COLORADO
Department of Health Care Policy & Financing

Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203

April 5, 2021

The Honorable Dominick Moreno, Chair
Joint Budget Committee
200 East 14th Avenue, Third Floor
Denver, CO 80203

Dear Senator Moreno:

Enclosed please find the Department of Health Care Policy and Financing's response to the Joint Budget Committee's Request for Information.

The Department is requested to submit a report by April 1, 2021, discussing the appropriate role for the Department in resolving issues between behavioral health providers and payers, including the Regional Accountable Entities (RAEs), around billing, parity of coverage, and prior authorizations. The report should include a description of the tools available to resolve conflicts. The report should assess and discuss the administrative burden on providers, such as cumbersome prior authorization procedures or lack of timely adjudication of claims, and any other challenges with implementing the regional accountability entity structure. As part of the report, please provide a detailed description of who operates the RAEs in each region, how the operators are selected, and how the Department evaluates and prevents potential conflicts of interest. Also, please discuss differences in the performance of the RAEs in implementing the Substance Use Disorder benefit and how the policies of the RAEs are affecting implementation.

If you require further information or have additional questions, please contact the Department's Legislative Liaison, Jo Donlin, at Jo.Donlin@state.co.us or 303-866-6912.

Sincerely,

Kim Bimestefer
Executive Director

KB/LK

Enclosure(s): Health Care Policy and Financing FY 2021-22 Department RFI

CC: Representative Julie McCluskie, Vice-chair, Joint Budget Committee
Representative Leslie Herod, Joint Budget Committee
Representative Kim Ransom, Joint Budget Committee
Senator Bob Rankin, Joint Budget Committee
Senator Chris Hansen, Joint Budget Committee
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Rachel Reiter, External Relations Division Director, HCPF
Jo Donlin, Legislative Liaison, HCPF

Role for the Department in Resolving Issues Between Behavioral Health Providers and Payers

In compliance with request dated March 18, 2021

April 5, 2021

Submitted to: Joint Budget Committee

COLORADO
Department of Health Care Policy & Financing

Contents

I. Request

The Department is requested to submit a report by April 1, 2021, discussing the appropriate role for the Department in resolving issues between behavioral health providers and payers, including the Regional Accountable Entities (RAEs), around billing, parity of coverage, and prior authorizations. The report should include a description of the tools available to resolve conflicts. The report should assess and discuss the administrative burden on providers, such as cumbersome prior authorization procedures or lack of timely adjudication of claims, and any other challenges with implementing the regional accountability entity structure. As part of the report, please provide a detailed description of who operates the RAEs in each region, how the operators are selected, and how the Department evaluates and prevents potential conflicts of interest. Also, please discuss differences in the performance of the RAEs in implementing the Substance Use Disorder benefit and how the policies of the RAEs are affecting implementation.

II. Introduction

The Department of Health Care Policy and Financing (Department) is aware that stakeholders have expressed a variety of concerns regarding the Department's administration of the capitated behavioral health benefit. The Department appreciates this opportunity to provide information about how the Department has been addressing these issues and its strategies for the future.

The Department is committed to providing Medicaid members access to a full continuum of behavioral health services. For over 20 years, the Department has collaborated with the State General Assembly and behavioral health providers to design and implement a robust behavioral health benefit package that is unmatched by any other health plan in the State. The full continuum of behavioral health services is only made possible under a managed care arrangement with the federal government. The Department's managed care arrangement allows for coverage of services that are not available under federal fee-for-service guidelines. These are non-traditional, community-based alternative services such as peer recovery services, respite care, clubhouse and drop-in centers, intensive case management, short-term inpatient stays in Institutions for Mental Diseases (IMDs) and other services essential for supporting recovery of individuals with serious mental illness. Managed care

arrangements also enable the Department to gain access to clinical expertise and provide a mechanism to provide predictable and stable funding to safety net providers.

In collaboration with stakeholders, Colorado is tackling large-scale behavioral health reform to improve services. Within Medicaid, this includes continued improvements in integrated physical and behavioral health under the Regional Accountable Entities (RAEs), the implementation of the Prescriber Tool that includes Opisafe – an addiction reduction and prevention tool, creating the plan to transition to Qualified Residential Treatment Programs to align with the implementation of the Family First Prevention Services Act, and the implementation of a new federal waiver to provide coverage for residential and inpatient substance use disorder (SUD) services.

