JOINT BUDGET COMMITTEE

# STAFF BUDGET BRIEFING
# FY 2024-25

# DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

(Behavioral Health Community Programs)

JBC WORKING DOCUMENT - SUBJECT TO CHANGE
STAFF RECOMMENDATION DOES NOT REPRESENT COMMITTEE DECISION

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ADDITIONAL RESOURCES

Brief summaries of all bills that passed during the 2023 legislative sessions that had a fiscal impact on this department are available in Appendix A of the annual Appropriations Report: https://spl.cde.state.co.us/artemis/gaserials/ga39internet/ga39202324internet.pdf

The online version of the briefing document, which includes the Numbers Pages, may be found by searching the budget documents on the General Assembly's website by visiting leg.colorado.gov/content/budget/budget-documents. Once on the budget documents page, select the name of this department's *Department/Topic*, "Briefing" under *Type*, and ensure that *Start date* and *End date* encompass the date a document was presented to the JBC.

# DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

## DEPARTMENT OVERVIEW

The Department helps pay health and long-term care expenses for low-income and vulnerable populations. To assist with these costs, the Department receives significant federal matching funds, but must adhere to federal rules regarding program eligibility, benefits, and other features, as a condition of accepting the federal money. The major programs administered by the Department include:

- **Medicaid** -- serves people with low income and people needing long-term care
- **Behavioral Health Community Programs** – provides capitated managed care payments for mental health and substance use disorder treatment
- **Children's Basic Health Plan** -- provides a low-cost insurance option for children and pregnant women with income slightly higher than the Medicaid eligibility criteria
- **Colorado Indigent Care Program** -- defrays a portion of the costs to providers of uncompensated and under-compensated care for people with low income, if the provider agrees to program requirements for discounting charges to patients on a sliding scale based on income
- **Old Age Pension Health and Medical Program** -- serves elderly people with low income who qualify for a state pension but do not qualify for Medicaid or Medicare

The Department also performs functions related to improving the health care delivery system, including advising the General Assembly and the Governor, administering grants such as the Primary Care and Preventive Care Grant Program, and housing the Commission on Family Medicine Residency Training Programs.

# DEPARTMENT BUDGET: RECENT APPROPRIATIONS

## DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

| FUNDING SOURCE | FY 2021-22 | FY 2022-23 | FY 2023-24 | FY 2024-25* |
|---|---|---|---|---|
| General Fund | $3,068,037,679 | $3,652,118,890 | $4,525,518,658 | $4,966,004,584 |
| Cash Funds | 1,682,425,600 | 1,856,769,698 | 1,769,169,191 | 1,819,098,761 |
| Reappropriated Funds | 87,047,288 | 95,031,721 | 105,145,754 | 121,939,636 |
| Federal Funds | 8,637,872,527 | 9,054,693,848 | 9,106,914,976 | 9,480,711,882 |
| **TOTAL FUNDS** | **$13,475,383,094** | **$14,658,614,157** | **$15,506,748,579** | **$16,387,754,863** |
| | | | | |
| Full Time Equiv. Staff | 654.9 | 745.0 | 787.9 | 797.3 |

*Requested appropriation.

Funding for the Department of Health Care Policy and Financing in FY 2023-24 consists of 29.2 percent General Fund, 11.4 percent cash funds, 0.7 percent reappropriated funds, and 58.7 percent federal funds.

## BEHAVIORAL HEALTH COMMUNITY PROGRAMS

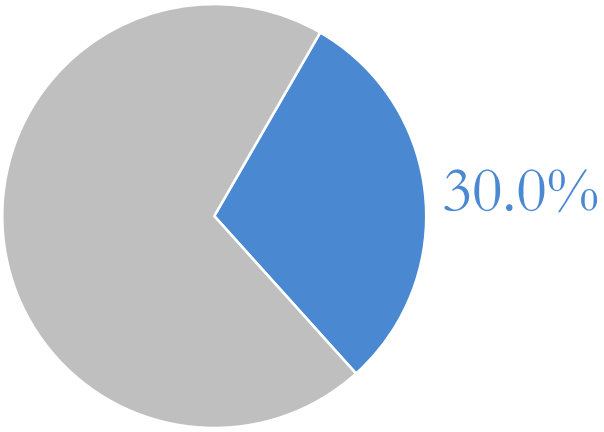
| FUNDING SOURCE | FY 2021-22 | FY 2022-23 | FY 2023-24 | FY 2024-25* |
|---|---|---|---|---|
| General Fund | $195,674,112 | $236,698,363 | $284,702,715 | $292,850,305 |
| Cash Funds | 64,031,141 | 92,552,246 | 91,030,034 | 91,910,564 |
| Reappropriated Funds | 0 | 0 | 0 | 0 |
| Federal Funds | 820,778,543 | 808,882,888 | 842,750,331 | 815,020,569 |
| **TOTAL FUNDS** | **$1,080,483,796** | **$1,138,133,497** | **$1,218,483,080** | **$1,199,781,438** |
| | | | | |
| Full Time Equiv. Staff | 0.0 | 0.0 | 0.0 | 0.0 |

*Requested appropriation.

Funding for the Behavioral Health Community Programs subdivision consists of 23.4 percent General Fund, 7.5 percent cash funds, and 69.2 percent federal funds in FY 2023-24.

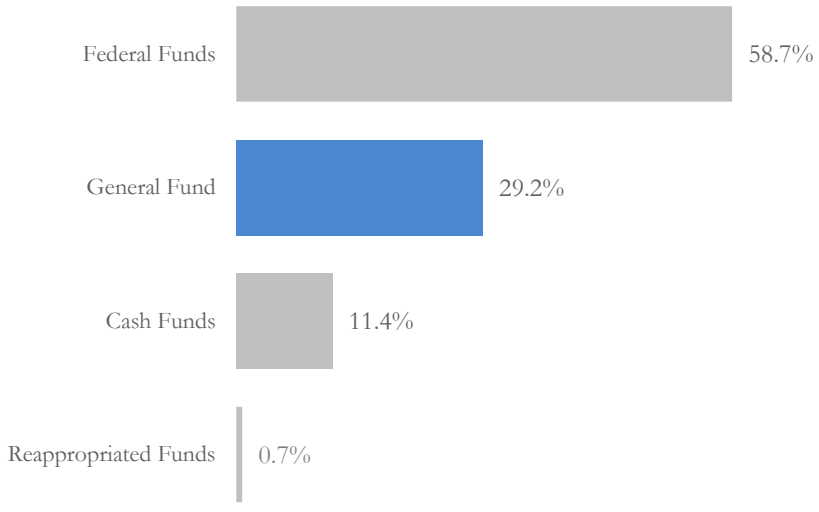
# DEPARTMENT BUDGET: GRAPHIC OVERVIEW

Department's Share of Statewide General Fund



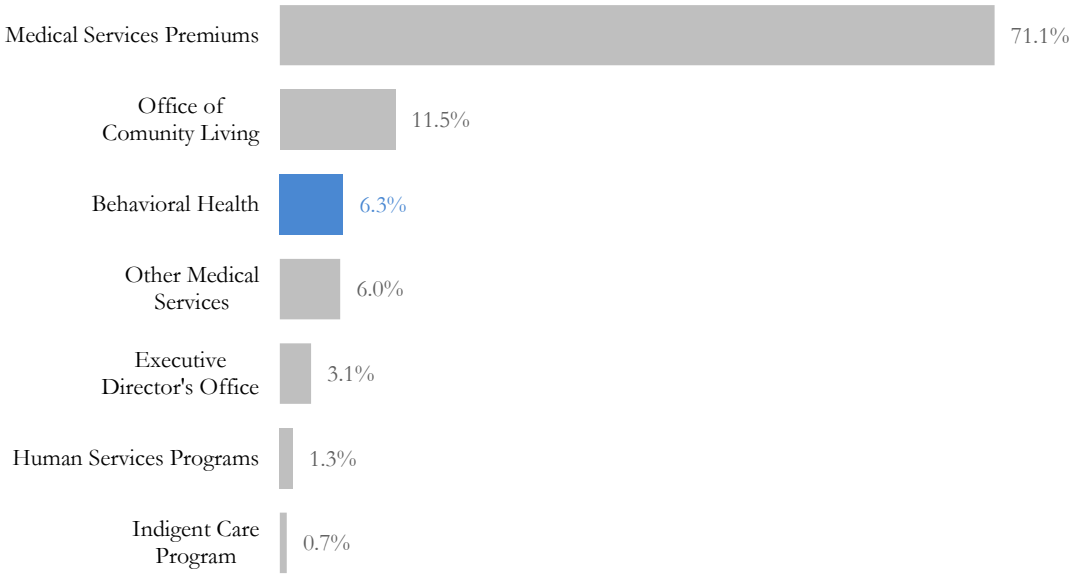

Based on the FY 2023-24 appropriation.

Department Funding Sources



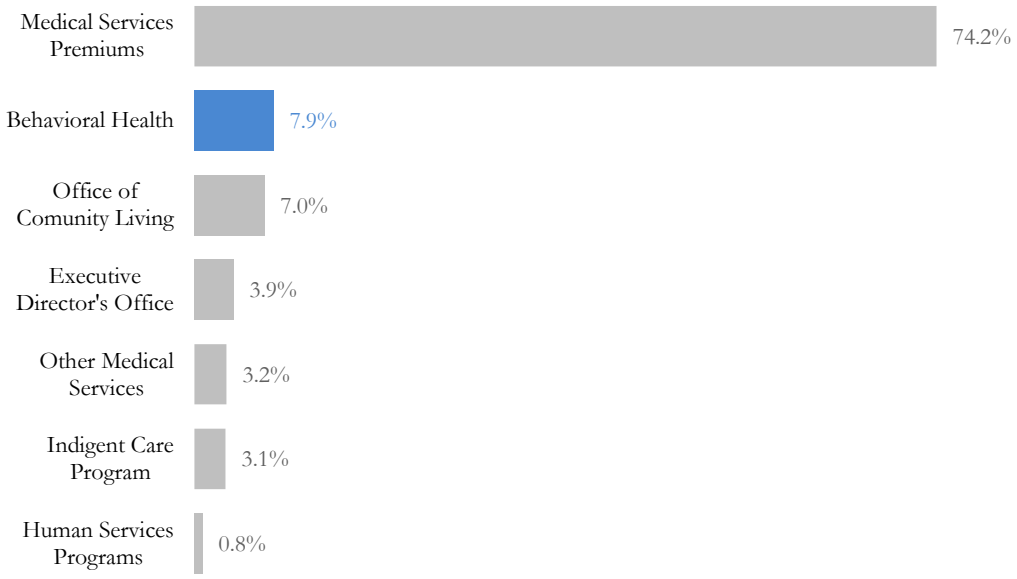

Based on the FY 2023-24 appropriation.

## Distribution of General Fund by Division




Based on the FY 2023-24 appropriation.

## Distribution of Total Funds by Division




Based on the FY 2023-24 Appropriation

# CASH FUNDS DETAIL

| CASH FUNDS APPROPRIATION DETAIL | | | | |
|---|---|---|---|---|
| FUND NAME | FY 23-24 APPROP | | PRIMARY SOURCES | PRIMARY USES (IN THIS DEPARTMENT) |
| Healthcare Affordability and Sustainability (HAS) Fee Cash Fund | $90,990,350 | [1] | Hospital fees | Behavioral health capitation payments ($90.3 million); Fee-for-service payments ($661,359) |
| Breast and Cervical Cancer Prevention and Treatment Fund | 39,684 | | Tobacco settlement and special license plate revenues | Behavioral health services for breast and cervical cancer patients. |
| **Total** | **$91,030,034** | | | |

[1] Exempt from TABOR.

# GENERAL FACTORS DRIVING THE BUDGET

Funding for this department consists of 29.2 percent General Fund, 11.4 percent cash funds, 0.7 percent reappropriated funds, and 58.7 percent federal funds. The largest sources of cash funds include: (1) hospital and nursing facility provider fees; (2) tobacco taxes and tobacco settlement funds; (3) local government funds (certified public expenditures); (4) recoveries and recoupments; (5) money from the Unclaimed Property Trust Fund that is transferred to the Adult Dental Fund; and (6) sales taxes diverted to the Old Age Pension Health and Medical Care Fund. The federal funds include matching funds for the Medicaid program (through Title XIX of the Social Security Administration Act) and matching funds for the Children's Basic Health Plan (through Title XXI of the Social Security Administration Act). The subsections below discuss some of the most important factors driving the budget.

## MEDICAID

Medicaid provides health insurance to people with low income and people needing long-term care. Participants generally do not pay annual premiums[1] and copayments at the time of service are either nominal or not required. The federal government and state government share responsibility for financing, administering, and policy setting for the program. See the December, 11, 2023, briefing for Medical Services Premiums for a more comprehensive overview of Medicaid funding and programs.

### (1) MEDICAL SERVICES PREMIUMS

See the December 11, 2023, briefing for Medical Services Premiums.

### (2) BEHAVIORAL HEALTH COMMUNITY PROGRAMS

Behavioral health services, which include both mental health and substance use-related services, are provided to Medicaid clients through a statewide managed care or "capitated" program. The Department contracts with Managed Care Entities (MCEs) to provide or arrange for behavioral health services for clients enrolled with each MCE. The MCEs include seven Regional Accountable Entities (RAEs) across the state, as well as Denver Health in the metro area. Each MCE receives a pre-determined monthly amount for each Medicaid client who is eligible for behavioral health services and enrolled with the MCE. The "per-member-per-month" rates paid to each MCE are unique for each Medicaid eligibility category in each geographic region. These rates are periodically adjusted based on clients' actual utilization of behavioral health services and the associated expenditures.

