Behavioral Health Community Programs: Services and Network Report

Response to a Request from the Colorado General Assembly Joint Budget Committee

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Submitted to: Joint Budget Committee

COLORADO
Department of Health Care Policy & Financing

Contents

I. Executive Summary

The Department of Health Care Policy & Financing (HCPF) submits this report in response to a request for information from the Joint Budget Committee regarding the Colorado Medicaid behavioral health program. It includes an overview of the capitated behavioral health services in fiscal year (FY) 2022–23 and the performance of the behavioral health managed care entities (MCEs). The report provides an overview of the behavioral health system by measuring member access to care, provider network expansion and contract timelines, and timeliness of payment. Colorado Medicaid members who access behavioral health services do not pay a copay or a deductible.

State Medicaid programs require continuous innovation and problem-solving to meet the needs of many stakeholders, including Health First Colorado (Colorado's Medicaid program) members and providers, while complying with state and federal regulations and honoring the mandate to manage taxpayer funds responsibly. HCPF is committed to continuing this important work with behavioral health.

A. The Behavioral Health Capitated Benefit

1. Description of Benefit

HCPF is the single state agency responsible for administering Health First Colorado benefits as a part of the state's Medicaid program. HCPF maintains contracts with eight MCEs; seven Regional Accountable Entities (RAEs) and Denver Health Medicaid Choice, a Managed Care Organization (MCO) for Denver County; which are responsible for administering, managing, and operating the Medicaid capitated behavioral health benefit by ensuring members have access to medically necessary covered behavioral health services.

This managed care model connects members with coordination of behavioral health services, responds flexibly to emerging needs, and works within a state-determined behavioral health budget to develop regional networks that ensure members have access to a full continuum of behavioral health services and primary care coordination. It also allows the state to offer special federally approved services for people with serious mental illness that can be difficult to support and reimburse in a fee-for-service model. These services are authorized by the federal Centers for Medicare and Medicaid Services (CMS) through a

1915(b)(3) waiver, also called “alternative” or B3 services, which are intended to help keep people healthy in their communities.

To be compliant with state and federal regulations, MCEs must spend at least 85% of their capitated behavioral health payments on direct treatment expenses for members, with the remaining 15% available for community supports and partnerships, alternative funding, support technologies, and other administrative and staff operating expenses. HCPF tracks, audits and reports MCE submissions on this requirement annually.

2. Utilization Management

MCEs are federally and contractually required to maintain a network of providers adequate to meet member needs based on utilization of services. Each MCE has its own utilization management program for behavioral health services to ensure the right care is provided in the right setting to improve quality, ensure least restrictive care settings, and promote more efficient and cost-effective care. MCEs are also required to follow any statewide utilization management policies, such as the limitation on prior authorization for psychotherapy. MCEs are responsible for meeting many federal requirements, including ensuring that members are accessing appropriate, medically necessary treatment.

MCEs are federally required to establish and maintain utilization management policies and procedures to safeguard against unnecessary utilization of care and services. Utilization management includes policies that review services provided, financial and clinical audits, setting appropriate limits on services, and in some cases, prior authorization requirements. With prior authorization, Medicaid programs balance the need to deliver services in a timely manner with the need to manage member care and ensure members are receiving the right care for their situation. Most services do not require prior authorization. Details about services for which MCEs require a prior authorization can be found in HCPF’s annual Parity Report[1].

[1] https://hcpf.colorado.gov/sites/hcpf/files/2024%20MHPAEA%20Parity%20Report%20Full%20Version.pdf

B. Behavioral Health Utilization FY 2022–23

In FY 2022–23, 19% of Health First Colorado members accessed capitated behavioral health services, which includes mental health and SUD services. By the end of this time period, member enrollment in the ACC averaged 1,594,150, which includes 110,285 members enrolled in Denver Health Medicaid Choice. Utilization trends for the behavioral health capitation are listed below. This report also includes trends across time for this data.

- 303,546 members used capitated behavioral health services. Among that group, 66.05% (200,498) used mental health services, 15.81% (47,986) used SUD services, and 56.41% (171,233) used B3 services.
- Of the 200,498 distinct utilizers of mental health services, 200,109 (99.81%) received outpatient mental health services. Inpatient mental health services were used by 11,959 (5.96%), and 3,885 (1.94%) received residential mental health services.
- Of the 47,986 utilizers of SUD services, 42,207 (87.96%) utilizers used outpatient services. 12,180 (25.38%) received residential treatment and 3,568 (7.44%) had an inpatient SUD stay.
- In FY 2022-23, 19% members used capitated behavioral health services, compared to 18.9% in FY 2021-22, 18.1% in FY 2020-21 and 19.4% in FY 2019-20. Note that enrollment significantly increased in FY 2020-21 due to the COVID-19 public health emergency.

C. Provider Network, Credentialing, and Contracting

Each MCE is responsible for establishing a network of providers in their region to serve the needs of members. These networks must include residential and inpatient facilities, safety net providers like community mental health centers, and the individual, small, and medium sized providers in the independent provider network. MCEs are required to complete the credentialing and contracting processes or deny network admission within 90 days for at least 90% of all provider applications. Since the requirement was set in January 2022, every MCE has been in compliance with contracting and credentialing times.

At the end of FY 2022-23, there were 11,417 MCE-contracted behavioral health providers, compared to 11,061 at the end of FY 2021-22. As a point of reference, there were 8,627 MCE-contracted behavioral health providers at

the end of FY 2020-21 and 6,391 at the end of FY 2019-20.[2] HCPF has set as a top priority to continue expanding the statewide contracted network of behavioral health providers through ongoing collaboration with providers, MCEs, and the community. Overall, during FY 2022-2023 the behavioral health statewide network grew by 10.87%. The Independent Provider Network (IPN) grew by over 77.99% during that same period.

As of quarter 3 of FY 2023-24, Network Adequacy reports for General Behavioral Health Service Categories indicate MCEs have expanded their practitioner networks and met greater than 99% of time and distance metric standards.

During the reporting period from January 1, 2023 - December 31, 2023, data indicate that 20,924 inpatient (residential and hospital) SUD services were utilized by 10,899 unique members. This reflects an increasing service utilization trend across the 1115 SUD Waiver Demonstration of episodes of care and number of unique members served.

D. Claims Processing and Provider Payments

In compliance with federal regulations, HCPF requires MCEs to adjudicate and pay 90% of all clean claims within 30 days of receiving them, and 99% of clean claims within 90 days of receipt. All MCEs met this standard in calendar year 2023.

E. Quality Oversight Practices

HCPF maintains workstreams to improve quality oversight including creating a form for the IPN to report any outstanding issues or concerns they have; establishing RAE health equity plans to identify priority populations; identification and inclusion of behavioral health quality measures within CMS core measures to promote better outcomes; and monitoring the implementation of House Bill 23-1243 Hospital Community Benefit bill to identify communities that identified behavioral health as a community need.

[2] Count includes unique providers, deduplicated across all RAEs, representing a total statewide contracted network for the Behavioral Health Capitation Benefit.

F. Improving Behavioral Health Services Statewide

HCPF continues to work with providers, MCEs, and state agencies to improve the provider experience in contracting, credentialing, and reimbursement with the goal of expanding the behavioral health safety net in Colorado and increasing access for members. Initiatives include:

- Support for Independent providers through collaborative action on credentialing and contracting, billing and coding, payment and reimbursement, service quality and communications.
- Collaborating with other state agencies to reform Colorado's behavioral health system with the goal of expanding access to care and enhancing the quality of care delivered to all people in Colorado.
- Development of the third phase of the Accountable Care Collaborative through robust stakeholder engagement ahead of a July 1, 2025, launch date.
- ARPA funds were used to provide grants to initiate efforts such as high-intensity outpatient service providers, permanent supportive housing for Medicaid members, and community transition supports.

