

DISTRICT COURT, CITY & COUNTY OF DENVER,
STATE OF COLORADO
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DATE FILED
September 30, 2025 2:58 PM
FILING ID: 8EFF9D5FE57BE
CASE NUMBER: 2025CV33489

Plaintiffs: COLORADO ASSOCIATION FOR BEHAVIOR ANALYSIS, a Colorado nonprofit corporation; ABA ACROSS ENVIRONMENTS, INC., a Colorado corporation; ANIMAS ABA, LLC, a Colorado limited liability company; AUTISM BEHAVIORAL VENTURES, LLC, a Colorado limited liability company, doing business as ASCEND BEHAVIOR PARTNERS; BEYOND BEHAVIOR, INC., a Colorado corporation; BLUE SPRIG PEDIATRICS, INC., a Delaware corporation, doing business as BLUE SPRIG BEHAVIOR CENTER; BY YOUR SIDE COLORADO, LLC, a Colorado limited liability company; CONTINUUM ASSOCIATES, INC., a Virginia corporation, doing business as CONTINUUM AUTISM SPECTRUM ALLIANCE; SEVEN DIMENSIONS BEHAVIORAL HEALTH, LLC, a Colorado limited liability company; SOAR HEALTH INC., a Delaware corporation, doing business as SOAR AUTISM CENTER; TRUMPET BEHAVIORAL HEALTH, LLC, a Delaware limited liability company, doing business as BLUE SPRIG; WILD SUN BEHAVIORAL SERVICES, LLC, a Colorado limited liability company; LORI AVERY, as legal guardian of A.A.; VALERIA DILLON, as parent and next friend of P.D., a minor; LAINIE GRAY, as parent and next friend of C.C., a minor; KEENA GREENWOOD, as parent and next friend of P.M., a minor; HEATHER HILLMAN, as parent and next friend of F.H., a minor; JAY ORTENGREN, as legal guardian of E.O.; ROBILYN ROBISON, as parent and next friend of O.R., a minor; AMY WARREN, as legal guardian of C.W.

v.

Defendants: COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING; KIM BIMESTEFER, in her official capacity; GOVERNOR JARED POLIS, in his official capacity; and the STATE OF COLORADO.

▲ COURT USE ONLY ▲

Case Number:

Courtroom/Division:

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**VERIFIED COMPLAINT FOR JUDICIAL REVIEW OF AGENCY ACTION,
DECLARATORY JUDGMENT, TEMPORARY RESTRAINING ORDER, AND
INJUNCTIVE RELIEF**

Plaintiffs Colorado Association for Behavior Analysis, a Colorado nonprofit corporation (“COABA”), the Provider Plaintiffs (as defined below), and the Beneficiary Plaintiffs (as defined below and, together with COABA and the Provider Plaintiffs, the “Plaintiffs”), by and through their counsel, Polsinelli PC, for their Verified Complaint against the Colorado Department of Health Care Policy and Financing (“HCPF” or the “Department”), Kim Bimestefer, in her official capacity, Governor Jared Polis, in his official capacity, and the State of Colorado (collectively, “Defendants”), hereby state and allege as follows:

INTRODUCTION

1. This is an action seeking declaratory and injunctive relief. Plaintiffs seek judicial review of, and an order setting aside the unlawful government action done through the Governor’s Executive Order D 2025 014 and HCPF’s corresponding actions in furtherance of that Order. These actions have the effect of materially changing, suspending, or otherwise reducing funding for pediatric behavioral therapy and autism spectrum disorder treatment services for Medicaid beneficiaries in violation of state and federal law. Defendants’ actions violate state and federal laws that require parity for mental and behavioral health services covered by Colorado Medicaid (otherwise known as “Health First Colorado”) by unlawfully singling out pediatric autism therapy services for reductions in coverage and reimbursement that are disparate from reductions proposed for other benefits of the Colorado Medicaid program. These changes will cause irreparable harm to Colorado patients and providers and threaten access to health care services for Health First Colorado beneficiaries based on arbitrary and capricious government action that violates state and federal law. Plaintiffs seek injunctive relief to remedy the Defendants’ errors and in order to fully protect important rights of Plaintiffs, providers, and patients, and prevent further irreparable harm to Plaintiffs.

PARTIES

2. Plaintiff Colorado Association for Behavior Analysis is a Colorado nonprofit corporation, and a 501(c)(6) nonprofit membership association, with its principal offices at 14707 E. 2nd Avenue, GL 100, Aurora, Colorado 80111.

3. COABA is the leading trade association representing the interests of behavior analysis providers throughout the State of Colorado. COABA is comprised of nearly 300 members throughout Colorado, representing a significant portion of the Medicaid provider community for behavior analysis services.

4. COABA is a person as defined by the Colorado State Administrative Procedure Act (“APA”), C.R.S. § 24-4-102(12), that will be adversely affected and is aggrieved by Defendants’ conduct and therefore has standing to bring this petition for judicial review in accordance with the provisions of the APA, including without limitation C.R.S. § 24-4-106(4).

5. Additionally, COABA has associational standing to prosecute the claims set forth herein because:

- a. COABA members have standing to sue in their own right;
- b. the interests COABA seeks to protect are germane to its purpose; and
- c. neither the relief requested, nor the claims asserted, requires the actual participation of all COABA members in this litigation.

6. Plaintiff ABA Across Environments, Inc., is a Colorado corporation with a principal office address of 4775 Centennial Blvd, Suite #106, Colorado Springs, CO 80921, and with locations in Colorado Springs.

7. Plaintiff Animas ABA, LLC, is a Colorado limited liability company with a principal office address of 146 Sawyer Dr Unit A1, Durango, CO 81303, US. Animas ABA serves Southwest Colorado, and was the first locally owned and operated ABA therapy clinic in La Plata County.

8. Plaintiff Autism Behavioral Ventures, LLC, is a Colorado limited liability company operating under the trade name Ascend Behavior Partners. Ascend has a principal office address of 8354 Northfield Blvd, Suite 300, Denver, CO 80238, US.

9. Plaintiff Beyond Behavior, Inc., is a Colorado corporation with a principal office address of 6698 S. Iris St., #620554, Littleton, CO 80162.

10. Plaintiff Blue Sprig Pediatrics, Inc., is a Delaware corporation registered to do business in the State of Colorado, and operating under the trade name Blue Sprig Behavior Center. Blue Sprig has a principal office address of 7500 San Felipe St, Suite 990, Houston, TX 77063.

11. Plaintiff By Your Side Colorado, LLC, is a Colorado limited liability company with a principal office address of 1300 Remington Rd Ste K, Schaumburg, IL 60173-4800, and with a service location in Colorado Springs.

12. Plaintiff Continuum Associates, Inc., is a Virginia corporation registered to do business in Colorado and operating under the trade name Continuum Autism Spectrum Alliance. Continuum has a principal office address of 8230 Leesburg Pike Ste 740, Vienna, VA 22182, and provides services in Lakewood.

13. Plaintiff Seven Dimensions Behavioral Health, LLC, is a Colorado limited liability company with a principal office address of 1035 El Rancho Rd, Evergreen, CO 80439 and with locations in Evergreen and Fort Collins.

14. Plaintiff Soar Health Inc. is a Delaware corporation registered to do business in Colorado and operates under the trade name Soar Autism Center. Soar has a principal office address of 3401 Quebec Street, Suite 110, Denver, CO 80207.

15. Plaintiff Trumpet Behavioral Health, LLC, is a Delaware limited liability company registered to do business in Colorado and operates under the trade name BlueSprig. BlueSprig has a principal office address of 7500 San Felipe Street, Suite 990, Houston, TX 77063, and service locations across the Front Range.

16. Plaintiff Wild Sun Behavioral Services, LLC, is a Colorado limited liability company with a principal office address of 685 Briggs St. Erie CO, 80516 and serving the Erie, Colorado community.

17. Each of the Plaintiffs identified in Paragraphs 6 – 16 (collectively, the “Provider Plaintiffs”) is enrolled in Colorado’s Medicaid program and engaged in the business of providing, *inter alia*, therapy services to children with autism, including without limitation applied behavior analysis (“ABA”) therapy services. The Provider Plaintiffs represent a broad range of ABA and other autism therapy service providers, and vary in size, geographic reach, and service offerings, but are united in their mission to provide care for vulnerable Colorado children.

18. Each of the Provider Plaintiffs is a “person” as defined by the APA, C.R.S. § 24-4-102(12), that will be adversely affected and is aggrieved by Defendants’ conduct and therefore has standing to bring this petition for judicial review in accordance with the provisions of the APA, including without limitation C.R.S. § 24-4-106(4).

19. Plaintiff Lori Avery is the legal guardian of A.A., who is a Colorado Medicaid beneficiary and who receives PBT services from Medicaid enrolled providers in Colorado. Plaintiff Lori Avery and A.A. reside in Golden, Colorado.

20. Plaintiff Valeria Dillon is the parent and next friend of P.D., a minor, who is a Colorado Medicaid beneficiary and who receives PBT services from Medicaid enrolled providers in Colorado. Plaintiff Valeria Dillon and P.D. reside in Golden, Colorado.

21. Plaintiff Lainie Gray is the parent and next friend of C.C., a minor, who is a Colorado Medicaid beneficiary and who receives PBT services from Medicaid enrolled providers in Colorado. Plaintiff Lainie Gray and C.C. reside in Fort Collins, Colorado.

22. Plaintiff Keena Greenwood is the parent and next friend of P.M., a minor, who is a Colorado Medicaid beneficiary and who receives PBT services from Medicaid enrolled providers in Colorado. Plaintiff Keena Greenwood and P.M. reside in Wheat Ridge, Colorado.

23. Plaintiff Heather Hillman is the parent and next friend of F.H., a minor, who is a Colorado Medicaid beneficiary and who receives PBT services from Medicaid enrolled providers in Colorado. Plaintiff Heather Hillman and F.H. reside in Evergreen, Colorado.

24. Plaintiff Jay Ortengren is the legal guardian of E.O., who is a Colorado Medicaid beneficiary and who receives PBT services from Medicaid enrolled providers in Colorado. Plaintiff Jay Ortengren and E.O. reside in Conifer, Colorado.

25. Plaintiff Robilyn Robison is the parent and next friend of O.R., a minor, who is a Colorado Medicaid beneficiary and who receives PBT services from Medicaid enrolled providers in Colorado. Plaintiff Robilyn Robison and O.R. reside in Arvada, Colorado.

26. Plaintiff Amy Warren is the legal guardian of C.W., who is a Colorado Medicaid beneficiary and who receives PBT services from Medicaid enrolled providers in Colorado. Plaintiff Amy Warren and C.W. reside in Morrison, Colorado.

27. Each of the Plaintiffs identified in Paragraphs 19 – 26 (collectively, the “Beneficiary Plaintiffs”) is a “person” as defined by the APA, C.R.S. § 24-4-102(12), that will be adversely affected and is aggrieved by Defendants’ conduct and therefore has standing to bring this petition for judicial review in accordance with the provisions of the APA, including without limitation C.R.S. § 24-4-106(4).

28. Defendant HCPF is a principal department of the Executive Branch of the State of Colorado and the single state agency responsible for administration of the Colorado Medical Assistance program commonly referred to as Medicaid. *See* 42 U.S.C. § 1396a(a)(5); C.R.S. § 25.5-4-104(1). The current public-facing name of the state’s Medicaid Program is Health First Colorado (“Colorado Medicaid”). HCPF is located at 1570 Grant Street, Denver, Colorado 80203.

29. Defendant Kim Bimestefer is the Executive Director of HCPF with an office address located at 1570 Grant Street, Denver, Colorado 80203.

30. Defendant Governor Jared Polis is the elected Governor of the State of Colorado and the head of the Executive Branch of the State of Colorado, whose office and official residence is located in Denver, Colorado.

31. Defendant State of Colorado is a sovereign state within the United States of America, organized and existing under the Constitution and laws of the State of Colorado. It is responsible for the administration and governance of public affairs within its jurisdiction.

JURISDICTION AND VENUE

32. This Court has subject matter jurisdiction over Plaintiffs' claims for relief pursuant to the Colorado Constitution, Article VI, Section 9, and C.R.S. § 13-51-101, *et seq.*

33. This Court has personal jurisdiction over Defendants because one or more of the Defendants are located within the City and County of Denver, and the Defendants are persons subject to suit under the APA. *See* C.R.S. § 24-4-106(4).

34. Venue is proper under Colorado Rule of Civil Procedure 98.

35. As discussed below, Defendants' actions are an unauthorized exercise of agency power contrary to APA requirements. Nonetheless, the Department's rule changes and/or rule interpretation, and application effectively constitute final agency action, and Plaintiffs therefore designate the following as the record of agency action pursuant to C.R.S. § 24-4-106(6):

- Executive Order D 2025 009;
- Executive Order D 2025 014 (the "Executive Order");
- Letter from the Colorado Office of State Planning and Budgeting to the Joint Budget Committee of the Colorado General Assembly (the "OSPB Letter");
- Colorado Senate Bill 25B-001; and
- Governor's Balanced Approach to Address the FY 2025-26 Budget Shortfall Due to Federal H.R. 1 presentation dated August 28, 2025 (the "Budget Presentation").

True and correct copies of these documents are attached to this Complaint as **Exhibits 1, 2, 3, 4, and 5** respectively.

FACTUAL BACKGROUND

A. *Pediatric Behavioral Therapies and Applied Behavior Analysis.*

36. Pediatric Behavioral Therapies (“PBT”) are a group of therapy modalities for children effective to modify behavior “using techniques such as reinforcement, enhanced communication, shaping, and modeling, all of which are particularly effective in improving adherence to treatment plans and medication regimens.” Caitlin Opland & Tyler J. Torrico, *Behavioral Therapy*, in STATPEARLS (Nov. 13, 2024), available at <https://www.ncbi.nlm.nih.gov/books/NBK609098/>.

37. Types of PBT include, but are not limited to, applied behavior analysis, cognitive behavioral therapy, cognitive behavioral play therapy, dialectical behavior therapy, exposure therapy, rational emotive behavior therapy, and social learning theory. *Id.*

38. HCPF more succinctly describes PBT on its website as “a treatment that helps change maladaptive behaviors” wherein “[p]rofessionals use [PBT] to replace bad habits with good ones.” See COLO. DEP’T OF HEALTH CARE POLICY AND FIN., *Pediatric Behavioral Therapies* (Sep. 23, 2025, at 18:58 MT), available at <https://hcpf.colorado.gov/pediatric-behavioral-therapies>.

39. Behavior analysis is the scientific study of behavior, focusing on understanding, predicting, and influencing actions through environmental factors and learning principles.

40. ABA is a type of PBT that uses behavior analysis principles to develop interventions and is a core treatment for children diagnosed with autism. See *Doe v. United Behavioral Health*, 523 F. Supp. 3d 1119, 1128 (N.D. Cal. 2021). ABA therapy is part of the prevailing standard of care and is a medically necessary intervention for children with autism, based on decades of research and conclusions of major health authorities. See, e.g., Susan L. Hyman, et al., *Identification, Evaluation, and Management of Children With Autism Spectrum Disorder*, 145 PEDIATRICS 1 (Jan. 2020). For children with an autism diagnosis, early and consistent intervention, including the delivery of ABA, is crucial to ensure that these children stay as healthy as possible. See U.S. DEP’T OF HEALTH & HUMAN SERVICES, *Mental Health: A Report of the Surgeon General*, 163-64 (1999) available at <https://collections.nlm.nih.gov/ext/document/101584932X120/PDF/101584932X120.pdf>.

41. A child or youth age 20 and under enrolled in Medicaid is eligible for Early and Periodic Screening, Diagnosis and Treatment (“EPSDT”) services. 10 C.C.R. § 2505-10:8.280.2; see also COLO. DEP’T OF HEALTH CARE POLICY AND FIN., *Health First Colorado EPSDT Policy* (June 2023), available at <https://hcpf.colorado.gov/sites/hcpf/files/EPSDT%20Policy%20Statement%20June%202023%20%28For%20Providers%29.pdf>. EPSDT services are a mandatory benefit for Medicaid-eligible children, and are subject to heightened requirements to ensure they are available to eligible beneficiaries. See Ctrs. for Medicare and Medicaid Servs., SHO #24-005, *Re: Best Practices for*

Adhering to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Requirements (Sept. 26, 2024) (attached as **Exhibit 6**) (the “SHO Letter”).

42. All goods and services described in Section 1905(a) of the Social Security Act (42 U.S.C. § 1396d(a)) are a covered benefit under EPSDT when medically necessary as defined at 10 C.C.R. § 2505-10:8.076.1.8, regardless of whether such goods and services are covered under the Colorado Medicaid State Plan. 10 C.C.R. § 2505-10:8.280.4.E.1. CMS guidance directs that “States will not be able to comply with the EPSDT requirements unless their Medicaid policies and procedures, including medical necessity criteria, prior authorization requirements, and Medicaid fair hearings, reflect consideration of this EPSDT obligation, which creates a higher standard of coverage for eligible children than for adults. States are also required to perform specific administrative duties, such as . . . ensuring the availability of providers who are qualified and willing to deliver services under EPSDT.” SHO Letter at 2 (internal citations omitted).

43. Reimbursement for services shall be in accordance with the regulations for pricing health services as reflected at 10 C.C.R. § 2505-10:8.280 for all EPSDT medical screening, diagnostic, and treatment services.

44. Under Colorado Medicaid, PBT, ABA, and other pediatric autism therapies are covered as EPSDT benefits. *See* COLO. DEP’T OF HEALTH CARE POLICY & FIN., *Pediatric Behavioral Therapies Information for Providers* (last visited Sept. 23, 2025) <https://hcpf.colorado.gov/pediatric-behavioral-therapies-information-providers>.

B. COABA Members’ and Provider Plaintiffs’ Participation in Colorado Medicaid.

45. COABA was established in 2014 and represents 300 individual and group providers of behavior analysis in Colorado. COABA’s members furnish a range of behavior analysis services to Colorado children every day. From the Front Range to the Western Slope, from the Eastern Plains to southern Colorado, COABA members provide behavior analysis care to Coloradans every day.

46. The mission of COABA is to advance the awareness, development, and access to the science and practice of behavior analysis in Colorado.

47. COABA members, including each of the Provider Plaintiffs, furnish care to medically and economically vulnerable Coloradans through their participation in Colorado Medicaid. As of May 2025, Colorado Medicaid provides health care coverage to approximately 1.2 million Coloradans. *See* THE COLORADO SUN, *Medicaid could be in for big changes in Colorado. Here are 14 charts explaining who would be affected.* (June 30, 2025), available at <https://coloradosun.com/2025/06/30/colorado-medicaid-explained-who-is-covered/>.

48. Without COABA members’ participation in Colorado Medicaid, many Colorado Medicaid beneficiaries would be deprived of access to behavioral health services, including ABA

services for children with autism. Medicaid beneficiaries in rural areas would be disproportionately harmed if COABA members are no longer able to provide care to Medicaid beneficiaries.

49. Unsustainable Medicaid reimbursement rates, which failed to keep pace with the rising costs of delivering specialized care, forced numerous Colorado Medicaid providers across the state to close permanently in 2023, leading to an access to care crisis. *See, e.g.,* Jennifer Brown, THE COLORADO SUN, *Autism centers are leaving Colorado, landing kids on waitlists while therapists beg for better pay rates* (July 24, 2023) available at <https://coloradosun.com/2023/07/24/autism-center-closures-medicaid/>; Karen Morfitt, CBS NEWS, *Colorado approaching a health care crisis when it comes to autism services for Children* (July 21, 2023) available at <https://www.cbsnews.com/colorado/news/autism-services-colorado-children-health-care-crisis-medicaid/>.

C. The 2025 Legislative Special Session and Delegation by the General Assembly to the Governor.

50. On August 6, 2025, Governor Polis called a special session of the General Assembly to address budget shortfalls caused by the passage of federal budget legislation. *See Exhibit 1.*

51. The General Assembly met in special session from August 21, 2025, to August 26, 2025. *See Exhibit 2* at 1.

52. The General Assembly passed Senate Bill 25B-001, Processes to Reduce Spending During Shortfall (“SB 25B-001”), which permits the Governor to suspend or discontinue, in whole or in part, the functions or services of any department, board, bureau, or agency of the state government by Executive Order if the Governor determines that there are not, or will not be, sufficient revenues available for expenditure during the fiscal year to carry on the functions of State government and to support its agencies and institutions. *Id.* at 2.

53. However, under Article V, Section 1 of the Colorado Constitution, the General Assembly cannot delegate its legislative power. The power of the General Assembly over appropriations is absolute. *Colo. General Assembly v. Lamm*, 700 P.2d 508, 519 (Colo. 1985) (citations omitted). Under the Colorado Constitution, the General Assembly is responsible for determining the amount of revenue to be expended in carrying out the public policies of the state. *See Dempsey v. Romer*, 825 P.2d 44, 56 (Colo. 1992) (citing Colo. Const. art. V, § 1; *Lamm*, 700 P.2d 508; *Anderson v. Lamm*, 195 Colo. 437, 579 P.2d 620 (1978); *Vivian v. Bloom*, 115 Colo. 579, 177 P.2d 541 (1947)). The responsible exercise of this power of the purpose requires the Legislative Branch to assume ultimate accountability for the appropriation process. *Id.* (citing *Vivian*, 115 Colo. 579, 177 P.2d 541).

54. The Executive Order and agency action done pursuant to the Executive Order are unconstitutional and violate “Separation of Powers” under the nondelegation doctrine. The Executive Branch cannot unilaterally select which programs to fund and to cut. In this case,

implementation of the Executive Order unlawfully injures Plaintiffs and their members and patients, as well as the entire PBT and ABA provider and patient community in Colorado.

55. Even if SB 25B-001 and the Executive Order are constitutionally permissible, any exercise of the Governor's authority under SB 25B-001 must be exercised in conformity with other applicable provisions of state and federal law.

56. On August 28, 2025, Governor Polis signed the Executive Order under the authority granted by SB 25B-001, ordering the suspension, in whole or in part, of certain state programs and services to meet a revenue shortfall in fiscal year 2025-26. **Exhibit 2**.

57. Also on August 28, 2025, the Governor's Office of State Planning and Budgeting issued a letter to the Joint Budget Committee of the Colorado General Assembly. See **Exhibit 3**. The OSPB Letter submitted, "in accordance with SB 25B-001," a "plan for spending reductions in the current fiscal year ending June 30, 2026," including spending reductions targeted at PBT and autism therapy services. To resolve a budget deficit of approximately \$783,000,000, the Executive Order identifies approximately \$252,000,000 in budget savings. Of this number, approximately \$102,000,000 is the result of direct reductions. Colorado Medicaid providers bear nearly 90% of these direct reductions, with nearly \$10,000,000 coming directly from PBT and autism therapy service providers. **Exhibit 3** at 1, 7, 11-12.

58. Specifically, the OSPB Letter identifies \$2,720,223 in reductions by adjusting the PBT reimbursement rates to "95% of the benchmark based on updated, current average rates," and approximately \$7 million in reductions by implementing "pre- *and* post-claim review of *all* pediatric autism behavioral therapy codes." *Id.* at 11-12 (emphasis added). Any identified savings from pre- or post-claim review would only be realized through the denial or retroactive recoupment of services that were previously authorized by the Department.

59. The Executive Order expressly orders the Office of the State Controller, within the Department of Personnel and Administration, to restrict the appropriations discussed above. **Exhibit 2** at 6.

60. Plaintiffs understand, and upon information and belief allege, that pursuant to the Executive Order, HCPF will be forced to reduce reimbursement to PBT and autism therapy providers specifically, thereby forcing a reduction in the availability of these services in the State of Colorado.

61. Upon information and belief, and as a result of the Executive Order, the financial and treatment limitations and requirements applicable to autism therapy services, including PBT, are now more restrictive than the predominant limitations applied to substantially all medical and surgical benefits covered by Colorado Medicaid. As a result, these actions are inconsistent with state and federal laws governing Colorado Medicaid.

62. Based on the Governor’s Budget Presentation, it appears that Defendants intend to take additional actions targeting PBT and autism therapy providers that would have similar, harmful effects on the availability of these services to Colorado children. **Exhibit 5** at 21.

D. The Federal Mental Health Parity and Addiction Equity Act.

63. Originally enacted as the Mental Health Parity Act of 1996 and significantly expanded by the Mental Health Parity and Addiction Equity Act in 2008 (collectively, “MHPAEA”), MHPAEA was designed to eliminate historical discrimination in insurance coverage for mental health and substance use disorder services. MHPAEA’s fundamental purpose is to ensure that health plans treat coverage for mental health and substance use disorder care on an equal footing with coverage for traditional physical health care services. To strengthen enforcement of these protections, Congress further amended MHPAEA in the Consolidated Appropriations Act (“CAA”) of 2021 to require plans to conduct and document detailed comparative analyses of their non-quantitative treatment limitations. *See* 42 U.S.C. § 300gg-26 *et seq.*

64. MHPAEA requires applicable health insurance plans to ensure that:

- a. the ***financial requirements*** applicable to mental health or substance use disorder (“MH/SUD”) benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits; and
- b. the ***treatment limitations*** applicable to mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

See 42 U.S.C. § 300gg-26(a)(3)(A); 42 C.F.R. § 438.910(b).

65. The MHPAEA applies to all Health First Colorado coverage of mental health and substance use disorder services, including PBT, ABA, and other autism therapies under Colorado law.

66. The term “financial requirement” includes deductibles, copayments, coinsurance, and out-of-pocket expenses, but excludes an aggregate lifetime limit and an annual limit. 42 U.S.C. § 300gg-26(a)(3)(B)(i).

67. The term “treatment limitation” includes both quantitative and non-quantitative limits and could be evidenced by limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment. 42 U.S.C. § 300gg-26(a)(3)(B)(iii). For MHPAEA purposes, covered health benefits are subject to one of four classifications: inpatient, outpatient, emergency, and prescription drugs. 42 C.F.R. § 438.910(b)(2).

68. PBT, ABA, and other autism therapy services at issue here are, in accordance with generally accepted independent standards of medical practice, properly considered outpatient mental health services subject to MHPAEA protections. *See, e.g.*, 89 Fed. Reg. 77586, 77594 (Sept. 23, 2024); U.S. Depts. of Labor, Treasury, and Health & Human Servs., *2024 MHPAEA Report to Congress*, 3 (January 2025) *available at* <https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/mental-health-parity/report-to-congress-2024.pdf> (highlighting success in removing restrictions on ABA therapy services). In fact, federal agencies have cited coverage and limitation restrictions for ABA services as the single most common basis for a determination of NQTL noncompliance. *See* U.S. Depts. of Labor, Treasury, and Health & Human Services, *2022 MHPAEA Report to Congress*, 19 (last accessed Sept. 29, 2025) *available at* <https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/mental-health-parity/report-to-congress-2022-realizing-parity-reducing-stigma-and-raising-awareness.pdf>.

a) *Prohibited Quantitative Treatment Limitations.*

69. A type of financial requirement or quantitative treatment limitation is considered to apply to substantially all medical/surgical benefits in a classification of benefits if it applies to at least two-thirds of all medical/surgical benefits in that classification. If a type of financial requirement or quantitative treatment limitation does not apply to at least two-thirds of all medical/surgical benefits in a classification, then that type cannot be applied to mental health or substance use disorder benefits in that classification. 42 C.F.R. § 438.910(c).

b) *Prohibited Non-Quantitative Treatment Limitations.*

70. A party subject to MHPAEA may not impose a non-quantitative treatment limitation (“NQTL”) for mental health or substance use disorder benefits in any classification unless, under the policies and procedures of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification. 42 C.F.R. § 438.910(d)(1).

71. Examples of non-quantitative treatment limitations include:
- a. Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
 - b. Formulary design for prescription drugs;
 - c. For plans with multiple network tiers (such as preferred providers and participating providers), network tier design;
 - d. Standards for provider admission to participate in a network, including **reimbursement rates**;
 - e. Plan methods for determining usual, customary, and reasonable charges;
 - f. Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols);
 - g. Exclusions based on failure to complete a course of treatment;
 - h. **Restrictions based on** geographic location, facility type, **provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan**; and
 - i. Standards for providing access to out-of-network providers.

42 C.F.R. § 438.910(d)(2) (emphasis added).

72. In its implementation of parity regulations applicable to Medicaid managed care, including 42 C.F.R. § 438.910(d), the United States Department of Health and Human Services, Centers for Medicare & Medicaid Services (“CMS”) “adopt[ed] the same approach to NQTLs in the application of parity requirements to Medicaid MCOs [Managed Care Organizations], PIHPs [Prepaid Inpatient Health Plan] and PAHPs [Prepaid Ambulatory Health Plan]” as had been adopted in the MHPAEA final regulations at § 146.136(c)(4). 81 Fed. Reg. 18390, 18404 (Mar. 30, 2016) (clarifications added). The MHPAEA final regulations reflect joint rulemaking by the Department of Treasury, Department of Labor, and Department of Health and Human Services, under which these agencies set forth the standards for NQTLs in group health plans. CMS later clarified the application of MHPAEA to Medicaid managed care organizations, and in doing so referenced the MHPAEA final regulations.

73. Adopting the reasoning behind those joint final regulations, CMS’s Medicaid managed care regulations provided examples of potential parity violations. One such example

“clarif[ied] that regulated entities may consider a wide array of factors in determining provider reimbursement methodologies and rates for both medical/surgical services and MH/SUD services, such as service type; geographic market; demand for services; supply of providers; provider practice size; Medicare reimbursement rates; and training, experience and licensure of providers. The NQTL provisions require that these or other factors be applied comparably to and no more stringently than those applied for medical/surgical services . . .” 81 Fed. Reg. 18390, 18404 (Mar. 30, 2016). In other words, the disparate application of rate methodologies (such as applying a lower rate percentage of a benchmark, or choosing to selectively update benchmarks) fails to comply with MHPAEA requirements.

74. CMS also cites the imposition of prior authorization requirements applied to outpatient mental health or substance use disorder services when such requirements are not applied to comparable medical/surgical services as a potential NQTL violation. *See* 81 Fed. Reg. 18390, 18401 (Mar. 30, 2016). Disparity between prior authorization requirements (or other claim review processes) indicates noncompliance with the MHPAEA.

c) CAA Amendments to MHPAEA

75. In 2021, Congress amended MHPAEA through the CAA to require plans that impose NQTLs to “perform and document comparative analyses of the design and application of NQTLs” and to make those analyses available upon request. 42 U.S.C. § 300gg-26(a)(8)(A). The statute specifies the content of such analyses, including: the plan terms to which each NQTL applies; the factors used to decide the NQTL will apply; the evidentiary standards supporting those factors; and a demonstration that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to mental health benefits, as written and in operation, are comparable to and no more stringent than those used for medical/surgical benefits in the same classification. *Id.* § 300gg-26(a)(8)(A)(i)–(iv).

76. Plans must provide a detailed, reasoned comparative analysis; “a general statement of compliance, coupled with a conclusory reference to broadly stated processes, strategies, evidentiary standards, or other factors is insufficient to meet this statutory requirement.” U.S. Depts. of Labor, Treasury, and Health & Human Services, *FAQs about Mental Health and Substance Use Disorder Parity Implementation and the Consolidated Appropriations Act, 2021 Part 45* 3, 5 (Apr. 2, 2021), *available at* <https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-45.pdf>. NQTLs implemented without an adequate comparative analysis do not satisfy MHPAEA obligations.

E. Colorado law requires parity and compliance with the MHPAEA.

77. In 2019, the Colorado General Assembly passed House Bill 19-1269, with the express legislative purpose to “address issues related to coverage of behavioral, mental health, and substance use disorder services under private health insurance and the state medical assistance program (medicaid).” *See* Bill Summary, HB 19-1269 (last accessed Sept. 26, 2025) <https://leg.colorado.gov/bills/hb19-1269>.

78. HB 19-1269 was intended to carry out the Colorado General Assembly’s intent that behavioral, mental health, and substance use disorder services be treated on equal footing with all other types of services, and to specifically expand MHPAEA’s reach to all Colorado Medicaid services.

79. Under HB 19-1269, HCPF has a statutory obligation to ensure that: (a) Colorado Medicaid benefits for behavioral, mental health, and substance use disorder services are no less extensive than benefits for any physical illness; and (b) Colorado Medicaid is in compliance with the MHPAEA, as defined in C.R.S. § 25.5-5-403(5.7), including the quantitative and nonquantitative treatment limitation requirements specified in 42 C.F.R. § 438.910 (c) and (d). *See* C.R.S. § 25.5-5-103(4)(a).

80. Under Colorado law, the MHPAEA means the federal “Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008”, Pub.L. 110-343, as amended, ***and all of its implementing and related regulations.***” C.R.S. § 25.5-5-403(5.7) (emphasis added).

a) Colorado Medicaid Pre-payment and Post-payment Review

81. HCPF has implemented and maintains a system for reducing medical services coding errors in Medicaid claims submitted to HCPF for reimbursement. C.R.S. § 25.5-4-300.7(1). This system applies generally to all Colorado Medicaid-covered services.

82. The system includes automatic, prepayment review of Medicaid claims through the use of nationally recognized correct coding methods in the Medicaid management information system, in accordance with 42 U.S.C. § 1396b(r) and regulations thereunder, as amended by Pub.L. 111-148, and any other subsequent acts of Congress. *Id.*

83. In accordance with this statute, HCPF utilizes a claims editing program to automatically review claims prior to payment to identify and correct improper coding for professional and outpatient services claims (in other words, to identify compliance with National Correct Coding Initiative, “NCCI,” edits). 10 C.C.R. § 2505-10:8.041.2.B.

84. Upon information and belief, there are no additional applicable prepayment/pre-claim review statutes, and HCPF’s other tool for prepayment/pre-claim review is prior authorization of services. In practice, HCPF implements *either* prior authorization *or* pre-payment review for certain services, but not both. *See, e.g.*, 10 C.C.R. § 2505-10:8.201.2.A.6.b.i.2 (endodontic services “Exempt from prior authorization process but may be subject to post-treatment and pre-payment review”); 10 C.C.R. § 2505-10:8.201.2.A.6.c (for adult dental services there “may not be time for prior authorization. Such emergency services shall be subject to post-treatment and pre-payment review.”); 10 C.C.R. § 2505-10:8.201.3 (“Emergency Services do not require a prior authorization before services can be rendered, and shall be subject to prepayment review.”). In all of these instances, pre-payment review is utilized where there is no prior authorization (often because the services are emergency services).

85. All Colorado Medicaid PBT services must already be pre-approved through a prior authorization process. See COLO. DEP'T OF HEALTH CARE POLICY AND FIN., *Pediatric Behavioral Therapies Billing Manual*, <https://hcpf.colorado.gov/pbt-manual>. The Executive Order requires an additional layer or layers of pre-claim review for all pediatric autism therapy services, a limitation that does not appear to be present in Department policies or procedures for any other type of service or treatment for any other condition.

86. The Executive Order also calls for post-payment review of all pediatric autism therapy services. To the extent this post-payment claims review is applied in a manner that is not also applied to comparable outpatient medical/surgical services, such post-payment review would also constitute a prohibited NQTL. See, e.g., U.S. Depts. of Labor, Treasury, and Health & Human Services, *2022 MHPAEA Report to Congress*, 20 (last accessed Sept. 29, 2025) available at <https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/mental-health-parity/report-to-congress-2022-realizing-parity-reducing-stigma-and-raising-awareness.pdf> (identifying retrospective review as a NQTL).

b) Medicaid Rate Methodologies

87. Under Colorado law, HCPF must establish rules for the payment of providers within the limits of available funds, where such rules must provide reasonable compensation to providers. C.R.S. § 25.5-4-401(1)(a).

88. HCPF must establish a schedule for an annual review of provider rates paid under the “Colorado Medical Assistance Act” so that each provider rate is reviewed at least every three years. C.R.S. § 25.5-4-401.5(1)(a).

89. The Medicaid provider rate review advisory committee or the joint budget committee may, by a majority vote, direct that HCPF conduct a review of a provider rate that is not scheduled for review during that year. C.R.S. § 25.5-4-401.5(1)(b). The advisory committee or the joint budget committee shall notify HCPF of the request for an out-of-cycle review by December 1 of the year prior to the year in which the out-of-cycle review will take place. *Id.*

90. PBT services were reviewed during the 2023 review cycle and are already set for regularly scheduled review again in 2026. See COLO. DEP'T OF HEALTH CARE POLICY AND FIN., Medicaid Provider Rate Review Three-Year Review Schedule, <https://hcpf.colorado.gov/medicaid-provider-rate-review-three-year-review-schedule>. See COLO. DEP'T OF HEALTH CARE POLICY AND FIN., *Medicaid Provider Rate Review Public Meeting*, 136, 138 (Aug. 22, 2025) available at <https://hcpf.colorado.gov/sites/hcpf/files/Medicaid%20Provider%20Rate%20Review%20Advisory%20Committee%20Presentation%20-%20August%202022%2C%202025%20%286%29.pdf> (“August 2025 Rate Presentation”). Neither the Medicaid provider rate review advisory committee nor the joint budget committee directed HCPF to conduct an out-of-cycle review for PBT as required by C.R.S. § 25.5-4-401.5(1)(b).

91. In the first phase of the rate review process, HCPF shall conduct an analysis of the access, service, quality, and utilization of each service subject to a provider rate review. HCPF shall compare the rates paid with available benchmarks, including Medicare rates and usual and customary rates paid by private pay parties, and use qualitative tools to assess whether payments are sufficient to allow for provider retention and Medicaid member access and to support appropriate reimbursement of high-value services. C.R.S. § 25.5-4-401.5(2)(a).

92. Following the analysis outlined above, HCPF shall work with the advisory committee and any stakeholders identified by HCPF or the advisory committee to review the analysis and develop strategies for responding to the findings, including any nonfiscal approaches or rebalancing of rates and strategies to address capacity issues that may exist in certain regions of the state. C.R.S. § 25.5-4-401.5(2)(b).

93. HCPF's rate benchmarking with the Medicaid provider rate review advisory committee generally follows two tracks. For services that are also covered by Medicare, rates are benchmarked based on a percentage of Medicare rates. For services like PBT, however, which do not have a Medicare reimbursement rate (because such services are not covered by Medicare), HCPF benchmarking generally relies on rates paid by other state Medicaid programs. Upon information and belief, it is HCPF's and the Medicaid rate review advisory committee's general custom that such rates for such services are set at a *minimum* of 100% of the benchmark rate, contrary to the directives in the Executive Order. For example, in the 2024 rate review cycle, both psychiatric residential treatment facility and private duty nursing services were benchmarked to other state Medicaid plans and were recommended at 100% of the benchmark. COLO. DEP'T OF HEALTH CARE POLICY & FIN., *Minutes of the Medicaid Provider Rate Review Quarterly Public Meeting*, 3-4, 6 (June 28 and July 12, 2024) available at https://hcpf.colorado.gov/sites/hcpf/files/Medicaid%20Provider%20Rate%20Review%20Advisory%20Committee%20Meeting%20Summary%20June%2028%20and%20July%2012%202024%20%281%29_0.pdf. In the 2025 rate review cycle, DIDD Dental and targeted case management services received similar recommendations for 100% of the benchmark. See August 2025 Rate Presentation at 25, 64.

