COLORADO
Department of Health Care Policy & Financing

1570 Grant Street
Denver, CO 80203

Behavioral Health: Independent Provider Network (IPN) Frequently Asked Questions

Update: April 2022

This document contains frequently asked questions by independent behavioral health care providers. Health First Colorado's (Colorado's Medicaid program) is administered by Regional Accountable Entities (RAEs) that make up our Accountable Care Collaborative (ACC) program throughout the state. The health care delivery system for behavioral health is through managed care. More information about the ACC Program and the RAEs is available on our ACC Provider and Stakeholder Resource Center.

Q1: Does Colorado's parity law (HB19-1269) require changes to our managed care behavioral health delivery system?

A: The Centers for Medicare and Medicaid Services (CMS) has confirmed Colorado's delivery system design is not a violation of Parity. The Mental Health Parity and Addiction Equity Act requires health plans to provide benefits for mental health and substance use disorder benefits that are comparable to and no more stringent than that which is provided for medical and surgical care. It is not a specific violation of parity for members to receive capitated mental health and substance use disorder benefits and fee-for-service medical and surgical benefits. You can learn more on our Parity webpage.

Q2: What actions can the Department of Health Care Policy & Financing (HCPF) take to hold Regional Accountable Entities (RAEs) accountable to their contracts?

A: The contract's material breach clause allows for termination for cause if a RAE refuses or fails to perform any of the provisions in the contract. The Department must notify the RAE of non-performance and allow them to correct the issue within a specified time period.

The Department has a progressive performance management process used to hold the RAEs accountable to contract obligations. This begins with informal performance feedback, such as a phone call, meeting, or email to point out a new performance issue for relatively minor issues that do not pose a high risk to member care or the Department.

The next step in the performance management process is developing an Action Monitoring Plan. This is used when the performance issue is not resolved after repeated clarification and feedback, or if the issue is new but does not pose a high risk to member care or the Department.

The last step in the progressive performance management process is issuing a formal Corrective Action Plan. This is used when the informal action plan was not effective or when the issue is pervasive, urgent, or high-risk to member care or the Department. This tool will also be used if an issue is identified as part of an external quality review.

Q3: How is the Department addressing the administrative burden for providers of contracting and credentialing with multiple RAEs?

A: The Department worked with the RAEs to streamline credentialing processes. Specifically, RAEs must complete the credentialing and contracting processes or deny network admission within 90 days for at least 90 percent of all provider applications.

RAEs must use the Council for Affordable Quality Healthcare (CAQH)ProView® application to collect data from individual providers as necessary to complete the credentialing and recredentialing processes.

RAEs must use the CAQH VeriFide™ application to perform provider primary source verification for the credentialing and recredentialing processes. RAEs may not require any additional documentation from individual providers for the purposes of credentialing, unless the purpose is to obtain a clean file.

RAEs have the authority to contract with individual providers at their own discretion so there is no plan to "contract with all RAEs in one step".

The Department is also 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.

Q4: Is there a statewide policy that informs how pre-licensed providers can render services?

A: With a few exceptions, the RAEs determine what providers to contract with as well as how they will pay those providers. All RAEs have agreed to provide opportunities for pre-licensed intern billing without a license or designation from the Office of Behavioral Health. The Department will provide additional guidance on unlicensed provider reimbursement in the coming year.

Q5: Is the Department able to remove barriers for newly licensed providers working to contract with RAE?

A: The Department will be updating the language in the Uniform Services Coding Standards (USCS) Manual effective July 1, 2022, to reflect a more flexible understanding of the expectation for this transition period. The RAEs have agreed to this policy/practice modification as well. "Practitioners, who are eligible to enroll in Medicaid and have applied for credentials with a RAE, may continue to submit claims under a supervising provider until they are contracted with a RAE."

Q6: Is the Department able to dictate RAE reimbursement rates?

