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Dear Colorado Representatives:

Thank you for taking the time to read this important letter. I am writing to you as a private citizen, business owner of a Colorado-based mental health group practice / clinic, registered voter, and active member of the Medicaid advocacy group called COMBINE. Our group practice has offices all over Colorado and with telehealth, we are able to serve constituents all over the state so our interest in this topic is far reaching, covering all Colorado districts. COMBINE constitutes a growing number of concerned citizens including licensed and prelicensed mental health practitioners who serve Medicaid members in private mental health practices across Colorado. I am also an active member of a Facebook group of Medicaid mental health providers; unfortunately, for many reasons, many of those providers have expressed that they have or will be relinquishing their Medicaid contracts, greatly reducing the already sparse Medicaid behavioral health provider network. We are grateful that expanding access to mental healthcare is one of your concerns and look forward to forging an allyship with you. We ask that you to consider recent developments (or continuing concerns) within the Medicaid behavioral health structure, which greatly impacts the care Medicaid Members receive. All the following points are equally important and deserve sincere attention as they significantly reduce or create insufficient access to care. None should be regarded as any more or less important than the other. Each point will be discussed in more depth below:

REVALIDATION, CREDENTIALING, AND CONTRACTING ISSUES

Licensed Mental Health Providers

The process for becoming a behavioral health Medicaid provider is unusually cumbersome. After first becoming licensed through the Department of Regulatory Agencies (DORA), one must complete a lengthy registration with the Council for Affordable Quality Healthcare (CAQH) (required by all insurance panels) and then become validated through Colorado's Dept of Healthcare Policy and Financing (HCPF - Health First Colorado). Unfortunately, the HCPF website is not particularly user intuitive, and it has some ill-planned aspects to it that can easily trigger errors (e.g., the cursor does not automatically start at the beginning of a line which can produce mistyped information.) Instructions for how to apply are confusing and very difficult to find; it is not clear what information is being asked for in many fields. The most vexing aspect is that there is no way to log back in and fix a known error or edit information once the application is submitted or resubmitted; one must wait until it is returned by them for corrections, which can take weeks and sometimes months. (The Medicaid portal in general has many problems that continue to exasperate administrative users).

Many new applicants (individual providers) who have not learned how to navigate this system through trial and error, often get their applications kicked back for "mistakes," and frequently wait weeks to hear of those errors. Many give up after a few attempts and never end up completing their application out of sheer frustration. (This is frequently posted by fellow clinicians in several of the mental health provider Facebook groups around Colorado.) Those who do stick with the process *may* see their initial state validation application completed within a month if nothing needs to be corrected. However, if corrections need to be made, which is more likely the case, it is often six weeks to several months for just this step in the process. Even seasoned group practice administrators who submit these regularly often see high wait times for their submissions; our group has one of many recent examples that took four months and was only pushed through (in less than two days) because, as a practice owner, I went up the chain of command at HCPF for someone high up to review it. It was literally lost in the shuffle and it was not the first time for our group. Another problem that many providers run into is that they may have been previously registered through another organization such as a MH center and they have never had access to their own login information, and it becomes very difficult for them or the group practice they may be joining to retrieve and change this information to reflect current accuracy, which is required for RAE contracting.

After applying through HCPF, if providers want to be able to take Medicaid for all clients they may see, they then must credential and contract with each of the seven Regional Accountable Entities (RAEs), which are managed by four different companies (three of those four being for-profit). They must apply to these four different entities with four different applications, processes, and timelines. The RAE with the fastest turnaround time and the easiest process for applications is Colorado Access (COA), the only true non-profit organization. They are the most organized, have the best provider services department and are typically decent at responding to questions and requests from providers with correct information. The other RAEs (Colorado Community Health Alliance – CCHA, Rocky Mountain Health Plans – RMHP, and Northeast Health Partners and Health Colorado, Inc. – Beacon) take several months to process provider applications, with CCHA and Beacon usually taking six months to one year for many providers and RMHP taking a few months but less than CCHA and Beacon.

Newly Licensed Providers with Active Medicaid Caseloads

Another particularly daunting and disorganized process is credentialing and contracting unlicensed providers who have already been seeing Medicaid clients under supervision, when they officially become licensed. This is allowed through CCHA, Beacon and RMHP but not Colorado Access – to be discussed later. It is rather astonishing that there is not a more definitive, streamlined, guaranteed process for those with active Medicaid caseloads when they become licensed to be validated, credentialed, and contracted in an expeditious fashion. They are a group of already dedicated Medicaid providers who are familiar with all the requirements of Medicaid. Yet, they must go through the same drawn-out four-step process as other newly licensed therapists to become official Medicaid providers (i.e., licensure, CAQH, state validation and contracting with the individual RAEs, which, as stated before the latter two can take several months to a full year). There is no expedited process for them to be validated with the state and they cannot validate until they are licensed. Their timeframe for validation is the same as everyone else's.

