July 29, 2023 (draft, not for release)

The July 2023 Federal Proposal Updating MHPAEA "Parity" and Colorado's Direction Forward for Medicaid Mental Health Care MHPAEA Compliance

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Introduction

The federal departments responsible for implementing the mental health Parity laws have issued rule changes and a lengthy narrative offering intentions, explanations, definitions, and research. Colorado's Medicaid system, as administered by HCPF and managed care entities must comply with MHPAEA (25.5-5-103). HCPF and MCEs will need support for bringing Parity reporting into compliance with these rules. Because these federal departments limit enforcement of MHPAEA to employee covered plans, a Colorado department must step into the shoes of the federal departments to hear complaints, evaluate HCPF and MCE compliance with MHPAEA, and accept and monitor corrective actions.

Legislative action is needed to update 25.5-5-103, increase FTEs and authority of the Behavioral Health Ombudsman in CRS 27-80-303, extend OSA authority to include MCEs that administer the Medicaid mental health program, direct HCPF to establish minimum rates and eliminate tiered rates, direct the state Board to establish a rate setting process that complies with MHPAEA, establish rules for provider directories for Title 25-5 Medicaid (following CRS 702-4-2-55-5), extend contracting duration limits set for medical services in SB21-126 to Title 25-5, and provide resources for HCPF and MCEs to comply with reporting requirements.

Background

The MHPAEA (Mental Health Parity and Addiction Equity Act) changes proposed by the federal government are relevant to Colorado Medicaid because HB19-1269 and HCPF's RAE contracts both incorporate MHPAEA Parity rules into the governance and operation of Colorado's (Title 25-5) Medicaid system, as administered by the Department of Health Care Policy and Finance.

> *CRS 25.5-5-103. Mandated programs with special state provisions - rules.*
> *(4) (a) the state department shall ensure that benefits under the medical assistance program for behavioral, mental health, and substance use disorder services are no less extensive than benefits for any physical illness and are in compliance with the MHPAEA*
> *(b) The state board shall adopt rules establishing the procedures for reimbursement pursuant to this subsection (4) by January 1, 2020.*

HCPF is a de facto health insurance organization, and in fact as Director Bimistefer reports, "the largest health insurance provider in the state," with more enrolled members than Anthem/BCBS/Elevance/Carelon/Beacon, Aetna, Cigna/Evernorth, Kaiser, Optum/United Healthcare, Friday, Bright Health, Oscar, or any other commercial carrier. HCPF, unlike all other health insurance providers, is not regulated by the Division of Insurance' Title 10.

The concept of Parity, both in spirit and letter, requires substantial similarity in processes that create "treatment limitations," between mental health care and medical health care. This is expressed in rule as:

> *"MHPAEA's fundamental purpose is to ensure that individuals ... who seek treatment for covered mental health conditions or substance use disorders do not face greater barriers to accessing benefits for such mental health conditions or substance use disorders than they would face when seeking coverage for the treatment of a medical condition or for a surgical procedure." (page 10)*

As indicated in the report, the federal departments have seen little change and little compliance with federal MHPAEA rules since 2014, and inequities in how mental health care is provided versus medical/surgical care continue to limit Americans' access to mental health treatment, and are therefore updating the rules of the law.

The Colorado independent providers (the "IPN", not the 17 CMHC Centers) that deliver Medicaid mental health care services are well aware of the impacts on care and access when Parity is not enforced, which contributes to difficulty attracting available providers to participate. Over 20,000 Colorado licensed professional counselors, marriage and family therapists, and social workers, qualified to provide care, choose not to.

Since the advent of the RAE system in 2018 Medicaid mental health care has been managed by Managed Care Entities (MCEs). This creates Parity challenges, as mental health care and medical care have operated substantially differently, and have created treatment limitations that are dissimilar. The US healthcare system has evolved into many health plan issuers contracting with service organizations, which are referred to in MHPAEA as Third Party Administrators (TPAs). Three organizations providing administrative services are:

> RAEs 2, 4, 6, 7: Anthem/Elevance/Carelon/Beacon/"CCHA"/"North East Health Partners"/"Health Colorado"
>
> RAE 1: United Healthcare/Optum/"Rocky Mountain Health Plan"
>
> RAEs 3,5 : Access Management dba "Colorado Access"

Repeatedly the federal departments affirm that reimbursement rates and policies that determine reimbursement rates, are treatment limitations, and therefore rate setting policies are regulated by the act.