A: RAEs have the sole authority to set reimbursement rates with providers under Managed Care authority. The Department cannot directly set rates for providers or require specific rates without significant changes to our federal approvals [42 CFR 438.6]. However, the state is working on some changes to our overall rate standards. Please see the response to the question below (Q7) that are relevant to improving rate reimbursements. The Department is pleased to see several RAEs share that they have recently increased a variety of service rates in 2022. The Department is also using American Rescue Plan Act funds to incentivize RAEs to support more intensive outpatient services, which should be coming in the next few months and supporting new and existing providers.

Q7: Why are there significant differences in reimbursement rates between the IPN and Community Mental Health Centers (CMHCs)?

A: IPN and CMHCs have distinct reimbursement structures that are not comparable as the requirements for the operations of each are vastly different. These structural and requirement differences cannot be accounted for when looking solely at a single service code. Additionally, IPNs receive a direct managed care fee-for-service reimbursement while CMHCs are generally given a sub-capitated rate (total allotment for all services provided each month). This rate cannot be explicitly tied to individual services. The Department is working to improve the cost reporting and payment methodologies for safety net providers. The new Behavioral Health Administration bill (HB22-1278) will make significant updates to the way providers are defined (see pages 4 and 26) and the way providers are paid (see page 105). We expect these changes to statute will allow safety net providers to get more equitable payment for comparable services. Please see the IPN Efforts for more details.

Q8: Why would I receive a letter from a RAE reviewing my use of certain billing codes?

A: RAEs are federally required to implement and maintain a compliance program that must include, among other things, the establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks. It also requires prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits,

correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies). This is federally required in order to reduce the potential for recurrence, and ongoing compliance with the requirements under the contract [42 CFR 438.608(a); 42 CFR 438.608(a)(1)(i)-(vii)]. The RAEs are required to send these letters to help providers understand how their billing practices compare to others, and to alert providers of any billing practices that might be out of sync, but the letters are not intended to dictate practice. The letter alerts you to your billing practices but does not require you to alter them.

Q9: Is there a way to review Network Adequacy Reports to see provider counts by county?

A: The Department is working to better share network adequacy information. To meet federal requirements and assess contract compliance, the Department collects and evaluates extensive data about RAE, Managed Care Organization and Child Health Plus primary care and behavioral health provider networks. Although each quarter the Department publishes narrative summary reports produced by each Managed Care Entity (MCE) and verified by an independent EQRO vendor, the Department has chosen not to publish more extensive text files used to determine contract compliance. Several factors affected this decision.

First, the MCE contracts largely determine network adequacy by assessing the time and distance between Health First Colorado (Colorado's Medicaid program) members and different types of providers. Therefore, viewed alone, a simple list of providers contracted in each county without information about the number of members in each county would be insufficient to determine whether an MCE met network adequacy standards. To protect member privacy, the Department can't divulge the lists or numbers of members in each county. Summarized information disaggregated by county would be misleading and open to misinterpretation.

Second, the quarterly text files are large. The Department determined narrative summary reports worked best for the limited website space and provided a more understandable summary of network adequacy compliance.

Q10: Will the Department require providers to have a Behavioral Health Entity (BHE) License?

A: Providers with a community mental health center designation will need to obtain a BHE license by July 1, 2022 to continue to be enrolled in Medicaid. All other group providers, as well as community mental health clinics that wish to retain a license, must comply with the BHE implementation plan and licensing standard, which can be found here.

It is important to note that with the BHA's implementation state requirements for a BHE license will continue to evolve, and providers who are not impacted as of July 1, 2022 may

be impacted in the future. Providers are encouraged to participate in upcoming stakeholder opportunities.

Q11: What changes are coming with ACC 3.0?

A: The current RAE contracts are renewed annually and end on June 30, 2025. The Department has started planning for ACC 3.0; however, it is very early in the process and no final decisions have been made. As part of ACC 3.0 development, the Department will engage multiple stakeholders including providers, members and advocacy organizations.

More information for Independent Provider Network providers is available on our IPN Forum webpage.