More broadly, the recent Behavioral Health Task Force, which we are actively leading along with the Colorado Department of Human Services, has recommended sweeping changes to the Colorado behavioral health care system going forward. The Task Force recommendations, outlined in the Blueprint for Behavioral Health Reform, along with legislative directives from Senate Bill 19-222 Individual At Risk for Institutionalization, will result in other upcoming changes to improve the state's behavioral health system, increasing access and better support for our members. The Department is working on the following efforts:

- We are in the process of drafting a gap analysis of the behavioral health providers and facilities by RAE region and will be creating regional plans and incentives with each RAE to fill in any gaps to increase contracting with behavioral health providers for FY 21-22.
- The Department is preparing an analysis of outpatient behavioral health rates across Medicaid, Medicare, and commercial payers, and how they impact the workforce. This will be published in Summer 2021 and will influence the behavioral health reform efforts across all state agencies. The report will be completed and posted by July or August 2021, and shared with stakeholders through the Beahvioral Health Reform Workgroup and Executive Committee.
- In accordance with SB 19-222, the Department is working with the Department of Human Services to deliver a comprehensive proposal to

strengthen and expand the behavioral health safety net system in Colorado. This includes new standards for providers, more support for wrap around and comprehensive services, and an updated value based payment model. This report is due to the General Assembly by July 1, 2021. We have hired a vendor to ensure that the value based model will work within and improve the managed care system for behavioral health. This model, per statute will be operational no later than July 2024.

Concurrent with all of this work, the Department is actively focused on getting Coloradans covered during this economic downturn while also driving vaccination uptake in our membership which will open up the economy, increase jobs and allow members to exit this year of isolation. All these strategic initiatives have a common goal of helping improve behavioral health care delivery, outcomes, and access.

While changes to improve access, prevent addiction, improve care delivery and enhance integration have widespread public support and will bring positive change to the Colorado behavioral health system and to Medicaid members, all of these initiatives represent change and disruption to the status quo. Some of these changes are also difficult to implement. And as with any new policy or program, it often takes time to learn where and how to improve operations and it take time for stakeholders – our providers, our members, our partners (i.e.: RAEs) - to adjust, accommodate and adapt to the number of changes that are in process.

The Department strives to be flexible and has best-practices to manage these new initiatives. First, the Department uses the available, often limited, information to design and set clear performance outcomes for the RAEs and for our providers. Prior to and during implementation of any change, the Department and its vendors actively educate and prepare providers, members, and other stakeholders for the new model of care. Once implemented, the Department closely monitors the system, making any immediate changes necessary while also allowing the system time to evolve, adapt and adjust. This step is followed by resetting outcome targets based on emerging information and leveraging additional tools to support the system in achieving the new goals. Due to the newness of the inpatient and residential SUD benefit and the Prescriber Tool, the Department is in the midst of steps one and two above.

As stated earlier, the Department is aware of a variety of concerns among stakeholders. The Department is committed to maximizing and reallocating available resources to address concerns as they surface and to increase supports to providers to help them adjust to new programs and policies. The Department is currently using a variety of methods to address the concerns brought to our attention:

- Actively research and intervene on complaints that come to the Department, including reaching out to the RAEs and facilitating resolutions with our provider partners.
- Increasing stakeholder engagement activities.
- Identifying and pursuing opportunities to standardize processes among RAEs.
- Leveraging our Department contracts to hold RAEs accountable.
- Enhancing training, standardization and transparency.

III. Department Role and Tools for Resolving Conflicts

The Department takes an active role in investigating and resolving complaints that are brought to its attention. To work through issues, the Department uses all of the tools available, from relationships with the RAEs and providers, to formal performance assurance levers available under the RAE contract.

Most of the recent complaints center around utilization management processes, contracting and reimbursement rates. In an effort to be more effective in addressing the different issues that have arisen recently, the Department has categorized issues into three general classifications:

- Challenges and/or inconsistencies across RAE practices.
- Lack of knowledge or experience with standard managed care practices, federal requirements and payment reform practices.
- Lack of familiarity with Medicaid requirements and standard practices.

