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Colorado Department of Health Care Policy and Financing

Behavioral Health Provider Rate Comparison Report

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Executive Summary

In 2022, the Colorado General Assembly passed House Bill 22-1268 Medicaid Mental Health Reimbursement Rates Report (HB 22-1268)[1], directing the Department of Health Care Policy & Financing (the Department or HCPF) to present a behavioral health rates report and recommendations on Medicaid reimbursement rates for providers in community mental health centers and independent mental health and substance abuse treatment providers. This report meets the requirements of HB 22-1268. The legislation states, "...it is imperative to determine whether a disparity exists, and the reasons for such possible disparities, in Medicaid reimbursement rates among providers of mental health services…". To determine whether a disparity in rates exists, the report addresses the two areas for analysis specified in HB 22-1268 and presents the required set of recommendations as outlined below:

1. "… IDENTIFY DISCREPANCIES, IF ANY, AND THE REASONS FOR SUCH DISCREPANCIES IN MEDICAID REIMBURSEMENT RATES PAID TO PROVIDERS OF A COMMUNITY MENTAL HEALTH CENTER AND INDEPENDENT MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT PROVIDERS FOR COMPARABLE SERVICES."

2. "…DETERMINATION OF AND RECOMMENDATIONS ON WHETHER REIMBURSEMENT RATES PAID TO COMMUNITY MENTAL HEALTH CENTER PROVIDERS AND INDEPENDENT MENTAL HEALTH AND SUBSTANCE USE TREATMENT PROVIDERS ARE ADEQUATE TO MEET OR EXCEED NETWORK ADEQUACY STANDARDS IN EVERY REGION OF THE STATE."

3. "A SET OF RECOMMENDATIONS ON CREATING EQUITABLE PAYMENT AND PAYMENT MODELS THAT MINIMIZE INAPPROPRIATE PAYMENT VARIATION IN COMPARABLE BEHAVIORAL HEALTH SERVICES BETWEEN THE PROVIDERS OF COMMUNITY MENTAL HEALTH CENTERS AND INDEPENDENT MENTAL HEALTH AND SUBSTANCE USE TREATMENT PROVIDERS."

In addition, the report provides insights and clarifications into the process for determining reimbursements to providers delivering behavioral health (BH) services, which includes care for both mental health and substance use disorders, to Health First Colorado members as well as how the Department can improve this process.

Consequently, this report is laid out in three parts.

- **Part 1** describes the behavioral health landscape within Health First Colorado (Colorado's Medicaid program). The different provider types, populations they serve and benefits that they are required to provide are described for context and comparability. The Department has included information on provider types, payment methodologies, and the respective

[1] https://leg.colorado.gov/bills/hb22-1268

responsibilities attributed to each, to better outline why rates may differ across providers and services.

- This section explains that the cost-based safety net payment methodology for Community Mental Health Centers (CMHCs) reflect the billable as well as non-billable critical support services provided to patients as well as additional costs needed for sustainable safety net operations. Accordingly, a rate paid by Medicaid for one hour of therapy at a safety net provider is representative of additional funding necessary to finance appropriate wraparound and social services that care for and help keep those with the highest needs healthy and connected to care. Part 1 of the report provides examples of non-billable costs that are reimbursed through the payment process.
- The Department also uses cost-based methodologies to establish Medicaid reimbursement rates for rural hospitals, rural health centers (clinics), and federally qualified health centers (FQHCs). In the future the Department will apply such cost-based reimbursements to a larger array of qualifying safety net providers, including those who fall in between a comprehensive large safety net provider and an individual practitioner that only offers a limited set of services. This report outlines how the populations served, the severity of illness, and the additional services required of safety net providers are essential in determining rates but are not necessarily represented in a procedure code level comparison.
- One critical conclusion from Part 1 of the report is that the Medicaid reimbursements to independent providers will never be as high as the safety net providers (today represented only by CMHCs) because the independent providers are not paid using a cost-based rate, as independent providers do not provide the same complexity of services required of safety net CMHC providers, nor do they have the same costs or see the same volume of high acuity patients as the CMHC safety net providers.
- This section recognizes that while elements of cost-based models should be preserved, additional accountability components connected to these higher payments must be continually improved. As well, reimbursement models must incentivize increased access, more equitable care models, and be more inclusive of small and medium sized community-based providers that are providing safety net care.

- **Part 2** presents an analysis of the utilization, rates, and costs to provide comparisons among different provider types. The analyses in this report identify differences in the reimbursement rates paid to different provider types. Key findings in Part 2 of the report include:
  - The comparison between Community Mental Health Centers (CMHC) cost-based reimbursements and Federally Qualified Health Centers, which are also reimbursed on a cost-based rate, are within about 3% of each other, though additional analysis is required for a full comparison.
  - The number of providers within the behavioral health network has increased for every region in the state within SFY 2021. The network adequacy standards have been

consistently met by the Managed Care Entities (MCEs) with no substantive violations. The report shows no direct negative impact associated with reimbursement rates was identified from this analysis with regards to network adequacy.

- The volume of services provided by the Independent Provider Network (IPN) has increased by 24% over the SFY 2021 time period. The weighted average reimbursement rate for Independent Providers increased by 6.9% year over year between SFY 2020 and SFY 2021.
- In the cost-based model used for CMHCs, there are a variety of complexities that may impact reimbursements. Some examples are provided below:
  - There has been a steady decline in average units of service provided since SFY 2018 for all three CMHC groups (small, medium, large) and a concurrent increase in RVUs between SFY 2020 and SFY 2021. This means that while units of service declined, the higher RVUs would have the effect of lowering the Base Unit Cost (BUC), and therefore the reimbursement rates, for a CMHC.
  - The BUC can vary significantly between individual CMHCs due to several factors, such as cost of labor, geographic area, center size and efficiency, differences in cost report preparation methods, differences in types of BH services provided, and differences in member needs.
  - During SFY 2021, CMS increased the RVU weights associated with many of the services provided by the CMHCs, causing a decrease in average BUC for the CMHCs.
- The report and the appendices describe the variations in payment methodologies and outlines why the direct comparisons of the rates by code does not provide an apples-to-apples comparison. That said, there is a 2x to 3x difference in the reimbursement rates between CMHCs and Independent Providers for the common codes selected.

- **Part 3** of the report contains a list of the initiatives already underway as well as the Department's recommendations to address discrepancies in Medicaid reimbursement rates and to respond to changes in the behavioral health landscape in Colorado, especially with regards to Health First Colorado programs. This section presents the numerous initiatives and recommendations from HCPF to meet the requirements of HB 22-1268. Below are the initiatives already underway:
  - Modernize the definition of safety net providers and associated safety net services.
  - Codify an "appropriate cost accounting methodology" and allow for a broader scope of providers to not only participate in providing safety net services but also to engage in cost-based payment modeling and provide input to the cost accounting methodology.
  - Engage with an outside contractor to examine the RVU weights to see if inappropriate weighting of procedure codes is causing an inflation of base unit costs in the cost reporting methodology.

  - Engage outside consultants to help design and implement a pilot value-based payment (VBP) model to ensure the creation of "equitable payment and payment models that minimize inappropriate payment variation".
  - The Department and the BHA have engaged in work to further improve network participation.
  - The Department and the BHA are collaborating to establish universal contracting provisions, pursuant to section 27-50-203, C.R.S., to ensure that the contracting provisions for all MCEs and all BH providers are consistent across the BH landscape and that all parties are held accountable to meeting shared expectations.
- The below include the recommendations not yet underway:
  - Update service definitions (i.e.: crisis services) and update their associated reimbursement rates to align with new provider definitions. Improve payment models and reporting accuracy (i.e.: cost reporting, RVUs, auditing and accounting guidelines). This will create more equity for the services provided and the reimbursement rates.
  - Evaluate appropriate payment methodologies as viable alternatives to the relative value unit (RVU) payment model. This will reduce payment disparities between safety net providers by enabling the Department to move away from a Medicare-based reimbursement model. This will create more appropriate reimbursements for "B3" services like drop-in centers and peer counseling, which are not recognized or reimbursed by Medicare.
  - Continue to improve safety net cost reports in order to better address cost-based models for providers of differing sizes and reporting capabilities.
  - Expand value-based payment models to a greater subset of safety net providers.
  - Continue to analyze and publicly post reimbursement rate reviews and analyses on behavioral health rates, to show changes over time. This may include SUD specific services. It may also include comparisons between the Medicaid independent providers reimbursements and commercial reimbursement rates, which would provide a more accurate (apples-to-apples) comparison versus a comparison to safety net providers.

The recommendations will be refined and expanded in the Department's action plan to be presented to the Joint Budget Committee by November 15, 2022, as required in HB 22-1268. This will include a more in-depth look into the variation in CMHC Base Unit Cost Averages for the larger volume CMHCs. The Department's goal is to continue to use cost-based methodology for safety net behavioral health providers, and the recommendations allow for that to continue in a more equitable and accountable way that benefits patients and providers.

This report follows a number of ongoing efforts for the Department to increase transparency and public reporting in provider costs and payments. Please see the Department's Hospital Report Hub[2] and the Department's Publications Page[3] for more tools and reports on health care costs in Colorado.

[2] https://hcpf.colorado.gov/hospital-reports-hub
[3] https://hcpf.colorado.gov/publications

Background

In 2021 and 2022, the Colorado General Assembly passed a set of historic behavioral health transformation laws, aimed to create a coordinated, cohesive, and effective behavioral health system that improves the lives of all Coloradans. These bills address myriad challenges and provide significant investment in the behavioral health infrastructure and build out access to quality mental health and substance use care for patients and families. Throughout this transformation the Department of Health Care Policy and Financing (the Department) is committed to maintaining transparency and accountability which includes a public report on payment models. The Behavioral Health Provider Rate Comparison Report is an overview of the current state of Medicaid-funded provider reimbursement.

At the time of this report, Health First Colorado is covering 1.65 million people, about one in four Coloradans. The way providers are paid is one of the most important levers to influence the health care system. In order to sustain a behavioral health safety net system, the Department must work with state, federal and community partners to support members, and lead financing strategies that maintain a strong network of quality providers. The state has worked to support safety net providers and provide a more robust and comprehensive set of services, some of which are hard to reimburse directly. This is a key tenant of the Department's responsibilities for Medicaid members and part of the Department's overall strategy to strengthen and expand the safety net, as required by state law and outlined in the 2021 implementation plan[4].

Currently safety net funding is based on statutory direction that pays community mental health centers and clinics in a way that considers the actual cost of services. The intent of safety net payments like these include:

- Support for providers who are engaging in best practices to improve care quality and incentivize those serving publicly funded clients.
- Recognition of costs associated with services that are hard to reimburse for directly, especially for a population that is more likely to be impacted by social determinants of health, like stable housing, food security, reliable transportation, interpersonal violence, and economic opportunity.
- Provision for capacity funding for rural or low volume communities, where there is not enough patient need to sustain a provider business, similar to how other essential services like fire stations are funded.

The state stands behind the need for a cost-based rate setting process for safety net providers. At the same time, this report outlines how the current rate setting process leads to significant variations in

[4] https://drive.google.com/file/d/1Dio5mfPXBkfMR5uDdILPlO11t-aA0aoz/view

payments that are not necessarily connected to the goals of improved access, addressing local need/volume, or improving member outcomes - indicating opportunities to refine the current safety net reimbursement model, most of which are already in process.

One of the bills passed in 2022 was the Behavioral Health Administration bill, HB 22-1278,[5] 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 bill tasked the BHA with collaborating to create new standards for providers and new standards for how providers are paid that consider not just the actual cost of services, but also critical factors such as service quality, access to care, access for priority populations, health equity and expanded use of value-based payments. Value-based payments connect publicly funded providers to flexible payments that reward evidence-based innovations, whole person care, and comprehensive access to care when it is needed.

The rates in this report represent a complex system that is going through significant transformation - a system built on laws that will no longer be in place in the future as previous statutory language is phased out over the next two years. As the Department collaborates with stakeholders, the BHA, and federal partners to expand value-based payments and expand provider networks, the provider payment methods will continue to be an essential lever to influence the system to achieve shared, transformative goals.

The Department considers this report a starting point, and looks forward to partnering with providers, advocates, patients and families, elected officials, and local community partners to improve its payment models to better serve members and sustain a reliable network of quality providers throughout Colorado.

[5] https://leg.colorado.gov/bills/hb22-1278

Introduction

In 2022, the Colorado General Assembly passed House Bill 22-1268 Medicaid Mental Health Reimbursement Rates Report (HB 22-1268),[6] directing the Department of Health Care Policy & Financing (the Department or HCPF) to present a behavioral health rates report and recommendations on Medicaid reimbursement rates for providers in community mental health centers and independent mental health and substance abuse treatment providers. This report meets the requirements of HB 22-1268. The legislation states, "...it is imperative to determine whether a disparity exists, and the reasons for such possible disparities, in Medicaid reimbursement rates among providers of mental health services…" The Department's analysis and recommendations address a variety of questions.

Part 1: Overview of Health First Colorado Behavioral Health Landscape

HB 22-1268 requires a comparison between Community Mental Health Centers (CMHCs) and the Independent Provider Network (IPN) for outpatient behavioral health (BH) services. BH is the broad term used to encompass mental health (MH) and substance use disorder (SUD) treatment such as individual and group therapy. The department has provided information about three key provider types to ensure a full understanding of the scope of services provided to members of Health First Colorado, Colorado's Medicaid Program. Within the broadest definition, where IPN includes all BH services outside of those provided by a CMHC, HCPF has further broken that group into Federally Qualified Health Centers (FQHCs) and then all other IPN providers. This further distinction is essential in understanding each reimbursement methodology for an accurate comparison where possible.

As directed in the legislation, the Department contracted with independent auditors, CBIZ Optumas (DBA Optumas; formerly Schramm Health Partners LLC) and Myers and Stauffer, to perform a BH rates analysis. This report will evaluate only outpatient services[7] and services provided under the Department's managed care delivery system, known as the Accountable Care Collaborative (ACC). BH services paid fee-for-service (FFS) are excluded to reflect the scope of analysis of rates for "...outpatient behavioral health provider[s] enrolled in Medicaid and contracted with a managed care entity…".

This report describes Colorado's current delivery system, as well as the methodologies in place to reimburse each of the three provider types referenced above. An introduction of payment systems in

[6] https://leg.colorado.gov/bills/hb22-1268

[7] Billing and procedure codes specific to inpatient psychiatric hospital and residential services were not included in the scope of this analysis, since this report was only intended to cover outpatient services.

place for the delivery system as a whole and for these specific providers sets the stage for an understanding of the rate comparisons contained in this report. To accomplish the objectives of the project, in Part 2 of this report, Optumas and Myers and Stauffer performed a variety of analyses, including:

1. Comparing rates between years for the same provider type,
2. Comparing rates between the CMHCs and the FQHCs based on average unit cost for a defined set of procedure codes and,
3. Comparing rates between the CMHCs and the non-FQHC IPNs for a defined set of procedure codes.

Though Optumas and Myers and Stauffer performed the analytics described above in Part 2, this report was prepared in collaboration with the Department. Part 1, Overview of the Health First Colorado BH Landscape, and Part 3, Summary, were authored by the Department, with collaborative input offered by Optumas, Myers and Stauffer.

The following provides brief context to the payment structure the Department uses to reimburse BH services and the different types of providers that render these Medicaid-covered services.

Behavioral Health Care Payment Structure

Payment Route 1: Department to Provider, referred to as Fee-for-Service (FFS)

There are limited and defined conditions under which the Department pays providers directly for the provision of BH services, without involvement from a Managed Care Entity (MCE). Examples include services for diagnoses that are not covered under the managed care system, services for members who are not assigned to a MCE, specific BH services which may be provided in a primary care setting (i.e. the Short-Term BH Benefit), screenings, and Medications for Opioid Use Disorder (MOUD) treatment. The FFS utilization comprises approximately 3.9% of the total Medicaid spend for BH services. BH providers who deliver services that fall within this space, and who are enrolled as Medicaid providers, submit claims directly to the Department and are reimbursed according to the FFS Fee Schedule published on the Department's website. For the purposes of this report, these services fall outside of the scope of services defined in legislation and will not be included in analysis or discussion of rate comparisons.