The rate setting process for medical/surgical services is significantly different from the rate setting process for mental health services for the same covered members receiving Medicaid benefits. The current Medicaid system is out of compliance with MHPAEA and related Colorado law and contracts.

Not only are the rate setting processes for mental health care different from processes to set rates for medical/surgical services, each RAE has a different rate setting process. This has created a wide variety of rates for the same service, which creates disparities of access to care within Colorado.

The Colorado administration, legislation, and stakeholders must join hands and work together to bring Colorado's Medicaid program into compliance, for the sake of operating lawfully and supporting the mental health of Coloradans.

Proposals

Amend Title 25-5-103(4)(b) to incorporate the updated federal MHPAEA rules and redirect the state board to adopt rules establishing the procedures for reimbursement by July 1, 2024.

Because the federal departments will not provide administrative infrastructure to examine and determine compliance by HCPF, which is in the role of a regulated insurer, a Colorado department independent of HCPF must step into the regulator's role. The Behavioral Health Ombuds office established in HB 18-1357 requires sufficient staff and authority to perform the compliance activity that otherwise would be performed by federal departments.

The federal regulation details several changes to existing oversight activities. Essentially the federal departments expect insurers and third party administrators to complete comparative analyses of treatment limitations regularly. Federal departments intend to increase the minimum number of requests to payers for these analyses from a minimum of 20 per year to 100.

Regulators then examine these reports for completeness and may request further information. New time periods for producing additional reports are in the changes. Federal departments then substantiate a finding of a violation, and request corrective action. Further, a notice of violation must be sent to enrolled members (with a 14 point headline stating "Attention! …" and the corrective action planned by the insurer).

MHPAEA does enable fines through the parts enacted through the IRS., and Colorado should create the authority to impose fines on the MCEs (Managed Care Entities) contracted to manage Medicaid mental health care. "In addition, employers that violate MHPAEA may be subject to an IRS excise tax. Generally, an excise tax of $100 per individual, per day will apply to MHPAEA violations, unless an exception applies. Any applicable excise taxes must be reported on IRS Form 8928, "Return of Certain Excise Taxes under Chapter 43 of the Internal Revenue Code."

Colorado needs an independent body to evaluate the comparative analysis HCPF is required to produce, with authority to compel additional data from MCEs and HCPF, and an administrative judicial process to hear and substantiate findings of MHPAEA violations. If violations are found, the administrative judicial process needs authority to order a repair for the lack of parity.

HCPF currently produces an annual Parity report, found here. The proposed federal rule changes will require at least the additional inclusion of a comparative analysis of the rate setting process, which has not yet been a component of the HCPF Parity report. The various rate setting processes for how rates are determined by the RAEs appears on pages 129 to 136 of the 2022 HCPF Report. The variations between RAEs and lack of similarity with medical rate setting processes are obvious. COMBINE's memorandum on the 2022 HCPF Parity report is here.

HCPF produces quarterly and annual network adequacy reports, found here. Network adequacy receives special attention in these rules. HCPF needs support for accurate tracking of the network, including accurate counts of providers and of available providers, accurate provider directories, and disaggregation for licensure tiers in reports, including accurate counts of services provided by licensed professionals, licensure candidates, and clinical university interns.

To address the rate setting process violation, Colorado has the authority under CMS (federal Medicaid/ Medicare) rules to create a minimum fee schedule for managed care operators to follow. While the state may not mandate rates, the state may mandate minimum rates. This allows for MHPAEA compliance by using a similar process to set rates for mental health care that is used to set rates for medical and surgical care.

Review of federal rule proposal

The introduction beginning on page 5 (and pages 170-176) provides excellent statistics, motivations for rule changes, challenges, and some history of recent compliance efforts. Ultimately access to outpatient mental health care saves health care dollars.

