CBHC | Colorado Behavioral Healthcare Council

Issues to be Prepared for When Talking with Legislators

Behavioral Health Administration (BHA) & BHASOs

Core Issue: Concerns about effectiveness, funding, and duplication with other state agencies.
Context: The BHA was created to streamline a historically fragmented system. CBHC supported this vision. However, implementation has introduced new operational challenges for providers

What you might hear:

- *"What do you think of the BHA?"*
- *"Is the new system (LIFTS/BHASOs) actually working?"*

Response Strategy:

- Start by noting that CBHC has a good relationship with the BHA: we supported the creation of the BHA and continue to work collaboratively with BHA and the newly launched BHASOs to ensure the new model is successful.
- Explain that the definition of the "safety net" has expanded to include nearly all behavioral health needs. Without new funding, this expansion unintentionally dilutes resources for people with the highest needs, particularly adults with serious mental illness (SMI) and children with serious emotional disturbance (SED).
- Highlight that overly prescriptive and duplicative requirements undermine provider expertise and contribute to workforce burnout.
    - Intrusive assessment and documentation requirements force clinicians to repeatedly "prove" medical necessity—a standard not applied to physical health care, raising parity and stigma concerns.
- Raise safety concerns related to the "no refusal" expectation for individuals with violent behaviors, which can put staff and other patients at risk in community-based settings.

Key Message: We support the goal of system coordination, but implementation must be simplified, adequately funded, and centered on clinical judgment and safety.

Behavioral Health Reform & System Efficiency

Bottom Line: Colorado's behavioral health system is administratively inefficient because financing was never unified—not because providers are doing anything wrong. The solution is financing reform and continued collaboration across the system.

What you might hear:

- *"Why do we have four RAEs and four BHASOs contracting with the same providers?"*
- *"Why are providers required to manage multiple contracts and oversight structures?"*
- *"Is this an efficient way to run the system?"*
- *"Are Medicaid and General Fund dollars actually coordinated?"*
- *"Has care coordination meaningfully improved?"*

Response Strategy:

- Acknowledge the concern: *"You're right—there is redundancy."*
- Reframe the cause:
    - This is not a care delivery problem—it's the result of layered reforms without a unified financing model.
    - Providers didn't design the structure; they've adapted to it to keep care accessible.
- Explain that Medicaid and General Fund dollars support the same continuum but flow through separate systems with separate rules, creating administrative burden.

- Note that care coordination remains a shared goal, but multiple oversight entities make it harder, not easier.

The Ask / Solution:
- Move toward one coherent payment model for behavioral health.
- Align Medicaid and state dollars through the CCBHC PPS, which reduces duplication, improves coordination, and protects access for people with serious mental illness—while maximizing federal match.

Key Message: Efficiency won't come from adding more administration—it will come from fixing how behavioral health is financed.

Behavioral Health Spending in the Medicaid Budget

Core Issue: Behavioral health is often cited as a major driver of Medicaid cost growth, without sufficient context.

What you might hear:
- *"Why is behavioral health spending growing so fast?"*
- *"Is Medicaid paying too much for these services?"*

Response Strategy:
- Acknowledge the concern about overall Medicaid growth, but reframe the narrative:
  - Behavioral health spending is increasing largely because more people are finally accessing care after years of underinvestment.
- Emphasize that behavioral health services are low-cost compared to the alternatives:
  - Community-based treatment prevents far more expensive outcomes like emergency room visits, hospitalizations, homelessness, child welfare involvement, and incarceration.
- Note that much of the spending growth reflects:
  - Increased acuity following the pandemic
  - Workforce cost increases due to inflation
  - Federal and state policy changes that appropriately expanded coverage
- Make clear that behavioral health is not driving waste—it is preventing it. For every $1 invested in behavioral health, Colorado saves $4 in avoided healthcare, homelessness, criminal justice, and other system costs (2021 CHI analysis).

Key Message: Cutting or constraining behavioral health spending shifts costs elsewhere in the system and worsens outcomes.

Utilization Management (UM)

Core Issue: With limited budget resources, the state is considering a number of UM tools including prior authorization which can delay care and interfere with clinical decision-making.

