1570 Grant Street
Denver, CO 80203

November 1, 2022

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

Dear Representative McCluskie:

Enclosed please find the Department of Health Care Policy & Financing's response to the Joint Budget Committee's Request for Information #2 regarding Medicaid member utilization of capitated behavioral health services in FY 2020–21 and the performance of the Regional Accountable Entities (RAEs) on network provider expansion, timeliness of processing provider claims within contract requirements, and timeliness of credentialing and contracting network providers.

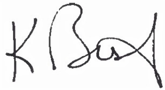
HCPF Legislative Request for Information #2 states:

> *Department of Health Care Policy and Financing, Behavioral Health Community Programs—The Department is requested to submit a report by November 1, 2022, discussing member utilization of capitated behavioral health services in FY 2020-21 and the Regional Accountable Entity's (RAE's) performance on network provider expansion, timeliness of processing provider claims within contract requirements, and timeliness of credentialing and contracting network providers.*

The report describes the capitated behavioral health benefit and summarizes how many members utilized behavioral health services during FY 2020–21. It also provides data on the time it took to process and pay provider claims in 2021. Finally, it describes how managed care entities contract with providers to expand their networks, reports on the timeliness of contracting and credentialing during 2021, and discusses steps taken to improve this process.

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 720-610-7795.

Sincerely,



Kim Bimestefer
Executive Director

KB/maq

Enclosure: Health Care Policy and Financing Response to the Department LRFI #2 Capitated Behavioral Health Services and Regional Accountable Entities

CC: Senator Chris Hansen, Vice-chair, Joint Budget Committee
Representative Leslie Herod, Joint Budget Committee
Senator Bob Rankin, Joint Budget Committee
Representative Kim Ransom, Joint Budget Committee
Senator Rachel Zenzinger, Joint Budget Committee
Carolyn Kampman, Staff Director, JBC
Robin Smart, JBC Analyst
Lauren Larson, Director, Office of State Planning and Budgeting
Noah Strayer, Budget Analyst, Office of State Planning and Budgeting
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Cristen Bates, Interim Medicaid Director, HCPF
Ralph Choate, Medicaid Operations Office Director, HCPF
Charlotte Crist, Cost Control & Quality Office Director, HCPF
Thomas Leahey, Pharmacy Office Director, HCPF
Tom Massey, Policy, Communications, and Administration Office Director, HCPF
Bettina Schneider, Finance Office Director, HCPF
Bonnie Silva, Office of Community Living Director, HCPF
Parrish Steinbrecher, Health Information Office Director, HCPF
Rachel Reiter, External Relations Division Director, HCPF
Jo Donlin, Legislative Liaison, HCPF

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

Nov. 1, 2022

Submitted to:

Joint Budget Committee

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Executive Summary

This report is in response to a request for information from the Joint Budget Committee to discuss member utilization of capitated behavioral health services in fiscal year (FY) 2020–21 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.

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. The Department is committed to continuing this important work with behavioral health.

The Behavioral Health Capitated Benefit

The Department is the single state agency responsible for administering Health First Colorado benefits. The Department maintains eight contracts with Managed Care Entities (MCEs), 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. Seven Regional Accountable Entities (RAEs) and Denver Health Medicaid Choice, a managed care organization for Denver County, are contracted with the Department to do this for the majority of behavioral health services. This managed care model connects members with coordination of behavioral health services, responds flexibly to emerging needs (like the pandemic), 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 would not be available under a fee-for-service model. These services are authorized by the federal Centers for Medicaid and Medicare Services (CMS) through a 1915b(3) waiver, also called B3 services, which are intended to help keep people healthy in their communities. The chart below gives an overview of some of the services covered by the inpatient, outpatient and B3 services.

Outpatient Services	Inpatient and Residential Services	Wraparound, Intensive Support B3 Services
• Individual, group, and family therapy • Medication management	• Emergency and crisis services • Inpatient hospital psychiatric care	• Prevention/Early Intervention • Clubhouses/Drop-in Centers • Vocational Services • Intensive Case Management

• Psychiatrist services • Outpatient hospital psychiatric services	• Residential and inpatient substance use disorder (SUD) treatment • Residential and inpatient withdrawal management	• Assertive Community Treatment • Residential Mental Health Treatment • Respite Care • Recovery Services/Peer Support

The Medicaid behavioral health benefit includes outpatient services such as individual and group therapy, medication management, psychiatrist services, and outpatient hospital psychiatric services. It also includes drug screening/monitoring and substance use recovery services, like medication-assisted treatment and intensive outpatient programs. The benefit also covers emergency services, inpatient hospital psychiatric care, and residential and inpatient substance use disorder (SUD) treatment.

