September 10, 2026

Colorado Access Behavioral Health Provider Town Hall

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Agenda

- Welcome & Introduction
- Compliance Corner
- Key Provider Updates
- Provider Education
- Questions

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Thank You for Joining Us

Colorado Access Members

Amber Pace

Senior Director of Behavioral Health Services

Sarah Vigil

Manager of Compliance Risk & Auditing

Renee Fletter

Supervisor of Claims Research

Bill Pierini

Senior Provider Network Contractor

Sarah Otto

Manager of Claims Technical Operations

Wonder Moore

Behavioral Health Program Manager

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Compliance Corner

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Setting Expectations: In Scope and Out of Scope

In scope

- Questions about the audit process
- What the audit covers and how it is conducted
- What providers can expect and how to prepare

Out of scope

- Questions about your particular audit situation
- Individual findings, records, or claims
- Case-specific follow-up should be handled outside the town hall

Audit-Ready Documentation

What providers should submit to support behavioral health claims

Use this guide before every audit submission

The Audit-Ready Record

A complete record tells one consistent story.

1. **Eligible provider**

   Licensed, credentialed, qualified for the service

2. **Active plan**

   Assessment and treatment plan in effect on the service date

3. **Medically necessary service**

   Documented need, intervention, and response

4. **Matching claim**

   Code, units, and duration agree with the note

Provider action: Submit a complete, organized record — not isolated notes.

Submission Checklist: Start Here

Member identifiers

Name on every document

Requested dates of service

Every date in the request — none omitted

Assessment

Signed, dated, and current for the period

Active treatment/service plan

In effect on each date of service

Progress notes

One per billed session, in date order

Credentials & supervision

Licenses, staff roster, supervision evidence, supporting policies

Provider action: Label files by member and date; verify every requested date is included.

Every Progress Note Must Show

Member name

Identify the member on the note itself

Date and time

Start/end time or total session duration

Place of service

Office, home, community, or telehealth

Reason for the service

Presenting symptoms, need, or goal addressed

Intervention provided

The specific technique or activity delivered

Response and progress

How the member responded; movement toward goals

Next plan

Follow-up, frequency, or plan changes

Signature & credential

Dated signature with credential or title

Provider action: Use a note template and complete every field.

Show Medical Necessity — Not Just Activity

Connect need to intervention

Tie the documented symptoms and functional impact directly to what you did in the session.

Explain clinical rationale

State why this service, at this level and frequency, was the right choice for this member.

Document response

Record how the member responded and what progress — or lack of progress — followed.

Justify duration and units

Support the time billed with session length and the clinical work that filled it.

Provider action: Write individualized detail that supports why this service and this amount were needed.

Signatures, Credentials, and Staff Qualification

Dated provider signature

Every note signed and dated by the rendering provider

Qualifying credential or title

Credential or title printed alongside the signature

Current license/certification

Valid and unexpired on the date of service

Staff roster

Names, roles, and qualifications of rendering staff

Required co-signatures

Supervisor co-signature where the program requires it

Proof for each provider

Qualification evidence for everyone who rendered a service

Provider action: Include proof of qualification for each rendering provider.

Supervision: What to Document

Written supervision plan

Policy naming the supervisor, supervisee, and required frequency

Qualified supervisor

License, credential, and approval to supervise on the service date

Supervision sessions logged

Dates, participants, and topics of each supervision contact

Co-signature on notes

Supervisor co-signs and dates notes where the program requires it

Supervisee scope of practice

Evidence the service was within what the supervisee may deliver

Evidence with the submission

Include the supervision policy and documentation logs, not just the signed notes

Provider action: Submit the supervision policy plus dated logs and co-signatures for each supervisee.

Assessments and Treatment Plans

Recent assessment

Completed within six months of the date of service

Clinician signature & credentials

Signed by the assessing clinician with credentials

Plan active on the service date

Effective dates must cover every billed session

Measurable goals

Specific, observable goals and interventions

Member signature

Member or guardian signature on the plan

Or documented explanation

If unsigned, document why and the outreach attempted

Provider action: Check effective dates and signatures before submission.

Consent and Telehealth

Consent to services

Signed member or guardian consent for treatment, current for the service period.

Telehealth consent

Separate documented consent to receive services by telehealth.

Audio-only rationale

Document clinical appropriateness and why no other delivery method was possible.

Provider action: Include consent records and modality rationale.

Avoid High-Risk Documentation Patterns

Cloned text

Notes copied session to session with no new clinical content

Conflicting facts

Dates, times, or details that contradict other records

Wrong pronouns or names

A clear sign of templated or mismatched documentation

Generic responses

"Member did well" without specifics or measurable progress

Illegible entries

Handwriting or scans a reviewer cannot read

Unexplained inconsistencies

Gaps between the note, the claim, and the plan

Provider action: Individualize each note and perform a quality review.

Denials: D15, D19

Recommended File Order

1. Cover / index
2. Eligibility & consents
3. Assessment
4. Active treatment plan
5. Chronological progress notes
6. Credentials & staff list
7. Supervision policy & evidence
8. Other supporting documents

Provider action: Use one indexed PDF or clearly numbered files when permitted.

Denials: D22–D24, A12, T5

Final Quality Check Before Sending

- Correct member and date range on every document
- All requested dates of service included
- Signatures and credentials present and dated
- Treatment plans active for each service date
- Each note matches its claim line
- Files readable, oriented, and complete
- No contradictions across documents

Provider action: Have a second person complete the checklist.