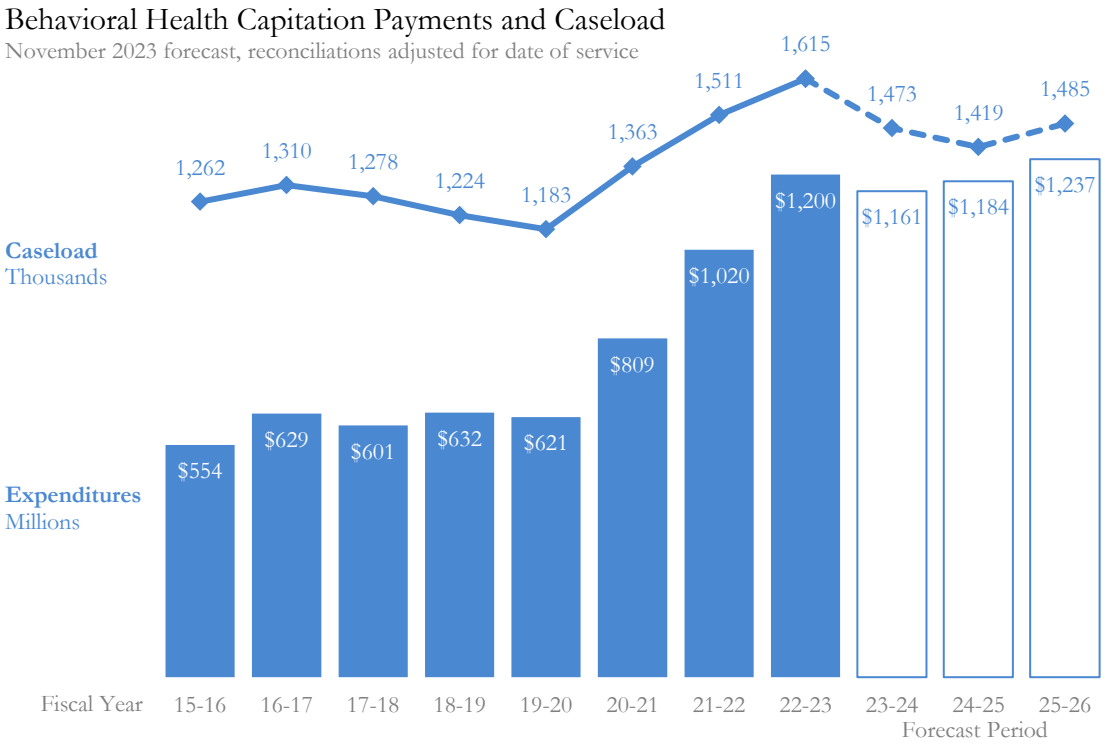
Behavioral health services are primarily supported by the General Fund and federal funds. For adults who are "newly eligible" pursuant to the federal Affordable Care Act (which includes adults without dependent children) the state receives a 90 percent federal match and the state share of costs is financed with the Healthcare Affordability and Sustainability (HAS) Fee. Services for these expansion adults represent a significant portion of total expenditures, but General Fund expenditures are driven more by children (because there are a lot of them) and people with disabilities (because the per capita expenditures are high).

[1] The exception where participants would pay a premium is the voluntary "buy-in" program for people with disabilities whose income is above the standard Medicaid eligibility criteria but below 400 percent of the federal poverty guidelines.

Capitated behavioral health program expenditures are affected by caseload changes, rate changes, and changes to the Medicaid State Plan or waiver programs that affect the diagnoses, services, and procedures that are covered for Medicaid clients. Caseload changes include changes in Medicaid eligibility, as well as demographic and economic changes that affect the number of individuals eligible within each category. Changes in the federal match rate for various eligibility categories also affect the State's share of expenditures.

There can be lags between when changes in utilization and cost of care are picked up in the behavioral health rates. For example, in FY 2015-16 capitation rates for many eligibility groups went down based on cost of care data from the prior year, helping to explain why overall expenditures decreased that year when overall enrollment increased.

Regarding more recent trends, in FY 2017-18 rates went down due to a change in federal managed care rules that limited how much Colorado could pay providers. In FY 2018-19 and FY 2019-20 the reductions in overall caseload were primarily in low utilizers of behavioral health services and the remaining members were higher utilizers, resulting in an increase in rates. In FY 2021-22 the rates came in higher than expected, primarily due to a higher percentage of Medicaid clients utilizing behavioral health services and partly due to an increase in substance use disorder treatment capacity. The projected decrease in expenditures and enrollment in FY 2023-24 is related to the expected end of the public health emergency and end of the federal prohibition on disenrolling Medicaid clients.




To better show the relationship between enrollment and expenditures, the chart above moves reconciliation payments to the fiscal year when the cost accrued, rather than the year it was paid. For this reason, the chart above will not exactly match the actual and projected cash expenditures.

With two exceptions, the caseload reported in the graph above is the same as the Medicaid enrollment, since behavioral health is paid per member per month. It is not the same as the number of utilizers of behavioral health services. The first exception is non-citizens, because for this population Medicaid covers emergency health services but not behavioral health. The second exception is elderly adults who qualify for Medicaid assistance with their Medicare premiums but have too much income to qualify for full Medicaid benefits. For these elderly adults Medicare covers behavioral health under Medicare's policies.

### (3) Office of Community Living

See the December 11, 2023, briefing for the Office of Community Living.

### (4) Indigent Care Program

See the December 11, 2023, briefing for the Indigent Care Program.

### (5) Medicare Modernization Act

See the December 11, 2023, briefing for Medicare Modernization Act.

# SUMMARY: FY 2023-24 APPROPRIATION & FY 2024-25 REQUEST

| DEPARTMENT OF HEALTH CARE POLICY AND FINANCING<br>BEHAVIORAL HEALTH COMMUNITY PROGRAMS | TOTAL FUNDS | GENERAL FUND | CASH FUNDS | REAPPROPRIATED FUNDS | FEDERAL FUNDS | FTE |
|---|---|---|---|---|---|---|
| FY 2023-24 APPROPRIATION: | | | | | | |
| S.B. 23-214 (Long Bill) | $1,218,483,080 | $284,702,715 | $91,030,034 | $0 | $842,750,331 | 0.0 |
| **TOTAL** | **$1,218,483,080** | **$284,702,715** | **$91,030,034** | **$0** | **$842,750,331** | **0.0** |
| | | | | | | |
| FY 2024-25 REQUESTED APPROPRIATION: | | | | | | |
| FY 2023-24 Appropriation | $1,218,483,080 | $284,702,715 | $91,030,034 | $0 | $842,750,331 | 0.0 |
| R2 Behavioral health forecast | (22,964,198) | 7,229,032 | 571,519 | 0 | (30,764,749) | 0.0 |
| R6 Provider rates | 113,636 | 27,304 | 6,741 | 0 | 79,591 | 0.0 |
| R7 Behavioral health continuum | 4,137,336 | 826,669 | 301,521 | 0 | 3,009,146 | 0.0 |
| Annualize prior year budget action | 11,584 | 64,585 | 749 | 0 | (53,750) | 0.0 |
| **TOTAL** | **$1,199,781,438** | **$292,850,305** | **$91,910,564** | **$0** | **$815,020,569** | **0.0** |
| | | | | | | |
| **INCREASE/(DECREASE)** | ($18,701,642) | $8,147,590 | $880,530 | $0 | ($27,729,762) | 0.0 |
| Percentage Change | (1.5%) | 2.9% | 1.0% | n/a | (3.3%) | 0.0% |

**R2 BEHAVIORAL HEALTH FORECAST:** The request includes a net decrease of $23.0 million total funds, including an increase of $7.2 million General Fund, in FY 2024-25 for projected changes in caseload, per capita expenditures, and fund sources for behavioral health services resulting from the end of the public health emergency. *Additional information is provided in the first issue brief.*

**R6 PROVIDER RATES:** The request includes an increase of $113,636 total funds, including $27,304 General Fund, for the Department's 1.0 percent across-the-board provider rate increase.

**R7 BEHAVIORAL HEALTH CONTINUUM:** The request includes an increase of $4.1 million total funds, including $826,669 General Fund, and 1.4 FTE in FY 2024-25 for this division and $4.5 million total funds and 2.0 FTE in FY 2025-26 and ongoing for enhanced behavioral health resources. *Additional information is provided in the first issue brief.*

**ANNUALIZE PRIOR YEAR BUDGET ACTION:** The request includes a net increase of $11,584 total funds for the FY 2024-25 impact of prior year budget actions, summarized in the table below.

| ANNUALIZE PRIOR YEAR BUDGET ACTION | TOTAL FUNDS | GENERAL FUND | CASH FUNDS | FEDERAL FUNDS | FTE |
|---|---|---|---|---|---|
| FY 23-24 R7 Rate adjustment | $11,584 | $3,876 | $749 | $6,959 | 0.0 |
| FY 23-24 R10 Youth complex needs | 0 | 60,709 | 0 | (60,709) | 0.0 |
| **TOTAL** | **$11,584** | **$64,585** | **$749** | **($53,750)** | **0.0** |

**OUT-YEAR GENERAL FUND REQUEST IMPACTS:** The following table describes the ongoing impacts of the FY 2024-25 requests for the following fiscal year.

| OUT-YEAR GENERAL FUND REQUEST IMPACTS | | | | | | |
|---|---|---|---|---|---|---|
| | FY 2024-25 | | FY 2025-26 | | DIFFERENCE | |
| | General Fund | FTE | General Fund | FTE | General Fund | FTE |
| R2 Behavioral health forecast | $7,229,032 | 0.0 | $28,001,388 | 0.0 | $20,772,356 | 0.0 |
| R7 Behavioral health continuum | 945,354 | 1.4 | 964,102 | 2.0 | 18,748 | 0.6 |

# INFOMATIONAL ISSUE: BEHAVIORAL HEALTH REQUESTS

The Department request for Behavioral Health Community Programs includes a forecast adjustment (R2) and one prioritized request to increase resources across the behavioral health continuum (R7). The overall request includes a net decrease of $18.7 million total funds, including an increase of $8.1 million General Fund, for behavioral health programs.

## SUMMARY

- The Behavioral Health forecast includes a net decrease of $23.0 million total funds, including an increase of $7.2 million General Fund. Adjustments primarily reflect the end of the Public Health Emergency.

- R7 Behavioral health continuum includes a net increase of $4.4 million total funds, including $945,354 General Fund, to implement four systems changes aimed at improving behavioral health services across the state.

## DISCUSSION

The Department requests a net decrease of $18.7 million total funds, including an increase of $8.1 million General Fund, for Behavioral Health Community Programs. The request is driven by the behavioral health forecast, which shows a decrease in caseload and federal match related to the end of the Public Health Emergency related to COVID-19.

### R2 BEHAVIORAL HEALTH FORECAST

The request includes a net decrease of $23.0 million total funds, including an increase of $7.2 million General Fund for the Behavioral Health Community Programs forecast. Adjustments are primarily attributed to the end of the Public Health Emergency (PHE) related to COVID-19 that will result in decreased caseload and federal match. The HCPF behavioral health budget consists of two line items, Capitated Payments and Fee-for-Service Payments.

#### CAPITATED PAYMENTS

Behavioral health services, including mental health and substance abuse treatment, are provided to Medicaid clients through a statewide managed care or "capitated" program. The Department contracts with 7 regional accountable entities (RAEs) to provide or arrange medically necessary health services to Medicaid members within a specified geographic location. RAEs must spend at least 85.0 percent of capitated payments on direct treatment for federal compliance.

Each RAE receives a pre-determined monthly amount for each Medicaid client who is eligible for services and enrolled with the RAE. These actuarially certified "pre-member-per-month" rates are unique for each eligibility category and each geographic region of the state. The Department adjusts rates periodically based on historical expenses and client utilization data. Eligibility categories for behavioral health include the following.

- Adults over 65;
- Individuals with disabilities;

- Low income adults;
- Expansion parents and caretakers;
- Modified Adjusted Gross Income (MAGI) adults;
- Eligible children;
- Foster youth; and
- Breast and cervical cancer prevention and treatment program participants.

Non-citizens and partial dual-eligible Medicare/Medicaid individuals are two Medicaid populations that are not eligible for behavioral health services through Medicaid. Medicaid clients enrolled in a Program of All-Inclusive Care for the Elderly (PACE) are also excluded from enrollment with a RAE. Certain behavioral health services for Medicaid clients are not covered by capitation, and are instead covered through other appropriations to the Department, including the following:

- Services provided through primary care;
- Services for individuals with intellectual and developmental; and,
- Services for children and youth in the custody of the Department of Human Services.

Children in the custody of Human Services through child welfare or the Division of Youth Services are enrolled in RAEs, and each RAE receives per-member-per-month payments for these individuals. However, behavioral healthcare in residential placements are not covered by the RAE and are not considered as part of the capitation rate.

The Department's forecast model examines the trend in capitation rates across each eligibility category and applies that trend to the average expense rate per claim. Four trend model forecasts are performed for each eligibility criteria and used to inform current and future year expenses. The Department's actuaries certify a capitation rate for each RAE and eligibility type for each fiscal year based on the calculated forecast, rate-setting process, and input from the RAEs.

**FEE-FOR-SERVICE PAYMENTS**

Fee-for-service payments reflect the appropriation for Medicaid members not covered by capitated payments. Services may not be covered because the Medicaid member is not enrolled with the RAE, or the service is not with the RAE contract. Medicare/Medicaid crossover claims are included in the fee-for-service category.

**PUBLIC HEALTH EMERGENCY**

Decreases in the behavioral health forecast are primarily attributed to the end of the Public Health Emergency (PHE) related to COVID-19. During the PHE, an enhanced federal match was provided if states adhered to certain criteria. Criteria included a continuous coverage requirement that prohibited states from disenrolling individuals from Medicaid benefits. The continuous coverage requirement and enhanced federal match ended March 31, 2023. The enhanced federal match gradually steps down from March through December 2023. As a result, caseload for behavioral health services is expected to decrease, and the General Fund share of expenses will increase beginning in FY 2023-24.

**FORECAST**

The Department forecast anticipates a decrease of $30.8 million federal funds and increase of $7.2 million General Fund primarily attributed to the end of the PHE and enhanced federal match step

down. The Department estimates a decrease in caseload from 1.6 million in FY 2022-23, to 1.47 in FY 2023-24 and 1.41 in FY 2024-25. The FY 2023-24 forecasted caseload reflects a decrease from the appropriated caseload of 1.5 million.

