMP location.

Other research suggests that larger practices are more able to integrate behavioral health or to make it available within their practice. This makes sense due to economies of scale in hiring and supporting the resources needed for a BH provider. To explore the relationship between practice size and the delivery of STBH services, as described above, we measured the average number of Health First Colorado members attributed to a PCMP location for the months the PCMP had at least one attributed member during the five year period. Each PCMP location was assigned to one of three different practice sizes for each location type (FQHC and non-FQHC). While a PCMP location remains in the same size category across years, the number of PCMPs in each category changes as locations may not have any attributed members in a single fiscal year. As noted above, there were more non-FQHC PCMP locations and they tended to be smaller (e.g., have fewer attributed members) compared to FQHC PCMP locations.

Figure 7 presents the percentage of PCMP locations delivering STBH services each year by PCMP type and size (small, medium or large).

Figure 7: Percentage of PCMP locations that Provided at Least One STBH Service, by Provider location Type, Size, and Year



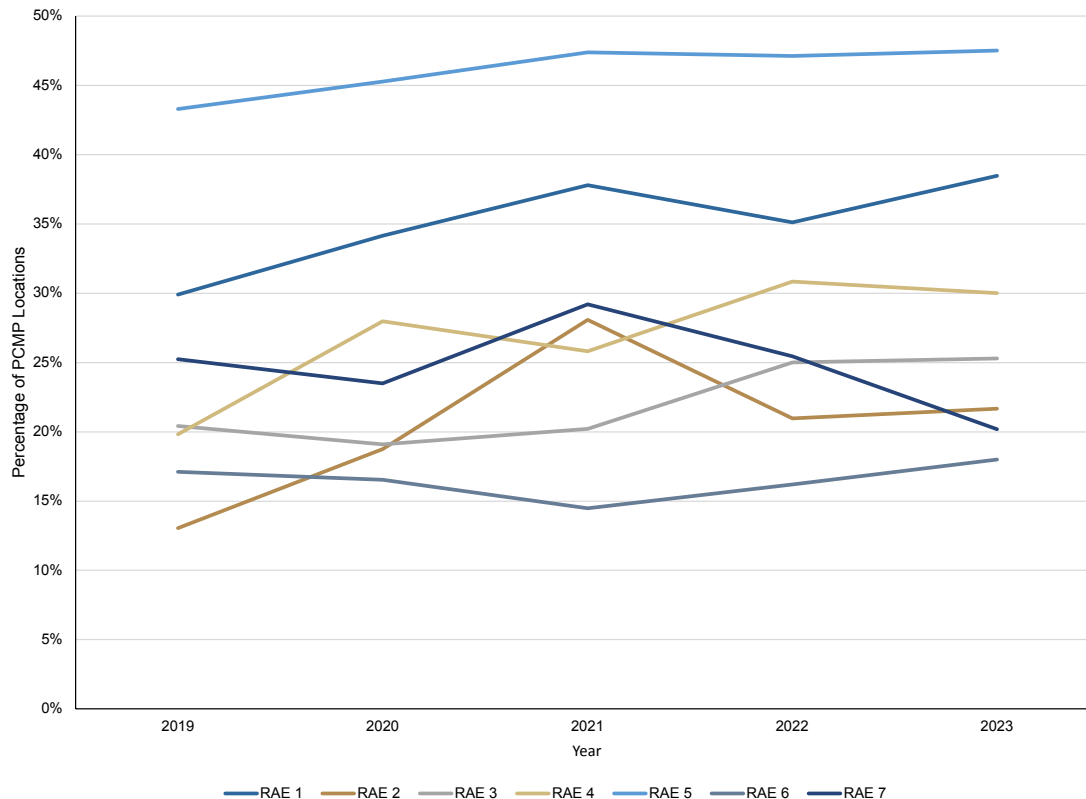
In general, the larger the practice the more likely it provided a STBH service in a calendar year. For example, some nine out of every 10 of the largest FQHC PCMP locations provided a STBH service, while about six or seven out of every 10 locations in the smallest FQHC category provided STBH services. This pattern held for the non-FQHCs as well, though their rates were much lower. The most striking finding is the difference in the percentage of PCMP locations delivering STBH services across all size categories with FQHC PCMP locations of all sizes being more likely to have provided the benefit than non-FQHC locations.

Were there different patterns in PCMP locations provision of STBH services across RAE regions?

As stated earlier, during the five year period 2019–2023 there were seven RAE regions. Each RAE was responsible for developing and supporting a network of primary care physical health providers designated as a PCMP, coordinating and paying for capitated BH services, and were governed by the same contractual requirements vis-à-vis developing a network of PCMPs and paying for BH services. However, RAEs also had flexibility in how they fulfill these requirements. Due to these flexibilities and potential differences in approach, it is possible that practices in some regions are more likely to provide STBH services than those in other regions.

Figure 8 presents the percentage of PCMP locations in each RAE that provided at least one STBH service in each of the five calendar years. This figure presents both a line graph of the trends in these percentages as well as a table showing the percentages for each RAE for each year.

