March 13, 2021

COMBINE Parity Concerns submitted for HCPF Parity Report

Comment here or email info@combinebh.org. We will submit our concerns before April 1 and we're happy to include your additional concerns or work with you to make our list more accurate and complete. We need your help to stop the exodus of providers from outpatient Medicaid behavioral health.

HCPF has requested stakeholder input for their annual parity report, and requested information before April 1, through this form :
https://docs.google.com/forms/d/1qIIGrLKZhesyPEGpl35uOEQ0sklww7V_WGjdvy5zAHw/viewform?edit_requested=true

"Scott Bennett - HCPF <scott.bennett@state.co.us>
Subject: Mental Health Parity Invitation for Public Comment
Hello,

The Department of Health Care Policy & Financing (Department) has begun work on the annual Mental Health Parity and Addiction Equity Act (MHPAEA) Report to assess the compliance of the Medicaid benefit with mental health parity laws. To inform this work, the Department is gathering stakeholder thoughts and experiences related to mental health parity that will be used to design the mental health parity analyses and inform its annual report.

If you are interested in submitting written comments, you can do so using this form.

The form will be open until April 1. The purpose is to collect feedback from stakeholders; the Department will not be responding to submitted comments.

Please share this request with any individuals or groups that may be interested in providing input.

Thank you,
Scott Bennett

Our reference for parity is:

MHPAEA, which does not cover Medicaid [sic MHPAEA covers Medicaid in states where Medicaid is managed by managed care entities], and SB19-1269, which does cover Medicaid in Colorado, and the HCPF-RAE contracts, which incorporate MHPAEA language.

Here's typical contract language between HCPF and the RAEs regarding parity:

14.15. Parity
14.15.1. The Contractor shall maintain compliance with all relevant State and Federal laws regarding Mental Health Parity and Addiction Equity Act (MHPAEA).
14.15.1.1. To meet the requirements of 42 CFR 440.395, the Contractor shall cover, in addition to services covered under the state plan, any behavioral health services necessary for compliance with the requirements for parity in mental health and substance use disorder benefits in 42 CFR part 438, subpart K. Identification of services will be contingent upon work done by parity contractor's analysis.
14.15.2. The Contractor may not impose Non-Quantitative Treatment Limits (NQTLs) for mental health or substance use disorder benefits in any classification unless, under the policies and procedures of the Contractor as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification.

14.15.2.1. The Contractor's pre-authorization requirements shall comply with the requirements for parity in mental health and substance use disorder benefits as described in 42 CFR 440.395(b)(4).
14.15.3. The Contractor shall provide to the Department all necessary documentation to show that behavioral health services provided through the MCE delivery system and/or through an external entity are compliant with the Federal parity requirements under 42 CFR 438, subpart K

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Presumably, 14.15.1 mandates compliance with SB19-1269 Parity.
"Subpart K" makes clear that reimbursement is a parity concern.

Reimbursement

1) In 2018 CCHA/Anthem originally offered 100% of the MPPRAC rate for counseling, approximately $103 for one hour of counseling. This minimally sufficient rate (compared to market and Medicare rates) attracted providers. Then, after a year of signing up providers, presumably for network adequacy, the rate was dropped to 80% on Jan 1, 2020.

This amounts to a bait-and-switch in contracting, which is an illegal deceptive trade practice.

This behavior by Anthem went unanswered by HCPF as far as providers could see. Anthem's explanation, furthered in public meetings by HCPF was that "Anthem needed to attract more psychiatrists." It is unlikely that lowering MA level reimbursement rates would attract more psychiatrists, and in the following year, there is no evidence that this policy change attracted psychiatrists.

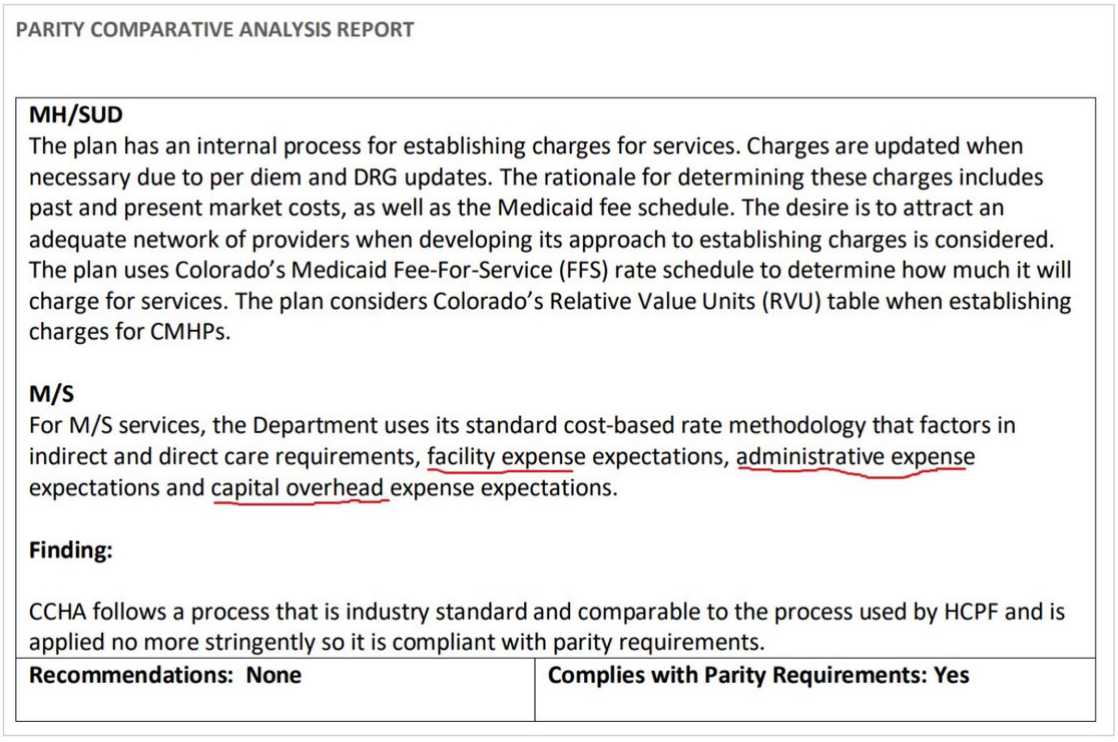
This increased providers' sense of vulnerability to essentially at-will rate changes and the sense that HCPF did not have providers' interest. The drop in participation was precipitous. CCHA reported 364 providers in Boulder County in October of 2019 and then 240 in October of 2020. This is a 1/3 drop in contracted provider participation.