> *"[M]ental health is crucial to a person's overall well being, and access to quality mental health and substance use disorder treatment is as essential for health as access to medical/surgical treatment. Moreover, failure to treat mental health issues can be costly. For example, depression is associated with increased risk of cardiovascular disease, diabetes, stroke, Alzheimer's disease, and osteoporosis, and an untreated substance use disorder may result in hospital emergency room care for a drug overdose. (page 170)*

Network adequacy, the key to supporting the mental health of Medicaid members, is highlighted :

> *A key component of access is the availability of an adequate number of appropriate providers within a plan's network. A survey of adults with private health coverage found that plan participants were more likely to perceive their mental health provider networks as inadequate when compared to medical provider networks. (page 9)*

Network size reporting is confounded currently in Colorado by the variety of methods RAEs follow when reporting network size to HCPF. These processes are not similar to how the size of the medical/surgical network is measured and impact access to treatment by giving legislators a false impression of the size of the network. For example, RAE 6 (Boulder, Golden) and RAE 7 (Colorado Springs area) are presented as having impossibly equivalent networks, since Anthem counts a provider in Boulder as a provider in Colorado Springs. These practices must be examined and if found in violation of Parity, changed.

Page 18 outlines the purpose for changes, "Specifically, the proposed regulations would:

- "Make clear that MHPAEA requires that individuals can access their mental health and substance use disorder benefits in parity with medical/surgical benefits.
- "Provide specific examples that that make clear that plans and issuers cannot use more restrictive prior authorization and other medical management techniques for mental health and substance use disorder benefits; standards related to network composition for mental health and substance use disorder benefits; and factors to determine out-of-network reimbursement rates for mental health and substance use disorder providers.

- "Require plans and issuers to collect and evaluate **outcomes** data and take action to address material differences in access to mental health and substance use disorder benefits as compared to medical/surgical benefits, with a specific focus on ensuring that there are not any material differences in access as a result of the application of their network composition standards.
- "Codify the requirement that plans and issuers conduct meaningful comparative analyses to measure the impact of NQTLs. This includes evaluating standards related to network composition, out-of-network reimbursement rates, and prior authorization NQTLs.

An example of outcomes data is evidence of provider participation in the network through actual claims, rather than lists of providers. Currently HCPF is unable to produce such data as supervised care is recorded as provided by a supervisor, masking the actual rendering provider.

> *"These proposed rules also aim to ensure that plans and issuers that offer mental health and substance use disorder benefits strive to attain and maintain mental health and substance use disorder treatment provider networks that are as robust as their medical/surgical provider networks in terms of available in-network providers and facilities–not just as shown by a list of names in a provider directory, but as measured by actual provider participation and as evidenced by participant usage.*

HCPF's Parity report will need additional data to meet new MHPAEA requirements. The federal departments are interested in how treatment limits (here referred to as an NQTL) **actually** impact the enrolled population.

> *"Under the current rules, plans and issuers are generally permitted to prepare NQTL comparative analyses without regard to the overall impact of NQTLs on participants and beneficiaries. This has contributed to plans and issuers looking for ways to characterize the processes, strategies, evidentiary standards, and other factors associated with an NQTL as being "comparable" and "applied no more stringently" through careful word choice, without regard to how, **in operation**, the limitation burdens participants and beneficiaries by limiting access to, or by limiting the scope and duration of, the plan's or issuer's mental health and substance use disorder benefits relative to medical/surgical benefits." (page 21)*

In operation, the different rate setting processes of the RAEs have contributed to limiting access to care, and therefore the processes must be similar to the rates setting processes for medical and surgical care to comply with MHPAEA. HCPF's Parity report must include data and a comparative discussion of these processes, and produce a plan to correct the difference.

Comparative analysis requirements

Page 32 details the elements required for a comparative analysis of processes that limit treatment:

(1) the specific plan or coverage terms or other relevant terms regarding the NQTLs and a description of all mental health and substance use disorder benefits and medical/surgical benefits to which each such term applies in each benefit classification;
(2) the factors used to determine how the NQTLs will apply to mental health or substance use disorder benefits and medical/surgical benefits;
(3) the evidentiary standards used to develop the identified factors, when applicable, provided that each factor shall be defined, and any other source or evidence relied upon to design and apply the NQTLs to mental health or substance use disorder benefits and medical/surgical benefits;
(4) the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than those used to apply the NQTLs to medical/surgical benefits in the benefits classification; and

(5) the specific findings and conclusions reached by the plan or issuer, including any results of the analyses that indicate that the plan or coverage is or is not in compliance with MHPAEA requirements.