A. Challenges and/or inconsistencies in RAE practices

In analyzing the complaints received, there are times when the RAEs are not complying with their contract or their own policies and procedures regarding items such as claims processing, prior authorizations, and contracting. In these instances, the Department plays a very active role.

The Department's role whenever a concern is brought to the Department's attention is to investigate it. This usually begins by talking with the RAE to understand what is happening or what has happened. The Department then askes the RAE to contact the provider to address the specific issue. If a provider does not feel the situation is appropriately addressed, the Department will host a joint meeting between the provider, the Department and the RAE to facilitate a resolution.

When an issue is significant or has not been properly resolved through informal means, the Department leverages formal tools within the contract to escalate the issue. These contract tools range from official warning letters and monitoring plans, to formal Corrective Actions, and can ultimately include termination for breach of contract. There have been several examples recently when the Department has placed RAEs on monitoring plans or under Corrective Action for problems that were not addressed satisfactorily.

During the investigation of an issue, there are times when the issue is rooted in variation or inconsistencies across the RAEs. While variation is a natural part of managed care and the Department's regional model, at times it can become a significant challenge or barrier for providers and/or members. In these instances, the Department takes an active role in driving appropriate standardization across the RAEs.

Recently, the Department has found that the most effective method for addressing systemic issues and establishing standardization is to create targeted forums between Department staff, the RAEs and the specific provider group that has expressed challenges. The Department successfully used this strategy to resolve a number of issues with the IMDs and has ongoing forums with hospital providers and child welfare agencies (See the fact sheet Accountable Care Collaborative: Role of Freestanding Psychiatric Hospitals and the Federal IMD Rule for more information). Resolutions can take the form of documented processes and procedures, memorandums of understanding, or amendments to the RAE contract.

The Department is in the process of establishing a forum with residential and inpatient SUD providers to more effectively collaborate on resolving

the various issues arising from implementation of the new benefit, including use of national standards for placement and how to braid funding from more flexible state sources, like the Office of Behavioral Health's block grant benefits.

B. Lack of knowledge or experience with standard managed care practices, federal requirements and payment reform practices

As stated in our introduction, managed care provides many benefits to the State. These benefits range from the extended array of behavioral health services, to enhanced assurances regarding member access to care and choice of provider, to accountability for outcomes. And this work is conducted in a way that is fiscally responsible, which allows the state to afford a greater continuum of benefits to Medicaid members to meet the increasing demands for behavioral health services.

As with any managed care program, the RAEs are responsible for contracting with a network of high-quality providers and employing utilization management to ensure services are medically necessary, that the services are achieving the intended outcomes and that financial resources are being used wisely. The RAEs, along with every commercial health plan, rely on evidence-based practices and published best practices to determine the appropriateness of services. For some providers, these practices may be unfamiliar or appear burdensome.

As Medicaid is a unique federal-state partnership intended to serve underserved and disabled individuals, the federal government has established additional rules to prevent managed care organizations from limiting access to care or benefitting from perverse incentive arrangements that may be present in a managed care arrangement. Many of these federal requirements are not found in commercial managed care arrangements, including provider choice protections, prohibitions against provider discrimination, member communication requirements, processes for handling grievances and appeals, timeliness for claims processing, and timelines and standards for authorization decisions and noticing of adverse benefit determinations. In particular for providers new to Medicaid under our SUD benefit, it can take time to adapt to these new Medicaid norms. Still, these protections have been developed in collaboration with the

public; many of these federal administrative checks and balance are designed to offer greater accountability, transparency and safeguards for both members and providers.

A number of the recent complaints are based on a misunderstanding of managed care or expectations that conflict with the core principles of managed care that help ensure the delivery of appropriate, quality care. There is particular confusion about the requirements placed on Medicaid managed care entities, and what the Department is allowed to direct and not direct the RAEs to do. Under a managed care arrangement, the responsibility for the program is shared between the Department and RAEs, with certain responsibilities primarily with one or the other party. The Department contracts with the RAEs to be administratively responsible for the capitated behavioral health benefit. This includes processing all authorization requests and claims. The Department's role is to provide oversight and ensure the RAEs comply with its contract as well as state and federal regulations. The Department ensures that the RAEs comply with the thorough federal requirements around adverse benefit determination notifications and the processing of grievances and appeals. The Department also receives encounter reporting information from the RAEs, which is housed in its data repository and is used to create insights on how the behavioral health program is operating. RAE contracted behavioral health providers are also enrolled in our Medicaid provider systems to enable access comparisons and the like.