II. Introduction and Overview of the Behavioral Health Capitated Benefit

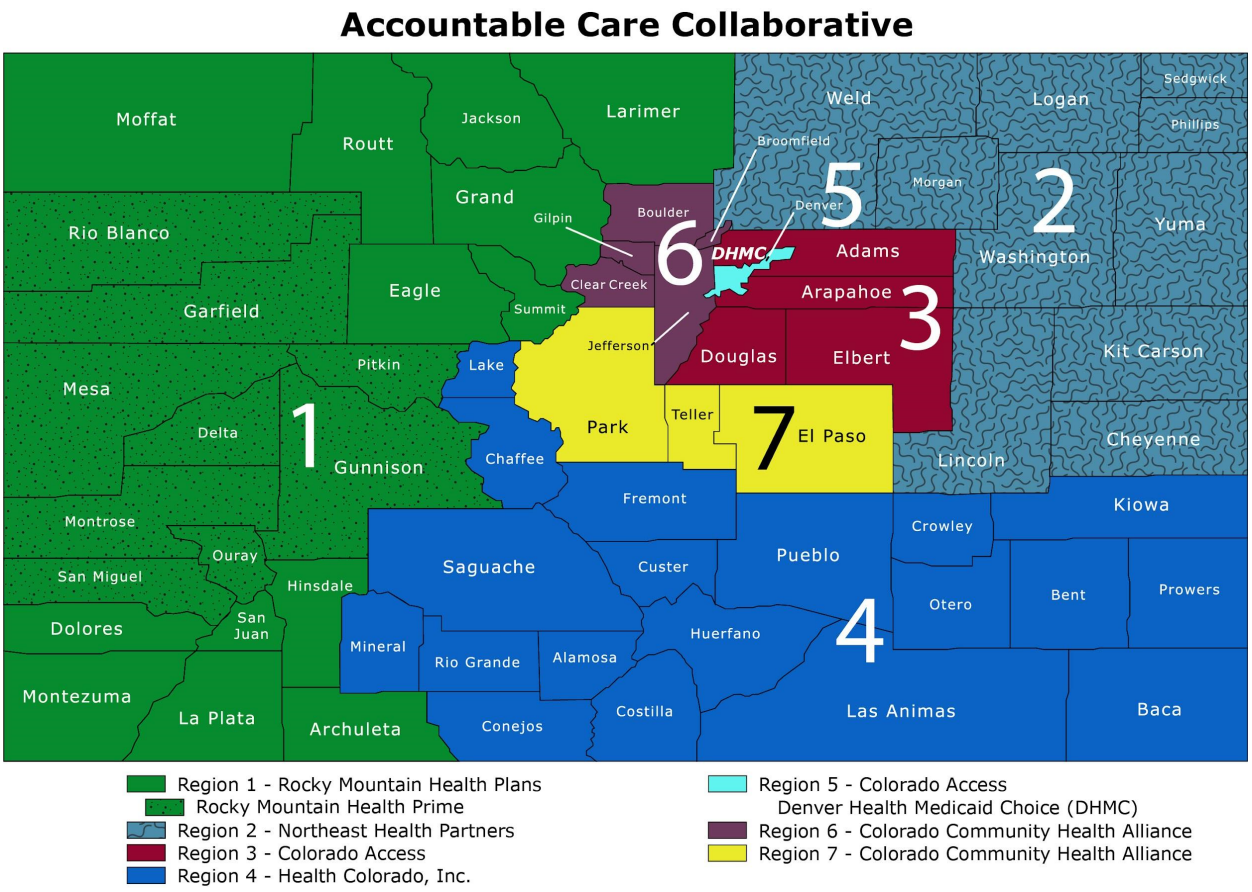
A. About This Report

The Department of Health Care Policy & Financing (HCPF) prepared this report in response to a request for information from the Joint Budget Committee to discuss member utilization of capitated behavioral health services in FY 2022–23 and the performance of the behavioral health managed care entities (MCEs) on network provider expansion, timeliness of processing provider claims within contract requirements, and timeliness of credentialing and contracting network providers. It includes aggregated data on the number of members accessing inpatient and residential mental health treatment, inpatient and residential substance use disorder (SUD) treatment, outpatient mental health and SUD services, and alternative services allowed under HCPF's waiver with the Centers for Medicare and Medicaid Services (CMS). The report also includes, for calendar year (CY) 2023, aggregated provider data by quarter showing changes in the number of providers contracted, monthly claims processing timeframes by each MCE, and timeliness of provider credentialing and contracting by each MCE. It also discusses how HCPF monitors these performance measures and the actions HCPF has taken to improve MCE performance and member behavioral health outcomes.

B. About the Behavioral Health Capitated Benefit

HCPF is the single state agency responsible for administering Health First Colorado. HCPF contracts with eight MCEs to administer, manage, and operate the Medicaid capitated behavioral health benefit by providing medically necessary covered behavioral health services. Seven Regional Accountable Entities (RAEs) and Denver Health Medicaid Choice, a Managed Care Organization (MCO) for Denver County, are contracted with HCPF to do this for most behavioral health services. Denver Health Medicaid Choice (DHMC), authorized through C.R.S 25.5-5-402 delivers physical health care in the Denver metro region and subcontracts with the RAE in Region 5 to administer the capitated behavioral health benefit. MCEs have primary accountability for promoting optimized behavioral health and wellness for all members and providing or arranging for the delivery of medically necessary mental health and SUD services.

Figure 1. Regions of the Accountable Care Collaborative (ACC) Phase 2



The managed care model offers several advantages for members. It helps with coordination of behavioral health services and allows the state to offer special benefits for people with Serious Mental Illness (SMI) that would not be available under a fee-for-service model. (These services, called “alternative” or “B3” services, are discussed in detail in the next section.) The managed care model also allows HCPF to respond quickly and flexibly to emerging needs, such as the need for behavioral health telehealth during the pandemic. Importantly, the managed care model allows the state to track progress on metrics and adjust policies or practices when the state is not getting the most value for its health care dollars. Additionally, the Behavioral Health Administration (BHA) is planning for Behavioral Health Administrative Service Organizations (BHASOs), which will consolidate SUD treatment and crisis services and include services offered by comprehensive community behavioral health centers. Although RAEs and BHASOs are similar, there are differences between populations served and function. The shared goals are to improve services to Coloradans, improve coordination and efficiencies across the

system and create consistency for providers while reducing administrative burden. BHASOs will be implemented by July 2025.

C. Behavioral Health Services Offered

Behavioral health is complex and often requires services from a care team and/or multiple providers. The Medicaid benefit includes outpatient services such as individual and group therapy, medication management, psychiatrist services, outpatient hospital psychiatric services, drug screening/monitoring and intensive outpatient programs. The benefit also covers emergency and crisis services, and residential and inpatient treatment.

The behavioral health benefit also covers alternative wraparound services - the previously mentioned “B3 services”. These include:

- Prevention
- Early Intervention
- Clubhouses
- Drop-in Centers
- Vocational Services
- Assertive Community Treatment
- Residential Mental Health Treatment
- Respite Care
- Recovery Services
- Peer Support

These B3 services offer members a way to connect with peers and develop life skills and a community of support. These services can be especially important for members with SMI, and those who have co-occurring mental health and SUD diagnoses, complex medical needs, cognitive disorders, or are involved with criminal justice systems.

These B3 services are one of the greatest flexibilities supported through a managed care system. Over half (57%) of individuals with behavioral health needs benefit from these services every year; that is nearly 11% of the total Medicaid population. Without a managed care option, in order to retain the current behavioral health benefit, all of these services would need to be moved under the Medicaid fee-for-service benefit authority and approved by the federal government. This would also require a review of cost and budget analysis for each service and any connected service, the development of state

administered utilization management for these services, and increased provider documentation and the need to submit an authorization request for each unit of service. Any of these services could be significantly limited based on the policy or budget analysis review. HCPF's current program is a demonstrated cost savings program that, unlike fee-for-service, allows for the flexible and responsive use of state funds. Managed care programs are also able to pay variable rates to providers based on the need in the region and set up higher rates for specialty services or special cases.

Table 1. Overview of Services Covered by the Inpatient, Outpatient and B3 Services within the Behavioral Health Capitated Benefit

Outpatient Services	Inpatient and Residential Services	Wraparound, Intensive Support B3 Services
• Individual, group, and family therapy • Medication management • Psychiatrist services • Outpatient hospital psychiatric services	• Emergency and crisis services • Inpatient hospital psychiatric care • Residential and inpatient substance use disorder (SUD) treatment • Residential and inpatient withdrawal management	• Prevention/Early Intervention • Clubhouses/Drop-in Centers • Vocational Services • Assertive Community Treatment • Residential Mental Health Treatment • Respite Care • Recovery Services/Peer Support

D. Behavioral Health Utilization Management

Federal laws and regulations require state Medicaid programs to have utilization management (UM) for benefits to safeguard against unnecessary utilization and to assure that payments are consistent with efficiency, economy, and quality of care. Federal regulations allow managed care plans to place appropriate limits on services for the purposes of UM, most prominent of which is the use of service authorization requests. Through its contracts with MCEs, HCPF expects MCEs to maintain a network of providers adequate to meet member needs based on utilization of services. Each MCE has its own UM program for behavioral health services to reduce waste and promote efficient and cost-effective care.

Because Medicaid can only pay for medically necessary services, an MCE is required to make a medical necessity determination when processing a request for authorization for any service. So even though a provider makes a recommendation for a specific service or treatment modality, or a clinician makes a recommendation for care based on a diagnosis and clinical

interview/assessment, an MCE is required to consider the medical necessity criteria established in 10 CCR 2505-10 section 8.076.1.8 and section 8.280.4E when approving or denying authorization and payment for services.

All MCEs are required to use a nationally-recognized UM tool, such as Interqual, 3M, or Milliman Clinical Guidelines (MCG) to process prior authorization requests. Additionally, due to the lack of uniform standards of UM for members under age 21, HCPF worked with the MCEs to create guidelines that can serve families and providers in identifying appropriate levels of care and which align with state medical necessity criteria. These have been published as the Colorado Statewide Standardized Utilization Management (SSUM) Guidelines for Youth Under 21 Years Old. All MCEs were required to use these guidelines effective July 1, 2023. This document will continue to be edited/added to as the MCEs work to create guidelines for each level of care.

In 2024, the General Assembly passed Senate Bill (SB) 24-135, amending HCPF's reporting requirements in relation to SUD utilization management that was previously required through SB21-137. HCPF published the final SUD Utilization Management report on July 1, 2024 which is an annual report including Demonstration Year 3 data (January - December 2023). The report is posted on HCPF's Ensuring Full Continuum SUD Benefits webpage.

The expansion of SUD services requires providers to use the American Society of Addiction Medicine (ASAM) criteria to assess level-of-care placement for members needing SUD services. For residential and inpatient services, these level of care determinations are reviewed by MCEs as part of the authorization process. HCPF has worked with MCEs to standardize initial authorization timeframes.

During Demonstration Year 3 of the expanded SUD benefit (January to December 2023), the average length of time it took to respond to a facility's request for authorization of initial services was under the required standard of 72 hours.

During this time period, 4,598 total initial requests were made, 4,331 initial authorizations were issued, and 94% of these authorizations were issued within 72 hours. Since January 1, 2022, the number of initial authorization days has been standardized across all MCEs. The minimum days for initial

authorization were updated in January 2024 to more closely align with average lengths of stay seen for each level of care over the last 2 years.

III. Behavioral Health Utilization in FY 2022-23

A. Utilization of Behavioral Health Services

Estimates of the need for behavioral health care are available from surveys at both the national and state levels. National estimates indicate that 22.8% of adults report having had any mental illness over the past year, and 18.1% of youth and adolescents under age 18 report having had a major depressive episode in the past year.[3] Colorado survey data show similar trends. According to the Colorado Health Access Survey, in 2023, 26.2% of Coloradans reported eight or more days of poor mental health in the 30 days prior to the survey.[4]

This report does not include utilization of behavioral health services paid fee-for-service, outside of the Capitated Behavioral Health Benefit, such as SUD emergency room services, medication assisted treatment, and the short-term behavioral health services (up to six visits) for low-acuity behavioral health needs at a member's primary care medical provider site. It also does not include the grant funding provided to communities to improve behavioral health services and capacity.

In FY 2022-23, 19% of Medicaid members used capitated behavioral health services, compared to 18.9% in FY 2021-22, 18.1% in FY 2020-21 and 19.4% in FY 2019-20. In FY 2020-21 and 2021-22, the volume of utilization of behavioral health services increased significantly as Medicaid enrollment significantly increased due to the COVID-19 public health emergency. This is why the percent of total utilization of capitated behavioral health (BH) services is shown as being lower in FY 2019-20.

Figure 2. Total Count of Members Accessing Behavioral Health Services Over Time, FY 2019-20 to FY 2022-23

[3] SAMHSA. 2023 National Survey on Drug Use and Health.
[4] Colorado Health Institute. 2024 Colorado Health Access Survey.

