## HB22-1268 "Behavioral Health Provider Rate Comparison Report" Analysis

September 5, 2022

COMBINE is a political committee advocating for a diverse, competent, and sustainable Colorado Medicaid mental healthcare workforce and represents the Independent Provider Network of contracted clinics.

**Introduction**

> *"The Mental Health Center of Denver receives $592 in Medicaid reimbursement for an hour of counseling, for example, compared to the $91 Medicaid pays an independent clinician for the same service. And the Denver center receives $818 for an hour of crisis intervention compared to the $47.50 an hour paid to the private provider."*
> *(https://www.denverpost.com/2021/12/05/colorado-mental-health-centers-investigation/)*

Reporting in 2021 revealed publicly the vast disparity between rates paid to "Centers", also called CMHCs (Community Mental Health Centers) and small providers contracted to provide Medicaid behavioral health care, collectively known as the IPN (independent provider network) for the exact same services, specifically 90791 (intake assessments) and 90837 (53+ minutes of individual counseling), which represent the majority of outpatient counseling. The quote above also shows 17x difference for an hour of crisis intervention.

Representatives Richard Holtorf (R-Akron), and Judy Amabile (D-Boulder) sponsored and passed the bipartisan HB22-1268 as the public and legislators wanted an explanation for the disparity.

The intention and requirements of this legislation are plain: "the state department shall publish a behavioral health rates report of medicaid reimbursement rates," and "the state department shall contract with an independent auditor to prepare the behavioral health rates report."

Further, the law requires "recommendations on creating equitable payment and payment models that minimize inappropriate payment variation in comparable behavioral health services."

[The report, produced by the Colorado Department of Health Care Policy and Finance], published August 15, 2022, is excellent in terms of describing the rate setting process and the costs incurred by the CMHCs and makes recommendations about modifying how CMHCs are paid.

The report also:

- Meets neither the letter nor the spirit of the law, which was, to contract with an independent auditor to both review and remedy the inequitable payment models existing currently,
- ignores the impact these inequitable rates impose on the workforce at Centers,
- maintains a vague and incomplete narrative about the rate setting process,
- obfuscates the corporate capture of the state's $1 billion Medicaid mental healthcare system,
- minimizes the work of the IPN and ignores the cost of that work,
- does not discuss MHPAEA Parity concepts relating to rates,
- minimizes the rate differences,
- does not provide context for important statistics,
- does not offer adequate recommendations to remedy the enormous payment variation,
- offers "value based payments" as the remedy to rate differences, and
- confuses the workforce, the public, and the legislators.

The explanation of the rate differences offered by HCPF is that rates for Centers "must" be higher than the rates for the IPN in order to pay the Centers for "non-billable" yet required safety net services.  This creates undesirable outcomes, most notably the exhaustion of the early career workforce. HCPF states that these inequitable rates are inevitable without discussing the significant and complex implications for the Centers, the IPN, and ultimately, for clients with Colorado Medicaid.

The Centers are caught in an unfair and untenable situation wherein, they have negotiated rates for services at huge multiples of what the IPN is paid in order to support large programs which provide necessary but non-billable services as well as the top-heavy Executive structure of the Centers.

In essence, the front-line staff at the Centers, often interns, and recent graduates with little experience, must generate revenue to fund mandated services solely through large volumes of counseling sessions. This puts an unbearable weight on the emotional bandwidth of front-line counselors, who are tasked with high caseloads and burn-out volume scheduling.  This leaves a void both at the Center and in our state. The Centers are left with large numbers of open positions they are unable to fill, clients are left with minimal services, or languishing on wait lists.

Meanwhile, the IPN also struggles to staff clinics given the difficulty in contracting and low-rates they are paid by Medicaid. The IPN is often unable to increase wages for staff, whether contracted or employed, due to the low, varied, and unpredictable rates.

**A common-sense solution is plain. The Centers must be reimbursed for all the actual services they provide, so that the counseling rate can be related to the cost of counseling, and not tied to the entire range of safety net services they provide.**

Unfortunately, HCPF's report does not address the all too common difficulty experienced by Colorado's Medicaid members who are searching for appropriate mental health care. Clinicians in the IPN often hear about long waiting times to get in for services, frequent turn-over of clinicians at Centers which leave members unwilling to pursue treatment with a clinician they believe will likely leave within a few months' time, or their inability to schedule regular appointments due to clinicians' high caseloads.