Once licensed, they are also no longer allowed to provider services under supervision of another licensed clinician (according to regulations set by HCPF) and are considered independently practicing providers. While HCPF allows them to backdate their state validation to their date of licensure, which is the only explicit effort made by any of these organizations towards the potential for continuity of care, HCPF takes no stance on how further contracting for these providers takes place; they leave everything up to the RAEs which leads to considerable confusion. Each of the RAEs has their own policies and procedures on this, although to be certain, they are incredibly unclear. When five different high-level reps at these RAEs were recently asked about their policies and procedures for contracting newly licensed providers with active caseloads, five different answers were given. Several higher-ups at CCHA noted that even SCAs could not be guaranteed for this interim period for continued treatment for these clients. Here are some direct quotes from emails from CCHA reps with respect to these newly licensed providers specifically: Julian Stines, Network relations Consultant: "Single Case Agreements are medically managed and typically only issued if an in-network provider is unable to provide the services requested." And Tiffany Lloyd, Lead Behavioral Healthcare Manager: "The request for an SCA may be denied due to providers available in network."

So, as soon as they become licensed, these providers either have to abruptly terminate care, which is therapeutically contraindicated -- OR -- for the purposes of continuity of care, they continue to see their clients with the hopes that they 1) will eventually be contracted with the RAEs, 2) may receive Single Case Agreements while waiting for official contracts to come through which are not guaranteed, and 3) that they may meet timely filing deadlines to submit their claims for the services they are continuing to provide. Of course, this last one is particularly dismaying because they could go several months working with no pay coming in and no assurance that they will ever get paid for services that actually occurred.

Requested Changes:

1) Clearer and more accessible instructions on the state validation process and a more user intuitive platform that permits immediate corrections to submitted without disrupting the application process
2) An easy to access tracking system for submissions for applicants
3) The Medicaid contracting process should be a lot less cumbersome. Ideally, one payer contract instead of several RAEs would be ideal when the RAE contracts end in 2025.

4) In the interim, RAEs should be required to finalize contracts with providers much faster, perhaps within no more than 4 months of an applicant's submission, assuming there are no egregious errors to correct on the part of the provider. The RAEs should face a penalty if this is not accomplished in that timeframe.
5) A clear, universal, fast-tracked process for the newly licensed providers with active Medicaid caseloads to be validated with the state and contracted with each RAE is essential. While they are waiting, they should be allowed to continue to submit claims under their supervisor for the sake of continuity of care (HCPF can change this rule) or have guaranteed single case agreements for 6 months increments starting from the date of licensure, to account for the time it takes to contract. The SCAs need to be approved immediately so the provider is guaranteed that their income from this work does not get disrupted and that the client is guaranteed continued care with their preferred provider.

REGIONAL ACCOUNTABLE ENTITY (RAE) ASSIGNMENT

Differences for medical vs behavioral health

Health First Colorado, which is overseen by HCPF, handles all medical claims; there is only one payer for medical providers to send their Medicaid claims across the state, which makes thing simple in that regard for both the medical provider and consumer. Instead, for behavioral health, the state is currently broken up into seven regions with seven different RAEs, currently managed by the four organizations mentioned previously.

RAE districting and contract bidding

Every few years, organizations may bid to take over the RAE contracts for one or two of these regions at most, so there will always be a minimum of four managing organizations if there are seven regions. Naturally, when this happens, the RAEs become redistricted, and providers have to choose if they will contract with any new RAEs because their old contracts become null and void with any RAE whose contract is terminated; because of the redistricting and regional bidding process they may also no longer be contracted to take Medicaid in their own region anymore as their local RAE may have changed. (This occurred during the last bidding process with COA and BHI as well as Beacon and CCHA). Until recently, the RAEs were only offering contracts to providers in their own region so if a client moved from one region to another, the provider was no longer able to see the client. While this has changed and providers are eligible to contract with all the RAEs now, it is imperative to note that restricting contracting to a provider's region only is very poor practice and needs to be addressed in policy documents, so this does not happen again. Providers should be able to freely contract with all RAEs should they choose, if the RAEs are going to continue to be a thing. Not all providers choose to go through the overwhelming process of contracting with all RAEs either for a variety of reasons, but this can have a powerfully negative impact both the provider and the client should the client's RAE change during a course of treatment, especially if the client does not know their RAE has changed.

Problematic Process for Assignment to RAEs

Medicaid consumers are assigned to their RAE not based on their physical address (where they live) but based on which county their Primary Care Physician is located. This may have been someone they have directly chosen or someone to whom they were assigned by Medicaid and they may not even be aware of whom that is unless and until they change the provider. Consumers are often confused or uninformed about their Medicaid behavioral health benefits and to which RAE they are assigned; many have no idea what a RAE is, particularly those who are new at using their benefits. Because clients often do not know to which RAE they are assigned or why/how, or they might live in one county, but their PCP is in another county and another RAE, providers must verify all client benefits, which could change at any time if their PCP changes.

If a client moves and they change their PCP, this will impact their care if their provider is not contracted with the client's new RAE. RAE to RAE transfer is a major impediment to continuity of client care. If the mental health provider is not contracted, there is no guarantee of a Single Case Agreement (SCA) because the RAE policies state a preference for Medicaid recipients to see only in-network providers, despite how that impacts their care. Likely, the client will be forced to switch to a new provider, after establishing a therapeutic bond with their original provider. For some more emotionally fragile clients, this could be very psychologically damaging for services to have to terminate so abruptly and for them to have to work with an entirely new person.