94. HCPF recently announced its intent to cut PBT reimbursement rates effective as of October 1, 2025 (the "October 1 Rate Cut"). COLO. DEP'T OF HEALTH CARE POLICY & FIN., *Special Provider Bulletin B2500528* (Sept. 2025), available at https://hcpf.colorado.gov/sites/hcpf/files/Special%20Provider%20Bulletin%20-%20Rate%20Reductions%20092025_B2500528_0.pdf (attached as **Exhibit 7**); see also COLO. DEP'T OF HEALTH CARE POLICY & FIN., *FY 2025-26 HCPF Budget Reductions Fact Sheet* (Sept. 2025), available at <https://hcpf.colorado.gov/sites/hcpf/files/FY%2025-26%20HCPF%20Budget%20Reduction%20Items%20Fact%20Sheet%20-%20Sept%202025.pdf> (attached as **Exhibit 8**).

95. All medical/surgical services covered by Colorado Medicaid had a 1.6% rate reduction imposed by the Executive Order. No medical/surgical service in the Executive Order, or throughout 2024-2025, received an out-of-cycle re-benchmarking or a re-calculation of the

benchmark payment rate. Furthermore, upon information and belief, no medical/surgical service had rates updated without the consultation of the Medicaid provider rate review advisory committee. This disparate treatment violates state and federal parity requirements.

F. Defendants' Actions Violate State and Federal Parity Requirements.

96. The Executive Order instructs HCPF to apply compulsory pre- *and* post-payment claims review to all pediatric autism therapy services—which are a type of outpatient mental health service covered by MHPAEA. The categorical imposition of both pre- and post-payment reviews has not been applied to outpatient medical/surgical claims.

97. The Executive Order further cuts rates for PBT services by updating the benchmark analysis to include other states' current reimbursement rates and arbitrarily setting Colorado Medicaid reimbursement at 95% of the updated benchmark.

98. Considered together and in light of the above facts, the Executive Order and the Governor's Budget Presentation violate both federal MHPAEA and Colorado state law by imposing NQTLs that:

- a. Subject pediatric autism therapy service claims to review processes and coverage limitations that are not imposed on comparable outpatient medical or surgical benefits; and
- b. Arbitrarily lower Colorado Medicaid reimbursement rates for PBT using a reimbursement methodology that is not applied to any outpatient medical or surgical service. More specifically, by mandating that: i) PBT reimbursement rates be re-benchmarked out-of-cycle absent the direction of the Medicaid provider rate review advisory committee or the joint budget committee, and furthermore that ii) rates be established at 95% of that benchmark, the Executive Order establishes a rate setting methodology that is unique to PBT services and not applied consistently to comparable outpatient medical/surgical services, which instead are subject to a 1.6% across-the-board rate reduction.

99. In addition, upon information and belief, the Executive Order and implementing actions by HCPF impose new NQTLs on PBT and pediatric autism therapy services without having conducted any type of comparative analysis to demonstrate that the NQTLs are in fact consistent with MHPAEA requirements. Under MHPAEA, Defendants bear the burden to complete and document—before implementation—a comparative analysis showing that, as written and in operation, these NQTLs are no more stringent than for comparable outpatient medical/surgical benefits.

100. Each of these actions violates Colorado law mandating parity between these benefits and medical or surgical benefits, as well as the MHPAEA. And each of these actions is arbitrary and capricious.

G. The Department's Denial of Due Process and Violation of the APA.

101. As a state agency, HCPF is bound by the Colorado APA. *See* C.R.S. § 24-4-103.

102. Under the APA, before HCPF can change a rule, reinterpret an existing rule in a substantially different manner, or otherwise adversely affect the Medicaid provider community by implementing different enrollment and reimbursement criteria, HCPF is required to afford interested persons and those affected by the changed rule a fair opportunity to participate in the decision-making process. *Id.* HCPF's Medical Services Board is responsible for adopting the rules that govern the Department's programs.

103. The APA requires HCPF to follow a specific public notice and comment rulemaking process before altering its rules or implementing new procedures such as the proposed changes referenced above. *See* C.R.S. § 24-4-103; *Regular Route Common Carrier Conf. of Colo. Motor Carriers Ass'n v. Pub. Utilities Comm'n of State of Colo.*, 761 P.2d 737, 748 (Colo. 1988).

104. As described above, the Executive Order and HCPF's actions to comply therewith, including changes to payment methodology, pre- and post-claim review, and singling out PBT and autism therapy services in a disparate manner, circumvent the rulemaking process required by the APA.

105. In enacting the APA, the General Assembly declared that "agency action taken without evaluation of its economic impact may have unintended effects" and that "it is the continuing responsibility of agencies to analyze the economic impact of agency actions and re-evaluate the economic impact of continuing agency actions to determine whether the actions promote the public interest." C.R.S. § 24-4-101.5.

106. The Governor's directives and HCPF's action to comply therewith will directly harm the public interest in various ways, including, but not limited to: (a) reducing access to care for Medicaid beneficiaries; (b) impairing providers' ability to care for their patients; and (c) imposing financial harm upon the provider community, including COABA members.

107. If an agency adopts a rule without substantially complying with the APA, then the rule is invalid. C.R.S. § 24-4-103(8.2)(a); *Home Builders Ass'n of Metro. Denver v. Pub. Utilities Comm'n of State of Colo.*, 720 P.2d 552, 562 (Colo. 1986).

108. HCPF's failure to comply, substantially or at all, with APA requirements invalidates its purported new policy directives and the Department's proposed material changes to its rules and/or existing rule interpretation.

109. HCPF has thereby failed to afford Medicaid providers and other stakeholders, including Plaintiffs, due process as required by law.

110. Further, as discussed herein, any rule change must ensure that (a) Colorado Medicaid benefits for behavioral, mental health, and substance use disorder services are no less extensive than benefits for any physical illness; and (b) Colorado Medicaid is in compliance with the MHPAEA. Both requirements have been disregarded and violated by Defendants' actions.

H. The Consequences of Defendants' Unlawful Changes.

111. Due to the Governor's and HCPF's dramatic changes and agency actions, including the October 1 Rate Cut, irreparable harm and consequences to Colorado Medicaid beneficiaries, COABA members, and Colorado Medicaid itself will occur if the *status quo* is not preserved until resolution of the issues set forth herein.

112. As discussed above, Colorado Medicaid has recent experience with meaningful access to care shortages for PBT and autism therapy providers, and Defendants' actions represent a direct return to those challenges. COABA members, and the Provider Plaintiffs, will face difficult decisions regarding the continued sustainability of Medicaid participation and the delivery of PBT, ABA and other therapy services to children diagnosed with autism spectrum disorders.

113. For the Beneficiary Plaintiffs and thousands of other Colorado Medicaid-covered children, time is of the essence: neurodevelopmental plasticity peaks in early childhood, and interruptions or delays in medically necessary ABA early in life cause enduring, irreparable losses in developmental gains that cannot be fully remediated later. Adele F. Dimian, et al., *Delay to Early Intensive Behavioral Intervention and Educational Outcomes for a Medicaid-Enrolled Cohort of Children with Autism*, 51 J. OF AUTISM AND DEVELOPMENTAL DISORDERS 4 (Apr. 2021); Lonnie Zwaigenbaum, et al., *Early Intervention for Children With Autism Spectrum Disorder Under 3 Years of Age: Recommendations for Practice and Research*, 136 Supp. PEDIATRICS 1 (Oct. 2015).

114. The reduction in access to care threatened by HCPF violates the General Assembly's declaration in the Colorado Medical Assistance Act that Colorado Medicaid is "to promote the public health and welfare of the people of Colorado by providing, in cooperation with the federal government, medical and remedial care and services for individuals and families whose income and resources are insufficient to meet the costs of such necessary services and to assist such individuals and families to attain or retain their capabilities for independence and self-care, as contemplated by the provisions of Title XIX of the social security act." C.R.S. § 25.5-4-102.

115. The Executive Order and Defendants' actions violate Colorado law requiring parity between PBT and other autism therapy services, and services available for any other illness. See C.R.S. § 25.5-5-103(4)(a).

116. The Executive Order and Defendants' actions further violate the MHPAEA through the imposition of inappropriate NQTLs on pediatric autism therapy services. Colorado law requires HCPF to comply with MHPAEA requirements with respect to these services.

117. The Executive Order and Defendants' actions are inconsistent with federal and state requirements related to coverage and reimbursement for EPSDT services, which are a mandatory Medicaid benefit and are subject to heightened standards for service and provider access for eligible Medicaid beneficiaries as described in the SHO Letter.

118. These changes also compromise Colorado Medicaid's compliance with the federal Medicaid Act, which requires states to enlist a sufficient number of providers to ensure that services are available to Medicaid beneficiaries to the same extent that they are available to the general population in the geographic area. 42 U.S.C. § 1396a(a)(30)(A).

119. Further, HCPF will be in noncompliance with federal requirements for Medicaid beneficiary access to covered services, including without limitation the requirement that mandatory EPSDT services be available to beneficiaries with reasonable promptness. *See, e.g.*, 42 U.S.C. § 1396a(a)(8).

120. Non-compliance with federal Medicaid requirements jeopardizes Colorado Medicaid's continued ability to receive federal financial participation for its services. *See, e.g.*, 42 U.S.C. § 1396a; 42 C.F.R. §§ 430.1, 430.10, 430.35.

121. HCPF has exceeded its statutory authority and its action will cause irreparable harm to Colorado Medicaid beneficiaries, COABA's members, and Colorado Medicaid itself. *See, e.g.*, Adele F. Dimian, et al., *Delay to Early Intensive Behavioral Intervention and Educational Outcomes for a Medicaid-Enrolled Cohort of Children with Autism*, J. OF AUTISM & DEVELOPMENTAL DISORDERS, 51:1054-1066, at 1063 (July 8, 2020) (discussing impacts of delay in intervention, concluding: "Cutting down on wait times for both diagnosis and service initiation should be prioritized by policy makers going forward.").

FIRST CLAIM FOR RELIEF
(Declaratory Judgment)

122. Plaintiffs incorporate by reference all of the previous allegations of this Complaint, as if fully restated herein.

123. This claim for declaratory judgment arises under the provisions of the Uniform Declaratory Judgments Law, C.R.S. § 13-51-101, *et seq.*, and under Rule 57 of the Colorado Rules of Civil Procedure.

124. Defendants' actions are arbitrary and capricious, in excess of statutory jurisdiction or authority, in violation of procedural rules, and generally contrary to law as more specifically pled above, including but not limited to violating state and federal parity law and federal access to care law.

125. Plaintiffs' legitimate interests are directly affected by Defendants' actions.

126. An actual case and controversy thus exists between Plaintiffs and Defendants.

127. Declaratory relief is proper because it would clarify the parties' respective rights and status with respect to state and federal law regarding Medicaid enrollment, access to care, and payment for PBT and pediatric autism therapy services.

128. A declaration by this Court that the portions of the Executive Order targeting PBT reimbursement rate methodologies and pre- and post-payment review of pediatric autism therapy services, and implementing changes by the Executive Branch, including without limitation HCPF's October 1 Rate Cut, are invalid would clarify the parties' rights, status, and other legal relations regarding Plaintiffs' and COABA members' involvement with Colorado Medicaid and their ability to provide important health care services to some of Colorado's most vulnerable residents, i.e., Medicaid beneficiaries.

129. Further, pursuant to C.R.S. § 13-51-101, *et seq.*, and Colorado Rule of Civil Procedure 57(a), Plaintiffs are entitled to an order declaring that the Department's apparent rule, order, or directive is unlawful and of no force or effect, and setting it aside.

SECOND CLAIM FOR RELIEF

(Failure to Comply with the State Administrative Procedure Act)

130. Plaintiffs incorporate by reference all of the previous allegations of this Complaint, as if fully restated herein.

131. Colorado's APA contains detailed requirements and procedures for state agencies, including HCPF, to promulgate new rules or modify existing rules. C.R.S. §§ 24-4-103(3), (4). These requirements and procedures include notice and a public hearing with opportunity for public participation. *Id.*

132. Defendants' changes to reimbursement methodology for PBT services, including the October 1 Rate Cut, and imposition of mandatory pre- and post-claim review processes for pediatric autism therapy services, are erroneous promulgations or modifications of Colorado Medicaid rules.

133. These actions would be contrary to existing policy and years of established HCPF practice. Accordingly, to the extent Defendants' actions constitute agency rulemaking, or a report of agency rulemaking, the agency's purported action is invalid, and may not be implemented or enforced by HCPF or its agents or representatives. C.R.S. § 24-4-103(8.2)(a).

134. For the reasons set forth above, Plaintiffs are entitled to an injunction, preliminary as well as permanent, enjoining Defendants and their agents and representatives from implementing and enforcing the changes to the Colorado Medicaid rules and requirements described herein.

THIRD CLAIM FOR RELIEF
(Unauthorized Order)

135. Plaintiffs incorporate by reference all of the previous allegations of this Complaint, as if fully restated herein.

136. To the extent HCPF's actions to implement the Executive Order, including the October 1 Rate Cut, or the Executive Order itself, may be construed as agency "orders," as defined by C.R.S. § 24-4-102(10), they are similarly infirm and void under the APA.

137. These purported orders are also arbitrary and capricious in that they would contravene years of sound practice and established procedure, they violate state and federal laws requiring parity, and would have a profound negative and threatening impact on pediatric autism therapy services, Colorado children with autism and the providers who care for them.

138. For the reasons set forth above, Plaintiffs are entitled to an injunction, preliminary as well as permanent, enjoining Defendants and their agents and representatives from implementing and enforcing the changes to the Colorado Medicaid rules as described herein.

FOURTH CLAIM FOR RELIEF
(Injunctive Relief)

139. Plaintiffs incorporate by reference all of the previous allegations of this Complaint, as if fully restated herein.

140. Notice of this request for injunctive relief is being provided to Defendants by service of this Complaint.

141. Plaintiffs have a reasonable probability and substantial likelihood of success on the merits of its claims.

142. There exists a real, immediate, and irreparable injury (as described above and incorporated herein by reference) that may be prevented by injunctive relief in order to maintain the *status quo*.

143. Plaintiffs lack a plain, speedy, and adequate remedy at law.

144. Should Plaintiffs and their members be required to wait until a full trial on the merits, and Defendants are allowed to implement the new Medicaid changes for PBT services, including the October 1 Rate Cut, Plaintiffs and the persons they serve will be irreparably harmed, as described above and incorporated herein by reference.

145. Plaintiffs will suffer irreparable harm should injunctive relief not be granted.

146. The potential injury to Defendants should injunctive relief issue does not outweigh the ongoing injury Plaintiffs and others will suffer should injunctive relief fail to issue.

147. The granting of an injunction will not disserve the public interest in this case, and the balance of equities favors an injunction.

148. An injunction prohibiting Defendants from implementing the proposed changes described herein will merely preserve the *status quo* pending a trial.

149. Plaintiffs therefore seek a preliminary injunction to enjoin implementation or enforcement of Defendants' changes described herein.

150. Further, under the APA, upon a finding that irreparable injury would result, as shown herein, HCPF is required to postpone the effective date of its action during this judicial review in order to preserve the rights of the parties pending conclusion of this lawsuit. C.R.S. § 24-4-106(5).

WHEREFORE, Plaintiffs respectfully request the Court to enter judgment against Defendants, awarding Plaintiffs the following:

- a. Entry of a temporary restraining order and preliminary injunctive relief: enjoining Defendants from implementing or enforcing the Medicaid changes for PBT and autism therapy services that are the subject of the Executive Order, including without limitation the October 1 Rate Cut, in order to preserve the *status quo* pending trial;
- b. A permanent injunction that enjoins Defendants from:
 - i. Taking any action in furtherance of the Executive Order that does not comply with state and federal law applicable to PBT and pediatric autism therapy services, including without limitation the MHPAEA; and
 - ii. Implementing any rule changes without proper rulemaking under the APA.
- c. Entry of a declaratory judgment, declaring the following:
 - i. That the portions of the Executive Order specifically targeting reimbursement rate methodologies for PBT services and pre-and post-payment review processes for pediatric autism therapy services are in violation of state and federal law, are invalid, and that they are void as a matter of law;
 - ii. That the actions taken to implement the offending portions of the Executive Order, including without limitation the October 1 Rate Cut and other rule

changes and/or rule interpretation changes at issue violate state and federal law, that they are invalid, and that they are void as a matter of law; and

iii. That any future NQTL affecting PBT or other pediatric autism therapy services may not be implemented or enforced unless supported by a pre-implementation, CAA-compliant MHPAEA comparative analysis, as well as operational proof of parity as required by MHPAEA.

d. Such other and further relief that the Court deems just and proper.

Respectfully submitted this 30th day of September 2025.

POLSINELLI PC

s/ Richard M. Murray

Richard M. Murray (#38940)

Jennifer L. Evans (#30117)

Ryan Thurber (#46346)

ATTORNEYS FOR PLAINTIFFS

VERIFICATION

I, Daniel Kurty, depose and state that I am the Executive Director of Wild Sun Behavioral Services, LLC, and am authorized to execute this Verification in the above-captioned action on its behalf, and that, based on and to the best of my personal knowledge, the facts set forth in the foregoing Verified Complaint are true. I declare under penalty of perjury under the laws of Colorado that the foregoing is true and correct.

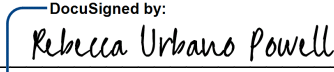
Executed on 9/29/2025

Signature: DocuSigned by:
Daniel Kurty
21F743C29EB7475...

VERIFICATION

I, Rebecca Urbano Powell, depose and state that I am the Executive Director of Seven Dimensions Behavioral Health, LLC, and am authorized to execute this Verification in the above-captioned action on its behalf, and that, based on and to the best of my personal knowledge, the facts set forth in the foregoing Verified Complaint are true. I declare under penalty of perjury under the laws of Colorado that the foregoing is true and correct.

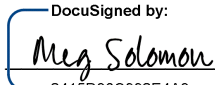
Executed on 9/29/2025

Signature: 
A6E8A3F886124D8...

VERIFICATION

I, Meg Solomon, depose and state that I am the Owner and Clinical Director, of ABA Across Environments, Inc. and am authorized to execute this Verification in the above-captioned action on its behalf, and that, based on and to the best of my personal knowledge, the facts set forth in the foregoing Verified Complaint are true. I declare under penalty of perjury under the laws of Colorado that the foregoing is true and correct.

Executed on 9/29/2025

Signature:  2415D30C992E4A3...

VERIFICATION

I, Sierra Foster, depose and state that I am the Owner, of Animas ABA, LLC, and am authorized to execute this Verification in the above-captioned action on its behalf, and that, based on and to the best of my personal knowledge, the facts set forth in the foregoing Verified Complaint are true. I declare under penalty of perjury under the laws of Colorado that the foregoing is true and correct.

Executed on 9/29/2025

Signed by:
Signature: Sierra Foster
2CAF138125F9453...

VERIFICATION

I, Jonathan Muller, depose and state that I am the Co-Owner and Co-Founder,
of Autism Behavioral Ventures, LLC, operating under the trade name Ascend Behavior Partners,
and am authorized to execute this Verification in the above-captioned action on its behalf, and that,
based on and to the best of my personal knowledge, the facts set forth in the foregoing Verified
Complaint are true. I declare under penalty of perjury under the laws of Colorado that the foregoing
is true and correct.

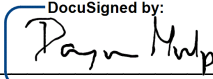
Executed on 9/30/2025

Signed by:
Signature: Jonathan Muller
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VERIFICATION

I, Dayna Murphy, depose and state that I am the Executive Director, of Beyond Behavior, Inc., and am authorized to execute this Verification in the above-captioned action on its behalf, and that, based on and to the best of my personal knowledge, the facts set forth in the foregoing Verified Complaint are true. I declare under penalty of perjury under the laws of Colorado that the foregoing is true and correct.

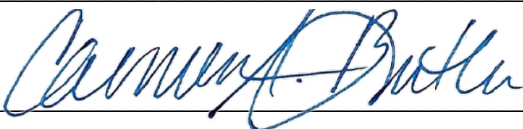
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VERIFICATION

I, Carmen Butler, depose and state that I am the Vice President, Legal Affairs, of BlueSprig Pediatrics, Inc. operating under the trade name of BlueSprig Behavior Center, and am authorized to execute this Verification in the above-captioned action on its behalf, and that, based on and to the best of my personal knowledge, the facts set forth in the foregoing Verified Complaint are true. I declare under penalty of perjury under the laws of Colorado that the foregoing is true and correct.

Executed on September 30, 2025

Signature: 

VERIFICATION

I, Heather Teichman, depose and state that I am the Senior Vice President of By Your Side Colorado, LLC, and am authorized to execute this Verification in the above-captioned action on its behalf, and that, based on and to the best of my personal knowledge, the facts set forth in the foregoing Verified Complaint are true. I declare under penalty of perjury under the laws of Colorado that the foregoing is true and correct.

Executed on 9/29/2025

Signed by:
Signature: Heather Teichman
508C9895B11440B...

VERIFICATION

I, Rebecca Urbano Powell, depose and state that I am the President of The Colorado Association of Behavior Analysis, and am authorized to execute this Verification in the above-captioned action on its behalf, and that, based on and to the best of my personal knowledge, the facts set forth in the foregoing Verified Complaint are true. I declare under penalty of perjury under the laws of Colorado that the foregoing is true and correct.

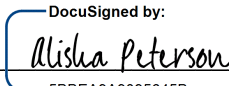
Executed on 9/29/2025

Signed by:
Signature: Rebecca Urbano Powell
604C486385BD4D1...

VERIFICATION

I, Alisha Peterson, depose and state that I am the Executive Director of Continuum Associates, Inc., operating under the trade name Continuum Autism Spectrum Alliance, and am authorized to execute this Verification in the above-captioned action on its behalf, and that, based on and to the best of my personal knowledge, the facts set forth in the foregoing Verified Complaint are true. I declare under penalty of perjury under the laws of Colorado that the foregoing is true and correct.

Executed on 9/29/2025

Signature:  5BBEA9A9095645B...

VERIFICATION

I, Ian Goldstein, depose and state that I am the Chief Executive Officer of Soar Health Inc.,
operating under the trade name Soar Autism Center, and am authorized to execute this Verification
in the above-captioned action on its behalf, and that, based on and to the best of my personal
knowledge, the facts set forth in the foregoing Verified Complaint are true. I declare under penalty
of perjury under the laws of Colorado that the foregoing is true and correct.

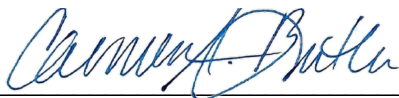
Executed on 9/29/2025

Signature: DocuSigned by:
Ian Goldstein
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VERIFICATION

I, Carmen Butler, depose and state that I am the Vice President, Legal Affairs, of Trumpet Behavioral Health, LLC operating under the trade name of BlueSprig, and am authorized to execute this Verification in the above-captioned action on its behalf, and that, based on and to the best of my personal knowledge, the facts set forth in the foregoing Verified Complaint are true. I declare under penalty of perjury under the laws of Colorado that the foregoing is true and correct.

Executed on September 30, 2025

Signature: 

VERIFICATION

For Minor Child

I, Keena Greenwood, depose and state that I am the Parent, of P.M., a minor, and am authorized to execute this Verification in the above-captioned action, and that, based on and to the best of my personal knowledge, the facts set forth in the foregoing Verified Complaint are true. I declare under penalty of perjury under the laws of Colorado that the foregoing is true and correct.

Executed on 9/29/2025

Signature:  DocuSigned by:
826568E0824B409...

VERIFICATION

For Adult Requiring Legal Guardianship

I, Lorri Avery, depose and state that I am the Parent and Legal Guardian of A.A., and am authorized to execute this Verification in the above-captioned action, and that, based on and to the best of my personal knowledge, the facts set forth in the foregoing Verified Complaint are true. I declare under penalty of perjury under the laws of Colorado that the foregoing is true and correct.

Executed on 9/30/2025

Signed by:
Signature: 
A1319517E9174CF...

VERIFICATION

For Minor Child

I, Lainie Gray, depose and state that I am the Parent, of C.C., a minor, and am authorized to execute this Verification in the above-captioned action, and that, based on and to the best of my personal knowledge, the facts set forth in the foregoing Verified Complaint are true. I declare under penalty of perjury under the laws of Colorado that the foregoing is true and correct.

Executed on 9/30/2025

Signature: *Lainie Gray*

DocuSigned by:

B6225B848E8E475...

VERIFICATION

For Minor Child

I, Robilyn Robison, depose and state that I am the
Parent _____, of O.R., a minor, and am
authorized to execute this Verification in the above-captioned action, and that, based on and to the
best of my personal knowledge, the facts set forth in the foregoing Verified Complaint are true.
I declare under penalty of perjury under the laws of Colorado that the foregoing is true and correct.

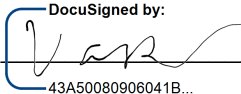
Executed on 9/29/2025

DocuSigned by:
Signature: Rakilyn Robinson
43F0A827B3D04D8...

VERIFICATION

For Minor Child

I, Valerie Dillon, depose and state that I am the Parent, of P.D., a minor, and am authorized to execute this Verification in the above-captioned action, and that, based on and to the best of my personal knowledge, the facts set forth in the foregoing Verified Complaint are true. I declare under penalty of perjury under the laws of Colorado that the foregoing is true and correct.

Executed on 9/30/2025
Signature:  43A50080906041B...

VERIFICATION

For Adult Requiring Legal Guardianship

I, Amy Warren depose and state that I am the Parent and Guardian, of C.W., and am authorized to execute this Verification in the above-captioned action, and that, based on and to the best of my personal knowledge, the facts set forth in the foregoing Verified Complaint are true. I declare under penalty of perjury under the laws of Colorado that the foregoing is true and correct.

Executed on 9/30/2025

Signed by:
Signature: Amy Warren
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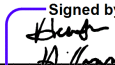
VERIFICATION

For Minor Child

I, Heather Hillman, depose and state that I am the Parent, of FH_____, a minor, and am authorized to execute this Verification in the above-captioned action, and that, based on and to the best of my personal knowledge, the facts set forth in the foregoing Verified Complaint are true.

I declare under penalty of perjury under the laws of Colorado that the foregoing is true and correct.

Executed on 9/30/2025

Signed by:

Signature: _____

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VERIFICATION

For Adult Requiring Legal Guardianship

I, Jay Ortengren, depose and state that I am the
Parent or Legal Guardian, of EO, and am authorized to
execute this Verification in the above-captioned action, and that, based on and to the best of my
personal knowledge, the facts set forth in the foregoing Verified Complaint are true. I declare
under penalty of perjury under the laws of Colorado that the foregoing is true and correct.

Executed on 9/30/2025

Signed by: 
Signature:
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DATE FILED
September 30, 2025 2:58 PM
FILING ID: 8EFF9D5FE57BE
CASE NUMBER: 2025CV33489

EXHIBIT 1



D 2025 009

EXECUTIVE ORDER

**Call for the First Extraordinary Session of the Seventy-Fifth General Assembly and
Directing a Statewide Hiring Freeze**

Pursuant to the authority vested in the Governor of the State of Colorado and, in particular, pursuant to Article IV, Section 2 and Article IV, Section 9 of the Colorado Constitution, and as recognized in Article V, Section 7, I, Jared Polis, Governor of the State of Colorado, hereby find that the following extraordinary occasions exist to convene the Seventy-Fifth General Assembly to meet in special session, and to take other actions including a hiring freeze, to address the fiscal crisis caused by recent federal action.

I. Background

On July 4, 2025, President of the United States Donald Trump signed H.R. 1 into law through the reconciliation process. H.R. 1 will cause an immediate and significant negative impact to State revenue – reducing State revenue by over \$1.2 billion in the current Fiscal Year, and by approximately \$700 million in Fiscal Year 2027 and Fiscal Year 2028.

While the General Assembly passed and I signed a balanced budget on April 28, 2025 for Fiscal Year 2026, because of federal tax changes for the current year that were subsequently passed by Congress but retroactively applied, the State budget is no longer balanced for the current year, no longer has a surplus under the Taxpayer's Bill of Rights (TABOR), and in fact faces a significant shortfall. The Office of State Planning and Budgeting (OSPB) projects the deficit for the current fiscal year to be \$783 million. Changes to State law are needed immediately to ensure the State's financial solvency and to re-balance the State budget in order to protect basic services that Coloradans rely on, including education, transportation, health care, and public safety.

The loss of revenue to the State of Colorado is largely due to increased tax deductions for corporations; OSPB estimates 70% of the revenue loss is from corporate tax cuts. Colorado's revenues are linked to federal tax policy changes more than most states due to Colorado's use of Federal Taxable Income and a characteristic known as "rolling conformity," which means that federal tax changes are automatically adopted into the State's tax code.

H.R. 1 also imposes increased expenses on the State, largely by shifting costs from the federal government to Colorado. Programs most impacted include the Supplemental Nutrition Assistance Program (SNAP) and Medicaid, due to Provider Fee reductions, newly-imposed work requirements, and additional requirements imposed on State and local governments to redetermine eligibility for Medicaid recipients more frequently. These expenses are anticipated to be between \$50-\$100 million in Fiscal Year 2027 and grow to nearly \$1 billion by 2032.

When accounting for the loss in federal funds due to H.R. 1's changes to Medicaid and SNAP, the impact on Colorado could total more than \$3 billion.

State government must take a holistic view of costs and revenue impacts to the State from H.R. 1. As a result, the Governor's Office looked to tax expenditures which are demonstrably ineffective, uncommon among other states, are not meeting their legislative intent, have a low return on investment, or do not align with the pro-growth goals of Colorado tax policy. I am calling this extraordinary session to ask the Colorado General Assembly to take immediate and needed TABOR-compliant action in a number of crucial areas to address the financial challenges the State is facing due to H.R. 1, re-balance the State's budget to ensure proper financial management, and preserve, as much as possible, critical State services and benefits for Coloradans. I am also asking the General Assembly to take action related to preserving access to health services, tackling the growing cost of private health insurance on the individual market, and addressing the impending and costly implementation of artificial intelligence (AI) legislation.

At the same time as we ask the General Assembly to act, I am also ordering State agencies to take immediate action to reduce costs. This Executive Order directs State agencies to implement a hiring freeze, effective August 27, 2025, and extending through December 31, 2025.

This call for an extraordinary session of the General Assembly does not prescribe the specific form that the legislation should take; however, as required by Article IV, Section 9 and Article V, Section 7 of the Colorado Constitution, the business to be transacted at this special session shall be limited to the matters stated in Section III of this Executive Order.

II. Purpose and Need

H.R. 1's immediate impact on Colorado's budget and ability to provide essential government services is severe. The State faces an immediate, dire budget shortfall that must be addressed as soon as possible to avoid even more severe actions in the future. I urge the General Assembly to consider and pass legislation that honors the difficult budget balancing work that occurred last session and makes needed policy and programmatic changes to preserve funding for several of Colorado's most critical services while meeting our constitutional obligation to balance our State budget.

Current statute addresses the impacts when the State is facing a significant revenue shortfall; it delineates that if the State would use more than half of the reserve, the Governor must submit a plan to keep the State from using more of the reserve. Historically, the reserve was 4%. Over the past 14 years, the General Assembly has recognized the need for a stronger reserve to protect critical State services during an economic downturn. The reserve currently sits at 15%, but the statute has not been updated, meaning that the State would need to spend \$1.22 billion to meet the current threshold. OSPB anticipates a 50% likelihood of a recession in the coming year. Joint Budget Committee staff estimates that in the face of a moderate recession, the State would

need an 18% reserve to weather the storm for two years. The General Assembly must take action to ensure the statute reflects the changing reserve and ensure that the State remains fiscally solvent in the face of a potential recession.

H.R. 1 makes significant changes to the structure and funding of SNAP. SNAP provides needed benefits to Colorado's most vulnerable populations and a significant economic impact to the State as a whole. It provides benefits to low-income families to supplement their grocery budget so they can afford nutritious food for their health and well-being. SNAP is distributed to participants in Colorado through the Electronic Benefits Transfer (EBT) system, which sends money to benefit cards that participants can use for SNAP-approved groceries at participating retailers. Prior to the passage of H.R. 1, over \$120 million in SNAP benefits provided to Coloradans each month were 100% federally funded. In addition, the federal government covered 50% of Colorado's administrative costs for SNAP.

With the changes to SNAP in H.R. 1, the federal administrative cost-sharing match will be reduced from 50% to 25%, creating a budget impact of nearly \$50 million annually. Additionally, beginning in October 2025, the federal government will begin a one-year measurement period to calculate Colorado's Payment Error Rate. This Payment Error Rate will be used to determine the State's share of funds that must be contributed to SNAP, meaning the federal government will likely no longer fund 100% of Colorado's SNAP benefits. The General Assembly must take immediate action during this extraordinary session to find avenues to continue funding this crucial program that helps low-income families afford groceries.

H.R. 1 negatively impacts health care as well. The targeted cuts to Medicaid will create more health care deserts in rural Colorado and raise insurance rates for everyone. H.R. 1 prohibits a federal match for services delivered to I.R.C. § 501(c)(3) nonprofit organizations that are classified as essential community providers that are primarily engaged in family planning services, reproductive health, and related medical care; provide for abortions beyond Hyde Amendment exceptions; and received more than \$800,000 in Medicaid payments in 2023. Coloradans who depend on these essential community providers, not only for reproductive health care but also to receive cost-saving preventative care and cancer screenings, will lose critical access to health care services. At the state level, we can amend State statutes to ensure Medicaid beneficiaries can continue to access care at these essential community providers. This is an immediate need and a simple fix to ensure all Coloradans have access to affordable health care, despite the federal government picking and choosing which providers can receive Medicaid payments for high-quality covered services.

In addition, Congress's failure to extend enhanced Health Insurance Premium Tax Credits, established by the American Rescue Plan Act of 2021 (ARPA) and extended by the Inflation Reduction Act of 2022 (IRA), in concert with the 2025 Marketplace Integrity and Affordability Final Rule and individual market changes set forth in H.R.1, will have a significant impact on health insurance rates in Colorado's individual health insurance market, as well as broader market impacts. July 2025 rate filings by insurance carriers with the Colorado Division of Insurance are, on average, 28% higher than 2025 rates with some requested rate increases on Colorado's Western Slope of almost 40%. While the State cannot extend federal premium tax

credits, we can add funds to Colorado's Health Insurance Affordability Enterprise (HIAE) in order to mitigate the impact of these extraordinary individual health insurance requested rate increases on individuals and families across the State. Without this additional support, projected coverage losses will be devastating for families and the health care system.

As a result of H.R. 1, in addition to the areas outlined above, we must look at all cost burdens statewide and ensure our State agencies can continue to provide critical and necessary services to Coloradans. This moment requires the State to ensure efficiencies and reduce burdens wherever possible. SB24-205, "Consumer Protections for Artificial Intelligence," rightly intended to focus on unwanted bias in certain AI-driven decision-making. Unfortunately, it has become increasingly clear that the application of SB24-205 inadvertently imposes high costs on the State, local governments, and covered businesses. Across State agencies, the estimated fiscal impact for implementation of SB24-205 is near \$5 million annually, which will otherwise require supplemental appropriations for this fiscal year due to the law's February 1, 2026 effective date. I was pleased to work together with the sponsor and the Attorney General on a [joint letter](#) indicating our shared commitment to ensuring this AI law works for Colorado, but these changes haven't happened yet and time is running short. Given the widespread agreement that changes need to be made and the short timeline between the start of session and the implementation date, I am asking the General Assembly to work toward solutions that reduce the fiscal and negative economic impact, and streamline the requirements of SB24-205 so that it meets the objectives of consumer protection and anti-discrimination while being simpler and less expensive to implement, and to consider providing additional time for implementation.

As the State faces budgetary pressures, it is my goal to continue to deliver critical services to Coloradans while implementing cost saving measures. In recognition of this Executive Order's request to the General Assembly to act, I am also taking executive action by ordering State agencies and departments managed by Governor-appointed executives to reduce costs by implementing a hiring freeze, effective August 27, 2025, and extending through the end of this year.

III. Proclamation

I, Jared Polis, Governor of the State of Colorado, with this proclamation find extraordinary occasions exist to convene the Seventy-Fifth General Assembly of this State and summon the members of the Seventy-Fifth General Assembly to meet in Special Session at 10:00 AM on August 21, 2025, at the State Capitol, in the City and County of Denver, and designate the following specific subjects for consideration, appropriate legislative action, and funding:

A. Fiscal

1. Concerning changes to C.R.S. § 24-2-102 and 24-75-201.5 regarding revenue shortfalls and insufficient revenue.
2. Concerning allowing the State to sell tax credits, including insurance premium tax credits, to certain taxpayers.

3. Concerning extending decoupling through an add back of the qualified business income deduction in C.R.S. § 39-22-104.
4. Concerning adjustments and reductions to the Home Office and Regional Home Office Rate Reduction in C.R.S. § 10-3-209.
5. Concerning expanding the foreign listed jurisdictions in C.R.S. § 39-22-303 to ensure companies are paying appropriate taxes in Colorado.
6. Concerning adjustments and reductions to the Sales Tax Vendor Fees in C.R.S. § 39-26-105.
7. Concerning decoupling through an add back of the federal Foreign-Derived Intangible Income (FDII) deduction.

B. Health Care

1. Concerning amendments to ensure access to services delivered by providers banned by H.R. 1 from federal Medicaid financing; and amendments to C.R.S. § 25.5-5-329 to ensure availability of Medicaid services to eligible individuals.
2. Concerning adjustments to the Health Insurance Affordability Enterprise (HIAE) to facilitate a reduction in premium increases and avoid health insurance coverage loss for those in the individual market and those unable to purchase health insurance through Connect for Health Colorado.

C. Food Security

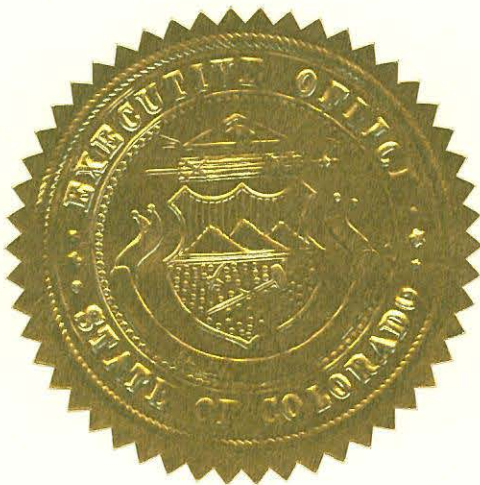
1. Concerning adjustments to the referred measures in HB25-1274 (Healthy School Meals for All Program) regarding the uses of the Healthy School Meals for All cash fund to include Supplemental Nutrition Assistance Program costs, and related statutory provisions.

D. Artificial Intelligence

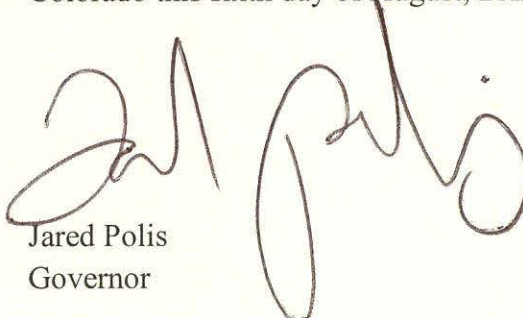
1. Concerning adjustments and reductions to the fiscal and implementation impacts of SB24-205 on covered businesses and State and local governments.