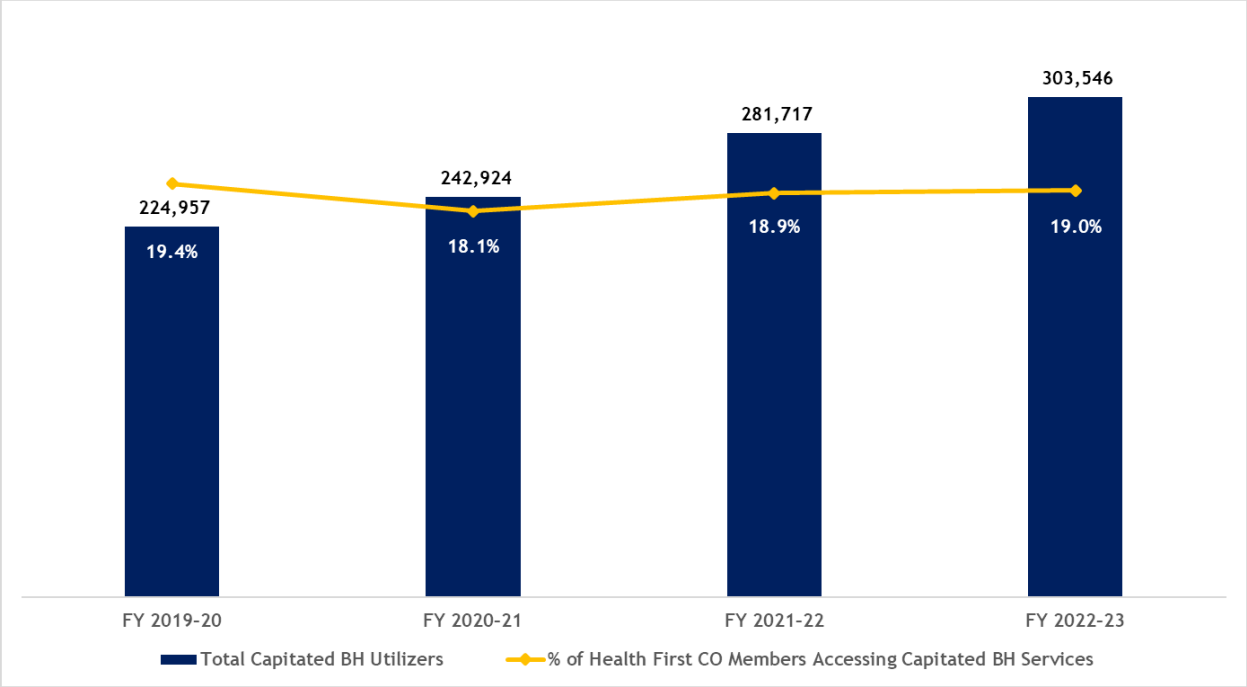


Table 2. Total Count of Members Accessing Behavioral Health Services Over Time, FY 2019-20 to FY 2022-23

	Total Capitated BH Utilizers	Average Monthly Member Enrollment	% of Total Utilizing Capitated BH
FY 2019-20	224,957	1,161,545	19.4%
FY 2020-21	242,924	1,343,597	18.1%
FY 2021-22	281,717	1,489,511	18.9%
FY 2022-23	303,546	1,594,150	19.0%

Utilization trends for the behavioral health capitation for FY 2022–23 are listed below. It is important to note that members could access multiple levels of care and or services for both MH and SUD conditions.

- 303,546 members used capitated behavioral health services. Members could receive inpatient and residential services, as well as outpatient and/or B3 services. The total accumulation of data is over 100% because many members receive more than one service. Of those who accessed a capitated behavioral health service, 66.05% (200,498) were for a primary mental health diagnosis, 15.81% (47,986) were for a primary SUD diagnosis.

- Of the 200,498 distinct utilizers of mental health services, 200,109 (99.81%) received outpatient mental health services. Inpatient services were used by 11,959 (5.96%) and 3,885 (1.94%) received residential mental health services.
- Of the 47,986 utilizers of SUD services, 42,207 (87.96%) utilizers used outpatient services. 12,180 (25.38%) received residential treatment and 3,568 (7.44%) had an inpatient SUD stay.
- B3 services were used by 56.41% (171,233) members.

Tables 3 through 7 show utilization of behavioral health services in FY 2022–23. For reference, average monthly member enrollment in the ACC during this time period was 1,594,150 and enrollment in Denver Health Medicaid Choice was 110,285.

Table 3. Members Accessing Behavioral Health Services, FY 2022-23

	Mental Health Services	Substance Use Disorder Services
Inpatient	11,959	3,568
Residential	3,885	12,180
Outpatient	200,109	42,207
B3 Services (SUD, MH and Co-Occurring)	171,233	

Table 4. Members Accessing Outpatient Behavioral Health Services, FY 2022-23, by MCE

MCE	Outpatient Mental Health Services	Outpatient Substance Use Disorder Services
RAE 1	35,427	7,642
RAE 2	12,386	2,902
RAE 3	45,053	8,174
RAE 4	19,715	5,268
RAE 5	22,523	5,315
RAE 6	28,784	5,686
RAE 7	30,600	5,731

Denver Health	10,514	2,833

Table 5. Members Accessing Inpatient and Residential Behavioral Health Services, FY 2022-23, by MCE

MCE	Inpatient Mental Health Services	Residential Mental Health Services	Inpatient Substance Use Disorder Services	Residential Substance Use Disorder Services
RAE 1	2,192	709	709	2,170
RAE 2	725	286	150	735
RAE 3	2,571	789	824	2,098
RAE 4	835	410	109	1,563
RAE 5	1,390	729	533	1,872
RAE 6	1,636	347	635	1,559
RAE 7	2,124	331	426	1,415
Denver Health	601	331	246	1,077

Table 6. Members Accessing B3 Services in FY 2022-23, by MCE

MCE	B3 Services
1	21,146
2	10,820
3	42,009
4	21,412
5	22,815
6	23,038
7	21,354
Denver Health	11,861

Table 7. Total Count of Members Accessing Behavioral Health Services through a Community Mental Health Center (CMHC) in Comparison to Other Providers, FY 2022-23

	CMHC	Other Providers	Total Members Using capitated BH Services	% of the Total Subpopulation that Received a Service at a CMHC**
Capitated Behavioral Health Overall	91,218	260,482	303,546	30.05%
Mental Health Services	77,197	156,539	200,498	38.50%
Substance Use Disorder Services	8,706	43,870	47,986	18.14%
B3 Services	64,787	127,764	171,233	37.84%

**Members could have also received one or more services from another provider

B. Behavioral Health Incentive Program Indicators

The Behavioral Health Incentive Program (BHIP) indicators provide insight into how ACC members access and utilize behavioral health care. Payment is based on annual performance and is not finalized until six to nine months following the end of the fiscal year to allow for claims runout and validation of performance. As a result of the timing, funds distributed to MCEs in FY 2023–24 were for MCEs' performance during FY 2022–23.

- **Engagement in Outpatient SUD Treatment**: Percent of members with a new episode of SUD who initiated outpatient treatment and who had two or more additional services for a primary diagnosis of SUD within 30 days of the initiation visit.
- **Follow-up within 7 Days after an Inpatient Hospital Discharge for a Mental Health Condition**: Percent of member discharges from an inpatient hospital episode for treatment of a covered mental health diagnosis to the community or a non-24-hour treatment facility who were seen on an outpatient basis by a mental health provider within seven days.

- **Follow-up within 7 Days after an Emergency Department Visit for SUD**: Percent of member discharges from an emergency department episode for treatment of a covered SUD diagnosis to the community or a non-24-hour treatment facility who were seen on an outpatient basis by a behavioral health provider within seven days.
- **Follow-up after a Positive Depression Screen**: Percent of members engaged in mental health service within 30 days of screening positive for depression.
- **Behavioral Health Screening or Assessment for Foster Care Children**: Percentage of foster care children who received a behavioral screening or assessment within 30 days of MCE enrollment.

Table 8 shows the percentage of members in each MCE who received the service described in each performance indicator. While not all MCEs received incentives, the ACC overall and each individual MCE has shown year over year improvement. Performance targets, highlighted in green below, are defined annually. These goals differ by indicator and are based on the performance of each MCE calculated using their own baseline performance.

Table 8. Behavioral Health Incentive Program Performance, FY 2022-23, by MCE

MCE	Outpatient SUD	Follow-up within 7 Days of Discharge for a Mental Health Condition	Follow-up within 7 Days of ED Visit for SUD	Follow-up within 30 Days of Positive Depression Screen	Behavioral Health Assessment for Children in Foster Care
RAE 1	55.76%	56.24%	37.88%	67.16%	14.86%
RAE 2	59.54%	51.08%	35.65%	83.84%	14.38%
RAE 3	52.20%	47.43%	28.16%	43.33%	9.92%
RAE 4	58.80%	69.57%	36.07%	37.80%	36.59%
RAE 5*	50.58%	47.03%	29.46%	49.28%	25.58%
RAE 6	51.62%	60.81%	34.15%	55.74%	13.25%
RAE 7	56.05%	33.90%	32.15%	59.70%	15.73%

Key: Green = Met target
**Denver Health is included in RAE 5 results.*

The behavioral health assessment for children in foster care metric was intended to incentivize collaboration between counties and MCEs and is not a reflection of all BH assessments for children in foster care. Many external factors affect this

metric and statewide MCE performance has more than doubled since the metric was created in FY 2018-19. HCPF is working with counties, RAEs, providers and other state agencies to improve standard screening protocols, resources, and increase access to care for children and youth with behavioral health needs.

IV. Provider Network, Credentialing, and Contracting

A robust provider network helps ensure equitable access to behavioral health care. HCPF continues to work with MCEs on provider networks and other ways to improve access to care, which is often affected by race, ethnicity, socioeconomic status, age, sex, disability status, sexual orientation, gender identity, and residential location. Medicaid members are traditionally at high risk for poor health outcomes, so access to the right providers is a particular priority. Each region of the state has a unique member base, provider network, and community stakeholders. Each region also has unique challenges in addressing disparities and meeting the needs of populations that often do not have the access to care they need.

This section explains the behavioral health provider network, which includes the types of behavioral health providers that contract with MCEs, the process of credentialing and contracting with providers, and provider network development.