This report goes to extensive lengths to describe the costs CMHC's pay to deliver their mandates (p. 55):

> 1. Personnel costs – Salaries, payroll taxes, and employee benefits of direct program staff and indirect administrative staff.
>
> *These same costs are borne by independent providers, though rarely do IPN clinics have top-heavy administration costs, and instead offer higher salaries to their clinicians.*
>
> 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.
>
> *Independent clinics also pay for supplies, instructional material, supervision, and transportation.*
>
> 3. Occupancy costs – Janitorial, maintenance and supplies, property insurance, rent, real estate taxes, and utilities.
>
> *Independent clinics have these same expenses. One difference is that typically the Directors of IPN clinics, which are small businesses, are "wearing many hats", and operating as directors, clinicians, and supervisors, and performing HR, marketing, IT, and janitorial tasks as well. Notably, this is mainly because these activities are not funded, directly or indirectly, as they are at the CMHCs.*
>
> 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 expenses for owned or leased vehicles.
>
> *Many of these costs are also borne by the IPN.*
>
> 5. Depreciation and amortization – Depreciation and amortization for all owned assets.

*IPN providers also own computers, tablets, mobile phones, printers, professional testing supplies, etcetera that depreciate.*

6. Professional fees - Non-clinical professionals and consultants who are not employees of the CMHC."

*Independent providers also pay accountants, lawyers, trainers, website developers, and other professionals.*

**There is no such description in the report of the costs the IPN bears, nor admission that the IPN bears similar costs and this is seen as a problematic aspect of this report.**

HCPF offers descriptions of the CMHC services that revenue from counseling supports, but there is no equivalent description of all the services or costs, outside of counseling itself, that the IPN supports, such as clinical training, supervision costs, and uncompensated transportation, in addition to everything that was mentioned above.

This is a report about CMHC costs and services, without discussion of the IPN costs and services. The report works hard to explain how CMHC rates are set, yet there is no equivalent explanation of how IPN rates are set.

**IPN Rate Setting not mentioned in the Rate Report**

Besides the approximately $1 billion in 'capitated' payments to the RAEs, HCPF has a small (around 3% of mental healthcare spending) fee-for-service program. In a rare example of MHPAEA Parity with medical health care, the description of HCPF's own mental health care rate setting process refers to a "standard cost based rate methodology" process, presumably matching HCPF's medical health care rate setting process.

"For Outpatient MH/SUD, the Department uses its standard cost based rate methodology that factors in indirect and direct care requirements, facility expense expectations, administrative expense expectations, and capital overhead expense expectations.

HCPF's rates for its fee-for-service program are influenced by the MPRRAC (Medicaid Provider Rate Review Advisory Council) and are within range of the prevailing wage. The rates are higher than any RAE rates, although Colorado Access offers rates within 5% of the MPRRAC rates. In some cases the RAE rates are more than 30% lower than HCPF's rates. The July 2022 MPRRAC rate schedule shows the rate for CPT code 90837 (a 53+ minute counseling session) as $128.03. Historical schedules can be retrieved here.

RAE rate setting processes however are not “similar” (as required by HB19-1269 Mental Health Parity) to medical rate setting or even similar to each other.

The processes each RAE uses to determine rates is described in the 2022 HB19-1269 mandated annual “Parity Report”, without reference in this Rate Report, in Appendix K, where vague and terse descriptions of how rates are determined by the RAEs are found on pages 129 to 136.

*Rocky Mountain Health Plan (region 1)*

"IP/OP/EC: [Rocky Mountain Health Plan] may determine reimbursement rates on the basis of State funding levels and/or fee schedules. Scarce services may receive special consideration for higher rates. This is true for all services."

Rocky does not report that individual conferencing with Rocky executives is required for rate increases, an opaque process with potential biases of all sorts, that’s not revealed to providers and is at least biased against introverts and less business minded clinicians.