IV. Directives

- A. In order to implement further cost control measures required to stabilize the State budget, I hereby order that all State agencies and departments managed by Governor-appointed executives institute a hiring freeze.
- B. Effective on August 27, 2025, I order State agencies to cease posting for new job opportunities with start dates in 2025, notwithstanding:
 - 1. Positions that are fully funded through TABOR-exempt funding sources are excluded; and
 - 2. The Governor's Office shall issue a directive outlining which positions will be exempt from this hiring freeze, including those necessary to ensure public safety and the safe and continuous operations of facilities in which people are in the care and custody of the State, and to implement changes to safety net programs required by H.R. 1.
- C. Additionally, I urge all other elected officials in the executive branch to implement a hiring freeze in their agencies to ensure that State government fulfills its obligations to reduce costs in our control and to further reduce the need for more disruptive cost-saving measures that will impact Coloradans.
- D. This Section IV shall take effect on August 27, 2025, and remain in effect until December 31, 2025, subject to the exemptions listed in Section IV.B, unless modified or rescinded by future Executive Order of the Governor.



GIVEN under my hand and the
Executive Seal of the State of
Colorado this sixth day of August, 2025.


Jared Polis
Governor

DATE FILED
September 30, 2025 2:58 PM
FILING ID: 8EFF9D5FE57BE
CASE NUMBER: 2025CV33489

EXHIBIT 2



D 2025 014

EXECUTIVE ORDER

Declaring Insufficient Revenues Available for Expenditures Due to H.R. 1 and Ordering Suspension, in Whole or in Part, of Certain State Programs and Services in Order to Meet a Revenue Shortfall in Fiscal Year 2025-26

Pursuant to the authority vested in the Governor of the State of Colorado and, in particular, pursuant to Article IV, Section 2 of the Colorado Constitution, and C.R.S. § 24-75-201.5, I, Jared Polis, Governor of the State of Colorado, hereby issue this Executive Order declaring that there are insufficient revenues available for expenditures due to President Trump signing H.R. 1 into law on July 4, 2025, and ordering the suspension, in whole or in part, of certain State programs or services in order to meet a revenue shortfall for Fiscal Year 2025-26 and balance the state budget.

I. Background and Purpose

On July 4, 2025, President of the United States Donald Trump signed H.R. 1 into law through the reconciliation process. H.R. 1 increases the federal budget deficit and is causing an immediate and significant negative impact to State revenue - reducing total State revenue by over \$1.2 billion in the current fiscal year, eliminating the State's surplus, and putting Colorado's budget roughly \$800 million out of balance in the current fiscal year, Fiscal Year 2025-26, and reducing revenue to the State by approximately \$700 million in Fiscal Year 2026-27 and Fiscal Year 2027-28.

While the General Assembly passed and I signed a balanced budget on April 28, 2025, for Fiscal Year 2025-26, because of the federal tax changes in H.R. 1 for the current year that were subsequently passed by Congress but retroactively applied, the State budget is no longer balanced for the current year, and there will no longer be Taxpayer's Bill of Rights (TABOR) surplus refunds to Colorado taxpayers. The State budget now faces a significant shortfall. The Office of State Planning and Budgeting (OSPB) projects that H.R. 1 has reduced State revenue by approximately \$1.2 billion this year, which includes over a \$1.0 billion reduction in General Fund and a nearly \$200 million reduction to the State Education Fund and Proposition 123 diversions for affordable housing. The General Fund revenue loss erases the near \$300 million surplus projected in June, resulting in a deficit this current fiscal year of \$783 million.

On August 6, 2025, I signed Executive Order D 2025 009, finding that extraordinary occasions exist to convene the Seventy-Fifth General Assembly to meet in Special Session to

address the fiscal crisis caused by H.R. 1. In the same Executive Order, I directed State agencies to implement a hiring freeze in order to reduce costs.

Pursuant to Executive Order D 2025 009, the General Assembly met in Special Session at the State Capitol beginning on August 21, 2025, and concluding on August 26, 2025. Just prior to signing this Executive Order D 2025 014, I signed Senate Bill 25B-001, Processes to Reduce Spending During Shortfall (SB 25B-001), which was passed by the General Assembly during Special Session. SB 25B-001 relocates what was formerly C.R.S. § 24-2-102(4) into C.R.S. § 24-75-201.5(1)(a). C.R.S. § 24-75-201.5 clarifies that the Governor may suspend or discontinue, in whole or in part, the functions or services of any department, board, bureau, or agency of the state government by Executive Order if the Governor determines that there are not, or will not be, sufficient revenues available for expenditure during the fiscal year to carry on the functions of State government and to support its agencies and institutions. Further, the Governor must promptly notify the Joint Budget Committee of the Executive Order.

Accordingly, pursuant to C.R.S. § 24-75-201.5(1)(a), I have determined “that there are not, or will not be, sufficient revenues available for expenditure during the fiscal year to carry on the functions of the state government and to support its agencies and institutions.” Therefore, by this Executive Order, I am suspending, in whole or in part, the functions and services of State government as detailed below to reduce expenditures before the end of Fiscal Year 2025-26.

Accompanying this Executive Order is a letter notifying the Joint Budget Committee, as well as the General Assembly, of this Executive Order and outlining the suspensions, in whole or in part, of certain State programs and services in this Executive Order, which satisfies the notice requirement in C.R.S. § 24-75-201.5. That letter also outlines \$146,711,985 in cash fund transfers to the General Fund and \$3,000,000 in additional savings that will be submitted to the Joint Budget Committee as Fiscal Year 2025-26 supplemental budget requests. In total, these transfers and savings amount to an additional \$149,711,985 in budget reductions for Fiscal Year 2025-26, which with the reductions below and the hiring freeze brings the total savings to \$252,205,360.

II. Directives

- A. I declare that there are not, or will not be, sufficient revenues available for expenditure during the current fiscal year to carry on the functions of the state government and to support its agencies and institutions, and that suspending, in whole or in part, programs and services set forth in this Executive Order are necessary.

-
- B. To satisfy the provisions of C.R.S. § 24-75-201.5(1)(b) requiring that “the governor shall promptly notify the Joint Budget Committee of an Executive Order issued by the Governor,” I direct that the Director of the Office of State Planning and Budgeting (OSPB) submit in writing to the Joint Budget Committee and members of the General Assembly the contents of this Executive Order for reducing expenditures.
- C. The following programs and services, totaling \$102,993,375 in General Fund and Cash Funds, are suspended, in whole or in part, for the duration of this Executive Order through the end of Fiscal Year 2025-26. Note \$500,000 for SBIRT is counted in this reduction and in transfers, so total savings from the below list is \$102,493,375.
1. Department of Corrections (DOC)
 - a. Three million six hundred eighty one thousand one hundred dollars (\$3,681,100) appropriated for Medical Services Subprogram, Transgender Healthcare from the General Fund is suspended and not available for expenditure.
 2. Department of Health Care Policy & Financing (HCPF)
 - a. Fifty four million nine hundred forty thousand eight hundred fifty six dollars (\$54,940,856) appropriated for Medical Services Premiums from the General Fund is suspended and not available for expenditure.
 - b. Two million five hundred thousand dollars (\$2,500,000) appropriated for Medical Services Premiums from the Adult Dental Fund is suspended and not available for expenditure.
 - c. Sixteen million one hundred twenty thousand eight hundred ten dollars (\$16,120,810) appropriated for Behavioral Health Capitation Payments from the General Fund is suspended and not available for expenditure.
 - d. One million four hundred fifty thousand two hundred seventy nine dollars (\$1,450,279) appropriated for Adult Comprehensive Services from the General Fund is suspended and not available for expenditure.

-
- e. Three million dollars (\$3,000,000) appropriated for Children's Extensive Support Services from the General Fund is suspended and not available for expenditure.
 - f. Five hundred thousand dollars (\$500,000) appropriated for Screening, Brief Intervention, and Referral to Treatment Training Grant Program from the Marijuana Tax Cash Fund is suspended and not available for expenditure.
 - g. Five hundred thousand dollars (\$500,000) appropriated for Reproductive Health Care for Individuals Not Eligible for Medicaid from the General Fund is suspended and not available for expenditure.
 - h. One hundred thirty one thousand two hundred fifty dollars (\$131,250) appropriated for Health Benefits for Children Lacking Access Due to Immigration Status from the General Fund is suspended and not available for expenditure.
3. Department of Higher Education (CDHE)
- a. Seven million five hundred sixty nine thousand seven hundred forty seven dollars (\$7,569,747) appropriated for fee-for-service contracts with state institutions from the General Fund is suspended and not available for expenditure.
 - b. One million five hundred fifty thousand four hundred eighty one dollars (\$1,550,481) appropriated for fee-for-service contracts with state institutions for specialty education programs from the General Fund is suspended and not available for expenditure.
 - c. Three million two hundred twenty thousand one hundred eighty eight dollars (\$3,220,188) appropriated for limited purpose fee-for-service contracts with state institutions from the General Fund is suspended and not available for expenditure.
 - d. Ninety seven thousand eight hundred twenty dollars (\$97,820) appropriated for Colorado Mountain College from the General Fund is suspended and not available for expenditure.
 - e. One hundred sixteen thousand one hundred fifty one dollars (\$116,151) appropriated for Aims Community College from the General Fund is suspended and not available for expenditure.

-
- f. One hundred sixty seven thousand seven hundred seventeen dollars (\$167,717) appropriated for Area Technical Colleges from the General Fund is suspended and not available for expenditure.
 4. Department of Human Services (CDHS)
 - a. Two hundred one thousand eight hundred forty three dollars (\$201,843) appropriated for Mental Health Institute at Fort Logan Personal Services from the General Fund is suspended and not available for expenditure.
 - b. One million five hundred seven thousand five hundred twelve dollars (\$1,507,512) appropriated for Mental Health Institute at Pueblo Personal Services from the General Fund is suspended and not available for expenditure.
 5. Department of Information Technology (OIT)
 - a. One hundred thousand one hundred twenty one dollars (\$100,121) reappropriated for Enterprise Solutions from the Department of Local Affairs is suspended and not available for expenditure.
 6. Department of Local Affairs (DOLA)
 - a. One hundred thousand one hundred twenty one dollars (\$100,121) appropriated for payments to the Office of Information Technology from the General Fund is suspended and not available for expenditure.
 7. Department of Public Health & Environment (CDPHE)
 - a. Two million dollars (\$2,000,000) appropriated for Health Disparities Grants from the General Fund is suspended and not available for expenditure.
 - b. Three million dollars (\$3,000,000) appropriated for Distributions to Local Public Health Agencies from the General Fund is suspended and not available for expenditure.
 8. Department of Revenue (DOR)
 - a. Two hundred fifty thousand dollars (\$250,000) appropriated for Executive Director's Office Administration and Support Personal

Services from the General Fund is suspended and not available for expenditure.

- b. One hundred twenty five thousand dollars (\$125,000) appropriated for Executive Director's Office Administration and Support Operating Expenses from the General Fund is suspended and not available for expenditure.
- c. One hundred twenty five thousand dollars (\$125,000) appropriated for Executive Director's Office Administration and Support Leased Space from the General Fund is suspended and not available for expenditure.
- d. One hundred thirty seven thousand five hundred dollars (\$137,500) appropriated for Division of Motor Vehicles Driver Services Operating Expenses from the General Fund is suspended and not available for expenditure.

D. I direct the Office of the State Controller, within the Department of Personnel and Administration, to restrict the appropriations identified in Section II(C) in the State's accounting system to ensure the balances revert to the General Fund.

III. Duration

This Executive Order shall take effect on September 1, 2025, and shall expire on November 30, 2025, unless modified or rescinded by future Executive Order.



GIVEN under my hand and the
Executive Seal of the State of
Colorado this twenty-eighth
day of August, 2025.

A handwritten signature in black ink, appearing to read "J. Polis".

Jared Polis
Governor

DATE FILED
September 30, 2025 2:58 PM
FILING ID: 8EFF9D5FE57BE
CASE NUMBER: 2025CV33489

EXHIBIT 3

August 28, 2025

The Honorable Senator Jeff Bridges
Chair, Joint Budget Committee
Colorado General Assembly
200 E. 14th Avenue, Third Floor
Legislative Services Building
Denver, CO 80203

Dear Chair Bridges and Members of the Colorado Joint Budget Committee:

Thank you for your work during the Special Session to take the necessary actions to balance the 25-26 state budget. As you know, H.R. 1 is causing precipitous and significant revenue shortfalls for the State. These are challenging times that force difficult financial decisions to maintain a balanced budget. The Governor signed an Executive Order (Attachment A) today that describes his plan for \$252.2 million in spending reductions for FY 2025-26 under the authority clarified in S.B. 25B-001. Attachment B describes these spending reductions. This complements the Governor's previous directive to executive branch agencies to reduce spending by implementing a temporary hiring freeze.

In accordance with SB25B-001, the Governor's Office of State Planning and Budgeting (OSPB) submits to the Joint Budget Committee this plan for spending reductions in the current fiscal year ending June 30, 2026. In addition, this document describes supplemental and FY 2026-27 budget requests that require statutory changes that the Governor will submit to the Joint Budget Committee.

It is imperative to act quickly to reduce spending. The plan set out in the attached Executive Order D 2025 014 is a targeted and practical approach to reduce spending quickly by \$252.2 million that will attempt to maintain the statutory reserve requirements directed by statute. In making this plan, we focused on specific line item reductions that can be made with the least possible impact to State programs and services, and not across the board cuts that may have significant unintended consequences for Coloradans.

While S.B. 25B-001 does not confer on the Governor the authority to make transfers or increase cash fund spending authority, the Governor's Office has

identified additional transfers and refinances that will balance the budget. The Governor's Office plans to request the following of the Joint Budget Committee as FY 2025-26 supplemental budget actions:

Balancing Holds for Transfers and Diversions to the General Fund	
Diversion of OEDIT Prop 123 Funds to GF	\$105,000,000
CollegeInvest Administration Fund	\$9,200,000
Discretionary Account of ARPA Refinance State Money Cash Fund	\$5,400,000
Disability Support Fund	\$5,000,000
Community Impact Cash Fund	\$4,000,000
School and Child Care Clean Drinking Water Fund	\$4,000,000
Small Business Recovery and Resiliency Fund	\$4,000,000
Local Government Severance Tax Fund	\$3,305,993
Mobile Home Water Quality Fund	\$3,000,000
Severance Tax Perpetual Base Fund	\$1,652,996
Severance Tax Operational Fund	\$1,652,996
Marijuana Tax Cash Fund	\$500,000
Total	\$146,711,985

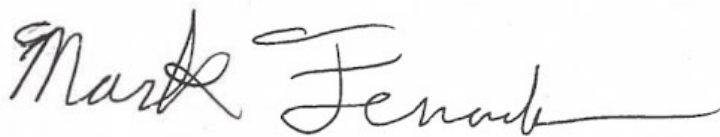
Other Balancing Holds	
HLD Savings from Hiring Freeze	\$3,000,000
Total	\$3,000,000

Total Budget Savings	
Executive Order Reductions (GF)*	\$102,493,375
Proposed Transfers and Diversions	\$146,711,985
Other Balancing Holds	\$3,000,000
Total	\$252,205,360

*This total excludes \$500,000 for the reduction to the SBIRT grants, since that is already counted under Proposed Transfers and Diversions.

Please do not hesitate to contact me directly with any questions or concerns at mark.ferrandino@state.co.us.

Sincerely,

A handwritten signature in black ink that reads "Mark Ferrandino". The signature is fluid and cursive, with a long horizontal line extending from the end of the name.

Mark Ferrandino
Director

CC:

Vice Chair Representative Shannon Bird, Joint Budget Committee

Senator Judy Amabile, Joint Budget Committee

Representative Emily Sirota, Joint Budget Committee

Senator Barbara Kirkmeyer, Joint Budget Committee

Representative Rick Taggart, Joint Budget Committee

Craig Harper, JBC Staff Director

Attachments:

Attachment A: Executive Order D 2025 014

Attachment B: Budget Savings Table

Attachment C: Budget Savings Detail for Institutes of Higher Education

Attachment A Begins on Next Page



D 2025 014

EXECUTIVE ORDER

Declaring Insufficient Revenues Available for Expenditures Due to H.R. 1 and Ordering Suspension, in Whole or in Part, of Certain State Programs and Services in Order to Meet a Revenue Shortfall in Fiscal Year 2025-26

Pursuant to the authority vested in the Governor of the State of Colorado and, in particular, pursuant to Article IV, Section 2 of the Colorado Constitution, and C.R.S. § 24-75-201.5, I, Jared Polis, Governor of the State of Colorado, hereby issue this Executive Order declaring that there are insufficient revenues available for expenditures due to President Trump signing H.R. 1 into law on July 4, 2025, and ordering the suspension, in whole or in part, of certain State programs or services in order to meet a revenue shortfall for Fiscal Year 2025-26 and balance the state budget.

I. Background and Purpose

On July 4, 2025, President of the United States Donald Trump signed H.R. 1 into law through the reconciliation process. H.R. 1 increases the federal budget deficit and is causing an immediate and significant negative impact to State revenue - reducing total State revenue by over \$1.2 billion in the current fiscal year, eliminating the State's surplus, and putting Colorado's budget roughly \$800 million out of balance in the current fiscal year, Fiscal Year 2025-26, and reducing revenue to the State by approximately \$700 million in Fiscal Year 2026-27 and Fiscal Year 2027-28.

While the General Assembly passed and I signed a balanced budget on April 28, 2025, for Fiscal Year 2025-26, because of the federal tax changes in H.R. 1 for the current year that were subsequently passed by Congress but retroactively applied, the State budget is no longer balanced for the current year, and there will no longer be Taxpayer's Bill of Rights (TABOR) surplus refunds to Colorado taxpayers. The State budget now faces a significant shortfall. The Office of State Planning and Budgeting (OSPB) projects that H.R. 1 has reduced State revenue by approximately \$1.2 billion this year, which includes over a \$1.0 billion reduction in General Fund and a nearly \$200 million reduction to the State Education Fund and Proposition 123 diversions for affordable housing. The General Fund revenue loss erases the near \$300 million surplus projected in June, resulting in a deficit this current fiscal year of \$783 million.

On August 6, 2025, I signed Executive Order D 2025 009, finding that extraordinary occasions exist to convene the Seventy-Fifth General Assembly to meet in Special Session to

address the fiscal crisis caused by H.R. 1. In the same Executive Order, I directed State agencies to implement a hiring freeze in order to reduce costs.

Pursuant to Executive Order D 2025 009, the General Assembly met in Special Session at the State Capitol beginning on August 21, 2025, and concluding on August 26, 2025. Just prior to signing this Executive Order D 2025 014, I signed Senate Bill 25B-001, Processes to Reduce Spending During Shortfall (SB 25B-001), which was passed by the General Assembly during Special Session. SB 25B-001 relocates what was formerly C.R.S. § 24-2-102(4) into C.R.S. § 24-75-201.5(1)(a). C.R.S. § 24-75-201.5 clarifies that the Governor may suspend or discontinue, in whole or in part, the functions or services of any department, board, bureau, or agency of the state government by Executive Order if the Governor determines that there are not, or will not be, sufficient revenues available for expenditure during the fiscal year to carry on the functions of State government and to support its agencies and institutions. Further, the Governor must promptly notify the Joint Budget Committee of the Executive Order.

Accordingly, pursuant to C.R.S. § 24-75-201.5(1)(a), I have determined “that there are not, or will not be, sufficient revenues available for expenditure during the fiscal year to carry on the functions of the state government and to support its agencies and institutions.” Therefore, by this Executive Order, I am suspending, in whole or in part, the functions and services of State government as detailed below to reduce expenditures before the end of Fiscal Year 2025-26.

Accompanying this Executive Order is a letter notifying the Joint Budget Committee, as well as the General Assembly, of this Executive Order and outlining the suspensions, in whole or in part, of certain State programs and services in this Executive Order, which satisfies the notice requirement in C.R.S. § 24-75-201.5. That letter also outlines \$146,711,985 in cash fund transfers to the General Fund and \$3,000,000 in additional savings that will be submitted to the Joint Budget Committee as Fiscal Year 2025-26 supplemental budget requests. In total, these transfers and savings amount to an additional \$149,711,985 in budget reductions for Fiscal Year 2025-26, which with the reductions below and the hiring freeze brings the total savings to \$252,205,360.

II. Directives

- A. I declare that there are not, or will not be, sufficient revenues available for expenditure during the current fiscal year to carry on the functions of the state government and to support its agencies and institutions, and that suspending, in whole or in part, programs and services set forth in this Executive Order are necessary.

-
- B. To satisfy the provisions of C.R.S. § 24-75-201.5(1)(b) requiring that “the governor shall promptly notify the Joint Budget Committee of an Executive Order issued by the Governor,” I direct that the Director of the Office of State Planning and Budgeting (OSPB) submit in writing to the Joint Budget Committee and members of the General Assembly the contents of this Executive Order for reducing expenditures.
- C. The following programs and services, totaling \$102,993,375 in General Fund and Cash Funds, are suspended, in whole or in part, for the duration of this Executive Order through the end of Fiscal Year 2025-26. Note \$500,000 for SBIRT is counted in this reduction and in transfers, so total savings from the below list is \$102,493,375.
1. Department of Corrections (DOC)
 - a. Three million six hundred eighty one thousand one hundred dollars (\$3,681,100) appropriated for Medical Services Subprogram, Transgender Healthcare from the General Fund is suspended and not available for expenditure.
 2. Department of Health Care Policy & Financing (HCPF)
 - a. Fifty four million nine hundred forty thousand eight hundred fifty six dollars (\$54,940,856) appropriated for Medical Services Premiums from the General Fund is suspended and not available for expenditure.
 - b. Two million five hundred thousand dollars (\$2,500,000) appropriated for Medical Services Premiums from the Adult Dental Fund is suspended and not available for expenditure.
 - c. Sixteen million one hundred twenty thousand eight hundred ten dollars (\$16,120,810) appropriated for Behavioral Health Capitation Payments from the General Fund is suspended and not available for expenditure.
 - d. One million four hundred fifty thousand two hundred seventy nine dollars (\$1,450,279) appropriated for Adult Comprehensive Services from the General Fund is suspended and not available for expenditure.

-
- e. Three million dollars (\$3,000,000) appropriated for Children's Extensive Support Services from the General Fund is suspended and not available for expenditure.
 - f. Five hundred thousand dollars (\$500,000) appropriated for Screening, Brief Intervention, and Referral to Treatment Training Grant Program from the Marijuana Tax Cash Fund is suspended and not available for expenditure.
 - g. Five hundred thousand dollars (\$500,000) appropriated for Reproductive Health Care for Individuals Not Eligible for Medicaid from the General Fund is suspended and not available for expenditure.
 - h. One hundred thirty one thousand two hundred fifty dollars (\$131,250) appropriated for Health Benefits for Children Lacking Access Due to Immigration Status from the General Fund is suspended and not available for expenditure.
3. Department of Higher Education (CDHE)
- a. Seven million five hundred sixty nine thousand seven hundred forty seven dollars (\$7,569,747) appropriated for fee-for-service contracts with state institutions from the General Fund is suspended and not available for expenditure.
 - b. One million five hundred fifty thousand four hundred eighty one dollars (\$1,550,481) appropriated for fee-for-service contracts with state institutions for specialty education programs from the General Fund is suspended and not available for expenditure.
 - c. Three million two hundred twenty thousand one hundred eighty eight dollars (\$3,220,188) appropriated for limited purpose fee-for-service contracts with state institutions from the General Fund is suspended and not available for expenditure.
 - d. Ninety seven thousand eight hundred twenty dollars (\$97,820) appropriated for Colorado Mountain College from the General Fund is suspended and not available for expenditure.
 - e. One hundred sixteen thousand one hundred fifty one dollars (\$116,151) appropriated for Aims Community College from the General Fund is suspended and not available for expenditure.

-
- f. One hundred sixty seven thousand seven hundred seventeen dollars (\$167,717) appropriated for Area Technical Colleges from the General Fund is suspended and not available for expenditure.
 4. Department of Human Services (CDHS)
 - a. Two hundred one thousand eight hundred forty three dollars (\$201,843) appropriated for Mental Health Institute at Fort Logan Personal Services from the General Fund is suspended and not available for expenditure.
 - b. One million five hundred seven thousand five hundred twelve dollars (\$1,507,512) appropriated for Mental Health Institute at Pueblo Personal Services from the General Fund is suspended and not available for expenditure.
 5. Department of Information Technology (OIT)
 - a. One hundred thousand one hundred twenty one dollars (\$100,121) reappropriated for Enterprise Solutions from the Department of Local Affairs is suspended and not available for expenditure.
 6. Department of Local Affairs (DOLA)
 - a. One hundred thousand one hundred twenty one dollars (\$100,121) appropriated for payments to the Office of Information Technology from the General Fund is suspended and not available for expenditure.
 7. Department of Public Health & Environment (CDPHE)
 - a. Two million dollars (\$2,000,000) appropriated for Health Disparities Grants from the General Fund is suspended and not available for expenditure.
 - b. Three million dollars (\$3,000,000) appropriated for Distributions to Local Public Health Agencies from the General Fund is suspended and not available for expenditure.
 8. Department of Revenue (DOR)
 - a. Two hundred fifty thousand dollars (\$250,000) appropriated for Executive Director's Office Administration and Support Personal

Services from the General Fund is suspended and not available for expenditure.

- b. One hundred twenty five thousand dollars (\$125,000) appropriated for Executive Director's Office Administration and Support Operating Expenses from the General Fund is suspended and not available for expenditure.
- c. One hundred twenty five thousand dollars (\$125,000) appropriated for Executive Director's Office Administration and Support Leased Space from the General Fund is suspended and not available for expenditure.
- d. One hundred thirty seven thousand five hundred dollars (\$137,500) appropriated for Division of Motor Vehicles Driver Services Operating Expenses from the General Fund is suspended and not available for expenditure.

D. I direct the Office of the State Controller, within the Department of Personnel and Administration, to restrict the appropriations identified in Section II(C) in the State's accounting system to ensure the balances revert to the General Fund.

III. Duration

This Executive Order shall take effect on September 1, 2025, and shall expire on November 30, 2025, unless modified or rescinded by future Executive Order.



GIVEN under my hand and the
Executive Seal of the State of
Colorado this twenty-eighth
day of August, 2025.

A handwritten signature in black ink, appearing to read "J. Polis".

Jared Polis
Governor

Attachment B: Budget Savings Table

Budget Savings Table

Department	Description	Savings	Notes
DOC	Right-sizing Transgender Healthcare Appropriation	-\$3,681,100	Right-sizes the appropriation based on actual spending and anticipated future need with no cut to services.
HCPF	Accountable Care Collaborative (ACC) Incentive Reduction	-\$750,000	Reduces payments to providers and Regional Accountable Entities for meeting performance outcomes.
HCPF	Adjust Community Connector rate to align with similar services	-\$3,000,000	Adjusts rates to align with similar services
HCPF	Adjust pediatric behavioral therapy rates to 95% of the benchmark based on updated, current average rates	-\$2,720,223	Reduces provider rates to reflect updated data from a benchmark analysis and adjust rates to 95% of the updated benchmark.
HCPF	Behavioral Health Incentive Reduction	-\$3,000,000	Reduces payments to providers and Regional Accountable Entities for meeting performance outcomes for behavioral health.
HCPF	Continuous Coverage End	-\$5,613,712	Ends provisions for continuous coverage for children to age 3, to align with expected loss of federal matching dollars
HCPF	Definitive Drug Testing	-\$1,719,785	Implements prior authorization for utilization exceeding 16 tests per year, to align with best

Attachment B: Budget Savings Table

Department	Description	Savings	Notes
			practice
HCPF	Eliminate Cover All Coloradans Outreach	-\$131,250	Eliminates funds for outreach with no reduction to services
HCPF	Eliminate the nursing facility minimum wage payment	-\$4,359,961	Eliminates supplemental payments as the prevailing minimum wage has increased above \$15/hr
HCPF	Immigrant Family Planning Reduction	-\$500,000	Reduces a historically underspent appropriation with no expected impact to services
HCPF	Implement pre- and post-claim review of all pediatric autism behavioral therapy codes	-\$7,000,000	Reviews pediatric autism behavioral health therapy codes to address recent dramatic increase in utilization
HCPF	Reduce dental provider rates	-\$2,500,000	Reduces FY 2024-25 dental rate increase by 44%
HCPF	Reduce Individual Residential Services and Supports (IRSS) rate to align with host home rate	-\$1,450,279	Aligns rates for similar services provided under IRSS and host home rates
HCPF	Reduction to the Access Stabilization Payments	-\$1,500,000	Reduces payments to rural, small, and pediatric providers that do not receive cost-based reimbursements as part of the Accountable Care Collaborative.
HCPF	Reinstate prior authorization of outpatient psychotherapy for services that exceed clinical best	-\$6,120,810	Reinstates prior authorization to align utilization with best practices for outpatient psychotherapy services

Attachment B: Budget Savings Table

Department	Description	Savings	Notes
	practices		
HCPF	Rollback FY 2024-25-26 1.6% provider rate increase	-\$38,277,175	Maintains provider rates at the FY 2024-25 level by rolling back the 1.6% increase.
HCPF	SBIRT grants: Reduce training grants for screening and interventions related to substance use	-\$500,000	Reduces SBIRT grants by 33%
CDHE	College Invest Transfer to the General Fund	-\$9,200,000	Transfers available fund balance with no expected impact to programs in this fiscal year.
CDHE	Half-year reduction to limited purpose fee-for-service contracts (FFS) program	-\$3,220,188	Reduces limited purpose fee-for-service contracts to the Institutions of Higher Education Governing Boards by 50%.
CDHE	IHE Operating Increase Reduction	-\$9,501,916	Reduces 30% of the incremental increase for FY 2024-25-26 to IHE Governing Boards, SEPs, and LDCs/ATCs. Higher education institutions are still seeing a \$22.1M increase in the current budget year relative to the previous year.
CDHS	Mental Health Hospitals Personal Services Reduction	-\$1,709,355	Reduces General Fund for costs that can be supported by existing patient revenue. Therefore, it will not impact programs in this fiscal year.
CDLE	Disability Support Fund Transfer to the General Fund	-\$5,000,000	Transfers available fund balance with no expected impact to programs in this fiscal year.

Attachment B: Budget Savings Table

Department	Description	Savings	Notes
DOLA	Additional Severance Tax Transfer to the General Fund (DOLA)	-\$3,305,993	Transfers TABOR non-exempt tax revenue that was accrued in FY 2024-25. With higher levels of severance tax revenue projected for FY 2025-26 and FY 2026-27, the Department can absorb this sweep within its fund management plan to maintain stability and continuity of programs.
DOLA	Reduction to OIT Payments	-\$100,121	Reflects lower need for Payments to OIT appropriation as building and modernizing work transitions to operations and maintenance
DNR	Additional Severance Tax Transfer to the General Fund (DNR)	-\$3,305,992	Transfers TABOR non-exempt tax revenue that was accrued in FY 2024-25. The revised fund balance after this revenue sweep plus forecasted FY 2025-26 revenues are estimated to provide the necessary resources to manage programs at their current appropriation levels for FY 2025-26.
CDPHE	Community Impact Cash Fund Transfer to the General Fund	-\$4,000,000	Transfers available fund balance with no expected impact to programs in this fiscal year.
CDPHE	Health Disparities Grant Reduction	-\$2,000,000	Reduces grant funds by 31%
CDPHE	Mobile Home Park Water Quality Fund Transfer to the General Fund	-\$3,000,000	Transfers available fund balance with no expected impact to programs in this fiscal year.

Attachment B: Budget Savings Table

Department	Description	Savings	Notes
CDPHE	Reduce Distributions to Local Public Health Agencies (LPHAs)	-\$3,000,000	Reduces appropriation to LPHAs while still keeping it higher than historical levels
CDPHE	School and Child Care Clean Drinking Water Fund Transfer to the General Fund	-\$4,000,000	Transfers available fund balance with no expected impact to programs in this fiscal year.
DOR	DMV Driver Services - Operating Expenses (6 month impact, -\$0.275M ongoing)	-\$137,500	Reduces administrative costs with no expected impacts to programs
DOR	Executive Director's Office Administration and Support	-\$500,000	Reduces administrative costs with no expected impacts to programs
OEDIT	OEDIT Proposition 123 Transfer	-\$105,000,000	Diverts Prop 123 funds from OEDIT to the GF. Per ballot language, Proposition 123 allows for a reduction in the income diversion amount when the state's revenues are below the TABOR cap. This reduction would maintain funds for OEDIT to maximize federal dollars, sustain housing tax credits, and ensure we hold gap financing opportunities harmless.
OEDIT	Small Business Recovery and Resiliency Fund Transfer to the General Fund	-\$4,000,000	Transfers available fund balance with no expected impact to programs in this fiscal year
Statewide	Hiring Freeze	-\$3,000,000	Reflects expected savings in Health Life Dental costs from the statewide hiring freeze ordered in Executive Order D 2025 009.

Attachment B: Budget Savings Table

Department	Description	Savings	Notes
Statewide	Refinance Discretionary Account of ARPA Refinance State Money Cash Fund Transfer to the General Fund	-\$5,400,000	Transfers available fund balance with no expected impact to programs in this fiscal year
		-\$252,205,360	

Attachment C: Budget Savings Detail for Institutes of Higher Education

Budget Savings Detail for Institutes of Higher Education

Institutions of Higher Education	Fee-for-service contracts	Fee-for-service contracts for specialty education programs	Limited purpose fee-for-service contracts	Total
Trustees of Adams State University	-\$209,102	\$0	-\$32,500	-\$241,602
Trustees of Colorado Mesa University	-\$366,065	\$0	-\$107,500	-\$473,565
Trustees of Metropolitan State University of Denver	-\$773,402	\$0	-\$107,500	-\$880,902
Trustees of Western Colorado University	-\$184,314	\$0	-\$82,500	-\$266,814
Board of Governors for the Colorado State University System	-\$1,098,935	-\$732,918	-\$370,267	-\$2,202,120
Trustees of Fort Lewis College	-\$174,006	\$0	-\$32,500	-\$206,506
Regents of the University of Colorado	-\$1,773,976	-\$817,563	-\$2,216,082	-\$4,807,621
Colorado School of Mines	-\$279,200	\$0	\$0	-\$279,200
University of Northern Colorado	-\$516,000	\$0	-\$32,500	-\$548,500
State Board for Community Colleges and Occupational	-\$2,194,747	\$0	-\$238,840	-\$2,433,587

Attachment C: Budget Savings Detail for Institutes of Higher Education

Institutions of Higher Education	Fee-for-service contracts	Fee-for-service contracts for specialty education programs	Limited purpose fee-for-service contracts	Total
Education State System Community Colleges				
Total	-\$7,569,747	-\$1,550,481	-\$3,220,188	-\$12,340,416

DATE FILED
September 30, 2025 2:58 PM
FILING ID: 8EFF9D5FE57BE
CASE NUMBER: 2025CV33489

EXHIBIT 4

An Act

SENATE BILL 25B-001

BY SENATOR(S) Amabile and Coleman, Bridges;
also REPRESENTATIVE(S) McCluskie and Sirota, Bacon, Boesenecker,
Brown, Clifford, Duran, Espenosa, Froelich, Garcia, Gonzalez R., Hamrick,
Jackson, Joseph, Lindsay, Lukens, Marshall, McCormick, Paschal, Smith,
Stewart K., Stewart R., Story, Taggart, Willford, Zokaie.

CONCERNING THE PROCESSES FOR THE GOVERNOR TO REDUCE SPENDING
WHEN THE STATE IS UNABLE TO MEET ITS FISCAL OBLIGATIONS, AND,
IN CONNECTION THEREWITH, REQUIRING THE GOVERNOR TO PRESENT
SPENDING REDUCTION PLANS TO THE JOINT BUDGET COMMITTEE AND
RECEIVE ADVICE FROM THE JOINT BUDGET COMMITTEE.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. In Colorado Revised Statutes, **amend with relocated provisions 24-75-201.5** as follows:

24-75-201.5. Revenue shortfalls - authority of the governor - when governor is required to act - definition. (1) [Formerly 24-2-102 (4)] (a) If, during any fiscal ~~period~~ YEAR, THE GOVERNOR DETERMINES THAT there are not, OR WILL NOT BE, sufficient revenues available for expenditure during ~~such period~~ THE FISCAL YEAR to carry on the functions

of the state government and to support its agencies and institutions, ~~and such fact is made to appear to the governor~~ THE GOVERNOR MAY, in the exercise of ~~his~~ THE GOVERNOR'S discretion, by executive order, ~~he may~~ suspend or discontinue, in whole or in part, the functions or services of any department, board, bureau, or agency of the state government; except that the authority of the governor to restrict the expenditure of ~~moneys~~ MONEY appropriated from the capital construction fund ~~shall~~ MUST be determined ~~by the provisions of section 24-75-201.5~~ IN ACCORDANCE WITH THE REQUIREMENTS IN SUBSECTION (4) OF THIS SECTION.

(b) (I) THE GOVERNOR SHALL PROMPTLY NOTIFY THE JOINT BUDGET COMMITTEE OF AN EXECUTIVE ORDER ISSUED BY THE GOVERNOR PURSUANT TO THIS SUBSECTION (1), INCLUDING AN EXECUTIVE ORDER ISSUED PURSUANT TO SUBSECTION (1)(c) OF THIS SECTION THAT EXTENDS THE OPERATION OF A PRIOR EXECUTIVE ORDER. AS SOON AS PRACTICABLE AFTER RECEIVING THE NOTIFICATION, AND EXCEPT AS PROVIDED IN SUBSECTION (1)(b)(II) OF THIS SECTION, THE JOINT BUDGET COMMITTEE SHALL HOLD A MEETING TO DISCUSS THE GOVERNOR'S PLANS FOR SUSPENDING OR DISCONTINUING ANY FUNCTIONS OR SERVICES OF ANY DEPARTMENT, BOARD, BUREAU, OR AGENCY OF THE STATE GOVERNMENT PURSUANT TO THIS SUBSECTION (1). THE JOINT BUDGET COMMITTEE SHALL MAKE ALL REASONABLE EFFORTS TO HOLD THE MEETING BEFORE THE FIRST DAY OF THE CALENDAR MONTH FOLLOWING THE ENTRY OF THE EXECUTIVE ORDER. AT THE JOINT BUDGET COMMITTEE'S MEETING, THE GOVERNOR OR THE OFFICE OF STATE PLANNING AND BUDGETING, OR BOTH, SHALL PRESENT THE EXECUTIVE ORDER TO THE COMMITTEE, AND THE COMMITTEE MAY PROVIDE ADVICE AT THE MEETING REGARDING THE SUSPENSION OR DISCONTINUATION OF ANY FUNCTIONS OR SERVICES.

(II) THE JOINT BUDGET COMMITTEE IS NOT REQUIRED TO HOLD A MEETING DESCRIBED IN SUBSECTION (1)(b)(I) OF THIS SECTION IF THE EXECUTIVE ORDER ISSUED PURSUANT TO THIS SUBSECTION (1) IS TO IMPLEMENT A PLAN DESCRIBED IN SUBSECTION (2) OF THIS SECTION AND THE JOINT BUDGET COMMITTEE HELD A MEETING IN ACCORDANCE WITH SUBSECTION (2)(b) OF THIS SECTION. THIS SUBSECTION (1)(b)(II) DOES NOT PROHIBIT THE JOINT BUDGET COMMITTEE FROM HOLDING A MEETING AND REQUESTING THE GOVERNOR OR THE OFFICE OF STATE PLANNING AND BUDGETING, OR BOTH, TO ATTEND THE MEETING.