Page 136 offers more details. A "comparative analysis include[s], at a minimum, with respect to each NQTL:

(1) a description of the NQTL;
(2) the identification and definition of the factors used to design or apply the NQTL;
(3) a description of how factors are used in the design or application of the NQTL;
(4) a demonstration of comparability and stringency, as written;
(5) a demonstration of comparability and stringency in operation; and
(6) findings and conclusions.

For example, the treatment limitation at hand is the rates setting process. For an adequate comparative analysis, HCPF would disclose the process by which medical/surgical rates are determined, and also disclose how mental health care reimbursement rates are determined, These descriptions would include the factors involved in rate setting. Then HCPF would offer a result of the analysis indicating compliance with MHPAEA or not.

Independent review

Since HCPF is required to operate the Medicaid program under MHPAEA rules, without the federal apparatus to collect and examine comparative analyses, and accept, investigate, and adjudicate complaints, the state of Colorado must stand up a program to take the place of the federal departments in implementing Parity.

Such a program would be tasked with evaluating the Parity report produced by HCPF for completeness according to these standards, which rightfully belongs to a sufficiently staffed Behavioral Health Ombuds office. The program would also direct HCPF to produce comparative analyses of treatment limits based on Medicaid member and Medicaid provider complaints. Currently HCPF chooses which treatment limitations receive the research resources.

Page 33 demonstrates the need for a MHPAEA program, independent of HCPF, to satisfy MHPAEA rules, for evaluation and enforcement. The Consolidated Appropriations Act of 2021 (a part of the MHPAEA laws) "... sets forth a process by which the Departments must evaluate the requested NQTL comparative analyses and enforce the comparative analyses requirements."

As described on page 33, some entity must determine HCPF's compliance and non-compliance. "...the plan or issuer [HCPF] must specify the actions it will take to come into compliance and submit additional comparative analyses that demonstrate compliance not later than 45 days after the initial determination of noncompliance. Following the 45-day corrective action period, if the relevant Department [CO BH Ombuds] makes a final determination that the plan or issuer is still not in compliance, the plan or issuer must notify all individuals enrolled in the plan or coverage of this determination, not later than 7 days after such final determination."

One set of teeth in the proposed federal regulation is a mailed paper notification to all enrolled individuals, after a final determination. COMBINE is dubious of the impact of this consequence, and Colorado should create an authority for the Behavioral Health Ombudsman to direct HCPF to eliminate the conditions violating MHPAEA via a writ of mandamus, forcing action. The federal rule aligns with this. On page 62, "Upon such a determination, the Departments **would direct the plan or issuer to not impose the NQTL** that is the subject of the comparative analysis, unless and until the plan or issuer can demonstrate compliance or take appropriate action to remedy the violation."

Page 154 describes the content of the mailed notification to all covered persons, including:

- a summary of any changes [HCPF] has made as part of its corrective action plan
- an explanation of any opportunity for a participant or beneficiary to have a claim for benefits reprocessed.
- a summary of the Secretary's [CO BH Ombuds] final determination that the plan or issuer is not in compliance with MHPAEA, including any provisions or practices identified to be in violation of MHPAEA,
- any additional corrective actions identified by the Secretary [CO BH Ombuds] in the final determination notice
- information on how participants and beneficiaries can obtain a copy of the final determination of noncompliance from [HCPF].
- any other actions the plan or issuer is taking to come into compliance with MHPAEA,
- information on when the plan or issuer will take (or has taken) such actions
- a clear and accurate statement explaining whether the Secretary [CO BH Ombuds] has indicated that those actions, if completed, will result in compliance.
- contact information for questions and complaints
- a statement explaining how participants and beneficiaries can obtain more information about the notice, including a phone number and an email or web portal address for the plan or issuer, and contact information for the relevant Department [CO BH Ombuds].