Figure 8: Percent of PCMP Locations in Each RAE that Provided STBH Services, by Year



As shown in Figure 8, PCMP locations in some regions were more likely to provide STBH services than others. RAE 5, which served Denver County during this 5-year period, had a higher percentage of PCMP locations providing STBH services compared to the other RAEs for all five years. Except for 2019, RAE 6 had the smallest percentage of PCMP locations providing STBH services in each year. RAEs 1 through 5 had higher percentages of PCMP locations providing STBH services in 2023 compared to 2019, while RAE 6 had relatively the same percentage and RAE 7 had a decrease of 5 percentage points in the PCMP locations providing STBH services from 2019 to 2023.

The high percentage of PCMP locations in RAE 5 may, in part, be a function of the higher percentage of PCMP locations in that region that were FQHCs. On average, over the five years of this analysis, 37.6% of the PCMP locations in RAE 5 were FQHCs. RAE 4 had a rate of 29.2% and RAEs 1 (14.8%), 2 (18.6%), and 7 (17.4%) had rates in the teens. RAEs 3 and 6 each had rates of about 10% of PCMP locations that were FQHCs. To assess the role that variation in FQHC PCMP locations played in the findings presented in Figure 8, we looked at the percentage of PCMP locations in each RAE that provided STBH services distinguishing between FQHCs and non-FQHC PCMP locations. Figures 9 and 10 present the percentage of FQHC and non-FQHC PCMP locations, respectively, that provided at least one STBH service in each year across the seven RAEs.

Figure 9: Percent of FQHC PCMP Locations that Provided STBH Services, by RAE and Year

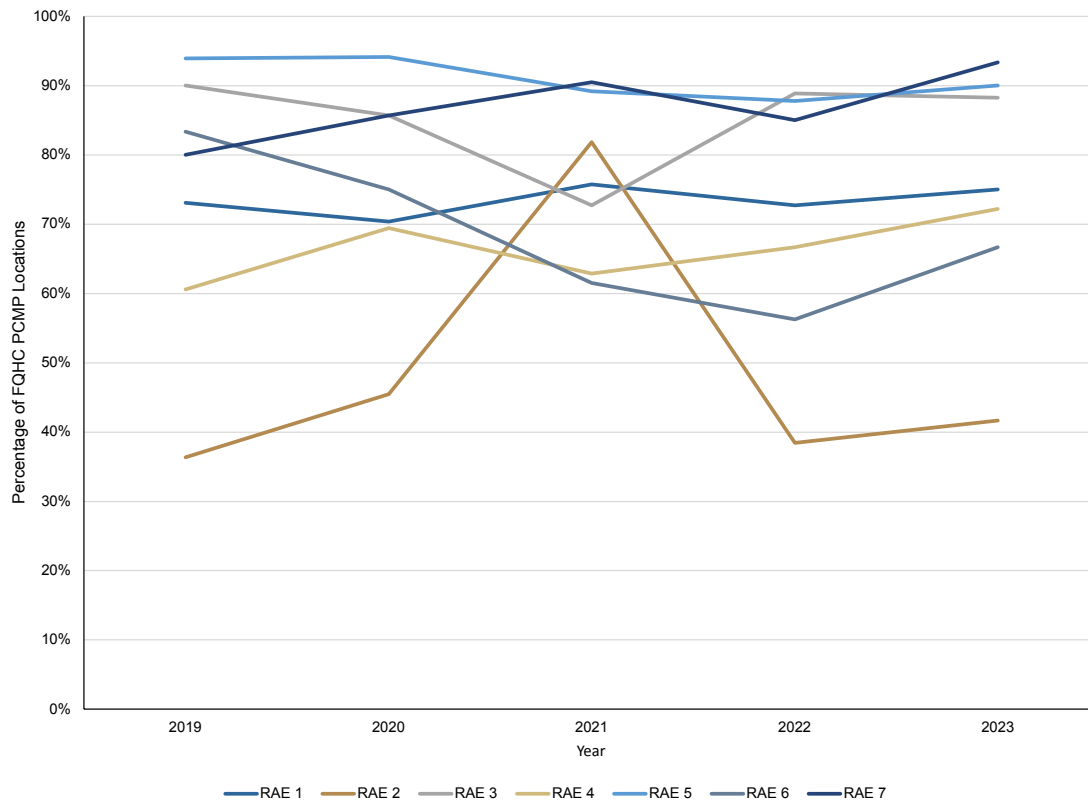
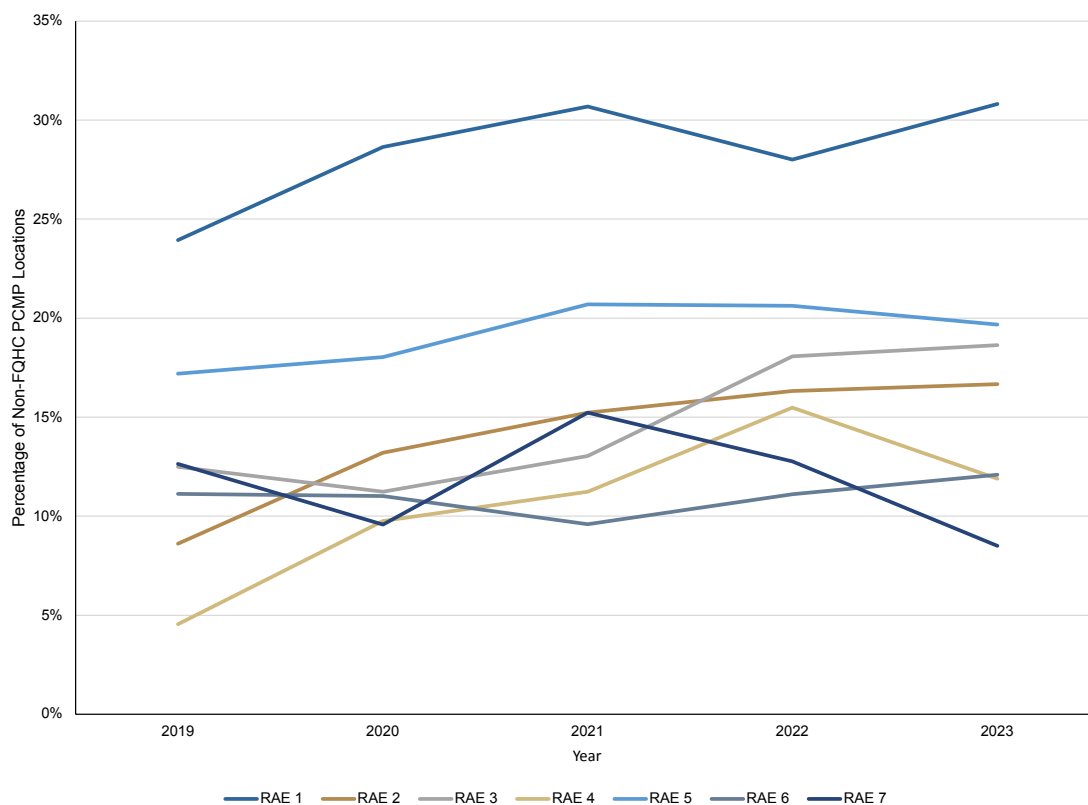