Payment Route 2: The Managed Care Delivery System, referred to as The Accountable Care Collaborative (ACC)

The Department has authority from the Center for Medicare and Medicaid Services (CMS) under a 1915(b)(3) waiver to pay for BH services through a managed care delivery system. The ACC is the managed care system that provides the structure by which health care is provided and paid for in Health

First Colorado. This structure focuses on integrating both behavioral and physical health care to improve member choice and engagement; strengthen coordination of services; pay providers for increased value they deliver; and ensure greater accountability and transparency.[8] The Department contracts with 8 Managed Care Entities (MCEs): 7 Regional Accountable Entities (RAEs) and 1 Managed Care Organization (MCO) [Denver Health Medicaid Choice], to administer, manage and operate the Medicaid capitated behavioral health benefit under the ACC by providing medically necessary covered BH services.[9] These entities are paid under a prospective capitated payment model. Additional information regarding the MCEs is included at Appendix B.

Under the 1915(b)(3) waiver the Department can provide "alternative" services managed through the RAEs. These are called "alternative" services because they are alternatives to inpatient level of care. Alternative services are intended to serve adults with Serious Mental Illness (SMI) diagnoses or children/adolescents with a Serious Emotional Disturbance (SED) diagnosis to keep them supported and living in the community. These services can include Clubhouse, Drop-in Center, Psychosocial Rehabilitation, Assertive Community Treatment (ACT), Intensive Outpatient Psychiatric (IOP), and Day Treatment services, to name a few. Alternative services are BH services not included in the State Plan. However, each State must ensure that all BH services covered under the State Plan are available and accessible to enrollees of the 1915(b)(3) waiver program. State Plan BH services include Inpatient Psychiatric Hospitalization, Inpatient (Hospital and Residential) SUD services, and Outpatient BH services for both MH and SUD diagnoses.

Behavioral Health Care Providers

BH 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 a "safety net of services" are provided in each region. Each MCE is responsible for establishing a network of BH providers in their region to serve the BH needs of their members. These networks must include both safety net providers and a range of additional group and individual providers, referred to as Independent Provider Network (IPN) providers. Within each provider type there is a wide variation in size, location, services delivered, and business models. Having a clear picture of these variables is fundamental to understanding how rates for providers are set.

[8] Colorado Department of Health Care Policy & Financing. (2020). *Accountable Care Collaborative*. HCPF Website. https://hcpf.colorado.gov/accphase2

[9] Rocky Mountain Health Plans (RAE 1) also operates an MCO called PRIME, which offers only physical health services.

Community Mental Health Centers (CMHCs)

Community Mental Health Centers (CMHC) are institutions that provide BH services and are designated by the BHA. CMHCs operate under section 27-66-101, C.R.S., to provide BH inpatient, outpatient, partial hospitalization, emergency, and consultative and educational services to Coloradans. These requirements are intended to ensure that CMHCs are prepared to deliver services at all times, despite significant fluctuation and variability in demand. CMHC are required to serve as "safety net" providers and are the primary providers for "Alternative" services mentioned above. Although the scope of this report is focused on outpatient services, the rates for CMHCs that will be described later in the report are rooted in this requirement to serve all members in their region and to provide all levels of care.

Independent Provider Network

Per Legislation, 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." The Department has determined that it would be most appropriate to separate Federally Qualified Health Centers from this group due to the distinctly different services provided and federal requirements imposed by this designation.

Federally Qualified Health Centers (FQHCs)

FQHCs are community-based health care providers that receive funds from the federal Health Resources and Services Administration (HRSA) Health Center Program to provide primary care services in underserved areas. They must meet a stringent set of requirements, including providing care on a sliding fee scale based on ability to pay and operating under a governing board that includes patients.[10]

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.[11]

FQHCs may enroll with Colorado Medicaid to receive reimbursement for services provided to Health First Colorado members. Though FQHCs were originally formed to provide primary care services (outpatient physical health care), FQHCs may also deliver dental and BH services. FQHCs provide services to persons of all ages, regardless of their ability to pay or health insurance status.

[10] https://www.hrsa.gov/opa/eligibility-and-registration/health-centers/fqhc/index.html
[11] Ibid.

Other Non-FQHC Independent Provider Network (IPN) Providers

The Non-FQHC IPN providers include everything from a single licensed BH provider (i.e. Licensed Clinical Social Worker or Licensed Psychologist) with an independent solo practice, as well as larger organizations with multiple sites across a region or the state. 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 Health First Colorado members up to the level they are licensed to provide. IPN providers are not statutorily obligated to provide the entire array of BH services required of CMHCs or FQHCs.

IPN providers are paid by an MCE based on individual contracts that identify the services (and/or service codes) that can be billed and the agreed-upon rate for each service/code. Similar to the CMHCs and FQHCs, the IPN can negotiate rates with an MCE. However, annual cost reports are not used to establish provider-specific reimbursement. Analysis of rates growth over time, and trends in IPN units and average payments are addressed in Part 2 of this report.

Behavioral Health Safety Net in Colorado

Need for Safety Net Payments

Historically, government funded health insurance programs like Medicare and Medicaid have relied on an infrastructure of physical and behavioral health clinics and critical access hospitals to provide a safety net for underfunded geographies, uninsured and underinsured populations, and individuals and families who are covered by public health programs. State, federal and local grants, specialty payments, and specially calculated cost-based rates in Colorado and nationally help these providers keep their doors open and serve low-income and higher need populations. In BH, these cost-based rates for safety net providers have primarily been used to set reimbursement for CMHCs and FQHCs. The rates are also inclusive of some care-related costs that are hard to reimburse for directly but are necessary to support Medicaid populations. Medicaid members as a population are more likely to need social supports and are more likely to face structural barriers to health based on disability status, race, gender, income, education, age, LGBTQ+ status, or other intersecting forces.

BH safety net providers also see a very high number of publicly funded clients. Other practices and independent providers may be enrolled in Medicaid, but only accept a small number of Medicaid clients, supporting their business with more commercially covered clients or by having clients pay cash for treatment. Safety net providers are seeing a very small percentage of commercially insured patients and are designed to specifically serve individuals who qualify for public assistance programs due to a low household income or disability.

What Safety Net Payments Fund

The Department supports the use of cost-based reimbursements to determine safety net provider rates. The safety net payments reflect not only the billable and other critical support services provided and also additional costs needed for sustainable operations. The Department also supports cost-based methodologies to establish reimbursement rates for rural hospitals, rural health centers (clinics), and FQHCs. In parallel, Medicare also uses cost reports for hospitals to set rates and consider allowable costs, inflation, and regional market costs related to salary, office space, etc. In the future, based on the changes made through the BHA bill, cost-based safety net funding will be allowed for all BH providers who qualify as safety net providers and agree to the related contractual terms. Below are some examples of types of patient-centered, whole person care that increase the cost of operations to CMHCs, thereby increasing their cost-based reimbursements compared to independent providers who do not provide these services.

- **Serving clients with criminal justice involvement**. When individuals with serious substance use and mental health disorders don't receive the care they need, they may end up in the criminal justice system. This may be due to expressions of their illness or acute intoxication or the use of illegal substances. Many safety net providers work to develop strong relationships with law enforcement and the court system so they can advocate for their clients to be treated in the community and avoid incarceration. This includes specific staff that go to hearings, help clients find a lawyer, conduct and share evaluations, and build relationships with the law enforcement programs to divert people from criminal justice and into treatment.
- **Family services for children with complex needs.** When an organization provides outpatient family services for a child at risk of out of home placement, there are many extra steps and supports beyond individual or family therapy. This circumstance often requires the safety net providers to build relationships and formal agreements with counties and schools, participate in related court proceedings, provide in-home services where drive time is not covered, and be available to help the parents learn how to best support their child. For children and adults that have conditions that involve outbursts or fits, there are important safety precautions needed for the in-home providers and for the family. Intermittent hospital stays for behavioral or physical health reasons require significant coordination with payers, hospital clinical staff, administrators, discharge planners, the family, and other members of the care team. Safety net, cost-based payments help provide flexible funding to organizations that treat patients with these types of complex needs.
- **Recovery services.** Most people with substance use disorder spend a small fraction of their lives in treatment and a very large part of their lives in recovery. Maintaining recovery requires a different set of services than treatment, including supports like recovery housing (i.e. Oxford house or sober living homes), recovery coaching, sober events, and other efforts that build community. Such supports are often essential for maintaining sobriety. Providing these services requires hiring and training individuals with lived experience, paying for community events, community outreach teams, on-call supports, and more.

- **Rural Access Challenges**. For Medication Assisted Treatment, clients need to take a dose every day to prevent craving, withdrawal symptoms, and maintain recovery from opioid use disorder. These medications are tightly controlled by federal and state agencies and must be administered and stored in a way that prevents misuse and diversion. In a mountain town, during uncertain weather, this may require special supports in which transportation, telehealth, formal agreements with local pharmacies, and significant time for documentation for any special circumstances related to dispensing critical medication.
- **Changing technology for better access.** During COVID, many safety net provider organizations had to rely heavily on telehealth to continue care for their clients. For social and geographic reasons, clients may not have had the right equipment or environment to participate. Many CMHCs paid for hot spots, cell phones, and tablets for clients to ensure connections with their clinical team.
- **Serving New Americans**. In addition to providing clinical care, safety net providers serving individuals new to the U.S., through immigration and/or refugee pathways, must help clients navigate across an unfamiliar community, possibly an unfamiliar language, and through systems of care that are unfamiliar. This includes connection with the local food pantry, how to access translation support, taking clients to pick up prescriptions, support them with making appointments with other providers, and connecting them with the community. In one agency, parents are connected with a newcomer support group and children are offered a 14-week trauma informed age-appropriate group to process the acculturation and experience of their immigration.
- **Outreach teams and community-based care models**. One of the essential ways that a provider team can connect with clients facing social barriers to care like unstable housing, homelessness, or lack of transportation, is to meet them in the community and provide drop-in locations for these clients to connect with clinical and social resources. Street outreach teams support new and existing clients while drop-in centers provide community supports that are essential to a client's well-being.

Different from Medicaid independent providers, the above represents just some of the services that cost-based safety net payments help support, often for Medicaid clients with the most complex and seriously illnesses. So, a rate paid by Medicaid for one hour of therapy at a safety net provider is actually representative of additional funding necessary to finance a number of appropriate wraparound and social services that care for and help keep those with the highest needs healthy and connected to care.

Expanding and Strengthening the Safety Net

In 2019, the Colorado General Assembly passed Senate Bill 19-222, "Individuals at Risk of Institutionalization." This required the Department to work with the BHA to develop a plan to strengthen and expand the safety net. In 2021, the Departments jointly published the "Comprehensive Plan to Strengthen and Expand the Behavioral Health Safety Net System",[12] which included specific recommendations on payments for the safety net.

While the departments identify elements of cost-based models that should be preserved, there is a clear recognition of additional and necessary accountability components connected to these higher payments. Specifically, SB 19-222 requires that the Colorado BH Safety Net System must:

- Proactively engage "hard-to-serve" individuals with adequate case management and care coordination throughout the care continuum
- Utilize adequate networks for timely access to treatment including high-intensity behavioral health treatment and community treatment for children, youth, adults, and other individuals
- Require collaboration with all local law enforcement and counties in the area
- Triage individuals who need alternative services outside the scope of the safety net system
- Promote patient-centered care and cultural awareness.

As outlined in the plan, safety net BH services need to be reimbursed in a way that is sustainable and recognizes the complexity of the population served, to encourage services like those listed above. The payment model should incentivize increased access, more equitable care models, and be more inclusive of small and medium sized community-based providers that are providing safety net care. The cost-based payment model that has been in place through Medicaid and BHA during the creation of this report did not take into consideration access, equity, or quality of services.

The cost-based model has been traditionally only available to a small set of providers comprised of 17 CMHCs (18 going forward). Changes to the system, outlined in Part 3, seek to protect the need for safety net funding but improve the way the State determines or calculates those respective cost-based rates and to expand the number of safety net providers with access to them. This includes improving the cost reports that determine the cost-based reimbursements, allowing for greater flexibility of funds, connecting the funding to outcomes to build accountability, and expanding the number of providers able to access these funds thereby creating competition and choice across geographies. Some of the changes needed, like modernized legislative definitions and updates to cost-reporting standards, are already underway. The changes will take time but will create a more appropriate difference between the Medicaid reimbursements to independent providers and the safety net providers. That said, one conclusion of this report is that the Medicaid reimbursements to independent providers will never be as high as the safety net providers because the independent providers are not paid on a cost-plus basis, do

[12] https://drive.google.com/file/d/1Dio5mfPXBkfMR5uDdILPlO11t-aA0aoz/view

not provide the same complexity of services required of safety net CMHC providers, nor do they have the same costs, nor do they see the same volume of high acuity patients as the CMHC safety net providers. The new provider definitions create an opportunity for small, medium, and specialty clinics that are truly providing safety net services, including whole-person team-based care, to participate in safety net reimbursement rates and related reporting as an “essential behavioral health safety net provider.” Currently, these agencies providing that higher level of support and care, but not at a CMHS level, are considered part of the Independent Provider Network.

Part 2: Behavioral Health Rates Analysis

The Department engaged Optumas to perform a comparison of Colorado Medicaid BH reimbursement rates across differing provider types, and to investigate the sources of variation in rates. Optumas partnered with Myers and Stauffer, LC on this project to leverage the unique expertise each organization possesses with the Health First Colorado (Colorado's Medicaid program) BH service delivery system.

Methodologies for Establishing Rates

CMHCs, FQHCs, and non-FQHC IPN providers can be paid through the MCEs or directly by the Department to provide care for Health First Colorado members. The procedure for determining how much a given provider may receive for a procedure varies depending on (1) the provider type and (2) the funding stream. Specifically, for outpatient services, these providers are paid:

- **CMHCs -** Via a unit cost derived from an annual cost report.
- **FQHCs -** Via an encounter rate derived from an annual cost report.
- **Non-FQHC IPN Providers -** Via negotiated rates.

Capitation Rate Development Overview

Capitation rates are a comprehensive risk contract that requires the RAEs to provide all covered BH services, unless explicitly excluded from the RAE contract. RAEs receive payment from the Department on a fixed per-member-per-month (PMPM) basis that is stratified by rate cell (aid category). Under the Federal and State regulations, the capitation rate must be developed and adhere to the actuarial principles and practices and certified by qualified actuaries.

Community Mental Health Centers

CMHCs can be paid either by a RAE (through capitated BH care funding) or directly by the Department (for FFS and specific codes; refer to *Behavioral Health Care Payment Structure*). The methods for determining the rates have been established by Department policy, legislation, and federal policy. State statute at section 25.5-4-403, C.R.S. obligates the Department to reimburse CMHCs for allowable costs, as CMHCs are required to maintain an infrastructure to provide an array of services that IPN providers are not required to offer – as explained in the section above. Additional information regarding the services provided by CMHCs may be found at Appendix C.

Allowable CMHC costs include direct and indirect expenses associated with programs and teams providing behavioral health services, such as personnel costs, client-related costs, occupancy costs, operating costs, depreciation and amortization, and professional fees. CMHC costs are reported annually

on the Colorado Unit Cost Report (CMHC Cost Report), which accumulates allowable costs and units of service provided to calculate the CMHC-specific Base Unit Cost (BUC). Details regarding the CMHC Cost Report and unit cost methodology can be found in Appendix D.

The RAEs contract with CMHCs to deliver services to Health First Colorado members. Contracted rates may come in varying forms, but there is no involvement by, or obligation of, the Department in the negotiation process. Ultimately, the negotiated rates in a managed care model are proprietary and disclosure of them violates Fair Trade laws. Capitated rates for the RAEs are set in part based on the BUC calculated by the cost reports. As a result, the analysis contained herein is based upon BUC figures from the CMHC Cost Reports (unless otherwise noted).

Federally Qualified Health Centers

FQHCs are paid by the RAEs for specialty behavioral health (SBH) visits of Health First Colorado members; similar to the CMHCs, the methods for determining the rates paid for SBH visits have been established by Department policy, legislation, and federal policy.

FQHC costs and visits are reported annually on the Colorado Medicaid FQHC Cost Report (FQHC Cost Report), which establishes allowable costs for purposes of calculating three per-visit, cost-based encounter rates: physical health rate, dental health rate, specialty behavioral health (SBH) rate. Details regarding the FQHC Cost Report and FQHC rate setting methodology can be found in Appendix E.

The RAEs contract with the FQHCs to establish rates for SBH visits. The RAEs are required, per CMS, to pay at least the SBH rate to FQHCs for these visits but may negotiate higher rates. Thus, the SBH rate serves as a floor for rate negotiations between the FQHCs and the RAEs.[13] Similar to the CMHCs, the analysis is based upon SBH encounter rates from the FQHC Cost Reports (unless otherwise noted) as a proxy in recognition that the actual negotiated rates vary by RAE and FQHC.