A. Behavioral Health Providers

Currently, HCPF separates outpatient service providers into two categories: Community Mental Health Centers (CMHCs) and the Independent Provider Network (IPN). In July 2024, new provider types and regulations were implemented by the Colorado Behavioral Health Administration. During this transition year, most community mental health centers and some new providers will be licensed as Comprehensive Safety Net Providers. HCPF has further broken down the IPN into Federally Qualified Health Centers (FQHCs) and all other independent providers. Behavioral health providers contract directly with MCEs for services each provider will offer. MCEs are obligated by HCPF, as administrators of the managed care system, to contract with CMHCs and FQHCs to ensure that a safety net of services are provided in each region. Each MCE is responsible for establishing a statewide network of behavioral health providers to serve the needs of members. These networks must include both safety net providers and IPN providers. Within each provider type, there is a wide variation in size, location, services delivered, and business models. As a part of the behavioral health transformation driven by community and legislative actions, the state is redefining provider types, modernizing the

service requirements, and creating new provider types. These new "Comprehensive" and "Essential" behavioral health safety net providers are built on national best practices and were created in partnership with key stakeholders to improve quality, service offerings, accountability, and opportunities for more sustainable provider reimbursements.

1. **Safety Net Providers**

   In FY 2023-24, HCPF collaborated with BHA on significant behavioral health system reform with the goal of expanding access to care and enhancing the quality of care delivered to all people in Colorado. As part of this reform, HCPF created new provider types to align with new BHA regulations establishing the behavioral health safety net. Behavioral health safety net providers serve priority populations and comply with the safety net no refusal requirements, ensuring that priority populations receive access to the care that they need to achieve whole person health.

   A BHA safety net approval demonstrates that a provider is in compliance with BHA safety net standards. Essential and Comprehensive Providers will still be required to hold any professional or facility licenses they are obligated to hold pursuant to federal or state law or regulations. Once approved, Essential and Comprehensive Providers will be reimbursed for services they provide through an alternative payment model (APM).

   A Comprehensive Provider is approved by BHA to provide care coordination and all of the following behavioral health safety net services, either directly or through formal agreements with behavioral health providers in the community or region:

   - Emergency and crisis behavioral health services
   - Mental health and substance use outpatient services
   - Behavioral health high-intensity outpatient services
   - Care management
   - Outreach, education, and engagement services
   - Mental health and substance use recovery supports
   - Outpatient competency restoration
   - Screening, assessment, and diagnosis, including risk assessment, crisis planning, and monitoring to key health indicators

An Essential Provider is approved by BHA to provide care coordination and at least one of the following behavioral health safety net services:

- Emergency or crisis behavioral health services
- Behavioral health outpatient services
- Behavioral health high-intensity outpatient services
- Behavioral health residential services
- Withdrawal management services
- Behavioral health inpatient services
- Integrated care services
- Hospital alternatives
- Additional services that BHA determines are necessary in a region or throughout the state

2. Independent Provider Network

The independent provider network (IPN) is broadly defined as any outpatient behavioral health provider enrolled in Medicaid and contracted with an MCE that is not licensed or designated as a community mental health center or other safety net provider. IPN providers include everything from a single licensed behavioral health provider with an independent solo practice (e.g., licensed clinical social worker or licensed psychologist) to large group practices. When reviewing behavioral health services, HCPF separates FQHCs into their own category due to the distinctly different services provided and federal requirements imposed by this designation, described separately in the next section.

To serve Health First Colorado members, providers must be enrolled with HCPF and contracted with at least one MCE. Each IPN may contract for a scope of services they wish to provide to members up to the level they are licensed to provide. IPN providers are not statutorily obligated to provide the entire array of behavioral services required of CMHCs or FQHCs.

IPN providers are paid by an MCE based on individual contracts that identify the services they can provide and the agreed-upon rate for each service. Independent providers negotiate their rates with the MCE and are not part of cost-based rate estimates conducted by the HCPF. However, IPN providers can become approved as an Essential provider and would be eligible to receive the rates published on the Essential Fee Schedule in

the State Behavioral Health Services (SBHS) Billing Manual effective July 1, 2024.

3. Federally Qualified Health Centers (FQHCs)

FQHCs are community-based health care providers that receive funds from the federal Health Resources and Services Administration (HRSA) Health Center Program to provide primary care services in underserved areas. They must meet a stringent set of requirements, including providing care on a sliding fee scale based on ability to pay and operating under a governing board that includes patients. FQHCs may be Community Health Centers, Migrant Health Centers, Health Care for the Homeless, and Health Centers for Residents of Public Housing. The defining legislation for FQHCs (under the Consolidated Health Center Program) is section 1905(l)(2)(B) of the Social Security Act. FQHCs may enroll with Colorado Medicaid to receive reimbursement for services provided to Health First Colorado members. Though FQHCs were originally formed to provide medical primary care services, they are also required to offer dental and behavioral health services. FQHCs provide services to persons of all ages, regardless of their ability to pay or health insurance status.

B. Contracting and Credentialing

1. Enrollment in Colorado Medicaid

Any provider who is enrolled as a Health First Colorado provider is eligible to contract with one or more MCEs to be a network provider. The first step, enrollment as a Health First Colorado provider, is required by both state and federal regulation. It verifies that a provider is eligible to provide services and is acting within their legal scope of practice. Enrollment requirements vary by provider type.

The time involved in this process can vary depending on the completeness and accuracy of the application. Timeliness is essential for this process, and HCPF has taken steps to improve timeliness by providing education and support for completing the application correctly and completely. However, timeliness must be balanced with thoroughness to protect both taxpayers and Health First Colorado members from potential fraud and abuse.

2. Provider Credentialing and Contracting for Behavioral Health Services

Once enrolled with HCPF as a Medicaid provider, behavioral health providers may contract with any MCE to offer services to members of that region of the state. Each MCE establishes its own contracts with its providers with its own requirements and reimbursement rates, within the parameters of the MCE's contract with HCPF. MCEs pay claims and authorize behavioral health services under the capitated behavioral health benefit.

The first step in the contracting process is credentialing. Credentialing allows MCEs to evaluate practitioners and facilities based on the identified standards, such as the National Committee for Quality Assurance (NCQA) standards. Part of the credentialing process is standardized across all managed care entities in the state; Colorado requires all health care entities and plans to use the Colorado Health Care Professional Credentials Application, a uniform application that streamlines the process and ensures that credentialing is complete and non-duplicative when providers apply to multiple MCEs. This simplifies the process of applying to contract with more than one MCE.

MCEs must complete the credentialing and contracting processes or deny network admission within 90 days for at least 90% of all provider applications. As part of this effort, all MCEs use the free online application platform provided by the Council for Affordable Quality Healthcare, Inc. (CAQH) for credentialing. Practitioners are not required to use the online CAQH platform and can apply using a paper version of the credentialing application if they wish.

MCEs are also required to use the CAQH Verified™ application for verification of primary source documents for the credentialing and recredentialing processes. MCEs may not require any additional documentation from individual providers for the purposes of credentialing unless documentation is needed to clarify a question.

Table 9 shows the percentage of providers credentialed and contracted within 90 days in calendar year 2023.

Table 9. Percentage of Providers Credentialed and Contracted Within 90 Days for Each Quarter, CY 2023, by MCE

MCE	CY 23 Q1 (Jan-Mar)	CY 23 Q2 (Apr-Jun)	CY 23 Q3 (Jul-Sep)	CY 23 Q4 (Oct-Dec)
RAE 1	98%	100%	99.33%	100%
RAE 2	96.27%	85.53%	90.83%	90.70%
RAE 3	96.67%	99%	98%	99.33%
RAE 4	96.27%	90.52%	90.83%	90.70%
RAE 5	96.67%	99%	98%	98.67%
RAE 6	100%	100%	100%	97.33%
RAE 7	100%	100%	100%	97.33%
Denver Health	96.67%	99%	98%	98.67%

In January 2022, MCE contracts were adjusted to codify the standard that contracting decisions be made within 90 days of receiving a provider application. Overall MCE's have continued to improve credentialing and contracting timelines. HCPF monitors their performance on a monthly basis. When performance has fallen below standards within a reporting period, MCE's quickly identify the issue for non-compliance and implement new processes, resolving issues in the following month. The Behavioral Health Accountability Dashboard includes MCE-contracted quarterly behavioral health provider totals and accountability metrics for each region and the monthly reports can found on the Behavioral Health Reform webpage.

As previously mentioned, HCPF is collaborating with providers, advocates, and the new Behavioral Health Administration on an Administrative Burden workgroup, to identify short- and long-term opportunities to reduce administrative burden for all types of behavioral health providers. Expanding the behavioral health safety net in Colorado will require ongoing improvements to the provider experience to continue to increase access for our members.

C. Network Management and Expansion

HCPF is committed to building provider networks so that all members can access the care they need. Federal and state managed care regulations require strict monitoring of provider access and adequacy to ensure members' needs are met. This includes provider-member ratios as well as distance and travel time, appointment wait times, cultural/linguistic competency and disability services. HCPF monitors behavioral health network adequacy through annual network adequacy reports and quarterly reports on network development. These quarterly reports reflect each MCE's contracting efforts and a quantitative analysis of where members live in relation to provider locations and services. They also include a qualitative analysis of whether contracted providers are accepting Health First Colorado members, and if they have the service capacity to provide care for the member population in the region. All network data submitted to HCPF is validated and reviewed for accuracy by a third-party external quality review organization.

In regions where providers are limited due to workforce shortages, MCEs have adopted innovative strategies to build the capacity of their networks so they can deliver the full continuum of covered behavioral health services. HCPF also prioritized $24M in grant funds for MCEs to expand and improve their network. MCEs may contract with new providers from other state systems (e.g., child welfare or criminal justice), establish new service modalities (telehealth), create value-based payments, recruit new providers, or help existing provider practices to expand their capacity to serve new populations or provide additional services.

Independent behavioral health providers and practitioners are a valued and necessary part of the behavioral health network in all regions, and their importance has grown as the need for behavioral health services grows in the wake of the COVID-19 pandemic. Behavioral health practitioners consist of individual psychiatrists and licensed psychologists, group psychiatry and psychology practices, licensed clinical social workers, licensed marriage and family therapists, licensed professional counselors, licensed addiction counselors, and behavioral health physician assistants.

A top priority that HCPF has set is to continue expanding the statewide contracted network of behavioral health providers through ongoing collaboration with providers, MCEs, and the community. At the end of FY 2022-23, there were 11,417 MCE-contracted behavioral health providers,

compared to 11,061 at the end of FY 2021-22. As a point of reference, there were 8,627 MCE-contracted behavioral health providers at the end of FY 2020-21 and 6,391 at the end of FY 2019-20.