Figure 10: Percent of Non-FQHC PCMP Locations that Provided STBH Services, by RAE and Year



As shown in Figures 9 and 10, in all RAEs, FQHC PCMP locations had a substantially higher percentage of locations that provided STBH services compared to non-FQHC PCMP locations. There are, however, notable differences across the RAEs and in the five-year trends of these percentages of non-FQHC PCMP locations compared to FQHC PCMP locations. For example, RAE 1 had the highest percentage of non-FQHC locations providing STBH services while it was in the middle of the other RAEs for the percentage of FQHC locations providing these services. In the last 2 years, RAEs 3, 5, and 7 had the highest percentage of FQHC PCMP locations providing STBH services with RAEs 3 and 7 increasing their percentages in these years.

RAE Experiences Implementing the STBH Benefit

To support the interpretation of the claims analysis results from the member and provider perspectives, KIIs were conducted with representatives from six of the seven RAEs to capture their experiences and perspectives regarding the implementation of the STBH benefit. During the interviews we explored various aspects of the implementation and how the STBH benefit influenced the planning and delivery of BH services within the RAEs. Representatives discussed their understanding of HCPF's goals related to the STBH benefit, support of integrated care before the introduction of the STBH benefit, the RAE's implementation support, barriers to implementation, and initiatives to boost STBH service utilization. Discussions also addressed factors contributing to successful implementation, barriers to members' access to BH services, and trends in utilization of the STBH benefit in the RAE. Additionally, we examined the appropriateness of the procedure codes included in the benefit and potential areas for improvement. Key themes were compiled and are presented below.

Understanding the STBH Benefit: Goals and Key Features

The interviews began with interviewees sharing their understanding of the STBH benefit and its intended goals. They expressed a common understanding that the overall aim of the STBH benefit was to support a truly integrated care model and ensure that behavioral health services are accessible alongside physical health services in primary care settings. RAE representatives also understood that the STBH benefit allowed BH providers in primary care settings to bill for up to six psychotherapy sessions without the need for a formal diagnosis, a requirement that previously existed to bill for services paid for under the capitated BH benefit. This change was viewed as making behavioral health care more accessible, especially for members with low-acuity BH needs.

During the interviews, representatives shared their understanding that the six authorized psychotherapy codes were intended to provide brief interventions, with patients requiring longer-term care being referred to Community Mental Health Centers (CMHCs). Some representatives pointed out that the benefit also addressed the need for billing codes for previously uncovered services, such as warm handoffs and referrals to integrated BH providers. Additionally, while the first six sessions are available through primary care FFS payments, patients could continue to receive further visits by the same BH providers if the practice was contracted with the RAE to provide capitated BH services.