Other Non-FQHC Independent Provider Network (IPN) Providers

The RAEs are required to establish a state-wide BH network via contracts with the non-FQHC IPN providers, which is not limited by geographic or regional location, to deliver behavioral health services to Health First Colorado members. Unlike the CMHCs, the non-FQHC IPN providers are not statutorily obligated to provide the suite of services described in Appendix C, nor do they report costs and encounters in an annual cost report.

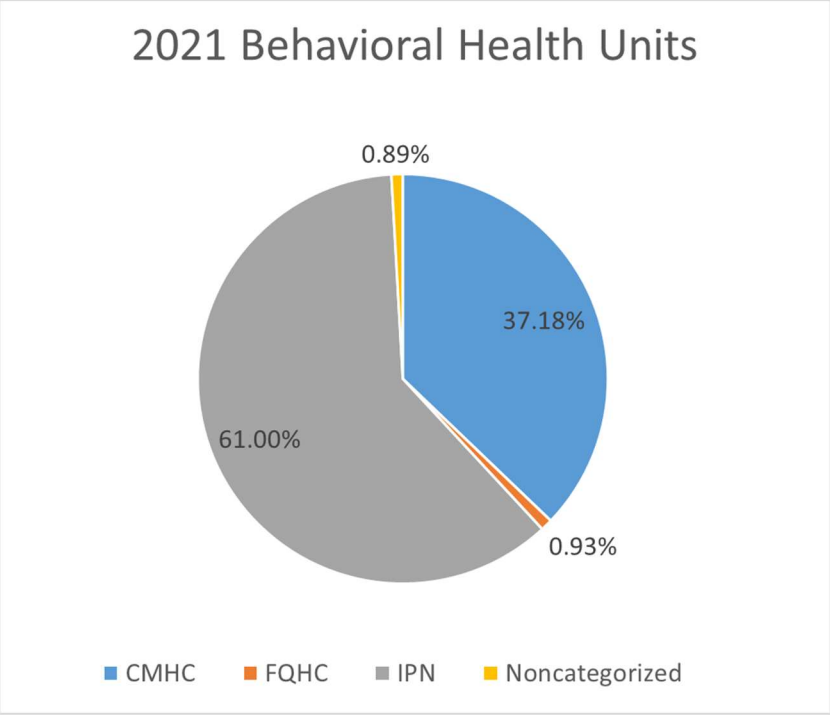
Contracted rates with non-FQHC IPN providers may come in varying forms, including fee schedules or percentage-adjusted fee schedules (for example, in areas where BH providers are few), sub-capitated

[13] Higher rates may be negotiated when prospective payment methods are used, as is the situation when capitation rates drive negotiated rates.

PMPM arrangements, or encounter rates. The negotiated rates inherent in the paid encounters from the RAEs were aggregated for this analysis.

Across the BH capitation program, the services are provided by many different provider types. In this report, the Department is only considering specific services in an outpatient setting as provided by the above provider types. For historical trends of utilization and costs, the Department is using a full set of utilization and cost information as this is how the CMHC and FQHC base costs are built. For the services considered for direct comparison of the CMHC and non-FQHC IPN providers in the following analysis, the breakout of utilization per provider type is illustrated in Figure 1. The reader will note the low volume of FQHC utilization. This is simply a function of the services outlined in the legislation to be compared, which excludes BH services provided by the FQHCs that do not fall under the managed care BH capitation. The below chart is not representative of the actual percent of BH services provided to Medicaid members by FQHCs.

Figure 1: Behavioral Health Units by Provider Type.



Rate and Utilization Trends

Trends in rates and units of service provided over the past several years were analyzed for each provider type, to identify rate and utilization fluctuations and to explore the catalysts for the fluctuations

observed. The CMHC unit costs and non-FQHC IPN rates were compared by procedure code. Also, the CMHC average unit cost and FQHC average unit cost were compared.

CMHC Trends

There are two elements of utilization that were analyzed for the CMHCs:

- **Units of Service Provided**
  The units of service provided represent the actual number of services provided during the period. However, this figure is not reflective of the resources or effort required to provide the services.

- **Relative Value Units (RVUs)**
  The relative value units (RVUs) intend to reflect the relative resources required to provide behavioral health services. RVUs are calculated by multiplying the number of units provided for a specific service by the associated RVU weight (see Appendix D).

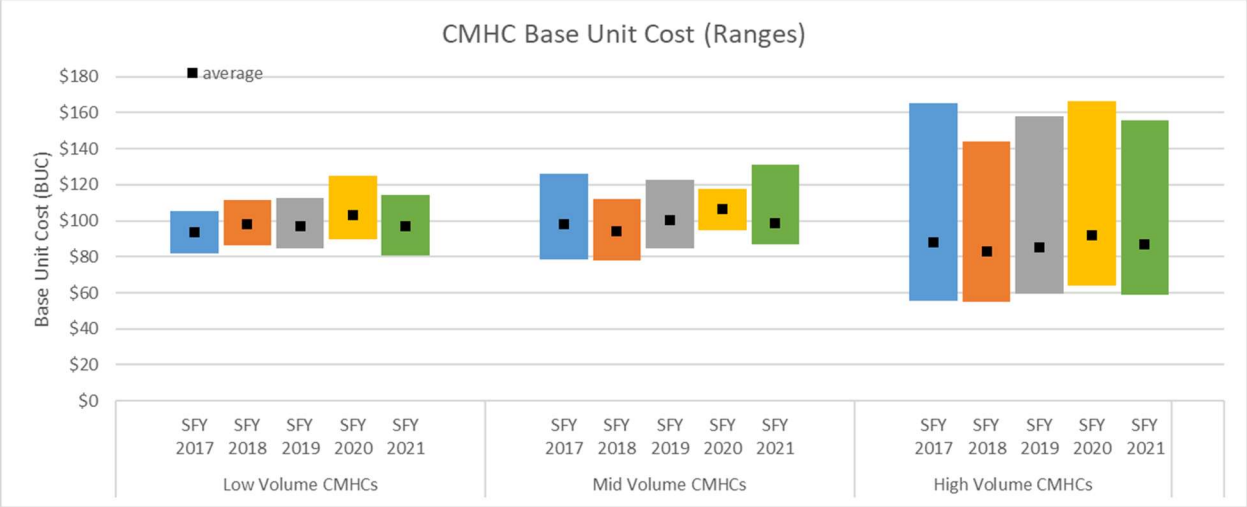
The CMHC providers were grouped into one of three buckets (identified below) for purposes of the trend analysis, based on the total number of Relative Value Units (RVUs, described in Appendix D) provided during SFY 2021. Results of the analyses performed are grouped as such.

1. Low Volume CMHCs (less than 200,000 RVUs - six CMHCs fell into this group)
2. Mid Volume CMHCs (between 200,000 and 400,000 RVUs - six CMHCs fell into this group)
3. High Volume CMHCs (more than 400,000 RVUs - five CMHCs fell into this group)

Base Unit Cost Trends

The unit cost for a service provided at a CMHC is dependent upon the Base Unit Cost (BUC), as described previously. The BUCs for SFY 2017 through SFY 2021 were accumulated based on the CMHC groupings previously identified. The range and median for each group and fiscal year are illustrated in Figure 2.

Figure 2: CMHC Base Unit Cost Averages and Ranges



The BUC is calculated for each CMHC by dividing the total allowable costs of providing RVU services by the total number of RVUs provided; thus, the BUC can be affected positively or negatively by changes to one or both components of the calculation. The BUC trend analysis shows fairly consistent BUCs between state fiscal years for the low and mid volume CMHC groups. The BUC can vary significantly between individual CMHCs due to several factors, such as cost of labor, geographic area, center size and efficiency, differences in cost report preparation methods, differences in types of BH services provided, and differences in member needs.

There are two additional mitigating factors that impacted the BUC calculation in the past few years:

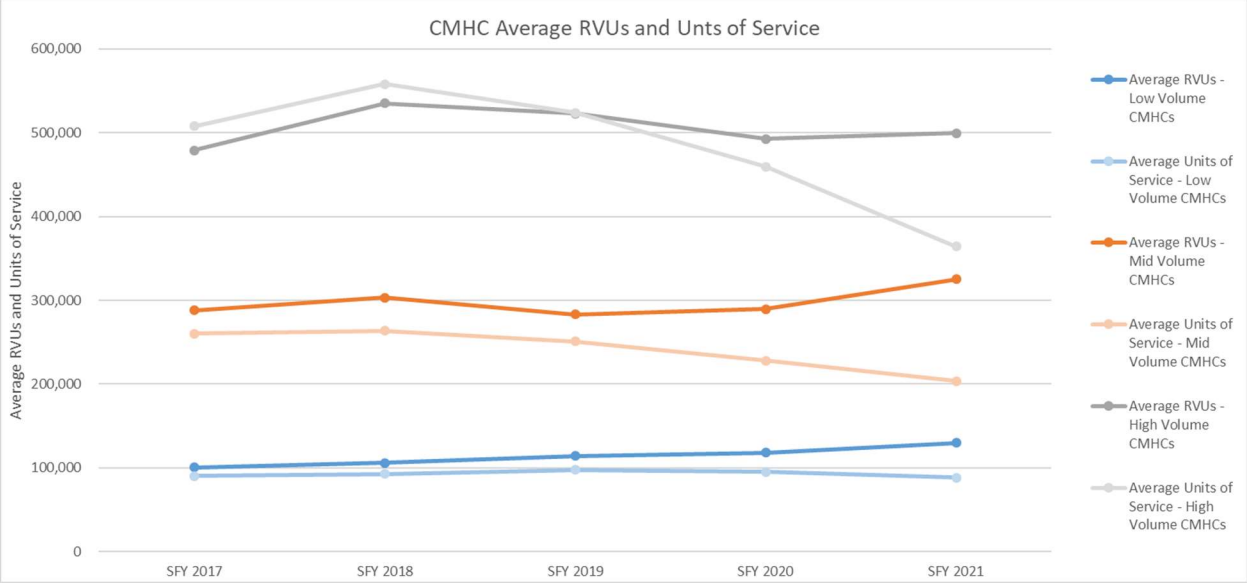
1. **The COVID-19 Pandemic**
   Due to the COVID-19 pandemic, allowable costs either remained stable or increased for most CMHC providers who were purchasing personal protective equipment, compensating for employee hazard pay, and implementing telehealth while utilization decreased due to closures, causing an increase in BUCs.

2. **Changes to the RVU Weights**
   During SFY 2021, CMS increased the RVU weights associated with many of the services provided by the CMHCs, causing a decrease in average BUC for the CMHCs.

Utilization Trends

The total units of service provided and the total RVUs for SFY 2017 through SFY 2021 were accumulated based on the CMHC groupings previously identified. The median for each group and fiscal year are illustrated in Figure 3.

Figure 3: CMHC Average RVUs and Average Units of Service



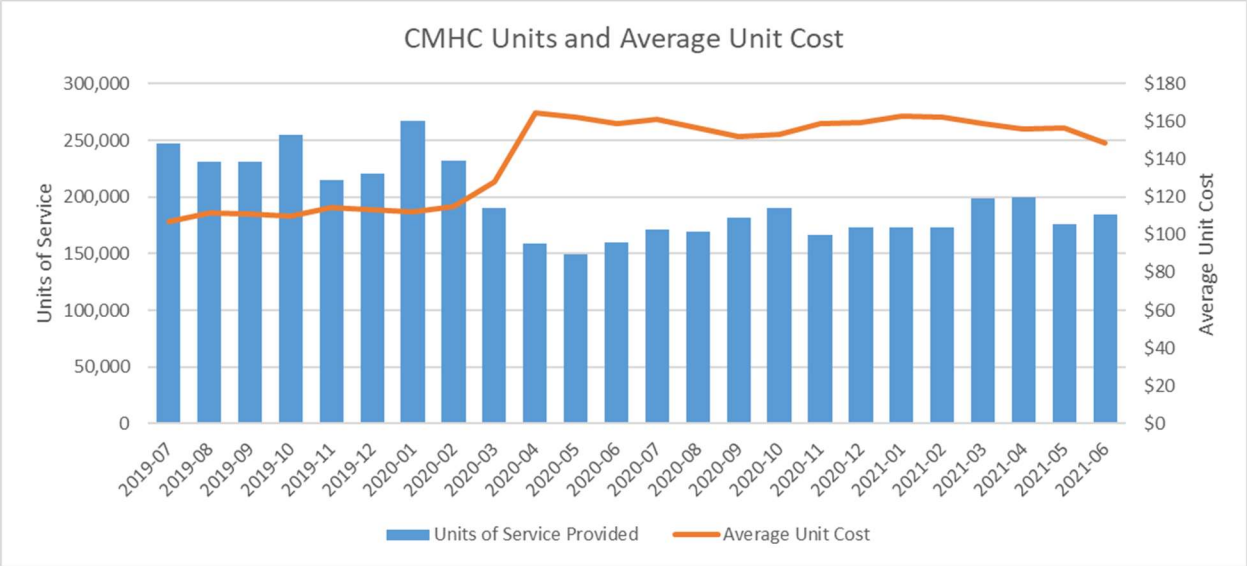
There has been a steady decline in average units of service provided since SFY 2018 for all three CMHC groups, most significantly reflected in the high-volume group. However, the same is not true for the total RVUs; specifically, there was an increase in RVUs between SFY 2020 and SFY 2021 for all three CMHC groups. This increase primarily resulted from the increase in RVU weights, as previously discussed. This means that while units of service declined, the higher RVUs would have the effect of lowering the BUC, and therefore the rates, for a CMHC.

Medicaid Utilization

The CMHC Medicaid utilization for SFYs 2020 and 2021 was analyzed to identify trends in the units of service provided and the average unit cost for Medicaid services provided. The average unit cost was calculated by dividing the total Medicaid payments from the RAEs to the CMHCs by the total units of service provided to Medicaid members. See Figure 4.[14]

[14] Figure 4 only includes the most common outpatient BH encounter codes that can be used by all providers (for both MH and SUD diagnoses) analyzed in this report. These codes are described on page 28.

Figure 4: CMHC Units of Service Provided and Average Base Unit Cost



There was a decline in units of service provided between Q3 and Q4 of SFY 2020, the timing of which correlates to the onset of the COVID-19 pandemic. The corresponding increase to the average unit cost at that same time is related to the increased costs and reduced utilization associated with the pandemic, as described above.

FQHC Trends

FQHC rates are effective 120 days after the FQHCs fiscal year ends, which does not correlate with the state fiscal year.[15] As a result, for purposes of this analysis, SBH rates were grouped into the state fiscal year in which each rate period best aligned.

FQHCs were grouped into one of three buckets based on the total number of specialty behavioral health visits in SFY 2021:

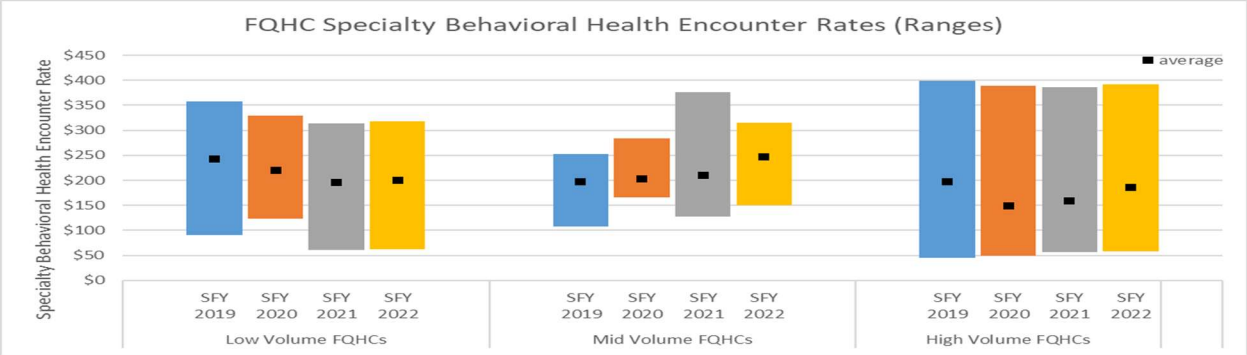
1. Low Volume FQHCs (less than 4,000 visits - eight FQHCs fell into this group)
2. Mid Volume FQHCs (between 4,000 and 15,000 visits - six FQHCs fell into this group)
3. High Volume FQHCs (more than 15,000 visits - six FQHCs fell into this group)

[15] A "late submission penalty" may be assessed to delay the FQHC's rate effective date, due to delinquent cost report submission.

Specialty Behavioral Health Encounter Rate Trends

The specialty behavioral health (SBH) encounter rates for SFY 2017 through SFY 2021 were accumulated based on the FQHC groupings previously identified. The range and median for each group and fiscal year are illustrated in Figure 5.