RMHP will only raise rates for select provider groups after the group requests a private meeting and Rocky assesses if they are a good fit for their “preferred provider network.” This process is also not publicly known so many providers are not able to receive these increases, which creates an unfair bias for business savvy practice owners who are “in the know.”

*Beacon (regions 2 and 4)*

"[Beacon] creates and maintains a fee schedule with Medicaid appropriate rates, uses available tools to determine usual and customary rates including, but not limited to, Colorado Fee For Services Medicaid Rates and standards, CMS Reimbursement Rates, or market standards."

Beacon rates are in fact significantly lower than Colorado Fee For Service Medicaid Rates (discussed above as MPRRAC rate), CMS Reimbursement Rates, or market standards (prevailing wages).

*Colorado Access (regions 3 and 5)*

"COA utilizes established reimbursement methods such as: DRG for inpatient; RBRVS, EAPG, and Colorado Medicaid fee schedule for outpatient. In addition, provider contracts may also include value based arrangements that provide incentives for meeting quality of care KPI’s."

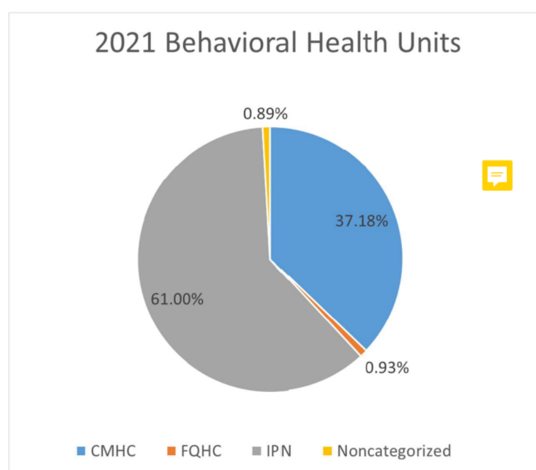
Colorado Access, the only non-profit manager, does in fact currently offer rates within 5% of the MPRRAC rates. Providers are grateful for the recent rate increases which have increased access for Denver and Aurora Medicaid members.

*CCHA/Anthem/Elevance (regions 6 and 7)*

“The factors that CCHA uses to determine provider reimbursement rates include: (a) provider location – urban vs.rural; (b) provider setting – office or facility; (c ) competitiveness of our rates; (d) CPT/HCPCS code being billed; (e) Medicare reimbursement and tables illustrating office expenses; (f) education level of provider; (g) frequency with which a provider type specific codes; (h) for new CPT/HCPCS codes, evaluation of whether it is a replacement of a prior code, which we would crosswalk to the prior Reimbursement amount, or a new code, where fees will be set based on relativity to surrounding codes; (i) Health First Colorado fee schedule; and (j) any legislative actions or requirements to our payment model.”

This rate setting process is dissimilar to the medical rate setting process, and dissimilar to HCPF’s mental health care rate setting process, and dissimilar to the other RAEs.

The exclusion of the rates, costs, and services related to the IPN is astonishing given the disclosure, on page 21, that the IPN provides more service than all of the CMHCs combined.



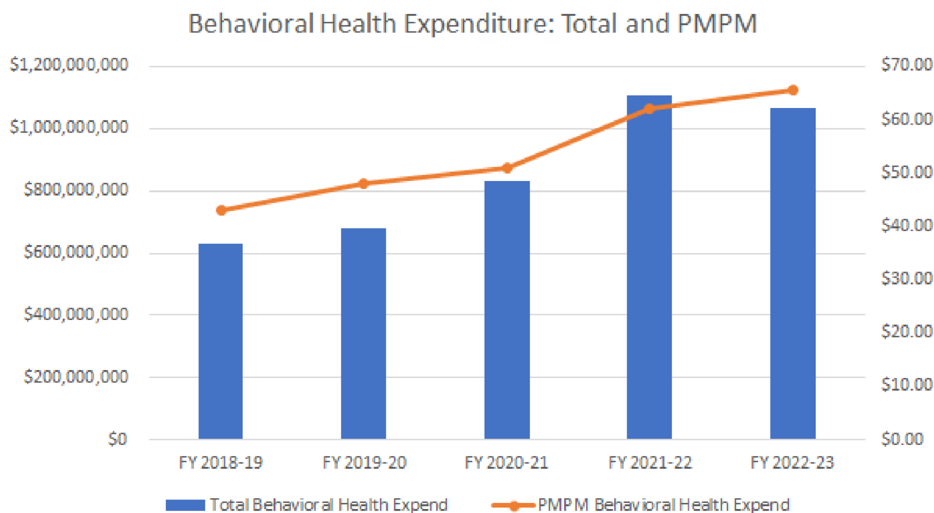

The entire discussion of IPN rates in this Rate Report is reduced to

> “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.” (p. 20)