The Department forecasts caseload decreases in all eligibility categories. The most significant change for FY 2023-24 is decreases for the breast and cervical cancer program, which is the smallest eligibility category. The largest decrease for FY 2024-25 is for expansion parents and caretakers. Forecast details are provided in the tables below.

| CAPITATED BEHAVIORAL HEALTH FORECAST | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | FY 2022-23 | | FY 2023-24 | | | | FY 2024-25 | |
| | Actual Caseload | Actual Expenditure | Appropriated Caseload | Appropriated Expenditure | Estimated Caseload | Estimated Expenditures | Estimated Caseload | Estimated Expenditures |
| Adults 65 and Older | 50,477 | $14,968,028 | 49,330 | $15,150,687 | 48,976 | $18,234,504 | 48,335 | $18,836,074 |
| Disabled Individuals | 97,232 | 145,780,215 | 96,871 | 156,580,850 | 94,724 | 187,294,615 | 94,476 | 195,557,135 |
| Low Income Adults | 229,663 | 157,565,288 | 224,620 | 169,326,614 | 218,728 | 141,353,396 | 216,926 | 146,752,157 |
| Expansion Parents | 104,683 | 50,066,636 | 83,511 | 38,603,446 | 82,018 | 35,388,334 | 71,304 | 32,211,592 |
| MAGI Adults | 530,332 | 518,559,621 | 500,403 | 516,209,612 | 489,921 | 481,413,331 | 478,976 | 492,809,052 |
| Eligible Children | 581,999 | 223,070,713 | 524,029 | 212,186,875 | 519,081 | 201,241,139 | 489,363 | 198,658,280 |
| Foster Care | 20,070 | 36,461,423 | 20,278 | 39,429,790 | 19,308 | 42,557,773 | 19,308 | 44,558,484 |
| Breast/Cervical Cancer | 133 | 95,760 | 143 | 107,795 | 129 | 83,366 | 129 | 87,269 |
| **Total** | **1,614,589** | **$1,146,567,684** | **1,499,185** | **$1,147,595,669** | **1,472,885** | **$1,107,566,458** | **1,418,817** | **$1,129,470,043** |

| FEE-FOR-SERVICE BEHAVIORAL HEALTH FORECAST | | | | |
|---|---|---|---|---|
| | FY 2022-23 ACTUAL EXPENDITURE | FY 2023-24 APPROPRIATION | FY 2023-24 ESTIMATED | FY 2025-26 ESTIMATED |
| Inpatient Services | $1,516,792 | $786,310 | $1,493,907 | $1,506,593 |
| Outpatient Services | 11,413,756 | 9,997,603 | 10,915,898 | 11,008,598 |
| Physician Services | 216,962 | 189,453 | 216,396 | 218,234 |
| **Total** | **$13,147,510** | **$10,973,366** | **$12,626,201** | **$12,733,425** |

## R7 BEHAVIORAL HEALTH CONTINUUM

The request includes an increase of $4.4 million total funds, including $945,354 General Fund, and 1.4 FTE in FY 2024-25. The request includes increased funding related to increasing support for multiple programs within the behavioral health continuum of care as described below.

| R7 BEHAVIORAL HEALTH CONTINUUM SUMMARY | | | | | | |
|---|---|---|---|---|---|---|
| | TOTAL FUNDS | GENERAL FUND | CASH FUNDS | REAPPROPRIATED FUNDS | FEDERAL FUNDS | FTE |
| Value Based Pricing Methodology | $349,000 | $174,500 | $0 | $0 | $174,500 | 0.0 |
| *Pricing Methodology FTE* | 116,658 | 46,663 | 11,666 | 0 | 58,329 | 0.9 |
| Partial Hospitalization | 1,025,500 | 243,900 | 67,807 | 0 | 713,793 | 0.0 |
| IMD Stays | 2,450,304 | 582,769 | 162,017 | 0 | 1,705,518 | 0.0 |
| Permanent Supportive Housing | 661,532 | 0 | 71,697 | 0 | 589,835 | 0.0 |
| *Supportive Housing FTE* | 56,304 | 22,522 | 5,630 | 0 | 28,152 | 0.5 |
| SUD Admin Decrease | (250,000) | (125,000) | 0 | 0 | (125,000) | 0.0 |
| **TOTAL** | **$4,409,298** | **$945,354** | **$318,817** | **$0** | **$3,145,127** | **1.4** |

### BEHAVIORAL HEALTH PRICING METHODOLOGIES FOR SAFETY NET PROVIDERS

Senate Bill 19-222 (Individuals at Risk of Institutionalization) required the Department to create a behavioral health safety net system, and incentives for providers to accept Medicaid recipients with severe behavioral health disorders. The bill included a one-time appropriation of $150,000 total funds

for the Department to hire a contractor to evaluate alternative payment plans. The fiscal note indicates that additional funding would be necessary in future fiscal years to actually implement provider incentives or address increased utilization.

House Bill 22-1278 (Behavioral Health Administration) charged the BHA with implementing a comprehensive behavioral health safety net system rather than HCPF. The bill further requires HCPF to align all community-based behavioral health safety net providers. The request notes that the Department has been coordinating with the BHA to identify viable payment reform options to embed quality-based metrics into the payment and reporting system for behavioral health.

The Department worked with a contractor through S.B. 19-222 to model rate methodologies for value-based payment (VBP) models for behavioral health safety net providers as defined by the BHA. VBP models are intended to reward inventive payments for the quality of care delivered by providers. VBP has the goal of moving toward compensating providers based on the quality, rather than the quantity of services delivered.[2]

The modeling resulted in selecting a single Prospective Payment System (PPS) rate for comprehensive providers, with carve outs for select services and utilization. Comprehensive Safety Net Providers are required to provide set safety net services as determined by the BHA and may not refuse service based on insurance. Essential Safety Net Providers may choose to provide one or more of the services required by Comprehensive providers. PPS rates are payments for all services in a specific time period (day, month) based on historic utilization. The Department currently utilizes PPS rates to reimburse Federally Qualified Health Centers (FQHC), and PPS is utilized under the Certified Community Behavioral Health Clinic (CCBHC) model.

The request includes $349,000 total funds, including $174,500 General Fund, ongoing to support a contractor to conduct actuarial analysis, rate reviews, and auditing for Comprehensive provider PPS rates and the Essential provider fee schedule to ensure compliance with statute. House Bill 22-1278 and H.B. 23-1236 (Implementation Updates to BHA) establish requirements for cost-based reimbursements and must be updated annually. The amount is based on similar contracts the Department has procured in the past, and includes assumed fees and workload related to actuarial, analytical, accounting, auditing, and review rates.

The request also includes $116,658 total funds, including $46,663 General Fund, for 1.0 FTE ongoing to set fee schedule rates for the safety net system. Workload is based on comparable work for the HCBS waiver programs. The position would be responsible for cross-state research, working directly with clinical staff, BHA staff, and contractors to implement and maintain rates. Once rate methodologies are set, the Department will incorporate the fee schedule rates into the RAE capitation rates through the budget process. The Department specifies that the request is not aimed at increasing the types of services available, but may increase the provider network and incentivize higher quality of care.

**PARTIAL HOSPITALIZATION PROGRAMS (PHP)**

House Bill 18-1136 (Substance Use Disorder Treatment) required the Department to secure a 1115 SUB Demonstration Waiver to cover services rendered in Institutions for Mental Disease (IMD) and a State Plan Amendment to cover residential services in other settings. Currently, the Department

[2] CMS VBP Models.

provides SUD services under the waiver to ensure a full continuum of care. As part of the waiver, the Department must follow American Society of Addiction Medicine (ASAM) criteria, which range from early intervention to intensive inpatient services.

The Department currently covers all levels of ASAM care except Partial Hospitalization. Partial Hospitalization is available to non-Medicaid patients through 98 providers across the state. The Department states that many of these providers are Medicaid providers, but do not offer this level of care to Medicaid members as it is not a covered benefit. The program provides clinical outpatient support for 20 hours per week, 5 days a week.

The request includes an increase of $1.0 million total funds, including $243,900 General Fund, to implement the PHP level of care. The Department estimates a total cost of $6.4 million to implement the program, offset by a decrease of $5.4 million from patients currently in a higher or lower level of care that would be more appropriately served through PHP. The Department states that establishing this service as a Medicaid covered benefit will reduce unnecessary reliance on inpatient coverage for those who could be better served in the community, as well as a higher level of care for patients who may currently cycle through residential withdrawal services. The Department worked with providers to understand how the benefit would impact utilization, and anticipates that implementing the program could result in long-term savings from decreased reliance on inpatient care.

**INSTITUTES OF MENTAL DISEASE STAYS (IMD)**

A facility with 16 or more beds primarily engaged in providing diagnosis, treatment, or care for individuals with mental health or substance use diagnoses is referred to as an Institute of Mental Disease (IMD). The federal government established an IMD exclusion in 1965 that prohibits states from receiving federal funding for stays within an IMD to reduce institutionalization and increase community based care.[3]

The Department covers eligible members for up to 15 days in an IMD as part of psychiatric inpatient coverage under the behavioral health capitation. Since 2016, federal restrictions allow federal match for IMD stays up to 15 days per calendar month only if a state has a Medicaid managed care plan and can offer IMD stays as an in-lieu-of-service.[4] Therefore, the Department currently reimburses IMD stays that do not exceed 15 days in a calendar month. A 16th day results in no payment for the stay at all.

The Department states that from 2020 to 2022 there was an average of 180 stays per year for members that need care longer than 15 days. The average length of stay from 2019 to 2022 varied from 28 to 34 days. Providers are not paid at all for services provided for those stays, resulting in an estimated 8,500 total IMD days per year that providers are currently not reimbursed. The current system incentivizes providers to prematurely discharge patients by the 15th day, which may not allow for appropriate treatment, transition planning, and cause patients to cycle back to inpatient care due to premature discharge.

[3] HCPF IMD Rule.

[4] https://www.macpac.gov/subtopic/payment-for-services-in-institutions-for-mental-diseases-imds/ https://www.kff.org/report-section/state-options-for-medicaid-coverage-of-inpatient-behavioral-health-services-report/

The request includes $2.5 million total funds, including $582,769 General Fund, to cover the first 15 days of IMD stays that exceed 15 days. The cost estimate includes daily cost of IMD stay, the current number of stays exceeding 15 days, and anticipated increases to the number of stay exceeding 15 days that would result from the policy change. The Department anticipates that is would need to amend the existing 1115 waiver to implement the request.

Under an 1115 IMD waiver, the Department could receive federal match for service provided in an IMD for up to 60 days per member, as long as the average length of stay does not exceed 30 days. While other states operate under this waiver, the request does not specify whether the Department intends to pursue an increased waiver or why it would not pursue this extension.

**PERMANENT SUPPORTIVE HOUSING (PSP)**

The Department has supported a Statewide Supportive Housing Expansion (SWSHE) pilot project in partnership with the Department of Local Affairs (DOLA) through ARPA funds approved in a FY 2021-22 budget request. The program is intended to assist unhoused Medicaid members with behavioral health needs in obtaining and retaining permanent housing. Participants receive housing vouchers from DOLA and tenancy support services through HCPF ARPA funds. Services include outreach, housing navigation, leasing navigation, and move-in assistance. Funding for the pilot is expected to expire December 2024.

The Department indicated that this portion of the request is evidence informed pursuant to S.B. 21-284 (Evidence-based Evaluations for Budget). CMS considers permanent supportive housing as an evidence-based practice that can improve outcomes for chronic health conditions, including behavioral health. The Executive Branch provided two reports from CMS and the Federal Department of Health and Human Services to support this level of evidence, and demonstrates that supportive housing can decrease emergency room visits, hospital stays, Medicaid costs, and criminal justice involvement.[5]

The Department intends to continue to research and collect data on program success through September 2024 with existing funding. Research will be used to determine whether the Department will pursue additional funding in future fiscal years to expand access through a 1115 demonstration waiver. In the meantime, the Department can receive federal match to continue limited services for members with a behavioral health diagnosis through an existing 1915b(3) waiver. The Department anticipates that program participants are eligible for a 90.0 percent federal match under the Affordable Care Act.

The request includes $717,836 total funds, including $22,522 General Fund, and 0.5 FTE to continue housing support services for current providers and approximately 700 members being served by the ARPA SWSHE pilot. Funding will continue support services for existing clients while the Department evaluates a 1115 waiver that would serve approximately 2,600 members per year. DOLA indicates that there are currently 3,000 permanent supportive housing units in the state, and anticipate and additional 300 units added annually. The FTE is a continuation of administrative work currently supported with ARPA funds. The position is expected to oversee provider selection, data collection, regulatory revisions, and coordinate system changes. The position also ensures adherence to state and federal regulatory and contractual requirements. The FTE is requested on an ongoing basis.

[5] PSP Literature Review.

# INFORMATIONAL ISSUE: CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS

A Certified Community Behavioral Health Clinic (CCBHC) model provides federal incentives for comprehensive behavioral health safety net providers. The Department indicates a commitment to apply for the next round of federal planning grants to pursue implementation of a CCBHC model, but also notes implementation challenges.

## SUMMARY

- Comprehensive behavioral health providers are overseen and receive funding from the Behavioral Health Administration, but receive a majority of funding from Medicaid.

- Comprehensive behavioral health providers could receive enhanced federal funds under a Certified Community Behavioral Health Clinic funding model.

- The Department has noted to staff a commitment to pursue and apply for the next round of planning grants related to the CCBHC model, but also notes concerns with implementation challenges. The Department has previously applied and not been awarded planning and demonstration grants.

## DISCUSSION

Following the implementation of the Federal Protecting Access to Medicare Act of 2014 (PAMA), the Substance Abuse and Mental Health Services Administration (SAMHSA) published criteria for Certified Community Behavioral Health Clinics (CCBHC). The CCBHC model was a frequent topic of interest during Committee and Staff Interim tours with Community Mental Health Centers (CMHC). CMHCs are overseen and receive funding from the Behavioral Health Administration (BHA), but are primarily Medicaid funded.

A CCBHC is a behavioral health organization certified in accordance with federal criteria. CCBHCs are safety net providers required to provide 24/7 crisis services, care coordination, and robust data collection in exchange for an enhanced federal funding. The method and amount of funding depends on state implementation.

### STATE IMPLEMENTATION

A state may first apply for a two-year planning grant to participate in a demonstration program. The planning grant is intended to support the certification of CCBHCs within the state, establish a Prospective Payment System (PPS), improve data collection and reporting, and engage stakeholders for implementation planning.[6] A state may then apply for a four-year demonstration program through Medicaid. CCBHCs in demonstration states are paid using PPS, which provides an enhanced and flexible reimbursement rate to support the cost of expanding services and increasing the number of clients served.[7]

[6] SAMHSA Planning Grants. (2023).
[7] National Council for Mental Wellbeing. CCBHC Success Center.

The Department first applied and was awarded a planning grant in 2016. However, the state never became a demonstration state. HCPF reapplied for a planning grant in partnership with the BHA in 2022, but was not awarded the grant. The Department indicates a commitment to the CCBHC model and intends to apply for the next round of planning grants released in 2024 and awarded in 2025. The Department further intends to implement a Prospective Payment System for safety net providers on July 1, 2024 outside of the CCBHC grant process.

Currently, there are 13 demonstration states and 17 planning grant states. An additional seven states have implemented formal planning efforts through state-level legislation. Overall, there are 500 CCBHCs and CCBHC grantees operating in 46 states. The Bipartisan Safer Communities Act provided increased funding to support the expansion of the CCBHC model nationwide, and SAMHSA indicates that 10 states will be added as demonstration states every two years beginning in 2024.[8] Stakeholders in Colorado seem to agree that federal support for CCBHC expansion will continue until every state is a demonstration state.

### Provider Implementation

An individual provider may become a CCBHC and receive SAMHSA grants regardless of whether the provider is within a demonstration state. Even though Colorado is not a demonstration state, CMHCs and Denver Health have successfully applied for and been awarded CCBHC planning and demonstration grants. Under this model, CCBHCs receive enhanced and flexible Medicaid funding, but are required to regularly reapply for grants to maintain the program.

### Implementation Benefits and Challenges

The Department provided the following information when asked for the benefits and challenges of implementing a CCBHC model.

| Benefits | Challenges |
|---|---|
| • Increases provider capacity, timely access to care, and improves patient outcomes;<br>• Flexible spending model using PPS help ensure more comprehensive services to anyone in need of care;<br>• Enables full spectrum of services provided in a single location;<br>• Enhances HCPF's ability to understand the needs of communities and service impacts through enhanced data collection; and,<br>• Sustainable funding model that increases access to care and increases total funding available as long as federal funding is maintained by CMS and SAMHSA. | • Extensive implementation process for certification that requires additional resources at the Department and provider level;<br>• Low numbers of providers have been able to meet criteria in other states;<br>• Significant increase in administrative burden for data collection requirements;<br>• Requires new and additional services of providers;<br>• Requires electronic medical record upgrades;<br>• Requires HCPF and BHA rule changes for Comprehensive Providers;<br>• Requires sub-contracting which may be complex and duplicative of RAEs; and,<br>• Providers and the state are at risk of expanding services and then loosing funding if federal legislation or funding changes. |

[8] SAMHSA Bipartisan Safer Communities Act. (2023).