RAE Support of Integrated Care Before the Introduction of the STBH Benefit

Prior to the introduction of the STBH benefit, RAE predecessors were already supporting the integration of behavioral health services within primary care practices. In Colorado, prior to the development of the RAEs, separate entities supported the delivery of physical and behavioral health for Medicaid members. Specifically, Regional Care Collaborative Organizations (RCCOs) supported the delivery of physical health and Behavioral Health Organizations (BHOs) supported the delivery of BH services under a capitated benefit. Overall, prior to the introduction of the STBH benefit, the RCCOs and BHOs were involved in a variety of innovative approaches to integrating behavioral health into primary care, often focusing on creating sustainable funding models and fostering close partnerships between primary care and local CMHCs.

Several RAE representatives mentioned that in their region before the introduction of the STBH benefit the same organization served as a RCCO and BHO, and these organizations were supporting integrated care through two models. One model leveraged partnerships with local CMHCs that involved embedding CMHC staff within primary care practices, allowing for the sustainable billing of co-located integrated care services under the capitated benefit. A second model helped primary care practices hire their own BH providers and establish agreements with a BHO to provide services paid for under the capitated benefit. Additionally, these organizations played a role in supporting integrated care through funding grants and/or providing practice transformation support services to primary care practices seeking to implement integrated care models. For example, practice transformation support was provided for primary care practices adopting integrated behavioral health care as part of the Colorado State Innovation Model (SIM) initiative. RAE representatives expressed a strong feeling that these efforts laid the groundwork for their implementation support of the STBH benefit.

While RCCO and BHO support of integrated care was helpful in implementing the STBH benefit, the introduction of the STBH benefit was perceived by some RAE representatives as disruptive to their earlier efforts to integrate BH services within primary care practices. One key disruption identified was the shift towards the exclusive use of the six STBH therapy codes, which some representatives viewed as reinforcing a siloed model between BH and physical health care, contrary to the integrated care models they had been working to build. In these models, BH interventions were intended to be seamlessly integrated into the care process, with a more organic flow of services that did not rely on formal therapy sessions or extensive documentation. The introduction of therapy codes with their associated time and documentation requirements, were viewed as in conflict with the more flexible and collaborative nature of their integrated care models, ultimately disrupting the workflow and reducing the natural transition between physical and BH providers.

Additionally, there was a consensus that the introduction of the STBH benefit led to some confusion regarding billing processes, which further disrupted integrated care workflows. The complexity of determining who to bill and how to navigate the new requirements reportedly created a level of uncertainty and frustration within practices. The transition also created tension in the relationship between the RAEs that had previously supported integrated care and HCPF due to initial low adoption rates of the STBH benefit. Representatives of these RAEs reported they were initially still using their previous integrated care models and encountered challenges in demonstrating the effectiveness of their models in relation to HCPF's goals for the STBH benefit. Despite these challenges, RAEs worked to adapt their approach to integrated care to harmonize with the newly implemented STBH benefit, even if it did not align perfectly with the use of the six therapy codes.

Another significant disruption raised in the interviews involved the employment status and integration of BH providers in primary care practices. As a result of changes in the capitated per member per month payment to account for the shift of services to the STBH fee for service coverage, some RAEs that had previously supported co-located CMHC BH providers in primary care practices adjusted funding of the CMHCs resulting in CMHC staffing reductions. While it was noted that many of these staff members were later rehired, the transition was disruptive for the affected CMHCs and the primary care practices that were using the co-located model. It was also noted that over time some practices shifted to bringing BH providers in-house instead of using a co-located model and this decreased the level of community integration and created additional challenges in workforce recruitment.

Implementation Support for the STBH Benefit: RAE Efforts, Challenges, and Initiatives to Improve Utilization

RAE EFFORTS IN PROVIDING SUPPORT

The RAEs played a critical role in supporting practices as they worked to successfully integrate and utilize the STBH benefit. RAEs implemented a wide range of tailored strategies to address both the operational and clinical challenges practices encountered in implementing the STBH benefit. These strategies aimed to streamline processes by focusing on building capacity, improving engagement, and enhancing the overall delivery of care. Some of the key supports the RAE representatives noted are:

- **Communicating comprehensive measures of success:** A key action was using the Accountable Care Collaborative Key Performance Indicators (KPIs) to show that the benefit, along with their integrated care model, were yielding positive outcomes, as the KPIs cover a range of behavioral health services, not just those related to the STBH benefit.
- **Providing integrated care support:** The RAE staff who were well-versed in various integrated models, worked closely with practices to align their capacity and needs, minimize disruptions, and facilitate the integration of the STBH benefit into existing workflows.
- **Building staff capacity for behavioral health activities:** The RAEs helped FQHCs secure behavioral health providers through a capitated benefit model, ensuring sustainable funding. Smaller practices, however, struggled with workforce shortages and lacked space for full-time behavioral health staff.
- **Providing educational and operational support:** The RAEs offered coaching and resources to help practices with coding, billing, and understanding the benefit. They also guided practices through the implementation process, including staffing, billing, and scheduling for behavioral health providers.
- **Addressing workforce issues:** In rural and frontier areas facing workforce shortages, particularly in behavioral health providers, the RAEs explored solutions like hybrid models and telehealth, while supporting practices with recruitment efforts and offering financial support to bridge funding gaps.
- **Assisting with contracting and credentialing for behavioral health staff:** The RAEs supported contracting and credentialing for behavioral health staff, especially for independent practices, as larger FQHCs faced fewer challenges with these administrative tasks.
- **Acting as a consultant and offering technical assistance:** In addition to offering educational support, the RAEs provided individualized consultative support to help practices address unique challenges, including direct assistance with billing and coding the STBH benefit within their care model.