The rules reiterate that process to determine reimbursement rates are an important treatment limit:

> *These proposed rules would also amend the illustrative, non-exhaustive list of NQTLs … with "standards related to network composition, including but not limited to, standards for provider and facility admission to participate in a network or for continued network participation, including* ***methods for determining reimbursement rates****, credentialing standards, and procedures for ensuring the network includes an adequate number of each category of provider and facility to provide covered services under the plan or coverage." (page 79)*

New rules, "add a requirement to provide that, when designing and applying an NQTL, [HCPF] must collect and evaluate relevant data in a manner reasonably designed to assess the impact of the NQTL on access to mental health and substance use disorder benefits and medical/surgical benefits, and consider the impact as part of the [HCPF's] analysis of whether such NQTL, in operation, complies with proposed [MHPAEA rules]). These proposed rules would permit the Departments {CO BH Ombuds] to specify the type, form, and manner for this data collection and evaluation in future guidance." (page 83 and 84).

Up to this point, HCPF has held the position that the MCE's may set mental health care service rates without HCPF influence. Compliance with MHPAEA would mean HCPF "collects and evaluates" data to assess the impact of the treatment limit, in this case the varying rate setting policies.

Remedies

Page 90 offers remedies for disparate outcomes that indicate Parity violations, including rate changes:

"Plans and issuers would be required to take action to address material differences in access or no longer impose the relevant NQTLs. Such actions could include, for example,

- ensuring that they or their service providers (as applicable) make special efforts to contract with a broad range of mental health and substance use disorder providers who are available,
- **including authorizing greater compensation or other inducements to the extent necessary**;
- expanding telehealth arrangements as appropriate to manage regional shortages;
- notifying participants and beneficiaries in clear and prominent language on the website, employee brochures, and the summary plan description of a toll-free number for help finding in-network providers;

- ensuring that the plan's or issuer's service providers (as applicable) reach out to the treating professionals and facilities to see if they will enroll in the network;
- and ensuring the network directories are accurate and reliable.

Pages 99 to 120 offer 12 "examples" of treatment limitations that may or may not be MHPAEA violations. These are illustrative of the variety of approaches insurers and TPAs take to limit treatment.

Tiered fee schedules

Example 4 on page 105 discusses a "tiered" reimbursement schedule.

> *"In operation, the plan reduces the reimbursement rate for mental health and substance use disorder non-physician providers from that paid to mental health and substance use disorder physicians by the same percentage for every CPT code but does not do the same for non-physician medical/surgical providers."*

This situation has close parallels in Colorado. HCPF has allowed MCEs to create tiered rates, based on education credentials and no other factors, to reduce reimbursements to the vast majority of providers, who have masters degrees and not PhDs or MDs. This occurred on January 1, 2020 when Anthem/CCHA reduced rates. An hour of psychotherapy is a service, and the service provider, regardless of degree, may have experience, expenses, adjacent unfunded programs, supervisory risks, professional recognition, additional education, inflation adjustment, and natural acumen, none of which are accounted for in the current reimbursement schemes.

Additionally, a large amount of care for Medicaid clients is provided under supervision. The reimbursement is illogically tied to the education credential of the supervisor, and no other factors. So two clinics offering the same service through supervised work will receive different rates if the billing supervisors have different education levels. There is no evidence that MDs, who currently occupy the top tier for rates, provide "better" individual trauma resolution, attachment or somatic based psychotherapy, family/couple counseling, or child therapy than an experienced masters level clinician.

Example 13 on page 118 specifically references reimbursement rates as a factor in network adequacy, a clear Parity concern, stating how "plans and issuers may comply with these proposed rules with regard to parity, including the requirement to collect and evaluate data, with respect to standards related to network composition, including standards for provider and facility admission to participate in a network or for continued network participation, **methods for determining reimbursement rates**, credentialing standards, and procedures for ensuring the network includes an adequate number of each category of providers and facilities to provide covered services under the plan or coverage.

Third party administrators (TPAs, aka MCEs)

The federal departments are clear that large service organizations, acting as third party administrators (TPAs), such as Colorado's MCEs, have the data and resources to support comparative analysis, and therefore these organizations are intimately involved with MHPAEA compliance:

> *Issuers and TPAs are therefore the ones most likely, and the ones the Departments have overwhelmingly observed, performing the work to evaluate NQTLs and provide the comparative analysis and required data.*
>
> *These proposed rules are expected to continue this trend of issuers and TPAs performing the required work for plans. While plans could be charged for these services, this arrangement provides for economies*

of scale in compliance as issuers evaluate NQTLs, produce or assist in producing the comparative analyses for their products and, in combination with TPAs, provide support for other requirements.