Here HCPF absolves itself of responsibility for protecting the IPN from the vicissitudes of the RAEs rate setting processes, which differ from RAE to RAE. Without access to the courts, or administrative support from HCPF, the IPN must seek protection from the General Assembly and the press.

The report does not ever mention the actual dollar amount of the program under consideration.

The mental health care portion of HCPF's budget is a 1,000 million dollar program (see page 69 of the HCPF FY 2022-23 JBC hearing slides,) with most of that money coming from the federal government, as per page 18 of the slide deck.




The total budget for all services; medical, mental health, substance use disorder treatment, home care, and etcetera is $4 billion from the Colorado general fund, and a total budget of around $13.5 billion.

The report does not tackle the issue of how the RAE managers are incentivised by profit nor does it report any dollar figure of how profitable this program is for the RAE managers. This profit drive is directly related to the reimbursement rates for the IPN, and therefore should be discussed in the report.

Likewise there is no mention of the obvious tension between keeping profit and providing service, or the millions of dollars paid to the managers each month. HCPF prides itself on running the department with a 4% overhead. Likewise the federal Social Security program operates on 0.6 % of annual benefits, far far below the 11- 15% cut that the Colorado Medicaid mental healthcare managers enjoy. The RAEs are obligated to spend 85% - 89% of what they are given, a healthy profit margin.

The IPN workforce is contracted and managed by the managing corporations, the corporations fronted by regional accountability entities or "RAE"s. The for-profit managing corporations are not identified in this report until Appendix B.

Anthem manages mental health care for CCHA. (Anthem is now rebranded Elevance.) Anthem, United Healthcare (which purchased Rocky Mountain Health Plan in 2016) and Colorado Access, benefit from regular access to the HCPF administrators. Beacon, another manager, which was acquired by Anthem in March of 2020, is, like all the managers, unnamed in the report except on page 49 in Appendix B. The fact that three of the four are for-profit entities is an important part of any conversation about rate setting and provider payout because profit will influence how these entities determine their rates.

Notably, if the IPN provides most of their services, they are incentivized to pay that workforce less to maintain their allowable level of profit..

The IPN contracted providers, who feel and act on an obligation to serve the poor, a spiritual and cultural value shared by many Colorado providers, have no choice but to contract with these corporations by the state if they want to serve this population; yet, the state and the managing companies offer no employment, no pension, no benefits, and no predictability.

Other workforces for government provided services, notably imprisonment, policing, and education, while under wage and working condition pressures, have some rights, particularly the right to organize and bargain as a collective. State workers and teachers are permitted to organize and do organize. The contracted mental healthcare workforce is prohibited from organizing by the National Labor Relations Act.

IPN contracts contain extremely one-sided provisions favoring the managing entities, notably gag orders, where the IPN is prohibited from disclosing the service rates. The IPN is also required to arbitrate individually, rather than collectively, and worst of all and most germane to this report, there is a requirement to accept that consideration (reimbursement rates) may be changed by the manager, not by the IPN, after contracts are signed. HCPF is aware of this, and there is no regulatory response.

With such solid support by the administration, the companies responsible for delivering mental health care dominate the workforce without consequence. Ultimately the variance and unpredictability lead providers to leave the networks and the remaining providers feel the press of higher demand.

***Sections***

***Does not meet the letter or the intent of the law***

COMBINE, a political committee organized to advocate for a diverse, sustainable, and competent Medicaid mental healthcare workforce, initiated discussions with Rep. Holtorf and Rep. Amabile before the 2022 General Assembly session, with the intention of enacting a minimum rate schedule for the IPN. HB22-1268 mandating a rate review report and action plan was the result of that effort, seen as a first step toward understanding and modifying the rate setting process.