RAE support varied between FQHCs and non-FQHCs due to differences in infrastructure, resources, and needs. FQHCs, with their existing infrastructure and established systems for behavioral health integration, were better equipped to manage billing and contracting. They relied more on the capitated benefit model, and needed less ongoing support, although periodic discussions helped refine and align their operations.

In contrast, non-FQHCs, particularly smaller, independent practices, faced more challenges with billing, coding, staffing, and financial management for the STBH benefit. These practices required more frequent coaching, including help with contracting, credentialing, and practice transformation.

The RAEs faced challenges in supporting practices with the STBH benefit, particularly around billing, staffing, and administrative procedures. Billing and coding, especially for low-acuity assessments and brief counseling sessions, caused confusion, requiring extensive support to avoid reimbursement delays or incorrect payments. Behavioral health workforce shortages, particularly in rural and frontier areas, were another major issue. The demand for professionals exceeded supply, making recruitment difficult, especially for smaller practices. While telehealth options helped, they also posed challenges in hiring and integrating remote workers into existing practice models. Smaller practices struggled with space for full-time behavioral health staff, while larger practices, though better resourced, faced difficulties integrating services into their existing operations.

Practices also had to navigate complex state requirements, credentialing, and prior authorization processes, creating hesitancy among practices in fully adopting the STBH benefit. The need for clarity in billing, coding, and service delivery, along with the fear of inadvertently violating regulatory rules, made some practices hesitant to fully embrace the STBH benefit. The RAEs worked diligently to close the knowledge gap, offering consultative support to help practices confidently implement the benefit while ensuring compliance with state and federal regulations.

Overall, the RAEs played a crucial role in helping practices integrate the STBH benefit, offering tailored support to address operational and clinical challenges. The RAEs' consultative approach and focus on workforce issues were key to successful integration and improved care delivery.

SPECIAL PROGRAMS AND INITIATIVES IMPLEMENTED BY RAES TO ENHANCE UTILIZATION OF STBH SERVICES

The RAEs implemented various innovative approaches to enhance the utilization of STBH services. These approaches included:

- **Supporting integrated care models as a whole, not just the benefit:** Several RAEs had practices in their region prioritize integrated care as a more comprehensive strategy to achieve the STBH benefit goals. They supported expanding existing integrated care models that incorporated behavioral health services within primary care settings rather than solely focusing on the STBH benefit. This approach was seen as sustainable and essential for long-term behavioral health integration.
- **Offering community incentive programs and grants:** Some RAEs supported expanding integrated behavioral health services through community incentive programs and grants, helping practices develop integrated care approaches. RAEs were directly involved in the distribution of grants and worked closely with CMHCs to enhance the service delivery network, enabling practices to build infrastructure for effective integrated care.
- **Promoting education and streamlined communication:** Communication was key to the RAEs' strategies to enhance the utilization of STBH services. They educated providers about the availability of STBH services through newsletters, training sessions, and outreach from care managers. Some RAEs also partnered with CMHCs to create workflows that streamlined the referral process, ensuring seamless care transitions and supporting providers in integrating behavioral health into their care models.
- **Ensuring continuity of care through provider network integration:** One RAE collaborated with primary care practices to integrate them into the capitated independent provider network, allowing patients to continue care with the same provider even after the six-session benefit limit. This initiative aimed to ensure continuity of care, prevent disruptions, and improve patient experience and outcomes.
- **Building workforce sustainability for integrated care:** Recognizing the importance of workforce sustainability, one RAE launched a community integration program to provide funding for primary care practices to hire behavioral health professionals, helping them overcome staffing challenges and ensure long-term sustainability in integrated care.
- **Enhancing STBH utilization through ongoing support:** To equip providers for effective STBH implementation, several RAEs offered quarterly and annual training, along with one-on-one support for workflow management and integration. These efforts aimed to enhance providers' capacity to meet patient needs and improve STBH program success.

The RAEs used various strategies focused on integrated care and ongoing support to boost STBH service utilization. While many initiatives were not aimed specifically at the STBH benefit, they aligned with its goals by facilitating a smooth integration of behavioral health into overall care delivery. These efforts were viewed as greatly improving access to care, encouraging provider collaboration, and ensuring behavioral health services were effective and accessible to those in need.