Figure 5: FQHC Specialty Behavioral Health Median Encounter Rates and Rate Ranges



The SBH rate trend analysis shows fairly large ranges for all three FQHC groups. However, the high-volume group generally has a lower average SBH rate than the low and mid volume groups and includes the statewide lowest and highest SBH rate for every year analyzed.

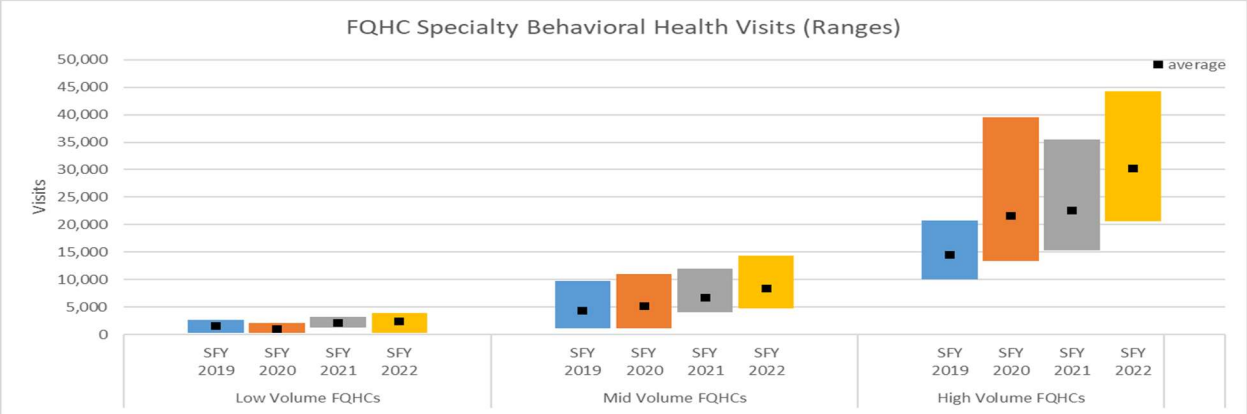
Average SBH rates increased in SFY 2022 for all three groups, but most especially in the Medium and High Volume FQHCs. This is primarily due to COVID-19 inflationary adjustments applied to "pre-COVID-19" SBH rates to set 2022 rates.

Utilization Trends

The total SBH visits for SFY 2019 through SFY 2022 were accumulated based on the FQHC groupings previously identified. The range and median for each group and fiscal year are illustrated in Figure 6.

The average SBH visits have trended upwards over the past few years for all three FQHC groups, but most especially for the Medium and High Volume FQHCs. Similar to the trends for the CMHC units of service provided, the ranges for SBH visits increase in size between FQHC groups and are most significant for the high-volume group.

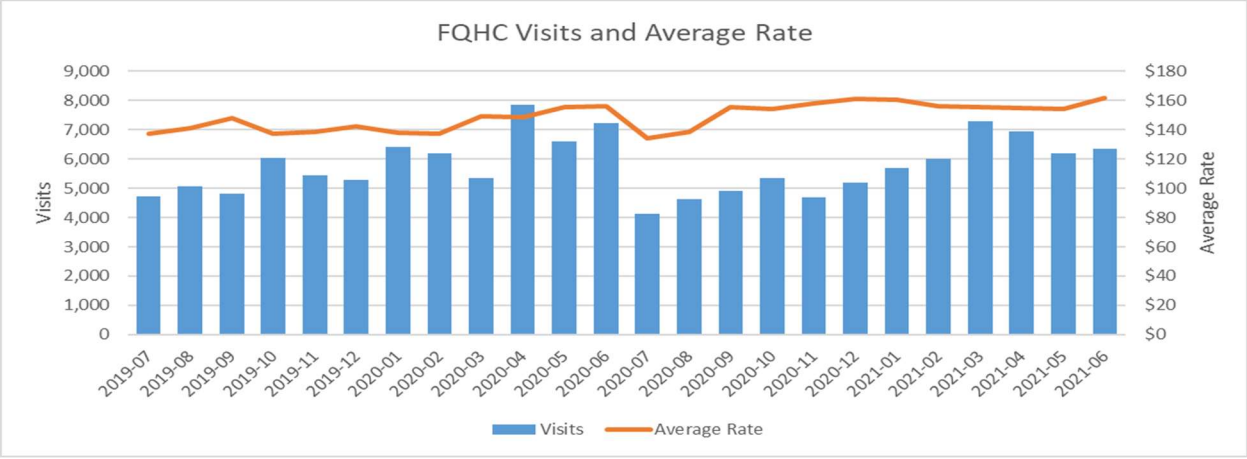
Figure 6: FQHC Specialty Behavioral Health Median Visits and Visit Ranges



Medicaid Utilization

The FQHC Medicaid utilization for SFYs 2020 and 2021 was analyzed, to identify trends in the units of service provided and the average rate for Medicaid services. The average rate was calculated by dividing the total Medicaid payments to the FQHCs by the total SBH visits provided to Medicaid members. See Figure 7.[16]

Figure 7: FQHC Visits and Average Rate



There was a significant increase in visits provided in the second quarter of 2020, the timing of which correlates to the onset of the COVID-19 pandemic. However, there was a corresponding decrease in the third quarter, which seems to align with the downward trend in utilization seen by the CMHC

[16] Figure 7 only includes the most common outpatient BH encounter codes that can be used by all providers (for both MH and SUD diagnoses) analyzed in this report. These codes are described on page 28.

population. Since that time, there has been an overall increasing trend in SBH visits. The average SBH rates have remained fairly consistent, except for a drop during June and July 2020.

Non-FQHC IPN Provider Trends

Behavioral health payments made by the RAEs to non-FQHC IPN providers for outpatient claims occurring between SFYs 2019 and 2021 were analyzed to identify trends. The analysis included consideration of the Third-Party Liability (TPL) payments, to estimate total reimbursement received by the provider for behavioral health services provided. SUD payments are included in this analysis but are not broken out separately. In recognition of safe harbor requirements, requiring that protected health information not be identifiable due to small sample size, the SUD payments could not be separated out due to the low proportion of services within the analysis.

Payments that occurred in a non-facility setting were isolated to evaluate year-over-year trends.

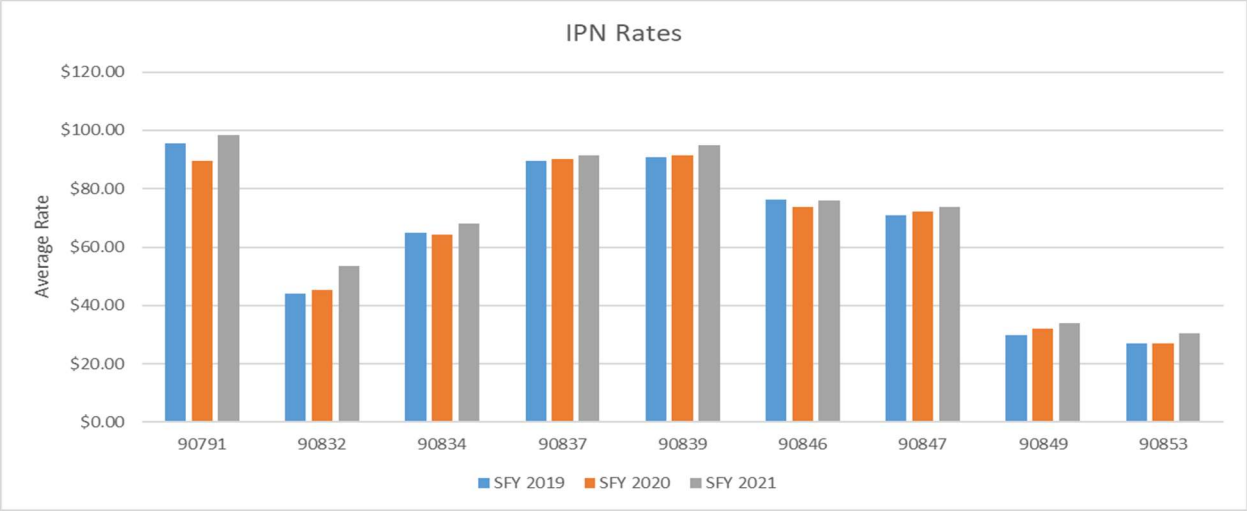
Rate Trends

Specific outpatient BH procedure codes were selected for the non-FQHC IPN rate analysis, based on relevancy to commensurate services provided by the CMHC providers. The selected codes are the most common outpatient BH encounter codes that can be used by all providers (for both MH and SUD diagnoses) analyzed in this report. This selection of BH procedure codes is used later in this report to compare non-FQHC IPN provider rates to CMHC provider rates. The nine codes below, selected for analysis represent those services most heavily utilized:

- **90791** – Psychiatric Diagnostic Evaluation
- **90832** – Psychotherapy with Patient – 30 minutes
- **90834** – Psychotherapy with Patient – 45 minutes
- **90837** – Psychotherapy with Patient – 60 minutes
- **90839** – Psychotherapy for Crisis – Initial 60 minutes
- **90846** – Family Psychotherapy without Patient – 50 minutes
- **90847** – Family Psychotherapy with Patient – 50 minutes
- **90849** – Multiple Family Group Psychotherapy
- **90853** – Group Psychotherapy

The total Medicaid payments for SFY 2019 through SFY 2021 were accumulated based on procedure code from the RAE encounter extract, and then divided by the total number of services provided for the code to estimate the average rate paid. The average rates for each procedure code and fiscal year are illustrated in Figure 8. Note the last two codes are for group services, so are lower than individual care services.

Figure 8: IPN Average Rates by Procedure Code

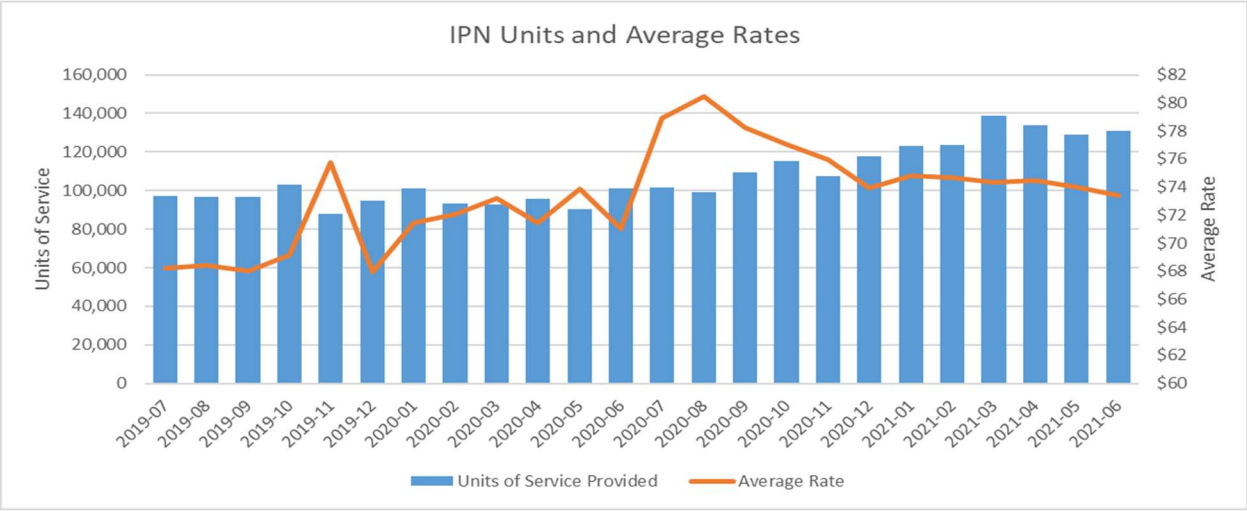


There were generally minimal changes in non-FQHC IPN average rates between years at a procedure code level. All codes indicate an increase in average rates in SFY 2021, but the magnitude is not significant. These average rates are compared to the CMHC rates for the same procedure codes later in this analysis.

Utilization Trends

Total Medicaid units of behavioral health services provided by non-FQHC IPN providers for SFY 2020 through SFY 2021 were analyzed to compare the number of units of service provided (the utilization of services) to the average payment for Medicaid recipients. See Figure 9.

Figure 9: IPN Units of Service and Average Rates



The average rates for non-FQHC IPN providers spiked during November 2019 and August 2020; however, in both instances the average rates declined quickly and were fairly steady during the last seven months of the period. Total units of service provided were stable but have steadily increased during that same time period. The average rate spike in July and August 2020 is most likely the result of a differing mix of services provided in response to the needs of the pandemic. Further research would be needed to determine the exact causes.

Rate Comparisons

In accordance with Legislation, the CMHC unit costs were compared to the two IPN provider groups, as follows:

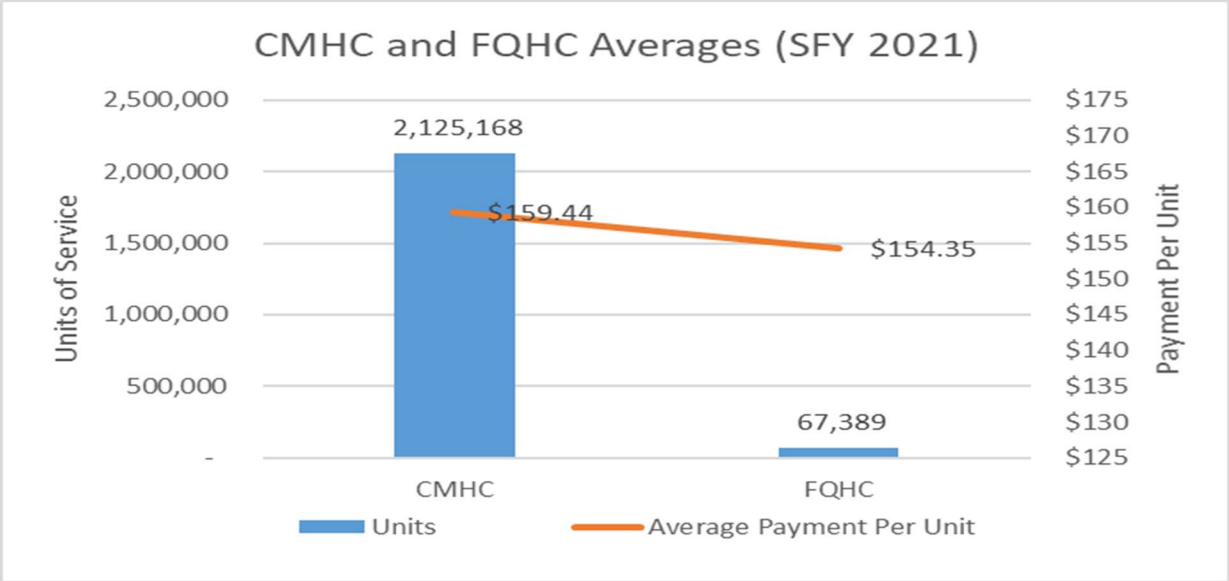
1. CMHC average payments compared to FQHC average rates
2. CMHC unit costs compared to non-FQHC IPN provider rates

CMHC Average Payment Compared to FQHC Average Payment

The variance in the average CMHC BUC and the average FQHC SBH rate was initially analyzed for SFY 2021 to identify the trends and assess the cause of the variances. However, the rate setting and reimbursement methodologies for these two provider types is vastly different, which complicates such a comparison. Though both figures are calculated via an annual cost report, the services provided, allowable costs, and resulting calculations are not fully aligned.

For this analysis, the average unit cost for CMHCs and FQHCs were calculated from the SFY 2021 cost reports (or the cost reports which were best aligned with this period). Similarly, the average CMHC total units and average FQHC SBH units were accumulated from the cost reports. See Figure 10.

Figure 10: CMHC and FQHC Units and Average Payment per Unit



The above analysis confirms that (on average) the CMHCs have significantly more behavioral health units than the FQHCs, which is expected considering the primary business operations of FQHCs expand beyond behavioral health. CMHCs and FQHCs are paid approximately the same amount for each unit of service billed (within about 3% of each other). Due to the varying rate setting methods (negotiations with the RAEs), covered services, and rate calculations, this analysis is comparing calculated rates rather than actual reimbursement. It does find, however, that rates derived using cost-based reporting are more closely matched than cost-based rates compared to negotiated rates.

CMHC Unit Costs Compared to Non-FQHC IPN Rates

The variances in amounts paid to the CMHC providers and the non-FQHC IPN providers were analyzed for a select group of procedures codes from SFYs 2019 through 2021 to identify the trends and assess the cause of the variances. However, the rate setting and reimbursement methodologies for these two provider types are vastly different, which complicates such a comparison and produces results that can be misinterpreted.