To be compliant with state and federal regulations, MCEs must spend at least 85% of their capitated behavioral health payments on treatment for members, with the remaining 15% available for community supports and partnerships, alternative funding, support technologies, and other administrative expenses. Since the start of Accountable Care Collaborative (ACC) phase II in 2018, all of the MCEs have met this medical loss ratio (MLR) requirement; usually, they spend much more than 85% on care and member supports.

These services are one of the greatest flexibilities supported through a managed care system. Almost half (46%) of individuals with behavioral health needs benefit from these services every year; that is over 8% of the total Medicaid population. Without a managed care option, in order to retain the current behavioral health benefit, all of these services must 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 for each unit of service. Any of these services could be significantly limited based on the policy or budget analysis review. Our current program is a demonstrated cost savings program that, unlike fee-for-service, allows for the flexible and responsive use of state funds.

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, reduce waste and

promote more efficient and cost-effective care. 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 unitization 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. Most services do not require prior authorization if the service is provided by a contracted provider; one notable exception is residential/inpatient substance use disorder (SUD) services, which do require prior authorization when they are not for the purpose of withdrawal management.

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. During the first demonstration year of the expanded SUD benefit (January–December 2021), 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, 3,555 total initial requests were made, 3,104 initial authorizations were issued, and 95% of these authorizations were issued within 72 hours.

Behavioral Health Utilization FY 2020–21

In FY 2020–21, 18.2% of Health First Colorado members accessed capitated behavioral health services, which include mental health, SUD, and B3 services. This does not include fee-for-service behavioral health services, such as medication assisted treatment or services for new members prior to joining an MCE. During this time period, average monthly member enrollment in the ACC was 1,343,597 and enrollment in Denver Health Medicaid Choice was 110,538. Utilization trends for the behavioral health capitation are listed below:

- 242,924 members used capitated behavioral health services. Among that group, 71.2% (172,903) used mental health services, 16.4% (39,946) used SUD services, and 46.7% (113,405) used B3 services.
- Of the 172,903 distinct utilizers of mental health services, 172,657 (99%) received outpatient mental health services. Inpatient services were used by 10,667 (6.2%), and 3,817 (2.2%) received residential mental health services.

- Of the 39,946 utilizers of SUD services, 37,057 (92.8%) utilizers used outpatient services. 5,559 (13.9%) received residential treatment and 1,491 (3.7%) had an inpatient SUD stay.[1]

While 18.2% of members received a capitated behavioral health service, that rate is not fully representative of how many members need care. Estimates of the need for behavioral health care are available from surveys at both the national and state level. National estimates indicate that 21.0% of adults and 17% of adolescents report having a mental illness.[2] Colorado survey data show similar trends. According to the 2021 Colorado Health Access Survey, 24.3% of all Coloradans report eight or more days of poor mental health in the 30 days prior to the survey.

Provider Network, Credentialing, and Contracting

Each managed care entity 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. Starting in January 2022, MCEs were required to complete the credentialing and contracting processes or deny network admission within 90 days for at least 90% of all provider applications.

At the end of FY 2020-21, there were 8,627 MCE-contracted behavioral health providers, compared to 6,391 at the end of FY 2019-20. By the end of FY 2021-22, the Department set a goal to grow even further in partnership with providers, MCEs, and community to expand the network to 11,017 behavioral health providers.

Despite workforce challenges, MCEs have continued to increase the total number of contracted behavioral health practitioners. The Department's goal was to add 950 newly enrolled independent behavioral health practitioners by June 30, 2022. By July 19, 2022, 1,150 providers had been added.

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[1] At various points in this time period, the MCEs used revenue codes for all residential treatment services and hospital stays.
[2] SAMHSA. 2020 National Survey on Drug Use and Health. https://www.samhsa.gov/data/sites/default/files/2021-10/2020_NSDUH_Highlights.pdf

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As of quarter 4 of FY 2021-22, Network Adequacy reports for General Behavioral Health Service Categories indicate the MCEs have expanded their practitioner networks and met greater than 99% of access standards.

Since the implementation of the residential SUD benefit, 33 providers at 58 locations provided covered residential services to 8,844 unique members who received 16,486 episodes of care.

Claims Processing and Provider Payments

In compliance with federal regulations, the Department requires that the MCEs 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 2021.