Keys to Success: RAE Insights on Factors and Strategies for Effective STBH Service Delivery

KEY STRATEGIES FOR SUCCESSFUL STBH SERVICE DELIVERY

A key to success highlighted by the RAEs was co-designing integrated care models in collaboration with practice providers. Engaging providers early on ensured that the models were financially viable and could be tailored to meet the specific needs of their patient populations. This collaborative approach allowed the RAEs to address practice specific challenges and develop effective, sustainable solutions for delivering STBH services, making integration a functional part of everyday care.

Financial sustainability was another crucial success factor. The RAEs aligned financial structures with integrated care models by using an encounter rate model, similar to FQHCs, to cover costs associated with behavioral health services. Streamlining the billing process, such as eliminating separate billing for STBH services, reduced administrative burdens and made the integrated care model more feasible. This financial alignment helped practices sustain their behavioral health services and focus more on patient care.

Workforce development played a vital role in the successful delivery of STBH services. The RAEs supported practices in hiring and integrating behavioral health professionals into primary care teams, offering guidance on staffing, training, and billing. Cross-training primary care staff to deliver integrated services ensured high quality care. Additionally, telehealth integration became a key strategy, enabling practices to overcome geographical barriers and provide flexible, scalable behavioral health support, especially in rural areas. This approach enhanced both the effectiveness and sustainability of the STBH benefit over time.

EFFECTIVE STRATEGIES DURING IMPLEMENTATION

During implementation, some RAEs focused on ensuring integrated care's financial viability by setting a minimum threshold for Medicaid members. This approach aligned the interests of both providers and the RAE, ensuring that enough Medicaid members received the benefits of the STBH services, thus making the program financially sustainable and reducing the administrative burden of managing separate billing systems. It allowed practices to incorporate integrated care more easily, streamlining operations with a single funding source, and ensuring long-term viability.

RAEs also collaborated with CMHCs to expand the reach of STBH services and ensure continuity of care, particularly for practices new to integrated care. These partnerships provided practices with established infrastructure and expertise, creating more sustainable care models. Additionally, RAEs worked with subcontractors to provide behavioral health professionals to practices that were struggling with staffing shortages, ensuring high-quality services despite limited resources.

Learning collaboratives were another key strategy, enabling practices to network, share best practices, and solve common challenges. These collaborative spaces fostered innovation, and problem solving, helping practices overcome obstacles and successfully integrate behavioral health services, contributing to the long-term success of the STBH benefit.

LEVERAGING PRIOR EXPERIENCE FOR SUCCESSFUL STBH BENEFIT IMPLEMENTATION

RAEs with previous experience as BHOs leveraged their knowledge of behavioral health utilization and access gaps to address challenges in integrating behavioral health into primary care settings. Their expertise allowed them to develop tailored solutions, bridging the gap between primary care and behavioral health providers, which facilitated smoother integration and improved patient access to comprehensive care.

Many RAEs also had experience with large-scale initiatives like the Colorado SIM model, which provided infrastructure for coordinating care across multiple providers and disciplines. This experience allowed the RAEs to integrate behavioral health services into broader care models more efficiently, ensuring effective implementation of the STBH benefit. Furthermore, lessons from past programs highlighted the importance of clear communication with providers and the need for well-established systems and processes to prevent common integration pitfalls.

Overlapping programs, such as SIM and the STBH benefit, created confusion around funding and program requirements as some practices struggled to navigate the various expectations and administrative processes associated with each program. Despite these challenges, RAEs used their past experience to improve coordination and streamline the process, ensuring smoother implementation and better integration of behavioral health services.

Barriers to Access: Challenges in Delivering and Receiving STBH Services

CHALLENGES IN DELIVERING STBH SERVICES: WORKFORCE SHORTAGES, SPACE LIMITATIONS, AND FINANCIAL BARRIERS

A major barrier to delivering STBH services was the shortage of behavioral health providers, especially in primary care settings, that complicated consistent access to care. This issue was exacerbated by the post-pandemic workforce shortage and salary constraints, particularly for FQHCs that struggled to compete for staff. Space limitations also hindered the integration of behavioral health services. Many practices lack the physical space to accommodate behavioral health providers, which negatively impacted care integration. Financial sustainability was another challenge. Confusion over service expectations in combination with complex reimbursement and billing processes creating operational difficulties, particularly for practices outside integrated health systems.

CHALLENGES IN ACCESSING STBH SERVICES: SOCIAL BARRIERS AND REGIONAL DISPARITIES

RAEs highlighted that health-related social needs, such as housing instability, transportation barriers, and unreliable contact information, significantly hindered members' access to STBH services. Patients facing housing instability often struggled with consistent engagement, and transportation challenges made attending in-person sessions difficult. Additionally, virtual care delivery was problematic for Medicaid populations with limited access to technology, and language barriers further complicated access, especially in diverse communities. Rural areas faced unique challenges, including a shortage of providers leading to difficulties in implementing integrated care models. Though some practices screened for social needs, integrating routine screening into workflows and arranging follow-up referrals remained inconsistent, creating gaps in care. Some practices had co-located social services along with behavioral health, however, many still lacked the infrastructure to fully address these needs, even when behavioral health providers were available.