- **CMHC Unit Cost Methodology**
  CMHC unit costs are established based on an RVU methodology and BUC calculation that encompass the allowable costs associated with all behavioral health services provided (not just the isolated behavioral health service for which the procedure code is evaluated). The allowable costs included in the BUC are related to a set of services that CMHC providers are statutorily obligated to provide (which IPN providers are not), as well as indirect and overhead costs

associated with CMHC operations. Details regarding this methodology, required CMHC services, and allowable costs can be found in Appendix C and Appendix D.

- **Non-FQHC IPN Rate Setting Methodology**
  Non-FQHC IPN rates are based on proprietary negotiated rates with the RAEs, as is customary in managed care models. The types of services and costs included in the BUC calculation for CMHCs are likely not considered in the negotiated non-FQHC IPN rates.

The first step in the analysis included an evaluation of average rates paid to the non-FQHC IPN providers for all procedure codes; this step was supplemented with a summary of units and total amount paid for non-FQHC IPN claims in SFY 2020. The results of this evaluation were used to identify the cohort of procedure codes that represented the bulk of Medicaid spending and units for non-FQHC IPN providers. As referenced previously, the nine codes below represent those services that were utilized most heavily:

- **90791** – Psychiatric Diagnostic Evaluation
- **90832** – Psychotherapy with Patient – 30 minutes
- **90834** – Psychotherapy with Patient – 45 minutes
- **90837** – Psychotherapy with Patient – 60 minutes
- **90839** – Psychotherapy for Crisis – Initial 60 minutes
- **90846** – Family Psychotherapy without Patient – 50 minutes
- **90847** – Family Psychotherapy with Patient – 50 minutes
- **90849** – Multiple Family Group Psychotherapy
- **90853** – Group Psychotherapy

The CMHC average unit costs for the selected procedure codes were compared to the average rates paid to the non-FQHC IPN providers for the same procedure codes. The results of this comparison are presented in Figure 11 and Figure 12. Figure 11 represents the 30-minute and 45-minute codes as well as the group therapy codes. Figure 12 represents the remaining 50-minute and 60-minute codes as well as the diagnostic evaluation code. As this report has explained, the below comparison does not fairly represent the costs borne by the safety net which are covered through the below reimbursements. Therefore, the comparison by codes is not an appropriate or “apples to apples” comparison.

Figure 11: Average CMHC Unit Cost and IPN Rate Comparison by Procedure Code

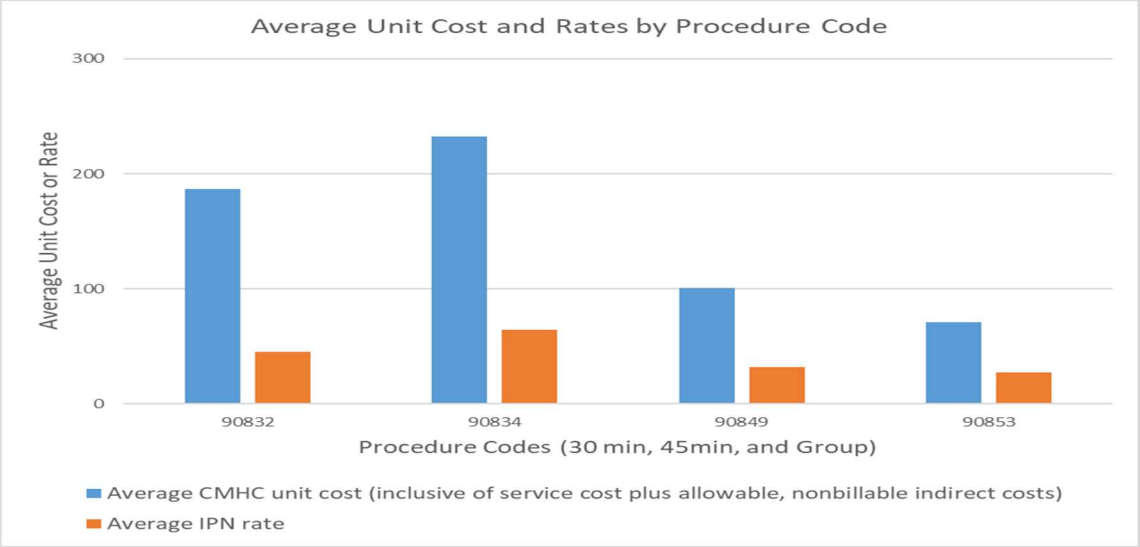
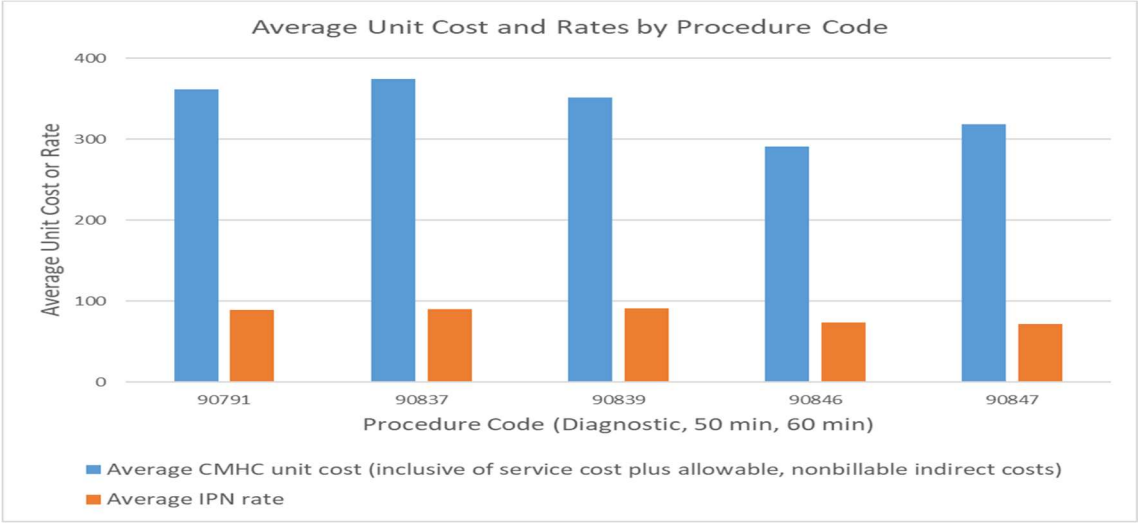


Figure 12: Average CMHC Unit Cost and IPN Rate Comparison by Procedure Code



Because indirect allowable services, such as the examples outlined in Part 1, are built into the payments for billable procedure codes, the results above indicate the CMHC providers are paid significantly higher, 2x and 3x higher, than the non-FQHC IPN providers for delivering service when the comparison is solely based on procedure code. However, as previously discussed, the CMHC unit cost methodology differs significantly from the non-FQHC IPN rate setting methodology, because the CMHCs rates are calculated on a cost basis, with costs covering other services not required to be covered by the IPN, such as community crisis response, peer programs, case management services, etc. As noted in Part 3, the

Department has adjusted the cost reporting model to increase the diligence around “reasonable” and therefore allowable costs. That said, one conclusion of this report is that the Medicaid reimbursements to independent providers will never be as high as the safety net providers because the independent providers are not paid on a cost-plus basis, do not provide the same complexity of services required of safety net CMHC providers, nor do they have the same costs, nor do they see the same volume of high acuity patients as the CMHC safety net providers. Safety net providers are also required to maintain a significant portion of operations regardless of volume – similar to emergency departments or fire departments that must maintain readiness.

Part 3: Summary and Recommendations

The Department, per HB 22-1268, was instructed to examine how BH rates are established, how BH services are paid to CMHC and non-CMHC contracted providers for outpatient services and create a set of recommendations on creating equitable payment and payment models that minimize inappropriate payment variation in comparable behavioral health services between the providers. This examination included an independent analysis comparing payments and models for payment between CMHCs and non-CMHCs, defined as the IPN, and stratified by the Department and the Independent Auditors into FQHCs and Other IPNs. This report provides context and insight, as well as data, to guide the evaluation of the BH rate methodologies and ensure payment structures for comparable services are more equitable.

The report lays out the framework for how BH services are delivered in the State of Colorado, identifying the limited set of services provided outside of the Managed Care Delivery System and the larger set of BH services provided through the ACC under the capitation. The report described the roles and responsibilities, including state and federal requirements, that both CMHCs and FQHCs have, including but not limited to, outpatient behavioral health services. The Department has provided this additional context about the broader scope of responsibilities these specific provider types have because the mechanisms for payment and the rates of payment are based entirely upon this whole scope of service and cannot be limited to the specified set of narrowly defined “outpatient behavioral health services” that are allowed as individually defined and delivered services provided by non-FQHC IPNs.

The two legislative requirements of the analysis were to “identify discrepancies, if any, and the reasons for such discrepancies in Medicaid reimbursement rates paid to providers of a Community Mental Health Center and Independent Mental Health and Substance Abuse treatment providers for comparable services” and a “determination of and recommendations on whether reimbursement rates paid to community mental health center providers and independent mental health and substance use treatment providers are adequate to meet or exceed network adequacy standards in every region of the state.” Below are two determinations based on the Independent Analysis completed.

In addition, legislation charged the Department to establish a set of recommendations on “creating equitable payment and payment models that minimize inappropriate payment variation in comparable behavioral health services”. This charge is addressed as both current process changes that have been enacted as well as additional recommendations for further process changes.

Determinations from Independent Analysis

HB 22-1268 specifies the Department will determine if discrepancies between reimbursement rates for comparable services exist. The Department's conclusion from this analysis is that rates paid to contracted BH providers are adequate to meet or exceed the contracted network adequacy standards in every region of the state.

Examination of Medicaid reimbursement rates paid to CMHCs and the IPN for comparable services finds that when comparing solely on the basis of a single procedure code with no further context as to the severity of illness, differences in population, or additional services provided, there are significant differences in rates between CMHCs and IPN providers. The variation in rates between CMHCs and non-FQHC IPN providers on average is 2x to 3x and can be attributed primarily to cost report payment methodology, outlined in part 2, under which the reimbursement rates for CMHCs are determined. Specifically, the Medicaid reimbursements to independent providers will never be as high as the safety net providers because the independent providers are not paid on a cost-plus basis, do not provide the same complexity of services required of safety net CMHC providers, nor do they have the same costs, nor do they see the same volume of high acuity patients as the CMHC safety net providers.

However, recent stakeholder engagement regarding cost-reporting has highlighted a possible factor exacerbating variation in reimbursement rates is the RVU/BUC methodology (see Appendix D). That is, some services have relative weights that may be inappropriately low relative to the resources needed. This means that while costs are still incurred by the CMHCs for these services, the total units may be undercounted. So, in the calculation of the BUC, the numerator has the costs but the RVUs in the denominator may be inappropriately low, causing an inflated BUC which would inflate the CMHC rate. This concern is currently being addressed in and will be discussed in more detail in "Changes in Processes and Systemic Innovations" below. The major factors impacting cost report calculations are infrastructure costs and costs incurred by the CMHCs related to providing safety net services as described in Appendix C.

The cost reports were updated in May 2022 by a committee of independent auditors and after representatives from the Department, the Colorado Department of Human Services, advocates, community partners, and representative members from the CMHCs and IPN had provided stakeholder input. In addition, the cost report template and the associated Auditing and Accounting[17] (A&A) guidelines have been posted on the Department's website. Changes to improve ongoing transparency for the cost-based reporting and RVU methodologies will be discussed further in the following sections detailing changes to process and further recommendations.

[17] https://hcpf.colorado.gov/behavioral-health-rate-reform

In accordance with legislation, the Department sought to determine whether reimbursement rates paid to CMHCs and IPNs are adequate to meet or exceed network adequacy standards in every region of the state. Analysis of current processes and infrastructure yielded the following findings:

- The MCEs, per contract with Health First Colorado, provide quarterly network adequacy reports.[18] The RAEs have met the reporting requirements and network adequacy standards outlined in their contracts with no substantive violations in every region of the state. From recent network reporting to the Department, the MCEs have seen an increase in the number of BH practitioners contracted within the SFY 2021 time period. Evaluating the role that rates play in continued expansion of network adequacy across the state was indirectly analyzed in this report, to the extent possible.
- The CMHC average BUC has been relatively consistent over the last several years, as shown in Figure 1.
- The IPN analysis from Figure 7 shows that the average rate for the IPN has increased for each of the codes considered by anywhere from 1-15% in SFY 2021 over the previous year**.** The weighted average of rates increased by 6.9% overall.
- The utilization analysis in Figure 8 shows that the number of services provided by the IPN also increased over the SFY 2021 time period by 21%.
- The compilation of these facts leads the Department to the conclusion that rates paid to contracted BH providers are adequate to meet or exceed the contracted network adequacy standards in every region of the state.

Provisions within HB 22-1278 will allow the Department to work to further increase provider participation, reduce administrative burden, especially across service disciplines as part of the launch of the BHA and the introduction of Universal Contracts.

Changes in Processes and Systemic Innovations

In 2021, many changes to the behavioral health services delivery system were initiated as the first phase of a multiyear behavioral health systemic and transformational process. Several of these changes to the delivery of BH services have changed the BH Landscape for Health First Colorado members. Examples of these fundamental shifts in services available to members and processes for accessing services include expansion of the Medicaid SUD benefit under the 1115 waiver, providing coverage of residential treatment services for members, changing the definition of safety net providers, and launching the BHA. Under the BHA, safety net providers may be licensed to provide essential services or comprehensive services. The BHA is also charged with removing barriers to participation through a streamlining and

[18] https://hcpf.colorado.gov/accountable-care-collaborative-deliverables

standardization of procedures for licensing, payments, and reporting between provider types and between differing payers.

These examples of alignment and expansion of services each required the Department to review and assess models for rate setting and policies governing managed care payment standards allowed under the Department's Accountable Care Collaborative (ACC). The Department recognizes its responsibility in providing oversight of how BH services are delivered and how those services are paid for on behalf of Health First Colorado members.

Concerns raised about the inequity of payment rates between CMHCs and IPN providers have been examined in this report and the Department has concluded the following:

- The CMHC rates are on average 2x to 3x that of the non-FQHC IPN providers.
- The difference in rate reimbursements between the CMHCs and the FQHCs is 3.2% on a per unit cost basis.
- The differences in payment stem mainly from the historic CMHC cost reporting, statutory definition of CMHCs and the way the Department must pay for safety net services. As stated, the cost reports were changed to impact rates effective July 2023 and the definition of safety net services and providers has also changed.

HB 22-1278 modernized the definition of safety net providers and associated safety net services. The new classification of safety net providers includes the specific services and responsibilities required and allows for two different classifications. This will result in more refined payments beginning July 1, 2024.

- Comprehensive Safety Net Providers (CSNPs) must provide all safety net services and Essential Safety Net Providers (ESNPs) must provide at least one safety net service as defined by HB 22-1278 and updated in section 27-50-301, C.R.S. Under the BHA changes for safety net provider definitions, new providers will be participating that previously have not functioned under a cost-based payment model. This allows appropriately licensed and credentialed members of the IPN to engage in the safety net space in all regions of the state if they meet statutory and regulatory requirements. The new definitions continue to provide a space for FQHCs as safety net providers and independently licensed providers that are licensed as individual practitioners, but do not hold any additional agency license.

The below additional modernizations are already implemented or in process to improve the Medicaid Behavioral Health payment models going forward.

- The provision for using reasonable costs in the cost reporting has been updated in section 25.5-4-403, C.R.S. to reflect updated safety net definitions. The revised language also codifies an "appropriate cost accounting methodology" and defines the required composition of the A&A guidelines committee. This allows for a broader scope of providers to not only participate in providing safety net services but also to engage in cost-based payment modeling and provide

input to the cost accounting methodology. This has the dual effect of increasing transparency to the cost reporting methodology and improving network participation for the safety net suite of services. For members of the IPN, this opens the opportunity to engage in cost-based reimbursement for engaging in safety net services, if they meet all requirements.

- In addition to the statutory changes, the Department engaged in a large, multi-stakeholder process to re-write the safety net cost reports. This engagement included stakeholders from MCEs, CMHCs, advocates and representatives of the IPN. The result is an updated cost report and the associated A&A guidelines[19] that intentionally improves transparency of cost centers and cost accounting methodologies for the cost-based reporting. This work to update and align the cost reporting to the new safety net services is ongoing and the Department has contracted with outside auditors to continue both stakeholder engagement and refinement. Under HB 22-1268, the updated cost reports, A&A guidelines, audited cost reports, and additional reference material will be posted to a public website by March 15, 2023.