These problems exist for both adult clients and children, but children are especially and particularly impacted by RAE changes. Problems occur frequently with children who receive services in multiple counties when their parents are divorced or share custody. If a child is registered with a RAE in one county but then visits a PCP for a medical visit in another county, their RAE then might automatically be switched as a result. If the child is receiving mental health services with a provider in the first county, the provider will not necessarily know of the switch until claims are denied. That child may then not be able to see that provider any longer if the RAE is not switched back or if the provider is not contracted with the other RAE.

Requested changes:

1) Having one non-profit entity, with adequate and separate oversight, to manage the state's behavioral healthcare would be the ideal goal. This helps to avoid the problems mentioned above with RAE assignments and contracting.
2) If RAEs are still to be a thing, Member assignment should be on a primary physical address, not based on the PCP.
3) Members and providers should have a quick and easy, universal way to look up the Member's RAE assignment. The current Medicaid portal is cumbersome and not all providers have their logins when they work for a larger private practice. It is also not always working properly.
4) Enact policy that all providers can apply to any RAE, regardless of office location.
5) Guaranteed SCAs for continuity of care when a provider is not contracted with a client's new RAE.
6) Increased consumer education on how medical and behavioral are different and how RAEs are assigned.

ADEQUATE ACCESS TO CARE

Transparency of network adequacy data

The available statistics of the number of therapists available in each region per # of Medicaid consumers for each RAE is not accurate or adequate. HCPF and the RAEs are contractually and legally obligated to provide accurate information but it is not. All the RAEs websites also list providers who are no longer contracted or taking Medicaid clients.

Prelicensure candidates and Interns

This is one of the only areas of significant complaint for Colorado Access (COA). COA administers behavioral health benefits for Medicaid Regions 3 and 5; these are some of the most populated counties in Colorado (Denver, Arapahoe, Adams, Douglas and Elbert) and have the most Medicaid recipients per capita. While Regions 3 and 5 insist that they are meeting network adequacy requirements set by the state, the ratios of available providers to the number of Medicaid Members is strikingly low, especially for children. Consumers report that they have a particularly difficult time finding a therapist who takes COA with reasonable availability. This could be significantly mitigated by allowing prelicensed and intern therapists to work with Medicaid clients under supervision like the other RAEs do. At present, COA requires a facility license or clinic designation for pre-licensure supervised therapy. The other RAE administrators (RAEs 1,2,4,6,7) do not require a facility license or clinic designation for prelicensed, supervised therapy. The process for a mental health practice to become designated as a mental health clinic through the Office of Behavioral Health is extensive, time-consuming, and requires the applicant to go through a series of tasks not typically required in private practice treatment. The current COA policy impacts network adequacy and creates a barrier for prelicensed professionals to receive important training opportunities. Because Colorado Access also administers Colorado Health Plan +, a statewide insurance for children, network adequacy is also impacted statewide by this policy. This means supervised pre-licensure externs and university supervised interns are unable to provide services except through Office of Behavioral Health licensed or designated facilities, for Medicaid members enrolled in RAE 3 or 5, and CHP+.

Shortage of Therapists who Meet Cultural Needs of Clients

A large number of Medicaid recipients are people of color, speak a language other than English, and/or identify as GLBTIQ. Most Medicaid providers are White, heterosexual, cisgender and monolingual (English only). There are not enough multilingual or culturally representative Medicaid providers to see the clients who are specifically looking for therapists with whom they can personally relate or who can communicate with them in their native language. Those providers who do identify as persons of color or GLBTIQ or who are multilingual are overloaded with

requests for treatment and cannot serve all the clients who want to see them. Most Medicaid recipients are paired with a provider who often cannot identify with their experiences, especially in mental health centers, and under certain circumstances, this can be an impediment to quality care. Despite whatever multicultural training White, heterosexual, monolingual providers may have had, training is not a substitute for connection based on lived experience. It is also not adequate to provide services to a client who speaks a language other than English with an English only speaking therapist. This bolsters the case for enabling supervised prelicensed and intern therapists to provide services as well, as it may increase the chances for more BIPOC, multilingual or GLBTIQ providers to be in the Medicaid provider pool. Although not intended to substitute for working with a BIPOC, GLBTIQ, or multilingual therapist, early career therapists should have as many opportunities as possible to learn from culturally competent supervisors while working with a diverse population. Notably, there are also not enough psychotropic prescribers who take Medicaid.

Requested Changes:

1) Transparency of network adequacy data as well as updating this data with more accuracy
2) A change in policy for COA to allow prelicensed therapists to provide therapy services under supervision
3) Create an incentivized plan to attract more qualified licensed therapists who identify in a culturally underrepresented group and/or who speak a language other than English.
4) Recruitment for prescribing psychiatrists and psychiatric NPs should be prioritized and incentivized. There are not enough prescribers who take Medicaid in general.