> *Because TPAs … overwhelmingly design the plans, administer the networks, manage claims, provide plan services, maintain and hold the data relevant to the comparative analyses, and drive MHPAEA compliance, they are in the best position to conduct comparative analyses, and to provide the analyses in an efficient and cost-effective manner. (page 187)*

Audit authority

Page 135 discusses the lack of authority for the federal government to regulate the Third Party Administrators, a challenge that needs resolution in Colorado for successful MHPAEA implementation.

> *"The Departments understand that, in practice, plan sponsors [HCPF] often rely on … service providers [Colorado's MCEs] to administer their benefits, including designing and implementing the limitations and coverage terms that are subject to MHPAEA requirements and providing them with comparative analyses (or detailed information to inform the development of comparative analyses) for the NQTLs that the … service providers themselves design and apply to mental health and substance use disorder benefits and medical/surgical benefits under the terms of the plan or coverage.*

The MCEs are not under the audit authority of the Office of State Auditors, as they are not state departments. MCEs repeatedly claim "trade secrets" when asked to produce data, such as reimbursement rate schedules. Representative Michaelson Jenet discussed extending OSA authority in the Legislative Audit Committee but that bill has not appeared yet.

The federal departments state, "The Departments are committed to using all available authority to ensure compliance by plans and issuers with MHPAEA for all entities that play a role in administering and designing benefits." Colorado should make this commitment.

Provider directories

Finally, Page 165 speaks to provider directories, which are a Parity concern due to the dissimilar processes each MCE has for producing directories. "Code section 9820(a) and (b), ERISA section 720(a) and (b), and PHS Act section 2799A-5(a) and (b), as added by section 116 of title I of Division BB of the CAA, 2021, establish standards related to provider directories."

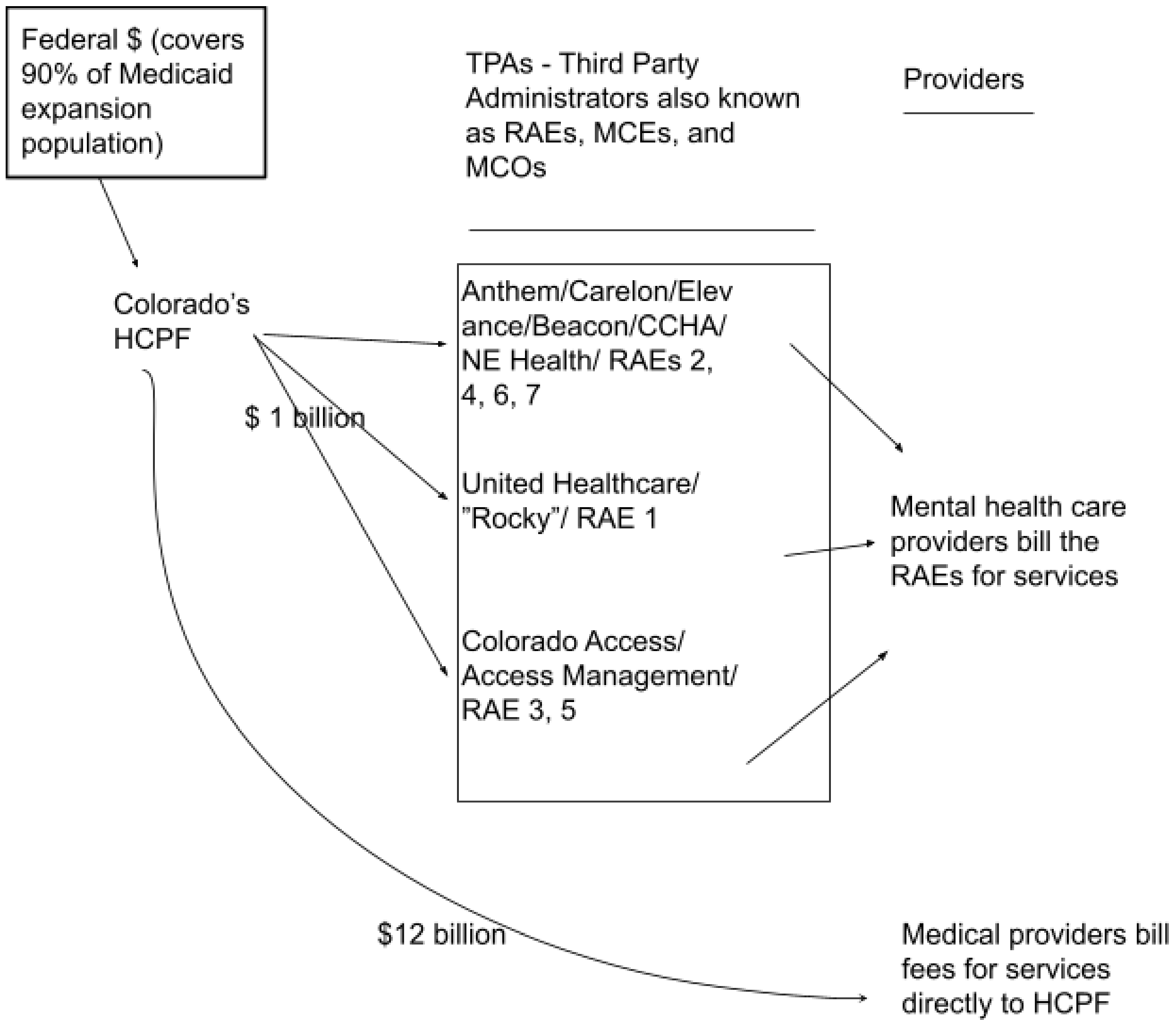
Directories are an important part of accessing the mental health benefit and inaccurate directories result in members experiencing frustration and abandoning care seeking. Colorado should establish some minimum rules for provider directories for Title 25-5 Medicaid, following CRS 702-4-2-55-5, which regulates provider directories for commercial insurance.