- From the 2021 stakeholder engagement, there were concerns raised about the RVU methodology. The Department has engaged with an outside contractor to examine the RVU weights to see if inappropriate weighting of procedure codes is causing an inflation of base unit costs in the cost reporting methodology. The goal of this active project is to further reduce inappropriate discrepancies in payment rates for comparable services. Evaluation of the RVU methodology will involve further multi-stakeholder engagement to identify problematic weights and work to appropriately account for them in future cost reports. The contract directs the outside contractor to run stakeholder engagement, determine and evaluate problematic RVUs and provide recommendations by March 2023.

- The Department has engaged outside consultants to help design and implement a pilot value-based payment (VBP) model to ensure the creation of "equitable payment and payment models that minimize inappropriate payment variation". The intention of this model is to reduce possible disparities in payment structures for a BH provider between differing MCEs. This model design takes into account quality metrics to improve outcomes and equity in payments. Initial stakeholder engagement has been completed on this project and the Department is now in the process of engaging actuaries to begin the buildout of the financial model. The Department is working to launch the initial pilot with a select group of providers in SFY 2024.

- While the independent analysis found no issue with rates MCEs paid for services impacting the ability of the MCEs to meet or exceed the minimum network adequacy standards, the Department and the BHA have engaged in work to further improve network participation. For

[19] https://hcpf.colorado.gov/behavioral-health-rate-reform

example, in 2021, the Department expanded SUD services to include inpatient (hospital and residential) services. This expansion required the establishment of SUD residential provider networks as part of the MCE contracts. MCEs have continued to grow their network of these SUD providers from zero to 33 with 56 locations over the first year of the benefit expansion. Alignment with the BHA provides further opportunity for the Department to continue aligning provider services with member needs.

- Additionally, the Department and the BHA are collaborating to establish universal contracting provisions, pursuant to section 27-50-203, C.R.S., to ensure that the contracting provisions for all MCEs and all BH providers are consistent across the BH landscape and that all parties are held accountable to meeting shared expectations. This, along with the above cost report changes, value-based payments, and other changes, will create a pathway for alignment of payments across the BHA and Health First Colorado for safety net services.

Recommendations

The Department appreciates the tremendous collaboration from legislators, state agencies and stakeholders in supporting the many improvements to Health First Colorado behavioral health payment models and overall Medicaid behavioral health funding. The Department acknowledges and looks forward to making continual progress in addressing additional opportunities that exist to ensure that Health First Colorado members with mental health and/or substance use needs have timely access to quality care when they need it. To ensure access to care, it is essential that providers of these BH services, including SUD, are receiving payments that support delivery of care in all parts of Colorado and that payments for the delivery of comparable services are equitable, give the contractual requirements associated with the various provider types. Based on the extensive analysis presented in this report and to address issues related to discrepancies in rates between community mental health center providers and the independent provider network, the Department presents the following recommendations:

1. **Update rates and service definitions to align with new provider definitions and improve payment models and reporting accuracy.**
   The Department recognizes one essential step forward is aligning rates services definitions with the programmatic definitions used by providers, the BHA, and Department policy staff. New provider definitions for crisis services, as an example, will help align the safety net services provided. This change aligns with plans for continued integration between the Department and the BHA, including the development of more integrated systems technologies.

2. **Evaluate appropriate payment methodologies as viable alternatives to the RVU payment model.**

Given the changes already being investigated with regards to the RVU methodology as described in the previous section, the Department recommends further exploration as to innovative payment models that could replace the existing model. The Department recommends, in collaboration with the BHA, hiring outside contractors to evaluate appropriate payment methodologies as viable alternatives to the RVU payment model. This recommendation includes robust stakeholder engagement, the appropriate investigation of federal authority as required by any additional payment methodologies, and a vigorous monitoring protocol for any payment methodologies engaged.

3. **Continue improvement for safety net cost reports.**
   The Department has already updated the cost reporting template to be completed by providers by November 2022, impacting rates effective July 2023. The Department recognizes further investigation into changes to the cost report structure are necessary to address the differing provider types, organization sizes, and feasibility of using existing cost reports. Per HB 22-1268, the Department will create a webpage to post the cost report templates, submitted cost reports, and explanatory materials. The Department will investigate the feasibility of differing cost reporting methodologies to improve cost-based models for providers of differing sizes and reporting capabilities.

4. **Expand value-based payment models to larger groups of providers.**
   The Department is already in the process of launching a value-based payment (VBP) pilot program for BH services with Health First Colorado. The Department further recommends, upon successful completion of the pilot, opening this VBP program to a larger network of providers to ensure equitable and flexible payments to safety net providers that incentivize whole-person quality care as well as improve quality, access and equity. This will require monitoring and reporting protocols to ensure improvements in quality, network engagement, and member outcomes. The expansion of the VBP models to the larger statewide network will likely require federal authority to change the payment methodologies of the MCEs. The Department recommends investigating federal authority for directed payments or other federal mechanisms to further expand VBP models within the Health First Colorado managed care BH program. Additional federal authorities, such as directed payment models, would also allow for greater transparency and understanding of BH rates across services and providers. The universal contracting innovations funded through HB 22-1302 and required by HB 22-1278, will be an essential tool to execute on these recommendations and contractual alignment for value-based payment models.

5. **Continue to analyze and periodically post publicly rate review and analysis on behavioral health rates, to show changes over time. This may include:**

- Comparison of the Medicaid IPN provider rates to commercial carrier rates paid on average for comparable behavioral health services. This creates a more accurate comparison than using safety net and FQHC providers. The latter two types of providers have more comprehensive responsibilities that the Health First Colorado reimbursement rates cover through the cost-based methodology.
- Identification of SUD-specific services to track how they are coded and represented for incorporation into any relevant analysis in the action plan.

In conclusion, the Department is committed to the continued transformation and improvement of Colorado's BH safety net while supporting and expanding Health First Colorado's Independent Provider Network (IPN). These recommendations include continuous improvement in stakeholder engagement, innovative payment strategies, quality outcomes, health equity, provider network participation, and equity in payments. A robust BH safety net and IPN is a top priority for the Department to improve the lives and health of the people we serve. The Department's initiatives with regards to this work will be outlined in further detail in the action plan posted on the Department's public website in alignment with the provisions of HB 22-1268.

Appendix A: Acronyms and Definitions

ACRONYMS AND DEFINITIONS	
ACC	**Accountable Care Collaborative** The program by which Health First Colorado attributes all Medicaid members to a primary care provider, and wherein each member is assigned to a RAE, to ensure members have access to the health care services they need and that they understand their benefits and can connect with resources for various needs.
AF	**Adjustment Factor** An element of the rate calculation that is used for Federally Qualified Health Centers rate calculation to establish a new prospective payment system rate when a qualifying change in the scope of services occurs. The adjustment factor is applied when indirect overhead costs exceed 20% of total allowable costs.
AFS	**Audited Financial Statements** The complete set of financial statements for an organization prepared by an independent certified public accountant.
APM	**Alternative Payment Methodology** A reimbursement calculation for Federally Qualified Health Centers which differs from the federally mandated prospective payment system rate.
BH	**Behavioral Health** The connection between behaviors and an individual's health, which includes mental health and substance use disorder services.
BIPA	**H.R. 5661 Medicare, Medicaid, and [State Children's Health Insurance Program] SCHIP Benefits Improvement and Protection Act of 2000** A federal law enacted by the United States Congress that set forth payment requirements for hospitals.

ACRONYMS AND DEFINITIONS	
BUC	**Base Unit Cost** The total allowable cost incurred by the CMHC during a fiscal year divided by the total number of RVUs provided during the fiscal year. See Appendix D for more detail.
CMHC	**Community Mental Health Center** A provider of behavioral health and substance use disorder services in Colorado that is required by Federal regulations to provide essential services.
CCR	**Code of Colorado Regulations** The state regulatory provisions governing health care services in Colorado.
CFR	**Code of Federal Regulations** The federal regulatory provisions governing health care services in the United States.
CMS	**Centers for Medicare and Medicaid Services** The federal agency responsible for administration of Medicare and Medicaid services in the United States.
CY	**Current Year** Relational reference to the most recent reporting period.
FFS	**Fee for Service** A payment methodology wherein health care providers are paid directly for services rendered based on a fee-schedule for each service code billed.
FQHC	**Federally Qualified Health Center** A community-based provider of primary, behavioral, and dental health services in Colorado.
FYE	**Fiscal Year End**

ACRONYMS AND DEFINITIONS	
	The last date of a one-year accounting period.
IPN	**Independent Provider Network** Individual or group behavioral health providers who are not affiliated with a Community Mental Health Center (CMHC). This is inclusive of SUD and MH service providers operating as individually licensed practitioners or in group practices.
KPI	**Key Performance Indicator** A quantifiable measure used to evaluate progress or success.
MCO	**Managed Care Organization** A health plan that offers a network of physical health providers that are managed by RAEs.
PCMP	**Primary Care Medical Provider** A physician (or clinic) assigned to, or chosen by, a patient to provide primary care services, and to keep track of the patient's health history and needs.
PMPM	**Per Member Per Month** A payment methodology where a managed care organization receives a fixed amount on a monthly basis for each individual enrolled in the organization.
PPS	**Prospective Payment System** A payment methodology where a health care provider is paid a predetermined, fixed amount, based on the classification of the patient into a prescribed group.
PY	**Prior Year** Relational reference to the reporting period immediately preceding the current year.

ACRONYMS AND DEFINITIONS	
RAE	**Regional Accountable Entity** A regional organization that supports a network of providers and connects Medicaid members with the physical and behavioral health care needed.
RBRVS	**Resource-Based Relative Value Scale** A system of payments to physicians for treating Medicare patients that takes into account the work done by the physicians, malpractice insurance, and practice expenses including staff salaries, overhead, supplies, and equipment.[20]
RCCO	**Regional Care Collaborative Organization** The regional organizations that managed the physical health benefits for Medicaid members prior to establishment of the RAEs.
RVU	**Relative Value Unit** A calculation to estimate the level of effort the provider incurs while providing a specific service on a procedure code basis. See Appendix D for more detail.
SFY	**State Fiscal Year** The 12-month period beginning July 1 and ending June 30 of the year referenced. For example, SFY 2020 represents the period July 1, 2019 through June 30, 2020.

Table A.1: Acronyms used in this report and their definitions.

[20] https://www.merriam-webster.com/medical/resource-based%20relative%20value%20scale

Appendix B: Managed Care Entities (MCEs)

Regional Accountable Entities and Managed Care Organizations

The following section provides an overview of the seven RAEs and two MCOs through which most behavioral health care is paid for in the Health First Colorado program. See Table B.1 and Figure B.2

Managed Care Entities	
Region	**Organization**
RAE Region 1	Rocky Mountain Health Plans (RMHP)
Managed Care Organization (MCO) Region 1	RMHP
RAE Region 2	Northeast Health Partners (NHP)
RAE Region 3	Colorado Access
RAE Region 4	Health Colorado, Inc. (HCI)
RAE Region 5	Colorado Access
MCO Region 5	Denver Health (DH)
RAE Region 6	Colorado Community Health Alliance (CCHA)
RAE Region 7	CCHA

Table B.1: The Managed Care Entities that support Health First Colorado members.

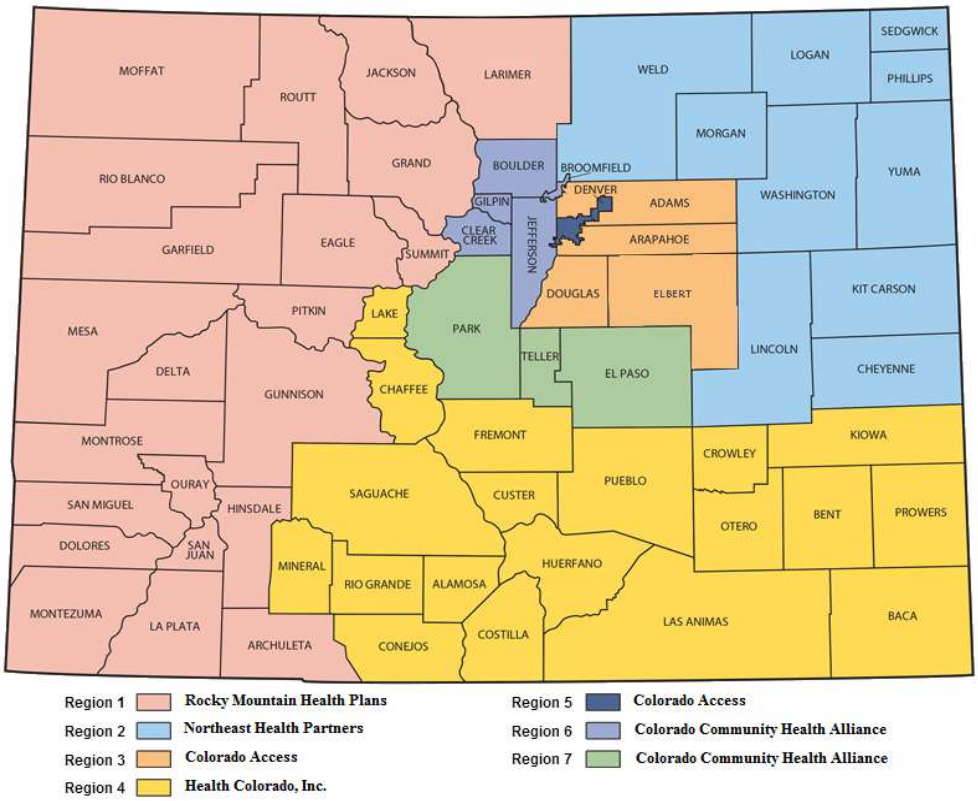


Figure B.2: Map of RAE and MCO regions.

The region-specific summaries below include an overview of the organization structure and related party[21] transactions. Transactions are considered related party when they occur between organizations with common ownership. These transactions are not unusual, but it is important to understand that the payer and payee in these transactions are one-and-the-same.

RAE/MCO Region 1 – Rocky Mountain Health Plan

RMHP serves members in western Colorado and Larimer County. The RAE is one of two regions that provides a complete Medicaid managed care plan, called Rocky Mountain Health Plan Prime, covering six counties in Western Colorado.

RMHP is owned by United HealthCare Services Inc. (United). All RMHP personnel are employees of United, and RMHP incurs an allocation of overhead expense from United.

RAE Region 2 – Northeast Health Partners, LLC

[21] A related party is an entity that shares common ownership with another. In this case, it is referring to RAEs that are owned by members of the CMHCs and/or FQHCs.

NHP serves members in 10 counties in northeast Colorado. NHP was formed by a group of CMHCs and FQHCs, who bid collectively as one entity on the RAE contract for ACC Phase II. NHP is owned by the following entities, each with 25% control:

1. Centennial Mental Health Center (a CMHC)
2. North Range Behavioral Health (a CMHC)
3. Sunrise Community Health Center (an FQHC)
4. Plan de Salud Del Valle (an FQHC)

Behavioral health encounterable services, sub-capitation payments to the CMHCs, and behavioral health incentive payments to the owning CMHCs and FQHCs are related-party transactions. The owning CMHCs and FQHCs also receive care coordination and KPI payments from the RAE.

Beacon Health Options provides administrative services to NHP but does not have an ownership interest in the RAE. In this capacity, Beacon Health Options provides the majority of the personnel for the RAE contract, including some "key personnel" positions required by the Department's contract with the RAE.

RAE Regions 3 and 5 – Colorado Access

Colorado Access is the RAE for Region 3, serving members in Adams, Arapahoe, Douglas, and Elbert counties. Colorado Access is also the RAE for Region 5, which serves members in Denver County. Access Management Services, LLC is a related party and provides administrative services to Colorado Access. All staff are employed through Access Management Services, LLC. Another related party organization, AccessCare Services, LLC, provides telehealth services, primarily for behavioral health.

RAE Region 4 – Health Colorado Inc.

HCI serves members in 19 counties in southern Colorado. HCI was formed by a partnership of CMHCs, an FQHC, and an administrative services company in response to the Department's request for proposals to become a RAE at the start of ACC Phase 2.

Six entities co-own HCI:

1. Health Solutions (a CMHC, 19.53% ownership)
2. Solvista Health (a CMHC, 19.53% ownership)
3. San Luis Valley (a CMHC, 19.53% ownership)
4. Southeast Health Group (a CMHC, 19.53% ownership)
5. Valley-Wide Health Systems Inc. (an FQHC, 2.33% ownership)
6. Beacon Health Options (an administrative services company, 19.53% ownership)

For the behavioral health funding stream, sub-capitation payments paid to the CMHCs are considered related party transactions. For the administrative PMPM funding stream, care coordination and KPI payments to the CMHCs and FQHCs are considered related-party transactions.