PRIOR AUTHORIZATIONS

General Concerns about Prior Authorizations

- Three of the seven RAEs have now established entirely separate / different prior authorization requirements, and this has created undue burdens on both the consumer as well as provider. This was recently five of the seven until CCHA abruptly stopped its prior authorization requirements without explanation, after only seven months of them being in effect (to be discussed below).
- It is an indisputable problem that for-profit companies are managing (and denying) BH benefits for Medicaid consumers. RMHP Medicaid is managed by United Healthcare, CCHA is managed by Anthem BCBS, and Northeast Health Partners and Health Colorado, Inc. are managed by Beacon Health Options which was recently purchased by Anthem BCBS. United and Anthem have lost several lawsuits in recent years for their attempts at limiting treatment to insurance consumers, several specifically related to denial of coverage through prior authorizations. There is financial incentive for these for-profit companies to deny or limit treatment as opposed to an entity like Colorado Access, which is a non-profit organization managing two of the RAEs, and interestingly, the only one that has not instituted prior authorization protocols for therapy.
- When they were in effect, the Dir of Network Mgmt at CCHA, Erica Kloehn's statement about the purpose of these preauthorizations: "The new authorization process is for the benefit of our shared members/clients with a focus on specific achievable and measurable goals in an evidence-based fashion." If they want to be assured that providers are working on appropriate treatment goals for the benefit of their clients, there is an audit process for that. Such is true for any of these authorizations from any RAE.
- All the RAEs have been clear that they will not review preauthorizations until the session limit is coming near as they want the most recent records. While the RAEs have 10 days to approve or deny treatment, the potential for this to take longer when they are inundated with requests can create significant treatment barriers, particularly continuance of care delays. We saw this with CCHA and see this with RMHP as well.
- This is incredibly anxiety-provoking for many clients who are unsure if they will be cut off from necessary treatment and providers who are telling their clients about this are seeing that their more anxious clients are decompensating around this topic; it is actually *creating* worsening anxiety for many clients. Clients are reporting that preauthorization policy is creating considerable anxiety for them. Many clients have reported to their therapists that they feel forced to "ration their care" in case they get denied and then need care later in the year. This policy will cause more psychological harm than good for many Medicaid recipients.
- The elimination or reduction of any further individual or family treatment could be within the first few months of the year and then clients are unable to seek treatment for the remainder of the year unless it escalates to a crisis situation, and they must then be hospitalized, which creates higher financial liability for the payer. Regular outpatient treatment is designed to help avoid more expensive, higher level of care.

- Consumers are being denied or are receiving reduced care with a covered diagnosis or treatment issues that are perhaps not severe but are still incredibly impactful in their daily functioning. Those deciding on whether requested care is "medically necessary" are making these decisions simply based on intake paperwork, treatment plans, diagnoses, and perhaps a few progress notes while the professional judgment of licensed, trained professionals who know the client better is disregarded. Their goal is also a reduction of symptoms, and not treating the whole, complex person. A reduction in symptoms does not treat the illness.
- This is an issue of forced destruction of the therapeutic alliance. Clients establish a trusting, therapeutic relationship with their private practice therapist; a positive therapeutic relationship is empirically validated to be one of the best indicators of treatment success. If not for these prior authorizations, these therapists have the capacity to continue treatment long-term when indicated, which reduces the exacerbation of their problems. Mental health centers already have an incredibly high turnover rate and clients often seek treatment in a private practice setting to avoid this turnover, as they want to work with someone without concern for premature termination.
- Mental Health Centers are exempt from prior authorization requirements, while private practice therapists and OBH designated clinics are not. Mental health centers should be held to the same standards as private practice therapists. So, either the preauthorizations should be discontinued for all or the MH centers should also be required to do them as well. The stated premise is that they are supposed to improve care for clients. If that is true, then all therapists who provide the care should be required to do it. The simple fact is, however, they do not provide better care for clients but they only make it worse.
- Aside from the continuity of care issues previously mentioned, which can derail positive treatment outcomes, mental health centers already do not have the capacity to handle the volume of incoming treatment requests and clients are already not able to see their MHC therapists often enough for treatment success. Referring clients to the mental health centers once preauthorizations are exhausted is not an acceptable solution (if this is even what therapists are supposed to be doing, as no real guidance has been given on where to send clients if denied).
- If Medicaid consumers are denied coverage, they are not allowed to pay for denied services out of pocket. It was confirmed by Ilias Politis at HCPF that under no circumstances are providers allowed to take payment from Medicaid recipients even if their services were denied and deemed "not medically necessary" by their RAE. Third-party payers, such as family members, are not allowed to pay for their continued treatment either. Providers who accept payment from them, even $1, are liable for criminal action and Medicaid recipients could lose their coverage permanently if they attempt to seek treatment and pay for it.
- The prior authorization process creates tremendous administrative and financial burdens on private group practices and individual private practice providers.
    - Many providers will need to manage multiple prior authorization processes as they may be contracted separately for each RAE.
    - While session counts renew on Jan 1 every year, clients begin treatment at any point during the calendar year which makes session counting and preauth submission processes extremely cumbersome. It requires an exceptionally organized monitoring process for each client, the number of sessions allowed before the required preauthorization, and then managing the information in an authorization, if granted.
    - For <u>each</u> client, a complete intake, updated treatment plan, completed / individualized authorization paperwork, and several progress notes would need to be sent, usually by fax. In some cases, such as for testing, medical records from other professionals needs to be gathered and sent as well. This is an average of 20-30 pages of documentation.
    - Providers and their businesses are not being reimbursed for this added work. It has cost businesses more for the added administrative time and supplies as necessary. When asked if rates could be increased or this time can be reimbursed, that request was denied by the RAEs.