The Department and the RAEs have been taking a number of actions to help providers and stakeholders better understand how the RAEs and a Medicaid managed care program function to improve process transparency, set expectations, and reduce challenges.

- The RAEs educate providers about their managed care practices and assist providers in complying with the practices. Strategies include trainings and webinars on different processes and procedures, toolkits, standard meetings with providers, hands-on technical assistance for individual practices around contracting and utilization management

practices, and participation in joint education efforts with the Department.

- The Department has participated in technical assistance and ongoing forums with different provider groups to clarify the different roles and responsibilities. In addition, the Department has contracted with a vendor to create a Medicaid managed care educational campaign to include fact sheets, presentation slides and other materials the Department can use with a variety of audiences to better understand roles and responsibilities and the benefits and flexibilities that exist in managed care that are not available in a fee for service system.

Another area of significant confusion is regarding Mental Health and Substance Use Disorder Parity (Parity). There is a common impression that Parity requires that access to services and reimbursement be equal, and that any use of utilization management is a violation of parity. However, parity regulations are focused on whether processes are comparable to and applied no more stringently within broad classifications of inpatient, outpatient, prescription drugs, and emergency care. The Department conducts a comprehensive assessment of compliance with Parity at least one time annually; these assessments have been approved by the Centers for Medicare and Medicaid Services (CMS). This year, in order to address these areas of confusion and evaluate the Department's processes for monitoring Parity, the Department has contracted with an external vendor to:

- Provide a written assessment of the Department's annual Parity report and whether the Department followed standard practices.
- Host an educational webinar describing parity and provide other documented materials.

C. Lack of familiarity with Medicaid requirements and practices

As the Department investigates different issues to determine whether it is a RAE management issue or a lack of understanding, it sometimes becomes apparent that a provider does not have a defensible complaint but is instead just expressing their grievance against the system. For example, substance use disorder residential programs may prefer to have an established length of stay for all clients. However, Medicaid is required to

use evidence-based clinical criteria to make length-of-stay determinations. Predetermined lengths of stay also do not align with the Department's principle for serving members in the least restrictive environment.

The Department acknowledges that public funding does require following complex rules that are not often included in commercial health plans and may be different for those SUD providers who are new to the Medicaid system. However, and as stated previously, these requirements have been established to protect both members and providers, to ensure services are most likely to meet a member's health needs, and to ensure the Department can manage the benefit appropriately.

In these instances, the Department uses all of the strategies referenced previously, from working directly with a provider and RAE, to providing additional and targeted education about Medicaid managed care rules and processes. It is sometimes challenging, but important, for the Department and other stakeholders to do the due diligence to determine whether a provider is presenting information accurately and completely instead of promoting changes that support a business model but do not align with state and federal regulations.

IV. Implementation of New Substance Use Disorder Services

The request by the General Assembly asked for information regarding the Department's implementation of the new residential and inpatient SUD benefit. As of the end of March, the RAEs have contracted with 30 unique providers across 48 locations. These contracts cover 1,352 SUD specific beds, representing 53% of the beds available at the time and 65% of the unique provider locations. The number of members in treatment across all American Society of Addiction Medicine (ASAM) levels of care has been increasing each week from 189 members during the first week of January to 300 members during the week ending March 26, 2021.

It is too early in implementation for the Department to provide any accurate assessment of the new services or the RAEs' management of the program. Given the SUD program is only three months old, and it takes time for providers to submit claims for reimbursement and the RAEs to process and report those

payments to the Department, the Department is just beginning to receive initial encounter data.

Given the delays in official reporting of encounter data, the Department has been manually collecting weekly data from the RAEs regarding members in treatment, estimated weekly costs, numbers of denials, average lengths of stay, and other critical data points. The Department is actively monitoring this data to ensure access is continuing to increase while providers and the RAEs improve utilization management processes. The transition to Medicaid reimbursement for these services required providers and the RAEs to learn and adopt a variety of new processes and procedures.