Beacon Health Options provides administrative services to HCI. In this capacity, Beacon Health Options provides the majority of the personnel for the RAE contract, including some "key personnel" positions required by the Department's contract with the RAE.

MCO Region 5 – Denver Health

Denver Health has operated a Medicaid health plan since 2004, called Denver Health Medicaid Choice (DHMC). DHMC is operated by Denver Health Medical Plan, which is a wholly owned subsidiary of Denver Health and Hospital Authority (DHHA). DHMC is a staff-model health plan, meaning rather than contracting with a network of providers to offer care to its enrollees, DHHA operates the medical facilities and employs the providers at those facilities. DHMC members can get care at the Denver Health main campus in downtown Denver, at any of Denver Health's nine Family Health Centers throughout metro Denver, and at the 18 school-based health centers also operated by Denver Health.

RAE Regions 6 and 7 – Colorado Community Health Alliance, LLC

In Region 6, CCHA serves members of Boulder, Gilpin, Clear Creek, Broomfield, and Jefferson Counties. In Region 7, CCHA serves members in Park, Teller, and El Paso Counties. Prior to July 1, 2018, CCHA operated as a RCCO. There are two entities in the organization structure named CCHA, and both are LLCs. To differentiate the two, the owner of the RAE contracts is referred to as "CCHA 1" or the joint venture. The other CCHA entity is referred to as "CCHA 2". CCHA 1 is a joint venture (50/50 partnership) between Anthem Inc. and CCHA 2. CCHA 2 owned the RCCO contract prior to ACC Phase II, and partnered with Anthem, Inc. to bid on the RAE contracts; hence the creation of the joint venture (CCHA 1). Management fees are paid to Physician Health Partners for administrative services, which has a 4% indirect ownership in the joint venture (CCHA 1) through its 8% ownership in CCHA 2.

The Department pays MCEs for Health First Colorado members' BH care through two mechanisms:

> **Administrative Per Member Per Month (PMPM) Payments:** Each MCE receives a set amount of money for every member enrolled in the RAE. These payments are given by the Department to the MCEs on a PMPM basis. These funds are intended to support care coordination for all BH, physical health, and social support services. The amount of PMPM payment may be increased if the RAE achieves a key performance indicator (KPI), a Department- determined performance metric meant to incentivize goals such as care quality or health care equity.
>
> **BH Capitation Payments:** MCEs receive BH capitation payments to administer BH benefits, including building statewide BH networks. Quality incentive payments also exist for BH, and additional revenue can be earned for achieving BH incentive measures. This capitation payment

is made on a monthly basis. For an MCE to receive reimbursement under the capitated BH benefit, the services must be for a covered BH diagnosis and billing code.

Appendix C: CMHCs and Services Provided

Figure C.1 identifies the regions covered by each CMHC in the state of Colorado.

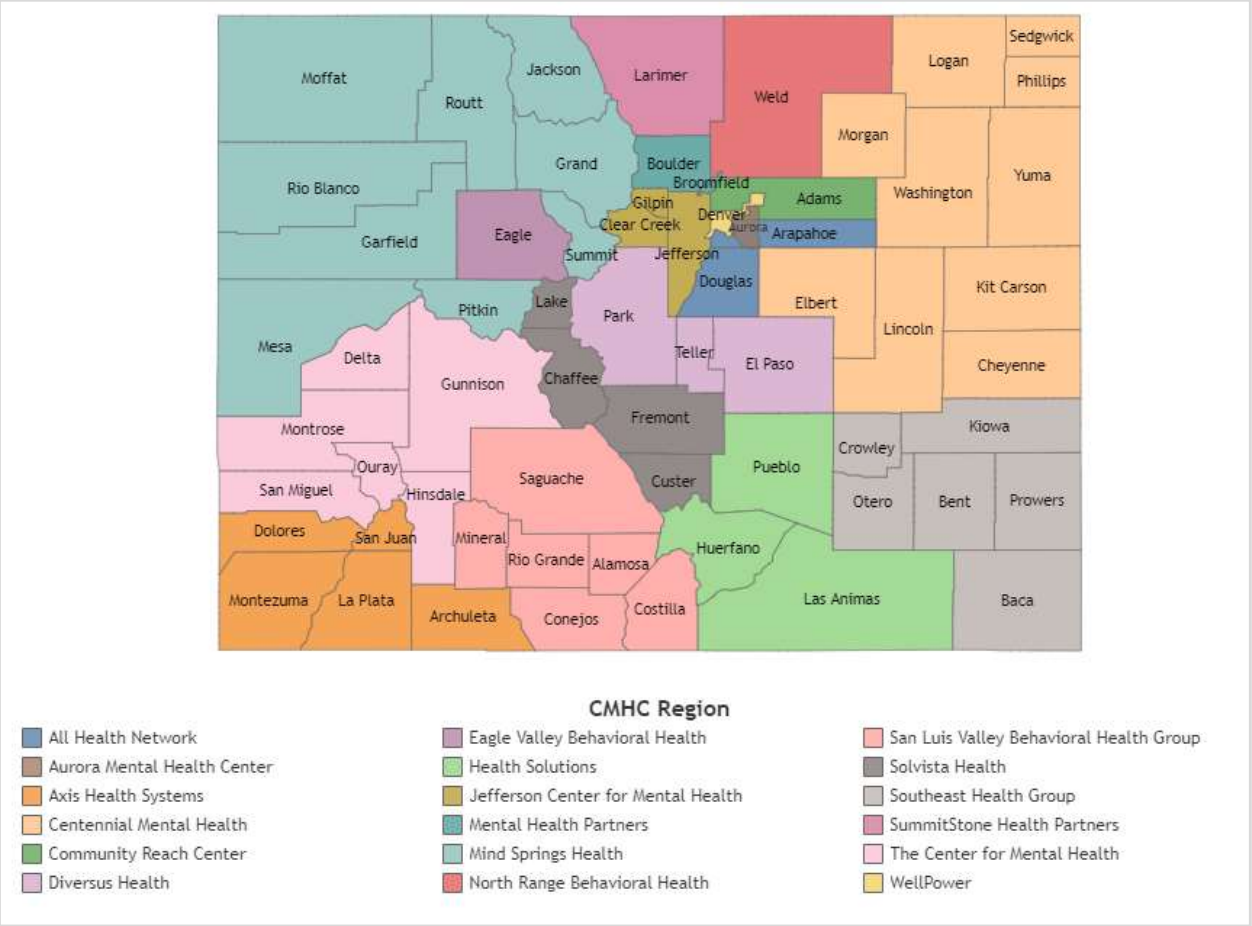


Figure C.1: Map of Community Mental Health Centers (CMHCs) and the areas they serve in Colorado.[22]

In addition to therapeutic services, other services provided by CMHCs include the following:

- Community crisis response, such as suicide and unexpected death debriefings for schools, stakeholders, partners
- Community presentations, training, involvement, and partnership on public health issues, such as suicide prevention, and mental Health First Colorado aid training

[22] Colorado Department of Human Services. (2022). *Find behavioral health help*. Behavioral Health Administration. https://bha.colorado.gov/get-behavioral-health-help

- Population-based social determinants of health screening and response support for identified needs
- Disaster response leadership, training, preparedness by means of drills and community response participation in the communities
- Housing support
- Medicaid eligibility support
- Donated medications programs for high-cost psychiatric drugs and distribution and patient medication assistance program management
- Patient transportation support to and from higher levels of care
- Team-based care, clinical supervision, clinical internships, and provider licensure supervision
- Develop resolution and staffing for patients awaiting placement when gaps in coverage or higher levels of care occur
- Peer programs, including specialized training program development and clinical oversight
- Case management services that support patient care, independence, and health outcomes
- Program development to address community needs and close critical gaps
- Participation in different standing community committees, management oversight groups, specialty courts, and stakeholder meetings

Appendix D: CMHC Unit Cost Methodology

CMHCs can be paid either by a RAE (through capitated BH care funding) or directly by the Department (for FFS and specific codes; refer to *How Behavioral Health Care is Paid For*). The past methods for determining the rates reviewed in this report have been established by Department policy, legislation, and federal policy, some of which is evolving as referenced in this report. The below cost methodology does not represent the future state of safety net payment methodology outlined in the Recommendations.

The costs incurred by the CMHCs for the provision and availability of BH services are captured each year via the Colorado Unit Cost Report (CMHC Cost Report). The CMHC Cost Report is a standard reporting tool developed by HCPF, the BHA, and representatives from the CMHCs; it is completed on an annual basis for each CMHC by individuals employed or contracted by the centers, and it captures all costs incurred during the state fiscal year. Principles governing the completion of the CMHC Cost Report and the reporting of costs therein are dictated within the behavioral health Accounting and Auditing Guidelines (A&A Guidelines). The A&A Guidelines were originally drafted in 2013 by HCPF, the Office of Behavioral Health, and an independent consultant; they are reviewed and updated annually by a committee composed of representatives from HCPF, the BHA, and the CMHCs.

The CMHC Cost Report contains the cost and encounter (units) data for the state fiscal year and is submitted by the CMHCs on November 30 of each year. They are subject to an annual cost report review process, wherein costs are evaluated by an independent certified professional accounting firm contracted by HCPF for allowability and proper reporting in accordance with the A&A Guidelines. The reviewed cost report is used by the Department, the BHA, and the RAEs for rate setting purposes. Verification that unallowable costs have been excluded from the BUC occurs during the annual cost report review process, wherein an independent certified public accounting firm is contracted by HCPF to review the cost reports prepared by the CMHCs and evaluate the reports for compliance with the A&A Guidelines.

The A&A Guidelines define the types of costs that are allowable in the Base Unit Cost (BUC) calculation. The BUC is calculated on an annual basis via the CMHC Cost Report and is utilized by HCPF, the BHA, and the RAEs to set reimbursement rates for the CMHCs.[23] The BUC captures total allowable costs (as defined within the A&A Guidelines) associated with the provision of BH services, and the total number of weighted BH services provided; the services provided are weighted through the relative value unit (RVU) methodology, wherein varying values (or weights) are assigned to each BH service.

[23] The CMHC Cost Report also calculates the average cost per patient day (per diem rates) for the provision of inpatient hospital and residential services. An analysis of these per diem rates was not included in the scope of this analysis.

The BUC is calculated as follows:

$$\textbf{BUC} = \frac{\text{Total Allowable Costs of Providing RVU Services}}{\text{Total Facility RVUs + Total Non-Facility RVUs}}$$

The RVU method is designed to establish relative values for each service, which are reflective of the varying resources necessary to provide each individual service in relation to all other BH services. This methodology was implemented by Colorado in 2009 and was founded on the resource-based relative value scale utilized by the Centers for Medicare & Medicaid Services (CMS) in the national physician fee schedule for Healthcare Common Procedure Code System (HCPCS) procedure codes. The weights associated with each BH service in the RVU method (distinguished by procedure code) are derived from the CMS physician fee schedule and are specific to the place of service in which a service is rendered, either classified as "facility," meaning at the CMHC, or "non-facility," meaning outside the CMHC. The weights associated with procedures may vary between facility and non-facility classifications if the relative resources required to deliver those procedures vary.

The total allowable costs of providing RVU services includes direct and indirect costs associated with programs and teams providing services with RVU weights. Allowable costs include items such as:

1. **Personnel costs** – Salaries, payroll taxes, and employee benefits of direct program staff and indirect administrative staff.
2. **Client-related costs** –External doctors, clinics, and hospitals; food provided to clients; medical supplies; payments to other service providers; supplies used by clients; and transportation for clients.
3. **Occupancy costs** – Janitorial, maintenance and supplies, property insurance, rent, real estate taxes, and utilities.
4. **Operating costs** – Dues, fees, licenses, subscriptions, equipment rentals and maintenance, insurance, office supplies, postage, printing, copying, telephone, travel of staff for business purposes, and vehicle expense for owned or leased vehicles.
5. **Depreciation and amortization** – Depreciation and amortization for all owned assets.
6. **Professional fees** – Non-clinical professionals and consultants who are not employees of the CMHC.

The cost of labor plays a significant role in the total costs incurred by the CMHCs and is heavily influenced by geographic location. The average wages by geographic area for all occupations in Colorado is presented in Figure D.1.[24]

[24] According to the Bureau of Labor Statistics, Department of Labor as of May 2020 (https://www.bls.gov/oes/current/oes_14500.htm)

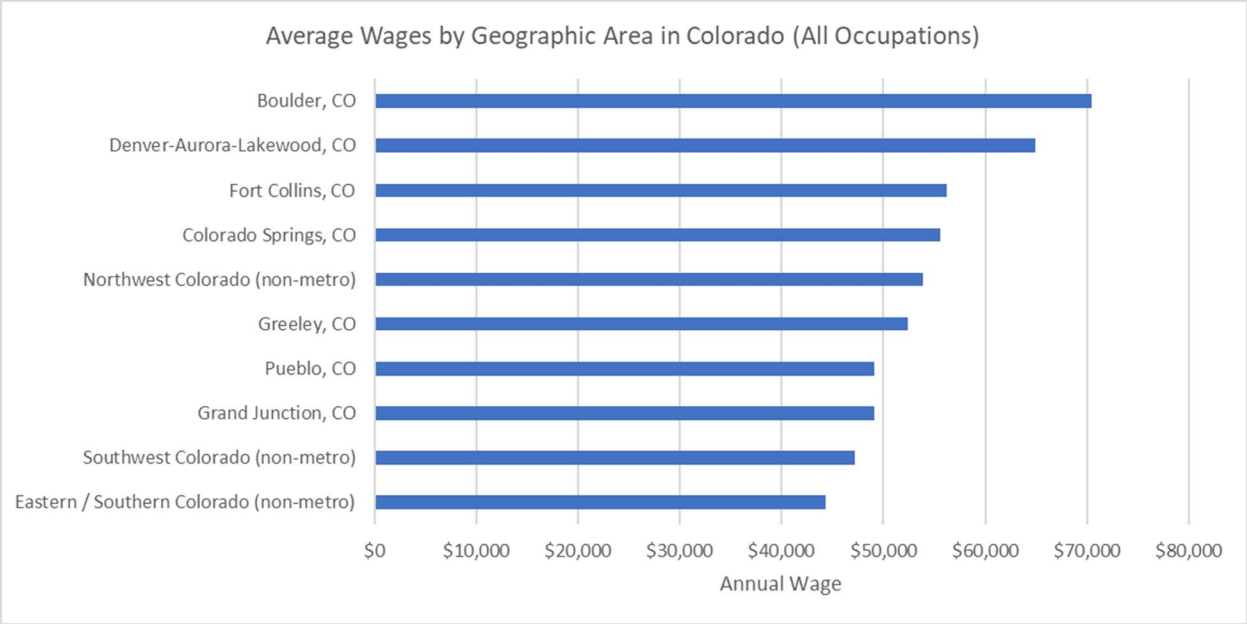


Figure D.1: Average Wages by Geographic Area in Colorado for All Occupations.

Costs not allowed in the BUC include items such as: most advertising and public relations, alcoholic beverages, bad debts, contingency reserves, donations and contributions, accelerated depreciation, entertainment, fines and penalties, fundraising, personal living, idle facilities, most interest, investment, profit for less-than-arm's-length transactions, most lobbying and outreach, personal gifts, and retainers. These costs are specifically identified as unallowable on the CMHC cost report and are excluded from the BUC calculation.

The facility and non-facility RVUs are calculated by multiplying the number of units of service provided for a specific procedure code by that procedure code's RVU weight:

Facility RVUs = Procedure Code Units x Facility Weight
Non-Facility RVUs = Procedure Code Units x Non-Facility Weight

When considering CMHC utilization, two elements must be considered:

- **Units of Service Provided**
  The units of service provided represent the actual number of services provided during the period. However, this figure is not reflective of the resources or effort required to provide the services. For example, one CMHC could provide 100 30-minute group psychotherapy sessions, while another could provide 100 55-minute hospital observation visits; in this example, both CMHCs provided 100 units of service, but the resources required to provide the hospital observation visits were substantially more than those dedicated to the group psychotherapy sessions.

- **Relative Value Units (RVUs)**
  The relative value units (RVUs) intend to reflect the relative resources required to provide behavioral health services, in order to address the disparity identified in the above example. RVUs are calculated by multiplying the number of units provided for a specific service by the associated RVU weight. In the previous example, the CMHC offering the group psychotherapy sessions would have a much lower number of RVUs than the CMHC providing the hospital observation visits. The total number of RVUs is used as the denominator in the base unit cost (BUC) calculation.