About COMBINE

COMBINE, a 501c4 trade association and Small Donor Political Committee, organizes Medicaid members and also the Independent Provider Network (IPN) of solo, small, and medium sized clinics that provide a majority of the Medicaid outpatient mental health care in Colorado. Currently (July 2023) COMBINE organizes around 170 clinics and over 900 mental health providers. COMBINE advocates for a diverse, competent, and sustainable Medicaid mental healthcare workforce. Andrew Rose, LPC, COMBINE's Policy Committee Chair, is responsible for this document and can be reached at andy@combinebh.org

Appendix A: Federal - HCPF - RAE - Provider Chart

Mental health care providers are subject to various third party managed care entities' rate setting processes, while medical/surgical providers are not.



Appendix B: Private equity capture

Top 10 corporate owners of Anthem, United Healthcare, and Alight Solutions, as of March 8, 2023, according to Finviz. This shows near complete control of the healthcare administration apparatus by out-of-state private equity firms.

Anthem	
Corporate Owner	Ownership (%)
The Vanguard Group	11.80%
BlackRock	9.40%
State Street Corporation	6.00%
FMR LLC	5.60%
T. Rowe Price Associates	4.10%
Principal Financial Group Inc.	3.40%
Dimensional Fund Advisors LP	3.20%
Bank of America Corp	3.10%
Invesco	3.00%
UnitedHealth Group	
Corporate Owner	Ownership (%)
The Vanguard Group	9.10%
BlackRock	8.05%
State Street Corporation	5.30%
FMR LLC	5.10%
T. Rowe Price Associates	3.70%
Principal Financial Group Inc.	3.20%
Dimensional Fund Advisors LP	2.90%
Bank of America Corp	2.80%
Invesco	2.70%
Alight Solutions (a large TPA)	
Corporate Owner	Ownership (%)
Vanguard Group	12.40%
BlackRock	10.10%
State Street Corporation	6.30%
The Vanguard Group Inc.	5.90%
FMR LLC	5.60%
T. Rowe Price Associates	4.00%
Principal Financial Group Inc.	3.60%
Dimensional Fund Advisors LP	3.50%
Bank of America Corp	3.30%