# APPENDIX A
# NUMBERS PAGES

Appendix A details actual expenditures for the last two state fiscal years, the appropriation for the current fiscal year, and the requested appropriation for next fiscal year. This information is listed by line item and fund source.

| | FY 2021-22 Actual | FY 2022-23 Actual | FY 2023-24 Appropriation | FY 2024-25 Request | Request vs. Appropriation |
|---|---|---|---|---|---|
| **DEPARTMENT OF HEALTH CARE POLICY AND FINANCING**<br>**Kim Bimestefer, Executive Director** | | | | | |
| **(3) BEHAVIORAL HEALTH COMMUNITY PROGRAMS**<br>Healthcare Affordability and Sustainability Cash Fund. | | | | | |
| Behavioral Health Capitation Payments | 852,041,516 | 1,073,070,076 | 1,207,509,714 | 1,187,271,197 * | |
| General Fund | 0 | 215,820,743 | 282,270,782 | 289,844,351 | |
| Cash Funds | 63,158,906 | 92,271,268 | 90,368,457 | 91,168,440 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | |
| Federal Funds | 788,882,610 | 764,978,065 | 834,870,475 | 806,258,406 | |
| Behavioral Health Fee-for-service Payments | 12,592,071 | 8,929,133 | 10,973,366 | 12,510,241 * | |
| General Fund | 2,280,953 | 1,692,019 | 2,431,933 | 3,005,954 | |
| Cash Funds | 871,824 | 558,233 | 661,577 | 742,124 | |
| Reappropriated Funds | 0 | 0 | 0 | 0 | |
| Federal Funds | 9,439,294 | 6,678,881 | 7,879,856 | 8,762,163 | |
| **TOTAL - (3) Behavioral Health Community Programs** | 864,633,587 | 1,081,999,209 | 1,218,483,080 | 1,199,781,438 | (1.5%) |
| *FTE* | 0.0 | 0.0 | 0.0 | 0.0 | 0.0% |
| General Fund | 2,280,953 | 217,512,762 | 284,702,715 | 292,850,305 | 2.9% |
| Cash Funds | 64,030,730 | 92,829,501 | 91,030,034 | 91,910,564 | 1.0% |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0.0% |
| Federal Funds | 798,321,904 | 771,656,946 | 842,750,331 | 815,020,569 | (3.3%) |

NOTE: An asterisk (*) indicates that the FY 2024-25 request for a line item is affected by one or more decision items.

## Appendix A: Numbers Pages

| | FY 2021-22 Actual | FY 2022-23 Actual | FY 2023-24 Appropriation | FY 2024-25 Request | Request vs. Appropriation |
|---|---|---|---|---|---|
| **TOTAL - Department of Health Care Policy and Financing** | 864,633,587 | 1,081,999,209 | 1,218,483,080 | 1,199,781,438 | (1.5%) |
| *FTE* | 0.0 | 0.0 | 0.0 | 0.0 | 0.0% |
| General Fund | 2,280,953 | 217,512,762 | 284,702,715 | 292,850,305 | 2.9% |
| Cash Funds | 64,030,730 | 92,829,501 | 91,030,034 | 91,910,564 | 1.0% |
| Reappropriated Funds | 0 | 0 | 0 | 0 | 0.0% |
| Federal Funds | 798,321,904 | 771,656,946 | 842,750,331 | 815,020,569 | (3.3%) |

# APPENDIX B
# FOOTNOTES AND INFORMATION REQUESTS

## UPDATE ON LONG BILL FOOTNOTES

The General Assembly includes footnotes in the annual Long Bill to: (a) set forth purposes, conditions, or limitations on an item of appropriation; (b) explain assumptions used in determining a specific amount of an appropriation; or (c) express legislative intent relating to any appropriation. Footnotes to the 2023 Long Bill (S.B. 23-214) can be found at the end of each departmental section of the bill at https://leg.colorado.gov/bills/SB23-214. The Long Bill footnotes relevant to this document are listed below.

There are no footnotes for this section.

## UPDATE ON LONG BILL REQUESTS FOR INFORMATION

The Joint Budget Committee annually submits requests for information to executive departments and the judicial branch via letters to the Governor, other elected officials, and the Chief Justice. Each request is associated with one or more specific Long Bill line item(s), and the requests have been prioritized by the Joint Budget Committee as required by Section 2-3-203 (3), C.R.S. Copies of these letters are included as an Appendix in the annual Appropriations Report (Appendix H in the FY 2023-24 Report): https://leg.colorado.gov/sites/default/files/fy23-24apprept.pdf
The requests for information relevant to this document are listed below.

### REQUESTS AFFECTING MULTIPLE DEPARTMENTS

3 Department of Health Care Policy and Financing and Department of Human Services, Behavioral Health Administration -- The departments are requested to provide the following updates regarding the implementation of the Non-Medicaid Behavioral Health Eligibility and Claims System by November 1, 2024: (1) the specific non-Medicaid programs that are utilizing the system for eligibility and/or claims purposes, including the specific uses for each program; (2) the number and percentage of clients and claims for which each program is using the system; (3) the number and percentage of providers that are using the system for each program; (4) the Departments' plans to expand the utilization to other programs (including programs housed outside of the BHA) and other providers through FY 2024-25 and in subsequent years; and (5) any efficiencies or payment issues identified through the use of the system thus far.

**COMMENT:** The RFI requests a response by 2024 and neither Department has yet provided a response.

## REQUESTS AFFECTING THE DEPARTMENT

3 Department of Health Care Policy and Financing, Behavioral Health Community Programs – The Department is requested to submit a report by November 1, 2023, discussing member utilization of capitated behavioral health services in FY 2021-22 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 should include aggregated data on the number of members accessing inpatient and residential mental health treatment, inpatient and residential substance use disorder treatment, outpatient mental health and substance use disorder services, and alternative services allowed under the Department's waiver with the Centers for Medicare and Medicaid Services. For Calendar Year 2022, the Department shall report aggregated provider data by quarter showing changes in the number of providers contracted, monthly claims processing timeframes by each RAE, and timeliness of provider credentialing and contracting by each RAE. Also, please discuss differences in the performance of the RAEs, how the Department monitors these performance measures, and any actions the Department has taken to improve RAE performance and client behavioral health outcomes.

**COMMENT:** The Department response provided the following information.

Member utilization – In FY 2021-22, 18.9 percent of Medicaid members accessed capitated behavioral health services including mental health and substance abuse treatment.

- 281,717 members used capitated behavioral health services;
- 1.2 percent used the short-term benefit;
- 46.7 percent had not previously accessed behavioral health services;
- 65.4 used mental health services;
- 15.5 used substance use disorder services;
- 99.9 percent used outpatient services;
- 5.7 percent used inpatient services; and,
- 88.2 percent of substance use disorder utilizers used outpatient services.

Network provider expansion – At the end of FY 2021-22, there were 10,298 contracted behavioral health providers, compared to 8,627 at the end of FY 2020-21 and 6,391 in FY 2019-20.

Timeliness of claims processing – HCPF requires RAEs adjudicate and pay 90.0 percent of all clean claims within 30 days and 99.0 percent of clean claims within 90 days in compliance with federal regulations.

Timeliness of credentialing providers – HCPF requires RAEs complete credentialing and contracting processes or deny network admission within 90 days for at least 90.0 percent of all provider applications.

Additional aggregate data is provided in the full report attached to the online version of this document.

# APPENDIX C
# DEPARTMENT ANNUAL PERFORMANCE REPORT

Pursuant to Section 2-7-205 (1)(b), C.R.S., the Department of Health Care Policy and Financing is required to publish an **Annual Performance Report** for the *previous state fiscal year* by November 1 of each year. This report is to include a summary of the Department's performance plan and most recent performance evaluation for the designated fiscal year. In addition, pursuant to Section 2-7-204 (3)(a)(I), C.R.S., the Department is required to develop a **Performance Plan** and submit the plan for the *current fiscal year* to the Joint Budget Committee and appropriate Joint Committee of Reference by July 1 of each year.

For consideration by the Joint Budget Committee in prioritizing the Department's FY 2024-25 budget request, the FY 2022-23 Annual Performance Report and the FY 2023-24 Performance Plan can be found at the following link:

https://www.colorado.gov/pacific/performancemanagement/department-performance-plans

COLORADO
Department of Health Care Policy & Financing

303 E. 17th Avenue
Denver, CO 80203

November 1, 2023

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

Dear Senator Zenzinger:

Enclosed please find the Department of Health Care Policy & Financing's response to the Joint Budget Committee's Request for Information #3 regarding Medicaid member utilization of capitated behavioral health services in FY 2021–22 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 #3 states:

> *Department of Health Care Policy and Financing, Behavioral Health Community Programs – The Department is requested to submit a report by November 1, 2023, discussing member utilization of capitated behavioral health services in FY 2021-22 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 should include aggregated data on the number of members accessing inpatient and residential mental health treatment, inpatient and residential substance use disorder treatment, outpatient mental health and substance use disorder services, and alternative services allowed under the Department's waiver with the Centers for Medicare and Medicaid Services.*

The report describes the capitated behavioral health benefit and summarizes how many members utilized behavioral health services during FY 2021–22. It also provides data on the time it took to process and pay provider claims in 2022. Additionally, it describes how managed care entities contract with providers to expand their networks, and reports on the timeliness of contracting and credentialing during 2022. Lastly, this report includes the performance of residential and inpatient substance use disorder treatment as required by House Bill 18-1136 (C.R.S. 25.5-5-325).

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 #3 Capitated Behavioral Health Services and Regional Accountable Entities

CC: Representative Shannon Bird, Vice-chair, Joint Budget Committee
Representative Rod Bockenfeld, Joint Budget Committee
Senator Jeff Bridges, Joint Budget Committee
Senator Barbara Kirkmeyer, Joint Budget Committee
Representative Emily Sirota, Joint Budget Committee
Craig Harper, Staff Director, JBC
Eric Kurtz, JBC Analyst
Mark Ferrandino, Director, Office of State Planning and Budgeting
Noah Strayer, Budget Analyst, Office of State Planning and Budgeting
Legislative Council Library
State Library
Cristen Bates, Medicaid and CHP+ Behavioral Health Initiatives and Coverage Office Director, HCPF
Ralph Choate, Medicaid Operations Office Director, HCPF
Charlotte Crist, Cost Control & Quality Improvement Office Director, HCPF
Adela Flores-Brennan, Medicaid Director, HCPF
Thomas Leahey, Pharmacy Office Director, HCPF
Rachel Reiter, 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
Jo Donlin, Legislative Liaison, HCPF

# Behavioral Health Community Programs: Services and Network Report

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

**November 1, 2023**

**Submitted to:**

*Joint Budget Committee*

COLORADO
Department of Health Care Policy & Financing

# Contents

# I. Executive Summary

This report is in response to a request for information from the Joint Budget Committee regarding the Colorado Medicaid behavioral health program. This includes an overview of the capitated behavioral health services in fiscal year (FY) 2021–22 and the performance of the behavioral health managed care entities (MCEs). This report provides an overview of the behavioral health system by measuring member access to care, provider network expansion and contract timelines, and timeliness of payment. Colorado Medicaid members who access behavioral health services do not pay a copay or a deductible, and 90% of claims are paid within 30 days. This report also includes the performance of residential and inpatient substance use disorder (SUD) treatment as required by House Bill 18-1136 (C.R.S. 25.5-5-325).

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 of Health Care Policy & Financing (HCPF) is committed to continuing this important work with behavioral health.

## A. The Behavioral Health Capitated Benefit

HCPF is the single state agency responsible for administering Health First Colorado benefits as a part of the state's Medicaid program. HCPF maintains contracts with eight MCEs, 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 HCPF 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 can be difficult to support and reimburse in a fee-for-service model. These services are authorized by the federal Centers for

Medicare and Medicaid Services (CMS) through a 1915(b)(3) waiver, also called 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.

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

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

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

## B. Utilization Management

MCEs are federally and contractually required to maintain a network of providers adequate to meet member needs based on utilization of services. Each MCE has its own utilization management program for behavioral health services to ensure the right care is provided in the right setting to improve quality, ensure least restrictive care setting, 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 utilization management policies and procedures to safeguard against unnecessary utilization of care and services. Utilization management includes

policies that review services provided, financial and clinical audits, setting appropriate limits on services, and in some cases, prior authorization requirements. Most services do not require prior authorization if the service is provided by a provider in the network.

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 second demonstration year of the expanded SUD benefit (January–December 2022), 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, 3,934 total initial requests were made, 3,624 initial authorizations were issued, or 92%. Of these authorizations, 90% were issued within 72 hours. Since January 1, 2022, the number of initial authorization days has been standardized across all MCEs.

### C. Behavioral Health Utilization FY 2021-22

In FY 2021–22, 18.9% of Health First Colorado members accessed capitated behavioral health services, which include mental health, SUD, and B3 services. Members can receive short-term behavioral health services (up to six visits) for low-acuity behavioral health needs at the member's primary care medical provider site. In FY 2021-22, about 1.20% (17,890) eligible members used the short-term behavioral health benefit. Additionally, of the 17,890 members, 8,330 had not previously accessed behavioral health services (46.56%). By the end of this time period, member enrollment in the ACC averaged 1,489,511, which includes enrollment in Denver Health Medicaid Choice of 110,538. Utilization trends for the behavioral health capitation are listed below. This report also includes trends across time for this data.

- 281,717 members used capitated behavioral health services. Among that group, 65.4% (184,253) used mental health services, 15.5% (43,731) used SUD services, and 57.3% (161,502) used B3 services.
- Of the 184,253 distinct utilizers of mental health services, 183,972 (99.9%) received outpatient mental health services. Inpatient services were used by 10,550 (5.7%), and 3,979 (2.2%) received residential mental health services.

- Of the 43,731 utilizers of SUD services, 38,562 (88.2%) utilizers used outpatient services. 10,432 (23.9%) received residential treatment and 2,967 (6.8%) had an inpatient SUD stay.
- In FY 2021-22, 18.9% members used capitated behavioral health services, compared to 18.1% in FY 2020-21 and 19.4% in FY 2019-20. Note that enrollment significantly increased in FY 2020-21 due to the COVID-19 public health emergency.

**D. 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. MCEs are required to complete the credentialing and contracting processes or deny network admission within 90 days for at least 90% of all provider applications. Since the requirement was set in January 2022, every RAE has improved contracting and credentialing times and has demonstrated that they are contracting and credentialing within contract standards.

At the end of FY 2021-22, there were 10,298 MCE-contracted behavioral health providers, compared to 8,627 at the end of FY 2020-21 and 6,391 at the end of FY 2019-20.[1] HCPF has set as a top priority to continue expanding the statewide contracted network of behavioral health providers through ongoing collaboration with providers, MCEs, and the community. Between Q4 2021-22 and Q1 2022-23, four RAEs completed major provider roster cleanups, removing at least 630 providers from the counts. However, through numerous collaborative provider recruitment efforts, nearly 1,400 providers were added in the next quarter and by December 31, 2022, the MCEs had reached 11,061 behavioral health providers.