Improving Behavioral Health Services Statewide

The Department plans to continue working with its contractors to improve the provider experience in contracting, credentialing and reimbursement.

- **Support for Providers:** During the past year, the Department put credentialing timeline requirements in place for the MCEs and worked with them to streamline the credentialing processes. During the upcoming year, the Department will collaborate in an Administrative Burden workgroup with providers, advocates, and the new Behavioral Health Administration (BHA) to identify opportunities to reduce administrative burden for behavioral health providers. Finally, the Department made adjustments to ensure that newly licensed providers can continue to bill for their services during their transition period from billing under a supervisor to billing independently.

- **Behavioral Health Administration (BHA):** HB 22-1278 created the BHA, a cabinet member-led agency that is designed to be the single entity accountable for driving coordination and collaboration across state agencies to address behavioral health needs. The BHA is tasked with collaborating to create new standards for providers and new payment models that consider not just the cost of services, but critical factors such as service quality, access to care, access for priority populations, and health equity.

- **Managed Care Standards:** In the MCE amendments that are currently in the final stages of the amendment process, there are dozens of changes being made, including: 1) updating the process for MCEs to investigate quality of care concerns for their enrolled members, and improving the process for reporting these

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concerns to the Department, 2) aligning the behavioral health billing codes with the Uniform Services Coding Manual, 3) removing prior authorization requirements of outpatient psychotherapy services for network providers, 4) clarifying that only American Society of Addiction Medicine (ASAM) criteria may be used for SUD level of care determinations, 5) requiring the MCEs to use the Universal Contracting Provisions once they are developed, 6) establishing behavioral health provider network expansion expectations, 7) requiring MCEs to contribute funding to the Behavioral Health Crisis Line, 8) requiring MCEs to have policies and procedures in place to help transition members from Colorado Mental Health Institutes to safe and alternative environments.

I. Introduction and Overview of the Behavioral Health Capitated Benefit

A. About This Report

This report is in response to a request for information from the Joint Budget Committee to discuss member utilization of capitated behavioral health services in FY 2020–21 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 SUD treatment, outpatient mental health and SUD services, and alternative services allowed under the Department's waiver with the Centers for Medicare and Medicaid Services. The report also includes, for calendar year 2021, 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 the Department monitors these performance measures and actions the Department has taken to improve MCE performance and member behavioral health outcomes.

Tracking on these metrics is also a priority for the Department to understand the status of our behavioral health networks and improve the behavioral health system. Providers are central to all we do for members, and the Department recognizes the importance of manageable administrative requirements and fair reimbursement. The Department is committed to supporting the workforce now and in the future to meet the behavioral health needs of a growing population with increasing behavioral health needs.

B. About the Behavioral Health Capitated Benefit

The Department is the single state agency responsible for administering Health First Colorado. The Department 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 for Denver County, are contracted with the Department to do this for most behavioral health services. 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

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 that would not be available under a fee-for-service model. (These services, called B3 services, are discussed in detail in the next section.) The managed care model also allows the Department to respond quickly and flexibly to emerging needs, such as the need for behavioral health telemedicine 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.

To be compliant with state and federal regulations, MCEs must spend at least 85% of the per member per month fees they receive on care for members (rather than administrative expenses). The behavioral health MCEs meet this medical loss ratio (MLR); usually, they spend more than 85% on care. Some behavioral health services are provided fee-for-service and do not fall under the capitated benefit, including some behavioral services offered in primary care settings.

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 for substance use disorder. The benefit also covers emergency and crisis services, inpatient hospital psychiatric care, and residential and inpatient substance use disorder treatment, including withdrawal management services.

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
- Intensive Case Management
- Assertive Community Treatment
- Residential Mental Health Treatment
- Respite Care
- Recovery Services/Peer Support

These alternative 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 serious mental illness, and those who have co-occurring mental health and SUD diagnosis, complex medical needs, cognitive disorders, or are involved with criminal justice systems.

Substance Use Disorder Benefit Expansion

On Jan. 1, 2021, Health First Colorado expanded its SUD benefit in accordance with House Bill 18-1136 to include residential level of care services, including withdrawal management, as part of behavioral health capitated managed care, which allows these services to be provided to members residing in institutions for mental diseases (IMD) with primary diagnoses of a substance use disorder. The expansion of the SUD benefit also supports state efforts to build provider capacity across the full ASAM continuum, improving access to medication-assisted treatment and better continuity of care across a continuum of evidence-based SUD services at varied levels of intensity.