Advocates were surprised initially by HCPF support, particularly the reduction of the fiscal note to $0 by the department. Although there have been recent and hopeful signs of collaboration, after the IPN advocated for more open and regular communication, HCPF has worked closely with the RAE managers while marginalizing the concerns and realities of the IPN, as evidenced by:

- HCPF offered no resistance to a 20% rate cut by CCHA/Anthem/Elevance/RAE 6,7 in January of 2020.

- HCPF took years to facilitate the JBC mandated 2% "pass through" rate increase when the RAEs simply kept the money.
- HCPF did not regulate or intervene when RAEs imposed and then removed prior authorization policies that were duplicative and administrative expenses. Administrative expenses are paid by rates.
- When payers threatened to "recoup" past payment due to a software error on their part, IPN clinics had to appeal to the press and legislators as HCPF did not assist.

To HCPF's credit, HCPF did support SB22-156, which prohibited prior authorizations and offered some regulation of recoupment. The IPN was surprised by the HCPF 2022 Parity Report, where the reason HCPF stated for supporting prohibiting prior authorizations was due to MHPAEA Parity concepts. We look forward to further acceptance of Parity in practice, and we strongly encourage further adherence to Parity laws in regard to behavioral health services.

HCPF stated that they already had the budget to produce such a report. What advocates feared, which was co-option of the independence of the report, has come to pass. HCPF contracted with an aligned contractor who has historically produced problematic quarterly network adequacy reports (where county provider count data is no longer presented), and who relies on continued business with HCPF. COMBINE is concerned with the lack of "independent" reporting here.

In Section II of the law, an independent report is required. "The state department shall contract with an independent auditor to prepare the behavioral health rates report," and yet,

> "Though Optumas and Myers and Stauffer performed the analytics described above in Part 2, <u>this report was prepared in collaboration with the Department</u>. Part 1, Overview of the Health First Colorado BH Landscape, and Part 3, Summary, <u>were authored by the Department</u>, with collaborative input offered by Optumas, Myers and Stauffer." (p. 11, underline added by editor)

The report does not meet the requirement for independence. Myers and Stuaffer authors various reports through contracts with HCPF.

<u>Nowhere in the "Rate Review Report" is there an actual rate</u>. HCPF offers, on page 20, that, "disclosure of them violates Fair Trade laws."

Reporting average rates belies the enormous variability in the rates paid by each of the managers. United Healthcare ("Rocky", RAE 1) currently pays the lowest, unless providers cultivate a personal relationship with their executives, who choose who will get higher rates based on opaque undisclosed criteria.

To illustrate the variation between RAEs, the difference between the Beacon (RAE 2,4) rate and the Colorado Access (RAE 3,5) rate (August 2022) cannot be exactly stated here, due to the gag-rule in the

RAE contracts, which the author of this report has signed. However in a proper, independent, rate review, a difference of approximately 32% would be reported.

***Does not address the impact on the workforce by the high rates for Centers***

The tragedy of the high rates paid to CMHCs for counseling, in order to fund other services, is the inevitably high caseloads, burn out, and long wait times in between sessions for clients. This report does not include the actual impact of this payment arrangement. There is no compilation of worker experience, who are generating enormous revenue for the Centers and receiving very little of that revenue.

***Continues an incomplete narrative about the rate setting process***

The rate setting processes differ for each RAE and that deserves discussion.

For example, in 2018 CCHA/Anthem attracted providers by offering “100% of the MPRRAC rate” and later, in January of 2020, reduced the rate to 80% of the fee schedule for all IPN providers in regions six and seven. When MPRRAC then raised the rates in 2021, Anthem suddenly produced their own fee schedule and said they were no longer using the MPRRAC schedule. An adequate report of rates and rate setting would include these details.