Table 10. Number of MCE-Contracted Behavioral Health Providers (by Unique National Provider Identifier), by Quarter

Fiscal Year and Quarter	Number of Contracted Behavioral Health Providers
FY 2021-22 Q4	11,061
FY 2022-23 Q1	9,870
FY 2022-23 Q2	10,641
FY 2022-23 Q3	11,232
FY 2022-23 Q4	11,417

Note: Enrolled providers were counted by unique NPI. Missing, duplicated or invalid NPIs were excluded.

Table 11. Number of MCE-Contracted Behavioral Health Practitioner Added by Quarter, CY 2023, by MCE

MCE	Q1 (Jan-Mar)	Q2 (Apr-Jun)	Q3 (Jul-Sep)	Q4 (Oct-Dec)
RAE 1	20	40	568	221
RAE 2	273	200	1,441	289
RAE 3	146	260	302	383
RAE 4	274	200	1,441	289
RAE 5	150	257	303	375
RAE 6	268	427	350	299
RAE 7	268	427	350	299
Denver Health	150	257	303	375

Table 12. Number of MCE-Contracted Behavioral Health Practitioners at the End of CY 2023, by MCE

MCE	2023 Year-End Total of Behavioral Health Practitioners
RAE 1	5,015

RAE 2	4,314
RAE 3	8,568
RAE 4	4,316
RAE 5	8,565
RAE 6	8,468
RAE 7	8,468
Denver Health	8,565

HCPF and MCEs also worked to build the provider network for the new residential and inpatient benefit for SUD treatment. HCPF meets individually with providers upon request to explain the enrollment process and answer questions. HCPF also expedited the review of SUD provider enrollment applications. During the reporting period from January 1, 2023 - December 31, 2023, data indicate that 20,924 inpatient (residential and hospital) SUD services were utilized by 10,899 unique members. This reflects an increasing service utilization trend across the 1115 SUD Waiver Demonstration of episodes of care and number of unique members served.

As mentioned in this report, expanded access to behavioral health care depends on increasing the number of providers who can deliver services. In FY 2023-24, HCPF continued the work of behavioral health system transformation to address access challenges propelled by an insufficient number of providers and lack of participation in insurance networks, both Medicaid and commercial plans. The ability of MCEs to meet behavioral health demands will improve as these transformation strategies are implemented. The ACC added over 1,061 (from June 30, 2023 to June 30, 2024) behavioral health providers this fiscal year, including licensed psychologists and licensed behavioral health clinicians. Practitioners were added in every quarter of this fiscal year period.

Table 13. Number of MCE-Contracted Behavioral Health Providers (by Unique National Provider Identifier), FY 2023-24 by Quarter

Fiscal Year and Quarter	Number of Contracted Behavioral Health Providers
FY 2023-24 Q1	12,105

FY 2023-24 Q2	12,092
FY 2023-24 Q3	12,269
FY 2023-24 Q4	12,478

Note: Enrolled providers were counted by unique NPI. Missing, duplicated or invalid NPIs were excluded.

D. Integrated Care

Since July 1, 2018 Medicaid Members have been able to receive short-term behavioral health services (up to six visits) for low-acuity behavioral health needs at the member's primary care medical provider site reimbursed under fee-for-service. In FY 2022-23, about 1.16% (18,450) eligible members used the short-term behavioral health benefit. Of these 18,450 members, 46.98% (8,667) had not previously accessed behavioral health services.

The Colorado Legislature passed House Bill 22-1302 in May 2022 with the goal of supporting, improving, and expanding integrated behavioral health services in Colorado. Through distribution of funds allocated by the American Rescue Plan Act (ARPA), HCPF received $31 million in funding for integrated behavioral health services in primary care settings. This funding offers short-term grants for physical and behavioral health care providers looking to implement or expand access to care and treatment for mental health and substance use disorders using an evidence-based integrated care model. Short-term grant funding was offered to 79 clinics encompassing 140 sites across Colorado to support expanding access to care. Sites are fully engaged and are participating in practice innovation, including workflow changes, billing and coding, and other practice efficiencies. The biggest challenge this project is experiencing is the lack of qualified licensed providers, which is lacking, especially in rural areas across Colorado.

Colorado's ability to truly sustain integrated care models at a statewide level will also require ongoing alignment across all payers - both public and private. HCPF will be submitting an Integrated Care Report related to this program in 2025.

V. Claims Processing and Provider Payments

HCPF pays the RAEs a flat administrative per-member-per-month (PMPM) fee that RAEs use for the full spectrum of care coordination and case management services, member engagement, practice support, population health and community investment. This administrative PMPM payment is the same for

every region and is not used to reimburse primary care claims; primary care medical providers (PCMPs) bill HCPF directly, fee-for-service, for most physical health care claims. Though by contract, RAEs must distribute at least 33% of these payments to their PCMPs for the work they do to serve as medical homes.

MCEs are responsible for processing behavioral health claims that fall within the capitated behavioral health benefit and paying providers the contracted rate. (HCPF has a fee-for-service rate for services that fall outside the managed care benefit and reimburses providers directly for these services.)

In compliance with federal regulations, HCPF requires MCEs to adjudicate and pay 90% of all clean claims within 30 days of receiving them, and 99% of clean claims within 90 days of receipt. **All MCEs met this standard in calendar year 2023**. A claim can consist of a bill for services, a line item of service, or all services for one member on a single bill. A "clean claim" is a claim that can be processed without obtaining additional information from the provider of the service or from a third party. This definition includes a claim with errors but does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity (42 CFR § 447.45).

Providers submitting claims to their MCE must provide adequate documentation and adhere to the provider's contracted with the MCE. Claims can be denied if they do not meet medical necessity requirements, but more often, they are denied due to inaccurate billing and documentation. For example, claims may be denied due to the use of the wrong modifier (a code that indicates details of a procedure or service).

Each MCE has a call center and provider relations staff to help providers with billing questions. They are required to respond to provider questions within two days.

VI. Quality Oversight Practices

A. Quality Management and Oversight

HCPF works collaboratively with other state agencies and partners to develop new processes and oversight to help ensure quality and protect patients without limiting access to care. In the rare but serious circumstance when providers are unable to ensure patient safety and/or quality, HCPF, BHA, Colorado Dept. of Public Health and Environment (CDPHE), Colorado Dept. of Human Services (CDHS), and MCEs work to ensure every impacted patient

receives direct outreach and support to transition their care to another provider. In the case that a provider chooses or is forced to close their doors, all members are supported directly in their care transition and our agencies work together to also help support the individual staff and practitioners connect to other open positions. With a limited workforce, easing the transition to providers is an essential part of supporting local community access. Additionally, HCPF is exploring strategies with BHA for data sharing as it relates to Behavioral Health Grievances per our Formal Agreement with the BHA to identify risks and trends to improve member safety.

B. Managed Care Provider Escalation Request

In February of 2022, HCPF created a communication form for the IPN. This form allows the opportunity for providers to report to HCPF any outstanding issues or concerns they have with the MCEs. This HCPF developed communication tool has been valuable for HCPF to identify challenges that providers may be experiencing in real time.

Providers initially are asked to present issues directly to MCEs for resolution, however there are situations where the providers need additional processes to escalate their concerns. This newly adopted procedure provides additional monitoring and oversight into how MCEs are addressing provider concerns. The insight gained allows for development of improved processes between the provider network, MCEs, and HCPF for the benefit of member access.

Since its inception, HCPF has received 353 unique provider concerns from 188 unique providers through this form. Providers may select multiple reasons when submitting concerns, therefore the illustration below does not represent unique outreach counts.

Figure 3. Total count of provider concerns by the category of concern, from FY 2022 - 23 to FY 2023 - 24

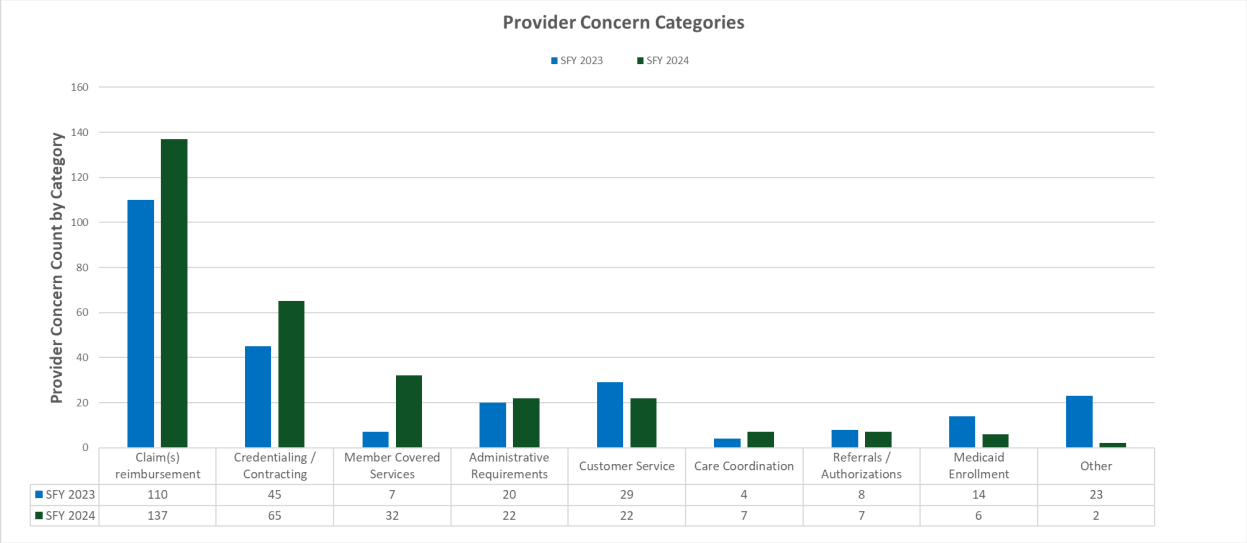
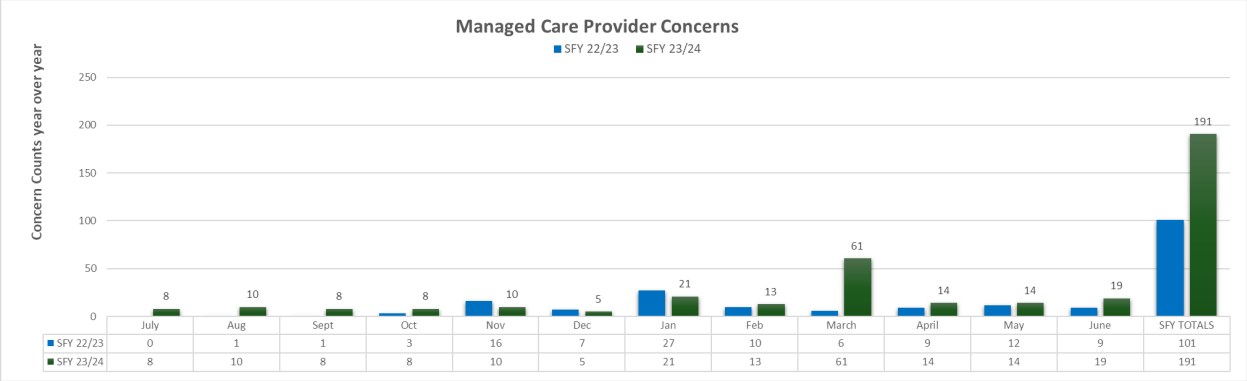


Figure 4. Total count of provider concerns by month, from FY 2022 - 23 to FY 2023 - 24



As more providers become aware of this form an increase in provider outreach to HCPF may be expected and show progress in HCPF support and oversight support. Trends and patterns of concern are identified, monitored and addressed by HCPF with MCEs. This is a valuable indicator of provider experience and informs where areas of opportunities exist for continued program improvement.