Behavioral Health Utilization Management

Each MCE maintains a network of providers and has its own utilization management program for behavioral health services to reduce waste and promote more efficient and cost-effective care. Many services do not require prior authorization if they are provided by a provider in the network. When required, the authorization process often includes a review to determine whether the service is expected to address the health condition or diagnosis, is provided according to accepted standards, is clinically appropriate, is not experimental, and is not more costly than other equally effective treatment options.

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, the Department 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. Most services do not require prior authorization if they are provided by a provider in the network; one notable exception is the requirement for prior authorization of residential/inpatient SUD services, except for withdrawal management which is exempt from prior authorization to accommodate the immediacy of care needs.

In 2021, the General Assembly passed SB 21-1371, mandating that the Department consult with the Office of Behavioral Health, now known as the Behavioral Health Administration, residential treatment providers, and managed care entities to develop standardized UM processes for residential and inpatient SUD treatment and a methodology for reporting UM data quarterly. These quarterly reports are posted on the Department website.[3]

The expansion of SUD services requires providers to use the ASAM criteria to assess level-of-care placement for members needing residential and inpatient SUD services. This assessment is reviewed by the MCEs as part of the authorization process. The Department has worked with the MCEs to standardize initial authorization timeframes.

During the first demonstration year of the expanded SUD benefit (January to December 2021), 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.

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During this time period, 3,555 total initial requests were made, 3,104 initial authorizations were issued, and 95% of these authorizations were issued within 72 hours.

II. Behavioral Health Utilization in FY 2020-21

Utilization of Behavioral Health Services

In FY 2020–21, 18.2% of Health First Colorado members accessed capitated behavioral health services, which include mental health, SUD, and B3 services. During this time period, average monthly member enrollment in the ACC was 1,343,597 and enrollment in Denver Health Medicaid Choice was 110,538. Utilization trends for the behavioral health capitation are listed below:

- 242,924 members used capitated behavioral health services. Members could receive services in mental health, substance use, or comprehensive 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:
    - 71.2% (172,903) used mental health services
    - 16.4% (39,946) used SUD services
    - 46.7% (113,405) used B3 services
- Of the 172,903 distinct utilizers of mental health services, 172,657 (99%) received outpatient mental health services. Inpatient services were used by 10,667 (6.2%) and 3,817 (2.2%) received residential mental health services.
- Of the 39,946 utilizers of SUD services, 37,057 (92.8%) utilizers used outpatient services. 5,559 (13.9%) received residential treatment and 1,491 (3.7%) had an inpatient SUD stay.[4]

While 18.2% of members received a capitated behavioral health service, that rate is not representative of how many members need care. Estimates of the need for behavioral health care are available from surveys at both the national and state levels. National estimates indicate that 21.0% of adults and 17% of adolescents report having a mental illness.[5] Colorado survey data show similar trends. According to the 2021 Colorado Health Access Survey, 24.3% of Coloradans report eight or more days of poor mental health in the 30 days prior to the survey.

[4] At various points in this time period, the MCEs used revenue codes for all residential treatment services and hospital stays.
[5] SAMHSA. 2020 National Survey on Drug Use and Health. https://www.samhsa.gov/data/sites/default/files/2021-10/2020_NSDUH_Highlights.pdf

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Tables 1 through 4 show utilization of behavioral health services in FY 2020–21. For reference, average monthly member enrollment in the Accountable Care Collaborative during this time period was 1,343,597 and enrollment in Denver Health Medicaid Choice was 110,538.

Table 1. Members Accessing Behavioral Health Services, FY 2020-21

	Mental Health Services	Substance Use Disorder Services
Inpatient	10,667	1,491
Residential	3,817	5,559
Outpatient	172,657	37,057
B3 Services	113,405	N/A

Table 2. Members Accessing Outpatient Behavioral Health Services, FY 2020-21, by MCE

MCE	Outpatient Mental Health Services	Outpatient Substance Use Disorder Services
1	30,000	6,251
2	11,303	2,817
3	37,833	7,030
4	17,631	4,926
5	17,914	4,267
6	25,075	5,332
7	27,076	5,251
Denver Health	10,038	2,380

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Table 3. Members Accessing Inpatient and Residential Behavioral Health Services, FY 2020-21, by MCE

MCE	Inpatient Mental Health Services	Residential Mental Health Services	Inpatient Substance Use Disorder Services	Residential Substance Use Disorder Services
1	1,822	735	227	845
2	551	270	35	259
3	2,169	880	327	935
4	643	323	31	642
5	1,098	568	272	961
6	1,611	335	238	669
7	2,298	439	194	616
Denver Health	573	308	175	655