(c) ~~Such~~ A discontinuance or suspension ~~shall become~~ MADE

PURSUANT TO THIS SUBSECTION (1) BECOMES effective upon the first day of the calendar month following the entry of ~~such~~ THE executive order and ~~shall~~ MAY continue for ~~such~~ A period of time, not to exceed three months, as ~~shall be determined by such~~ SET FORTH IN THE executive order. If, during ~~any such~~ THE period of time, ~~it again appears to the governor~~ DETERMINES that ~~such~~ THE deficiency of revenues ~~still persists, from time to time, he~~ THE GOVERNOR may extend the operation of ~~such~~ THE executive order for a ~~like~~ period of time not to exceed three ~~months; but~~ MONTHS.

(d) The state ~~shall not be~~ IS NOT liable for the payment of any claim for salaries or expenses SUBJECT TO A SUSPENSION OR DISCONTINUATION PURSUANT TO THIS SUBSECTION (1) purporting to have accrued against any ~~such~~ department, board, bureau, or agency during any ~~such~~ period of THE suspension OR DISCONTINUATION, and the controller shall not issue ~~nor may~~ AND the state treasurer SHALL NOT honor any warrant therefor. ~~Elective officers shall not be subject to the provisions of this article, parts 2 and 11 of article 30, and articles 31, 35, 36, and 101 to 111 of this title.~~

~~(1)~~ (2) (a) Whenever the revenue estimate for the current fiscal year prepared BY THE GOVERNOR in accordance with section 24-75-201.3 (2), OR AN INTERIM REVENUE ESTIMATE PREPARED BY THE GOVERNOR, indicates that general fund expenditures for ~~such~~ THAT fiscal year based on appropriations then in effect will result in ~~the use of~~ USING AN AMOUNT OF THE RESERVE DESCRIBED IN SECTION 24-75-201.1 (1)(d) THAT IS EQUAL TO THE LESSER OF THREE PERCENT OF GENERAL FUND APPROPRIATIONS FOR THE FISCAL YEAR OR one-half or more of the reserve required by section 24-75-201.1 (1)(d), the governor shall formulate a plan for reducing ~~such~~ general fund expenditures so that ~~said~~ THE reserve, as of the close of the fiscal year, will be ~~at least~~ BELOW THE AMOUNT REQUIRED IN SECTION 24-75-201.1 (1)(d) BY NO MORE THAN AN AMOUNT EQUAL TO THREE PERCENT OF GENERAL FUND APPROPRIATIONS FOR THE FISCAL YEAR OR one-half OR MORE of the amount required by ~~said~~ section 24-75-201.1 (1)(d), AS APPLICABLE. IF THE GOVERNOR IS IMPLEMENTING A PLAN PURSUANT TO SUBSECTION (2)(d) OF THIS SECTION, THE GOVERNOR IS NOT REQUIRED TO FORMULATE AND IMPLEMENT A PLAN PURSUANT TO THIS SUBSECTION (2)(a).

(b) The governor shall promptly notify the general assembly of ~~the~~ A plan CREATED BY THE GOVERNOR PURSUANT TO THIS SUBSECTION (2). THE JOINT BUDGET COMMITTEE SHALL HOLD A MEETING AS SOON AS PRACTICABLE AFTER THE GENERAL ASSEMBLY IS NOTIFIED OF THE PLAN. AT

THE JOINT BUDGET COMMITTEE'S MEETING, THE GOVERNOR OR THE OFFICE OF STATE PLANNING AND BUDGETING, OR BOTH, SHALL PRESENT THE PLAN TO THE COMMITTEE, AND THE COMMITTEE MAY PROVIDE ADVICE AT THE MEETING REGARDING THE PLAN.

(c) The GOVERNOR SHALL PROMPTLY IMPLEMENT A plan ~~shall be promptly implemented by the governor~~, CREATED BY THE GOVERNOR PURSUANT TO THIS SUBSECTION (2) using the procedures set forth in ~~section 24-2-102 (4)~~ SUBSECTION (1) OF THIS SECTION or SECTION 24-50-109.5 or any other lawful means.

~~(b) to (g) Repealed.~~

~~(h)~~ (d) Whenever the revenue estimate for the current fiscal year, prepared BY THE GOVERNOR in accordance with section 24-75-201.3 (2), OR AN INTERIM REVENUE ESTIMATE PREPARED BY THE GOVERNOR, indicates that general fund expenditures for that fiscal year based on appropriations then in effect will result in the use of an amount of the reserve required by section 24-75-201.1 (1)(d) that would result in that reserve equaling less than one billion dollars, the governor shall formulate a plan for reducing ~~such~~ general fund expenditures so that ~~said~~ THE reserve, as of the close of the fiscal year, will be at least one billion dollars. ~~The governor shall promptly notify the general assembly of the plan and promptly implement the plan in accordance with section 24-2-102 (4) or 24-50-109.5 or any other lawful means.~~ THE PROCEDURES AND REQUIREMENTS IN SUBSECTIONS (2)(b) AND (2)(c) OF THIS SECTION APPLY TO A PLAN FORMULATED PURSUANT TO THIS SUBSECTION (2)(d). IF THE GOVERNOR IS IMPLEMENTING A PLAN PURSUANT TO SUBSECTION (2)(a) OF THIS SECTION, THE GOVERNOR IS NOT REQUIRED TO FORMULATE AND IMPLEMENT A PLAN PURSUANT TO THIS SUBSECTION (2)(d).

(e) AS USED IN THIS SUBSECTION (2), "INTERIM REVENUE ESTIMATE PREPARED BY THE GOVERNOR" MEANS AN UPDATED REVENUE ESTIMATE IN THE TIME BETWEEN TWO ESTIMATES MADE BY THE GOVERNOR PURSUANT TO SECTION 24-75-201.3 (2), WHICH INTERIM ESTIMATE IS PREPARED BY THE GOVERNOR, DESIGNATED BY THE GOVERNOR AS AN INTERIM REVENUE ESTIMATE THAT IS AN UPDATE TO THE MOST RECENT PRIOR REVENUE ESTIMATE, TRANSMITTED TO THE GENERAL ASSEMBLY, AND PRESENTED AT A MEETING OF THE JOINT BUDGET COMMITTEE AS AN INTERIM REVENUE ESTIMATE THAT IS AN UPDATE TO THE MOST RECENT PRIOR REVENUE

ESTIMATE.

(2) (3) In formulating a plan for the reduction of general fund expenditures as required by ~~subsection (1)~~ SUBSECTION (2) of this section, the governor may consider any recommendations for reducing general fund expenditures of the institutions of higher education submitted by the Colorado commission on higher education, after consultation with the governing boards of ~~such~~ THE institutions.

~~(3) Repealed.~~

(4) Whenever the governor has formulated and implemented a plan to reduce general fund expenditures in accordance with ~~subsection (1)~~ SUBSECTION (2) of this section, and ~~such~~ THE plan reduces general fund expenditures in an amount equal to or greater than one percent of all general fund appropriations for the fiscal year, the governor, after consultation with the capital development committee and the joint budget committee, may transfer general fund ~~moneys~~ MONEY from the capital construction fund into the general fund. Pursuant to this subsection (4), the governor ~~will~~ MAY ONLY restrict the capital construction projects in the reverse order of the priorities as established by the capital development committee unless approved by the capital development committee and the joint budget committee.

(5) NOTWITHSTANDING THE AUTHORITY IN THIS SECTION TO FORMULATE AND IMPLEMENT A PLAN TO REDUCE GENERAL FUND EXPENDITURES, THE GOVERNOR SHALL NOT REDUCE GENERAL FUND EXPENDITURES BY THE JUDICIAL DEPARTMENT, THE LEGISLATIVE DEPARTMENT, OR ELECTIVE OFFICERS OTHER THAN THE GOVERNOR PURSUANT TO THIS SECTION.

SECTION 2. In Colorado Revised Statutes, 24-2-102, **repeal** (4); and **add** (5) as follows:

24-2-102. Appointment of officers and employees. (4) ~~If, during any fiscal period, there are not sufficient revenues available for expenditure during such period to carry on the functions of the state government and to support its agencies and institutions and such fact is made to appear to the governor, in the exercise of his discretion, by executive order, he may suspend or discontinue, in whole or in part, the functions or services of any~~

~~department, board, bureau, or agency of the state government; except that the authority of the governor to restrict the expenditure of moneys appropriated from the capital construction fund shall be determined by the provisions of section 24-75-201.5. Such discontinuance or suspension shall become effective upon the first day of the calendar month following the entry of such executive order and shall continue for such period of time, not to exceed three months, as shall be determined by such executive order. If, during any such period of time, it again appears to the governor that such deficiency of revenues still persists, from time to time, he may extend the operation of such executive order for a like period of time not to exceed three months; but the state shall not be liable for the payment of any claim for salaries or expenses purporting to have accrued against any such department, board, bureau, or agency during any such period of suspension, and the controller shall not issue nor may the state treasurer honor any warrant therefor. Elective officers shall not be subject to the provisions of this article, parts 2 and 11 of article 30, and articles 31, 35, 36, and 101 to 111 of this title.~~

(5) ELECTIVE OFFICERS SHALL NOT BE SUBJECT TO THE PROVISIONS OF THIS ARTICLE 2, PARTS 2 AND 11 OF ARTICLE 30, AND ARTICLES 31, 35, 36, AND 101 TO 111 OF THIS TITLE 24.

SECTION 3. In Colorado Revised Statutes, 24-30-1404, **amend** (7)(e) as follows:

24-30-1404. Contracts - definition. (7) (e) In the event that the governor restricts or delays the expenditure of money for a project for which a professional services contract is required pursuant to the authority granted to the governor in ~~section 24-75-201.5~~ SECTION 24-75-201.5 (2), the deadlines imposed in subsection (7)(a) of this section for ~~such~~ THE projects ~~shall be~~ ARE tolled until such time as the restriction or delay is no longer in effect, at which time the professional services contract must be executed and encumbered and any contract with the contractor must be entered into within six months.

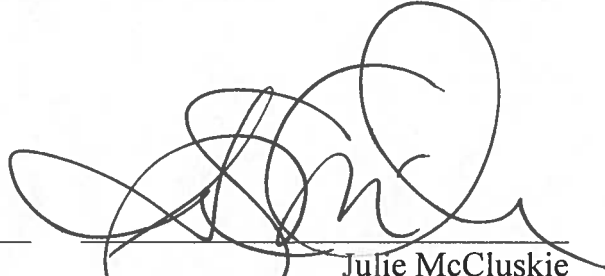
SECTION 4. Applicability. This act applies to revenue estimates and interim revenue estimates presented, and executive orders issued, on or after the effective date of this act.

SECTION 5. Safety clause. The general assembly finds,

determines, and declares that this act is necessary for the immediate preservation of the public peace, health, or safety or for appropriations for the support and maintenance of the departments of the state and state institutions.



James Rashad Coleman, Sr.
PRESIDENT OF
THE SENATE



Julie McCluskie
SPEAKER OF THE HOUSE
OF REPRESENTATIVES

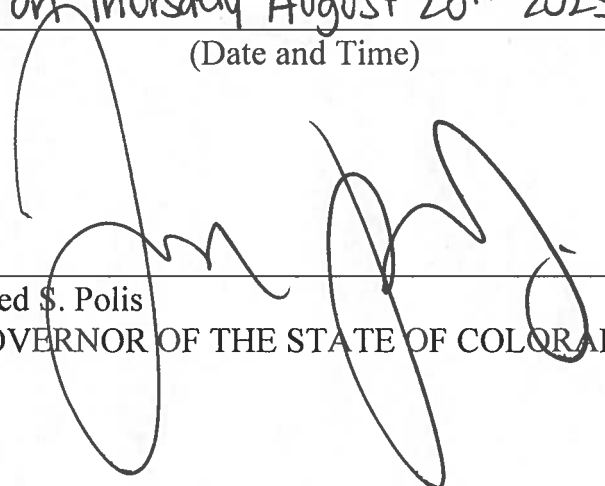


Esther van Mourik
SECRETARY OF
THE SENATE



Connor Randall
ACTING CHIEF CLERK OF THE HOUSE
OF REPRESENTATIVES

APPROVED on Thursday August 28th 2025 at 10:23am
(Date and Time)



Jared S. Polis
GOVERNOR OF THE STATE OF COLORADO

DATE FILED
September 30, 2025 2:58 PM
FILING ID: 8EFF9D5FE57BE
CASE NUMBER: 2025CV33489

EXHIBIT 5



Balanced Approach to Address the FY 2025-26 Budget Shortfall Due to Federal H.R. 1

Governor Jared Polis

OSBF Director Mark Ferrandino

Thursday, August 28, 2025

Changes to federal tax policy in H.R. 1 are immediate and significant with a \$1.2B negative impact to state revenues in FY 2025-26. The impacts on state expenditures from reduced federal funds starts small and grow over time with the largest impact in the out years growing to nearly \$1B.

TABOR surplus and budget balancing compared to OSPB June Forecast

Updated TABOR Surplus Estimates following H.R. 1. in \$M

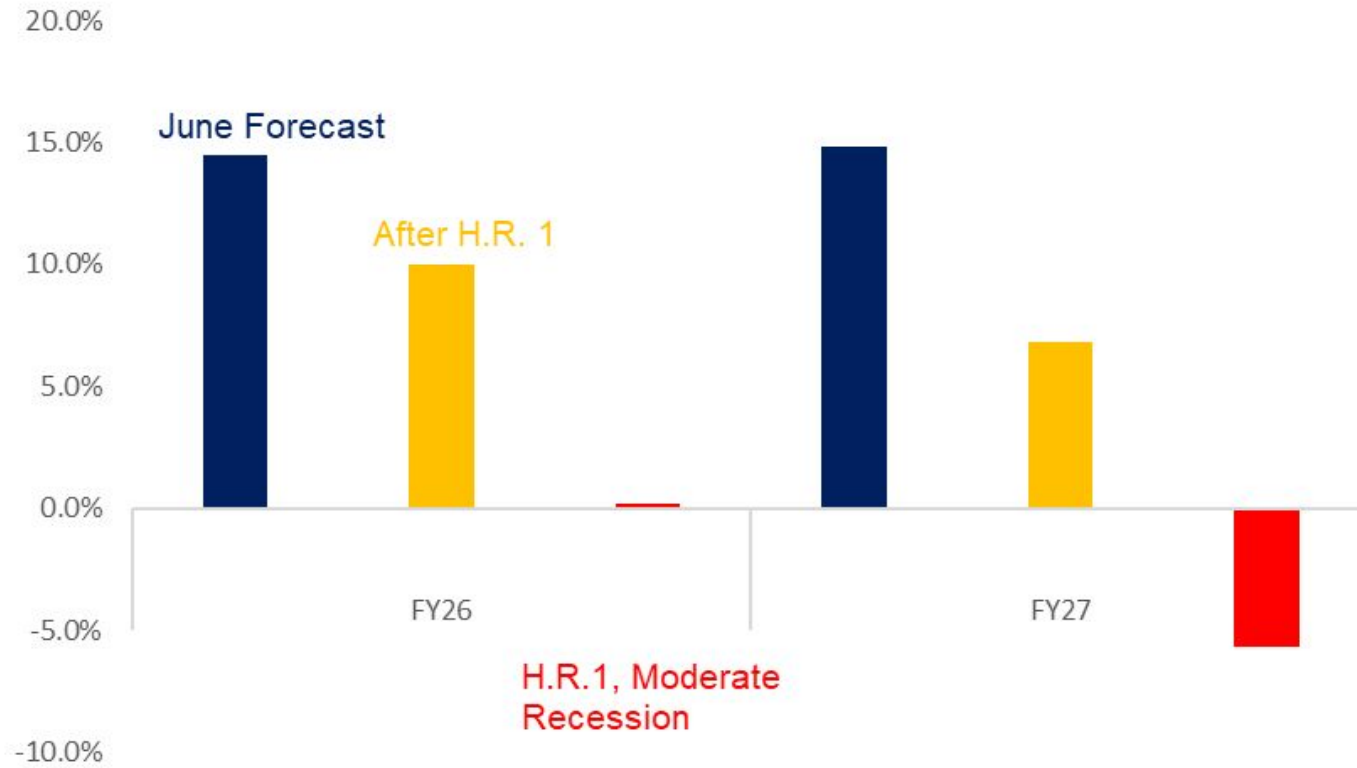
(\$millions)	FY 2024-25	FY 2025-26	FY 2026-27
June 2025 OSPB Forecast TABOR Surplus	+\$224.0	+\$289.0	+\$536.4
H.R. 1 Federal Tax Policy Impacts (midpoint)	\$0	-\$1,203	-\$679
<i>GF Impacts from H.R. 1</i>	<i>\$0</i>	<i>-\$1,031.2</i>	<i>-\$612.8</i>
<i>Impacts to SEF/123 Diversions from H.R. 1</i>	<i>\$0</i>	<i>-\$171.8</i>	<i>-\$66.2</i>
Change in FATC/EITC Triggers from June Forecast	\$0	\$0	+\$487.8
Updated TABOR Surplus Estimate w/ impact of H.R. 1 (GF non-exempt only)	+\$283.2*	-\$742.2	+\$411.4

*Updated TABOR surplus estimate for FY 2024-25 includes June revenue actuals received after the June 2025 forecast publication.

- In the June forecast, the General Fund in FY 2025-26 was estimated to be in a deficit position of \$40.9M (0.2% drop in reserve). This estimate would have likely led to a balanced budget after considering reversions, which are ~\$80M in a 'normal' year. Due to revenue impacts from H.R. 1, **FY 2025-26 is now projected to be in a deficit position of \$783.1M,** after combining the prior position with \$742.2M less GF retained by the state
- Family Affordability (FATC) and Expanded Earned Income (EITC) tax credits were assumed to be fully available in Tax Year 2027 in the June forecast, but the revenue loss from H.R. 1 turns these off.

After incorporating H.R. 1's impacts, there is not sufficient reserve to cover a moderate recession

Reserve as a Share of GF Appropriations



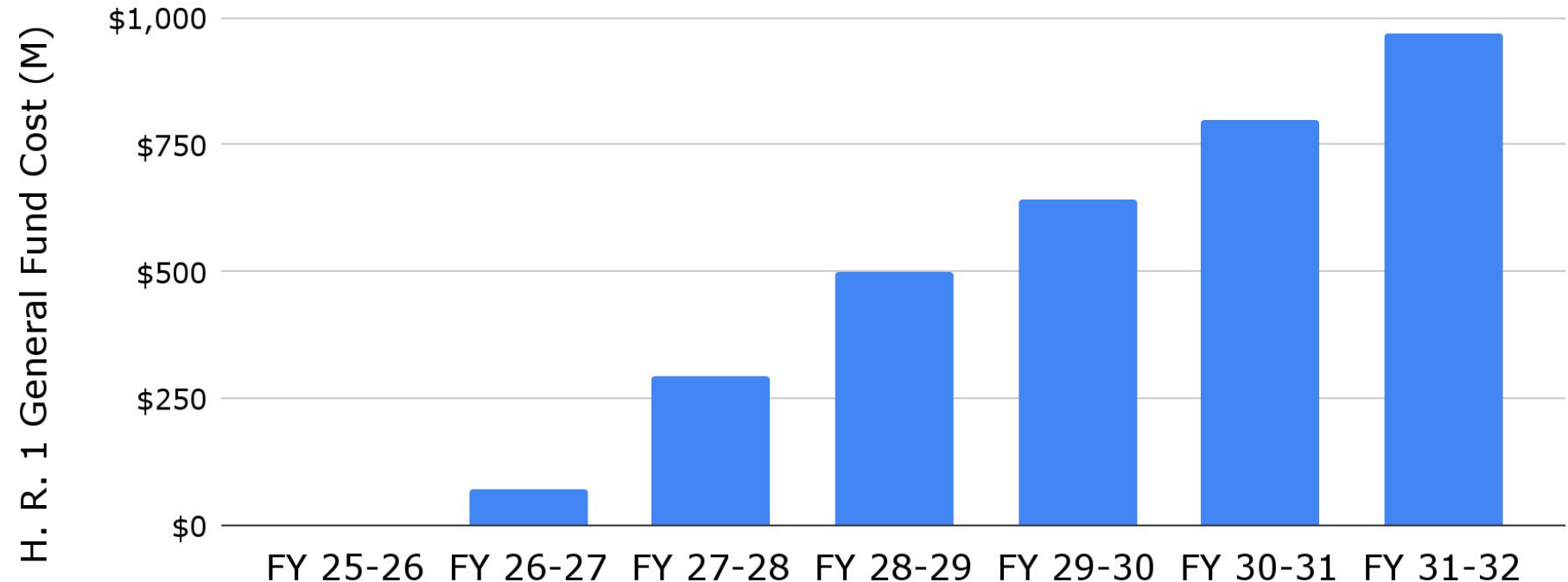
- OSPB estimates that the revenue impacts of H.R. 1 results in an estimated 10.0% reserve in FY26 and 6.8% in FY27 if no actions are taken to address impacts.
- Sufficient reserve is needed in case of a downturn in the economy. In the June forecast, OSPB estimated a 50% chance of a recession. Additionally in June, OSPB provided a moderate recession scenario with a 25% chance of occurring that would lower the reserve by \$1.6B this FY.
- Therefore, under a moderate recession, the remaining 10.0% reserve in FY26 would be required to cover the revenue shortfall this year.

H.R. 1 Ongoing Budget Impacts

This table shows growing costs due to H.R. 1.

Largest costs are:

- SNAP Match and Administration
- HCPF Work Requirements and 6 month Eligibility
- Assumed backfill of Hospital Provider Fee



Other known impacts to FY 2025-26 Budget

- HCPF Overexpenditure, \$43.5M net after \$21.5M reversion. Main drivers are long term services and supports, including
 - Home and Community-Based Services (HCBS) Waivers
 - Long Term Home Health
- HCPF/DHS H.R. 1 costs, \$3.3M
- Combined with the \$783.1M, the new amount below the 15% reserve is expected to be \$829.9M
- In addition, we expect \$10-20M in September 1331 from three different agencies (DOC, DPA and CDPHE)

Balanced approach that implements fiscal solutions, spending reductions and measured use of the reserve to address the FY 2025-26 Budget Shortfall Due to Federal H.R. 1

Special Session Actions

- Fiscal Impacts, not including income diversions, total \$245.2M:
 - [HB25B-1001](#) Qualified Business Income Deduction Add-Back (\$41.4M)
 - [HB25B-1002](#) Corporate Income Tax Foreign Jurisdictions (\$32.1M)
 - [HB25B-1003](#) Insurance Premium Tax Rate for Home Offices (\$44.1M)
 - [HB25B-1004](#) Sale of Tax Credits (total \$200M in sales, with \$100M support to the GF)
 - [HB25B-1005](#) Eliminate State Sales Tax Vendor Fee (\$27.6M)
- After special session actions, the revised amount below a 15% reserve is \$584.7M

Basis for Spending Reduction Decisions

- Consider previously proposed reductions
- Analyze FY 2026-27 Department savings proposals
- Realize savings from expected reversions due to lower spending
- Preserve K-12 education and public safety funding
- Assess short and long term impacts
 - Focus on addressing immediate shortfall
 - Continue progress on long term structural issues
- Limit reserve usage to no more than 2%
 - Enable pay back over a number of years
 - Limit significant budget pressure beyond that caused by H.R. 1

Transfers and Cash Fund Impacts

OSPb will submit supplemental budget requests to the Joint Budget Committee for a total of \$146.7M in cash fund transfers to the General Fund

OEDIT \$105M Proposition 123 Transfer

- OSPB and LCS July interim presentations to the legislature project FY 2025-26 state revenues below the TABOR cap
 - Voter approved measure language allows for a reduction in the income diversion amount when state revenues are below the TABOR cap
 - Current statute 29-32-104 (5) allows for a reduction in FY 2025-26 only if the LCS March 2025 forecast for FY 2025-26 is below the TABOR cap; given the unforeseen H.R. 1 impacts the Governor recommends expanding statute for the trigger language to account for other changes in expectations
- OSPB forecasts a \$307.7M FY 2025-26 Prop 123 diversion, of which \$184.6M would be OEDIT's share (before the transfer) to expend in FY 2026-27
- After the transfer, the \$79.6M remaining for OEDIT to expend towards Prop 123 goals will be tailored towards maximizing federal match dollars, housing tax credits, and ensuring we hold gap financing opportunities harmless

Transfers to the General Fund

- OEDIT
 - \$4M from CLIMBER (Colorado Loans to Increase Mainstreet Business Economic Resiliency).
 - CLIMBER is a COVID era small business revolving loan recovery program that has focused on funding small businesses. The Small Business Recovery and Resiliency Fund has additionally begun to support affordable housing projects in coordination with CHFA. Sufficient unencumbered fund balances amounting to \$4M are available to sweep to support GF deficit.

Transfers to General Fund

- CDHE \$9.2M from College Invest due to fund balance that exceeds demand
- CDLE \$5M from the Disability Support Fund due to revenues and fund balance that exceeds spending authority
- CDPHE
 - \$3.0M from the Mobile Home Park Water Quality Fund due to available fund balance without impact to current year operations
 - \$4.0M from the Community Impact Cash Fund due to balance and growing annual revenues that exceed spending authority and change in waterfall from 80% to 100% on July 1, 2025 that will increase revenues even more
 - \$4.0M from the School and Child Care Clean Drinking Water Fund, leaving \$10M available for completion of current program and potential expansion

Transfers to General Fund

- DOLA \$3.3M from the Local Government Severance Tax Fund due to increase in FY 2024-25 severance tax revenues
- DNR
 - \$1.7M from the Severance Tax Perpetual Base Fund due to increase in FY 2024-25 severance tax revenues
 - \$1.7M from the Severance Tax Operational Fund due to increase in FY 2024-25 severance tax revenues
- HCPF \$0.5M from MTCF due to $\frac{1}{3}$ reductions of SBIRT training grants for screenings related to substance use
- Statewide \$5.4M from the Refinance Discretionary Account of the ARPA Refinance State Money Cash Fund (originally \$15.4M held for balancing before [HB25B-1006](#) used \$10M for HIAE)

Spending Reductions

OSPB will submit supplemental budget requests to the Joint Budget Committee for a total of \$105.5M to reflect the Executive Orders

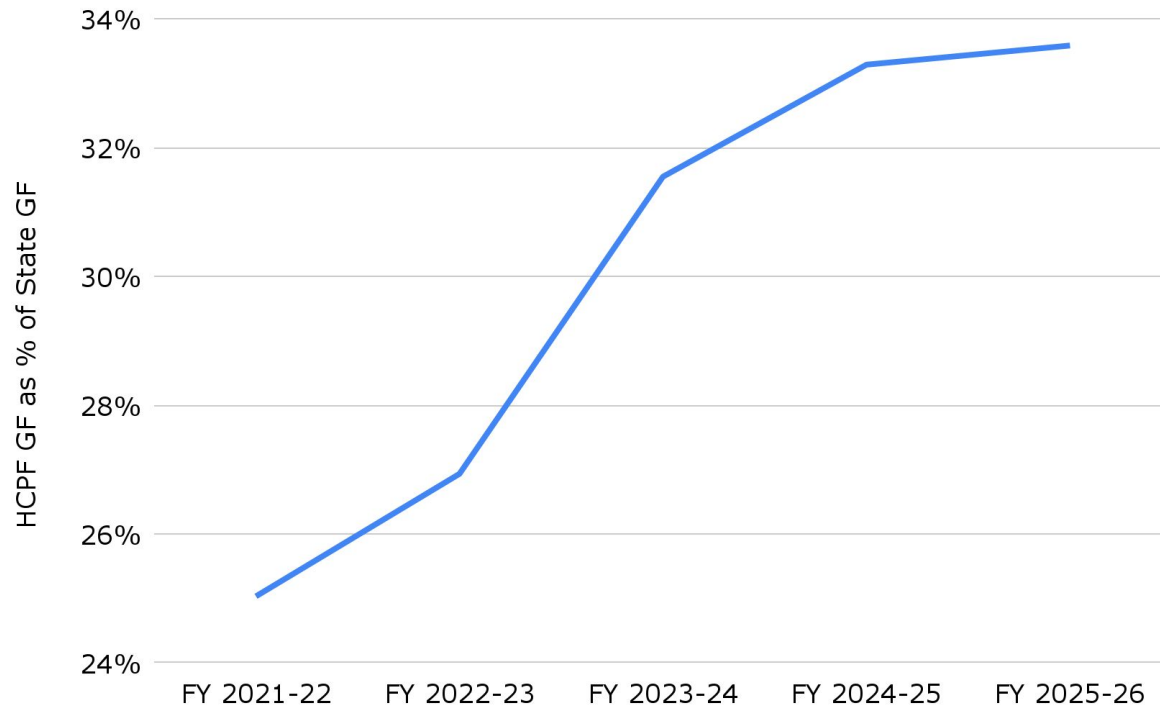
FY 2025-26 GF Reduction Plan by Agency

Department	Pre Special Session Growth % (24-25 vs 25-26)	Post Executive Order Growth %	Decrease from FY 2025-26 Appropriations
DOLA	-12.76%	-12.91%	-0.17%
CDPHE	-5.83%	-9.20%	-3.58%
DOR	-2.20%	-2.61%	-0.41%
CDHE	-0.59%	-1.34%	-0.76%
DHS	0.93%	0.80%	-0.13%
DOC	1.11%	0.76%	-0.34%
HCPF	7.10%	5.59%	-1.42%
Total Executive Branch (Under Governor Control)	3.47%	2.79%	-0.66%

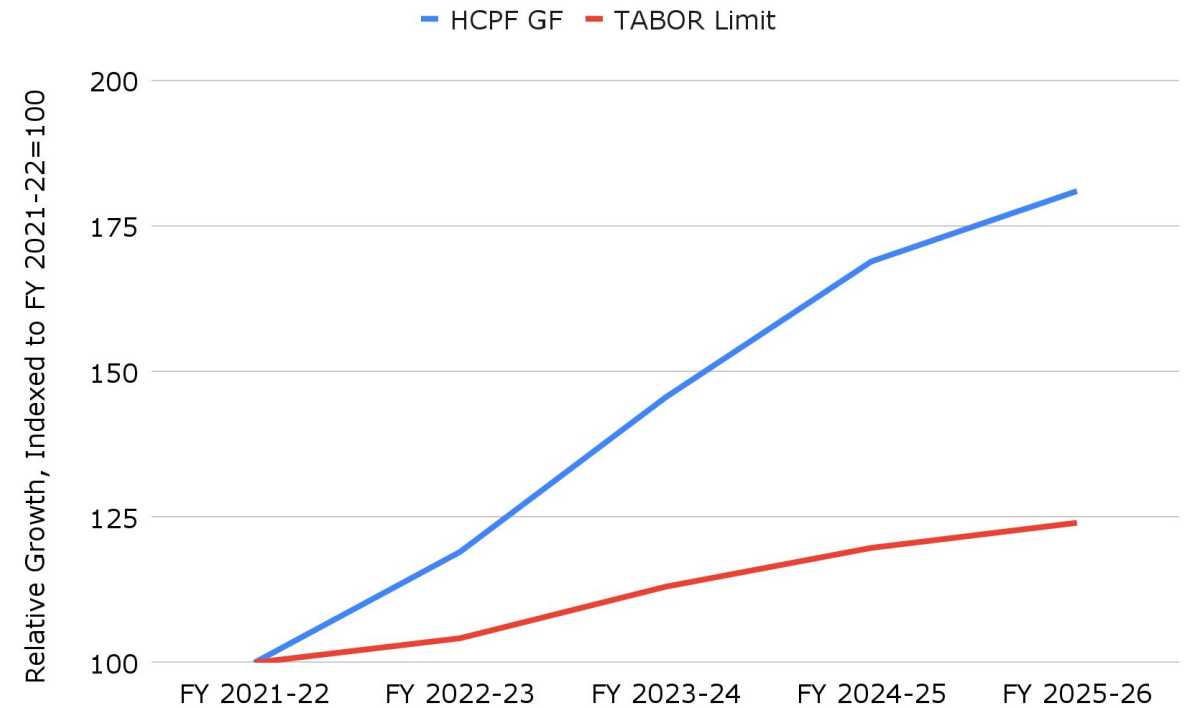
- CDHE negative -0.59% Pre Special Session Growth reflects a relocation of the State Forest Service budget lines to DNR, an one-time reduction in COP payment obligations of \$4.4M and an one-time annualizing out of a technical one-time appropriation of \$30M for H.B. 23-1246 Support In Demand Career Workforce program.

Health Care Policy & Financing Growth

HCPF GF Accounts for a Growing Proportion of State GF



HCPF GF is Growing Substantially Faster Than the TABOR Limit



Health Care Policy & Financing Reductions

Reductions in provider rates and payments

- \$38.3M reduction by maintaining FY 2024-25 provider rates by rolling back the 1.6% across-the-board provider rate increase for FY 2025-26
 - Other states are reducing their Medicaid provider rates
 - Idaho will reduce reimbursement rates by 4% next week
 - North Carolina will cut rates by 3% for all providers, with some receiving 8-10% cuts, and eliminate some services altogether, effective Oct 2025
- \$3.8M reduction in incentive payments for Accountable Care Collaborative and Behavioral Health incentives
- \$3.0M reduction by adjusting Community Connector rate, consistent with similar services

Health Care Policy & Financing Reductions

Reductions in provider rates and payments (cont.)

- \$4.4M reduction by eliminating the nursing facility min wage payment supplemental
 - The supplemental payments were intended to address low prevailing wages, but they are not necessary due to increases in the prevailing minimum wage and will be underspent.
- \$1.5M reduction in Access Stabilization Payments
- \$2.5M reduction by shrinking the FY 2024-25 dental provider rate increase by 43.6%.
- \$2.7M reduction to adjust rates for pediatric behavioral therapy (PBT)
 - Updates the benchmark analysis to include other states' current rates
 - Rates are adjusted to 95% of the benchmark rate
 - PBT spending is running at 30% annual growth
 - PBT for 6,000 children for FY 2024-25 exceeds spending for ER visits for ~400,000 members.

Health Care Policy & Financing Reductions

Cost Containment strategies to curb potential overuse of services and align with best practice:

- \$6.1M reduction by restoring Prior Authorization Requests (PARs) for outpatient psychotherapy for services that exceed clinical best practices
 - Significant 17% increase in utilization when PARs were eliminated
- \$1.7M reduction by limiting Definitive Drug Testing to 16 tests per year; additional testing will require PARs
- \$7.0M reduction by implementing pre- and post-claim review of all pediatric autism behavioral therapy codes
 - Dramatic utilization growth and OIG audit raises significant risk of federal clawbacks
 - Review providers and claims to ensure providers are credentialed and licensed and services are necessary and appropriate

Pediatric Behavioral Therapies (PBT/ABA)

Clawbacks are expected, including for Colorado, after Office of Inspector General (OIG) National PBT/ABA provider audit release this fall.

Drivers:

- Private equity provider behavior
- Requiring minimum patient hrs/wk (ie: 20 to 40 hrs)
- Billing for uncredentialed providers, naps, playtime
- Copying Electronic Health Record (EHR) entries from patient to patient, fake work billings

Potential Solutions:

- Policy & benefit design changes
- Address private equity behavior
- Advancing prior auth criteria
- Pre & post payment review
- Provider medical record audits
- Rollback of rate increases
- Additional fraud referrals

306%

increase in paid amount between FY 2018-19 and FY 2023-24; +61% paid trend/yr. +30% PMPM trend/yr.