C. Health Equity and Social Determinants of Health

Health equity continues to be a key priority for HCPF as outlined in the Department Health Equity Plan. MCEs are an important partner in the commitment to meaningfully address and eliminate health disparities. In FY 2023-24, MCEs submitted their individual health equity plans, which illustrate robust strategies to improve quality of care for their regions in the following focus areas: maternity and perinatal health, behavioral health and prevention. These plans identify current work that is making an impact,

priority populations and ways to leverage what is already being done to reduce disparities. HCPF continues to send each MCE member-level data files, by indicator, with demographic fields (age, county, disability, gender, language and race/ethnicity) that can be used to identify priority populations. Each MCE will choose its own priority populations for each indicator and calculate results for each priority population based on the needs of their region.

HCPF has prioritized health equity transformation, with one of the focus areas around behavioral health. This past fiscal year 2023-24, HCPF increased in-network providers, expanded the behavioral health mobile crisis response benefit and developed the behavioral health secure transportation benefit. Working towards closing disparities, HCPF continues to align and work with MCEs on the following core measures, to include: Follow-up after Emergency Department visit for mental illness (NQF 3489), Follow-up after Emergency Department visit for Alcohol and Other Drug Abuse or Dependence (NQF 3488) Follow-up after Hospitalization for Mental Illness (NQF 0576), and Screening for Depression and Follow-up Plan (NQF 0418). To learn more, you can review MCE's individual health equity plans.

D. House Bill 23-1243 Hospital Community Benefit

Many Colorado hospitals are considered non-profit or are tax-exempt through state law. As such hospital community benefit spending is intended to supplement waived tax revenues for the betterment of the community since these hospitals do not pay taxes. Colorado hospitals invested $1.09 billion in community benefits in hospitals' fiscal year 2021, not including Medicaid shortfall. HCPF's 2024 Colorado Hospital Community Benefit Annual Report found that behavioral health-related needs were the top prioritized community-identified need overall in reporting hospitals' community benefit implementation plans (93.3% of hospitals prioritized behavioral health-related needs).

The goal of House Bill (HB) 23-1243 was to ensure that hospitals' community benefit investment dollars are far more aligned with the actual needs of the community, and that the hundreds of millions of community benefit dollars are directly impacting the changing needs of the community to the betterment of Coloradans for years to come. Communities have robust and differing needs, such as food insecurity, housing insecurity, or behavioral

health access gaps. Meeting those needs more directly is a key objective of this bill — through sustainable, year-over-year funding. Further, as those needs change and evolve, this bill is designed to continue to proactively respond by listening to the changing perspectives and voices of the community, creating a sustainable, collaborative means of addressing our most prominent challenges — community by community, year after year.

This bill builds on HB19-1320 to further increase non-profit and tax-exempt hospital transparency and accountability in listening to the community as decisions are made on how community benefit dollars are spent across Colorado. This bill only applies to Colorado's non-profit and otherwise tax-exempt hospitals, including Denver Health and UCHealth University of Colorado Hospital. Critical Access hospitals are exempt from reporting for Hospital Community Benefit Accountability (HCBA).

HB23-1243 accomplishes five main objectives:

First, it requires the hospitals to provide more specific and detailed spending information, so policymakers and communities across the state can clearly tell what activities and initiatives are being funded, and how those initiatives compare with what the community asked for.

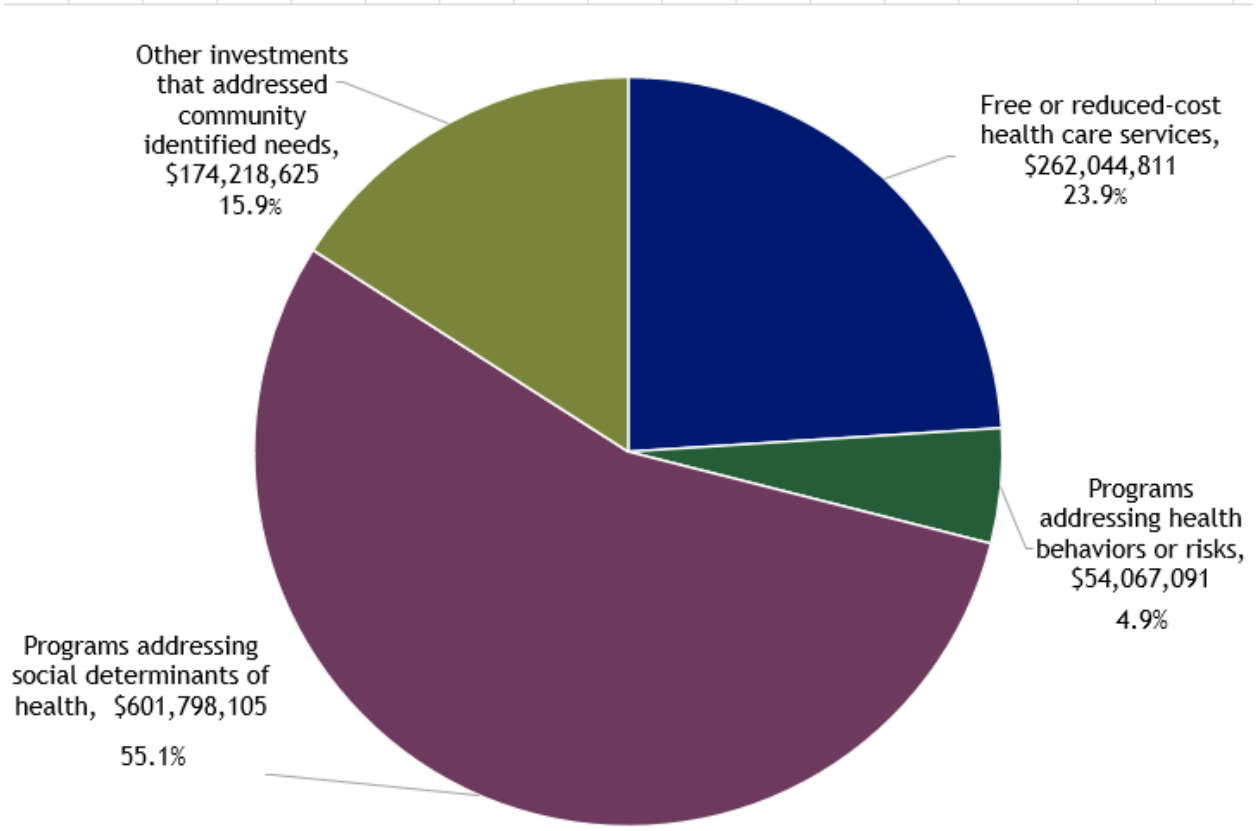
Second, the bill requires the hospital to solicit, consider, and provide the community the opportunity for feedback in creating their community benefit implementation plan and any changes to spending priorities, improving on the current annual public engagement process.

Third, the bill expands requirements for HCPF to undertake stakeholder work to develop community engagement best practices and efficiencies. HCPF undertook this work in late 2023, and working with the Colorado Health Institute produced a Best Practices in Community Engagement Guide available on the HCPF HCBA webpage, along with a repository of resources for community engagement.

Fourth, the bill includes the calculation of the value of the not-for-profit hospitals' tax exemption to be calculated by the Colorado Department of Revenue. Colorado's communities need sound estimates of the value of the tax exemption to understand the value of hospitals' community benefit spending in lieu of paying taxes.

Fifth, the bill adds reasonable non-compliance measures.

Figure 5: FY 2021 Community Investments by HCBA categories



In Figure 5, the hospital community benefit spending is broken out by HCBA categories for FY 2021. Behavioral Health priorities are primarily split between programs addressing social determinants of health and programs addressing health behaviors or risks. Under HB23-1243 reporting hospitals are now required to break out Behavioral Health spending into its own category starting with the 2025 Hospital Community Benefit Accountability Report, to be delivered to the General Assembly on January 15, 2025. With this breakout, HCPF and community members will be better equipped to determine if hospitals' community benefit priorities align with spending amounts.

Hospitals' submissions of their Community Health Needs Assessments (CHNAs) to HCPF are critical for analysis of how hospitals incorporate community needs into their implementation plans. HCPF found that hospitals collectively identified behavioral health as a prioritized health need. **Specifically, 93.3% of hospitals submitted reports prioritizing behavioral health.** Overall, behavioral health was the top priority identified by hospitals, followed by access to care/resources with 80.0% of hospitals identifying this as a priority.

Chronic disease management followed with 57.8% of hospitals prioritizing it as a need.

VII. Improving Behavioral Health Services Statewide

A. Utilization Management and Service Improvements

It is important that MCEs be able to select and implement UM policies and procedures to manage risk. HCPF continues to set parameters and provide support to MCEs seeking to streamline their UM processes. In this calendar year, development of a UM dashboard is underway, with anticipated piloting to begin this fall. The dashboard is being developed in collaboration with MCEs, HCPF Data Analytics Services, and a contractor. This will help HCPF monitor diagnoses attached to requests and denials for behavioral health service, response times to authorizations for services and lengths of authorizations approved.