Table 4. Members Accessing B3 Services (Employment Services, Respite Care, Case Management, Drop-In Centers) FY 2020-21, by MCE

MCE	B3 Services
1	19,610
2	7,920
3	23,870
4	14,414
5	11,243
6	15,992
7	16,358
Denver Health	5,861

Behavioral Health Incentive Program Indicators

Each year, the MCEs are eligible to earn up to 5% of their annual behavioral health capitation payment for reaching performance metrics. These are additional funds authorized by the General Assembly and CMS. Below is a description of the behavioral health incentive program indicators used to measure and incentivize MCE performance in behavioral health in FY 2020–21.

1. **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.
2. **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.
3. **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.
4. **Follow-up after a Positive Depression Screen**: Percent of members engaged in mental health service within 30 days of screening positive for depression.
5. **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 5 shows the percentage of members in each MCE who received the service described in each performance indicator.

Table 5. FY 2020-21 Behavioral Health Incentive Program Performance 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
1	47.90%	44.80%	32.46%	57.49%	16.39%
2	50.80%	50.07%	29.64%	87.09%	18.60%
3	45.09%	56.76%	30.50%	43.47%	15.41%
4	48.51%	70.43%	36.49%	50.19%	33.11%
5	36.65%	56.03%	35.25%	39.21%	28.57%
6	41.61%	64.51%	35.30%	47.48%	17.82%
7	54.10%	41.42%	32.75%	73.39%	23.29%
Denver Health	*	*	*	*	*

*Not enough data available for reporting.

III. Provider Network, Credentialing, and Contracting

A robust provider network is one important way to ensure equitable access to behavioral health care. The Department 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, including 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

Two major types of providers offer behavioral health outpatient services: Community Mental Health Centers (CMHCs) and independent providers, which comprise the Independent Provider Network (IPN). The Department 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 the state, 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 network of providers in their region 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.

Safety Net Providers (Community Mental Health Centers)

In 2022, the General Assembly passed HB 22-1278, the Behavioral Health Administration bill, which created new definitions for behavioral health safety net providers. These new definitions for comprehensive and essential behavioral health safety net providers and FQHCs will go into effect in 2024. Until that time, the state's primary behavioral health safety net is comprised of community mental health centers and clinics. Community Mental Health Centers (CMHCs) are institutions that operate under section 27-66-101, C.R.S., to provide behavioral health inpatient, outpatient, partial hospitalization, emergency, and consultative and educational services to Coloradans. These requirements are intended to ensure that CMHCs are prepared to deliver services at all times, despite fluctuation and variability in demand, patient need, and patient severity. CMHCs are required to serve as safety net providers and are the primary providers for alternative/B3 services.

The Department recognizes that the safety net provider system in Colorado, currently comprised primarily of the CMHCs, is not always meeting these existing standards for providers or the needs of their communities. Through community feedback, state-led reviews and recommendations, ranking and transparency reports, internal data, and thoughtful legislation, the Department is working with our state, federal and community partners to improve accountability in the safety net. Section V below, Improving Behavioral Health Services Statewide, includes an overview of seven key initiatives underway that will drive significant improvements in safety net accountability.

Independent Provider Network

The independent provider network (IPN) is broadly defined as any outpatient behavioral health provider enrolled in Medicaid and contracted with a managed care entity that is not licensed or designated as a community mental health center. 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 organizations with multiple sites across a region or the state.

It is important to note that although FQHCs are technically part of the IPN, the Department separated FQHCs into their own category due to the distinctly different services provided and federal requirements imposed by this designation. Therefore, FQHCs will be described separately in the next section.

To serve Health First Colorado members, providers must be enrolled with Medicaid 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.

Federally Qualified Health Centers

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 may also deliver 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

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 the

Department 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.

Provider Contracting and Credentialing for Behavioral Health Services

Once enrolled as providers, behavioral health providers may contract with any of the MCEs 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 the Department. MCEs pay claims under the capitated behavioral health benefit and authorize behavioral health services.

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 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.

The Department worked with the MCEs to streamline credentialing processes during FY 2020–21. 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 6 shows the percentage of providers credentialed and contracted within 90 days in calendar year 2021.