2) The reimbursement cut from 100% to 80% violated parity as expressed in SB19-1269. Reimbursement is an obvious treatment limitation, as low reimbursement means less providers which means less access to care. The process for determining rates should be similar. Contrary to this, medical rates are set by MPPRAC and mental healthcare rates are set by RAEs however they want. These processes are obviously not similar.

3) HCPF 2020 Parity report, produced by CedarBridge Group, obfuscated the different rate setting processes and concluded there was no parity concern, even though the document went on to list four parity concerns, identifying "opportunities to prevent potential future parity compliance violations."

In numerous places in the document, CedarBridge Group determines that the rate setting processes are different, and inexplicably declines to find a parity concern:

For example, page 175 describes rate setting for Anthem, Outpatient care:



PARITY COMPARATIVE ANALYSIS REPORT

MH/SUD
The plan has an internal process for establishing charges for services. Charges are updated when necessary due to per diem and DRG updates. The rationale for determining these charges includes past and present market costs, as well as the Medicaid fee schedule. The desire is to attract an adequate network of providers when developing its approach to establishing charges is considered. The plan uses Colorado's Medicaid Fee-For-Service (FFS) rate schedule to determine how much it will charge for services. The plan considers Colorado's Relative Value Units (RVU) table when establishing charges for CMHPs.

M/S
For M/S services, 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.

Finding:

CCHA follows a process that is industry standard and comparable to the process used by HCPF and is applied no more stringently so it is compliant with parity requirements.

Recommendations: None	**Complies with Parity Requirements: Yes**

CedarBridge Group explains that mental healthcare reimbursement rates are set by an "internal process" that prioritizes attracting an adequate network, and a nod to the MPPRAC FFS schedule. While Anthem may use the MPPRAC schedule as a basis, they then adjust for their own unstated reasons.

For medical rates, facility, administrative, and capital overhead costs are included in the calculation. These processes are obviously different. CedarBridge Group further compares the rate setting processes to HCPF's processes rather than compare them to each other, as required for a proper analysis.

Disparity in reimbursement between Centers and contracted counselors

Centers (Community Mental Health Centers) receive significantly different reimbursement rates for the same service that contracted clinicians receive. In some cases, the same 90837 hour of therapy gains a Center over $300, while contracted services received well below $100.

While these rates may make sense given the unfunded or braided-funded services provided by Centers, it shows that there is no compliance with parity in rate setting.

2020 CedarBridge Group Parity report recommendations

The Executive letter to Senator Fields states,

"recommendations included aligning prior authorization determination timelines, standardizing medical necessity processes, and ensuring appropriate member access to providers. The Department will coordinate with the managed care entities to research CedarBridge Group’s recommendations to determine which are appropriate for implementation."

We are concerned that Anthem's prior authorization program, introduced March 1, 2021, has no stated timelines for either prior authorization determinations or appeal timelines.

The RAEs have expressed that Centers are not obliged to file prior authorization requests for outpatient counseling. We are of course concerned about the administrative load and frequency of these requests and are confounded by the policy that Centers' clinicians are free of this burden.

We are also concerned that there is no standardization of medical necessity determination between the RAEs, and no comparisons or oversight regarding these mental healthcare standards and medical standards.

For example, United Healthcare, which manages RAE 1 (Rocky), has communicated that the standards for determining prior authorization for mental healthcare were compared to Occupational Therapy and Physical Rehabilitation to determine parity compliance. This is not an appropriate comparison.

Of course the precipitous drop in provider participation lowers members' access to provider.

The CedarBridge Group report suggested attention to these concerns (p. 4):

NQTLS:

While all RAEs utilize MH/SUD prior authorization determination timelines in compliance with statute, it is recommended that all are brought into alignment with comparable medical/surgical timelines.