By making the RAEs and their various rate setting processes invisible, and presenting an average rate, HCPF implies that there is some sensible rate setting process for the IPN. There does not appear to be any such thing. HCPF did not respond when Anthem decimated the IPN counseling rates in January of 2020. Later, HCPF revealed that this cut was in response to CCHA/Anthem underestimating the expense of caring for our population, a risk they were rewarded to take. Notably, that risk was then passed on to the IPN. CCHA/Anthem essentially moved the risk onto the providers without them knowing that they were vulnerable to sudden downward rate changes.

Lawmakers, providers, and the public are left in the dark about the reality of contracting with RAEs, which all have different rate setting policies.

***Obfuscates the corporate capture of the state’s Medicaid mental healthcare system***

This report, through Appendix B, explains the Medicaid managed care system as a geographic patchwork of seven RAEs (Regional Accountability Entities) giving the impression that there are 7 managers. There is no discussion of who actually receives the capitated payments from the state for managing these regions except for allusions in Appendix B.

In fact, there are organizations consuming nearly $1 billion a year, with HCPF arranged allowances of 11-15% profit taking. They are listed in Appendix B in an appreciated nod to transparency.

United Healthcare, a for-profit company, the largest health insurer in the United States, purchased Rocky Mountain Health Plan in July of 2016, which manages region one.

For-profit Anthem (now rebranded "Elevance"), the second largest health insurance company in the United States, manages mental healthcare for regions six and seven, and through Anthem's purchase of Beacon in March of 2020, a private equity leveraged acquisition of untold billions of dollars, also receives the profits from the administration of regions two and four.

Region 2 is called North East Health Partners and is actually owned by CMHCs, who pay Anthem/Beacon for administration,
"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)"

Anthem/Beacon and some CMHCs own the RAE that manages Region 4 (Pueblo area)
"Six entities co-own HCI [Region 4]
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)"

Colorado based non-profit Colorado Access manages regions three and five, which are essentially Denver and Aurora. Unsurprisingly, this non-profit RAE pays the highest rates, similar to the prevailing wage for Denver.

Restricting care by reducing the size of the provider network increases the revenue of these managers. The RAEs are paid per capita monthly. In other words, they receive monthly payments based on the number of members in their regions. The payment is not based on the care provided.

So there is an incentive to restrict care in order to increase profitability, which may be less present for Colorado Access, a non-profit organization. IPN providers have no leverage as RAEs, well within the margins of the wholly inadequate state network adequacy standards, don't need IPN provider presence

in order to stay in compliance.  On the contrary, the state has mandated that RAEs contract with all CMHCs in the geographic boundaries of a RAE, providing CMHCs with bargaining leverage.

Further, this mechanism of RAE payment and profit demands explanation and transparency in a proper Rate Report.  In the details is the "medical loss ratio" or "MLR," which HCPF reports (elsewhere) as between 89% and 85% depending on "key performance indicators."  Which means RAEs keep 11 to 15% of what they receive monthly.  Additionally, the definition of "care" is opaque and deserves transparency.

***Minimizes the work of the IPN and hides the cost of that work***

Colorado's eighteen Centers struggle and strive to provide services for a population in crisis, and deserve the funding needed to do the job they are mandated to do.  The report describes the complexities and costs of operating Centers.

Conversely, the report does not describe the services provided by the IPN beyond a mention of the service codes that the IPN bills for.  The report also does not describe the costs incurred by the IPN when providing the services.

***No mention of MHPAEA Parity issues***

The report does not mention Colorado's mental health "Parity" law, HB19-1269, which incorporates federal law into Colorado, and includes Medicaid, unlike federal law.  Federal MHPAEA compliance is also specifically mentioned in HCPF-RAE contracts. Breaches are ignored by HCPF, the RAEs, and the current Colorado attorney general's office.

Parity, simply, means processes that limit treatment that exist in behavioral health must be "similar" to physical medical healthcare.  The federal government makes plain that reimbursement rates are a Parity concern in the Code of Federal Regulations 42-438 subpart K, and it's obvious that lower rates will attract less providers to provide a given service, limiting treatment.

Not only are the rate setting processes very different between the RAEs (see our Report on HCPF's 2022 Parity Report), the rate setting process for medical services is vastly different (and therefore a violation of Parity exists)  from any of the RAEs' rate setting process.  The report makes no mention of the MPRRAC, the Medicaid Provider Rate Review Advisory Council that produces a Medicaid fee schedule, which medical providers enjoy but to which behavioral health providers are not entitled, except for the small fee-for-service program.