Table 6. Percentage of Providers Credentialed and Contracted Within 90 Days for Each Quarter in 2021, includes CY 22 Q1 - Q2 by MCE

	RAE 1 Rocky	RAE 2 Northeast	RAE 3 & 5 CO Access	RAE 4	RAE 6 & 7 CO Community	Denver Health

	Mtn Health Plans	Health Partners		Health Colorado, Inc.	Health Alliance	
CY 21 Q1	100%	100%	89%	79%	*	89%
CY 21 Q2	100%	98%	90%	86%	*	90%
CY 21 Q3	100%	45%	92%	45%	92%	92%
CY 21 Q4	100%	63%	87%	63%	75%	87%
CY 22 Q1	96%	97%	99%	97%	100%	100%
CY 22 Q2	100%	100%	100%	100%	100%	100%

* Prior to January 2022, RAEs 6 and 7 collected only credentialing data rather than both credentialing and contracting data. It is therefore not comparable and is not listed here.

In January 2022, MCE contracts were adjusted to codify the standard that contracting decisions be made within 90 days of receiving a provider application. Since that date, every RAE has improved contracting and credentialing times and has demonstrated that they are contracting and credentialing at least 90% of applicants within 90 days.

As previously mentioned, the Department 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

The Department is committed to building provider networks so that all members can access the care they need, and MCEs are tasked with building quality networks that serve the region. This goal is, however, also impacted by the inadequate number of behavioral health providers in the state, which the state is addressing in a number of ways. Federal and state managed care regulations require strict monitoring of provider access and adequacy to ensure members' needs are being met. This includes not only provider-member ratios, but distance and travel time, appointment wait times, cultural/linguistic competency, and disability services.

The Department monitors behavioral health network adequacy through annual network adequacy reports as well as quarterly reports focused on network development efforts. 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 the Department is validated and reviewed for accuracy by a third-party external quality review organization.

In regions where providers are limited due to national shortages, MCEs have adopted innovative strategies to build the capacity of their networks so they can deliver comprehensive behavioral health services. 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.

For example, in addition to developing its SUD treatment infrastructure, one MCE has developed a unique payment system with two large multi-provider primary care clinics, where members can receive high-quality primary care and behavioral health care in an integrated setting. The MCE has also focused on improving care transitions between office-based opioid and alcohol dependency treatment and a therapy-based program. For rural members, the MCE collaborates with addiction specialists to provide SUD treatment by telemedicine.

Table 7. Number of MCE-Contracted Behavioral Health Providers (by Unique National Provider Identifier), by Quarter

Fiscal Year and Quarter	Number of Enrolled Behavioral Health Providers
FY 2019–20 Q4	6,391
FY 2020–21 Q1	7,451
FY 2020–21 Q2	7,984
FY 2020–21 Q3	8,307
FY 2020–21 Q4	8,627

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

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.

Group practices include practices at FQHCs, rural health centers, and community mental health centers.

Despite workforce challenges, the MCEs have continued to increase the total number of contracted behavioral health practitioners. The Department's goal was to add 950 newly enrolled independent behavioral health practitioners by June 30, 2022. By July 19, 2022, 1,150 providers had been added. Practitioners were added in every quarter of 2021 in all regions. A solicitation was also released in 2022 in partnership with the Department of Regulatory Affairs (DORA) encouraging all licensed behavioral health providers in the state to join the Medicaid network through the RAEs. The combination of additional Medicaid behavioral health funding which has been received over the last several years ($400M more since 2018), unique provider outreaches like that referenced, the ARPA dollars being invested to transform Colorado's behavioral health system, the 20+ legislative bills memorializing this funding investment as well as other transformative policies all will serve to help the RAEs increase their contracted network access over the coming years. This is complex issue that requires a multi-faceted community response from the RAEs, state and regulatory agencies, community partners, education systems, and creative policies. Even with the existing efforts, the workforce shortages will take time to cure and the Department is committed to supporting and leading on workforce development strategies.