The Department has already implemented a number of activities to support providers and improve implementation, including:

- Regularly scheduled technical assistance between Department staff, RAEs, and SUD providers to address identified issues.
- The Department has instructed the RAEs to use a peer review process with the SUD providers after every denial so providers better understand the reason for the denial.
- The Department directed the RAEs to work collaboratively to establish initial authorization length of stay standards for different levels of care to reduce the burden on providers.
- RAEs are establishing processes so that SUD providers that are not able to accept a new member because their beds are full can assess the member and refer the member to the RAE to help with placement or to provide wraparound services until a bed becomes available.
- The Department has contracted with an SUD clinician and consultant to serve as a liaison between the Department and SUD providers, particularly around improving utilization of the American Society of Addiction Medicine level of care criteria.

At the same time, the Department is planning a number of actions to improve implementation in the future. These actions include:

- Utilizing available data to create a plan for the RAEs for next fiscal year to correct and close the gap between current performance and the Department expectations regarding access to services.
- Implementing additional training for providers and the RAEs on utilization management and the American Society of Addiction Medicine level of care criteria.
- Implementing the American Society of Addiction Medicine Continuum computerized decision support system to improve consistency of the application of level of care criteria among the RAEs and SUD providers.

The Department will continue to monitor implementation and new data as it becomes available to identify additional strategies that need to be used to improve implementation of these essential new services.

V. Regional Accountable Entities

The General Assembly also requested information about the selection of the RAEs, the ownership of the RAEs, and the Department's management of conflicts of interest.

The Department conducted a formal procurement process in 2017 using a request for proposals (RFP), in accordance with state procurement rules. The Department published a draft of the RFP for public comment and revised the final RFP based on feedback received.

To ensure the chosen vendors met the needs of the broader community and to prevent a conflict of interest in the choice of vendor, the Department included representatives from the stakeholder community in the selection process. Community members were chosen who did not have a conflict of interest or bias in the outcome, but who had significant knowledge of the Medicaid system. A group of community representatives and Department staff not involved in the design and creation of the RFP conducted an impartial review of all proposals and selected the final RAE contractors that were determined to be most advantageous to the State. Figure 1 identifies each RAE Region and Table 1 provides the name and legal partners of each RAE.

Figure 1. Map of Accountable Care Collaborative Regions

Table 1. Regional Accountable Entities by Region

Region	RAE Name	Legal Partners/Owners
1	Rocky Mountain Health Plans	• Rocky Mountain Health Plans (a subsidiary of United Healthcare)
2	Northeast Health Partners	• Centennial Mental Health Center • North Range Behavioral Health • Salud Family Health Centers • Sunrise Community Health
3 & 5	Colorado Access	• Colorado Access

Region	RAE Name	Legal Partners/Owners
4	Health Colorado, Inc.	• Beacon Health Options • Health Solutions • San Luis Valley Behavioral Health Group • Solvista Health • Southeast Health Group • Valley-Wide Health Systems
6 & 7	Colorado Community Health Alliance	• Anthem, Inc. • Centura Ventures, LLC • Physician Health Partners, LLC • Primary Physician Partners, LLC
Denver Health	Denver Health Medicaid Choice	• Denver Health Medical Plan (a subsidiary of Denver Health and Hospital Authority)

The Department was invested in retaining a regional model and leveraging the strengths of both local, community-based vendors with national vendors to continue to evolve the program.

Lastly, within the RAE contract, the Department included requirements to encourage transparency around conflicts of interest. This includes annual disclosures of ownership and control interests in the RAE, public posting of each RAE's governing body, and the creation of a RAE Governance Plan that describes how the RAE will protect against any perceived conflict of interest.

VI. Conclusion

The Department appreciates this opportunity to describe how it takes complaints from providers, members and other stakeholders extremely seriously. This document attempts to convey both the traditional tools the Department uses to manage the Accountable Care Collaborative, while

describing the Department's recent and planned strategies to escalate and expedite resolution to a number of current community concerns. It also underscores the unique and dynamic time we are in, including an increase in behavioral demand due to the COVID impact, the implementation of the SUD benefit, the implementation of the Prescriber Tool and the management of the federal Families First Prevention Services Act. We are actively partnering across Departments, providers and our contractors to maximize the behavioral health opportunities and to address systemic challenges.