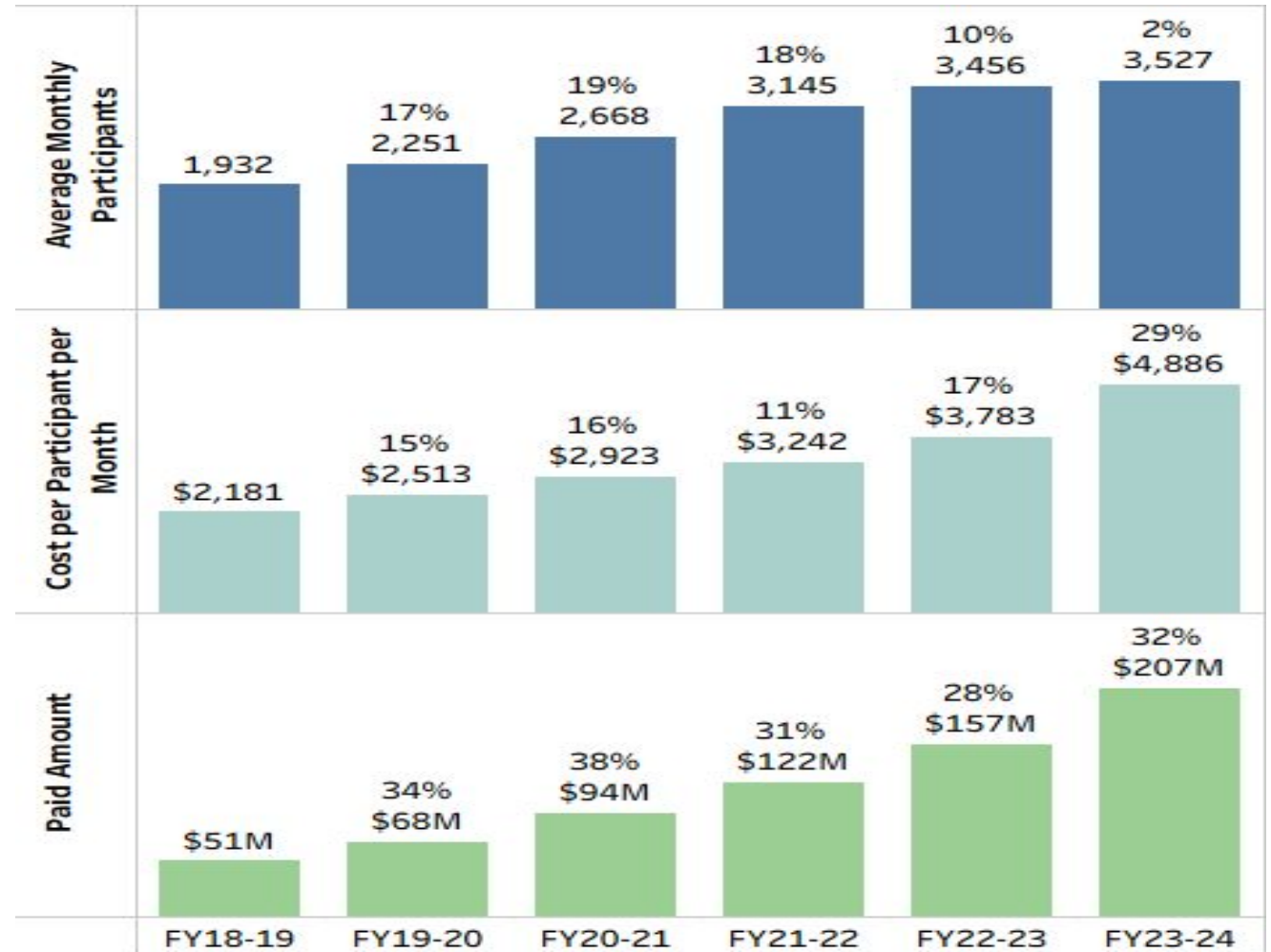


EXHIBIT 5, 21 of 30

Health Care Policy & Financing Reductions

Additional reductions

- \$5.6M reduction by eliminating Continuous Coverage for children to age 3
 - CMS has indicated it will not provide federal match and will not approve or review 1115 waiver
- \$1.45M reduction in Individual Residential Services and Supports (IRSS) rates to align with host home rate
- Additional, smaller cuts amount to \$0.6M

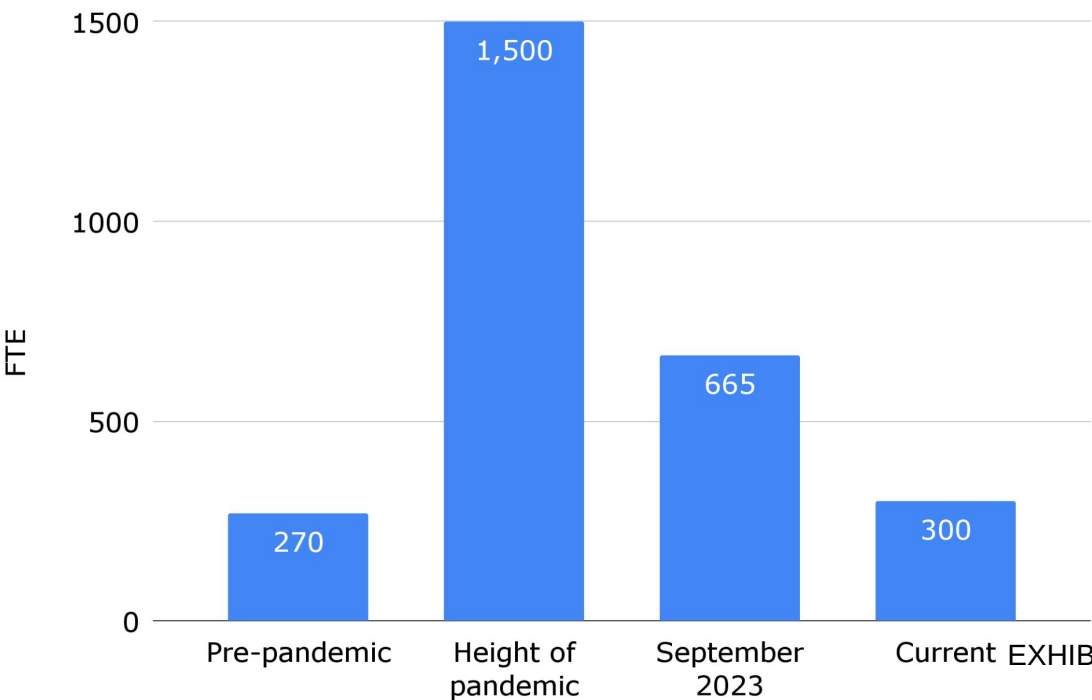
Higher Education (CDHE) Appropriation Reductions

- \$9.5M (30%) reduction to the FY 2025-26 operating increase for Governing Boards, Special Education Programs (SEP), Area Technical Colleges (ATC) and Local District Colleges (LDC).
 - \$7.5M total operating cut across Governing Boards
 - \$1.5M total cut to SEP
 - \$0.2M total cut to LDC
 - \$0.1M total cut to ATC
- \$3.2M (50%) reduction to limited purpose Fee for Service (FFS) programs
 - Improve Healthcare Access for Older Coloradans
 - Career and Technical Education and Apprenticeship Alignment
 - Career Pathways
 - Food Systems Advisory Council
 - Support Educator Workforce
 - Cybercoding Cryptology
 - Rural Healthcare Track

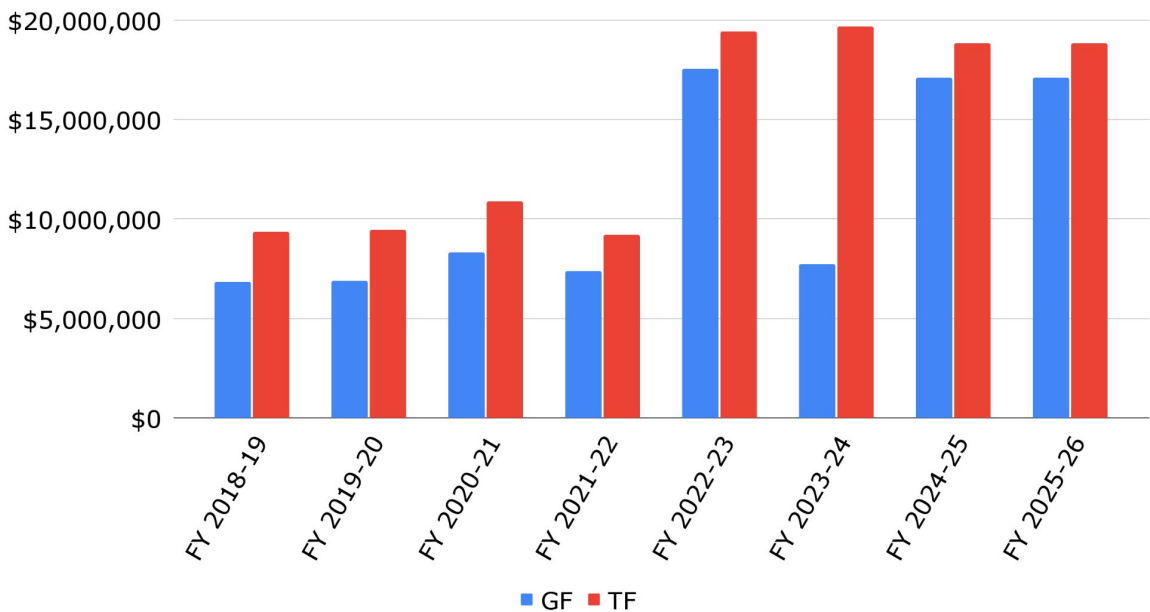
Public Health & Environment (CDPHE) Reductions

- \$2.0M appropriation reduction to Health Disparities Grants, which results in a \$4.3M total fund appropriation
- \$3.0M appropriation reduction to Distributions to Local Public Health Agencies, leaving \$15.8M, which is well above pre-pandemic levels and is well below reductions to DCPHR since the pandemic

Disease Control and Public Health Response (DCPHR)



Long Bill Distributions to Local Public Health Agencies (LPHA)



Other Appropriation Reductions

- DOC \$3.7M adjustment to right-size Transgender Healthcare appropriation based on actual spending and anticipated future need with no cut to services.
- CDHS \$1.7M reduction to mental health hospitals. These costs can be supported by existing patient revenue.
- DOR \$0.6M in total administrative cost reductions (Executive Director's Office and DMV operating expenses) that can be absorbed by the department without impact to programs
- DOLA \$0.1M adjustment to reflect lower need for Payments to OIT appropriation as building and modernizing work transitions to operations and maintenance

Balancing Actions Summary

Summary of Balancing Actions

Summary of Balancing Actions (\$ Million)	
Starting Position	-\$40.9
HR 1	-\$742.2
HR 1 Administrative Expenses	-\$3.3
HCPF Over-expenditures	-\$43.5
Total Deficit	-\$829.9
Fiscal	\$245.2
Cuts & Balancing	\$252.2
Reserve Impact of Cuts	\$15.3
Total Balancing Actions	\$512.7
Remaining	-\$317.2
Reserve Adjustment	\$328.7
Final Position	\$11.6

Note: Money in excess of 13% reserve being held for expected September Emergency 1331s

By making spending cuts in FY 2025-26, this leads to ongoing savings in FY 2026-27 to help reduce the budget hole created largely by H. R. 1 reduced revenue collections and the need to cover homestead with GF in FY 2026-27.

Questions?



Thank You

www.colorado.gov/OSPb



DATE FILED
September 30, 2025 2:58 PM
FILING ID: 8EFF9D5FE57BE
CASE NUMBER: 2025CV33489

EXHIBIT 6

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid
Services 7500 Security Boulevard, Mail
Stop S2-26-12
Baltimore, Maryland 21244-1850



SHO # 24-005

**RE: Best Practices for Adhering to Early
and Periodic Screening, Diagnostic, and
Treatment (EPSDT) Requirements**

September 26, 2024

Dear State Health Official:

The Centers for Medicare & Medicaid Services (CMS) is committed to improving health outcomes for children and youth enrolled in Medicaid and the Children's Health Insurance Program (CHIP) by working with states as they comply with the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirements.¹ This letter, along with regular technical assistance webinars and planned future guidance for states, is intended to provide states with the information they need to meet EPSDT requirements.² CMS will be working with all states to ensure adherence to these requirements.

Executive Summary

The EPSDT requirements are a cornerstone of the Medicaid program and ensure robust health coverage for children. Children enrolled in Medicaid and eligible for EPSDT are entitled to services that can be covered under EPSDT rules. The goal of EPSDT is to ensure that individual eligible children get the health care they need, when they need it, in the most appropriate setting. Section 1905(a)(4)(B) and (r) of the Social Security Act (the Act) entitles eligible children under the age of 21 to Medicaid coverage of health care, diagnostic services, treatment, and other measures described in section 1905(a) that are medically necessary to correct or ameliorate defects and physical and mental illnesses and conditions, whether or not such services are

¹ Children eligible for EPSDT generally include beneficiaries under the age of 21 enrolled: in Medicaid through a categorically needy group; in Medicaid through a medically needy group in a state that has elected to include EPSDT in the medically needy benefit package; in a Medicaid-expansion CHIP program; or in a separate CHIP program that has elected to cover EPSDT. This includes beneficiaries with an institutional level of care who are eligible for Medicaid by virtue of their enrollment in a home and community-based services (HCBS) waiver under section 1915(c) of the Social Security Act. EPSDT is not available to beneficiaries without satisfactory immigration status who are eligible only for treatment of an emergency medical condition and other groups of individuals under age 21 who are eligible only for limited services as part of their Medicaid eligibility, such as, for example, family planning services.

² This communication was printed, published, or produced and disseminated at U.S. taxpayer expense.

covered under the state plan.³ States will not be able to comply with the EPSDT requirements unless their Medicaid policies and procedures, including medical necessity criteria, prior authorization requirements, and Medicaid fair hearings, reflect consideration of this EPSDT obligation, which creates a higher standard of coverage for eligible children than for adults.⁴ States are also required to perform specific administrative duties, such as informing eligible beneficiaries of the availability of EPSDT, submitting annual reports to CMS, and ensuring the availability of providers who are qualified and willing to deliver services under EPSDT.⁵

CMS and the states have a unique partnership in operating Medicaid and CHIP: CMS ensures that states meet federal requirements, but federal law also gives states options for implementing their Medicaid and CHIP programs in a manner tailored to their communities' needs. As of May 2024, 38 million children were enrolled in Medicaid and CHIP.⁶ Additionally, as of the date of this letter, 16 states with a separate CHIP have elected to cover a package of services that adhere to Medicaid EPSDT requirements for beneficiaries who are enrolled in a separate CHIP.⁷ Children covered through a Medicaid expansion CHIP are entitled to EPSDT.⁸

Section 11004 of title I of division A of the Bipartisan Safer Communities Act (BSCA) requires the Secretary of Health and Human Services (HHS) to issue guidance to states on EPSDT Medicaid coverage requirements “that includes best practices for ensuring that children have

³ While babies, children, adolescents, and youth may have distinct health care needs, throughout this document, CMS uses “child” and “children” to describe all EPSDT-eligible beneficiaries under the age of 21. In those instances where a policy, strategy, or best practice is specific to a subset of EPSDT-eligible individuals under the age of 21, we specifically identify and define those individuals. Additionally, for minor beneficiaries, the involvement of parents, legal guardians, and other caregivers is often necessary to ensure access to benefits. When we refer to a child’s family, that term is meant broadly to include all persons who would be considered a child’s family under applicable law.

⁴ Medicaid “fair hearings” are also sometimes colloquially called appeals. In this document, we will use the term “fair hearing” to refer to the request that individuals can make when they disagree with an action taken by the state. See 42 C.F.R. part 431, subpart E and more detail below at subsection “iv. Ensuring Consideration of EPSDT in States’ Medicaid Policies and Procedures” in “I. Promoting EPSDT Awareness and Accessibility.”

⁵ Section 1902(a)(43)(A) and (D) of the Act, and 42 C.F.R. §§ 441.56(a) and 441.61(b).

⁶ According to the CMS May 2024 Enrollment Trends Snapshot, approximately 38 million children were enrolled in Medicaid and CHIP. For the purposes of these data, “children” represents the number of children enrolled in the Medicaid program and the total enrollment for separate CHIP programs as of the last day of the reporting period. The data are limited to only those individuals who are eligible for comprehensive benefits (e.g., emergency Medicaid, family planning-only coverage, and limited benefit dual eligible individuals are excluded). States use the definition of “child” as included in the state’s Medicaid state plan in reporting performance indicator data to CMS, and these definitions vary from state to state. See: <https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/downloads/may-2024-medicaid-chip-enrollment-trend-snapshot.pdf> and <https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html>.

⁷ Optional coverage of EPSDT services in separate CHIPs reflects all Medicaid EPSDT requirements, including coverage of all section 1905(a) services. As of the date of this letter, 16 states elect the option to provide EPSDT in a separate CHIP. Of these 16 states, 10 states cover EPSDT for all separate CHIP-enrolled individuals: Arizona, Georgia, Idaho, Kansas, Louisiana, Maine, Oklahoma, Rhode Island, South Dakota, and Wisconsin. The other 6 states cover EPSDT for some but not all separate CHIP-enrolled populations: California, Massachusetts, Minnesota, Missouri, New Jersey, and Washington.

⁸ 42 C.F.R. § 457.70(c)(2).

access to comprehensive health care services, including children without a mental health or substance use disorder (SUD) diagnosis.”⁹

To meet this directive, CMS completed an extensive document review of state EPSDT beneficiary-informing materials, state provider manuals, and managed care contracts, including looking for examples of optimal EPSDT implementation. CMS also considered internal and external EPSDT subject matter expertise, the relevant academic literature, data from and evaluations of CMS programs, and feedback from parents and other caregivers of EPSDT-eligible children, as well as other interested parties.

This guidance is intended to provide an overview of EPSDT requirements and how states can meet the goal of EPSDT: the right care, to the right child, at the right time, in the right setting. The guidance discusses policies, strategies, and best practices to maximize health care access and utilization for EPSDT-eligible children. It is divided into three broad topics:

- **Promoting EPSDT awareness and accessibility** to ensure eligible beneficiaries have comprehensive coverage, are aware of their coverage, know how to access Medicaid benefits, and have supports like transportation and care coordination to facilitate getting the care that they need.
- **Expanding and using the child-focused (EPSDT) workforce** by broadening provider qualifications, using telehealth, encouraging the use of interprofessional consultation, and using payment methodologies to address provider shortages and to help assure that there are an adequate number of health care providers available to meet the needs of beneficiaries.
- **Improving care for EPSDT-eligible children with specialized needs**, with a particular focus on how EPSDT requirements relate to the unique needs of children with behavioral health conditions, children in foster care, and children with disabilities or other complex health needs.¹⁰

Each section of the guidance summarizes federal requirements, followed by strategies and best practices to support states’ implementation of those requirements. CMS recognizes that what works in one state may not be feasible in another; we are not requiring states to adopt best practice examples, nor are the best practice examples exhaustive. However, these best practices have proven to be effective avenues utilized by states to comply with EPSDT requirements and we encourage states to consider adopting, as appropriate, the strategies and best practices in this guidance to help improve care and health outcomes for children. For comprehensive information about EPSDT requirements, please refer to *EPSDT – A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents*.¹¹

⁹ Pub. L. 117-159.

¹⁰ Throughout the letter, we use the term “behavioral health conditions” to encompass mental health conditions and substance use disorders.

¹¹ See: <https://www.medicaid.gov/medicaid/benefits/downloads/epsdt-coverage-guide.pdf>.

States have the option of delivering some or all section 1905(a) services through managed care plans (MCP), a state-administered fee-for-service system, or a combination of delivery systems.¹² Regardless of how significant the MCPs' role may be in administering EPSDT, the state retains ultimate responsibility for assuring compliance with EPSDT requirements.

Many children enrolled in Medicaid and CHIP also receive services through other federally funded programs, and state Medicaid agencies may partner with other state agencies to ensure that children's needs are met. States utilizing such an approach must follow federal administrative claiming rules regarding claiming Federal Financial Participation (FFP) for administrative expenditures subject to section 1903(a) of the Act.¹³ States must also adhere to appropriate cost allocation requirements and coordination of benefits requirements.^{14, 15}

CMS is committed to supporting states as they work to ensure they meet EPSDT requirements. CMS will continue to host regular technical assistance webinars for states, and we encourage states to reach out with questions or tailored assistance requests by emailing the EPSDT mailbox at EPSDT@cms.hhs.gov.

¹² The term "managed care plan," when utilized in this document, refers to Medicaid-participating Managed Care Organizations (MCO), Prepaid Inpatient Health Plans (PIHP), and Prepaid Ambulatory Health Plans (PAHP).

¹³ See: <https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD122094.pdf>.

¹⁴ Subpart E of 45 C.F.R. Part 95.

¹⁵ Section 1902(a)(25)(A) of the Act.

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Overview of EPSDT Requirements

EPSDT requirements were added to the Act in 1967 and have been strengthened and amended since first enacted. Sections 1902(a)(43) and 1905(r) of the Act and the implementing regulations require states to inform eligible beneficiaries or their families about the availability of EPSDT; cover screening, diagnostic, and treatment services; and report to CMS a variety of information about the services provided each year.¹⁶ Section 1905(r) of the Act entitles eligible children to a comprehensive array of prevention, diagnostic, and treatment services. Well-child visits, referred to in statute as screening services, are the foundation of EPSDT coverage and are a crucial entry point for identifying concerns and conditions that require follow-up care. These visits are intended to be comprehensive and include age-appropriate screenings, referrals to diagnostic and specialty services, and referrals to establish ongoing dental, vision, and hearing care. States are required to develop or adopt a schedule of recommended screenings; most states have adopted the Bright Futures periodicity schedule developed by the American Academy of Pediatrics (AAP) or a modified version thereof.¹⁷ All states are required to provide coverage of appropriate immunizations to EPSDT-eligible children according to the pediatric vaccine schedule established by the Centers for Disease Control and Prevention (CDC).¹⁸ Each state is also required to develop or adopt a dental periodicity schedule in consultation with recognized dental organizations involved in child health.

EPSDT-eligible children may require diagnosis and treatment of an illness or condition that was not present during, or was identified outside of, a well-child visit. States are required to cover comprehensive services, including all services that could be covered under section 1905(a) of the Act that are needed to correct or ameliorate health conditions for EPSDT-eligible children. For example, if an EPSDT-eligible child has an ear infection, a broken arm, a vision change, or a mental health episode, the state must cover medically necessary section 1905(a) services from a qualified provider to correct or ameliorate the condition, regardless of whether the condition was present and identified during a well-child visit.

Furthermore, CMS interprets the “correct or ameliorate” requirement to mean that a service need not cure a condition in order to be covered under EPSDT as a medically necessary service. Services that maintain or improve a child’s current health condition are also covered under

¹⁶ See 42 C.F.R. § 441.56.

¹⁷ The Bright Futures program is funded by the Health Resources and Services Administration (HRSA) through a five-year cooperative agreement with the AAP and creates and shares clinical national guidelines for pediatric well-child visits for children birth through the age of 21. See: <https://mchb.hrsa.gov/programs-impact/bright-futures>.

¹⁸ Under section 1905(r)(1)(B)(iii) of the Act, states must cover, for beneficiaries under age 21 who are eligible for EPSDT services (including beneficiaries enrolled in Medicaid-expansion CHIPs who are eligible for EPSDT), appropriate immunizations (according to age and health history) on the CDC Advisory Committee on Immunization Practices (CDC/ACIP) pediatric immunization schedule (which identifies CDC/ACIP recommended vaccines for those through age 18). Consistent with section 1905(r)(5) of the Act, other vaccinations recommended by ACIP and non-ACIP-recommended vaccines and vaccine administration are covered for beneficiaries eligible for EPSDT, if the service is determined to be medically necessary for the beneficiary based on an individualized assessment and state medical necessity criteria. For more information, including on Inflation Reduction Act mandated Medicaid coverage of vaccinations for EPSDT-eligible beneficiaries ages 19 and 20, see the *Coverage and Payment of Vaccines and Vaccine Administration under Medicaid, the Children’s Health Insurance Program, and Basic Health Program* toolkit, available at: <https://www.medicicaid.gov/medicaid/quality-of-care/downloads/vacines-coverage-payment.pdf>.

EPSDT because they “ameliorate” a condition; they prevent a condition from worsening or prevent development of additional health problems. Thus, services such as physical and occupational therapy, for example, are covered when they have an ameliorative, maintenance purpose.

States have the option of delivering some or all section 1905(a) services through MCPs, a state-administered fee-for-service (FFS) system, or a combination of delivery systems. No one delivery system is favored over another, but states must ensure they adhere to EPSDT requirements regardless of the delivery system(s) being utilized. When states use MCPs to deliver some or all EPSDT benefits, states must clearly delineate the MCPs’ responsibilities in the managed care contract to help ensure that the MCPs understand the full scope of their obligations under EPSDT. States must monitor and oversee MCPs and must have mechanisms in place to hold MCPs accountable for fulfilling all contracted responsibilities. Regardless of how significant an MCPs’ role may be in administering EPSDT, the state retains ultimate responsibility for assuring compliance with EPSDT requirements.¹⁹

EPSDT requires that states cover services described in section 1905(a) of the Act when they are medically necessary for an EPSDT-eligible child. These services must be covered “whether or not such services are covered under the state plan.”²⁰ CMS interprets this to mean that, if an optional 1905(a) service is not covered for adults, the 1905(a) service must still be made available to EPSDT-eligible children when it is medically necessary. Section 1905(a) of the Act describes a variety of mandatory services (e.g., physician, hospital, and laboratory and x-ray services) and optional services (e.g., prescription drugs, personal care services, and rehabilitative services).²¹ States must ensure EPSDT-eligible children have access to the full range of coverable services enumerated in section 1905(a) regardless of whether they are mandatory or optional and assure that the children’s families and caregivers are aware of and have access to those services to meet an individual child’s needs.

A comprehensive array of services has long been statutorily required under EPSDT, which ensures that eligible children can access a child health benefit package that meets their individual needs. Available services for EPSDT-eligible children must not be limited to those that are convenient for the state to cover simply because they are aligned with services typically available for adults. For example, states must cover a range of behavioral health services that meet the assessed needs of an EPSDT-eligible child and not rely solely on inpatient and counseling services as sufficient to meet the requirements of EPSDT. States must adhere to EPSDT requirements, which create a higher standard of coverage for eligible children than adults, when administering their Medicaid programs.

¹⁹ See e.g., section 1932(e)(1)(a) of the Act, Section 1902(a)(4) of the Act, 42 C.F.R. §§ 438.66 (requiring states to have monitoring systems for their managed care programs), 438.206 (requiring states to ensure that all services covered under the state plan are available and accessible to MCP enrollees), 438.210 (requiring managed care contracts to identify, define and specify the benefits to be covered by the plan) and 438.700 (sanctions for noncompliance).

²⁰ Section 1905(r)(5) of the Act.

²¹ Section 1902(a)(10) of the Act identifies whether services listed in 1905(a) are mandatory or optional.

States will not be able to comply with EPSDT requirements unless they consider these requirements when establishing medical necessity criteria, setting prior authorization requirements, and conducting Medicaid fair hearings. Furthermore, states cannot ensure compliance with EPSDT requirements unless they have processes in place to oversee, verify, and enforce these requirements, regardless of whether services are delivered through FFS or managed care.

EPSDT Policies, Strategies, and Best Practices to Maximize Health Care Access and Improve Health Outcomes

States implement EPSDT in varying ways due to different Medicaid program designs, payment methodologies, delivery systems, and state licensure laws and regulations. To better understand how states are operationalizing EPSDT requirements, CMS conducted a thorough review of states' EPSDT beneficiary-informing materials, provider materials, and state managed care contracts; held listening sessions with interested parties, including state Medicaid agencies, parents and other caregivers of EPSDT-eligible children, and advocates; and reviewed various states' coverage and provision of specific EPSDT services.

In this letter, we have assembled EPSDT strategies and best practices that we identified during our research. Specifically, within various EPSDT topics and subtopics, we outline first what states are required to do under applicable federal statutes, regulations, and CMS's interpretation of the applicable statutes and regulations (collectively referred to as "policies" in this SHO); highlight strategies that states currently use to meet the federal requirements; and then describe one or more best practices (i.e., model strategies). These best practices may not apply to all states but serve to highlight parts of state programs that are notable or high performing. In many cases, a strategy or best practice is included only once in this letter (i.e., under only one topic or subtopic) but is applicable across many EPSDT topics and subtopics. Similarly, while some of the strategies and best practices we include focus on a particular type of Medicaid delivery system—either FFS or managed care—many of the strategies and best practices could be implemented by states under a FFS delivery system or by an MCP with proper state oversight. In many cases, aligning policies across delivery systems could be a best practice to promote streamlined access to care. States are encouraged to identify and implement the strategies and best practices that will have the most impact on the EPSDT-eligible children in their state.

I. Promoting EPSDT Awareness and Accessibility

Helping families and caregivers understand how their children's Medicaid coverage works and how to use their children's benefits is an important step to ensuring that children get the care they need. During listening sessions with state Medicaid agencies, parents, other caregivers of EPSDT-eligible children, and advocates, CMS heard repeatedly that some families do not fully understand the breadth of and how to access the services available to EPSDT-eligible children.²² During listening sessions, many interested parties reported that families may be asking for help for their children but may not understand what type of services or specialists to request, or where to go for help.

²² Throughout March and April of 2023, CMS held a series of listening sessions with advocates from 24 states, parents and caregivers from 18 states, and 26 state agency representatives.

States are responsible for ensuring that EPSDT-eligible children or their families are informed about EPSDT requirements, have necessary assistance with transportation and scheduling appointments when needed, receive screening and diagnostic services at appropriate intervals, and receive follow-up treatment as needed.²³ Additionally, states must ensure that their policies and procedures, such as determining medical necessity, consider EPSDT requirements and, likewise, must ensure that all EPSDT-eligible children in the state have access to the full EPSDT scope of coverage and services, even if the state contracts with an MCP to deliver some or all of the services available under EPSDT. To that end, this section describes: i. EPSDT informing requirements; ii. EPSDT requirements regarding scheduling assistance and transportation; iii. improving health care accessibility using care coordination and case management for EPSDT-eligible children; iv. considering EPSDT in states' Medicaid policies and procedures; and v. meeting requirements related to EPSDT and managed care.

i. Improving Awareness of Available Services through EPSDT Informing Requirements

Table 1: EPSDT Informing Policies, Strategies, and Best Practices

Policies	States are required to use a combination of written and oral methods to inform beneficiaries and their families about the services available to EPSDT-eligible children “generally, within 60 days of the individual’s initial Medicaid eligibility determination and in the case of families which have not utilized EPSDT services, annually thereafter.”²⁴ States must effectively make this information available to individuals who are blind or deaf, or who cannot read or understand the English language.²⁵ Many states that utilize a managed care delivery system satisfy EPSDT informing obligations by including this responsibility in their contracts with MCPs. If a state delegates informing enrollees of the EPSDT requirements to an MCP, the state’s contract with the MCP should include the specific timelines and standards required under EPSDT.²⁶ MCPs must use a state-developed model enrollee handbook to define which benefits are covered under the MCP and how to access these benefits.²⁷ In addition, the handbook must also provide information on how and where to access benefits covered by the state, including how transportation is provided to these benefits.²⁸ This required information must be provided in an accessible format, in prevalent non-English languages, and be available in alternative formats
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²³ Sections 1902(a)(43) and 1905(r) of the Act and 42 C.F.R. §§ 431.53, 441.56, and 441.62.

²⁴ Section 1902(a)(43) of the Act and 42 C.F.R. § 441.56(a)(4).

²⁵ 42 C.F.R. § 441.56(a)(3).

²⁶ The Center for Medicaid & CHIP Services (CMCS) also issued a CMCS Informational Bulletin (CIB) regarding EPSDT coverage requirements for children and youth in managed care and it includes more information about informing requirements. This CIB is available at: <https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/cib010517.pdf>.

²⁷ 42 C.F.R. § 438.10(c)(4).

²⁸ 42 C.F.R. § 438.10(g)(2)(ii).

Policies (cont.)	upon request and at no cost to the enrollee. ^{29,30} The MCP may provide this information by mail or electronically when the accessibility requirements defined in regulations are met. ³¹
Strategies	<u>Write EPSDT materials in easy-to-understand language.</u> Some states mail printed materials directly from the state Medicaid agency and post these materials on the state’s Medicaid website. This information is written in easy-to-understand language and includes an explanation of EPSDT’s “correct or ameliorate” standard in materials describing well-child, behavioral health, vision, and dental services. States are encouraged to use plain language at an easy-to-understand grade-level to communicate the breadth and depth of the EPSDT requirements, including how to access services. For example, instead of using the statutory “correct or ameliorate” language, states could use “treat or improve” or “prevent a child’s condition from getting worse.” Additionally, states are encouraged to review their practices as they relate to the national standards for culturally and linguistically appropriate services (CLAS), and states must inform families of the availability of language assistance services and offer this assistance to individuals who have limited English proficiency or other communication needs. ^{32,33}
Best Practices	<i>Use clear language in provider and family handbooks to describe the breadth of available services.</i>³⁴ States should use clear language in both their provider and family handbooks to ensure EPSDT-eligible children understand the entirety of services available under EPSDT, and that use of the EPSDT acronym is not required to request these services. For example, our review found provider handbooks that included statements such as “services are covered even if the services are not covered for adults” or “child beneficiaries are entitled to a broader scope of services than adults.” Additionally, some beneficiary-facing materials describe EPSDT as “more robust than the benefit for adults and...designed to assure that children receive early detection and care, so that health problems are averted or diagnosed and treated as early as possible.” <i>Supplement a beneficiary handbook with web-based information, social media platforms, and electronic communication.</i> In addition to mailing a

²⁹ 42 C.F.R. § 438.10(a) defines a prevalent non-English language as one determined to be spoken by a significant number or percentage of potential enrollees and enrollees that are limited English proficient.

³⁰ 42 C.F.R. § 438.10(c)-(d).

³¹ 42 C.F.R. § 438.10(a) and (c)(6).

³² 42 CFR § 435.905(b).

³³ See: <https://thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedCLASStandardsBlueprint.pdf>.

³⁴ While states are not required to use handbooks for Medicaid FFS delivery systems, states are required to use a combination of written and oral methods to inform beneficiaries and their families about the services available to EPSDT-eligible children, as noted above. As a result, some states have implemented this requirement by developing handbooks or fliers on services delivered via FFS.

Best Practices (cont.)	beneficiary handbook, social media platforms and electronic communications can be important tools to disseminate information about services available under EPSDT requirements and to engage with community members. Educational videos and targeted communications can reach Medicaid-eligible families in the community. Some states reported seeing a noticeable increase of beneficiaries responding to state-initiated social media campaigns. States and MCPs can provide text reminders to a child’s family to bring the child in for a check-up and keep contact information up to date with the state. ^{35, 36}
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ii. Providing Required EPSDT Support Services: Scheduling Assistance and Transportation

EPSDT requires that states provide supports to beneficiaries in addition to covering clinical services. For example, federal regulations require that state Medicaid agencies offer, and provide if requested, necessary assistance with scheduling appointments for, and transportation to, services, as well as coordination with related programs, which is discussed in “*iii. Using Care Coordination and Case Management to Improve Health Care Accessibility and Continuity for Children*” subsection below.³⁷

Table 2: EPSDT Scheduling Assistance Policies, Strategies, and Best Practices

Policies	Federal regulations require that state Medicaid agencies offer necessary assistance with scheduling appointments for services. ³⁸
Strategies	<u>Incentivize MCPs to assist with appointment scheduling.</u> The health care system can be difficult to navigate and extra support with scheduling appointments may assist with children getting access to the care they need. In some states that use MCPs to deliver medically necessary services to EPSDT-eligible children, the contract language itemizes in specific, measurable ways the state’s requirements for the MCPs to contact and send

³⁵ Phone calls and text messages, initiated either directly by the state agency or through a state contractor or partner, must be compliant with Federal communications laws such as the Telephone Consumer Protection Act. For more information, see: <https://www.fcc.gov/document/fcc-provides-guidance-enable-critical-health-care-coverage-calls>.

³⁶ The *Streamlining the Medicaid, Children’s Health Insurance Program, and Basic Health Program Application, Eligibility Determination, and Renewal Processes* final rule (89 FR 22836) requires state Medicaid agencies to keep beneficiary contact information up to date by obtaining regular updates from reliable sources, including managed care plans and the U.S. Postal Service National Change of Address database. When beneficiary mail is returned to a state Medicaid agency with no forwarding address, the state must check its Medicaid Enterprise System, as well as information from reliable sources, for updated contact information. If the state is still unable to determine the beneficiary’s address, the state must make a reasonable effort to contact the beneficiary, which includes making at least two attempts to contact the beneficiary through two or more modalities to obtain updated address information. While the final rule is effective June 3, 2024, states have 18 months after the effective date of the rule to comply with these requirements. See: <https://www.federalregister.gov/documents/2024/04/02/2024-06566/medicaid-program-streamlining-the-medicaid-childrens-health-insurance-program-and-basic-health>.

³⁷ 42 C.F.R. §§ 441.62, 431.53, 441.61.

³⁸ 42 C.F.R. § 441.62.

Strategies (cont.)	reminders to families and to provide scheduling assistance. This can be included at the MCP or provider/clinic level. For this strategy to be effective, states should have a process in place to oversee and continually evaluate how the MCP is operationalizing the contract language in practice.
Best Practices	Regardless of delivery system, some states or their MCPs perform initial telephonic outreach and scheduling support to families. Specific best practices for conducting this outreach and scheduling support are described below. <i>Offer a beneficiary services contact line.</i> Some states offer a “beneficiary services” contact line staffed by the Medicaid agency to help with finding appropriate providers that are accepting new patients. <i>Maintain practice-level dashboards.</i> One state with high utilization rates of well-child visits maintains a dashboard to create summary and detailed (i.e., member-level) reports on high-risk beneficiaries, utilization, and quality measure performance. The state makes these reports available to clinics so that, in addition to generally tracking their performance, the clinics can use the reports to target outreach and reminders, in particular for children with missing or late well-child visits. <i>Require MCPs to provide proactive outreach and assistance to members.</i> Some high-performing states require MCPs to reach out to their members and inform them about services available under EPSDT requirements, in addition to the minimum requirement that services covered under the state plan are available and accessible to enrollees in a timely manner and providing a member handbook.³⁹ In some cases, these MCPs are contractually required to use information from the Medicaid agency’s monthly data retrieval to identify all enrollees who are due or overdue for a well-child visit. These enrollees are then contacted by their respective MCP and assisted with scheduling the service as soon as possible. While this best practice was identified in a managed care delivery system, proactive outreach and scheduling assistance has been implemented in FFS and could be modified for use by states with Primary Care Case Management (PCCM). <i>Establish Children’s Resource Centers.</i> One state established Children’s Resource Centers to help families navigate programs that span multiple agencies, drawing on funding for children with special needs available to state maternal and child health agencies through the Title V Maternal and Child Health Services Block Grant Program. To increase the number of families utilizing Children’s Resource Centers, Medicaid administrative funds have been used with other funding to establish a statewide telephone and web-based hotline. The state has extensively promoted this new hotline,

³⁹ 42 C.F.R. § 438.206(a) establishes the minimum coverage requirement.

Best Practices (cont.)	which parents can call to speak with staff (trained as resource guides) to receive guidance on identifying and accessing programs.
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Table 3: EPSDT Transportation Policies, Strategies, and Best Practices

Policies	Non-Emergency Medical Transportation (NEMT) plays an essential role in enabling access to medically necessary services, and states are required to assure that beneficiaries have access to necessary transportation.⁴⁰ The assurance of transportation is not a requirement for states to pay for a ride, but rather a requirement to make certain that every Medicaid beneficiary who has no other means of transportation has access to transportation needed to receive covered care. To comply with EPSDT requirements, states must inform EPSDT-eligible children and their families in clear and nontechnical language that this necessary assistance with transportation is available.⁴¹ Beyond the general transportation assurance requirement, Medicaid EPSDT regulations at 42 C.F.R. § 441.62 require that states offer and provide EPSDT-eligible beneficiaries with “necessary assistance with transportation as required under § 431.53[.]”⁴² In determining what constitutes necessary transportation for eligible children under age 21, the state should consider the needs and best interests of the child when providing additional assistance with transportation to covered services. CMS interprets the references in 42 C.F.R. §§ 441.53 and 441.62 to “necessary” transportation and “necessary” assistance with transportation to mean that states must also cover the cost of transportation for any person who needs to accompany an eligible child to their medical service(s). Transportation for the person accompanying the child includes coverage for trips to and from the service (e.g., roundtrip for admission, roundtrip for discharge), including in cases of out-of-state trips. Additionally, if a child is receiving residential or facility-based care (e.g., inpatient, neonatal intensive care unit (NICU), psychiatric residential treatment facility (PRTF), etc.) and the presence of the parent, family member, or other caregiver is necessary so that they can actively participate in the treatment/intervention for the direct benefit of the child, then the state may pay for transportation for the parent, family member, or caregiver without the child present in order to ensure the child’s medically necessary services are provided (e.g., to provide breast milk or breastfeed, participate in family therapy, medical decision making, and consent for surgery, etc.). Alternatively, the cost of a parent, caregiver, or other family member’s transportation for the direct benefit of the child could be considered part of the cost of the medical service (e.g., inpatient hospital benefit, etc.) and
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⁴⁰ Section 1902(a)(4) of the Act and 42 C.F.R. § 431.53.

⁴¹ 42 C.F.R. §§ 441.56, 441.62.

⁴² 42 C.F.R. § 441.62.

Policies (cont.)	included in another service payment, rather than paid separately as a distinct service. ⁴³
Strategies	<u>Take advantage of the flexibilities to design and operate the assurance of transportation.</u> States have considerable flexibility in the design and operation of the assurance of transportation, if they otherwise meet the requirements noted above and described in the Medicaid Transportation Coverage Guide.⁴⁴ Generally, states may assure transportation as an administrative activity, as an optional medical service, or a combination of these. When provided pursuant to 42 C.F.R. § 431.53, transportation is covered as an administrative activity under the state plan and is matched at the standard 50 percent FFP rate provided under section 1903(a)(7) of the Act for administrative expenditures. Transportation can be assured as an optional medical service if included in the state’s approved state plan, but only when provided by a provider to whom a direct vendor payment can be made by the Medicaid agency.⁴⁵ States can claim FFP at the state’s regular Federal Medical Assistance Percentage (FMAP) for NEMT and emergency medical transportation when furnished as an optional medical service under an approved state plan, which may be higher than the administrative federal match rate. Additionally, states may cover transportation as an optional medical service delivered through managed care authorities, such as a section 1932(a) state plan amendment, section 1915(b) waiver, or section 1115 demonstration authority under the Act.⁴⁶ Many states utilize a broker model, in which a state competitively procures an independent entity to assess need and manage transportation in a designated area. States have the option under state plan authority to establish an NEMT brokerage program and receive the state’s regular FMAP for medical assistance.⁴⁷ It should be noted that expenditures for broker-arranged NEMT can also be claimed as an administrative activity.
Best Practices	<i>Use a fixed risk-based payment under transportation broker models and require the broker to develop a beneficiary app to schedule trips.</i> We interviewed one state about its high-performing transportation broker model, which aimed to increase oversight of the transportation benefit and simplify the process for beneficiaries. Initially, the new system caused significant disruption due to increased demand, but ultimately led to improved access

⁴³ See: <https://www.medicaid.gov/federal-policy-guidance/downloads/smd23006.pdf>.