STBH Service Utilization: Trends in the Use of STBH Services Across Different RAE Regions

UTILIZATION PATTERNS FOR STBH SERVICES ACROSS DIFFERENT RAE REGIONS

RAEs observed that while the utilization of STBH services increased over time, it did not reach their expected levels. Over the five years, there was more integration of care in RAE regions compared to the program's start, but many of the services provided did not fall under the formal STBH benefit. Variations in utilization across regions were largely influenced by factors such as population size and the availability of FQHCs. Larger regions, especially metropolitan areas, benefited from more diverse staffing and resources, which likely contributed to higher utilization in the corresponding RAEs. In contrast, smaller practices across all regions struggled to effectively deliver STBH services. Additionally, restrictive coding practices created challenges for billing, preventing practices from appropriately capturing and reimbursing for all the services provided. The following factors were identified as potential influencers of low utilization rates:

- **Challenges in tracking behavioral health service utilization:** The RAEs used quarterly reports to monitor high-volume behavioral health services, shifting from visit codes – which often failed to capture the full range of services – to a diagnosis-based data approach. This was intended to provide a more accurate representation of services, especially since many providers were billing for services beyond the STBH benefit. However, inconsistencies in billing practices still posed challenges in obtaining a clear picture of overall utilization.
- **Challenges in billing and procedure coding:** Some practices, especially FQHCs, continued to bill under older systems, leading to inconsistent use of the new STBH codes. The RAEs emphasized that the six existing codes were designed for longer sessions and were not a good fit for the low-acuity, short-term nature of the STBH services. They suggested incorporating shorter, more flexible codes, such as those for 15-minute sessions, and adding codes for screenings, case management, and family therapy would have better supported integrated care. Some independent providers could access more appropriate codes, and the RAEs believe expanding code options could improve care coordination and access to services.

Hopes for the Future: Perspectives on ACC Phase 3

The RAEs expressed optimism for the direction of ACC Phase 3, particularly with initiatives like HB 22-1302, that were viewed as solid foundations for the necessary changes in integrated care. They suggested that instead of starting from scratch, Colorado could benefit greatly from adapting successful models from other states, such as Wisconsin, and tailoring these to fit the state's unique needs. However, they also pointed out that the STBH benefit could have been more significant if a more appropriate set of codes had been used, especially ones that would better integrate therapy into primary care settings.

The RAEs highlighted that HCPF seems to be learning from the successes of other states, which is encouraging for the future of ACC Phase 3. They recommended that Colorado continue to examine and incorporate successful models from similar states, while ensuring that there is increased involvement from stakeholders in shaping the overall approach. Furthermore, the RAEs emphasized the importance of providing financial support, such as grants, to practices that might be hesitant to adopt new models due to financial constraints. This support would help build confidence and encourage the broader embrace of integrated care.

Looking toward the future, the RAEs expressed hope that the ongoing policy changes, particularly in ACC Phase 3, would be approached adopting a systems perspective. They praised the state's commitment to integrated care through policy shifts like the SIM and 1302 programs, but cautioned that solutions should be viewed holistically to avoid unintended disruptions. Some of the policy changes implemented as part of the STBH benefit had negative consequences for some practices, primarily because they were not considered within the broader system. The RAEs urged that future policy decisions account for the complex system of physical and behavioral healthcare delivery to ensure more effective and sustainable improvements in integrated care. Key areas for action highlighted by the RAEs are outlined below.

- **Clearer guidance and well-defined assessment criteria:** The RAEs emphasized the need to integrate both population health management and complex care management for individuals with behavioral and physical health conditions, proposing separate toolkits for general integrated care and for managing complex cases like dual diagnoses. They also urged HCPF to more carefully assess providers' levels of integration, noting that simply offering services like telehealth is insufficient for true integration. They also noted that practices in the 1302 program often struggled due to a lack of clear guidance and support.
- **Addressing operational challenges and strengthening integrated care for Medicaid Populations:** The RAEs identified several operational challenges, especially for the Medicaid population. They expressed concerns about the removal of the six-visit limit and its impact on FQHCs. RAEs urged HCPF to adjust the payment system to ensure proper funding and integration into provider rates. The RAEs also emphasized the need to address operational barriers, such as reimbursement for warm handoffs and consultations, and stressed that clear definitions, targeted toolkits, and ongoing financial support are essential for overcoming these challenges. They called for a more structured approach and clearer guidelines to ensure effective implementation of integrated care, particularly in managing the complexities of coding and addressing the diverse needs of Medicaid recipients.
- **The need for training and workforce development:** The RAEs stressed the importance of workforce development, particularly in training providers on the range of primary care behavioral health models. They suggested HCPF establish partnerships with universities and provide routine, accessible training opportunities to build a well-prepared workforce for integrated care. They highlighted the 1302 program's website as a valuable resource for ongoing development and called for state-aligned initiatives that go beyond basic compliance to ensure meaningful improvements in care delivery.