Table 8. Number of MCE-Contracted Behavioral Health Practitioner Added by Quarter, Calendar Year 2021

Managed Care Entity	Q1 (Jan-Mar)	Q2 (Apr-Jun)	Q3 (Jul-Sep)	Q4 (Oct-Dec)
Denver Health	205	180	140	162
RAE 1	35	14	7	12
RAE 2	127	120	1,386	269
RAE 3	142	180	152	165
RAE 4	127	120	1,385	269
RAE 5	205	180	140	162
RAE 6	242	76	166	185
RAE 7	242	76	166	185

Table 9. Number of MCE-Contracted Behavioral Health Practitioners at the End of CY 2021

Managed Care Entity	2021 Year-End Total of Behavioral Health Practitioners
Denver Health	6,983
RAE 1	3,290
RAE 2	3,166
RAE 3	7,040
RAE 4	3,164
RAE 5	6,983
RAE 6	4,113
RAE 7	4,113

The Department and MCEs also worked to build the provider network for the new residential and inpatient benefit for SUD treatment. In 2020 and 2021, the Department met individually with providers upon request to explain the enrollment process and answer questions. The Department also expedited the review of SUD provider enrollment applications. In the first year of the expanded benefit (Jan. 1 to Dec. 31, 2021), 33 providers at 58 locations offered covered residential services to 8,844 unique members who received 16,486 episodes of care.

IV. Claims Processing and Provider Payments

MCEs are responsible for processing behavioral health claims that fall within the managed behavioral health benefit and paying providers the contracted rate. (The Department 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, the Department requires that the MCEs adjudicate and pay 90% of all clean claims within 30 days of receiving them, and 99% of clean claims within 90 days of receipt. 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 contract 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.

Table 10. Percent of MCEs Meeting Claim Adjudication and Provider Response Standards 2021, by MCE

	RAE 1	RAE 2	RAE 3	RAE 4	RAE 5	RAE 6	RAE 7
% of clean claims paid or adjudicated within 30 days	99.6%	100%	99.0%	100%	99.4%	99.5%	99.5%
Response to provider questions within two business days	100%	100%	100%	100%	100%	100%	100%

V. 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. However, the Department continues to set parameters and provide support to MCEs seeking to streamline their utilization management processes. Recent examples are a single standardized SUD Initial Authorization form; timeliness standards for inpatient/residential SUD programs (within 72 hours) and SUD treatment for pregnant and postpartum Special Connections members (within 24 hours); required use of ASAM criteria to make level-of-care placement decisions for residential/inpatient SUD services; and no prior authorization for medication-assisted treatment or withdrawal management services.

In addition, the Department has 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 and monitoring protocol:

A. Increasing rates of member engagement in treatment;
B. Increasing retention in treatment;
C. Decreasing overdose deaths;
D. Decreasing emergency department utilization;

E. Decreasing readmissions at the same or higher level of care; and
F. Increasing access for physical health conditions.

To meet the objectives and support providers in delivering a full continuum of services, the Department will continue to support MCE expansion of the SUD provider network and explore the expansion of ASAM level 2 services. This level of care includes both partial hospitalization and intensive outpatient services.

B. Support for Independent Providers

Independent behavioral health providers are an essential part of the behavioral health services network. Expanding the behavioral health safety net in Colorado requires ongoing improvements to the provider experience to continue to increase access for members. The Department recognizes the need to minimize administrative burden and increase support for providers while still maintaining compliance with state and federal regulations. During the past year, the Department put credentialing timeline requirements in place for the MCEs and worked with them to streamline the credentialing processes. Each MCE operates independently from the others, so it was not possible for a provider to contract with multiple MCEs with one submitted application; MCEs are now required to use a standard form and are prohibited from asking for additional documentation unless required to obtain a clean file.

To ensure that newly licensed providers can continue to bill for their services, the Department updated the language in the Uniform Services Coding Standards (USCS) Manual effective July 1, 2022, to indicate that practitioners who are eligible to enroll in Medicaid and have applied for credentials with an MCE may continue to submit claims under a supervising provider until they are contracted with an MCE. This change was made to reflect a more flexible understanding of the expectation for this transition period.

C. Behavioral Health Administration

One of the bills passed in 2022 was HB 22-1278, which created the Behavioral Health Administration (BHA), a cabinet member-led agency that is designed to be the single entity responsible for driving coordination and collaboration across state agencies to address behavioral health needs. This law tasks the BHA with collaborating to create new standards for providers and new payment models that consider not just the cost of services, but critical factors such as service quality, access to care, access for priority populations, and health equity.

The BHA will evolve over several years with core functions being added over time and full capacity being achieved in 2024. The BHA will require ongoing iteration and refinement as it addresses the priorities in the Blueprint for Behavioral Health

Reform, identifies new and emerging behavioral health challenges to tackle, and invests in evidence-based practices to achieve positive outcomes for Coloradans.

The Blueprint for Behavioral Health Reform outlines three phases of work, which have rolling deadlines. As the BHA is getting established over the next two years, it will also focus on implementing care coordination and the recommendations from the six pillars that form the foundation of a comprehensive behavioral health system: access, affordability, workforce and support, accountability, local and consumer guidance, and whole-person care.