What you might hear:
- **"***We have to do something to get spending under control."*
- *"Isn't utilization management necessary to prevent overuse?"*

Response Strategy:
- Agree on the goal of responsible stewardship, then pivot:
  - Behavioral health already operates in a resource-constrained environment, and there is little evidence of overutilization.
- Explain that UM in behavioral health often:
  - Delays urgently needed care
  - Overrides clinical judgment

    - Increases administrative burden without improving outcomes
- Point out the parity issue:
    - Behavioral health faces far more restrictive UM than physical health services, despite parity laws.
- Share real-world impacts:
    - Delayed authorizations can mean crisis escalation, ER use, or justice system involvement.

Key Message: Smart cost control means investing in timely, clinically appropriate care—not administrative barriers.

Competency & Forensic Crisis System

Context: High-profile cases and federal scrutiny have highlighted the need for reform. Legislation is expected in the coming session.

What you might hear:

- *"The competency system is out of control—how do we fix it?"*
- *"Why is this costing the state so much?"*

Response Strategy:

- Emphasize that jails and hospitals are not treatment settings, yet they are bearing the burden of system failures.
- Explain that delays in competency restoration:
    - Prolong incarceration for people with mental illness
    - Increase costs dramatically
    - Do not improve public safety or clinical outcomes
- Stress the need for:
    - Earlier intervention and diversion
    - Community-based restoration options
    - Adequate step-down and discharge capacity
- Reinforce that Comprehensive Safety Net Providers (CSNPs) are willing partners but cannot absorb forensic responsibilities without funding and infrastructure.

Key Message: True reform reduces both costs and human harm by treating people earlier and in the right setting.

Medicaid Payment Model (PPS)

Core Issue: Colorado's Prospective Payment System (PPS) is a step forward, but misalignment and rate issues threaten sustainability.

What you might hear:

- *"Have you lost money with the new payment model?"*
- *"Are the kinks worked out yet?"*

Response Strategy:

- Emphasize our long-standing support for PPS and note that our goal is to refine the current model so that it aligns perfectly with federal CCBHC standards.
- Acknowledge that PPS works better for some providers than others, largely depending on payer mix and service array.
- Explain that a major challenge is misalignment between Colorado's PPS and the federal CCBHC model the state is moving toward.
- This forces providers to operate under two overlapping systems, creating administrative double-work.
- Note that PPS rates are cost-based but often reflect historic costs, not current inflation or workforce realities.

The Ask: Encourage the legislator to press HCPF to fully align PPS with CCBHC standards and update rates to reflect real-world costs.

Access to Care & Wait Times

What you might hear:

- "My constituents can't get an appointment."
- "Has care coordination actually improved?"

Response Strategy:

- Clarify that not all waits are the same:
  - Is the delay for a prescriber, a specific intensive service, or routine outpatient care?
- Identify the bottleneck:
  - Workforce shortages, especially psychiatrists and advanced practitioners
  - Rigid regulatory and clinical requirements that limit productivity
  - Higher acuity, requiring more time-intensive assessments and treatment planning

Key Message: Access improves when the workforce is supported and regulations allow clinicians to practice efficiently.

Handling General Negativity or "Tough Love" Comments

What you might hear:

- *"The system was overhauled because providers weren't getting the job done."*

Response Strategy:

- Stay calm and fact-based—do not be defensive.
- Explain that CSNPs serve individuals with SMI, co-occurring disorders, and complex social needs—populations no one else is lining up to serve because the work is difficult and underfunded.
- Highlight unfunded mandates:
  - Many required services are not reimbursable by Medicaid or commercial insurance.
  - Capacity funding has not kept pace with expanded expectations under the BHA.

Key Message: Providers are not the problem—we are holding the system together with insufficient resources.

Discussing Specific Legislation

What you might hear:

- "What do you think about [X bill]?"

Response Strategy:

- Refer to the CBHC Key Bills document (shared the morning of Day at the Capitol).
  - If CBHC does not yet have a position, say so.
- Describe how the issue affects your patients, clinicians, and community.
- Ask the legislator how *they* are thinking about the bill.
- Offer to have the CBHC lobby team follow up with additional information.

Tip: Your lived experience as a provider is often more persuasive than technical details alone.