***Minimizes the rate differences***

Several times in the document HCPF reports that, “there is a 2x to 3x difference in the reimbursement rates between CMHCs and Independent Providers.” (p 5, 33, 36, 38) From Susan Greene’s reporting as well as documents obtained through CORA, the difference is in fact as great as 6.5x and in some cases even greater. HCPF does the people a disservice by minimizing the variance.

***Does not provide context for important statistics (network adequacy, decline in service, rates)***

HCPF asserts in various ways that “The network adequacy standards have been consistently met by the Managed Care Entities (MCEs) with no substantive violations” (p. 4, p. 37, and paraphrased on p. 39).

This is true, and also leaves out any discussion of what the network adequacy standard is, or whether the current network adequacy standards actually meet the needs of the people. Every CMHC and every IPN provider is well aware of the demand for services and the lack of providers to meet the need. Over 10,000 qualified Colorado LPC, LMFT, LCSW and PSY providers refuse to participate in the network because of the low rates, arbitrary and changing licensing fees, unnecessary reporting (such as the CCAR), fear, experience of arbitrary management, and lack of support by the state.

The managers’ contracts are public documents, in an appreciated nod to transparency, and can be read here. Note on page 67 of the RAE 6 CCHA contract that the network adequacy standard is 1 provider for every 1800 members. This standard favors the corporate managers in its laxity.

> *9.4.11. The Contractor shall ensure that its Provider Network meets the following practitioner to Client ratios and distance standards:*
> *9.4.11.1. Adult primary care providers: One (1) practitioner per eighteen hundred (1,800) adult Members.*

The report references the quarterly network adequacy reports which are published by HCPF without acknowledging that the authors of those regular reports are the same as the authors of this Rate Review Report.

COMBINE has a longitudinal project examining these reports and quarterly makes CORA requests of HCPF for the raw data produced by the RAEs and transmitted to HCPF. The results are disheartening and call for legislative or administrative intervention. For example, prior to 2021 the reports offered a count of providers per county. That disaggregation is now gone. Thus there is no baseline to measure providers dropping out or adding to the system.

Due to this obfuscation, there is simply no way to measure the impact of policy changes on the workforce. Additionally reports have had odd large black redaction squares and incorrect dates for reporting periods and publication. COMBINE published some results in 2021.

Another example of a concerning statistic without context is on page 5, “There has been a steady decline in average units of service provided since SFY 2018 for all three CMHC groups (small, medium, large),” which begs explanation.

Page 37 offers this statistic: “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.“ This hides the drop in participation after the 20% cut in January of 2020. For example, for Boulder County, the HCPF network adequacy reports from 2019 and 2020, which disaggregated provider counts by county, showed a ⅓ drop (from 364 to 240) provider participation. There is now no way to see these impacts.

“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.” This ignores the 20% cut to rates in 2020.

***Offers “value based payments” as the remedy to rate differences***

The IPN clinicians are concerned about the repetition of the phrase “value based payments” repeatedly in HCPF planning documents. The reality is that there is no brake on RAE managers’ behavior and the managers are free to decide on their own in regards to rates and payment policy.

Since the current network adequacy standard is so easily met, RAEs have no other regulation to comply with that would encourage them to increase the size of their networks, by offering prevailing wages.

“Value Based Payments” is an invention of management consulting companies and is bandied about with the implication that outcomes will increase and expenses will be lowered. There are mixed results across the land and legislators must be vigilant when the term is offered as if there’s a magic bullet to creating a more economical healthcare system.

One form of VBP requires tracking “Key Performance Indicators” (KPIs) that must improve in order to receive payment. In many cases the KPIs currently used in the various RAEs experimental VBP trial programs are inappropriate for outpatient psychotherapy. For example, “hospital readmission” may happen one time in a year for a clinic with over 600 clients, which would be difficult to improve.

So, payment to providers based on such a parameter does not make sense in the context of outpatient behavioral health. Other KPIs are often similar in that they do not relate to outpatient mental health.