D. Safety Net Accountability

HCPF and the BHA are collaborating with stakeholders to drive seven different workstreams intended to improve the performance and accountability of the behavioral health safety net, currently comprised primarily of Community Mental Health Centers (CMHCs), to better meet the needs of the communities they serve. These efforts outlined below include: a modernization of safety net provider definitions; revising, amending, or repealing regulations for behavioral health safety net providers; improved transparency and standards for safety net cost reports; development of alternative and value-based payment models in Medicaid; and creation of new universal contract provisions for all providers that contract with the state for behavioral health services to hold them accountable and outline these new provisions across state payers.

- **Legislation to Expand and Strengthen the Behavioral Health Safety Net.** To support the state behavioral health safety network, as introduced in SB-222 and the subsequent report to strengthen and expand the safety net, new definitions of the safety net and safety net provider are emerging to the benefit of all Coloradans, especially those who are low- income and suffer from Serious Mental Illness (SMI). These definitions will ensure new criteria to be a safety net provider, while increasing the number of providers who can be part of the safety net system. The impacts of this bill have already begun, and will be fully complete by July 1, 2025.
- **Rewriting the provider standards for all behavioral health providers.** HB22-1278 modernized the definition of safety net providers and associated safety net services, which also created a new provider type for small and medium sized safety net providers. The BHA will be revising, amending or repealing their provider standards, and other regulations, based on these statutory changes. These first set of new rules will be effective by July 1, 2023.
- **HCPF Cost Reporting and Safety Net Rate Setting.** To increase diligence on rate setting for CMHCs, which will bring CMHCs in parallel to the

FQHCs and the HCPF MCO cost reports, HCPF released new Cost Report templates for the CMHCs in May of 2022. All CMHCs must submit their cost information to HCPF in November 2022 using these new templates. Those insights will be used to set new rates effective July 2023. The cost reports and the rate reviews will be posted publicly by March 15, 2023.

- **Alternative Payment Models (APMs) and Value-Based Payments (VBPs).** HCPF is working with stakeholders and the BHA to develop new reimbursement methodologies for safety net providers that create greater accountability to the community and reward member outcomes. Specifically, the new APMs will create sufficient flexibility for providers to meet the needs of the community and members, while the VBP will better correlate reimbursements with results. While these payments will evolve on an iterative basis, the initial APM will be effective July 2024.
- **Universal Contract Provisions.** Two bills (HB 22-1278 and HB 22-1302) require HCPF and BHA to work together and develop Universal Contract provisions that will define expectations for behavioral health providers that contract with the state for behavioral health services. The Universal Contract provisions will standardize contract content expectations around things such as data collection and reporting, access to care, compliance with behavioral safety net standards, claims submission, billing for procedures, etc. Concurrently, payers like HCPF and the BHA will be held accountable for financial reporting, utilization review, provider service, Medicaid claim payment turnaround time, and more. The initial Universal Contract provisions will be developed by July 2023.
- **Agency CMHC Audits.** A number of standard state oversight activities and community concerns in 2021 resulted in a Tri-Agency Audit (HCPF, CDHS, CDPHE) of CMHC Mind Springs Health in January 2022. After a number of visits, discussions, additional MSH audit segments conducted by the Agencies, and a detailed Corrective Action Plan designed to drive better results and service to the community, a final Corrective Action Plan (CAP) was accepted, with limited caveats, on Aug. 26, 2022 by HCPF, CDPHE, and the BHA. The agencies are monitoring and driving MSH improvements and compliance independently, due to the breadth of findings and CAP requirements underway.
- **Investments in increasing Medicaid provider rates and network.** The expansion of HCPF's Medicaid Behavioral Health network outlined in this report is a reflection of the provider reimbursement rates it is providing. HCPF has multiple projects that target the expansion of the provider network. In that spirit, more than $400M in additional funding to RAEs to increase Medicaid BH rates and access has been funded since 2018 through FY 2021-22. HCPF increased RAE behavioral health budgets by about 6% in FY 2021-22 (about three times the across the board increase

provided to all Medicaid providers that year). Further, each RAE was required to increase provider networks with a focus on substance use disorder (SUD) residential, medication assisted treatment (MAT), intensive outpatient (IOP) services, and child/youth services.

The Department looks forward to working with stakeholders and the BHA to continuously identify areas for improvement and to successfully implement the BHA's vision for a people-first behavioral health system.

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