As of quarter 3 of FY 2022-23, 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.

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

As of December 2022, the end of the second demonstration year of the SUD 1115 Demonstration Waiver allowing coverage of residential SUD services, 54 providers at 83 locations provided covered residential services to 9,713 unique members who received 18,533 episodes of care.

**E. Claims Processing and Provider Payments**

In compliance with federal regulations, HCPF 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 calendar year 2022.

**F. Quality Oversight Practices**

HCPF maintains workstreams to improve quality oversight including: creating a form for the Independent Provider Network (IPN) to report any outstanding issues or concerns they have; establishing RAE health equity plans to identify priority populations; identification and inclusion of behavioral health quality measures within CMS core measures to promote better outcomes; supporting the RAEs in building out network capacity gaps specifically with high-intensity outpatient service providers; monitoring the implementation of HB23-1243 Hospital Community Benefit bill; and the Quality of Care process.

**G. Improving Behavioral Health Services Statewide**

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

- Support for providers through collaborative action on credentialing and contracting, billing and coding, payment and reimbursement, service quality and communications.
- Coordination with the Behavioral Health Administration (BHA) to align policies impacting programs, services and payment methods; improve the performance and accountability of the behavioral health safety net; and improve the behavioral health rate structure.
- Development of the third phase of the Accountable Care Collaborative through robust stakeholder engagement ahead of a July 1, 2025, launch date.

- Streamlining administrative requirements for providers regarding credentialing, contracting, payment recoupment, use of ASAM criteria, and auditing.
- Completed a Behavioral Health Provider Rate Comparison Report and implemented recommendations in collaboration with the BHA and stakeholder groups. An Action Plan Update Report was published in August 2023 detailing the ongoing improvements.

# II. Introduction and Overview of the Behavioral Health Capitated Benefit

## H. About This Report

The Department of Health Care Policy & Financing (HCPF) prepared this report in response to a request for information from the Joint Budget Committee to discuss member utilization of capitated behavioral health services in FY 2021–22 and the performance of the behavioral health managed care entities (MCEs) on network provider expansion, timeliness of processing provider claims within contract requirements, and timeliness of credentialing and contracting network providers. It includes aggregated data on the number of members accessing inpatient and residential mental health treatment, inpatient and residential substance use disorder (SUD) treatment, outpatient mental health and SUD services, and alternative services allowed under HCPF's waiver with the Centers for Medicare and Medicaid Services (CMS). The report also includes, for calendar year (CY) 2022, aggregated provider data by quarter showing changes in the number of providers contracted, monthly claims processing timeframes by each MCE, and timeliness of provider credentialing and contracting by each MCE. It also discusses how HCPF monitors these performance measures and actions HCPF has taken to improve MCE performance and member behavioral health outcomes.

This report also contains the performance data on residential and inpatient SUD treatment required by HB 18-1136 (CRS 25.5-5-325(3)(a)) which is being specifically identified for clarity. The required data includes:

- The number of persons who received services pursuant to this section and the service provided [see Table 4]
- The length of time that services were provided [see Table 2]
- The location where services were provided, to identify distinctions between residential facilities and general hospitals [see Table 6]

One of the required data points, effectiveness of services provided, is extremely challenging to report as there is not an agreed upon definition of "effective" in the literature or as standard practice in the community. The rate of relapse could be considered for illustrating effectiveness; however, it is not specifically reportable based on a lack of standardized definition of relapse in the field. An approximation of relapse, defined as a member returning to the same or higher level of care, is one of the goals of the SUD

1115 waiver which HCPF reports to CMS and publishes quarterly. Finally, additional reporting of information on the SUD benefit utilization specific to residential and inpatient services is reported quarterly and published as part of SB21-137. This bill outlines the methodology for reporting utilization management data on a quarterly basis.

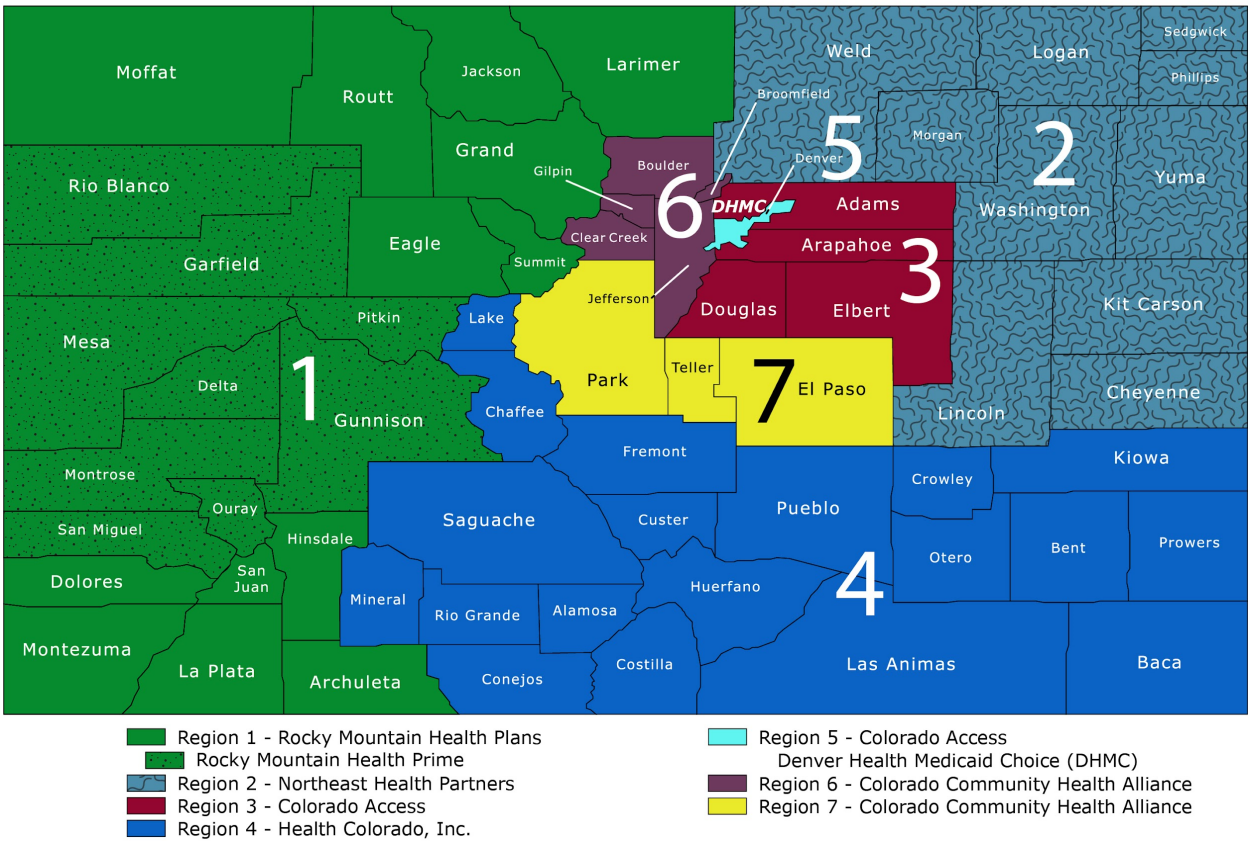
Tracking on these metrics is also a priority for HCPF to understand the status of our behavioral health networks and improve the behavioral health system. Providers are central to all we do for members, and HCPF recognizes the importance of manageable administrative requirements and fair reimbursement. HCPF 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.

## I. About the Behavioral Health Capitated Benefit

HCPF is the single state agency responsible for administering Health First Colorado. HCPF contracts with eight MCEs to administer, manage, and operate the Medicaid capitated behavioral health benefit by providing medically necessary covered behavioral health services. Seven Regional Accountable Entities (RAEs) and Denver Health Medicaid Choice, a managed care organization for Denver County, are contracted with HCPF 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**

## 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 HCPF 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. Additionally, the Behavioral Health Administration (BHA) is planning for BHASOs, which will be a consolidated delivery model providing a continuum of community mental health, crisis services, and SUD services, with the implementation date of July 1, 2025.

### J. 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 SUD treatment. The benefit also covers emergency and crisis services, inpatient hospital psychiatric care, and residential and inpatient SUD 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.

The alternative wraparound B3 services are one of the greatest flexibilities supported through a managed care system. Over half (57%) of individuals with behavioral health needs benefit from these services every year; that is nearly 11% of the total Medicaid population. Without a managed care option, in order to retain the current behavioral health benefit, all of these services would need to be moved under the Medicaid fee-for-service benefit authority and approved by the federal government. This would also require a review of cost and budget analysis for each service and any connected service, the development of state administered utilization management for these services, and increased provider documentation and the need to submit for each unit of service. Any of these services could be significantly limited based on the policy or budget analysis review. HCPF's current program is a demonstrated cost savings program that, unlike fee-for-service, allows for the flexible and responsive use of state funds. Managed care programs are also able to pay

variable rate to providers based on the need in the region and set up higher rates for specialty services or special cases.

**K. 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 an SUD. The expansion of the SUD benefit also supports state efforts to build provider capacity across the full American Society of Addiction Medicine (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.

As of January 2023, there are now 61 enrolled residential providers across the state offering all levels of adult residential SUD services. Adolescent services are very limited with only one Medicaid enrolled provider and two licensed facilities in the state. Effective July 2023, payments have been increased for adolescent SUD residential providers to incentivize provider participation in offering these services.

**L. 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. One example is residential/inpatient SUD services, which do require prior authorization when they are not for the purpose of withdrawal management.

Federal laws and regulations require state Medicaid programs to have utilization management (UM) for benefits to safeguard against unnecessary utilization and to assure that payments are consistent with efficiency,

economy, and quality of care. Federal regulations allow managed care plans to place appropriate limits on services for the purposes of UM, most prominent of which is the use of service authorization requests. Through its contracts with MCEs, HCPF expects MCEs to maintain a network of providers adequate to meet member needs based on utilization of services. Each MCE has its own UM program for behavioral health services to reduce waste and promote efficient and cost-effective care. 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 SB21-1371, mandating that HCPF 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 HCPF's Regulatory Resource Center webpage.

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

During the second demonstration year of the expanded SUD benefit (January to December 2022), 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, 3,934 total initial requests were made, 3,624 initial authorizations were issued, and 90% of these authorizations were issued within 72 hours. Since January 1, 2022, the number of initial authorization days has been standardized across all MCEs.

# III. Behavioral Health Utilization in FY 2021-22

## M. Utilization of Behavioral Health Services

In FY 2021–22, 18.9% 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. Members can receive short-term behavioral health services (up to six visits) for low-acuity behavioral health needs at the member's primary care medical provider site. In FY 2021-22, about 1.20% (17,890) eligible members used the short-term behavioral health benefit. Of these 17,890 members, 46.56% (8,330) had not previously accessed behavioral health services. During this time period, average member enrollment in the ACC was 1,489,511 and enrollment in Denver Health Medicaid Choice was 110,538. Utilization trends for the behavioral health capitation are listed below:

- 281,717 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:
  - ✓ 65.4% (184,253) used mental health services
  - ✓ 15.5% (43,731) used SUD services
  - ✓ 57.3% (161,502) used B3 services
- Of the 184,253 distinct utilizers of mental health services, 183,972 (99.9%) received outpatient mental health services. Inpatient services were used by 10,550 (5.7%) and 3,979 (2.2%) received residential mental health services.
- Of the 43,731 utilizers of SUD services, 38,562 (88.2%) utilizers used outpatient services. 10,432 (23.9%) received residential treatment and 2,967 (6.8%) had an inpatient SUD stay.

Table 2 shows the average length of stay for members at each level of care across all MCEs for January 1, 2022 - December 31, 2022, based on completed services delivered (as measured by claims data filed), as compared to services authorized by the MCEs. Colorado data is generally consistent with ASAM guidelines regarding dimensions of care and a progression through the continuum.

**Table 2. Average Length of Stay Per Length of Care Across the MCEs for January 2022 – December 2022**

| ASAM LOC | Description | Average Length of Stay (Days) |
|---|---|---|
| **3.1** | 24-hour structure with available trained personnel; at least 5 hours of clinical service/week | 37.4 |
| **3.3** | 24-hour care with trained counselors to stabilize multidimensional imminent danger; less intense milieu and group treatment for those with cognitive or other impairments unable to use full active milieu or therapeutic community | 20.4 |
| **3.5** | 24-hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment; able to tolerate and use full active milieu or therapeutic community | 22.2 |
| **3.7** | 24-hour nursing care with physician availability for significant problems in Dimensions 1, 2 or 3; sixteen hour/day counselor availability | 17.8 |
| **3.2WM** | Moderate withdrawal, but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery | 4.1 |
| **3.7WM** | Severe withdrawal and needs 24-hour nursing care and physician visits as necessary; unlikely to complete withdrawal management without medical, nursing monitoring | 9.6 |

18.9% of members received a capitated behavioral health service. 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.[2] 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. In FY 2021-22, 18.9% members used capitated behavioral health services, compared to 18.1% in FY 2020-21 and 19.4% in FY 2019-20. In

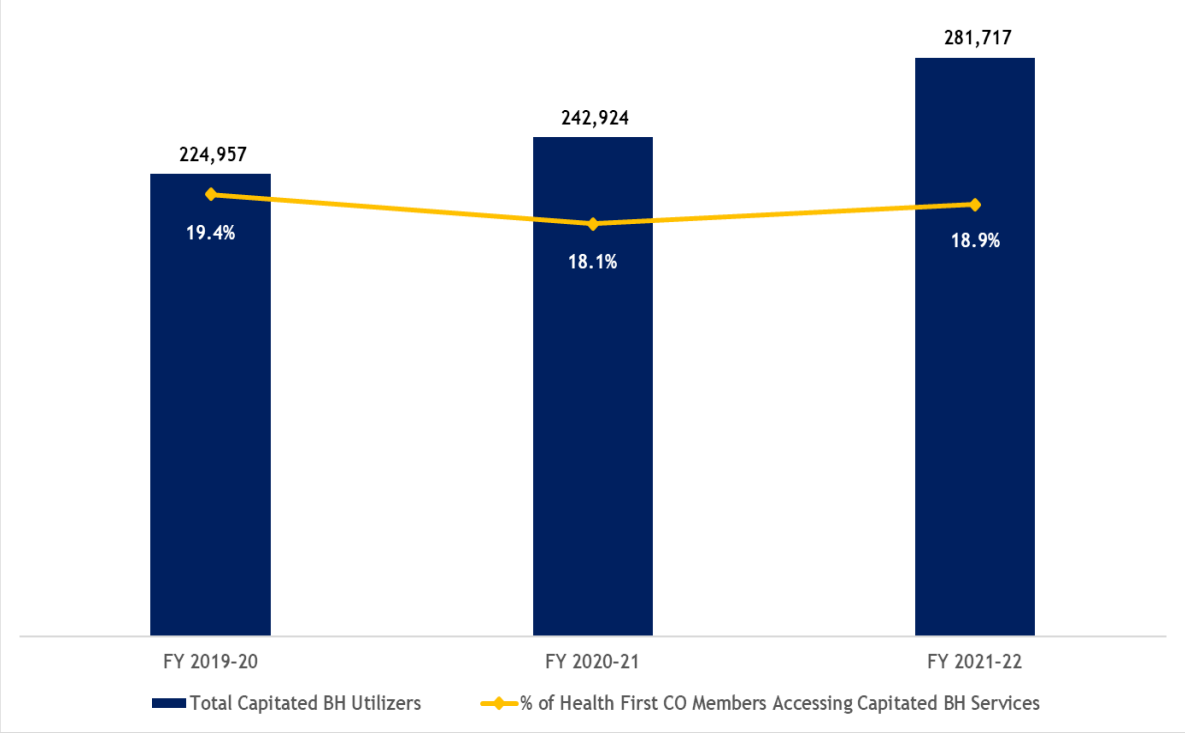
[2] SAMHSA. 2020 National Survey on Drug Use and Health.