While improvement in “stakeholder involvement” is mentioned in the recommendations, the current track record of inclusion of the IPN in policy needs improvement, as exemplified by the recent notification of changes to supervision qualifications without consultation with the IPN, despite regular meetings with COMBINE in which those changes could have and should have been discussed.

The IPN must interact with all the managers in order to serve the population, particularly clinics north of Denver, where they deal with Ft Collins clients (RAE 1), Weld County clients (RAE 2), Boulder/Broomfield County clients (RAE 6) and Denver clients (RAE 3,5).

This will mean managing multiple "value based payment" arrangements with varying reporting requirements, varying "key performance indicators" and varying pay rates, billing processes, and claim cycle times.

Medical providers will not have to manage this, reducing their administrative costs, which improves access relative to BH providers, which, again, has Parity implications.

***Confuses the workforce, the public, and the legislators.***

The document inaccurately claims, on page 10, that, "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." Any adequate discussion of the "current delivery system" in a Rate Review Report would report actual rates, and this report does not. There is no differentiation of the RAEs, who behave and pay independently of each other.

By reporting average rates rather than actual rates, the report hides the information the law asks for while encouraging the reader to believe that the current delivery system is accurately and completely described.

On page 12 HCPF discusses "seven regional accountability entities" when the providers actually contract through four service companies (United Healthcare/Rocky, Anthem/Elevance/CCHA, Anthem/Beacon, and Colorado Access).

Readers of the report are faced repeatedly with the assertion that, "the Medicaid reimbursements to independent providers will never be as high as the safety net providers." This phrasing appears several times in the document (p. 4, 17, 34, 36 ), and represents the core of HCPF's narrative.

HCPF suggests that the system is immutable (by repeating the word 'never') and that the system is proper.. As discussed above, this reimbursement system is not proper and produces suboptimal outcomes.

In several places HCPF reports that the IPN "negotiates" rates with the managers, as on pages 14, 19, 20, 21, and 32. For example, on page 32 the report reads, "IPN rates are based on proprietary negotiated rates with the RAEs, as is customary in managed care models." Such negotiations are not the reality of many of the IPN providers. There may be occasional negotiations, however the parties are far from equal in bargaining power. Individual IPN providers actually have no power in these "negotiations."

In Part 3, which the report admits HCPF wrote, states on page 35 that "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 actually provides no rate data except for aggregated averages. The report does not adequately "guide the evaluation of BH rate methodologies" because it leaves out any description of rate setting by the RAEs.

Central to Representative Holtorf and Representative Amabile's law is "[HCPF] shall prepare, ... a set of recommendations on creating equitable payment and payment models that minimize inappropriate payment variation in comparable behavioral health services between [Centers] and [the IPN]"

Such a set of recommendations does not appear in the report and as stated before, the report does not adequately address the similarities in costs of services expended by the IPN and only focuses on this for the CMHCs, which does not create an appropriate comparison.

There are however encouraging signs in the recommendations, which speak to modifying how Centers are paid. However, there is no discussion of how the IPN rate setting process will be modified.

It is also not appropriate that HCPF chooses to compare IPN Medicaid rates to "commercial carrier rates," rather than prevailing wages, as the commercial market struggles to attract providers, and is challenged to deliver care due to closed networks, low rates, secretive rate negotiating processes, while imposing cost sharing on commercial members which is illegal in Medicaid.

**Conclusion**

Members of COMBINE believe now is the time for strong measures in support of Colorado's Medicaid members–by providing a diverse, sustainable, and competent mental health workforce that supports both the larger Centers and the IPN.

The Colorado legislature and administration could support this workforce and facilitate the treatment so many Coloradans need by:

- Studying, mandating, and enforcing network adequacy standards guaranteeing sufficient care for Medicaid members and other insured people. The state has various network adequacy standards, such as those for commercial health insurance, the Colorado Option, and Medicaid.
- Requiring a minimum rate for services, such as MPRRAC rates, as allowed by CMS for states under managed care.
- Legislating transparency for all factors in the Medical Loss Ratio calculation.
- Prohibiting funding of mandated safety net services by billing for unrelated clinical services.
- Requiring rate setting processes comply with HB19-1269 Parity and MHPAEA Parity concepts.