<u>Colorado Community Health Alliance (CCHA)</u>

- For seven months (March through August of 2021), they instituted a prior authorization requirement <u>for all providers seeing that client</u> for additional mental health treatment beyond the first 20 in a calendar year. (It included all mental health therapy CPT codes 90832, 90834, 90837, 90846, 90847). Since this has been halted, the focus needs to be on how it has affected providers in the aftermath of its discontinuation. There

was no transparency or explanation for the suspension but it was obvious that the requirement created a large burden on CCHA staff as well as providers. Who knows whose complaints inspired the change?
- Since the halting of this on September 1, many providers have seen a large amount of denied claims for "not having a preauthorization." It is November and this is still going on, despite reassurances from Julian Stines at CCHA that this software glitch will be corrected.
- Many CCHA providers decided to terminate their contract because of the preauthorization policy (as well as their massive cut in contracted rates), which will create a substantial shift in available providers. On several Medicaid and therapist specific Facebook groups, there have been a considerable number of providers who have indicated they have already given notice to terminate or will be doing so soon.
- As an aside, CCHA gave no ability to email these requests with possibly 20-30+ pages of documentation. They were only allowed to be faxed or sent through their Availity portal for each individual client using specific, individualized request paperwork. Many providers reported running into significant submission problems with Availity. Their Availity tool does not allow for backdating also, which is essential for newly licensed providers who are applying to continue seeing their current clients (whom they saw when they were being supervised) so any authorizations for SCAs must be faxed.
- Notably also, CCHA consumers were not properly notified of their preauth change when the preauthorization requirement was instated. It was left up to the providers to inform their clients of this change. This is contractually negligent and unacceptable.

Rocky Mountain Health Plans Medicaid (RMHP)
- Until recently, RMHP instituted a prior authorization requirement for additional 60-minute sessions (CPT code 90837) after the first 12 are exhausted in a calendar year (i.e., 3 months or less of weekly treatment). They recently changed it to 20 sessions for 90837 and starting Jan 1, 2022, will be adding family sessions into the mix (90846 and 90847).
- This was 20 total for the year, so the provider would somehow be required to know if another provider has billed or is billing these codes. Session counts are not based on the total usage by the consumer, not by the individual provider. Providers are expected to submit preauthorizations to continue treatment even if they may be unaware if a client is utilizing mental health benefits with another provider. For example, if one provider is seeing a client for individual therapy and another provider is seeing that same client for family therapy, all those sessions count towards the 20, so they may run out sooner than expected, despite both providers' efforts to count the number of sessions used. There is no effective way for either provider to know when they are nearing the 20-session limit. If providers are unaware that it is time to submit a preauthorization, their claims will be denied with no recourse for payment, and this unfairly places the responsibility on providers to track this appropriately.
- Notably, a "60-minute" or 90837 session is most often the length of time considered most appropriate by the psychological community to generate significant psychological gains in individual therapy, regardless of diagnosis. However, RMHP considers a 60-minute session an "extended therapy session" and only authorizes 45 minutes or less after the first 20 are exhausted, unless their *internal* authorization department determines there is medical necessity to approve any additional 90837 sessions. This of course, will be even further reduced when their family sessions are added to that mix.
- RMHP stated to several providers that their policy was instituted to control the possibility that providers were either fraudulently billing for 90837 sessions or were overutilizing them when "not medically necessary." There are already audit procedures in place to tackle these concerns and prior authorizations across the board is not the best solution. Adding family sessions into the mix further complicates this as well.
- Although treatment plans are only required by contract every six months, RMHP was automatically denying a prior authorization if the treatment plan was not current within 30 days. They only authorized 12 sessions at a time, now 20. So in actuality, with these new preauthorization requirements, treatment plans needed to be created every 6 weeks if the client is seen 2x/wk or every 3 months if seen once a week. The 20 session limit may or may not continue this problem.
- Meg Taylor, VP Community Integration stated: "All diagnosis listed in the coding manual are covered. All sessions billed for 90837 need to meet our medical necessity criteria whether they are the initial 12 sessions or additional sessions that required prior authorization. While a member with a chronic diagnosis may need ongoing treatment to maintain stability, a chronic diagnosis in itself does not necessitate the use of 90837 60 minute sessions." This is a parity issue, as they are denying care for covered diagnoses.

Region 4 - Health Colorado Inc. (managed by Beacon Health Options, an Anthem BCBS company)

- Health Colorado, Inc. - Instituted a prior authorization requirement for all providers seeing that client for additional mental health treatment beyond the first 6 in a calendar year. (Includes all mental health therapy CPT codes 90832, 90834, 90837, 90846, 90847). This is 6 total for the year per Member, not based on the provider, so providers would be required to know if another provider has billed or is billing these codes.
- They then require preauth, with different documentation requirements for sessions 7 through 15, 16 through 25, and then beyond 26. This is any for any combination of the codes above, so again, it is based on the total number used by the client, not by the provider, which unfairly places the responsibility on providers to know when the client is close to that session count number.
- Some of the required criteria for submission: For sessions 7 through 15 the therapist MUST attest to coordinating care with the client's PCP or psychiatric prescriber (which may be an unrealistic or unnecessary expectation). For sessions 26+, it appears only cases of current and extreme severity must be presented for continued care (including noting to what level the client can manage their ADLs).
- No ability to email these requests with possibly 20+ pages of documentation. Must be faxed or sent through their Provider Connect portal for each individual client using specific, individualized preauth paperwork.