FY 2020-21, Medicaid enrollment significantly increased due to the COVID-19 public health emergency. So, while utilization of behavioral health services increased significantly in FY 2020-21 and FY 2021-22, the percent total is lower than FY 2019-20.

**Table 3. Total Count of Members Accessing Behavioral Health Services Over Time, FY 2019-20 to FY 2021-22**

| | Total Capitated BH Utilizers | Enrollment | % of Total Utilizing Capitated BH |
|---|---|---|---|
| **FY 2019-20** | 224,957 | 1,161,545 | 19.4% |
| **FY 2020-21** | 242,924 | 1,343,597 | 18.1% |
| **FY 2021-22** | 281,717 | 1,489,511 | 18.9% |

**Figure 2. Total Count of Members Accessing Behavioral Health Services Over Time, FY 2019-20 to FY 2021-22**




Tables 4 through 8 show utilization of behavioral health services in FY 2021-22. For reference, average monthly member enrollment in the Accountable Care Collaborative during this time period was 1,489,511 and enrollment in Denver Health Medicaid Choice was 110,538.

**Table 4. Members Accessing Behavioral Health Services, FY 2021-22**

| | Mental Health Services | Substance Use Disorder Services |
|---|---|---|
| **Inpatient** | 10,550 | 2,967 |
| **Residential** | 3,979 | 10,432 |
| **Outpatient** | 183,972 | 38,562 |
| **B3 Services (SUD, MH and Co-Occurring)** | 161,502 | |

**Table 5. Members Accessing Outpatient Behavioral Health Services, FY 2021-22, by MCE**

| MCE | Outpatient Mental Health Services | Outpatient Substance Use Disorder Services |
|---|---|---|
| **RAE 1** | 32,338 | 6,908 |
| **RAE 2** | 11,347 | 2,691 |
| **RAE 3** | 40,110 | 7,155 |
| **RAE 4** | 18,083 | 4,959 |
| **RAE 5** | 19,887 | 4,542 |
| **RAE 6** | 27,338 | 5,474 |
| **RAE 7** | 28,009 | 5,163 |
| **Denver Health** | 10,628 | 2,667 |

**Table 6. Members Accessing Inpatient and Residential Behavioral Health Services, FY 2021-22, by MCE**

| MCE | Inpatient Mental Health Services | Residential Mental Health Services | Inpatient Substance Use Disorder Services | Residential Substance Use Disorder Services |
|---|---|---|---|---|
| **RAE 1** | 1,912 | 790 | 699 | 1,987 |
| **RAE 2** | 611 | 304 | 117 | 584 |

| | | | | |
|---|---|---|---|---|
| **RAE 3** | 2,240 | 810 | 664 | 1,864 |
| **RAE 4** | 636 | 438 | 66 | 1,287 |
| **RAE 5** | 1,137 | 686 | 397 | 1,681 |
| **RAE 6** | 1,544 | 316 | 484 | 1,173 |
| **RAE 7** | 1,992 | 316 | 348 | 926 |
| **Denver Health** | 572 | 366 | 245 | 1,102 |

**Table 7. Members Accessing B3 Services (Employment Services, Respite Care, Case Management, Drop-In Centers), FY 2021-22, by MCE**

| MCE | B3 Services |
|---|---|
| **1** | 19,953 |
| **2** | 9,593 |
| **3** | 37,932 |
| **4** | 19,534 |
| **5** | 20,509 |
| **6** | 23,299 |
| **7** | 20,926 |
| **Denver Health** | 12,292 |

**Table 8. Total Count of Members Accessing Behavioral Health Services through a Community Mental Health Center (CMHC) in Comparison to Other Providers, FY 2021-22**

| | CMHC | Other Providers | Total Members Using capitated BH Services | % of the Total Subpopulation that Received a Service at a CMHC** |
|---|---|---|---|---|
| **Capitated Behavioral Health Overall** | 97,012 | 226,984 | 281,717 | 34.44% |

| | | | | |
|---|---|---|---|---|
| **Mental Health Services** | 81,884 | 128,487 | 184,253 | 44.44% |
| **Substance Use Disorder Services** | 9,939 | 37,828 | 43,731 | 22.73% |
| **B3 Services*** | 71,235 | 108,239 | 161,502 | 44.11% |

*HCPF has an expanded definition for B3 Services for FY 2022
**Members could have also received one or more services from another provider

### N. Behavioral Health Incentive Program Indicators

The Behavioral Health Incentive Program (BHIP) indicators provide insight into how members access and utilize behavioral health care. Payment is based on annual performance and is not finalized until six to nine months following the end of the fiscal year to allow for claims runout and validation of performance. As a result of the timing, funds distributed to the MCEs in FY 2022–23 were for the MCEs' performance during FY 2021–22.

- ✓ Engagement in Outpatient SUD Treatment: Percent of members with a new episode of SUD who initiated outpatient treatment and who had two or more additional services for a primary diagnosis of SUD within 30 days of the initiation visit.
- ✓ Follow-up within 7 Days after an Inpatient Hospital Discharge for a Mental Health Condition: Percent of member discharges from an inpatient hospital episode for treatment of a covered mental health diagnosis to the community or a non-24-hour treatment facility who were seen on an outpatient basis by a mental health provider within seven days.
- ✓ Follow-up within 7 Days after an Emergency Department Visit for SUD: Percent of member discharges from an emergency department episode for treatment of a covered SUD diagnosis to the community or a non-24-hour treatment facility who were seen on an outpatient basis by a behavioral health provider within seven days.
- ✓ Follow-up after a Positive Depression Screen: Percent of members engaged in mental health service within 30 days of screening positive for depression.
- ✓ Behavioral Health Screening or Assessment for Foster Care Children: Percentage of foster care children who received a behavioral screening or assessment within 30 days of MCE enrollment.

Table 9 shows the percentage of members in each MCE who received the service described in each performance indicator. While not all MCEs received incentives, the ACC overall and each individual MCE has shown year over year improvement. Performance targets, highlighted in green below, are defined

annually. These goals differ by indicator and are based on the performance of each MCE calculated using their own baseline performance.

**Table 9. Behavioral Health Incentive Program Performance, FY 2021-22, by MCE**

| MCE | Outpatient SUD | Follow-up within 7 Days of Discharge for a Mental Health Condition | Follow-up within 7 Days of ED Visit for SUD | Follow-up within 30 Days of Positive Depression Screen | Behavioral Health Assessment for Children in Foster Care |
|---|---|---|---|---|---|
| **RAE 1** | 53.72% | 50.79% | 35.87% | 61.43% | 13.12% |
| **RAE 2** | 54.79% | 53.59% | 30.94% | 83.99% | 16.56% |
| **RAE 3** | 51.53% | 46.84% | 26.33% | 46.69% | 14.88% |
| **RAE 4** | 55.64% | 66.21% | 32.45% | 49.03% | 27.05% |
| **RAE 5** | 49.33% | 49.46% | 30.20% | 48.98% | 28.93% |
| **RAE 6** | 45.40% | 58.07% | 31.92% | 52.98% | 18.09% |
| **RAE 7** | 61.34% | 32.59% | 31.96% | 65.09% | 16.12% |
| **Denver Health** | 53.72% | 50.79% | 35.87% | 61.43% | 13.12% |

*Key: Green = Met target*

The behavioral health assessment for children in foster care metric was intended to incentivize collaboration between counties and MCEs and is not a reflection of all BH assessments for children in foster care. Many external factors affect this metric and statewide MCE performance has more than doubled since the metric was created in FY 2018-19. HCPF is working with counties, RAEs, providers and other state agencies to improve standard screening protocols, resources, and increase access to care for children and youth with behavioral health needs.

## IV. Provider Network, Credentialing, and Contracting

A robust provider network is one important way to ensure equitable access to behavioral health care. HCPF continues to work with MCEs on provider networks and other ways to improve access to care, which is often affected by race, ethnicity, socioeconomic status, age, sex, disability status, sexual orientation, gender identity, and residential location. Medicaid members are traditionally at high risk for poor health outcomes, so access to the right providers is a particular priority. Each region of the state has a unique member base, provider network, and community stakeholders. Each region also has unique challenges in addressing

disparities and meeting the needs of populations that often do not have the access to care they need.

This section explains the behavioral health provider network, 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

Currently, the Department separates outpatient service providers into two categories: Community Mental Health Centers (CMHCs) and independent providers, which comprise IPN. HCPF has further broken down the IPN into Federally Qualified Health Centers (FQHCs) and all other independent providers. Behavioral health providers contract directly with MCEs for services each provider will offer. MCEs are obligated by 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. As a part of the behavioral health transformation driven by community and legislative actions, the BHA is redefining provider types, modernizing the service requirements, and creating new provider types. These new "comprehensive" and "essential" behavioral health safety net providers are built on national best practices and were created in partnership with key stakeholders to improve quality, service offerings, accountability, and opportunities for more sustainable provider reimbursements.

### 1. Safety Net Providers

In 2022, the General Assembly passed HB22-1278, 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 previously operated 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 were intended to ensure that CMHCs are prepared to deliver services at all times, despite fluctuation and variability in demand, patient need, and patient severity. During this transition, CMHCs will continue to serve as safety net providers and remain the primary providers for alternative/B3 services.

HCPF 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, HCPF is working with our state, federal and community partners to improve accountability in the safety net. Section VI below, Improving Behavioral Health Services Statewide, includes an overview of key initiatives underway that will drive significant improvements in safety net accountability, quality, access, and sustainable funding.

### 2. 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 or other safety net provider. IPN providers include everything from a single licensed behavioral health provider with an independent solo practice (e.g., licensed clinical social worker or licensed psychologist) to large organizations with multiple sites across a region or the state. When reviewing behavioral health services, HCPF separates FQHCs into their own category due to the distinctly different services provided and federal requirements imposed by this designation, described separately in the next section.

To serve Health First Colorado members, providers must be enrolled with 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 and are not part of cost-based rate estimates conducted by the Department.

### 3. 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 are also required to offer dental and behavioral health services. FQHCs provide services to persons of all ages, regardless of their ability to pay or health insurance status.

## B. Contracting and Credentialing

### 1. Enrollment in Colorado Medicaid

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

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

## 2. Provider 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 HCPF. 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.

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 10 shows the percentage of providers credentialed and contracted within 90 days in calendar year 2022.

**Table 10. Percentage of Providers Credentialed and Contracted Within 90 Days for Each Quarter, CY 2022, by MCE**

| MCE | CY 22 Q1 (Jan-Mar) | CY 22 Q2 (Apr-Jun) | CY 22 Q3 (Jul-Sep) | CY 22 Q4 (Oct-Dec) |
|---|---|---|---|---|
| **RAE 1** | 83.2% | 85.6% | 78.3% | 98.3% |
| **RAE 2** | 41.2%* | 90.8% | 97% | 92% |
| **RAE 3** | 98.7% | 100% | 99.9% | 95.3% |
| **RAE 4** | 41.2%* | 90.8% | 97% | 91.7% |
| **RAE 5** | 98.7% | 100% | 99.9% | 95.3% |
| **RAE 6** | 95.8% | 95.2% | 100% | 100% |
| **RAE 7** | 95.8% | 95.2% | 100% | 100% |
| **Denver Health** | 98.7% | 100% | 99.9% | 95.3% |

*After contracts were adjusted in January 2022 to codify the standard that contracting decisions be made within 90 days of receiving a provider application, RAEs 2 and 4 made significant improvements to meet this standard.

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 by the last quarter.

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

### C. Network Management and Expansion

HCPF is committed to building provider networks so that all members can access the care they need, 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.

HCPF monitors behavioral health network adequacy through annual network adequacy plans 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 HCPF is validated and reviewed for accuracy by a third-party external quality review organization.

In regions where providers are limited due to national workforce 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.

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.

At the end of FY 2021-22, there were 10,298 MCE-contracted behavioral health providers, compared to 8,627 at the end of FY 2020-21 and 6,391 at the end of FY 2019-20. A top priority that HCPF has set is to continue expanding the statewide contracted network of behavioral health providers through ongoing collaboration with providers, MCEs, and the community. Between Q4 2021-22 and Q1 2022-23, four RAEs completed major provider roster cleanups, removing at least 630 providers from the counts. However, through numerous collaborative provider recruitment efforts, nearly 1,400 providers were added in the next quarter and by December 31, 2022, had reached 11,061 behavioral health providers. A solicitation was 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 a 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 HCPF is committed to supporting and leading on workforce development strategies.

**Table 11. 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 2020-21 Q4** | 8,627 |
| **FY 2021-22 Q1** | 8,567 |
| **FY 2021-22 Q2** | 10,298 |
| **FY 2021-22 Q3** | 9,668 |
| **FY 2021-22 Q4** | 11,061 |

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

**Table 12. Number of MCE-Contracted Behavioral Health Practitioner Added by Quarter, CY 2022, by MCE**

| MCE | Q1 (Jan-Mar) | Q2 (Apr-Jun) | Q3 (Jul-Sep) | Q4 (Oct-Dec) |
|---|---|---|---|---|
| **RAE 1** | 18 | 26 | 18 | 30 |
| **RAE 2** | 188 | 155 | 97 | 175 |
| **RAE 3** | 150 | 164 | 199 | 109 |
| **RAE 4** | 188 | 154 | 97 | 176 |
| **RAE 5** | 150 | 164 | 203 | 109 |
| **RAE 6** | 218 | 184 | 154 | 244 |
| **RAE 7** | 218 | 184 | 154 | 244 |
| **Denver Health** | 150 | 164 | 203 | 112 |

**Table 13. Number of MCE-Contracted Behavioral Health Practitioners at the End of CY 2022, by MCE**

| MCE | 2022 Year-End Total of Behavioral Health Practitioners |
|---|---|
| **RAE 1** | 4,010 |
| **RAE 2** | 3,144 |
| **RAE 3** | 8,189 |
| **RAE 4** | 3,144 |
| **RAE 5** | 8,196 |
| **RAE 6** | 6,576 |
| **RAE 7** | 6,576 |
| **Denver Health** | 8,196 |

HCPF and MCEs also worked to build the provider network for the new residential and inpatient benefit for SUD treatment. In 2021 and 2022, HCPF met individually with providers upon request to explain the enrollment process and answer questions. HCPF also expedited the review of SUD provider enrollment applications. By December of 2022, the end of the second demonstration year of the expanded benefit under an 1115 waiver, 54

providers at 83 locations offered covered residential services to 9,713 unique members who received 18,533 episodes of care.