Contracting with the CMHCs

The MCEs negotiate reimbursement rates with the CMHCs and may establish a fee-for-service payment structure, sub-capitation arrangements, or risk sharing agreements with the CMHCs. Reimbursement from the MCEs may or may not reflect the BUC. While a variety of reimbursement methodologies exist between the RAEs and the CMHCs, the agreements generally fall into one of the following three categories:

1. **Fee-for-Service (FFS) Payments.** FFS arrangements entail CMHCs billing the RAE for each service provided, and receiving reimbursement based on a fee schedule. The contractual negotiation between the RAE and the CMHC establishes the fee schedule agreed to by both parties. The fee schedule can be based on the CMHC's BUC multiplied by the relative value weight for each service, or the fee schedule may differ from the BUC. In a FFS arrangement, there is generally no need for retroactive adjustments since reimbursement occurs when a service is provided for an agreed upon price.

2. **Sub-capitation Arrangements.** Sub-capitation arrangements structure payment from the RAE to the CMHC as a per member per month (PMPM) prospective payment. The PMPM payment amount considers expected utilization, and the reimbursement per service ultimately agreed to between the RAE and the CMHC, such as the BUC or other price per service. After a period of time (such as annually), the CMHC's actual utilization is compared to the PMPM payments received. Because the CMHC is not "at risk" in these arrangements, the RAE will reconcile claims to the prospective payments made, in order to ensure the CMHC is reimbursed for all services provided. Lump sum payment may be made by the RAE if actual utilization multiplied by rates agreed to in the contract exceed the PMPM payments made to the CMHC. Conversely, the reconciliation could result in the CMHC owing back to the RAE if actual utilization results in lower payment than the PMPM paid. These arrangements are characterized by the RAE retaining risk associated with patient utilization, since the CMHC is reimbursed for all services provided.

3. **Risk Sharing Agreements.** Risk sharing agreements also structure payment from the RAE to the CMHC as a PMPM payment. Similar to sub-capitation arrangements without risk sharing, the

PMPM payment amount is based on an estimate that considers expected average utilization per member, and the reimbursement per service agreed to between the RAE and the CMHC, such as the BUC or other rates. These arrangements include some level of risk to the CMHC in situations where utilization exceeds the utilization level on which PMPM reimbursement was established. The CMHC will not necessarily be reimbursed by the RAE in a retroactive reconciliation to consider actual utilization. However, there is generally a level of variation from expected utilization/payment that will trigger additional reimbursement to or from the CMHC, referred to as a "risk corridor". Risk share agreements consider a portion of reimbursement withheld by the CMHCs as financial reserves to cover unanticipated utilization of services.

Appendix E: FQHC Encounter Rates Methodology

FQHCs focus on outpatient services in the categories of physical health (such as primary care services), dental health, and BH services. The costs and visits for services are reported by the FQHCs each year in the Colorado Medicaid FQHC Cost Report (FQHC Cost Report). The Medicaid Cost Report Instructions for FQHCs (FQHC Cost Report Instructions) govern the reporting of costs and visits within the FQHC Cost Report. The FQHC Cost Report Instructions are reviewed and updated annually by the Department, with input from FQHC representatives.

The FQHC Cost Report Instructions describe cost reporting principles and establish costs allowable in the FQHC encounter rates. Unallowable costs include “carved out” services, which are reimbursed through mechanisms other than the cost report, as well as certain types of costs like bad debts, donations, and marketing. Encounter rates are cost-based rates calculated for each FQHC, which are paid per patient visit. FQHC cost reports are used by the Department to establish FQHC-specific reimbursement rates effective 120 days after the FQHC’s fiscal year-end.

For Colorado’s FQHCs, a visit is defined as a one-on-one, face-to-face, interactive audio, interactive video, or interactive data communication encounter between a center client and one of the following providers:

1. Physician.
2. Dentist.
3. Dental hygienist.
4. Physician assistant.
5. Nurse practitioner.
6. Nurse-midwife.
7. Visiting nurse.
8. Podiatrist.
9. Clinical psychologist.
10. Clinical social worker.
11. Licensed marriage and family therapist.
12. Licensed professional counselor.
13. Licensed addiction counselor.

14. Supervised persons pursuing mental health licensure as defined in their respective practice acts.[25]

The Department establishes a specialty BH (SBH) rate to reimburse FQHCs for BH procedure codes. The RAEs are required to pay at least the SBH rate to FQHCs for BH services but may negotiate higher rates. Thus, the SBH rate serves as a floor for rate negotiations between the FQHCs and the RAEs.

FQHC Encounter Rates

Similar to the other provider types discussed in this report, RAEs negotiate payment rates with the FQHCs. However, RAEs are required by the Department to pay at least the encounter rates established by the Department for SBH services. Though RAEs are permitted to pay higher than the rates established by the Department, they may not pay lower rates.[26] The Department has implemented quarterly reporting requirements to monitor compliance in this area. As a result, the Department's SBH rates serve as a floor for rate negotiations between the FQHCs and the RAEs.

Accountable Care Collaborative Per Member Per Month Payments

FQHCs and other primary care providers serve as Primary Care Medical Providers (PCMPs) as part of the ACC. The PCMPs receive per member per month (PMPM) payments from the RAE in their region for Medicaid members attributed to the practice. RAEs are required to pass ACC PMPM funds to PCMPs but have the flexibility to establish unique payment structures. As a result, PMPM payments to practices, such as FQHCs, vary between regions and practices. For example, some FQHCs provide care coordination services on behalf of the RAE for enhanced PMPM payments.

Other Incentive Payments

Like CMHCs, FQHCs are eligible to receive payments from the RAE for achieving Key Performance Indicators (KPIs). However, the distribution of KPI funds and other incentives earned by the RAE is up to the discretion of the RAE.

The Department sets FQHC encounter rates in accordance with federal authority[27] set forth in the Social Security Act (the Act). The Act requires Medicaid programs to pay at least the Prospective Payment System (PPS) rate and provides states the option to establish an alternate payment methodology (APM). Under this authority, the Department has established PPS rates for the FQHCs, and has chosen to

[25] 10 CCR 2505-10 8.700.1.B. Visit may also include a supervised person pursuing a mental health therapy licensure.
[26] Higher rates may be negotiated when prospective payment methods are used, as is the situation when capitation rates drive negotiated rates.
[27] Section 702(b) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA), included in the Consolidated Appropriations Act of 2000, Public Law 106- 554.

establish an APM for its FQHCs. As required, FQHCs receive at least the PPS rate, should the APM rate be lower than the PPS rate in any given year.

Prospective Payment System Rates

In accordance with the Act, Medicaid payment for services provided at FQHCs in existence prior to 2001 are based on the *"amount (calculated on a per-visit basis) equal to 100 percent of the average of the costs of furnishing* [FQHC services] *during fiscal years 1999 and 2000 which are reasonable and related to the costs of furnishing services."*[28] This rate calculation description from the Act translates to the below baseline PPS rate calculation for each FQHC in existence prior to 2001.

$$\textbf{2001 PPS Rate} = \frac{\text{1999 Allowable Costs + 2000 Allowable Costs}}{\text{1999 Visits + 2000 Visits}}$$

Following 2001, the PPS rate was inflated annually by the Medicare Economic Index.

If an FQHC has a qualifying change in the scope of services the FQHC provides after the PPS rate is established, the Department calculates an adjustment to the PPS rate. For example, if an FQHC did not formerly provide BH services, and began providing BH services, this could qualify as a change in the FQHC's scope of services. One of two formulas is used to calculate the new PPS rate when there is a qualifying change in the scope of services provided by an FQHC.

The first formula is used if the FQHC's overhead costs are 20% or less of total allowable costs. Abbreviations for prior year (PY) and current year (CY) are used in the formulas below:

$$\textbf{New PPS Rate} = \frac{\text{(PY PPS Rate * PY Visits) + (CY Costs – PY Costs)}}{\text{CY Visits}}$$

The second formula is used if the FQHC's overhead costs are more than 20% of total allowable costs. In this scenario, an adjustment factor (AF) is added to limit overhead costs included in the new PPS rate.

$$\textbf{New PPS Rate} = \frac{\text{(PY PPS Rate * PY Visits) + (CY Costs – PY Costs) *(AF/0.8)}}{\text{CY Visits}}$$

FQHCs that come into existence in 2001 or later are subject to a baseline PPS rate calculated "based on the rates established…for other such centers or clinics located in the same or adjacent area with a similar case load or, in the absence of such a center or clinic, in accordance with the regulations and

[28] Social Security Act of 1965, Section 1902(bb)(2), Payment for Services Provided by Federally Qualified Health Centers and Rural Health Clinics.

methodology referred to [above] or based on such other tests of reasonableness as the Secretary may specify."[29]

In order to create a documented, approved methodology for establishing PPS rates for new FQHCs, the Department initiated a State Plan Amendment, effective July 1, 2018, which describes the PPS rate setting methodology for new FQHCs, as follows:

> *The Department will use reasonable cost and visit data from the first cost report submitted with cost and visit data from the first full fiscal year after a freestanding FQHC enrolls with Colorado Medicaid to set the finalized PPS rate. Reasonable costs are determined using the State's Medicaid specific FQHC cost report.*[30]

PPS rates are effective 120 days after the first full fiscal year of operations. This allows PPS rates to be established as soon as possible when a full year's information is available, according to the calculation below.

$$\textbf{Initial PPS Rate} = \frac{(1^{st}\text{ Full Year Allowable Costs}) \times (\text{Inflation})}{1^{st}\text{ Full Year Visits}}$$

Alternative Payment Methodology

The Act requires the establishment of a baseline PPS rate for each FQHC, as described in the previous section. The Act also allows states to reimburse FQHCs via an alternative payment methodology (APM), provided the APM is agreed to by the State and the FQHC; and results in payment to the FQHC that is at least equal to the amount the FQHC would have received under the PPS rate methodology.[31]

The Department implemented a new methodology for calculating APM rates, effective July 1, 2018. This current methodology calculates three separate encounter rates for FQHC services:

1. Physical Health Rate.
2. Dental Health Rate.
3. Specialty Behavioral Health (SBH) Rate.

The rate setting methodology establishes the APM rate as the lower of the annual rate or the base rate for each encounter rate category.

[29] Social Security Act of 1965, Section 1902(bb)(3), Payment for Services Provided by Federally Qualified Health Centers and Rural Health Clinics.
[30] Colorado State Plan Amendment SPA CO-18-0014, Attachment 4.19-B, effective July 1, 2018.
[31] Social Security Act of 1965, Section 1902(bb)(6), Payment for Services Provided by Federally Qualified Health Centers and Rural Health Clinics.

1. **Annual Rate:** FQHCs' audited encounter rate, calculated as total allowable costs (per category) divided by visits, with inflation applied.
2. **Base Rate:** The base rate is calculated using the most recent three years of audited costs and visits, with inflation applied, to calculate an encounter rate.

Physical Health Rate

The physical health rate includes costs related to direct covered health care services that are not considered dental services or SBH services, and thus included in the encounter rates for those services. This includes costs for:

- Physicians, physician assistants, nurse practitioners, and nurse midwives.
- Nurses, nurse aides, and medical assistants.
- Medical supplies, equipment, and repairs.
- BH services that are not included in the State's BH Capitation contract with RAEs or covered by the state's reimbursement for short-term BH services.
- An allocation of covered health care services that are applicable to all three encounter rates (e.g., medical records, patient transportation, and case management).
- An allocation of overhead.[32]

The Department's APM rate methodology includes a "quality modifier" for the physical health rate in order to incentivize participation in the Department's quality incentive program for FQHCs. Up to 4% of each FQHC's physical health rate may be withheld if the FQHC does not earn the maximum quality modifier. Earning the maximum quality modifier equates to earning 100% of the physical health rate and having none withheld. Additionally, FQHCs that earn the maximum quality modifier are eligible for redistribution dollars from FQHCs that do not earn all their physical health rate due to achieving less than the maximum quality modifier. FQHCs that do not earn the maximum quality modifier may have their physical health rate reduced by 1%, 2%, 3%, or 4% due to the scores received in the quality program. An FQHC's quality modifier is determined by the FQHC's performance on quality indicators in the previous calendar year. This quality incentive impacts only the physical health rate, and not the specialty BH rate.

Dental Health Rate

The dental health rate includes the direct costs of providing dental services, as well as an allocation of shared and overhead costs. This includes costs for:

[32] The covered health care services are applicable to all three rates, and overhead costs are allocated within the cost report template based on reported direct costs.

- Dentists and dental hygienists.
- Dental supplies, equipment, and repairs.
- An allocation of covered health care services that are applicable to all three encounter rates (e.g., medical records, patient transportation, and case management).
- An allocation of overhead.

Specialty Behavioral Health Rate

The SBH rate includes costs for services provided through the Colorado behavioral health Capitation contracts, costs associated with short-term BH services, and an allocation of shared and overhead costs. This includes costs for:

- Clinical psychologist and clinical social worker.
- Licensed marriage and family therapist, licensed professional counselor, and licensed addiction counselor.
- SBH supplies.
- An allocation of covered health care services that are applicable to all three encounter rates (e.g., medical records, patient transportation, and case management).
- An allocation of overhead.

The three encounter rates are designed to capture the cost per visit associated with providing one of the three types of services, rather than accumulating total cost and visit information for the FQHC into an all-inclusive rate. The rate paid for SBH services (whether the PPS or APM rate), is used for analysis and comparison in this report.

Many FQHCs began providing SBH services for the first time during SFY 2019, so SBH utilization was very low (or zero) for many FQHCs initially standing up their SBH service lines that year. There were two factors contributing to the resulting downward trend in average SBH rates from SFY 2019 to SFY 2021:

1. **Use of Physical Health Rate**

   FQHCs are paid the Physical Health (PH) encounter rate at the onset of providing SBH services, because the SBH rate cannot be set due to a lack of SBH costs and visits on the prior cost report. PH rates are often higher than SBH rates due to higher wages paid to PH provider staff (such as physicians) as compared to behavioral health provider staff (such as licensed professional counselors), as well as other factors.

2. **Start-up of SBH Services**

   When FQHCs begin providing a new service, costs and visits can be unstable. Often, FQHCs experience low utilization initially, as potential clients may be unaware of the new service

offered. At the same time, FQHCs may incur costs for hiring, training, and staffing the new type of service that are disproportionate to low utilization. Increased costs with low utilization contribute to higher SBH rates. However, as utilization picks up, the SBH cost per visit may normalize over time. This can also lead to a decrease in SBH rates after an initial start-up period.

COVID-19 APM Rate Setting Methodology

The COVID-19 pandemic impacted FQHCs operations in a variety of ways, causing significant fluctuation in costs and visits. Most commonly, utilization sharply declined and new types of expenses were incurred to outfit staff and facilities with protective equipment. Some FQHCs made large investments in telehealth infrastructure, and FQHCs took a variety of approaches to managing staff.

The Department implemented inflationary adjustments to the APM rates to avoid establishing reimbursement rates to be paid in future rate periods that would not accurately reflect FQHC operations during the future rate period. The Department implemented inflationary rate adjustments, which involves using the most recent pre-pandemic APM rates applying inflation to set rates for the subsequent year.

These inflationary adjustments started for FQHCs with fiscal year ending May 31, 2020 and were implemented for rates effective December 11, 2020.

Most specialty BH claims are billed to the RAEs; however, if criteria as outlined previously are met, certain services may be billed FFS directly to the Department. Additionally, the scenarios described for CMHCs that result in Department payment of capitated BH services (e.g. retroactive eligibility and members that opt out of the RAE) apply to FQHCs as well.

FQHC Patient Population

FQHCs serve diverse populations of patients, regardless of insurance coverage or ability to pay. Within the SBH service line, FQHCs receive a single encounter rate for a large number of different procedure codes covered by the state's capitated behavioral health benefit. In any given year, the mix of services provided, and acuity of the population served could increase or decrease the resources required to serve the patient population, even if the number of visits remains stable.

FQHC Business Models and Strategies

FQHCs vary in size, location, and patient populations they serve. In addition, business models vary among FQHCs, and leadership direction drives business operations. Strategic initiatives, such as expansion and mergers, shape the future of the organization's operations and footprint. Managerial decisions lead to the expenditures incurred, and efforts such as marketing can influence utilization. Even accounting system set-up and cost report preparation procedures have an impact on the SBH reimbursement rates ultimately set.