Region 2 - Northeast Health Partners (managed by Beacon Health Options, and Anthem BCBS company)

- Northeast health Partners - Instituted a prior authorization requirement for all providers seeing that client for additional mental health treatment beyond the first 26 in a calendar year. (Includes all mental health therapy CPT codes 90832, 90834, 90837, 90846, 90847). This is 26 total for the year, so the provider would be required to know if another provider has billed or is billing these codes.
- This is any for any combination of the 90832, 90834, 90837 90846, 90847 CPT codes, so again, it is based on the total number used by the client, not by the provider, which unfairly places the responsibility on providers to know when the client is close to that session count number.
- No ability to email these requests with possibly 20+ pages of documentation. Must be faxed or sent through their Provider Connect portal for each individual client using specific, individualized preauth paperwork.

Psychological Testing Preauthorizations

The preauthorization process for psychological testing through all Medicaid RAEs also requires revision. Autism and other developmental disability assessments and treatment are covered through the state (not the RAEs) when the diagnosis is primary. Although ADHD is categorically a developmental disorder in the DSM-5 (the same category as Autism), it is the only developmental disorder that is "covered" by the RAEs as opposed to the state Medicaid plan when it is a primary diagnosis. No prior authorization is required for testing through the state, but it is required for all testing through the RAEs.

In a recent conversation with one of the staff psychiatrists at Colorado Access who approves/denies testing preauthorizations, he stated that COA routinely denies 90% of their psychological testing requests. Many of the requests the RAEs receive are for ADHD evaluations for both adults and children and many are seeking a differential diagnosis to ensure the client is not misdiagnosed or receiving medication for ADHD when they should not be (usually addictive, controlled substances), or if they should be taking medication or be treated for another diagnosis entirely. Oftentimes a client's medical professionals, such as their current, established therapist or their primary care physician, or even their psychiatric prescriber, have referred them for an evaluation because the case may be complex. Although it is COA's policy that a psychiatric prescriber should be equipped to accurately diagnose ADHD without any psychological testing, sometimes psychiatric prescribers also refer for testing. They recognize that testing for ADHD with a trained testing psychologist who specializes in ADHD assessment is an integral part of the ADHD diagnosis process and/or they feel they cannot adequately diagnose because of the complexity of the case.

Moreover, to even consider approving a testing authorization, the client must be in active treatment with a psychiatrist or psychiatric NP before they are granted an ADHD evaluation and the psychologist requesting the evaluation must submit medical documentation from the prescriber that they cannot adequately assess whether ADHD is a proper diagnosis. They will not consider an approval without this. This is not even a realistic

expectation as it is incredibly challenging for a Medicaid recipient to find a prescriber who takes Medicaid as there are not very many who do. Those who do are often booked out for months.

Unfortunately, once an evaluation is denied, there is no recourse for the client. There is no definitive (or acceptable) course of action a client may take when their services are denied when a provider submits a testing preauthorization on their behalf. So what is a client to do when that ADHD testing is denied? They are forbidden to pay for those services out of pocket so testing cannot be completed. They literally just cannot get the testing done at that point because someone from their RAE determined it was not medically necessary. This is true even if a third party wants to pay for the testing for them as well.

Requested Changes:

- Prior authorizations are doing more harm than good to Medicaid Members, their families or caregivers, and the Members' providers. Prior authorizations for regular mental health treatment should be discontinued. There are no circumstances in which preauthorizations will improve care.
- For any behavioral health service in which prior authorization continues to be required:
    - Prior authorizations should be reviewed by a team of three or more individuals who have active licenses to practice in counseling or psychology, have practiced for several years prior to their role in authorizations, and are intimately familiar with diagnosis and treatment parameters. They should not work directly for the payer unless the payer is a true non-profit agency.
    - For psychological testing, one or more actively Licensed Psychologists should be on the review team with considerable experience in the types of psychological testing that is being requested.
    - There should be established criteria for medical necessity for approval or denial published for both consumers and providers that are easy to understand. The exact parameters should be made available to providers as well.
    - They should be based on the number of sessions per provider, not the total used by the Member, as this is near impossible to track.
    - There should be an easy, real-time way to track the number of sessions utilized.
    - These requests should be able to be securely emailed. They should not have to be faxed or sent through portals that don't work as they are supposed to.
- Allow self- and third-party payments for Medicaid recipients when services are denied for medical necessity. Patients would not be denied medical treatment if they decided to pay for their own care in any other circumstance.
- If the state covers Autism testing and treatment, as well as every other developmental disability except ADHD, ADHD should also be covered by the state. They also do not require preauths for Autism so ADHD should be treated similarly.