Require the RAEs and MCOs to use the statutory definition of medical necessity in applying their policies and processes.

Require that MH/SUD providers not be restricted from participation in the network by geographic location, facility type, or specialty.

Colorado Access' restriction on pre-licensure therapy without OBH facility licensure

The Uniform Service Coding Standards Manual governs Medicaid in Colorado, and indicates that university interns and pre-licensure professionals are qualified to provide services. Unlike everywhere else in Colorado, Colorado Access currently limits such practice to facilities that are licensed by the Office of Behavioral Health, an impediment to access to members, who are clustered around Denver and Aurora. This policy has economic and racial implications, as more immigrants and people of color reside in the area.

This may not be a parity concern, as medical services typically take place in licensed facilities. However, there is no governing body or resource that could examine such questions related to parity.

Member Attribution

Attribution is made plain in the 2017 RAE RFP on page 23 (3.3.5).

"Using either a claims-based attribution methodology or a Client choice based attribution methodology, the Department will attribute Clients to a PCMP. Based
on the PCMP’s geographic location, the PCMP Practice Site will be contracted with only one RAE.

The geographic location of the Member’s attributed PCMP will determine the
Client’s assignment to a RAE. Members will be able to choose a PCMP at any time through the Department’s enrollment broker.”

The current attribution policy violates parity and causes treatment limitation. Because members are allocated to the RAEs by physical address of their PCP, mental health care gets interrupted.

For example, children in high conflict divorce, where they get treatment in Boulder under CCHA/Anthem, then go to a clinic in Denver with a medical concern, are automatically re-attributed to Colorado Access. Then they come back to Boulder for more play therapy, then we bill, then the claim gets denied, because we were never notified of the switch. The parent is then burdened with calling HealthFirst to get the re-attribution reversed.

Network Adequacy

We are greatly concerned that network adequacy, a parity concern, is established, overseen, and adjusted differently between medical providers and mental health care providers. Regrettably, statistics regarding the networks, which RAEs are obligated to report and HCPF is obligated to publish, are opaque, delayed, and scanty.

An analysis of Network Adequacy Reports is here.

HCPF Validation, and RAE Credentialing and Contracting Times

We are concerned in general that parity is either not well understood by HCPF or disregarded. Parity must be incorporated into governance.

For example, this year's SB21-126 "Timely Credentialing Of Physicians By Insurers" could be amended to include mental healthcare, as it would if parity were a serious consideration that HCPF was tracking and supporting.

Prior Authorization

CCHA/Anthem introduced a prior authorization program which commenced March 1, 2021. The section called "Utilization Management" in the HCPF-CCHA contract details requirements for informing HCPF of these new schemes. We are concerned about HCPF's oversight of the prior authorization program and efforts to comply with Parity.

The contract mandates that members are notified of a benefit change. CMS is clear that introducing a new prior authorization program changes benefits. CCHA/Anthem failed to notify members, leaving the drama for therapists to deal with.

Anthem's prior authorization program does not comply with parity. Medical requires treatment of underlying causes. If you have stomach pains, you should get more than aspirin, because you could have an appendix about to burst.

The care guidelines produced by Anthem do not allow for treatment of underlying causes.

They mention "symptom reduction" and "functional improvement." This is a dangerous path. Our PTSD clients may show functional improvement and symptom reduction because they are avoiding trauma triggers. Avoidance itself is a symptom of trauma. Rather than approving treatment for the underlying unprocessed trauma, we anticipate treatment denials.

Medication management is billed and administered differently than counseling.

The Anthem prior authorization program creates non-parity. All medication management services (except for mental health centers) now get billed to FFS Medicaid as they are considered medical services. So, essentially any medical CPT codes (99202-99205 & 99212-99215) are unlimited while psychotherapy codes are not. Additionally, the add-on psychotherapy codes for prescribers (90833 etc.) are unlimited.

Essentially if a prescriber uses a psychotherapy code it is unlimited but if a therapist does it is not.

Commercial insurance prior authorizations are regulated

While commercial insurance regulation and Medicaid regulation occur in different spheres, HB19-1211 extends prior authorization protections to commercial consumers, and should be extended to the Medicaid consumers.

Since there is no Parity governance, or resource to review parity concerns, the prior authorization protections offered to medical Medicaid services are unknown.

Payer mix

HCPF has advertised that physicians may control their payer mix (not accept Medicaid clients and still accept private pay) while mental healthcare has no such freedom.

Extension codes

RAEs pay medical for "extension codes" for sessions that go much longer than typical, but not behavioral health.

Governance

HCPF could create a governance structure to review Parity concerns and assure Parity compliance. Such a committee would have expert knowledge of the processes and procedures that govern NQTLs for both medical and the mental health services.

Massachusetts parity law describes governance, see https://malegislature.gov/Bills/191/S2546

Parity Enforcement

SB19-1269 has no private cause of action, leaving enforcement of Parity concerns in doubt. Without strong interest and adherence by HCPF, the RAEs receive the signal that Parity concerns will not be examined.