As mentioned in this report, expanded access to behavioral health care depends on increasing the number of providers who can deliver services. In FY 2022-23, HCPF continued the work of behavioral health system transformation to address access challenges propelled by an insufficient number of providers and lack of participation in insurance networks, both Medicaid and commercial plans. The ability of the MCEs to meet behavioral health demands will improve as these transformation strategies are implemented. Higher reimbursement rates help to increase the number of participating providers. In FY 2022-23, all RAEs increased rates for behavioral health providers, with a specific focus on expanding the independent provider network (IPN). In addition, HCPF and the RAEs worked together to put policies in place to enroll pre-licensed clinicians working under supervision as Medicaid providers. The ACC added over 3,000 behavioral health practitioners this fiscal year, including licensed psychologists and licensed behavioral health clinicians. Practitioners were added in every quarter of this fiscal year in all regions.

HCPF continues to expand the number of behavioral health providers participating in the Independent Provider Network. Table 14 conveys how each Regional Accountable Entity increased the total number of independent providers from quarter 1 through quarter 3 of State Fiscal Year 2022-2023.

**Table 14. Net change in contracted BH independent providers, FY 2022-23 quarter 1 through quarter 3, by MCE**

| FY 2022-23 | Q1 (Jul-Sept) | Q2 (Oct-Dec) | Q3 (Jan-Mar) | NET Change Q1 to Q3 |
|---|---|---|---|---|
| **RAE 1** | 3,361 | 4,010 | 4,027 | 666 |
| **RAE 2** | 3,298 | 3,144 | 3,363 | 65 |
| **RAE 3** | 5,662 | 8,189 | 7,747 | 2,085 |
| **RAE 4** | 3,297 | 3,144 | 3,364 | 67 |
| **RAE 5** | 6,742 | 8,196 | 7,754 | 1,012 |
| **RAE 6** | 5,999 | 6,576 | 6,994 | 995 |
| **RAE 7** | 5,999 | 6,576 | 6,994 | 996 |

### D. Provider Directory Audit

RAE provider directories help members find network providers, so it is crucial that the online provider directory information is accurate, updated and easy to locate and navigate, ensuring access to health care at the right time, the right place and the right setting. During the fiscal year, HCPF contracted with a vendor to audit these provider directories, identify potential deficiencies and make recommendations for improvement. Some recommendations that came out of the audit were to improve search parameter functionality, perform annual audits of the directories, maintain updated contact information for providers, ensure all provider type filters are operational and regularly test functionality and accessibility tools.

## V. 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. (HCPF has a fee-for-service rate for services that fall outside the managed care benefit and reimburses providers directly for these services.)

In compliance with federal regulations, HCPF requires 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 calendar year 2022**. 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 15. Percent of MCEs Meeting Claim Adjudication and Provider Response Standards for SFY 2022-23, 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 | 99.5% | 99.8% | 97.1% | 99.9% | 97.2% | 99.5% | 99.5% |
| Response to provider questions within two business days | 99.7% | 100% | 100% | 100% | 100% | 100% | 100% |

## VI. Quality Oversight Practices

### A. Managed Care Complaints

In February of 2022, HCPF created a communication form for the independent provider network. This form allows the opportunity for providers to report to HCPF any outstanding issues or concerns they have with the Medicaid MCEs.

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

Since its inception, HCPF has received 151 unique provider concerns from 100 unique providers through this form. Providers may select multiple reasons when submitting concerns, therefore the illustration below does not represent unique outreach counts.

**Figure 3. Total count of provider complaints by the category of concern, February 2022 - July 2023**

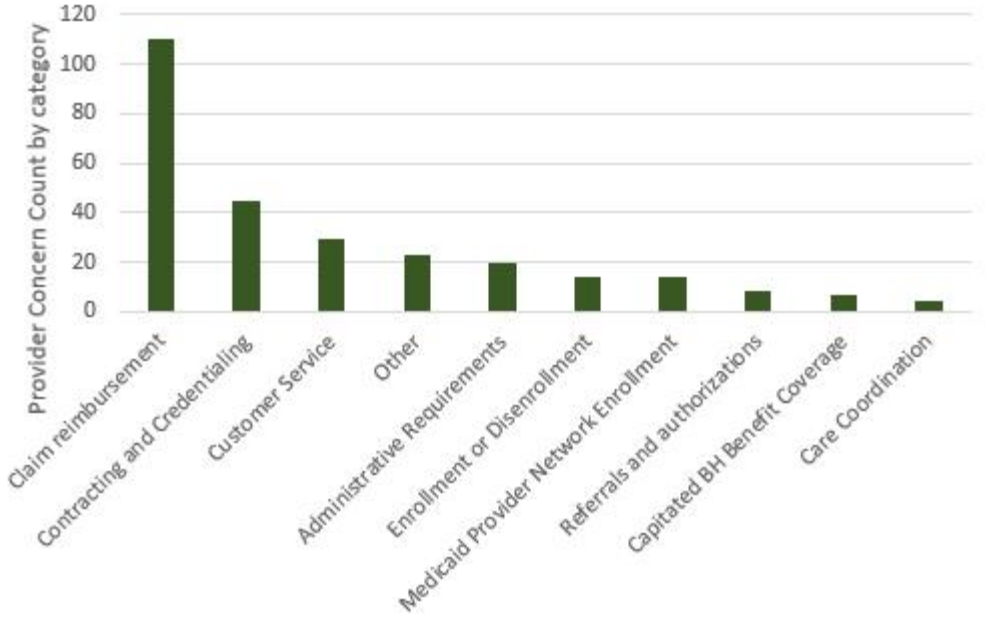
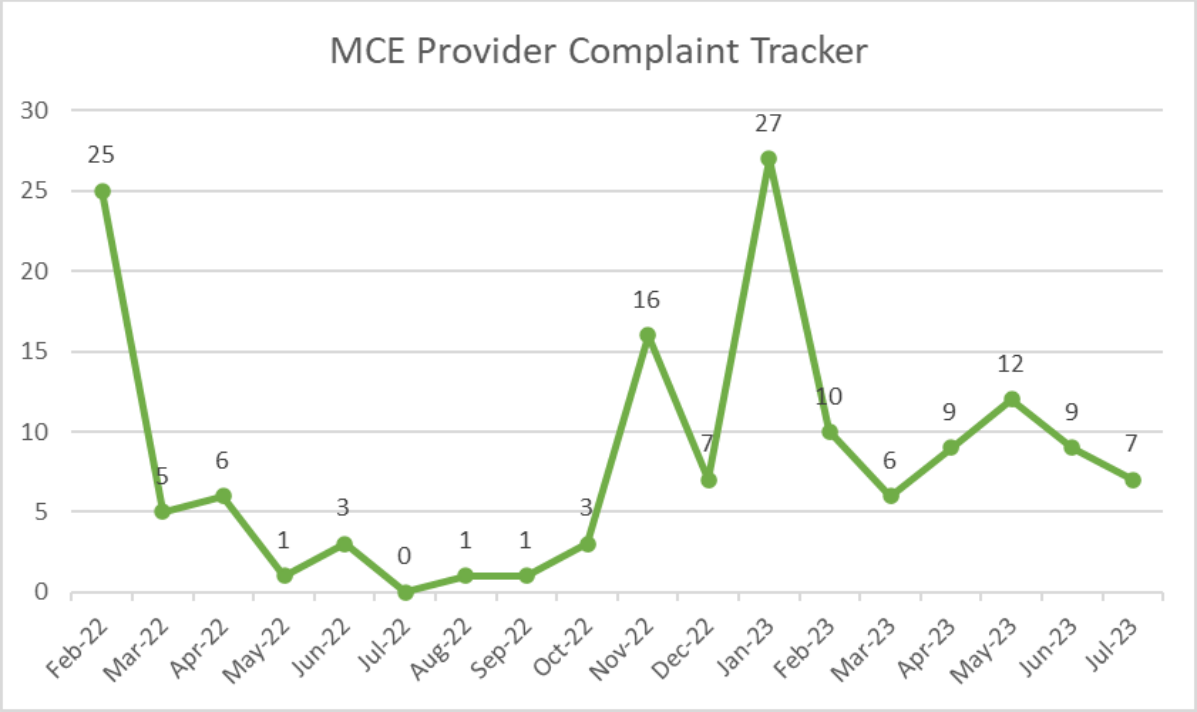



**Figure 4. Total count of provider complaints by month, February 2022 - July 2023**




As more providers become aware of this form an increase in provider outreach to HCPF may be expected. Trends and patterns of concern are identified, monitored and addressed by HCPF with the MCEs. This is a valuable indicator of provider experience and informs where areas of opportunities exist for continued program improvement. Beginning July 2023, a requirement was

added to the MCE contract to track provider inquiries on their phone line, which includes complaints. The phone line will further aid in program improvement.

### B. Health Equity and Social Determinants of Health

During FY 2023–24, each RAE will create a health equity plan that identifies priority populations, work that is currently making an impact and ways to leverage what is already being done to reduce health disparities. HCPF will also continue its work to design Medicaid look alike programs for populations who would be eligible for Medicaid and Child Health Plan Plus (CHP+) if not for their documentation status, including pregnant people, postpartum people through 12 months, and children up to age 18 years. Finally, HCPF will continue to collaborate with Colorado's Office of eHealth Innovation on the development of the Social Health Information Exchange (SHIE), a platform to securely share social health information between providers involved in whole-person care. With behavioral health as one of the focus areas in HCPF's Health Equity Plan, each RAE is responsible for developing regional health equity plans outlining specific strategy, timeline, resources, investments, partnerships, incentives, and other goals to identify differences and disparities that impact their members. In alignment with quality metrics, four behavioral health core measures have been identified, which include Follow-up after Emergency Department visit for mental illness (NQF 3489), Follow-up after Emergency Department visit for Alcohol and Other Drug Abuse or Dependence (NQF 3488), Follow-up after Hospitalization for Mental Illness (NQF 0576), and Screening for Depression and Follow-up Plan (NQF 0418).

### C. High-Intensity Outpatient Service Providers

Through American Rescue Plan Act funding, HCPF prioritized significant funding on supporting the RAEs in building out network capacity for gaps that exist in the behavioral health safety net system specifically at the level of care between institutionalization and basic community-based outpatient care. This was developed as a result of SB19-222[3] because of the risk of people being institutionalized for lack of high intensity outpatient services.

This fiscal year, RAEs started work to build network capacity to address gaps in the behavioral health safety net system, particularly in the transition from

[3] Colorado Senate Bill 19-222.

institutional to community-based outpatient care and for those at risk of institutionalization or reinstitutionalization. Each RAE submitted a plan for identifying gaps in their region, providers who currently offer these services to see if they could expand their reach and providers who could add this to their service delivery model. RAEs have received $14M in funding so far to distribute to providers through a proposal process.

### D. HB23-1243 Hospital Community Benefit

Hospital Community Benefit dollars are intended to act like "in lieu of tax contributions" for the betterment of the community since not-for-profit hospitals don't pay taxes. Colorado hospitals invested $965 million in community benefits in 2020-21, not including Medicaid shortfall. HCPF's Colorado Hospital Community Benefit Annual Report found that communities across the state overwhelmingly want hospitals to invest in behavioral health services (95% of hospitals' Community Health Need Assessments included behavioral health as a priority for the community).

The goal of HB23-1243 was to ensure that hospitals' community benefit investment dollars are far more aligned with the actual needs of the community, and that the hundreds of millions of community benefit dollars are directly impacting the changing needs of the community to the betterment of Coloradans for years to come. Communities have robust and differing needs, such as food insecurity, housing insecurity or behavioral health access gaps. Meeting those needs more directly is a key objective of this bill - through sustainable, year over year funding. Further, as those needs change and evolve, this bill is designed to continue to proactively respond by listening to the changing perspectives and voices of the community, creating a sustainable, collaborative means of addressing our most prominent challenges - community by community, year after year and for years to come.

This bill builds on HB19-1320 to further increase non-profit, tax exempt hospital transparency and accountability in listening to the community as decisions are made on how Community Benefit dollars are spent across Colorado. This bill only applies to Colorado's larger nonprofit, tax-exempt hospitals. Like HB19-1001, this bill does not apply to the 32 Critical Access Hospitals.

HB23-1243 accomplishes five main objectives:

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

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

Third, the bill expands requirements for HCPF to undertake stakeholder work to develop community engagement best practices and efficiencies.

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

Fifth, the bill adds reasonable non-compliance measures.

### E. Quality of Care Process

HCPF is notified of the Quality of Care (QOC) concerns or grievances and records the data internally. It checks if the MCEs are completing the investigations and adhering to the state statutes. Feedback from the MCE's investigations is collected according to the set timelines. The QOC grievance Standard Operating Procedure and contract amendments are scheduled to be implemented in the winter cycle.

## VII. Improving Behavioral Health Services Statewide

### A. Utilization Management and Service Improvements

It is important that MCEs be able to select and implement UM policies and procedures to manage risk. However, HCPF continues to set parameters and provide support to MCEs seeking to streamline their UM processes. In this calendar year, development of a UM dashboard is underway, with anticipated piloting to begin this fall. A transition from data collection on excel sheets to direct data input is scheduled for January 2024. The dashboard is being developed in collaboration with the MCEs, HCPF Data Analytics Services, and a contractor. This group aims to leverage the data elements collected from the reporting required by SB21-137 and expand the UM dashboard to include all services requiring pre-authorization by MCEs.

In addition, HCPF 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:

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

To meet the objectives and support providers in delivering a full continuum of services, HCPF 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 and increasing access for members requires ongoing improvements to the provider experience. HCPF recognizes the need to minimize administrative burden and increase support for providers while still maintaining compliance with state and federal regulations.

In fiscal year 2022-23, stakeholder engagement with the behavioral health independent provider network (IPN) continued. The goal of this initiative is to identify barriers and create mutually agreeable action plans for addressing issues. The purpose of Phase I, which took place from April to June 2022, was to gather information from stakeholders and establish a safe space to share perspectives, build relationships and develop a foundation for a collaborative problem-solving process. This phase identified the shared interests of all parties, a summary of what is working in the system, a list of system issues by stakeholder groups, and the identification of ten barriers.

The goals of Phase II, which took place this fiscal year from October 2022 to June 2023, was to explore the barriers identified in Phase I and recommend mutually agreeable action plans to address them. Five action teams focused on these key areas: Credentialing and Contracting, Billing and Coding,

Payment and Reimbursement, Service Quality and Communications. The action teams followed a structured problem-solving and process improvement framework to develop recommendations and implementation plans. HCPF is now launching an ongoing IPN Forum and Working Group to move these recommendations forward and provide space for IPN providers to share concerns and information and identify barriers.