PARITY ISSUES

There are considerable differences between how medical and behavioral health services are administered in Colorado, which constitute parity violations, some with respect to the Mental Health Parity and Addiction Equity Act (MHPAEA). Medicaid recipients are being denied services for covered diagnoses, which may be the most egregious offense related to parity. It should be noted that there are several violations of parity: "processes that limit treatment must be similar for BH as for medical." Some of the many problems include:

1) Provider contracting, preauthorizations, rate setting -- The RAE system has a major structural obstacle to parity: Attribution is tied to the physical address of the medical provider's office. A medical provider contracts with a single payer while a BH provider must contract with four organizations that each have different policies. Medical providers have none of the burden caused by the need for multiple contracts nor do they have the hassles of preauthorization directly from the payer or different reimbursement rates from several different contracted entities. Medical and behavioral prior authorizations are also handled differently in that HCPF chose a 3rd party for Prior Authorization review for Medical (KePro), while BH auths are reviewed directly by the RAE payers (which we have established are all owned and managed by for-profit companies).
2) Controlling the payer mix -- According to a Nov 4, 2020 and March 25, 2021 email sent by Colorado Health Care Policy and Financing (HCPF) attempting to recruit Medicaid medical providers, it states that Health First Colorado medical providers are able to regulate their payer mix while behavioral health RAE contracted providers are not allowed to do this by contract (e.g., see any CCHA contract section on Non-Discrimination /

Provider's Duties and Obligations to Medicaid Members). So essentially, a medical provider who is registered to accept Medicaid through the state may cap how many Medicaid patients they see but BH providers are forbidden from doing this.

3) Timely filing discrepancies: HCPF allows 365 days for filing medical claims, mental health claims for some RAEs must be filed in 120 days.
4) Medication management is billed and administered differently than therapy. So while patients have unlimited medication benefits and the prescriber can then also use unlimited E&M counseling codes, counseling with a mental health therapist is limited through the preauthorizations. CPT codes may also be denied for extended sessions for behavioral health but paid for medical, which is a treatment limitation.
5) The rates for treatment are reviewed and set by the MPRRAC -- Medicaid Provider Rate Review Advisory Committee – and these are the rates offered to medical providers but not behavioral health providers. RAEs set their own rates for providers, as low as 60% of what MPRRAC sets.

Requested Changes:

1) Equal coverage of medical and behavioral health services
2) Equal pay for medical and behavioral health services which is set by MPRRAC
3) Equal contracting requirements for medical and behavioral health services
4) Equal application of preauthorizations for medical and behavioral health services
5) Equal opportunities for medical and behavioral health providers to determine their payer mix
6) Equal timely filing requirements for medical and behavioral health services

FINANCIAL CONCERNS

Poor reimbursement rates

As mentioned previously, the RAEs are managed by for-profit companies and they set the rates for behavioral health providers, without any real option to negotiate the contract. RAEs set their own rates, which are all different from one another and lower than the rates set in Health First Colorado's rate schedule. These rates are also significantly lower than most commercial plans and require more work on the part of the providers. Family therapy rates are abominably lower than individual therapy rates as well, even though family therapy oftentimes requires more emotional energy from a therapist or specialized training. Current compensation also does not reflect the extra required work to create and submit preauthorizations or the formal treatment planning and documentation compliance that must meet very specific standards for Medicaid.

If providers were compensated appropriately for their time, expertise, and compassionate treatment, more providers would be interested in contracting to provide care to this population. Unfortunately, inadequate pay structure makes that less desirable. Notably, CCHA, the newest RAE offered a refreshingly reasonable fee structure for the first year or so of their contract but then reduced their rates by over 20% and now they are well below competitive market rates for psychological treatment. Many providers have decided to terminate their contract with CCHA for this reason as well as the new preauthorization requirements. In several Facebook groups for therapists, a large number of providers stated they have already given notice to terminate their RAE contracts (which will likely not show up in network adequacy reports). Also, Mental Health Centers did not get the 20% cut to their fees from CCHA and are paid considerably more for the same CPT codes than a private practice therapist uses for the exact same service. Inadequate compensation coupled with the extra work is a major deterrent for private practice providers who would otherwise serve this population.

No Show Fees Not Allowed

With private pay and with commercial insurance plans, it is a regular practice to set, communicate, and enact a financial consequence for late cancellations and no-shows. If it is written into the initial service agreement between the provider and client, the client becomes responsible to pay for the time they reserved with their provider. For all other commercial contracts, no shows become client responsibility because it is considered a non-covered service. It creates respect for the provider's valuable time and expertise and is often a great motivator for clients to take their treatment seriously. Medicaid is the only major payer that prohibits this and this needs to change.

Timely Payment and Recoupment Issues

This is one of the biggest hot button provider issues as of November 2021 and has created even more dissatisfaction among providers who were already dealing with CCHA preauthorizations and rate cuts; even more providers on the Medicaid FB group have indicated they have or will be giving notice of termination of their Medicaid contracts as the recent large recoupment notices have been the last straw for them. These recoupments could literally put these providers out of business as they are in the many thousands of dollars. A few facts:

1) The recoupment notices for most providers are based on a submission issue that box 24J on the CMS 1500 form is apparently missing a rendering NPI.
2) The CCHA March 2020 and November 2020 newsletters state that claims with NPI issues would automatically be rejected as of March 25, 2020, but CCHA paid these claims for almost two years without rejection and are now recouping the funds for thousands of claims, and in many cases for several thousand dollars, for services that were rendered and paid for. They were not initially or automatically rejected as was promised by CCHA.
3) Notably, there is no mention of any additional NPI billing issue in any other 2020 newsletter until September, when they include: “Important note: CCHA will start recouping claims that have paid without an NPI for the rendering provider beginning January 1, 2021. Claims with dates of service from July 1, 2019 to December 31, 2020, are in scope for the recoupment. Recoupment can be avoided if claims are corrected to include the NPI for the Rendering Provider, and submitted and accepted by CCHA by December 31, 2020. CCHA will waive the corrected claim timely filing limit for corrected claims submitted and accepted until December 31, 2020, for this issue.” Note the 2019 date does not match what was stated in the March 2020 newsletter.
4) CCHA’s November 2020 newsletter admits they failed to implement proper claim rejections for this issue, and they are now shifting this costly responsibility to providers: “CCHA implemented a front-end edit to reject claims missing the NPI for a rendering provider on October 1, 2020. We've since identified an unintended consequence, and we are in the process of modifying the edit.” It further states that it is a known issue: “We realized an unintended consequence with claims submitted through Availity, where Availity is erasing the NPI for the rendering provider if it is the same as the billing provider… Until the edit is modified, CCHA is recycling claims on a weekly basis that were previously rejected for this reason, and providers will not need to take any further action.”
5) Also in the November 2020 newsletter: “If you are a solo practice provider (without a group) and bill under your individual TIN, then you should submit your claims with the Individual NPI… CCHA is in the process of modifying the edit to remove solo practice providers (without a group or Type 2 NPI)… Solo practice provider's claims will not be subject to recoupments, if you are a solo practice provider (without a group or Type 2 NPI), and bill under your Individual TIN.”
6) No mention of anything NPI billing related in any 2021 newsletter at all. The LAST mention was in Nov 2020 when they said providers need not take further action.
7) For many, their letter did not indicate an option to resubmit claims. It only indicated that they had 60days to repay the amount or it would be garnished from future payments. For many, this places and incredible administrative and financial burden on already overtaxed providers.
8) Two examples of many: one of the few bilingual, Spanish-speaking practitioners in our community, received a recoupment notice for almost $18K. She already resubmitted multiple claims when this was first announced and is now doing it a third time, as if the first resubmission did not ever occur. Another BIPOC therapist received a recoupment letter for almost $20K in total. The letters received by these providers and others state that this recoupment must be paid within 60-days and it does not mention any possibility or encouragement to resubmit claims. It is a demand letter for repayment of services rendered for errors made by the BCBS-owned software, not by the providers themselves. This is theft of service on a large scale by a big corporation that does not want to pay its providers.
9) In general, many providers have been reporting they have had trouble with getting paid for their services in a timely fashion or have had many claim denials for mistakes made by the payer, usually by CCHA, as noted previously. Some of our colleagues have seen recoupments from several years past, as far back as 2015. The payer should be responsible to catch these errors in a far more timely fashion, preferably at the time of payment, not years later. Any of these claims should have received immediate rejections by CCHA if they were not submitted properly at the outset, as was promised in their newsletters. It is financially and emotionally distressing for private practice providers to have thousands of dollars taken back for errors made by the payer many months or years later.

Requested Changes:

1. Rates should be competitive with market value rates and should be increased to reflect standard of living inflation.
2. Contract negotiations above the offered contract rate should be an option for providers who can speak a second language or are members of traditionally marginalized groups. There needs to be additional incentives to attract more of these providers so Medicaid members can be ethically served.
3. Private practice therapists should be paid the same rate as the mental health centers for the same CPT codes, especially when private practice therapists are held to a higher standard of care for delivering the same exact service.
4. Raise family therapy rates to something comparable to individual treatment.
5. Treatment planning and preauthorization requests should be compensated by every Medicaid payer.
6. No show fees should be allowed as a noncovered service. Even allowing a lower, set rate would be far more acceptable than nothing.
7. There should be a shorter time limit on recoupment for payer-made errors. There should also be a shorter time-limit on recoupment for provider-made errors, assuming the errors were made without intent to falsify claims.

SUMMARY

The most important take away from this is that establishing one central non-profit payer with a competitive fee schedule for behavioral health is the ideal goal. This would eliminate many of the problems addressed in this letter above. While we are aware that RAEs are part of the picture through 2025, a more simplified structure should be the ultimate goal after that point.

Until that is a possibility, the current RAEs need to establish policies that make managing behavioral health for Medicaid easier on the consumer and provider. There should be greater focus on establishing attractive incentives for behavioral health providers to become Medicaid-affiliated, especially for those who are most able to ethically provide services to special populations. Discontinuing preauthorizations altogether, limiting recoupments, allowing for prelicensed therapists to provide supervised services and raising rates to something more competitive would be the best-case scenario. Assigning RAEs based on the Member's physical address would also be a productive step. Medicaid validation, credentialing, and contracting for all providers should also be more efficient and faster processes should be established across the board.

Change through legislation will be the only way we see equitable care for Colorado residents and proper treatment of those who provide those services. There is a large group of providers who would be very interested in setting up a personal meeting (in-person or over Zoom) with you and your staff, and other interested legislators to help create this change. Thank you so very much for your time and interest in these important issues.

Respectfully and gratefully,

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