Denials: All

Key Provider Updates

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Supportive Services Rate Changes

Rate decreases effective December 1, 2026 - Medicaid and CHP+

Reimbursement rates for the following nonclinical supportive services codes decrease for both Medicaid and CHP+.

Service Code	Current: Licensed Masters	Current: NP, PA, PhD, PsyD	Current: MD, DO	New Rate (all licenses)
H0023	$10.50	$11.55	$13.65	**$7.71**
H2015	$9.21	$9.24	$10.92	**$7.71**
H2016	$221.15	$221.15	$221.15	**$123.36**
H2017	$8.40	$9.24	$10.92	**$7.71**
H2018	$109.20	$120.12	$141.96	**$123.36**
H2021	$9.87	$9.87	$9.87	**$7.71**
H2022	$236.83	$236.83	$236.83	**$123.36**
H2027	$15.75	$17.33	$20.48	**$7.71**
T1016	$16.66	$18.33	$21.66	**$7.71**
T1017	$16.66	$18.33	$21.66	**$7.71**

New rates apply to all rendering providers regardless of license. T1016 is not a Medicaid benefit; the new rate applies to CHP+ only.

Codes Removed from Base Fee Schedule

Effective December 1, 2026 - available only by contract amendment

These codes are tied to fidelity-monitored evidence-based models that require provider certification and/or documented fidelity oversight.

Service Code	Brief Description
H0036 HA	Functional Family Therapy (FFT) or Community Psychiatric Supportive Treatment (CPST), per 15 mins
H0037 HA	Functional Family Therapy (FFT) or Community Psychiatric Supportive Treatment (CPST), per diem
H0039	Assertive community treatment, per 15 mins
H0040	Assertive community treatment program, per diem
H2030	Mental health Clubhouse services, per 15 mins
H2031	Mental health Clubhouse services, per diem
H2033	Multisystemic therapy for juveniles, per 15 mins

Providers seeking authorization for these services should submit a request, with certification and/or fidelity documentation, to provider.contracting@coaccess.com.

Prior Authorization: CO-SOC Services

Prior authorization required as of December 1, 2026

Colorado Access will require prior authorization for the following Colorado System of Care (CO-SOC) services.

Service Code	Brief Description
H2000 HA	Enhanced Standardized Assessment (ESA)
T2022 HA	Enhanced Multi-Systemic Therapy (EMST)
T2022 HK	Enhanced Functional Family Therapy (EFFT)
T2022 HT	Enhanced High Fidelity Wraparound (EHFW)

Initial authorization information is on the Prior Authorization & UM Resources page at coaccess.com. Questions: provider.contracting@coaccess.com

What Is a Recovery Residence?

As defined in Colorado Revised Statutes (C.R.S.) 27-80-129

A "recovery residence," "sober living facility," or "sober home" means any premises, place, facility, or building that provides housing accommodation for individuals with a primary diagnosis of a substance use disorder.

The residence must

- Be free from alcohol and nonprescribed or illicit drugs.
- Promote independent living and life skill development.
- Provide structured activities and recovery support services intended to promote recovery from substance use disorders.
- House individuals whose primary diagnosis is a substance use disorder.

It does not include

- A private residence where a relative of the owner must abstain or receive services as a condition of residing there.
- The supportive residential community for people who are homeless at the Fort Lyon property (24-32-724).
- A facility approved for residential treatment by the Behavioral Health Administration.
- Permanent supportive housing units within affordable housing developments.

Source: Colorado Revised Statutes 27-80-129.

Behavioral Health Recovery Residence Policy

Health First Colorado policy - enforced by the RAEs effective October 1, 2026

What the policy says

- Behavioral health services delivered in a Recovery Residence are not billable to Medicaid - fee for service or RAE.
- Recovery Residences are certified as supportive living; they are not licensed to deliver SUD clinical or supportive services.
- They do not meet any Place of Service code, including 12-Home or 14-Group Home.
- Mobile Crisis Response providers are exempt and may continue crisis services in these settings.

What providers must do

- Stop billing behavioral health services delivered in Recovery Residence settings as of October 1, 2026.
- Providers certified by Ohio Recovery Housing and contracted with a RAE must sign and submit the HCPF attestation to their RAE by October 1, 2026.
- Be ready to report any relationship with a Recovery Residence, and members residing in one, if your RAE requires it.

Provider Education

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We Want Your Feedback

Behavioral health provider town hall meeting survey

Share your feedback on our Town Hall

We are asking all behavioral health providers to complete a short survey on the Colorado Access behavioral health provider town hall meetings. Your input helps shape future topics, format, and timing.

Two ways to complete the survey

- Visit the survey link below
- Scan the QR code with your phone camera

https://forms.cloud.microsoft/r/mXQzVT5RET

Scan to complete the survey

Thank you for taking a few minutes to share your feedback with Colorado Access.

Stay Connected & Contacts

Provider resources & key contacts

Provider Emails

Sign up for Colorado Access provider emails to receive important updates, trainings, and resources.

Visit: www.coaccess.com/providers/

BH Town Hall Meetings

Register: www.coaccess.com/providers/

Questions regarding registration: clinical@coaccess.com

The slide deck and video will be uploaded no later than the following Friday.

Meeting materials: www.coaccess.com/providers/resources/trainings/

Contacts

General questions
Customer Service (800) 511-5010

Provider Network Services
providernetworkservices@coaccess.com

Claims questions
claimsresearch@coaccess.com

Contracting
provider.contracting@coaccess.com

Credentialing
credentialing@coaccess.com

Payment Questions
For questions unique to your contract please contact
provider.contracting@coaccess.com

Please note: Medicaid FFS questions should be directed to HCPF.

Questions

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