In each project phase, independent behavioral health providers had the opportunity to provide feedback on their interactions and key touchpoints as well as transactions with HCPF and the RAEs via an IPN satisfaction survey. The results of this survey, first administered in 2022 and again in 2023, indicate improvement in satisfaction and service quality.[4] Overall, survey respondents are more satisfied with being a Medicaid provider and they indicated that their relationships with the RAE improved in the one-year period during which the collaboration project occurred. Improvement is also evident across all eleven indicators of interaction between providers, HCPF, and the RAEs. The eleven indicators measured include: enrolling with HCPF as a Medicaid provider; contracting with RAE; credentialing with RAE; receiving service preauthorization with RAE; coding, preparing, and submitting claims to RAE; coding, preparing, and submitting claims to HCPF; resolving claim issues related to RAE; receipt of payment from RAE; receipt of payment from HCPF; and responding to audits by RAE.

### C. Behavioral Health Administration

One of the bills passed in 2022 was HB22-1278, 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 behavioral health programs/services that are regulated by the BHA, 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 the coming years with increased functionalities being added over time. The BHA will require ongoing iteration and refinement as it addresses the priorities in the Blueprint for Behavioral Health Reform,

[4] The IPN Satisfaction Survey can be found in the IPN, RAE, HCPF Collaboration Project Phase II report.

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 ramping up to full capacity, it will focus on implementing care coordination, expanding the safety net, procuring Behavioral Health Administrative Service Organizations (BHASOs) and continuing to carry out 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 aligned workstreams intended to improve the performance and accountability of the behavioral health safety net, 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 if and when necessary; 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, in order to hold these behavioral health programs/services 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 net, as introduced in SB19-222 and the subsequent report to strengthen and expand the safety net, new definitions for safety net related terminology are emerging to the benefit of all Coloradans. These definitions will ensure that the criteria to be a safety net provider simultaneously represents a lessening of provider administrative burden, while also incentivizing an increase in the number of providers who will 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. The BHA will be revising, amending, or repealing their provider standards for approved safety net providers and behavioral health providers operating programs/services in the regulatory purview of the BHA, and other regulations, based on statutory need. The first set of these rule adjustments are currently in front of the State Board of Human Services and are slated to be effective by January 1, 2024.

- **Delivery System Reform.** HCPF and BHA respectively are in-process with planning for the next evolution of their respective behavioral health care delivery systems. HCPF is planning for ACC Phase III, which will be the next iteration of the Accountable Care Collaborative model beginning July 1, 2025. The BHA is planning for BHASOs, which will be a consolidated delivery model providing a continuum of community mental health, crisis services, and SUD services; also, with the implementation date of July 1, 2025.
- **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. Starting November 2022, all CMHCs must submit their cost information to HCPF using these new templates. Those insights from the cost reports will inform the rate-setting process. Cost reports and rate reviews are posted publicly on HCPF's Behavioral Health Rate Reform web page. HCPF will be developing updated rules to reflect the transition from CMHCs to comprehensive and essential safety net providers and support the cost reporting and rate setting efforts.
- **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 improved member outcomes. Specifically, the new APMs will create financial flexibility for providers to meet the needs of Health First Colorado members by increasing access to behavioral health services. The VBP will also improve incentive reimbursements using quality metrics from state-wide accepted modalities. While these payments will evolve on an iterative basis, the initial APM will be effective July 2024.
- **Universal Contract Provisions.** Two bills (HB22-1278 and HB22-1302) require HCPF and BHA to work together and develop Universal Contract Provisions (UCPs) that will define expectations for behavioral health

providers that contract with the state for the provision of behavioral health services. The UCPs will standardize contract content expectations around things such as data collection and reporting, access to care, compliance with behavioral safety net standards, claims submission, and billing for procedures. Concurrently, agencies 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 UCP draft has been developed, and extensive stakeholder engagement will occur during the summer and fall of 2023. The first roll out of the UCPs will be reflected in FY 2025 contracts.

- **Investments in increasing Medicaid provider rates and networks.** The expansion of HCPF's Medicaid behavioral health network outlined in this report reflects the provider reimbursement rates it is currently providing and developing. 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 behavioral health 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 SUD residential, medication assisted treatment, intensive outpatient services, and child/youth services.

HCPF 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.

## E. ACC Phase III Planning

Current contracts with the RAEs will end on June 30, 2025. HCPF is in the process of designing the next iteration of the ACC, referred to as Phase III, which will begin on July 1, 2025. Because the ACC is Health First Colorado's delivery system, Phase III is a critical part of efforts to improve care quality, service, equity and affordability. Stakeholders will be given multiple opportunities in FY 2023–24 to provide input and voice their desires and concerns for ACC III.

HCPF is proposing several areas of change for ACC III, including a reduction in the number of regions from seven to four in order to ensure sustainable

investment in regional infrastructure and better leverage efficiencies of the RAEs, while also enabling RAEs to meet the unique needs of their communities. Another proposed change is an adjustment to how members are assigned to a PCMP and possible expansion of the provider types that can serve as PCMPs. Specific to behavioral health, ACC Phase III will incorporate and build upon the 19 priorities identified by the original Behavioral Health Task Force appointed by Governor Polis, leverage the ARPA dollars allocated in support of the Behavioral Health Transformational Task Force's recommendations report and the many bills passed since that time to fulfil those recommendations. It will also propel many of the behavioral health changes currently underway, while implementing a variety of new improvements. Overall, HCPF and the RAEs will focus on the following areas for the Health First Colorado behavioral health system[5]:

1. Increasing collaboration and accountability with the BHA
2. Increasing access, capacity, and strategic expansion of the provider network
3. Reducing administrative burden for members and providers
4. Paying providers for improving patient health
5. Identifying and filling historical service gaps in the care continuum
6. Children and youth specific service continuum

Clinical goals include improving engagement in treatment for mental health and substance use disorders; closing racial/ethnic disparities for childhood immunizations and well-child visits; improving care for people with diabetes and hypertension; achieving national averages in preventive screenings; and reducing maternal disparity gaps.

Proposed payment models will build on existing models. HCPF will continue the capitated behavioral health benefit to encourage the effective utilization of the full continuum of behavioral health services and provide avenues for addressing health-related social needs. Administrative payments will continue to be paid to the RAEs for care coordination, provider support and management of whole-person care. Incentive payments will continue to tie a portion of RAE funding to achieving established outcome targets.

[5] Accountable Care Collaborative Phase III Concept Paper

Use of alternative payment models will increase, as described in the Health First Colorado Value section of this report. Other current efforts in value-based payments, including hospital transformation, prescription drug payments and nursing home payments.

**Figure 5. ACC Phase III Timeline of Stakeholder Engagement Activities**


## F. Action plan to improve the behavioral health rate structure

HCPF is completing the actions items listed below to implement the recommendations for improving the behavioral health rate structure, as published in the Behavioral Health Provider Rate Comparison Report[6]. More information about each of these action items can be found in the Action Plan on Behavioral Health Reimbursement Rates[7].

- HCPF, in collaboration with the BHA, is creating new Medicaid provider types in claim processing and data IT systems to align with the new HB22-1278 statutory definitions and aligning payments with licensing requirements. The new statute also clarifies that Federally Qualified Health Centers are behavioral health safety net providers.
- HCPF has worked in collaboration with the BHA and outside stakeholders to build and clarify the definition of Mobile Crisis Response services and Behavioral Health Secure Transport services.

[6] BH Provider Rate Comparison Report.
[7] BH Reimbursement Rates Action Plan.

- HCPF engaged an outside vendor to review and evaluate the Relative Value Unit (RVU) weights used in the current, cost-based methodology for behavioral health safety net providers.
- The BHA, working with HCPF, updated reporting requirements for new safety net providers under the BHA. This includes requirements for cost reporting, financial reporting, submission of claims, and appropriate licensing. HCPF completed the first round of updated reporting requirements from CMHCs in 2022, including adding statutory service categories and limits on allowable costs.
- HCPF and the BHA are working to add further structure to the definition of safety net providers, incorporating the new definitions for comprehensive behavioral health safety net providers and an updated regulatory structure.
- HCPF and its vendor, in cooperation with the BHA, held in-depth cost report stakeholder engagement with a robust set of outside stakeholders including representatives of Community Mental Health Centers, Regional Accountable Entities, and provider groups. The result was an updated cost report and accompanying updated A&A guidelines.
- 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. For new safety net providers, the Department will provide additional support to ensure ease of transition and understanding of reporting requirements.
- For new safety net providers, the Department will provide additional support to ensure ease of transition and understanding of reporting requirements. This includes vendor support for the cost reporting requirements for the comprehensive safety net providers. HCPF will also be contracting for additional cost report training to begin in spring/summer 2023.
- HCPF is beginning discussions with the Centers for Medicare and Medicaid Services to seek approval for Directed Payments, an allowance for HCPF to direct its managed care entities on how to pay for services under very specific rules.
- HCPF engaged with the Division of Insurance (DOI) to compare the Medicaid Independent Provider Network reimbursement rates with those paid by commercial insurance plans. Additionally, HCPF is engaging with DOI to compare the SUD reimbursement rates with those paid by commercial insurance plans. See below for the publicly available Center for Improving

Value in Health Care tool that HCPF utilized to compare average[8] rates for the outpatient psychotherapy codes.

**Table 16: Average Commercial and Medicaid Independent Network Provider Cost, by Procedure Code**

| Procedure Code | Description | Commercial Average | Medicaid IPN Average | Medicaid Percentage of Commercial |
|---|---|---|---|---|
| 90791 | Psychiatric Diagnostic Evaluation | $118.00 | $110.58 | 93.7% |
| 90832 | Psychotherapy – 30 minutes | $57.00 | $56.46 | 99.0% |
| 90834 | Psychotherapy – 45 minutes | $76.00 | $67.46 | 88.8% |
| 90837 | Psychotherapy – 60 minutes | $103.00 | $91.24 | 88.6% |
| 90839 | Psychotherapy - Crisis | $113.00 | $94.73 | 83.8% |
| 90846 | Family Psychotherapy without patient | $81.00 | $76.44 | 94.4% |
| 90847 | Family Psychotherapy with patient | $84.00 | $74.06 | 88.2% |
| 90849 | Multiple Family Group Psychotherapy | $55.00 | $56.62 | 102.9% |

[8] Average is defined as the sum of the values divided by the number of values. This includes all values in the data set.

| | | | | |
|---|---|---|---|---|
| 90853 | Group Psychotherapy | $41.00 | $37.90 | 92.4% |

Table 16 above documents the average rates of pay for the nine behavioral health procedure codes used in the Behavioral Health Provider Rate Reimbursement Report for both commercial and Medicaid IPN providers. The column labeled "Medicaid Percentage of Commercial" shows IPN rates represented as the percentage of commercial rates paid.

## G. Administrative Simplification for Behavioral Health Providers

The following are the MCE contract amendments executed in FY 22-23 that are relevant to behavioral health:

- Clarified the provider credentialing policy measurement period. The MCE is required to complete the credentialing and contracting processes or deny network admission within 90 days for at least 90% of all Provider applications. The 90 days is to begin upon the submission of a Provider's written request to contract with the MCE.
- Required a universal contract to be used for CMHCs once it is developed by the BHA.
- Added a deliverable to document requirements of the Conflict-of-Interest bill[9]. An MCE may be required to submit quarterly data about rates paid to providers in their network.
- Updated the Provider Termination Notice to match federal regulation.
- Added language for recoupment limitations around retroactively recovering some provider payments.
- Added a requirement to track provider inquiries on MCE phone lines. The MCE is to maintain, staff, and publish the number for a toll-free telephone line that Providers may call regarding general information, administrative support, and complaints.
- Added language holding the RAE accountable for their system migration including due dates, performance standards, statistics reporting.
- Clarified that ASAM criteria is only to be used for utilization management of SUD services.

[9] Colorado Senate Bill 22-106.

- Added a new exhibit to the High Intensity Outpatient statement of work. The RAE is to oversee the expansion and coordination of High-intensity Behavioral Health Treatment offered by providers located in the RAE's region, specifically focusing on supporting members who are transitioning to the community from a higher level of care and individuals at risk of institutionalization.
- Added a deliverable requirement for MCEs to provide a health equity plan to identify and address specific and targeted health disparities that impact Members within their respective region.
- Simplified and standardized the audit tools.
- Added a deliverable to document how they will meet the Language Assistance Requirements.

**H. Reviewing improvements**

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

- **Expanding the availability of behavioral health services through Integrated Care**. HCPF launched a $29 million Integrated Care Grants program designed to increase access to behavioral health services in over 150 locations. The program offers short-term grant funding for physical and behavioral health care providers looking to implement or expand access to care and treatment for mental health and substance use disorders using an evidence-based integrated care model.
- **Securing federal funds for behavioral health.** Through the American Rescue Plan Act funds, HCPF chose to prioritize individuals with behavioral health needs in the strategy to improve home and community-based services. The team currently has 17 distinct projects in operation with a focus to enhance or expand behavioral health services by September 2024 totaling approximately $140 million dollars.
- **Permanent supportive housing for Medicaid members.** The Statewide Supportive Housing Expansion (SWSHE) pilot helps people secure housing and provides permanent supportive housing services for Medicaid members in 28 locations across the state. This project has served over 500 people since it began in December 2022. This program also is aligned with the Peer Support Grants for Housing Stability project launched on June 1, 2023, with

14 participating grantees. Funding expands Housing Stability Peer Support Services for Medicaid members experiencing homelessness who meet criteria for permanent supportive housing, having a behavioral health need.

- **Improving community crisis response, mobile crisis and secure transport benefits launched July 1, 2023**. Secure Transportation is a new benefit, one of the first nationally, that provides trauma-informed specialized transportation services for individuals in a behavioral health crisis from the community to a facility or between providers (i.e., from the emergency room to a psychiatric hospital or substance use treatment center).
- **Building out criminal justice partnerships**. Initial survey feedback from county jails achieved a 90% response rate, showing that many of our criminal justice partners are interested in developing solutions together. The survey helped establish a baseline understanding of existing Medicaid enrollment processes in jails, relationships between jails and DHS offices, and identified barriers and support needed to improve Medicaid enrollment in jail settings. Respondents were individuals working in each jail in a variety of roles, including Sheriffs, Jail Captains, Program Managers, Case Managers and JBBS staff.
- **Community transition grants.** As of March 29, 2023, HCPF contracted $14 million to nine grantees to provide behavioral health transition services for individuals leaving institutions. These projects prioritize serving high-risk populations with high-intensity outpatient services and all include sustainability plans post grant funding period.
- **Provider licensing support**. HCPF implemented a policy to cover behavioral health clinicians while they are getting licensed help to support new providers in the system and expanding the workforce. The policy took effect July 1, 2022.
- **Setting minimum rate standards through directed payments.** HCPF established a Directed Payment policy and fee schedule to take effect July 1, 2023, for Regional Accountable Entities related to community-based services for members under 21 years old. This program sets minimum rate standards for certain high need services and will reduce barriers to members accessing the level of care they need.