Summary and Conclusions

The implementation of the Short-Term Behavioral Health benefit in Colorado's Medicaid program represented an important step toward improving access to behavioral health services in primary care settings. While overall utilization of STBH services remained low, averaging less than 2% of Health First Colorado members annually, the benefit appears to have provided meaningful access for certain populations, particularly pregnant individuals, youth in foster care, and those with lower-acuity behavioral health needs. Importantly, more than half of members who accessed STBH services also received capitated behavioral health services, and in many cases from the same provider, suggesting that the benefit complemented existing care rather than replacing it.

The analysis revealed notable disparities in utilization across racial and ethnic groups, regions, and practice types. American Indian/Alaska Native members were most likely to use STBH services, while Asian and Native Hawaiian/Other Pacific Islander members had the lowest rates of behavioral health service use overall. Regional variation was also significant, with RAE 5 (Denver) showing the highest uptake of STBH services, likely reflecting greater availability of FQHCs and integrated care infrastructure. These patterns underscore the need for further research into barriers to care across demographic and regional populations.

Provider-level findings highlight the critical role of FQHCs in delivering STBH services. FQHCs were far more likely than non-FQHC practices to provide these services, and their larger size and integrated care models facilitated adoption. However, smaller and rural practices faced persistent challenges, including workforce shortages, space limitations, and administrative complexity. These barriers, combined with restrictive coding options and confusion around billing processes, contributed to lower utilization rates and limited the STBH benefit's potential impact.

Key informant interviews with RAEs reinforced these findings and provided insight into implementation challenges and successes. RAEs played a pivotal role in supporting practices through technical assistance, workforce development, and financial sustainability strategies. However, the introduction of the STBH benefit disrupted some existing integrated care models and created tension between flexibility and formal coding requirements. RAEs emphasized the importance of aligning financial structures, expanding appropriate billing codes, and addressing operational barriers to sustain integrated care as policy changes that could have enhanced the value of implementing a STBH benefit.

Looking ahead, the lessons learned from the STBH benefit can inform future policy initiatives, including ACC Phase 3. RAE representatives recommended clearer guidance, expanded code sets to better reflect integrated care workflows, and targeted financial and workforce support — particularly for smaller practices and rural areas. Addressing social determinants of health and ensuring integrated care processes that align with demographic and regional needs can facilitate equitable access to physical and behavioral health services.

In summary, while the STBH benefit did not achieve widespread utilization, it provided valuable access for some populations and offered insights into the opportunities and challenges of integrating behavioral health into primary care. Future efforts can build on these lessons to design policies and integrated care programs that are flexible and sustainable models of care that meet the diverse needs of Medicaid members in Colorado, as well as other states. While ACC Phase 3 and other behavioral health integration initiatives hold considerable promise for advancing integrated care, reaching their full potential will require policy refinements, targeted investments, and a commitment to a statewide comprehensive system that minimizes unintended consequences and ensures long-term success.

Appendix: PCMP Criteria*

The Department (HCPF) has identified the following criteria for PCMPs:

- Provider is enrolled as a Colorado Medicaid provider.
- Provider is licensed and able to practice in the State of Colorado.
- Provider holds an MD, DO, or NP provider license with additional licensing and provider type qualifications.
- Provider is certified as one of the following specialties: pediatrics, internal medicine, family medicine, obstetrics and gynecology, or geriatrics. Community mental health centers and HIV/infectious disease practitioners may qualify as PCMPs with the Contractor's approval if all other PCMP criteria are met.
- The practice, agency, or individual provider renders services utilizing one of the following Medicaid Provider types:
 - Physician
 - Osteopath
 - Federally Qualified Health Center
 - Rural Health Clinic
 - School Health Clinic
 - Family/Pediatric Nurse Practitioner
 - Clinic-Practitioner Group
 - Non-physician Practitioner Group
- Provide some level of care coordination.
- Provide 24/7 phone coverage with access to a clinician that can triage health need.
- Adopt and regularly use universal screening tools, uniform protocols, and guidelines/decision trees/ algorithms to support clients in accessing necessary treatments.
- Track the status of referrals to specialty care providers and provides the clinical reason for the referral along with pertinent clinical information.
- Weekly availability of appointments on a weekend and/or on a weekday outside of typical workday hours (Monday – Friday 7:30 am – 5:30 pm).
- Using available data to identify special patient populations who may require extra services and support for health or social reasons. The practice has procedures to proactively address the identified health needs.
- Collaborate with patient, family, or caregiver to develop an individual care plan for Members with complex needs.
- Utilize an electronic health record or are working with the RAE to share data with HCPF.

* Section 1915(b) Waiver Proposal for The Colorado Medicaid Accountable Care Collaborative: Primary Care Case Management and Prepaid Inpatient Health Plan Program; Accountable Care Collaborative: Limited Managed Care Capitation Initiative and Special Connections: Postpartum Months Three through Twelve. Submitted March 2, 2018 for Waiver Period July 1, 2018 to June 30, 2023 Revised May 1, 2018, May 15, 2018, January 1, 2020, and October 2, 2020. An amendment effective January 1, 2021 to June 30, 2023.



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