⁴⁴ Ibid.

⁴⁵ 42 C.F.R. § 440.170(a)(2).

⁴⁶ Managed care programs can include NEMT as part of the benefits coverage for MCOs and PAHPs or by NEMT-only managed care plans. See 42 C.F.R. § 438.9 addressing regulatory requirements for MCPs that cover only NEMT.

⁴⁷ Section 1902(a)(70) of the Act and 42 C.F.R. § 440.170(a)(4).

Best Practices (cont.)	and dramatically reduced costs per trip. The broker is paid a fixed, monthly risk-based payment for all eligible beneficiaries. The contract includes a performance withhold of 3%, contingent on the broker's service delivery performance scorecard. This state also uses its broker contract to improve data and reduce the beneficiary burden to access services. In the state's broker contract, the broker is required to provide data dashboards that allow the state to review near real-time trip details and to develop an app for beneficiaries to use to schedule trips.
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iii. Using Care Coordination and Case Management to Improve Health Care Accessibility and Continuity for Children

Care coordination and case management are used to describe a range of activities that link individuals to services and can vary in intensity depending on a child and family's needs.⁴⁸ Medicaid defines case management as services furnished to assist individuals who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, and other services.⁴⁹ Care coordination is the organization of a patient's care across multiple providers and may focus on a specific service or condition, such as referring and connecting individuals to other programs that support mental health recovery. Care coordination is not defined in section 1905(a) as a service but can be covered in certain circumstances. MCPs are required to provide medically necessary care coordination to enrollees.⁵⁰

For children, especially young children, care coordination and case management are typically provided to the child through the parent or other caregiver. For families, care coordination and case management can ease the process of receiving services by helping to manage the care of the child, reducing duplication of effort, and limiting gaps between service providers. For older youth, families may not be as closely involved but the youth and/or family may still require extra assistance coordinating care in a complex delivery system.

For older children who will soon be transitioning out of coverage that is subject to EPSDT requirements, care coordination and case management can facilitate the development of a comprehensive care plan that outlines the transition process, including referrals to appropriate providers and services. Planning should begin well in advance of a beneficiary's transition and can be facilitated by transition coordinators or care managers who can help coordinate appointments, transfer medical records, and connect families with new health care providers.

The level of care coordination and case management must be appropriate for the complexity of the beneficiary's situation and one approach may not be sufficient to meet varied needs. Every state offers one or more approaches to care coordination and case management; however, it may be to the state's advantage to assess its care delivery program to determine if additional approaches may be useful. Additionally, when a state has multiple approaches for care

⁴⁸ See: <https://www.medicaid.gov/sites/default/files/2019-12/epsdt-care-coordination-strategy-guide.pdf>.

⁴⁹ 42 C.F.R. § 440.169(a).

⁵⁰ 42 C.F.R. § 438.208.

coordination and case management or is considering adding another approach, the state should ensure that these approaches are streamlined to minimize the risk that an EPSDT-eligible child will experience a duplication of services.

Table 4: EPSDT Care Coordination and Case Management Policies, Strategies, and Best Practices

Policies	Medicaid regulations do not define “care coordination,” nor is it a specific section 1905(a) service, but it can be covered if it meets the definitions and requirements of existing Medicaid authorities. For example, states can cover care coordination under the rehabilitative services benefit in section 1905(a) of the Act.⁵¹ Case management is a section 1905(a) service in Medicaid. Like many other components of the EPSDT mandate, not every child needs case management, but every child must have case management available to them when it is medically necessary. When children are assessed to need section 1905(a) services, EPSDT obligations require states to ensure that the children receive these services. Like other services covered under EPSDT, case management covered under EPSDT must address a child’s specific needs.⁵² One child may need care coordination between two providers (e.g., between a primary care provider and an orthopedic specialist for a child with a broken bone), whereas another child with co-occurring medical, developmental, and/or behavioral health conditions may need more complex case management to support the child’s access to services and supports provided by a wide range of providers, state agencies, and the education system. Given the role of the education system in the lives of children, states are encouraged to include collaboration with Local Educational Agencies as an accepted practice within Medicaid case management and care coordination to reduce service fragmentation and enhance comprehensive coordination of Medicaid services across settings.^{53, 54} More detailed information about the delivery of Medicaid services in schools can be found in the 2022 CMCS Informational Bulletin <i>Information on School-Based Services in Medicaid: Funding, Documentation and Expanding Services</i> and subsequent 2023 guidance
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⁵¹ Section 1905(a)(13) of the Act and 42 C.F.R. § 440.130(d).

⁵² Section 1905(r)(5) of the Act.

⁵³ See: https://www.medicaid.gov/faq/index.html?search_api_fulltext=ID:166416.

⁵⁴ Local Educational Agencies are public boards of education or other public authorities legally constituted within a state for either administrative control or direction of, or to perform a service function for, public elementary or secondary schools in a city, county, township, school district, or other political subdivision of a state. 34 C.F.R. § 300.28.

Policies (cont.) *Delivering Services in School-Based Settings: A Comprehensive Guide to Medicaid Services and Administrative Claiming.*^{55, 56}

For older children (youth), transitioning from pediatric to adult care is generally a smooth process. However, in some circumstances, particularly for youth with complex medical, developmental, or behavioral health conditions and youth in foster care, approaching the age limit for EPSDT eligibility is a critical time. Any youth no longer entitled to EPSDT who maintains Medicaid eligibility would transition to the Medicaid benefit package(s) available to adults in their respective state; the services included in their adult benefits might be subject to amount, duration, or scope limitations that did not apply under EPSDT.⁵⁷ Because states are not required to cover optional section 1905(a) benefits for adults, some services may no longer be available and, if possible, case managers and care coordinators should identify alternatives during this critical time. Depending on the state, some youth may no longer be eligible for Medicaid and would need to transition into other coverage.

Strategies

There are multiple Medicaid authorities under which states can deliver care coordination and case management. Some, but not all, of these authorities are included in the scope of services covered under EPSDT. Below are the various vehicles for care coordination and case management.

- PCCM: According to the Act, “primary care case management services,” an optional section 1905(a) benefit, means case management-related services (including locating, coordinating, and monitoring of health care services) provided by a primary care case manager under a PCCM contract.⁵⁸ If a state is delivering care in a PCCM delivery system, individual services are paid FFS and each beneficiary is assigned a primary care provider who acts as case manager in the sense that the provider makes sure well-child services are received as recommended, referrals are provided and followed up, and ongoing health issues are monitored for each child assigned to the practice. The provider receives a small monthly amount to perform these activities.
 - MCPs: Medicaid MCOs, PIHPs, and PAHPs are required by regulation to coordinate health care services for each of their enrollees and to designate a person or entity, such as a primary care practice or other ongoing source of care appropriate to the child’s needs, to provide an
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⁵⁵ See: <https://www.medicaid.gov/federal-policy-guidance/downloads/sbscib081820222.pdf>.

⁵⁶ See <https://www.medicaid.gov/medicaid/financial-management/downloads/sbs-guide-medicaid-services-administrative-claiming.pdf>.

⁵⁷ For more information about amount, duration, or scope limits that can and cannot apply under EPSDT requirements, see the Policies section of “Table 6: EPSDT and Managed Care Policies, Strategies, and Best Practices,” which is located in the “v. Using Managed Care to Improve Awareness of and Accessibility to Services Available Under EPSDT” subsection of this section.

⁵⁸ Sections 1905(a)(25) and (t)(1) of the Act, 42 C.F.R. § 440.168.

Strategies
(cont.)

ongoing source of care and coordinate services accessed by the enrollee.⁵⁹ Coordinating health care services for their enrollees is also a critical MCP function inherent to a managed care delivery system at the plan level. Care must be coordinated across settings of care and delivery systems when a child receives Medicaid services through an MCP, and an MCP must also coordinate care furnished to its enrollees through the state's FFS program, other MCPs, and community support providers.⁶⁰

- Community Health Workers (CHW): CHWs are individuals who have strong ties to the communities they serve and who provide a range of services addressing the health and social needs of beneficiaries, including EPSDT-eligible children and their families. They may be members of communities who are typically underrepresented in health care settings or may be specifically qualified to provide culturally competent care. CHWs may conduct activities such as health promotion and education, patient outreach and follow-up, assistance in navigating the health care system, translation and interpretation of medical information, and care coordination. Certain services provided by CHWs can be covered under the preventive services or rehabilitative services benefits in section 1905(a) of the Act, so long as those services meet regulatory requirements, including that they are recommended by a physician or other licensed provider.⁶¹
- Case Management/Targeted Case Management: Case management services are established in 1905(a) of the Act and defined in regulation as “services furnished to assist individuals, eligible under the State plan who reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, education, and other services.”⁶² Therefore, case management services must be available to EPSDT-eligible children who meet medical necessity criteria for this service. States have additional flexibility under section 1915(g) to target these case management services to a subgroup of Medicaid beneficiaries, such as Medicaid beneficiaries in foster care. In these instances, case management is referred to as “Targeted Case Management” (TCM). Using TCM authority, states do not need to comply with federal requirements for statewideness and comparability of services, enabling them to target case management to an area within the state and/or to defined subgroups of Medicaid beneficiaries (the targeted population).⁶³ Because the TCM flexibility is defined in section 1915 (and not 1905(a)), it does not fall under EPSDT requirements. As a result, while every EPSDT-eligible child must have access to section

⁵⁹ 42 C.F.R. § 438.208(b).

⁶⁰ Ibid.

⁶¹ Section 1905(a)(13) of the Act and 42 C.F.R. § 440.130(c) and (d).

⁶² Section 1905(a)(19) of the Act and 42 C.F.R. § 440.169(a). See also section 1915(g)(2)(A) of the Act.

⁶³ Section 1915(g)(1) of the Act and 42 C.F.R. § 440.169(b).

Strategies
(cont.)

1905(a) case management services when medically necessary, states are not required to ensure availability of TCM for EPSDT-eligible children.

Case management includes the following four components:⁶⁴

1. Comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social, or other services.
 2. Development (and periodic revision) of a specific care plan based on the information collected through the assessment.
 3. Referrals and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services.
 4. Monitoring and follow up activities.
- Health Homes: Health Homes and Health Homes for Children with Medically Complex Conditions, while not covered as part of the EPSDT requirements, are optional Medicaid state plan benefits that support care coordination for eligible people, including children, with chronic conditions, and for children with medically complex conditions.^{65,66,67} Health Home services include comprehensive care management; care coordination; comprehensive transitional care, including appropriate follow-up, from inpatient to other settings; patient and family support; and referral to community and social support services.
 - Administrative Case Management: Case management as an administrative activity (rather than as a covered Medicaid service) involves the facilitation of access to and coordination of services covered under the state's Medicaid program.⁶⁸ These activities can include, for example, facilitating access to specialty care and coordinating appointments with multiple providers. A state may not claim costs for administrative activities if the activities are an integral part or extension of a direct medical service.⁶⁹

⁶⁴ 42 C.F.R. § 440.169(d).

⁶⁵ Sections 1945 and 1945A of the Act.

⁶⁶ Section 1905(r)(5) of the Act requires states to cover health care, diagnostic services, treatment, and other measures described in section 1905(a). Health Homes are described in sections 1945 and 1945A of the Act and are, therefore, not included under the EPSDT mandate.

⁶⁷ For more information about section 1945A health home services, including care management and care coordination, that are provided by out-of-state providers for Medicaid-eligible children with medically complex conditions, see CMCS's CIB: <https://www.medicaid.gov/federal-policy-guidance/downloads/cib102021.pdf>.

⁶⁸ These activities are commonly referred to as "administrative case management," although statute and regulation do not include such terminology. See section 1903(a)(7) of the Act and 42 C.F.R. § 433.15.

⁶⁹ See: <https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD122094.pdf>.

Best Practices *Use community-based care management entities (CME) to coordinate care for children who need moderate or intensive care coordination.* One state provides care coordination on a tiered basis depending on a child’s level of need. Limited care coordination is delivered by MCPs for children with typical care coordination needs. For children who need moderate or intensive care coordination, the state utilizes community-based CMEs whose care coordinators develop a care plan that is guided and driven by the child and their family. This level of care coordination is more extensive and frequent, and involves links to services and resources, and coordination with providers.

In this state, CMEs are community-based organizations that serve as the locus of accountability for children and families by providing moderate- to intensive-care coordination and building community resources. CMEs are charged with identifying the formal and informal resources in their geographic area so they can be incorporated into care coordination plans, gathering children and family or caregiver feedback about how effectively they were able to use these resources, and working with local leaders and other interested parties to expand informal resources that children and families need. These services can help prevent family involvement in the child welfare system by supporting families in their own homes and communities.

iv. Ensuring Consideration of EPSDT in States’ Medicaid Policies and Procedures

States will not be able to comply with the EPSDT requirements unless their Medicaid policies and procedures, including medical necessity criteria, prior authorization requirements, and Medicaid fair hearings, reflect consideration of the EPSDT requirement to cover section 1905(a) services necessary to correct or ameliorate identified medical needs for EPSDT-eligible children. Medical necessity criteria cannot have the effect of imposing a limit on the amount, duration, or scope of services that can never be exceeded for EPSDT-eligible children, nor can they be arbitrary or result in inappropriate limits on access to a service.⁷⁰ States must ensure their policies and procedures are consistent with EPSDT’s “correct or ameliorate” standard and do not default to the criteria used for adult beneficiaries.

Table 5: Policies, Strategies, and Best Practices for Ensuring Consideration of EPSDT in States’ Medicaid Policies and Procedures

Policies	Regardless of delivery system, children entitled to EPSDT must have access to services that can be covered under section 1905(a) of the Act when those
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⁷⁰ Section 1905(r)(5) of the Act; per 42 C.F.R. § 438.210(a)(5)(i), each contract between a state and an MCP must specify what constitutes medically necessary services in a manner that is no more restrictive than that used in the state Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in state statutes and regulations, the state plan, and other state policy and procedure.

Policies (cont.) services are necessary to correct or ameliorate an identified medical need. Thus, while services available to adults may include limits on the amount, duration, and scope of services that can never be exceeded (i.e., a “hard limit”), states are not permitted to apply these kinds of limits to any service covered under EPSDT in either a FFS or managed care delivery system. Similarly, if an optional section 1905(a) service is not covered for adults, that section 1905(a) service must still be made available to EPSDT-eligible children when it is medically necessary. States are ultimately responsible for ensuring EPSDT-eligible children receive the coverage required by the Medicaid statute and regulations, even if some or all of that care is covered through an MCP.⁷¹

That said, states may impose—and may permit MCPs to impose—utilization controls to safeguard against unnecessary use of care and services in a manner that is consistent with the EPSDT requirements.⁷² For example, a state may establish limits on the amount, duration, or scope of services that may be exceeded with prior authorization and/or a medical necessity review (i.e., a “soft limit”). Importantly, under CMS’s interpretation of section 1905(r)(5), prior authorization must be conducted on a case-by-case basis, evaluating each child’s needs individually, and it must not delay the delivery of needed treatment services. Additionally, under CMS’s interpretation of section 1905(r), states may not impose prior authorization requirements for EPSDT screening services. In sum, CMS expects states to align prior authorization or other utilization controls broadly for services covered under EPSDT with what Congress has described as the “preventive thrust” of the EPSDT benefit.⁷³ Note that new requirements regarding timing of prior authorization decisions and reporting state data about prior authorizations will apply to Medicaid FFS and managed care delivery systems beginning in 2026.⁷⁴

Whenever a state Medicaid agency takes an adverse action (which includes a termination, suspension, or reduction in eligibility or services/benefits), it must provide at least 10 days’ advance notice and information on fair hearing rights.⁷⁵ Medicaid agencies must provide notice and fair hearing rights for a denial of a request for a benefit or service, including a prior authorization request denied in whole or in part, as this action would cause a “denial or change in benefits and services.”⁷⁶ Adverse action and denial notices must contain a statement of the intended action, the specific reasons and legal support for the action, an explanation of the individual’s fair hearing rights (including the right to request an expedited fair hearing, right to

⁷¹ 42 C.F.R. § 438.210(a).

⁷² 42 C.F.R. §§ 440.230(d), 438.210.

⁷³ See also H.R. Rep. No. 101-247 at 399-400, reprinted in U.S.C.C.A.N. 1906, 2125-26; <https://www.medicaid.gov/medicaid/benefits/downloads/epsdt-coverage-guide.pdf>. See also 42 C.F.R. § 438.210(b)-(e).

⁷⁴ 42 C.F.R. §§ 440.230(e)(1) and (3), 438.210(d) and 438.210(f).

⁷⁵ 42 C.F.R. Part 431, Subpart E.

⁷⁶ 42 C.F.R. § 435.917(a) and (b)(2).

Policies (cont.) representation, and when continued benefits will be provided), and how to request a fair hearing.⁷⁷

Notice of denials, including prior authorization decisions, or of adverse actions must be provided in writing, written in plain language, accessible to persons with limited English proficiency and individuals with disabilities, and, if provided in an electronic format, compliant with rules relating to electronic notices and information.⁷⁸

State Medicaid agencies must exercise appropriate oversight of their Medicaid fair hearing system to ensure fair hearing decisions correctly apply all relevant federal and state law, regulations, and policies, including the EPSDT “correct or ameliorate” standard.⁷⁹ Fair hearing officials must have access to agency information necessary to issue a proper hearing decision, including information concerning state policies and regulations.⁸⁰ For example, a hearing officer who conducts a hearing challenging the termination, suspension of, or reduction in covered benefits or services for an EPSDT-eligible child must have access to the state’s policies and procedures that implement the EPSDT’s “correct or ameliorate” standard and have sufficient training in such policies.⁸¹ The hearing decision must identify the evidence and laws or regulations supporting the decision, including consideration of EPSDT requirements, as applicable.⁸²

To contest an adverse benefit determination from a managed care plan, beneficiaries must file an appeal or grievance with the plan before requesting a state fair hearing for Medicaid or a state external review for separate CHIP.⁸³ More detail on requirements for managed care adverse determinations is provided below in the “*v. Using Managed Care to Improve Awareness of and Accessibility to Services Available Under EPSDT*” subsection.

Strategies	<u>Ensure EPSDT subject matter expertise across the state Medicaid agency.</u> As EPSDT requirements impact most aspects of Medicaid—including services that vary widely, from dental to pediatric subspecialty care, and may involve FFS and managed care delivery systems—states should disseminate EPSDT expertise across the agency. States should employ personnel with EPSDT expertise to inform policy development, programmatic implementation, and oversight. EPSDT subject matter experts can work with other agency personnel, informing coverage decisions and applications of medical necessity, to ensure that EPSDT-related state policies are consistent with
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⁷⁷ 42 C.F.R. §§ 435.917(b)(2)) and 431.206-210.

⁷⁸ 42 C.F.R. §§ 440.230(e)(2), 435.917, 435.918, 438.10, and 438.210.

⁷⁹ 42 C.F.R. §§ 431.10(c)(3)(i)-(ii) and 431.205(a).

⁸⁰ 42 C.F.R. § 431.240(c).

⁸¹ 42 C.F.R. §§ 431.240(c) and 432.30.

⁸² 42 C.F.R. Part 431 Subpart E. See also: <https://www.medicaid.gov/resources-for-states/downloads/mdcid-fair-hrings-prtnr-rsource.pdf>.

⁸³ 42 C.F.R. §§ 438.402 and 457.1260(b)(2).

Strategies (cont.)	federal requirements. In cases where a state is unable to hire personnel who already have expertise in EPSDT, the state could partner with external organizations to support the training of existing personnel in EPSDT requirements. When appropriate, staff could be supported by employing pediatric Skilled Professional Medical Personnel (SPMP); states can access an increased matching rate of 75% FFP to support those activities..⁸⁴ <u>Require managed care plans and Medicaid fair hearing officials to document consideration of EPSDT, when applicable.</u> States can require that managed care appeal resolutions and Medicaid fair hearing decisions, already required to be provided to beneficiaries in writing, include clear evidence that EPSDT requirements were considered during the appeal or fair hearing process. <u>Collect and analyze prior authorization and fair hearing data related to children.</u> As noted above, the new requirements regarding reporting of aggregate information on prior authorization approvals, denials, and timeliness are not yet in effect. However, in advance of those requirements, states can analyze their own information on prior authorizations and appeals by age, service category, and health plan to identify any issues related to authorizations for EPSDT-eligible children. <u>Offer EPSDT-specific provider training.</u> Providers are often the primary source of information for beneficiaries; therefore, it is essential they do not assume that hard limits on adult services apply to children. They should understand and be able to convey the beneficiary’s right to timely diagnostic and treatment services. Because Medicaid providers request authorization of medical services for EPSDT-eligible beneficiaries, they should clearly understand how to request additional medical services. States can also work with health care professionals’ organizations to provide training on EPSDT policy to the organizations’ membership and can structure trainings to qualify for continuing education credit.
Best Practices	<i>Regularly review decisions for prior authorization requests, managed care appeals, and/or state fair hearing requests for services provided to EPSDT-eligible children, by MCP or service type, for clinical appropriateness.</i> One state, upon evaluating data on decisions for prior authorization requests, decided to eliminate the requirement for prior authorization for certain services, while keeping the prior authorization process intact for other services. States can perform the same type of review to ensure prior authorization processes are appropriate across MCPs. States have a variety of oversight mechanisms, including state audits, post-payment reviews, and reviews by an External Quality Review Organization (EQRO), that they can

⁸⁴ For more information on SPMP, see the “i. Improving Care for Children with Behavioral Health Needs” subsection in “III. Improving Care for Children with Specialized Needs.”

Best Practices use to ensure prior authorization requests and claims denials are clinically appropriate.
(cont.)

Create and require EPSDT-specific web-based provider training. One state created an EPSDT-specific provider training website and portal to ensure that its providers understand all aspects of EPSDT. The training website is easy to navigate, and providers have flexibility to access the training when they are available and are therefore not dependent on availability of agency or MCP staff. The state monitors provider training through login and completion of a post-training test.

Prioritize EPSDT-specific expertise. Some states prioritize having EPSDT leadership and staff-level expertise to provide agency-wide input and guidance. These staff act as expert consultants across the state agency to ensure that EPSDT requirements are considered and included in decision-making. Further, some states require MCPs to have an EPSDT point of contact who is responsible for EPSDT at the plan-level.

Extend EPSDT technical assistance to MCPs. One state provides its MCPs with the opportunity for EPSDT-specific review by state staff of the MCPs' member-facing materials as a means of ensuring consistency in EPSDT implementation.

v. *Using Managed Care to Improve Awareness of and Accessibility to Services Available Under EPSDT*

The majority of states deliver care through a managed care delivery system, and an overwhelming majority of children receive some or all care through managed care. Medicaid managed care provides for the delivery of Medicaid state plan benefits through MCPs that contract with the Medicaid agency. States can structure their managed care programs to require voluntary or mandatory enrollment of Medicaid beneficiaries through Medicaid managed care authorities (e.g., 1932(a) state plan authority, 1915(b) waiver authority, 1915(a) contract authority, etc.). MCPs are typically paid by the state through a risk-based payment such as a capitation rate and negotiate their own payment rates with providers, unless otherwise directed by the state (e.g., a state directed payment). Enrollees select from among an MCP's network of providers. States must also have an enrollment system for all Medicaid managed care programs, which must include when and how often enrollees may select a different MCP.⁸⁵

When states use MCPs to deliver some or all EPSDT benefits, states must clearly delineate the MCPs' responsibilities in the managed care contract to help ensure that the MCPs understand the full scope of their obligations under EPSDT.⁸⁶ States must monitor and oversee MCPs and must have mechanisms in place to hold MCPs accountable for fulfilling all contracted

⁸⁵ 42 C.F.R. § 438.54(b).

⁸⁶ See 42 C.F.R. §§ 438.210(a)(1)-(3), 438.66, 438.206.

responsibilities.⁸⁷ Regardless of how significant the MCPs' role may be in administering EPSDT, the state retains ultimate responsibility for assuring compliance with EPSDT requirements.

States utilize the requirements in the 42 C.F.R. Part 438 regulations to help ensure that enrollees are aware of, and have access to, medically necessary services in accordance with EPSDT requirements. For example, regulations require that states develop and enforce network adequacy requirements and that states use their managed care contracts to mandate MCP compliance with regulatory requirements and enable enforcement as indicated. The 2024 *Medicaid and Children's Health Insurance Program Managed Care Access, Finance and Quality* rule (2024 Managed Care Rule) introduced important new requirements for timely access to care, including pediatric-specific timely access requirements, and managed care network adequacy.⁸⁸ These requirements will become applicable over the next several years, and states should maintain a focus on EPSDT requirements and children's access to services as they implement these new provisions.⁸⁹

Table 6: EPSDT and Managed Care Policies, Strategies, and Best Practices

Policies	As noted above, the 2024 Managed Care Rule introduced new requirements that will become applicable over the next several years. As such, we have separated the EPSDT managed care policy information into two sections: 1) Current statutory and regulatory requirements (which are relevant today); and 2) Upcoming changes related to the 2024 Managed Care Rule. <i>Current statutory and regulatory requirements</i> When a managed care delivery system is used to deliver some or all services required under EPSDT, states must identify, define, and specify the specific EPSDT services that the MCP is required to cover in the MCP's contract.⁹⁰ Depending upon the type of MCP and contractual arrangement, the MCP may be responsible for all medically necessary covered services for EPSDT-eligible children while other MCPs or a state's FFS program covers other services; for example dental services may be covered outside of the MCP. When states include some services covered under EPSDT in their managed care contracts but exclude specific section 1905(a) services from such managed care contracts, the contract must be explicit that the MCP is required to cover all medically necessary section 1905(a) services except those that are explicitly excluded. The state maintains the obligation under EPSDT requirements to ensure a child receives coverage of those explicitly excluded medically necessary services to correct or ameliorate identified medical needs. If an MCP is contractually responsible for <i>all</i> medically necessary services for EPSDT-eligible children, the MCP is obligated to
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⁸⁷ Section 1932(e)(1)(a) of the Act; 42 C.F.R. §§ 438.66 and 438.700.

⁸⁸ See: <https://www.federalregister.gov/documents/2024/05/10/2024-08085/medicaid-program-medicare-and-childrens-health-insurance-program-chip-managed-care-access-finance>.

⁸⁹ For a full list of applicability dates for Final Rule provisions, see <https://www.medicare.gov/medicare/managed-care/downloads/applicability-date-chart-mc.pdf>.

⁹⁰ 42 C.F.R. § 438.210(a).

Policies (cont.) ensure access to those services, including access to services that may not otherwise be listed as a covered service in its contract.⁹¹

Outside the scope of section 1905(a), states may also choose to give MCPs the contractual authority to provide in lieu of services and settings (ILOS) for certain services and settings. An ILOS offered by an MCP must be approvable as a service or setting through a waiver under section 1915(c) of the Act or a state plan authority, including section 1905(a), 1915(i), or 1915(k) of the Act.⁹² For EPSDT-eligible children, 1905(a) services must be provided when medically necessary and thus cannot be included in an MCP's contract as an ILOS. ILOS are provided at the option of an MCP and an EPSDT-eligible child, when the ILOS can be expected to reduce or eliminate the future need to utilize section 1905(a) services or settings.^{93,94} As an example, a few states are using ILOSs for youth with serious emotional disturbance to provide supports for caregivers, including respite care.

MCPs can also voluntarily provide services that are in addition to those covered under the state plan. These services, often called value-added services, are optional and need not be strictly medical in nature but must improve health care quality. States and their actuaries cannot include the cost of these voluntary services when determining capitation rates.⁹⁵

Medicaid services delivered to EPSDT-eligible children through a managed care delivery system must be determined by an MCP to be medically necessary services in a manner that is no more restrictive than that used in the state's Medicaid program in accordance with the EPSDT standard, not the standard that might be otherwise utilized for adults.⁹⁶ States' and MCPs' determination of whether a service is medically necessary for an individual child must be made on a case-by-case basis, taking into account the particular needs of the child.⁹⁷ The state or MCP should consider the child's long-term needs, not just what is required to address the immediate situation. Given the obligation under EPSDT requirements to ensure a child receives coverage of medically necessary section 1905(a) services to correct or ameliorate identified medical needs, medical necessity reviews cannot have the effect of imposing a hard limit for EPSDT-eligible children, nor can they result in inappropriate limits on access to a service.⁹⁸

MCPs must ensure that utilization management adheres to EPSDT principles and takes into consideration a particular child's needs.⁹⁹ While states and

⁹¹ 42 C.F.R. § 438.210(a)(2), citing subpart B of 42 C.F.R. Part 441.

⁹² 42 C.F.R. §§ 438.3(e)(2) and 438.16.

⁹³ 42 C.F.R. § 438.16(b).

⁹⁴ 42 C.F.R. § 438.3(e)(2).

⁹⁵ 42 C.F.R. § 438.3(e)(1)(i), 45 C.F.R. § 158.150.

⁹⁶ 42 C.F.R. § 438.210(a).

⁹⁷ Section 1905(r)(5) of the Act and 42 C.F.R. §§ 438.210(a)(2) and (a)(5).

⁹⁸ Section 1905(r)(5) of the Act and 42 C.F.R. § 438.210(a).

⁹⁹ 42 C.F.R. §§ 438.210(a)(4)-(5).

Policies (cont.) MCPs may use prior authorization and other utilization management strategies to ensure that care is being used appropriately, utilization management should not create excessive administrative burden that results in the delay or denial of medically necessary services. Our listening sessions revealed concerns about states and MCPs using commercially available utilization management software to review prior authorization requests. While many states and MCPs rely on this software to streamline the process of authorizing care, states must ensure that any software used by MCPs in this process is consistent with the EPSDT requirement to cover medically necessary care that can be covered under section 1905(a), as well as regulatory requirements for coverage and authorizations of services.¹⁰⁰ States and MCPs should also ensure that the managed care appeals process is operationalized consistent with EPSDT principles and that the staff making appeal decisions understand and adhere to these principles.

States and MCPs should help to ensure the availability and accessibility of services for children by educating providers on EPSDT requirements. It is particularly important for providers to understand that the adult section 1905(a) benefits packages are a subset of services that should be available for an EPSDT-eligible child and hard service limits for adults do not apply to an EPSDT-eligible child's medically necessary care. Lacking this knowledge, it is possible a provider may not request a service for an EPSDT-eligible child because they think the service is not covered.

Services under EPSDT, like all Medicaid services, must be provided with "reasonable promptness."¹⁰¹ MCPs must maintain a sufficient network of providers with pediatric expertise who can be accessed in a timely manner.¹⁰² If an EPSDT-eligible child does not have timely access to a network provider for medically necessary care, the MCP must arrange for and cover medically necessary covered services out-of-network, including out-of-state if necessary, for as long as the MCP's provider network is unable to provide the medically necessary services.¹⁰³ This includes cases in which an enrollee cannot access a medically necessary service within a timeframe contractually imposed on the MCP. In situations where a provider indicates, or the MCP determines, the standard timeframe for a service authorization "could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function," the MCP must make an expedited decision. Specifically, the MCP must make an authorization decision and provide notice to the provider and enrollee as expeditiously as the enrollee's

¹⁰⁰ 42 C.F.R. § 438.210.

¹⁰¹ Section 1902(a)(8) of the Act.

¹⁰² See Section 1932(b)(5) of the Act, Section 1902(a)(4) of the Act, 42 C.F.R. § 438.206(a) and (b)(1).

¹⁰³ 42 C.F.R. § 438.206(b)(4).

Policies (cont.) health condition requires and no later than 72 hours after receiving the request for the service..¹⁰⁴

Upcoming changes related to the 2024 Managed Care Rule

Under the 2024 Managed Care Rule, for rating periods beginning on or after July 9, 2027, states are required to develop and enforce appointment wait time standards for routine appointments for several different service categories, including pediatric primary care services, pediatric outpatient mental health and SUD services, obstetric/gynecological services, and a service of the state's choice. These standards must adhere to maximum appointment wait time standards of 15 business days for primary care and obstetric/gynecological services, and 10 business days for outpatient mental health and SUD. The wait time standards for outpatient mental health and SUD services and primary care are measured separately for pediatric and adult populations. States, however, may choose to establish shorter maximum appointment wait times..¹⁰⁵

The 2024 Managed Care Rule also includes important provisions to ensure that each MCP is meeting appointment wait time standards and to strengthen states' ability to monitor and address MCPs' access to care issues. The 2024 Managed Care Rule requires states to collect a variety of information on MCP performance, including a provider payment analysis demonstrating each MCP's level of payment for certain services, an enrollee experience survey, secret shopper surveys for appointment wait time standard compliance, and evaluations of the accuracy of electronic provider directories..^{106, 107} These provisions become applicable for rating periods beginning on or after July 9, 2026, July 9, 2027, and July 10, 2028, respectively..¹⁰⁸

These provisions will give states significantly more information about managed care enrollees' access to care that they can use to better understand and address barriers to care. Secret shopper surveys will give states evaluative data on MCPs' compliance with appointment wait time standards; provider payment analyses will give states more information to evaluate the effect of payment rates on provider networks; and the enrollee experience survey can examine factors affecting utilization of services beyond numbers of network providers. This may include the degree to which written materials, transportation, quality of care, and other factors may be discouraging or preventing enrollees from accessing necessary care.

¹⁰⁴ 42 C.F.R. § 438.210(d)(2)(i).

¹⁰⁵ 42 C.F.R. § 438.68(e).

¹⁰⁶ 42 C.F.R. §§ 438.68(f), 438.66(b)(4) and (c)(5), 438.207(b).

¹⁰⁷ These provisions in the 2024 Managed Care Rule requires these for MCOs, PIHPs, and PAHPs. They do not apply to PCCM entities and PCCMs except for the enrollee experience surveys at state option.

¹⁰⁸ For a full list of applicability dates for Final Rule provisions, see <https://www.medicaid.gov/medicaid/managed-care/downloads/applicability-date-chart-mc.pdf>.

Policies (cont.)	However, the survey must be thoughtfully developed in order to produce meaningful results. States may want to consider validating the survey through an EQRO as part of the annual external quality review (EQR) conducted for MCPs. For Medicaid programs, EQR and EQR-related activities performed on MCPs are eligible for up to a 75% enhanced federal match when conducted by a qualified EQRO and when the EQR-related activities are completed using methodologies consistent with the updated EQR protocols.¹⁰⁹
Strategies	<u>Incentivize performance improvement for services covered by MCPs.</u> States may use state directed payments (SDP) to direct MCPs' payments to providers to achieve goals related to performance improvement, fee schedules, and delivery system reform.¹¹⁰ Several states have implemented pediatric-specific SDPs to improve quality and access by offering enhanced rates or a minimum fee schedule for eligible pediatric providers.^{111, 112} <u>Utilize ILOSs to enhance and expand access to health care services and settings.</u> ILOSs allow states and MCPs to enhance 1905(a) services and settings.¹¹³ For example, states and MCPs can minimize the risk of EPSDT-eligible children being placed in out-of-home settings by providing ILOSs, including home and community-based services (HCBS), to EPSDT-eligible children.¹¹⁴ Additionally, ILOSs can be used to expand the breadth of available behavioral health care settings, thereby helping to ensure EPSDT-eligible children receive care in the most medically appropriate setting for their needs. <u>Focus on pediatric provider networks.</u> States are required to ensure that Medicaid MCPs maintain provider networks that are sufficient to provide accessible and timely care to enrollees, including EPSDT-eligible children.¹¹⁵ This may include the state evaluating the ratio of children to MCP providers, including children with disabilities, as an oversight function and determining whether the number of pediatric subspecialists is sufficient

¹⁰⁹ FFP at the 75% rate is available in expenditures for EQR, (including the production of EQR results) and the EQR-related activities set forth in § 438.358 when performed on MCOs and conducted by EQROs and their subcontractors. In comparison, for PIHPs, PAHPs, or PCCM entities, FFP at the 50% rate is available in expenditures for EQR-related activities conducted by any entity that does not qualify as an EQRO, and for EQR (including the production of EQR results) and EQR-related activities performed by an EQRO on entities other than MCOs. See: 42 C.F.R. § 438.370.

¹¹⁰ All SDPs must comply with applicable federal requirements, including those at 42 C.F.R. § 438.6.

¹¹¹ 42 C.F.R. § 438.6.

¹¹² See: <https://www.medicaid.gov/medicaid/managed-care/guidance/state-directed-payments/index.html>.

¹¹³ 42 C.F.R. §§ 438.3(e)(2), 438.16.

¹¹⁴ Title II of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973 require that services for individuals with disabilities be provided in the most integrated setting appropriate to the needs of qualified individuals with disabilities. These statutes may prohibit child welfare agencies from encouraging out-of-home placements to receive services, where out-of-home placements are not the most integrated setting appropriate, and such placement would be unnecessary under the statutes and the Supreme Court's decision in *Olmstead*.

¹¹⁵ Section 1932(b)(5) of the Act, Section 1902(a)(4) of the Act, 42 C.F.R. §§ 438.68(a)-(b), 438.206(a).

Strategies (cont.)	to address the needs of the population enrolled. States may then utilize the flexibility they have to develop or revise a specific quantitative network adequacy standard or appointment wait time standard beyond those already required to target an area under the EPSDT mandate where there is a suspected or confirmed gap in network adequacy. For example, the needs of a specific population of an MCP's enrollees may require specific types of subspecialty providers. <u>Monitor and improve MCPs' performance in ensuring access to care for children.</u> As states implement the 2024 Managed Care Rule provisions related to secret shopper surveys, payment analyses, and enrollee surveys, states can gain insight on their MCPs' performance in assuring access to services per EPSDT requirements by keeping a focus on findings related to children.
Best Practices	<i>Use and enforce managed care contract language to require MCPs to use best practices.</i> To improve awareness of, and access to, services for which coverage is required under the EPSDT mandate when some or all of those services are delivered in a managed care delivery system, states can include managed care contract language to implement a variety of practices, such as: - Contacting parents to assist with scheduling a well-child visit unless the parent declines. - Tracking whether children are due or overdue for well-child visits, as well as whether they received dental check-ups in line with timeframes identified in the managed care contracts. - Issuing sanctions or financial incentives (such as incentive arrangements) based on the MCP's annual reports on pediatric metrics.¹¹⁶ - Tracking primary care providers' referrals to dentists. - Including in enrollee handbooks the availability of and how to obtain specific specialty care, such as private duty nursing, personal care, and medical equipment. - Providing clinics and primary care providers with a monthly list of children due and overdue for a well-child visit for that clinic to perform outreach and ensure the member has access to prompt services, while ensuring that these efforts to reach members are coordinated with MCP outreach to the same families. - Training providers on how members access NEMT, along with missed appointment assistance provided by the MCP, to encourage a shared understanding of how to use Medicaid benefits.

¹¹⁶ States can use a variety of strategies for incentive arrangements, including those described at 42 C.F.R. §§ 438.6(b)(2), 438.6(b)(3), and 438.700.

Best Practices
(cont.)