HCPF has also prioritized SUD needs for pregnant/parenting people and youth. Continued refinement of the UM report will allow for increased data- driven decision making to meet the goals and objectives outlined in the 1115 waiver SUD demonstration and monitoring protocol:

- Increasing rates of member engagement in treatment;
- Increasing retention in treatment;
- Decreasing overdose deaths;
- Decreasing emergency department utilization;
- Decreasing readmissions at the same or higher level of care; and
- Increasing access for physical health conditions.

B. Support for Independent Providers

HCPF has continued the work outlined by the Phase 2 Final Report submitted by Arrow Performance Group (APG), a third-party independent contractor. We have held a quarterly IPN Collaborative to keep IPN providers engaged and monitoring issues specifically impacting the IPN. This meeting reports out communication efforts, behavioral health policies, billing/coding, rates, legislative updates, and updates from the ongoing IPN working group.

Additionally, HCPF created the IPN Working Group to focus on moving forward the 21 recommendations that came out of APG's effort to identify improvements to the Medicaid behavioral health landscape. This work has resulted in meaningful change and improvements for the IPN that includes

expanding covered clinical diagnoses, identifying a billing policy for extended clinical encounters for evidence-based practices as well as dyadic interventions, simplifying the SBHS Billing manual by removing unnecessary modifiers, creating a Third-Party Liability resource and establishing a single RAE outpatient behavioral health audit tool, among other improvements.

Each RAE has worked to improve their relationship with and the experience of the IPN. One RAE has improved their process to proactively outreach providers to resolve billing issues, implemented system updates for easier navigation and improved their forums for engaging providers and the educational resources available to them. Another RAE streamlined their credentialing and contracting to create a more efficient process for providers, while also engaging extensively with providers to provide education, answer questions and ensure they have the resources needed to provide care to Health First Colorado members.

Since 2022, APG has conducted annual surveys to measure provider satisfaction and experiences both with HCPF and RAEs. The survey measured general provider satisfaction and experiences around provider services, such as enrollment, contracting and credentialing, submitting prior authorization requests, submitting claims and resolving issues, receiving payments and responding to audits. Results from the most recent survey found significant improvements in HCPF and RAE ratings across all measures between 2022 and 2024, with no average ratings decreasing from any year. Additionally, overall IPN provider satisfaction with being a Medicaid Provider as well as with RAEs has improved each year over the last two years.

Figure 6. Overall Satisfaction Across All RAEs from 2022-2024

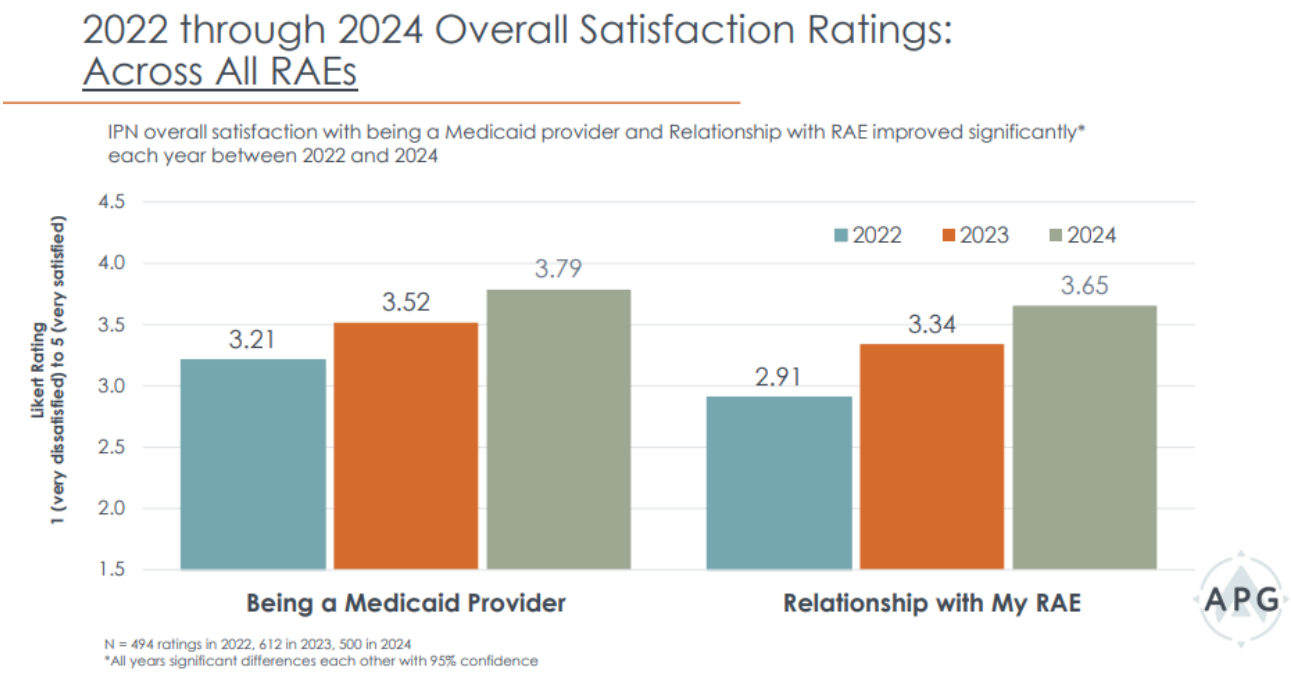
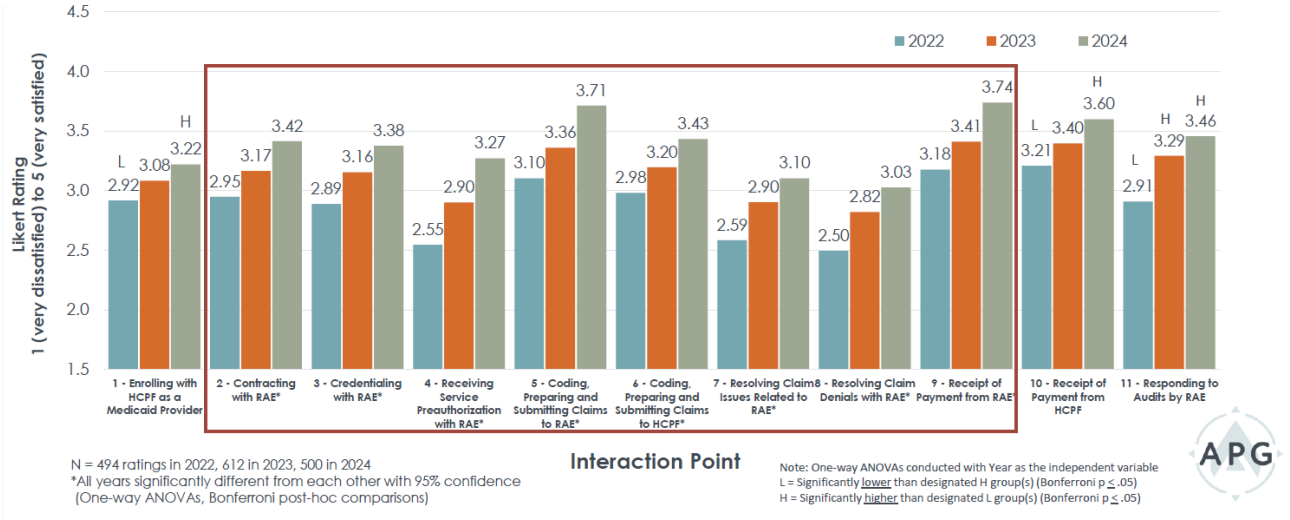


Figure 7. Satisfaction Ratings by Interaction Point Across All RAEs from 2022 to 2024



C. Safety Net Accountability

A key aspect of behavioral health system reform has been the expansion of the behavioral health safety net, with the goal of expanding access to care and enhancing the quality of care delivered to all people in Colorado. Major elements of this reform effort include:

- The creation of new safety net provider types (Comprehensive and Essential) based on BHA provider rules. These providers serve priority populations and comply with the safety net no refusal requirements, ensuring that all Coloradans receive access to the care that they need to achieve whole-person health. HCPF safety net system changes went live in July 2024 in partnership with BHA, and providers contract with MCEs in order to provide behavioral health services to Health First Colorado members.
- The development of new payment methodologies for safety net providers. Pursuant to House Bill 22-1278, HCPF, in collaboration with the BHA, developed and implemented cost informed Alternative Payment Models (APMs) for Comprehensive and Essential Providers. These APMs introduce greater sustainable and flexible payment models that expand accountability to the community to increase member access to a full continuum of behavioral services. HCPF is directing MCEs to pay safety net providers using the HCPF developed APMs. As of July 1, 2024, Comprehensive Providers are reimbursed under a prospective payment system (PPS) methodology. A PPS is a flexible, advanced reimbursement model that ties payment to daily encounters instead of to individual services. This means that a provider will receive an encounter payment for each patient they see in a day, and the payment is the same regardless of which services are provided so long as the services are covered by the PPS rate. The PPS is provider specific, as it is based on each Comprehensive Provider's actual costs, including the cost of serving people who are uninsured or underinsured,including uncompensated claims from commercial insurance. The PPS provides flexible, sustainable, and predictable funding. In addition to requiring RAEs to reimburse Comprehensive Providers at their PPS rate, they must also offer the Comprehensive Providers in their Region a value-based payment arrangement for meeting measurable outcomes that improve member access to quality care. This model was developed in partnership with providers, advocates, actuaries, community partners and approved by the Center for Medicare & Medicaid Services. Additionally, RAEs must reimburse Essential Providers, at a minimum, according to a cost-informed Essential Provider Fee Schedule. This fee schedule is based on historical reimbursement for services that are now defined by the BHA as Essential Safety Net Services in Section 2 CCR 502-1-12.4.

Colorado is in the process of significant behavioral health system reform with the goal of expanding access to care and enhancing the quality of care delivered to all people in Colorado. As part of this reform effort, HCPF is investing in Training and Technical Assistance (TTA) for behavioral health providers. Health Management Associates has been contracted to provide comprehensive TTA to address the diverse needs and goals of providers. The TTA program is designed for all behavioral health providers, encouraging participation from those currently receiving public funds or considering accessing them in the future. The focus is on expanding benefits and services, improving access to care, and elevating quality.