Convene MCPs around shared quality goals. Convening MCPs as a group to work toward specific, measurable improvement goals in pediatric performance measures has been effective in increasing children’s utilization of well-child care. States can set performance targets and expectations for MCPs to serve as the basis for quality improvement and convene MCPs to strategize and work toward those targets to improve the care that children receive. Ideally, states take a leadership role in guiding MCPs to work on a set of initiatives, benchmarking performance, and cataloging and disseminating statewide any MCPs’ improvement strategies that have been particularly effective.

Implement a non-clinical Performance Improvement Project (PIP) to ensure occurrence of well-child visits. MCPs are required to engage in PIPs in clinical and non-clinical areas each year to objectively measure performance, implement interventions, evaluate the effectiveness of these interventions, and initiate activities to sustain improvement.¹¹⁷ One state with particularly high well-child visit utilization implemented a non-clinical PIP to help ensure data accuracy and to ensure that when well-child visits occur, the associated data are captured and reported correctly.

Include children with disabilities or other complex medical needs in managed care quality strategies. States with managed care programs must develop and maintain a managed care quality strategy to set measurable targets and improve the quality of care within the state’s Medicaid program.¹¹⁸

- States that serve children with disabilities or complex medical needs in managed care are encouraged to include pediatric subspecialty care measures in their quality strategy to ensure this small population remains a focus.¹¹⁹

Improve quality and utilization for children through optional focus studies in annual EQR. States with MCPs also must ensure that a qualified EQRO conducts an annual EQR for each contracted MCP. EQR is the analysis and evaluation by an EQRO of aggregated information on the quality, timeliness, and access to the health services that an MCP or its contractors provide to beneficiaries. The mandatory and optional EQR-related activities provide opportunities to assess specific areas of MCP performance and provide information that can be used to improve health care access for children.¹²⁰

- States with managed care programs may include optional focus studies within their annual EQR, including a focus study to investigate an area

¹¹⁷ 42 C.F.R. § 438.330(d).

¹¹⁸ 42 C.F.R. § 438.340.

¹¹⁹ For more information about policies, strategies, and best practices related to children with disabilities or other complex health needs, see the “iii. Improving Care for Children with Disabilities or Other Complex Health Needs” subsection in the “III. Improving Care for Children with Specialized Needs” section.

¹²⁰ 42 C.F.R. §§ 438.350, 438.358.

Best Practices (cont.)	of concern or establish a baseline for current utilization. ¹²¹ This offers a broad opportunity to improve quality and utilization for children through analysis of well-child visit utilization variations by age, geography, and MCP, as well as rates of prior authorization approvals and denials. States' expenditures for EQR of MCOs may be eligible for FFP at a 75% match rate, including the production of the EQR technical report for MCOs and EQR-related activities performed on MCOs, when conducted by the state's contracted EQRO for managed care organizations that have a contract under section 1903(m) of the Act. ¹²²
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II. Expanding and Using the Children-Focused (EPSDT) Workforce

CMS has heard from states that in some regions and for some services, state Medicaid agencies have difficulty enrolling providers, and research supports these experiences. For example, workforce data collected by the Health Resources and Services Administration (HRSA) indicate that the availability of pediatricians varies, with the number of pediatric physicians per 100,000 individuals ranging from 7.9 to 68.0 across states in 2023.¹²³ HRSA also projected that, by 2036, metro areas will have 98% supply adequacy for pediatric physicians and nonmetro areas will only have 69% supply adequacy.¹²⁴ CMS recognizes that provider availability issues and distribution vary among states. However, states have been working creatively within federal requirements to expand the EPSDT workforce, in particular by: i. broadening provider qualifications, ii. using telehealth, iii. encouraging the use of interprofessional consultation, and iv. using payment methodologies that incentivize EPSDT provider participation.¹²⁵

When implementing any of the strategies or best practices in these areas, states should be mindful of administrative burden, which providers have cited as a barrier to Medicaid participation. If possible, states should consider taking steps to reduce the administrative burden on providers by streamlining provider enrollment, performing cost-benefit analyses of prior authorizations, and/or changing prior authorization for categories of requests that are typically approved. Similarly, states should ensure that provider payment rates are adequate to establish a sufficient network of providers.¹²⁶ Although adequate payment rates are not, in and of themselves, enough to ensure a sufficient network, without them, any other steps a state might take to improve the provider workforce likely will be less effective.

¹²¹ 42 C.F.R. § 438.358(c)(5).

¹²² 42 C.F.R. § 438.370(a).

¹²³ See: <https://data.hrsa.gov/topics/health-workforce/ahrf>.

¹²⁴ See: <https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/state-of-primary-care-workforce-2023.pdf>.

¹²⁵ By “EPSDT workforce” we mean providers whose medical expertise focuses on health care services for individuals under the age of 21 (e.g., pediatricians, pediatric cardiologists, etc.), as well as any general practitioners who have the relevant training and knowledge to provide care to these children and youth.

¹²⁶ See section 1902(a)(30)(A) of the Act, which requires states to assure that payments for Medicaid services are consistent with efficiency, economy, and quality of care, and are sufficient to enlist enough providers so that care and services are available under the Medicaid state plan at least to the extent that such care and services are available to the general population in the geographic area.

*i. Broadening Provider Qualifications to Expand the EPSDT Workforce***Table 7: Policies, Strategies, and Best Practices for Broadening Provider Qualifications to Expand the EPSDT Workforce**

Policies	Generally, in Medicaid FFS programs, states must ensure that a Medicaid beneficiary may obtain covered services from any institution, agency, pharmacy, person, or organization that is qualified and willing to furnish the services to that particular beneficiary.¹²⁷ States have broad flexibility to establish reasonable provider qualifications related to the fitness of the provider to perform covered medical services, and states can require that MCPs use network providers that meet these standards.¹²⁸ In addition, federal statute and regulations require that many Medicaid benefits be provided by physicians or other licensed practitioners. Where that is not the case, states may expand the range of existing providers of Medicaid-covered services by providing training and support and creating paraprofessional qualifications for other provider types to expand the pool of available providers.
Strategies	<u>Develop non-licensed practitioner types.</u> Many states have added practitioner types that do not require licensure to deliver care where allowable.¹²⁹ This includes, for example, allowing peer support practitioners to deliver services to children and to parents/legal guardians when for the direct benefit of the child under a number of different Medicaid authorities, including section 1905(a) services such as rehabilitative services.¹³⁰ These practitioners expand the workforce available to serve beneficiaries and allow licensed providers, such as social workers, psychologists, and psychiatrists, to focus on the more complex or clinically intensive services that they alone can provide. Additionally, expanding the use of recovery or other therapeutic groups allows licensed providers to serve more people, while also providing access to elements of peer support. <u>Broaden the role of existing providers.</u> Some states have offered optional provider training, along with rate increases, to expand the ages of individuals the provider will see, thereby reducing referrals to pediatric subspecialists. Other states have expanded access to primary care provider consultation for mild-to-moderate psychiatric conditions, relieving some pressure on participating child psychiatrists. Several examples described below ask more

¹²⁷ Section 1902(a)(23)(A) of the Act and 42 C.F.R. § 431.51(b). See also 42 C.F.R. § 441.61(b).

¹²⁸ See: 42 C.F.R. §§ 431.51(c)(2), 438.214(a) and (b).

¹²⁹ See: <https://downloads.cms.gov/cmsgov/archived-downloads/smdl/downloads/smd081507a.pdf> and <https://www.medicaid.gov/federal-policy-guidance/downloads/faq06052024.pdf>.

¹³⁰ See: <https://www.medicaid.gov/federal-policy-guidance/downloads/faq06052024.pdf>.

Strategies (cont.)	of primary care providers, and we note that to be successful, these practices need to be adequately paid for and supported.
Best Practices	<i>Incorporate oral health into children’s primary care visits.</i> One state model linking oral health with primary care has shown promise by improving oral health care for young children. According to standards of medical practice, young children have primary care visits more frequently than older children, and incorporating oral health into these visits has yielded success. States may train primary care providers and pay them for services including oral evaluations or screenings, risk assessments, parent or caregiver counseling, and fluoride varnish application. States may also establish procedures to support referrals to ongoing dental care.¹³¹ <i>Support and incentivize general practitioners to serve younger children.</i> A different approach that has yielded an increase in available dental practitioners is to provide training, support, and enhanced payments to general dentists to increase their ability to serve younger children. Children younger than five may require specialized instruments and behavioral support for dental examinations and treatment, and some general dentists may be hesitant to treat them. One state trains general dentists in behavioral techniques and makes enhanced payments for the extra time it may take to serve this population. Partner organizations, funded in part by Medicaid administrative expenditures, provide support to children and families to connect to participating providers. This approach has yielded an increase in the numbers of participating providers willing to serve very young children. This best practice was identified with dentists but could be applied with other providers and services as well.

ii. *Using Telehealth to Expand the EPSDT Workforce*

Table 8: Telehealth Policies, Strategies, and Best Practices to Address EPSDT Workforce Shortages

Policies	State Medicaid agencies have a great deal of flexibility in developing coverage and payment parameters for Medicaid services delivered via telehealth, including services provided to EPSDT-eligible children. ¹³² For Medicaid services that states allow to be delivered using telehealth, states must continue to meet any federal requirements related to coverage of the benefits and other applicable federal law, including the requirements of Title XIX of the Act and federal regulations (as interpreted in published CMS
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¹³¹ For resources from a 14-state learning collaborative to improve oral health prevention in primary care, please visit CMCS’s Oral Health Quality Improvement Resources website, available at:

<https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/oral-health-quality-improvement-resources/index.html>.

¹³² See: <https://www.medicaid.gov/medicaid/benefits/downloads/telehealth-toolkit.pdf>.

Policies (cont.)	guidance), and the parameters of a state’s CMS-approved Medicaid state plan and/or demonstration projects and waivers.
Strategies	<u>Allow providers to deliver services via telehealth.</u> To address EPSDT provider shortages, states have the option to enroll additional individual providers, and/or enable additional provider types, to render services via telehealth.¹³³ For instance, subject to state enrollment and scope of practice laws and policy, states could potentially enroll and pay out-of-state providers to deliver services to EPSDT-eligible children via telehealth. <u>Address workforce shortages in rural and medically underserved areas by allowing services, including behavioral health services, to be delivered using telehealth.</u> Workforce shortages in rural or medically underserved areas can be mitigated by state Medicaid agencies allowing providers to deliver services, including behavioral health services, using telehealth. To address behavioral health workforce challenges in particular, states may use strategies like optimizing Pediatric Mental Health Care Access (PMHCA) programs and using telehealth as a model of integration.¹³⁴ Mental health care access programs are a high-value means of supporting pediatric primary care providers to manage mild to moderate mental health and SUD treatment without the need to refer patients to specialty care.
Best Practices	<i>Enroll out of state providers.</i> While not specific to pediatric providers, one state allows out-of-state providers to deliver services via telehealth under a “Border Status” policy.¹³⁵ This policy allows certain providers—such as providers in a state that physically borders the state and all out-of-state independent laboratories, regardless of location—to potentially enroll in the state’s Medicaid program. All of these providers are subject to the same provider requirements as in-state providers.

iii. *Encouraging the Use of Interprofessional Consultation to Address EPSDT Workforce Shortages*

Table 9: Interprofessional Consultation Policies, Strategies, and Best Practices to Address EPSDT Workforce Shortages

Policies	Interprofessional consultation is defined as a situation in which the patient’s treating physician or other qualified health care practitioner requests the opinion and/or treatment advice of a physician or other qualified health care practitioner with specific specialty expertise to assist the treating practitioner with the patient’s care without patient face-to-face contact with the
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¹³³ Ibid.

¹³⁴ See: <https://mchb.hrsa.gov/sites/default/files/mchb/about-us/pmhca-fact-sheet.pdf> and <https://www.samhsa.gov/resource/ebp/telehealth-treatment-serious-mental-illness-substance-use-disorders>.

¹³⁵ See: <https://www.medicaid.gov/medicaid/benefits/downloads/telehealth-toolkit.pdf>.

Policies (cont.) consulting practitioner. For the consulting physician to receive direct payment from Medicaid, the services must be directly relevant to the individual patient’s diagnosis and treatment, and the consulting practitioner must have specialized expertise in the particular health concerns of the patient. Interprofessional consultation is intended to expand access to specialty care and foster interdisciplinary input on patient care. Interprofessional consultation services may be covered under a variety of Medicaid state plan benefits, such as physician services, services of other licensed practitioners, and rehabilitative services. Both the treating practitioner and the consulting practitioner must be enrolled in Medicaid or CHIP.¹³⁶

Strategies Mitigate the need for referrals to pediatric subspecialists by connecting primary care providers and child behavioral health providers using a PMHCA program. PMHCA programs exist in 46 states and 8 entities.¹³⁷ These programs provide child psychiatry consultation to primary care providers in real time and have been demonstrated to be beneficial both for individual consultation and for disseminating best practices through training to enhance the capacity for diagnosis and treatment provided within primary care. Primary care providers can call a number and be connected to a child psychiatrist who can consult on individual patients. State PMHCA programs provide primary care providers with the support they need to diagnose and treat children with mild to moderate behavioral health conditions, resulting in a reduction in the number of families waiting for referrals to pediatric subspecialists.

Subject to section 1903(a) of the Act, many states are able to claim FFP for some of the costs incurred to administer a PMHCA program, subject to Medicaid administrative claiming rules.¹³⁸ Additionally, states can partner with their PMHCA lead agency (which may be the Health and Human Services agency, the Behavioral Health Agency, or Title V agency within the state Health and Human Services Department) to ensure funding sustainability through claiming for Medicaid covered services delivered to EPSDT-eligible Medicaid beneficiaries.

Best Practices *Adopt the Collaborative Care Model (CoCM).* Interprofessional consultation is one of the components of the CoCM, an evidence-based approach that integrates and improves both behavioral and physical health among individuals of any age, including children.¹³⁹ CoCM uses a team-based approach in which a treating practitioner addresses patients’ mental health

¹³⁶ See: <https://www.medicaid.gov/federal-policy-guidance/downloads/sho23001.pdf>.

¹³⁷ See: <https://mchb.hrsa.gov/programs-impact/programs/pediatric-mental-health-care-access>.

¹³⁸ See: <https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD122094.pdf>.

¹³⁹ For more information on interprofessional consultation and CoCM, see: <https://www.medicaid.gov/federal-policy-guidance/downloads/sho23001.pdf>.

Best Practices (cont.)	and SUD conditions while supported by a behavioral health care manager and a psychiatric consultant. CoCM is used by numerous state Medicaid agencies and has demonstrated success in expanding access to and improving outcomes in behavioral health care by integrating a behavioral health care manager with a primary care provider at an office location. These providers then collaboratively manage a caseload of children with behavioral health conditions through weekly consultations with a psychiatrist and other behavioral health practitioners, often through telehealth. The integration of telehealth within the collaborative care model both improves access to psychiatrists for Medicaid beneficiaries and increases the caseload that can successfully be managed by a limited behavioral health workforce.
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iv. *Using Payment Methodologies that Incentivize EPSDT Provider Participation*

Table 10: Payment Methodology Policies, Strategies, and Best Practices to Address EPSDT Workforce Shortages

Policies	States have considerable flexibility under Medicaid authorities to develop Medicaid payment methodologies, including payment incentives for services delivered to EPSDT-eligible children. States are required under a FFS delivery system to “assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.”¹⁴⁰ In managed care, states contract with MCPs to provide some or all Medicaid benefits, as specified in the contract, to Medicaid beneficiaries enrolled in the MCP. Generally, states prospectively pay MCPs a risk-based capitation rate (typically a per member per month payment) for providing services to a Medicaid enrollee. Capitation rates are required to be actuarially sound, meaning that the rates are projected to provide for all reasonable, appropriate, and attainable costs for services and populations covered under the contract.¹⁴¹ Please also note that all federal statutory and regulatory requirements apply to payments made for services covered under EPSDT, regardless of service delivery system, including requirements applicable to the sources of the non-federal share.¹⁴²
Strategies	<u>States may explore options to enhance or structure Medicaid payment rates to reward providers for delivering high quality care to EPSDT-eligible children.</u> Often, states with higher rates of utilization of well-child visits

¹⁴⁰ Section 1902(a)(30)(A) of the Act.

¹⁴¹ 42 C.F.R. §§ 438.2, 438.4.

¹⁴² See for example, sections 1902(a)(73)(A), 1902(a)(30), 1902(a)(2), 1903(w) of the Act, 42 C.F.R. Part 447 Subpart B, 42 C.F.R. Part 433 Subpart B, and 42 C.F.R. § 440.200, et seq.

Strategies (cont.)	have established a variety of financial enhancements to reward providers for delivering this care. While some states have enhanced rates for primary care services delivered to EPSDT-eligible children, others may withhold a percentage of rates or pay quality incentives based on MCP or practice performance on Child and Adolescent Well-Child Visit quality measures. States may also include adjustments in their FFS rate setting methodologies that increase rates by state-specified amounts or percentages and recognize standards used for rate-setting, such as national health care cost indices. Some states benchmark FFS Medicaid payment rates to specific rates (i.e., releases of published Medicare rates).¹⁴³ While this serves as an important data point when considering rate sufficiency, many services that may be medically necessary for EPSDT-eligible children are not covered by Medicare. CMS may also consider for approval Medicaid state plan FFS methodologies in which states benchmark Medicaid rates to other publicly published rates for pediatric services from a non-Medicaid entity. In addition, states may use Medicare or other rates that are publicly published by a payer other than the state Medicaid agency to inform their own state rate development processes to the extent that rates are widely available to the public and updated at a regular interval.¹⁴⁴ In managed care delivery systems, states may also utilize state directed payments to direct MCPs' payments to providers to achieve goals related to performance improvement, fee schedules, and delivery system reform.^{145, 146}
Best Practices	<i>Attract providers to the Medicaid program using differential rates.</i> States commonly set different FFS provider rates in different geographical regions to attract providers in regions where care may be scarce, and MCPs may negotiate payment rates with providers based on specific needs.¹⁴⁷ States

¹⁴³ Please note that the *Ensuring Access to Medicaid Services* final rule amended 42 C.F.R. § 447.203, effective July 9, 2024, to require payment rate analyses comparing state Medicaid payment rates with Medicare rates for specified categories of service, which may include services delivered to EPSDT-eligible children. See: <https://www.federalregister.gov/documents/2024/05/10/2024-08363/medicaid-program-ensuring-access-to-medicaid-services>.

¹⁴⁴ For more information on state plan amendment payment requirements, see: <https://www.medicaid.gov/resources-for-states/spa-and-1915-waiver-processing/medicaid-spa-processing-tools-for-states/index.html>. For more information on requirements for comprehensive methodology descriptions, see: <https://www.medicaid.gov/state-resource-center/downloads/spa-and-1915-waiver-processing/fed-req-pymt-methodologies.docx>.

¹⁴⁵ 42 C.F.R. § 438.6(c).

¹⁴⁶ For more information about state directed payments, see the “v. *Using Managed Care to Improve Awareness of and Accessibility to Services Available Under EPSDT*” subsection in the “I. Promoting EPSDT Awareness and Accessibility” section.

¹⁴⁷ We remind states that in accordance with 42 C.F.R. § 438.4, Medicaid managed care capitation rates must be developed in accordance with the standards specified in § 438.5 and generally accepted actuarial principles and practices. Any differences in the assumptions, methodologies, or factors used to develop capitation rates for covered populations must be based on valid rate development standards that represent actual cost differences in providing covered services to the covered populations. Any differences in the assumptions, methodologies, or

Best Practices (cont.) that utilize managed care may require MCPs to participate in service payment models intended to recognize value or outcomes over volume of services or performance improvement initiatives.¹⁴⁸ States and MCPs may also consider different provider rates based on the age of the child or the complexity of care, or for pediatric subspecialists or other difficult-to-recruit providers. Higher-performing states, as measured by both the Child Core Set of Quality Measures and the CMS-416, have established a variety of financial incentives targeting well-child visits. Some states have enhanced FFS provider rates for primary care services for EPSDT-eligible children, while others pay quality incentives based on MCP or practice performance on Child and Adolescent Well-Child Visit quality measures.

III. Improving Care for Children with Specialized Needs

Children with specialized needs face unique health care issues that may impact their development. For example, a high percentage of children involved in foster care have been exposed to trauma, which can create wide-ranging and lasting adverse effects on developmental functioning, and physical, social, and emotional well-being.¹⁴⁹ Early detection and treatment in these situations is particularly important for achieving optimal health for children with increased or complex health needs. As such, EPSDT can be a crucial tool in addressing the needs of these children, including: i. children with behavioral health needs; ii. children in foster care; and, iii. children with disabilities or other complex health needs.

Additionally, states should carefully consider the transition coordination mentioned in the “*iii. Using Care Coordination and Case Management to Improve Health Care Accessibility and Continuity for Children*” subsection of the “I. Promoting EPSDT Awareness and Accessibility” section, particularly for children with specialized needs as they near the age of transitioning out of EPSDT eligibility. It is critical that these individuals have assistance with coordinating appointments, transferring medical records, and connecting with new health care providers to ensure continuity of, and access to, necessary health care.

i. Improving Care for Children with Behavioral Health Needs

“Behavioral health” is not an identified, stand-alone service defined within the Act. States are specifically required under the EPSDT provisions of the statute to include an assessment of both physical and mental health development in EPSDT-required screenings, as well as diagnostic and treatment services to correct or ameliorate illnesses and conditions identified by that screening.¹⁵⁰ However, states have broad discretion to cover behavioral health services and supports (including mental health and SUD treatment, peer supports, and/or other services) under a variety of benefit categories in section 1905(a) of the Act, such as physician and clinic services,

factors used to develop capitation rates must not vary with the rate of FFP associated with the covered populations in a manner that increases federal costs.

¹⁴⁸ 42 C.F.R. § 438.6(c).

¹⁴⁹ See: <https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-07-11.pdf>.

¹⁵⁰ Section 1905(r)(1)(B) and 1905(r)(5) of the Act.

Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) services, inpatient and outpatient hospital services, and rehabilitative services. Previous guidance issued in 2018, *Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance*, includes a detailed table of Medicaid authorities that may apply to specific mental health services discussed below.¹⁵¹

Delivering mental health and SUD treatment services poses challenges unlike those in other areas of care. The breadth of behavioral health needs for children throughout their development can be most effectively met by a delivery system that can address a range of needs, beginning with early prevention and including an array of covered treatments. While the demand for behavioral health services has grown, many behavioral health providers do not participate in any health coverage networks, accepting patients who pay out-of-pocket only. This has impacted the availability of these services, resulting in widespread reports of children who are unable to access care. Despite these challenges, some states have reformed their behavioral health delivery system for children and successfully identify and address their behavioral health needs by providing a range of services that are available when and where children need them.

The strategies for improving coverage of and access to behavioral health services below are not exhaustive. As part of technical assistance to states, CMS anticipates publication of a Children’s EPSDT Behavioral Health Toolkit.

Table 11: EPSDT Policies, Strategies, and Best Practices for Improving the Delivery of Behavioral Health Services

Policies	Consistent with section 1905(r)(5) of the Act, states must provide coverage for an array of medically necessary mental health and SUD services along the care continuum in order to meet their EPSDT obligation. Within children’s mental health, there is not yet a nationally available standard, such as Bright Futures for well-child screening and periodicity schedules, for assessing patient needs and describing the continuum of care using a common language. However, there is a broad range of mental health and SUD service types, providers, and settings that can be covered under section 1905(a). The extent of possible coverage allows states to cover a broad array of behavioral health services necessary to achieve good outcomes for children. A service array of behavioral health care that is consistent with EPSDT requirements includes, but is not limited to: 1) screening and assessment; 2) services to build skills for mental health and/or to address early signs or symptoms of concern with or without a diagnosis; 3) community-based services at varying levels of intensity necessary to correct or ameliorate a wide range of behavioral health acute and/or chronic conditions, including routine community-based services as well as community-based services to meet more intensive needs; 4) services to
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¹⁵¹ See: <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf>.

Policies (cont.) address urgent and crisis needs; and 5) inpatient care only when medically necessary.¹⁵²

States have an obligation to assess the availability of 1905(a) services to meet EPSDT-eligible children’s individualized assessed needs, ensure that there are an array of services to meet those needs, and establish and apply medical necessity criteria, but they have flexibility in how they meet that obligation. States are expected to adhere to long-standing EPSDT obligations for eligible individuals from birth to age 21.

As discussed earlier, states are required to develop or adopt a schedule of recommended screenings to determine the existence of physical or mental illnesses or conditions for EPSDT-eligible children.¹⁵³ Most states have adopted the Bright Futures periodicity schedule developed by the American Academy of Pediatrics or a modified version thereof.¹⁵⁴ Periodicity schedules recommend a schedule for screening services, including developmental, mental health, and SUD screenings, and states must ensure children have access to those screenings according to the state-determined schedule. States are required to cover treatment for children’s medical needs, per the requirement at section 1905(r)(5) of the Act to cover all section 1905(a) services needed to “correct or ameliorate” health conditions for EPSDT-eligible children.¹⁵⁵

States should avoid requiring an EPSDT-eligible child to have a specific behavioral health diagnosis for the provision of services, as screenings may identify symptoms that require attention but do not meet diagnostic criteria. This may be particularly salient when addressing the developmental and behavioral health needs of children under age 5.¹⁵⁶ States may not categorically exclude eligible children who have a disability, including an intellectual or developmental disability, from receiving coverage for and provision of behavioral health services.¹⁵⁷ As with a physical health condition, states must ensure that behavioral health symptoms that are identified through screening are addressed in a timely way, as waiting for an illness to develop rather than addressing symptoms when they arise is not consistent with section 1905(r)(5) of the Act.

As states implement EPSDT, they should be mindful of other federal requirements that intersect with the provision of health care services to

¹⁵² In addition to Medicaid requirements, states are obligated to meet the requirements of the Americans with Disabilities Act and *Olmstead*. Compliance with Medicaid requirements, or receipt of the Secretary’s approval of specific Medicaid programs, does not necessarily indicate compliance with civil rights statutes, including the ADA.

¹⁵³ Section 1905(r)(1)(A)(i) of the Act. See also section 1905(r)(1)(A)(ii) of the Act, regarding coverage of screening services at intervals outside the state-established schedule, if medically necessary.

¹⁵⁴ *Ibid.*

¹⁵⁵ Section 1905(r)(5) of the Act.

¹⁵⁶ See: <https://www.medicaid.gov/federal-policy-guidance/downloads/bhccib08182022.pdf>.

¹⁵⁷ See: Title II of the Americans with Disabilities Act, 42 U.S.C. 12132; Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. 794(a); sections 1902(a)(10)(B) and 1905(r)(5) of the Act; and 42 C.F.R. § 440.240.

Policies (cont.) children. Consistent with federal disability rights laws and the Supreme Court’s decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999), states must ensure that services covered under EPSDT are provided in the most integrated setting appropriate for the child, which includes clinics, or in schools, and at home, and must avoid unnecessary placements in segregated treatment settings.^{158, 159} As children should be cared for in the most integrated setting appropriate for their needs, inpatient and residential levels of care must not be the default treatment setting, either explicitly or because of a lack of capacity of services offered in integrated settings, including for children and youth with severe needs, and should be reserved for children with acute needs on a short-term basis.¹⁶⁰ Lastly, states must ensure compliance with the mental health parity requirements in the Mental Health Parity and Addiction Equity Act (MHPAEA) (Pub. L. 110-343) by ensuring that any financial requirements or treatment limitations imposed on mental health and substance use disorder services in separate CHIPs, in Medicaid Alternative Benefit Plans, and for enrollees in Medicaid managed care organizations (MCO) are no more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical services in the same benefit classification.^{161, 162}

States should take advantage of the numerous section 1905(a) benefits under which behavioral health services can be covered, as well as the different types of providers who can deliver these services.¹⁶³ In addition to licensed providers, states may create qualifications for other practitioners, where CMS regulations defining the applicable benefit allow, to expand access to services.

Medicaid agencies have long employed SPMP to ensure that the administration of the program is informed by, and aligned with, clinical standards on behalf of Medicaid beneficiaries; states can access an increased federal matching rate of 75% to support those activities. In 2024, CMS newly allowed states to claim the increased SPMP matching rate with respect to expenditures for employees who have obtained a master’s degree in social work or a master’s degree in another behavioral health field, or a higher degree, provided they are licensed as independent practitioners by the state

¹⁵⁸ Title II of the Americans with Disabilities Act, 42 U.S.C. § 12132; 28 C.F.R. § 35.130(d); Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. 794; 45 C.F.R. § 84.76; Section 1557 of the Affordable Care Act, 42 U.S.C. 18116; 45 C.F.R. § 92.207(b)(6).

¹⁵⁹ See: <https://downloads.cms.gov/cmsgov/archived-downloads/smdl/downloads/smd011400c.pdf>.

¹⁶⁰ Ibid.

¹⁶¹ 42 C.F.R. part 438, subpart K (§§ 438.900 through 438.930), 440.395, and 457.496.

¹⁶² For more information about the mental health and SUD parity requirements for managed care in Medicaid and CHIP, see CMCS’s CIB, available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/cib06122024.pdf>. Parity also applies to Alternative Benefit Plans, section 1937 of the Act and 42 C.F.R. § 440.395.

¹⁶³ See: <https://downloads.cms.gov/cmsgov/archived-downloads/smdl/downloads/smd011400c.pdf>. See also: <https://www.hhs.gov/civil-rights/for-individuals/special-topics/community-living-and-olmstead/index.html>.

Policies (cont.) and all other SPMP requirements are met.¹⁶⁴ This policy will support states to reach the goals set forth in CMCS's *Mental Health and Substance Use Disorder Action Plan*, through hiring and maintaining the specialized expertise needed to administer a robust Medicaid program that can meet beneficiaries' mental health and SUD needs.¹⁶⁵

Certified Community Behavioral Health Center (CCBHC) services were added to section 1905(a) of the Act in 2024; guidance on this state plan service category is forthcoming.¹⁶⁶

Also in 2024, CMS issued guidance to states regarding *Accessing Enhanced Federal Medicaid Matching Rates for State Information Technology Expenditures to Improve Access to Mental Health and Substance Use Disorder Treatment and Care Coordination*.¹⁶⁷ States can claim enhanced federal Medicaid matching rates for certain expenditures to support the 988 suicide and crisis line and to otherwise improve access to and coordination of treatment and support services for children and youth with mental health and SUD needs.

There are special considerations for behavioral health services for separate CHIPs. States that have separate CHIPs must cover behavioral health services needed to screen, diagnose, and treat a broad range of mental health and SUD conditions in a culturally and linguistically appropriate manner.¹⁶⁸ In addition, similar to Medicaid, all states with separate CHIPs must cover medications for addiction treatment and tobacco cessation services.¹⁶⁹ States may demonstrate compliance with mental health parity requirements for separate CHIPs by covering all services under section 1905(r) of the Act (including section 1905(a) services in accordance with section 1905(r)(5)), without excluding coverage for any such services for any particular condition, disorder, or diagnosis, to be deemed compliant.¹⁷⁰

Strategies States use a combination of strategies to meet children's behavioral health needs, including creating a children's behavioral health benefit package with a range of section 1905(a) services to adhere to EPSDT requirements, as well as other state plan services (e.g., services authorized under section 1915(i), 1915(j), 1915(k) and/or 1945) and waiver services. Services authorized through 1915 and 1945 authorities can be used to augment section 1905(a)

¹⁶⁴ See: <https://www.medicaid.gov/federal-policy-guidance/downloads/smd24001.pdf>.

¹⁶⁵ See: <https://www.medicaid.gov/medicaid/benefits/downloads/cmcs-mntl-helth-substnce-disrdr-actn-plan.pdf>.

¹⁶⁶ Section 209, Title I, Division G, Consolidated Appropriations Act, 2024, Pub. L. 118-122, (enacted March 9, 2024). See: <https://www.congress.gov/118/bills/hr4366/BILLS-118hr4366enr.pdf>.

¹⁶⁷ See: <https://www.medicaid.gov/federal-policy-guidance/downloads/cib06142024.pdf>.

¹⁶⁸ Section 2103(c)(5) of the Act; also see SHO# 20-002: <https://www.medicaid.gov/federal-policy-guidance/downloads/sho20001.pdf>.

¹⁶⁹ Sections 1905(a)(4)(D) (tobacco cessation for pregnant individuals in Medicaid), 1905(a)(29) (medication-assisted treatment for opioid use disorders in Medicaid), and 2103(c)(5) (mental health and substance use disorder services in CHIP) of the Act.

¹⁷⁰ 42 C.F.R. § 457.496(b).

Strategies
(cont.)

services covered under EPSDT. Access can be improved to a broad range of services through structural elements such as a single point of entry. Critical components of a high functioning behavioral health system for children include 1) a single point of entry, 2) supporting the management of children with mild to moderate needs in primary care settings, 3) covering a range of specialty care provided in the community to meet the specific needs of children when and where they arise, and 4) relying on inpatient behavioral health treatment only when medically necessary.

Support the management of children with mild to moderate behavioral health needs in primary care settings. Children with mild to moderate behavioral health conditions can benefit from strategies that support the development of integrated pediatric primary care, some components of which can be covered under section 1905(a) benefits, as detailed in previous guidance.¹⁷¹ Many states have decreased barriers to integration by allowing Medicaid payment for activities performed by integrated behavioral health clinicians, which allow children to continue to be served in primary care settings. Some states have removed prohibitions on same day billing, including allowing different practitioners in the same setting to bill for services provided on the same day as long as they are not duplicative, to enable “warm hand offs” rather than requiring families to seek care elsewhere or return another day. Other states incentivize integration by adding Behavioral Health Integration and psychiatric Collaborative Care Model services and rates to their state plan.¹⁷²

All states must cover developmental and behavioral health screening for EPSDT-eligible children as described in section 1905(r)(1) and (5). A few states require that providers use an evidence-based, age-appropriate developmental or behavioral health screening tool during every well-child visit. States have increased developmental and behavioral health screening rates by paying add-on rates to primary care providers for using an evidence-based screening tool during well-child and follow-up visits and by using quality incentive payments to support reaching screening goals.

Cover the broad range of specialty care that can be authorized under section 1905(a) to meet EPSDT obligations and consider augmenting that coverage with services authorized under section 1915(c) and 1915(i) of the Act. States have used a range of Medicaid-coverable services to help meet children’s behavioral health needs, including crisis services, CCBHC services,

¹⁷¹ See: <https://www.medicaid.gov/federal-policy-guidance/downloads/bhccib08182022.pdf>.

¹⁷² For more information about Behavioral Health Integration and the psychiatric Collaborative Care Model, see CMS’s MLN Booklet on Behavioral Health Integration Services, available at: <https://www.cms.gov/files/document/mln909432-behavioral-health-integration-services.pdf>. For more information about Collaborative Care Models, see also the “iii. Encouraging the Use of Interprofessional Consultation to Address EPSDT Workforce Shortages” subsection in “II. Expanding and Using the Children-Focused (EPSDT) Workforce.”

Strategies (cont.)	outpatient mental health and SUD treatment, and intensive home-based services. - <u>Crisis services</u>: Crisis services may be provided in a facility, at home, or in the community. Mobile Crisis Intervention (MCI) services are available 24/7 and may be provided in the home or any setting where a crisis may be occurring and includes rapid response, individual assessment, and crisis resolution by trained mental health and SUD treatment professionals and paraprofessionals. States cover MCI under a range of Medicaid authorities, including 1905(a), as outlined in the 2021 <i>Medicaid Guidance on the Scope of and Payments for Qualifying Community-Based Mobile Crisis Intervention Services</i>.¹⁷³ Because of states' broad discretion in setting provider qualifications, states can require MCI providers to receive training on the unique issues that arise when working with children and youth, such as ways to engage with parents and/or guardians who are on scene; special consent issues that arise with minors; and specific information on the facilities and providers that are most equipped to work with a child or youth in crisis. - <u>CCBHCs</u>: CCBHC services are a newly established benefit under section 1905(a) as a model for delivering behavioral health care. Several states are addressing the need for specialized behavioral health care through the development of CCBHCs, which are designed to ensure access to coordinated, comprehensive, 24/7 behavioral health care and include staff with expertise in addressing trauma and promoting the recovery of children with serious emotional disturbance.¹⁷⁴ States that include services ranging in intensity that are easily accessible can decrease emergency department utilization and inpatient hospitalization rates and can help avoid unnecessary child welfare system involvement. - <u>Outpatient mental health and SUD treatment</u>: All states are required to cover medically necessary outpatient mental health and SUD treatment for EPSDT-eligible children, as this treatment falls under several section 1905(a) benefit categories. States have broad discretion to license and credential providers of these services; most states cover a range of qualified providers and practitioners, such as peer support practitioners, CHWs, or other professional supports, to augment the professional staff in their network and ensure maximum service availability. - <u>Intensive home-based services</u>: Intensive home-based services may include therapy, care coordination, parent and/or youth peer services,
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¹⁷³ See: <https://www.medicaid.gov/federal-policy-guidance/downloads/sho21008.pdf>.

¹⁷⁴ For more information on CCBHCs and the CCBHC demonstrations authorized under section 223 of the Protecting Access to Medicare Act (PAMA), as expanded under section 11001 of the BSCA of 2022, see the Consolidated Appropriations Act of 2024, Public Law 118-122 and CMS's Section 223 Demonstration Program to Improve Community Mental Health Services website, available at: <https://www.medicaid.gov/medicaid/financial-management/section-223-demonstration-program-improve-community-mental-health-services/index.html>.

Strategies
(cont.)

and behavioral interventions, among others. Many states cover components of intensive home-based services under section 1905(a). Some states identify children with more serious behavioral health needs and develop a section 1915(c) HCBS waiver program to prevent placement in residential care. Intensive care coordination (ICC) is usually provided in accordance with a detailed service plan to provide therapeutic supports to help the child develop skills to successfully function in the community. Many states reported providing ICC through a TCM benefit for children with Serious Emotional Disturbance, where the Intensive Care Coordinator partners with the child and their family to convene a team of cross-sector service providers, community members, friends, and other supports to develop a comprehensive and individualized plan of care.^{175, 176}

Other services coverable under section 1905(a) may allow children and youth to access intensive treatment without the need for out-of-home placement, including the therapies provided in the context of Partial Hospitalization Programs or Intensive Outpatient Programs. Some state Medicaid programs cover parent peers, whose work is critical to supporting parents to allow children with more intensive needs to remain at home. States may choose from several different federal Medicaid authorities to add coverage of peer support services to their state plans, including the rehabilitative services benefit that has most often been cited by states for this purpose, as well as the preventive services benefit.¹⁷⁷ Some parent-facing services can be paid for through the child's Medicaid benefit if the service is provided for the direct benefit of the child.^{178, 179}

Rely on behavioral health treatment provided in inpatient and residential settings only when necessary. Inpatient treatment should not be used as a default intensive treatment, including due to a lack of capacity in community-based settings, but should be reserved for children and youth who cannot be safely and effectively treated in those settings. For EPSDT-eligible beneficiaries, states are required to cover medically necessary psychiatric inpatient hospitalization in a general hospital, a freestanding psychiatric hospital, or a psychiatric residential treatment facility under the section 1905(a) “inpatient psychiatric services for individuals under age 21”

¹⁷⁵ See: <https://store.samhsa.gov/sites/default/files/intensive-care-youth-coordination-pep19-04-01-001.pdf> and <https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-05-07-2013.pdf>.

¹⁷⁶ ICC activities can be covered under the TCM benefit if they meet Medicaid requirements at 42 C.F.R. § 440.169(b).

¹⁷⁷ Section 1905(a)(13) of the Act. See: <https://www.medicaid.gov/federal-policy-guidance/downloads/faq06052024.pdf>.

¹⁷⁸ See: https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/clarifying-guidance-support-policy_215.pdf.

¹⁷⁹ See: <https://www.medicaid.gov/federal-policy-guidance/downloads/cib051116.pdf>.

Strategies (cont.)	benefit..^{180, 181} States or their contracted MCPs must have adequate inpatient capacity either in- or out-of-network to meet the service needs of their EPSDT-eligible beneficiaries..¹⁸² <u>Establish a single point of entry for the behavioral health system.</u> A few states have established a behavioral health system with a single point of entry that can be accessed by parents, clinicians, schools, juvenile justice, and foster care agencies, as well as youth themselves. This approach greatly reduces the complexity and delays in accessing and obtaining care. <u>Cover section 1905(a) services in separate CHIP programs to be deemed compliant with mental health parity.</u> One approach states may use in separate CHIPs to demonstrate compliance with mental health parity requirements is to cover the same services as those covered under the Medicaid EPSDT benefit. In order to be deemed compliant with mental health parity requirements through this approach, separate CHIP coverage must align with all Medicaid requirements for EPSDT, including coverage of section 1905(a) services in accordance with section 1905(r)(5) of the Act..¹⁸³
Best Practices	<i>Create a seamless and comprehensive behavioral health system for children.</i> One state approached the delivery of behavioral health services to children and youth by creating a system that provides a seamless and comprehensive array of behavioral health services with a single point of entry. The state Medicaid agency establishes payment and coverage policy, pays for services, and creates and monitors a contract with an administrative services organization (ASO), for which the state claims federal administrative match. The ASO provides streamlined implementation and coordination of the range of youth behavioral health services and acts as a single point of entry to the system through a toll-free number staffed by clinicians who provide assessment and triage, as well as utilization management. The ASO also hosts a statewide electronic health record and out-of-home bed-tracking system. This state uses a range of authorities, including section 1905(a), other Medicaid state plan authorities (e.g., 1915(i)), and section 1115 demonstration opportunities, to cover a care continuum to meet the behavioral health needs of children with mental health, substance use, and/or intellectual and developmental disorders. The array of covered services includes state plan services, such as case management, psychiatry and psychology services, medication management, counseling, intensive in-home services, and TCM, as well as mobile crisis intervention services, which can be covered under a number of different Medicaid authorities, such as

¹⁸⁰ 42 C.F.R. § 440.160.

¹⁸¹ See section 1905(a)(16)(A) of the Act and 42 C.F.R. § 441.151.

¹⁸² 42 C.F.R. §§ 438.206(b), 441.61(b).

¹⁸³ 42 C.F.R. § 457.496(b).

Best Practices (cont.)	sections 1905(a) and 1915(i) of the Act, for example. The state further uses its section 1115 demonstration authority to expand eligibility to youth who are not otherwise Medicaid or CHIP eligible but who are at risk of out-of-home placement so that virtually all youth who are assessed to be at risk of out of home placement are eligible. The section 1115 demonstration also covers services such as enrichment activities to enhance community inclusion, social/emotional learning services, home and vehicle modifications, and respite care. Primary care clinicians make use of the state's PMHCA program to enable children with mild to moderate mental health needs to be managed without entering the specialty care system. The state participates in the Medicaid CCBHC demonstration opportunity, which has increased capacity for child behavioral health specialty care when needed. Since adoption of this model, the state's out-of-home placements have been reduced by 60%, and most children are able to receive care while remaining in their current living situation.
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ii. Improving Care for Children in or Formerly in Foster Care

While children in foster care represent less than 2% of all children enrolled in Medicaid, they are an especially vulnerable population whose safety and well-being are the legal responsibility of the state. Children in Title IV-E foster care, children who were in title IV-E foster care but who are now receiving title IV-E kinship guardianship or adoption assistance, and former foster youth up to age 26 are automatically eligible for Medicaid and are entitled to the same range of EPSDT services as other EPSDT-eligible children. Children in or formerly in foster care have higher rates of physical and behavioral health care needs compared with children without a history of foster care involvement. Children in foster care may not live close to their home communities or may move from place to place, disrupting the relationship with primary care, dental, and other providers. State Medicaid agencies can work with the state child welfare agency to identify and address the priority needs for children in or formerly in foster care in their state and to ensure that they have access to the Medicaid covered services to which they are entitled. While receipt of Title IV-E is one eligibility pathway to Medicaid, many children who have contact with the child welfare agency or are otherwise at risk of foster care often have Medicaid eligibility that entitles them to EPSDT unrelated to their entry into foster care.

Table 12: EPSDT Policies, Strategies, and Best Practices for Children in Foster Care

Policies	Within a few days of placement in foster care, or as statutorily obligated, states should ensure that children receive an initial assessment of acute physical and behavioral health needs, followed by a comprehensive visit similar to a well-child visit. Title XIX specifically enumerates receipt of benefits under Title IV-E of the Act as categorically entitling eligible children
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Policies (cont.) to Medicaid and EPSDT.¹⁸⁴ Title IV-B of the Act requires the state child welfare agency to develop a health care coordination and oversight plan for their children involved in foster care with input from the state Medicaid agency, pediatricians, other health care experts, child welfare service experts, and recipients of these services.¹⁸⁵

To address challenges in the transition to adult coverage and care, state Medicaid agencies are required to maintain coverage for former foster youth until age 26, including for those foster youth who were enrolled in another state when they turn age 18.^{186, 187} These youth retain EPSDT eligibility until age 21.

Strategies Develop and maintain a collaborative relationship with the child welfare agency to ensure that children in foster care receive all medically necessary services to which they are entitled under EPSDT requirements. The child welfare agency can provide expertise to the state Medicaid agency in identifying the specific needs of the population of children in foster care or those at risk of out-of-home placement so that the Medicaid agency can develop effective policies to meet those needs. Collaboration between Medicaid and child welfare agencies can support implementation of EPSDT requirements if a child enters foster care.

Support youth in foster care by using dedicated MCPs, covering “wraparound” services, paying enhanced provider rates for primary care visits, and/or using an EQR study to examine health care utilization among these youth. States have adapted Medicaid to address the unique health care needs of youth in foster care in different ways. Several states have dedicated MCPs that serve these children and youth exclusively, with rates reflective of their needs, and states monitor performance improvement metrics specific to foster youth. Other states cover “wraparound” services that include caregiver support and are specifically designed for children in or at risk of out-of-home placement. Other states pay enhanced provider rates for primary care visits to reflect the extra time that may be needed when a child enters care or moves to a new family placement and to help ensure an adequate supply of providers to meet the timeliness goals of their programs. A few states have their EQR perform a focus study to examine foster care health care utilization patterns; states serving this population outside of managed care could perform a similar analysis.

Best Practices *Require MCPs to assign a liaison and trauma-informed care manager to children in foster care.* One state enrolls children in foster care into the same MCPs as other children but requires each MCP to have a foster care liaison

¹⁸⁴ Section 1902(a)(10)(A)(i)(I) of the Act.

¹⁸⁵ Section 422(b)(15)(A) of the Act.

¹⁸⁶ See: <https://www.medicaid.gov/federal-policy-guidance/downloads/sho22003.pdf>.

¹⁸⁷ See: <https://www.acf.hhs.gov/sites/default/files/documents/cb/im2304.pdf>.

Best Practices (cont.) and trauma-informed case managers assigned to these beneficiaries. These dedicated staff coordinate with the state’s child welfare agency, Medicaid agency, and providers. They perform additional outreach to and educate foster parents, who may need extra assistance navigating two complex systems of care. Additionally, these case managers provide transitional assistance as youth age out of foster care, return home, or live with a permanent family. The complex needs of children in foster care may result in higher capitation rates paid to the MCPs.¹⁸⁸

Implement an MCP dedicated to children in foster care. Other states have implemented an MCP dedicated solely to serving children and youth in foster care. A statewide MCP for children in foster care allows the state Medicaid agency to draft a contract that includes the requirements of both the Medicaid and child welfare agencies and enables the MCP to specialize and focus on the special needs of this population. These MCPs provide foster families with case managers who are trained to understand the foster care landscape, the MCPs’ network adequacy requirements are built to reflect the needs of the population enrolled, and the reporting requirements reflect performance measures specific to the needs of the population in foster care and child welfare requirements for timeliness.

iii. *Improving Care for Children with Disabilities or Other Complex Health Needs*

Children with disabilities or other complex health needs often have a combination of functional limitations, chronic health condition(s), ongoing use of medical technology, and high resource need and use. These children usually require a robust set of section 1905(a) services provided by primary care and pediatric subspecialists, as well as numerous therapists. These children also may have behavioral health conditions or developmental or intellectual disabilities that add complexity to their clinical presentation. Case management, as previously described in this letter, is an essential tool for coordinating across a beneficiary’s care team to ensure that these children, when eligible for EPSDT, receive the medically necessary services they are entitled to under EPSDT requirements.

Table 13: EPSDT Policies, Strategies, and Best Practices for Children with Disabilities or Other Complex Health Needs

Policies	Children with disabilities or other complex health needs may qualify for Medicaid or CHIP on the same bases as other children, and, in some cases, may qualify on the basis of their disability or their corresponding needs for long-term services and supports. ¹⁸⁹ The policies, strategies, and best
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¹⁸⁸ 42 C.F.R. § 438.4.

¹⁸⁹ Section 1902(a)(10) and (e)(3) of the Act, 42 C.F.R. §§ 435.100-300; Section 2102(b)(1)(A) of the Act, 42 C.F.R. § 457.320(a)(6).

Policies (cont.) practices included herein are not intended to be limited only to children who qualify for Medicaid based on a disability.

EPSDT requirements are critically important for eligible children with disabilities or other complex health needs, who may or may not qualify for Medicaid due to their disability and may or may not meet an institutional level of care or be at risk of requiring institutionalization. The intersection of EPSDT requirements with requirements for other Medicaid authorities, such as managed care and HCBS authorities, as well as for other federal programs, can be complicated. Many children with disabilities or other complex health needs receive health services through multiple federal programs, including the Title V Maternal and Child Health program, with special provisions relating to intersecting entitlements that can be complex for families to navigate.¹⁹⁰ Medicaid agencies are required to have an interagency agreement with their Title V agencies and may choose to develop interagency agreements with other state agencies.¹⁹¹ Importantly, Title V is a secondary payer after Medicaid—an exception to the general rule of Medicaid being the payer of last resort.¹⁹²

States may not require children determined to be disabled by their state or the Social Security Administration, or children receiving services under Title V, to enroll into certain types of managed care without an approved section 1915(b) waiver or section 1115 demonstration authority.¹⁹³ If states seek section 1915(b) waiver authority, they must demonstrate that restricting the beneficiary’s freedom of choice of provider does not substantially impair access to medically necessary services of adequate quality.¹⁹⁴

To meet their EPSDT obligations and the needs of children with disabilities or other complex health needs, states should have an adequate number of enrolled providers, and MCPs should have a sufficient provider network, including pediatric specialists and children’s hospitals, wherever possible, to deliver section 1905(a) medically necessary covered services.¹⁹⁵ States must develop and enforce pediatric-specific network adequacy standards for certain provider types in most managed care programs.¹⁹⁶ States can claim the increased SPMP federal matching rate to support employing qualified individuals who have advanced skills and the expertise necessary to ensure that states understand how to meet the needs of children with disabilities or other complex health needs.^{197, 198}

¹⁹⁰ See: <https://crsreports.congress.gov/product/pdf/IF/IF12685>.

¹⁹¹ 42 C.F.R. § 431.615.

¹⁹² Section 505(a) of the Act.

¹⁹³ Sections 1932(a)(2)(A)(i)-(iii), 1915(b), and 1115 of the Act, and 42 C.F.R. § 438.50(a).

¹⁹⁴ Section 1915(b) of the Act.

¹⁹⁵ See section 1902(a)(30)(A) of the Act and 42 C.F.R. §§ 441.61, 438.68.

¹⁹⁶ 42 C.F.R. § 438.68(b) and (e).

¹⁹⁷ 42 C.F.R. § 433.15(b)(5).

¹⁹⁸ 42 C.F.R. § 432.50(d).

Policies (cont.) Children with disabilities or other complex health needs can often require specialized care not available close to home. To ensure that EPSDT-eligible children receive timely access to providers, including pediatric subspecialists, states and MCPs should have clear procedures on how to access out-of-network and/or out-of-state providers. For EPSDT-eligible children enrolled in Medicaid managed care who need access to out-of-network care, states and their MCPs must ensure mechanisms exist to guarantee timely access to medically necessary services.¹⁹⁹ States are required to pay for EPSDT-eligible children’s medically necessary 1905(a) services furnished by out-of-state providers (such as pediatric subspecialists) when the state determines on the basis of medical advice that the services are more readily available in another state.²⁰⁰

For children whose medical needs cannot be met by in-state providers and for whom the state has identified an out-of-state provider to deliver medically necessary services, states should screen and enroll out-of-state providers within an abbreviated timeframe to help ensure that children can access care in a timely fashion. Additionally, states should develop standard agreements with other states governing coverage and payment for services furnished to Medicaid-eligible children living in another state by providers screened and enrolled in the other state(s). For example, states could streamline the process of enrolling out of state providers by relying on the enrollment screening conducted by other states based on criteria outlined in agreements between states.^{201, 202} Regardless of whether the care is delivered by out-of-network or out-of-state providers, states are required to assure transportation and scheduling assistance for EPSDT-eligible children.²⁰³

While doing so is not required under EPSDT, states may develop approaches to cover services in addition to those covered under section 1905(a), with the goal of maintaining children with disabilities or other complex health needs in integrated home and community-based settings or helping them return to their community. This may assist states with their community integration obligations under Title II of the Americans with Disabilities Act, Section 504 of the Rehabilitation Act of 1973, and the Supreme Court’s decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999).²⁰⁴ HCBS may be covered under a

¹⁹⁹ 42 C.F.R. § 438.206.

²⁰⁰ Section 1902(a)(16) of the Act and 42 C.F.R. § 431.52.

²⁰¹ 42 C.F.R. § 431.52.

²⁰² See: <https://www.medicaid.gov/federal-policy-guidance/downloads/cib102021.pdf>.

²⁰³ 42 C.F.R. §§ 431.53, 441.62.

²⁰⁴ For more information on the *Olmstead* decision, see CMS’s series of five “*Olmstead* letters,” which identify policies and provide technical support, tools, and resources for states to support their efforts to build robust, community-based systems that support community integration and community living: <https://www.medicaid.gov/federal-policy-guidance/downloads/SMD011400C.pdf>; <https://www.medicaid.gov/federal-policy-guidance/downloads/smd072500a.pdf>; <https://www.medicaid.gov/federal-policy-guidance/downloads/smd072500b.pdf>;

Policies (cont.) number of authorities to help individuals receive care at home and in the community.²⁰⁵ This includes, for example, HCBS waivers under section 1915(c) of the Act and state plan HCBS under section 1915(i) of the Act. Services that can only be covered under section 1915 of the Act, and that cannot be covered under section 1905(a), are not included under EPSDT.²⁰⁶

Under section 1915(c) of the Act, individuals must meet a specified institutional level of care (hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities) and be part of one or more of the following target groups or any subgroups thereof: aged or disabled or both, individuals with intellectual or developmental disabilities or both, or individuals with mental illness. These section 1915(c) waiver programs may be condition-specific, such as for children with Autism Spectrum Disorder (ASD), or may be more general, such as for those who are technology dependent or medically fragile.²⁰⁷ States may also specify the minimum and maximum age of individuals enrolled in a section 1915(c) waiver program. Under section 1915(i) of the Act, individuals are required to meet state-defined needs-based criteria to access state plan HCBS. A state has the option to establish eligibility criteria for state plan HCBS under section 1915(i) based on age, diagnosis, disability, and/or Medicaid eligibility group.

The section 1915(c) waiver program and state plan 1915(i) HCBS authorities both require states to develop a written person-centered service plan (PCSP) for each beneficiary to identify services and supports needed to function successfully in the community and to assure their health and welfare. The PCSP must reflect the services and supports (both paid and unpaid) that are important to meet an individual's needs identified through an assessment of their functional needs.²⁰⁸

As discussed above, under section 1905(r)(5) of the Act, the EPSDT mandate includes coverage of any medically necessary service under section 1905(a) of the Act. States must determine whether any medically necessary services

<https://www.medicaid.gov/federal-policy-guidance/downloads/smd011001a.pdf>; and

<https://www.medicaid.gov/federal-policy-guidance/downloads/smd011001b.pdf>.

²⁰⁵ In addition to HCBS waiver programs under section 1915(c) of the Act and state plan HCBS under section 1915(i) of the Act, which are discussed more fully in this SHO, states can also cover HCBS under section 1915(k) of the Act and section 1915(j) of the Act. Section 1915(k) of the Act establishes the optional Community First Choice (CFC) benefit, which allows states to provide eligible Medicaid enrollees with HCBS attendant services and supports under the state plan. Section 1915(j) of the Act establishes an optional service delivery model for HCBS in which states can allow individuals to self-directed personal care services (PAS) as an alternative to traditional agency-delivered services. PAS includes personal care and related services provided under the Medicaid state plan or HCBS provided under a section 1915(c) waiver program.

²⁰⁶ Section 1905(r)(5) of the Act.

²⁰⁷ For more information about the Medicaid options, including 1915(c) HCBS waivers, to cover services for children with ASD, see CMCS's CIB and the related FAQ, available at, respectively:

<https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/CIB-07-07-14.pdf> and <https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/downloads/FAQ-09-24-2014.pdf>.

²⁰⁸ 42 C.F.R. §§ 441.301(c)(2), 441.725(b).

Policies (cont.) included on an EPSDT-eligible child's PCSP are coverable as section 1905(a) services under EPSDT obligations before covering them under a 1915(c) HCBS waiver program, or a state plan option under 1915(i) (HCBS), 1915(j) (self-directed personal care services), or 1915(k) (Community First Choice). As a result, any 1915(c) waiver program services and state plan 1915 services that could be covered under a section 1905(a) benefit must be covered first as a section 1905(a) service for EPSDT-eligible children.

While states have the option to include extended section 1905(a) services under section 1915 authorities (i.e., a section 1905(a) service with an extended amount, duration, or frequency compared to what is available for that 1905(a) service under the Medicaid state plan), that does not change the underlying EPSDT requirement at section 1905(r)(5) to cover EPSDT-eligible children's medically necessary section 1905(a) services. For example, a section 1915(c) waiver program may include coverage of extended 1905(a) services (i.e., covering for individuals enrolled in the waiver program a section 1905(a) service in an amount greater than otherwise permitted under the state plan). Even though the section 1915(c) waiver program covers section 1905(a) services beyond what is covered under the state plan, the state would still be required to cover medically necessary section 1905(a) services for EPSDT-eligible children, whether or not they are enrolled in the waiver program, in the amount, duration, or scope that is medically necessary for the individual child, in order to comply with section 1905(r)(5).

However, the state must cover waiver program services for EPSDT-eligible children enrolled in the section 1915(c) waiver program that differ from any coverage required under EPSDT under section 1905(r). Additionally, CMS interprets section 1905(r)(5) to mean that a state's decision to cover a section 1905(a) service under a section 1915 authority cannot be used to deny, delay, or limit access to medically necessary section 1905(a) services for which coverage is required under EPSDT.

An EPSDT-eligible child who is also eligible under a section 1915(c) waiver program or 1915 state plan benefit may need section 1905(a) services above and beyond what is medically necessary, to enable them to live in the community and avoid institutionalization. In this case, the child is entitled to all necessary services: those that are identified in their approved PCSP that assist the child to function in the home and community and avoid institutionalization via a section 1915(c) waiver program or section 1915 state plan authority, as well as any medically necessary section 1905(a) services under EPSDT. It is the responsibility of states to ensure that EPSDT-eligible children receive all services to which they are entitled.

EPSDT-eligible Medicaid-enrolled children who are on a waitlist for a section 1915(c) HCBS waiver program are entitled to all medically necessary

Policies (cont.) section 1905(a) services under EPSDT while on the waitlist..²⁰⁹ States cannot limit the number of individuals served by state plan 1915(i) HCBS and, as a result, any EPSDT-eligible child who meets the state’s 1915(i) enrollment criteria is entitled to the 1915(i) services and supports identified in their PCSP, as well as any medically necessary section 1905(a) services under the EPSDT obligation..²¹⁰

Strategies Expand MCP enrollment to include children with disabilities or other complex health needs. An increasing number of states are expanding enrollment in their MCPs to include children with disabilities or other complex health needs and other populations not previously enrolled..²¹¹ Some states have developed specific MCP contracts and enroll these children into specialized MCPs. This strategy has the benefit of focusing on pediatric subspecialty networks, tailored reporting on relevant requirements, and enhanced care coordination. Other states enroll children into existing MCPs with other children, potentially streamlining administration while still allowing for enhanced care coordination. In both cases, including these children in state managed care quality strategies and focused EQRO studies helps demonstrate quality of care for the population.

To understand how to meet the needs of these children, states and their MCPs should identify the population of high-need children and adolescents. This may require using diagnosis and/or service utilization data, identification by providers, or entitlement for Supplemental Security Income. States might use a standardized assessment tool to determine an individual child’s needs and what services they may need.

Provide care coordination. Due to the number of services and providers involved in care for children with disabilities or other complex health needs, quite a few states offer moderate to intensive care coordination for these beneficiaries. Regardless of delivery system, moderate to intensive care coordination helps ensure a single point of contact for families and provides integration among the child’s providers. Care coordinators streamline access to services and minimize redundancies or gaps in care by coordinating among the child’s Medicaid providers and other child-serving agencies to ensure that families do not have to conduct their own research about which agency or agencies can help them. States can establish an executive level children’s cross-agency team to ensure consistency in policy and implementation.

²⁰⁹ Under a section 1915(c) HCBS waiver program, states may limit the number of individuals who may be served by the waiver. Section 1915(c)(3) of the Act.

²¹⁰ 42 C.F.R. § 441.725.

²¹¹ Certain children with special health care needs may not be required to enroll into mandatory managed care without an approved section 1915(b) waiver or section 1115 demonstration authority. See section 1932(a)(2)(A) of the Act.

Best Practices *Coordinate programs for children and youth with disabilities or other complex health needs, provide them with a broad range of non-medical services, and implement a program to help their families navigate care.*

One state coordinates several programs focused on addressing the needs of children and youth with disabilities or other complex health needs by locating them all in a single administrative unit to create a cohesive system of care. The state also convenes an advisory council made up of parents of these children and youth, state and county agency staff, advocates, and providers to provide insight into the common challenges that families of children and youth with disabilities or other complex health needs encounter.

This state operates a statewide section 1915(c) waiver program that provides a broad range of nonmedical services, tailored to the needs of these children, that complements medical services provided under EPSDT. This includes services like parental skills training, respite care, and home modifications.

The state has also implemented programs to help families navigate the system of care. The state pays qualifying hospitals for TCM provided by a team that includes a provider, a nurse, and a care coordination assistant. To help improve awareness of these and other programs within and outside of Medicaid, the state has also launched a statewide telephone and web-based hotline for families to receive guidance on identifying and accessing programs.

Conclusion

CMS is committed to ensuring children get the care they need, when and where they need it, and that states adhere to EPSDT requirements. The EPSDT mandate represents a critical part of the Medicaid program that is designed to ensure eligible children have access to essential medical, dental, behavioral health, and developmental services from an early age. As Medicaid has grown more complex, navigating access to these services has become more difficult, with coordination and assistance ever more important to access care. By focusing on the critical importance of health care access and utilizing best practices to provide services to EPSDT-eligible children, states can help children and their families address and overcome barriers they may face in obtaining comprehensive health care services. The collective effort and shared commitment of CMS, state Medicaid agencies, health care providers, and caregivers is essential in advancing the coverage goal of EPSDT—the right care, to the right child, at the right time, in the right setting—to help ensure children in Medicaid have the opportunity to reach their full health potential.

CMS is eager to work with states as they work to ensure that EPSDT requirements are being met for their beneficiaries. We will continue to host periodic technical assistance webinars for states, and we encourage states to reach out with questions or tailored assistance requests by emailing the EPSDT mailbox at EPSDT@cms.hhs.gov.

Sincerely,

/s/

Daniel Tsai
Deputy Administrator and Director

DATE FILED
September 30, 2025 2:58 PM
FILING ID: 8EFF9D5FE57BE
CASE NUMBER: 2025CV33489

EXHIBIT 7

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4	Home and Community-Based Services (HCBS)

Rate Reductions for Services Billed on Professional Claims and Institutional Hospital Claims

On August 28, 2025, pursuant to Article IV, Section 2 of the Colorado Constitution, and C.R.S. § 24-75-201.5, Governor Polis issued [Executive Order D 2025 014](#) declaring insufficient revenues available for expenditures and ordering the suspension, in whole or in part, of certain State programs or services in order to meet a revenue shortfall for Fiscal Year (FY) 2025-26 and balance the state budget.

The Department of Health Care Policy & Financing (the Department) *will reduce all fee-for-service rates previously increased by 1.6% as a result of legislative appropriations for FY 2025-26.* This is pursuant to the Executive Order and consistent with the Governor's Office presentation to the Joint Budget Committee.

When does the rate change begin?

The rates will be reduced for dates of service on or after October 1, 2025.

Which provider types are impacted?

This will affect providers who bill using the Professional claim form (CMS 1500) and hospital providers who bill on the Institutional (UB-04) claim form.

Dental services, some Home and Community Based services and Pediatric Behavioral Therapies will be targeted for a rate adjustment exceeding the 1.6% decrease.

All other professional fees will be impacted by the across-the-board rate reductions.



Hospital

An email will be sent to hospital stakeholders to review the 30-day posting of new hospital rates. Impacted rates include:

- Inpatient APR-DRG hospital base rates
- Outpatient EAPG hospital base rates
- Per Diem Specialty & Psychiatric hospital base rates

Contact Diana Lambe at Diana.Lambe@state.co.us with any questions relating to inpatient hospital rates.

Contact Sean Paschke at Sean.Paschke@state.co.us with any questions relating to outpatient hospital rates.

Della Phan at Della.Phan@state.co.us with any questions relating to rehabilitation, long-term acute care, or psychiatric hospital rates.

Dental

Targeted rate adjustments for Dental rates effective for dates of service (DOS) beginning October 1, 2025, can be found in the table below. The Department calculated that a 15.5% reduction to the July 2024 rate for each of these codes would meet the required savings target. The Department believes that applying the reduction preserves the intent of the General Assembly to the greatest extent possible by ensuring that the codes which had the most significant disparities do not receive a disproportionate reduction. In almost all cases, rates remain higher than they would if the increase to each code was reduced by 43.6%. A 1.6% reduction to all other codes will apply based on the Executive Order to roll back rate increases that were implemented on July 1, 2025.

Procedure Code	Code Description	Rate Effective 10/01/2025
D0120	Periodic oral evaluation	\$32.41
D0140	Limited Oral Evaluation Problem Focused	\$44.90
D0150	Comprehensive Oral Evaluation	\$51.57
D1110	Prophylaxis Adult	\$82.39
D1120	Prophylaxis Child	\$61.72
D1206	Topical fluoride varnish	\$35.46
D1351	Sealant Per Tooth	\$48.25
D1352	Prev resin rest, perm tooth	\$83.93
D1354	Interim Caries Arresting Medicament Application, Per Tooth	\$46.08
D2740	Crown, Porcelain/Ceramic substrate	\$717.54
D2750	Crown Porcelain High Noble Metal	\$710.70
D2751	Crown Porcelain Base Metal	\$648.14
D2752	Crown Porcelain Noble Metal	\$674.56
D2790	Crown Full Cast High Noble Metal	\$733.98
D2794	Crown Titanium	\$707.16

Procedure Code	Code Description	Rate Effective 10/01/2025
D2930	Prefab Stainless Steel Crown Primary	\$167.72
D3310	End Therapy, anterior tooth	\$675.80
D3320	End Therapy, bicuspid tooth	\$775.46
D3330	End Therapy, molar	\$937.37
D3346	Retreatment Root Canal Anterior	\$770.31
D3347	Retreatment Root Canal Bicuspid	\$882.28
D3348	Retreatment Root Canal Molar	\$1,052.92
D4341	Periodontal Scaling & Root Planing	\$225.20
D4342	Periodontal Scaling 1 to 3 Teeth	\$160.28
D4910	Periodontal Maintenance	\$125.91

Pediatric Behavioral Therapy

Targeted rate adjustments for Pediatric Behavioral Therapies effective for dates of service (DOS) beginning October 1, 2025, may be found in the table below.

Procedure Code	Code Description	Rate Effective 7/1/2025	Rate Effective 10/1/2025
97151	BHV ID ASSMT BY PHYS/QHP	\$27.59	\$27.09
97153	ADAPTIVE BEHAVIOR TX BY TECH	\$18.17	\$17.20
97154	GRP ADAPT BHV TX BY TECH	\$11.51	\$8.81
97155	ADAPT BEHAVIOR TX PHYS/QHP	\$26.62	\$25.80
97158	GRP ADAPT BHV TX BY PHY/QHP	\$17.83	\$9.34

Durable Medical Equipment

The rate decrease applies to manually-priced claims that follow the Manufacturer's Suggested Retail Price (MSRP) less or invoice acquisition plus methods only.

Method/Source	2025 Decrease (1.6% Decrease- Effective Oct 1, 2025)
Durable Medical Equipment	
MSRP less	13.78%
Invoice acquisition cost plus	24.06%
Prosthetics	
MRSP less	13.78%
Invoice acquisition cost plus	24.06%

Home and Community-Based Services (HCBS)

Home and Community-Based Services (HCBS) will be impacted by the 1.6 percent across-the-board decrease.

Targeted rate reductions for Home and Community-Based Services (HCBS) must be approved by the Centers for Medicare and Medicaid Services (CMS) through the waiver amendment process. Providers will be notified when specific targeted rate reductions for HCBS services will be effective in future provider bulletins.

Fee schedules may be found on the [Provider Rates and Fee Schedule web page](#).

[Provider Services Call Center](#)

1-833-468-0362

DATE FILED
September 30, 2025 2:58 PM
FILING ID: 8EFF9D5FE57BE
CASE NUMBER: 2025CV33489

EXHIBIT 8

**COLORADO**Department of Health Care
Policy & Financing303 E. 17th Ave. Suite 1100
Denver, CO 80203

FY 2025-26 HCPF Budget Reductions Fact Sheet

September 2025

On Aug. 28, 2025, Governor Polis signed [Executive Order D25 014](#) that reduces General Fund expenditures to bring Colorado's budget into balance for the current fiscal year, State Fiscal Year 2025-26 (FY 2025-26). Some of the reductions will impact programs administered by the Department of Health Care Policy & Financing (HCPF). In alignment with [HCPF's Medicaid Sustainability Framework](#) (slide 9), the Governor directed HCPF to enact the following budget reduction measures that target Medicaid trend drivers, reduce Medicaid spending, and help balance the state budget. These initial measures will result in \$79.1 million in reductions to the General Fund. Unfortunately, further reductions may be implemented in the coming months.

We appreciate the collaborative partnership with providers and stakeholders as we work together to develop a path forward to ensure the sustainability of the Medicaid program while navigating this difficult time.

Budget reductions are listed in chronological order based on implementation dates beginning August 28, 2025.

\$5.6 million in General Fund reduction for halting implementation of continuous coverage for children ages 0-3

- The Centers for Medicare and Medicaid Services (CMS) has indicated it will not provide federal match funding for this coverage expansion policy and will not approve or renew 1115 waiver provisions that include continuous coverage for Medicaid members.
- Given this guidance, Colorado will cease implementation and revert the general fund appropriation intended for continuous coverage.

Implementation Date: August 28, 2025

\$4.4 million General Fund reduction by eliminating the nursing facility minimum wage supplemental payment

- Set in statute to sunset next year, this payment was in place to supplement wages prior to the minimum wage in nursing facilities rising above \$15.00/hour.
- With this change, the department will end the distribution of the funds one year early.
- Nursing Facility rates will not be impacted by the 1.6% across-the-board (ATB) reduction.

Implementation Date: August 28, 2025 - payments will not go out in Spring 2026.



\$500,000 General Fund reduction to Immigrant Family Planning Services from SB 21-009 Reproductive Health Care Program

- This program provides family planning and family planning-related services to individuals who would qualify for Medicaid, except for their citizenship status.
- This program has historically underspent its budget, which is currently \$2.6 million of state-only funds; therefore, this reduction is absorbable and will not reduce access to these important services.

Implementation Date: August 28, 2025

\$131,000 General Fund reduction to eliminate Cover All Coloradans Outreach

- This reduction will not change eligibility for Cover All Coloradans.
- Funding was included in the implementing legislation, HB22-1289, for a grant program to fund education and outreach to support the initial launch of Cover All Coloradans.

Implementation Date: August 28, 2025

\$38.3 million General Fund reduction by rolling back the 1.6% provider rate increase passed for FY 2025-26

- HCPF will post the updated rate tables [here](#) as soon as possible.
- The historic average Across the Board (ATB) increase in provider reimbursements before COVID, and the related introduction of federal stimulus dollars, averaged 0.62% annually. The ATB provider rate increases from FY 2021-22 to FY 2024-25 ranged from 2-3%, or about 3 times to 5 times higher than typical, historic annual ATB rate increases. The 1.6% ATB increase was 2.5 times higher than historic averages.
- Eliminating the 1.6% ATB increase after 3 months (effective October 1) approximates a 0.4% ATB annual increase, which is more in line with the historic 0.62%.

Expected Implementation Date: October 1, 2025

\$500,000 General Fund reduction by eliminating grants to train providers for a well-established screening tool and interventions related to substance use, and repurposing the Marijuana Cash Tax Fund to offset the General Fund

- Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a well-established screening tool, used to assess the need for alcohol or drug abuse treatment.
- The funds that will be reduced go to a vendor that provides training to providers. Free training at the state level has not been well attended, but free federal training will remain available for providers who wish to utilize it.
- SBIRT screening is still a covered Medicaid benefit.

Expected Implementation Date: October 1, 2025



\$2.5 million General Fund reduction by reducing FY 2024-25 Dental Provider Rates

- This reduction relates to a group of codes that received increases effective July 1, 2024 to align HCPF's Medicaid fee-schedule with commercial rates. Some codes were adjusted to match 100% of the commercial benchmark; others were adjusted to match 70% of the commercial benchmark.
- This adjustment will reduce those rates which received targeted increases, but will be applied equitably so that rates which had a significant disparity with commercial rates are not disproportionately affected.
- The final rate for each of the effective codes reduces the rate increase implemented July 1, 2024 by 15.5%.
- This reduction preserves the intent of the original rate action to correct significant rate disparities while still achieving the required savings.

Expected Implementation Date: October 1, 2025.

\$2.7 million General Fund reduction by resetting the pediatric behavioral therapy rates to 95% of the new benchmark

- This benchmark includes updated rates for all comparator states, including Nebraska.
- These rates will not be subject to the 1.6% ATB provider rate reduction.

Expected Implementation Date: October 1, 2025

\$7 million General Fund reduction by implementing pre- and post- claim review of all pediatric autism behavioral therapy codes due to expected audit findings

- The Office of Inspector General (OIG) preliminary exit meeting for Audit A-09-24-02004 occurred on July 22, 2025. OIG provided an audit summary that highlighted methodologies used and initial findings that included a number of billing discrepancies and errors. The final audit findings should be released this fall.
- HCPF received funding for FY 2025-26 to contract with a vendor to conduct prepayment claim reviews of high risk providers. Providers of pediatric autism behavioral therapies will be reviewed for inclusion in the prepayment work. Additionally, HCPF will utilize a vendor to determine applicable post-payment reviews of providers and claims for autism services to ensure the providers are credentialed and licensed, and the services are necessary and appropriate.

Expected Implementation Date: Auditing efforts to begin October 1, 2025, and be ongoing throughout the year.

\$1.7 million General Fund reduction for inpatient and outpatient drug testing

- Currently, there are no limits on the number of drug tests per member.
- HCPF will implement a limit of 16 tests per year per individual before a prior authorization is needed to authorize additional testing.

Expected Implementation Date: October 10, 2025



\$6.1 million General Fund reduction to reinstate Medicaid prior authorization of outpatient psychotherapy for services that exceed clinical standard best practices

- Per SB 22-156, Medicaid removed Prior Authorization Requests (PARs) for outpatient psychotherapy.
- Since implementing the legislation, HCPF saw a 17% increase in aggregate utilization, with the most significant increase in utilization of more than one session a week for 6-12 months, reflective of a marked change in provider behavior.
- This change will maintain access to outpatient psychotherapy services for Medicaid members and ensure that members are receiving the appropriate levels of care.
- PARs will not be in place for initial visits, just for providers claiming more than 20-24 sessions per patient in a calendar year.

Expected Implementation Date: HCPF will adjust the RAE contracts to reflect this change effective January 1, 2026.

\$3.0 million General Fund reduction by adjusting the Community Connector rate to better align with similar benefits and services

- HCPF is aligning rates based on service scope, training requirements, and comparability to similar services to ensure the sustainability of Colorado's Medicaid program. (Community Connector has different training requirements than certain licensed services; the rate is being aligned accordingly.)
- Further details are available in a [memo released about this rate cut](#).

Expected Implementation Date: January 1, 2026

\$1.5 million General Fund reduction to the Access Stabilization Payments to rural, small, and pediatric providers by implementing these payments effective January 2026, assuming CMS approval, versus retrospectively to July 2025.

- Providers have not received any of these payments yet. This reduction delays implementation of the payment to glean savings for FY 2025-26.
- Providers can still expect these payments beginning in January 2026, assuming HCPF receives federal approval.

Expected Implementation Date: The payment start date is delayed from July 2025 to January 2026.

\$1.5 million General Fund reduction to align the Individual Residential Services and Supports rates for host home and family caregiver homes

- Individual Residential Services and Supports (IRSS) is a service available exclusively in the Developmental Disabilities (DD) waiver, offering residential services in various settings.
- Currently, providers are billing different rates for Host Home services rendered by a contractor and Host Home services provided by a family caregiver, with a higher rate paid to family caregivers. (They are billing at the 'Staffed Home' rate.) This should not



be the case; Host Homes and family caregiver homes are staffed in the same manner, with those providing services sharing the residence.

- HCPF intends to change rules to clarify that family caregivers must bill at the same rate as Host Home providers.

Expected Implementation Date: After the rules are passed, expected in March 2026.

\$750,000 General Fund reduction to Incentive Payments in the Accountable Care Collaborative (ACC Quality Program)

- These payments are used to incentivize Regional Accountable Entities (RAEs) and Primary Care Medical Providers (PCMPs) to reach health and performance outcomes.
- This is about a 25% reduction to the total amount that can be earned by PCMPs and the RAEs for the first payment for the primary care quality improvement projects. There are two additional payments in FY 2026-27 for which the appropriation is not impacted.

Expected Implementation Date: The impacted payments are expected to go out in March 2026

\$3 million General Fund reduction for Behavioral Health Incentive Program (BHIP) payments

- These payments are distributed annually to the RAEs for achievement of certain behavioral health outcomes and performance metrics within their regions, with 66%-90% of awarded incentive funds passed through to behavioral health providers.
- This represents about a 31% reduction in the incentive payments for last year's performance period.

Expected Implementation Date: Payments for performance in FY 2024-25 will be reduced in spring 2026.

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