There are two major types of training topics: (1) Behavioral Health Reform Awareness and Readiness and (2) Safety Net Competency. Trainings are facilitated by a team of subject matter experts, in partnership with state agencies and local and national experts to create engaging content. For more information on the TTA Program, see the executive summary.

D. Preparing for Accountable Care Collaborative Phase III

Current RAE contracts, initiated in 2018, will end on June 30, 2025. HCPF is in the process of designing and implementing the next iteration of the Accountable Care Collaborative (ACC), referred to as Phase III, which will begin on July 1, 2025. Because the ACC is Health First Colorado's delivery system, Phase III is a critical part of efforts to improve care quality, service, equity and affordability.

Significant work was completed in FY 2023-24 to support the design and implementation of ACC Phase III. HCPF released both the ACC Phase III Concept Paper, which outlined the proposed program design and key changes and the ACC Phase III Draft Contract which outlined the proposed contract requirements for the RAEs. HCPF hosted approximately 70 stakeholder meetings with over 3,000 attendees over the course of the fiscal year to gather feedback on the proposed programs, policies and contract requirements outlined in these documents. From May to July 2024, HCPF posted the formal request for proposal for the RAEs. An evaluation committee of subject matter experts reviewed each proposal and HCPF issued an intent to award four contractors in September 2024.

HCPF is proposing several areas of change for ACC Phase III, including:

- A reduction in the number of regions from seven to four to ensure sustainable investment in regional infrastructure and better leverage efficiencies of the RAEs.
- An adjustment to how members are assigned to a Primary Care Medical Provider (PCMP).
- An increased focus on health equity by requiring dedicated personnel, staff training and a regional committee.
- The alignment of payment models across markets through partnerships with the Center for Medicare and Medicaid Innovation's Making Care Primary, and the Colorado Division of Insurance to reduce administrative burden for providers.
- A PCMP structure that evolves from a Primary Care Medical Home to an Accountable Care Organization (ACO)-like model, which rewards outcomes not just actions.
- The continuation of provider and member tool innovation, like cost and quality indicators, eConsults and the Social Health Information Exchange (SHIE).
- Improved processes for children and youth accessing behavioral health care services and the implementation of high-fidelity wraparound and supports for high acuity youth.
- Advances in care coordination and program accountability to improve quality, close disparities and drive affordability.

HCPF will continue the capitated behavioral health benefit to encourage the effective utilization of the full continuum of behavioral health services and provide avenues for addressing health-related social needs. Administrative payments will continue to be paid to the RAEs for care coordination, provider support and management of whole-person care. Incentive payments will continue to tie a portion of RAE funding to achieving established outcome targets. Alignment with alternative payment models will continue, as described in the Health First Colorado Value section of this report.

E. Cost Report to improve the behavioral health rate structure

In order to determine the rates for Comprehensive Providers, HCPF analyzes cost reports submitted by providers. To increase transparency of rate setting for the new Comprehensive Providers, and to bring reimbursement for these providers in alignment with how FQHCs are reimbursed, HCPF released new Cost Report templates for the Comprehensive Providers in June of 2024. Starting November 2024, all Comprehensive Providers must submit their cost

information to HCPF using these new templates. The new cost report structure creates better alignment for the PPS payment methodology. Cost reports and rate reviews are posted publicly on HCPF's Behavioral Health Rate Reform webpage. HCPF is developing updated rules to reflect the transition from CMHCs to Comprehensive and Essential safety net providers and support the cost reporting and rate setting efforts.

F. Reviewing improvements

Over the past years, HCPF has worked closely with BHA, community partners, members and families, and other state agencies to improve and transform the behavioral health safety net system. Below are some successful program and policy changes that HCPF has implemented so far.

- **Partial Hospitalization Program.** In FY 2023-24, the Joint Budget Committee approved the R7 Behavioral Health Continuum budget request which authorized the expansion of SUD coverage to include ASAM 2.5 Partial Hospitalization Programs. Partial hospitalization programs provide 20 hours or more of clinically intensive programming each week to support patients who are living with an SUD condition and an unstable medical and/or psychiatric condition in need of daily monitoring and management in a structured outpatient setting. Coverage for these services began July 1, 2024, thereby completing coverage for the full continuum of SUD services.
- **Securing federal funds for behavioral health.** Through the American Rescue Plan Act funds, HCPF chose to prioritize individuals with behavioral health needs in the strategy to improve home and community-based services. The team is concluding its ARPA work where approximately $140 million dollars were used to enhance or expand behavioral health services through September 2024. ARPA funds were used to grant funding to initiate efforts such as high-intensity outpatient service providers, permanent supportive housing for Medicaid members, and community transition grants.
- **High-intensity outpatient service providers.** In FY 2023-24, MCEs worked to address gaps in the behavioral health safety net system, particularly in the transition from institutional to community-based outpatient care. Each MCE was contracted to disperse a total of $1,714,000 ARPA funds to increase access to high intensity outpatient services through capacity building efforts. These services include expanding availability of high intensity services for children, youth, and

young adults, members of the LGBTQIA+ community and adults at high risk of institutionalization. Many providers in each region opted to apply funding to expand their treatment centers, purchase company vehicles to aid with transportation for members, address workforce challenges to increase the availability of services for those at risk of institutionalization and provide staff training and certification to offer a greater array of evidence-based high intensity therapeutic interventions and services.

- **Permanent supportive housing for Medicaid members.** Permanent Supportive Housing (PSH) is an intervention that combines housing and support services for individuals with a disability, including those whose disability is related to a behavioral health diagnosis and a history of homelessness. In December 2022, HCPF launched the Statewide Supportive Housing Expansion (SWSHE) pilot project with the Colorado Department of Local Affairs, through funding made available by Section 9817 of the American Rescue Plan Act (ARPA). The pilot served a total of 869 Medicaid members throughout the life of the project (December 2022 - September 2024). As of June 2024, 695 Health First Colorado members were actively enrolled in the pilot and receiving wraparound services. Of these, 317 had been previously homeless but were able to secure a housing voucher prior to the pilot, and 378 secured housing as part of the program. The SWSHE pilot was completed on Sept. 30, 2024. Urban Institute is now in the process of completing an evaluation to study its impact on Medicaid utilization.
- **Community transition grants.** As of March 29, 2023, HCPF contracted $14 million to nine grantees to provide behavioral health transition services for individuals leaving institutions. These projects prioritize serving high-risk populations with high-intensity outpatient services and all include sustainability plans post grant funding period. Grant funding ends on September 30, 2024.
- **Improving community crisis response, mobile crisis and secure transport benefits**. In FY 2023-24, HCPF and BHA worked to implement the Mobile Crisis Response benefit which funds standardized services across the state for members. The updated benefit allows teams to provide a trauma-informed, community-based crisis response at any time to anyone in Colorado experiencing a behavioral health crisis in a wide variety of community-based settings, regardless of age, insurance status, residency or prior utilization. HCPF enrolled 16 Mobile Crisis Response

providers who answered 490 community calls for service from July 1, 2023 to March 31, 2024. In FY 2023-24, HCPF implemented a new benefit, Behavioral Health Secure Transportation, to help get members in a behavioral health crisis to the best place for treatment in a less traumatizing manner. In the first year, 12 providers enrolled to provide this benefit which has led to 3,308 trips for Health First Colorado members.

- **Building out criminal justice partnerships**. To better support this population, HCPF is significantly expanding Medicaid connection to incarcerated individuals, those who are transitioning back into the community, and individuals with a history of incarceration. HCPF established the Criminal and Juvenile Justice Collaborative, a standing group of key stakeholders including MCEs, in FY2023-24, to build out these expansive policies in partnership with jails, prisons, youth corrections, counties, members, families, and other key stakeholders. In addition, HCPF is developing a Criminal Justice Strategic Plan and engaging regularly with partners across the state to plan for implementation of Medicaid Reentry Services. Reentry services are one of the key components that HCPF requested in the 1115 Waiver Amendment application that was submitted to CMS in April 2024. A team from Colorado, representing HCPF, Department of Corrections, Division of Youth Services and BHA, was accepted to the Medicaid & Corrections Policy Academy. This opportunity will support our statewide efforts to develop a shared language and encourage strong partnership development and future coordination for the implementation of reentry services. These efforts support HCPF's work to meet minimum requirements for reentry services for youth, as mandated in the Consolidated Appropriations Act of 2023, Section 5121.
- **Setting minimum rate standards through directed payments.** Under the Capitated Behavioral Health Benefit MCEs have sole responsibility and discretion to contract with service providers, as well as to set provider rates. However, HCPF understands that there are unique situations where targeted action is necessary to support network access and growth for specific services. In such circumstances, HCPF will establish a "Directed Payment" as a minimum reimbursement rate for specific services that MCEs must pay. When a Directed Payment is created, HCPF will ensure MCEs are adequately funded to reimburse providers at these rates. In July 2023, HCPF issued a directed payment

for high intensity outpatient services for adolescents, including Functional Family Therapy (FFT), Multi-systemic Therapy (MST), Comprehensive Community Support Services, and Community-Based Wrap-Around Services.

- **Enhancements for children & youth community services.** HCPF co-led the effort to pass House Bill 24-1038, which added resources for system of care services, specifically assessments and intensive care coordination, and expanded Colorado's Children's Habilitation Residential Program eligibility to children whose mental health meets a level of disability. In addition, HCPF has held dozens of stakeholder meetings and hired national experts to build a more robust System of Care beyond the services outlined in HB24-1038. As a result, a full implementation plan for a System of Care will be produced in February 2025.
- **Continuing analysis of children & youth residential services.** As noted in the Directed Payment Legislative Report, HCPF is continuing to monitor utilization and payment for Qualified Residential Treatment Programs (QRTP) and Psychiatric Residential Treatment Facilities (PRTF) by the MCEs. HCPF is working with the MCEs to ensure accurate billing and claims submission in order to have clean data for this analysis. Additionally, HB 24-1038 provided funding for HCPF to contract with a vendor to conduct an actuarial analysis to help establish an appropriate reimbursement rate for PRTFs. Informed by both of these efforts, HCPF will be able to determine if a Directed Payment is necessary to support child-serving residential providers in a way that continues to insure access to these services for Colorado's youth. Finally, as a result of HB 24-1038 BHA will begin reimbursing QRTPs for room and board for youth not in the custody of County DHS in order to align payment across payers for these providers. This is a significant component to supporting providers caring for youth with the most acute behavioral health needs.