COMBINE Response to 2022 HCPF Parity Report

July 20, 2022

Dear Press and Legislators,

The Honorable Rhonda Fields,
Senator Joann Ginal, Vice Chair, Health and Human Services Committee Senator
Janet Buckner, Health and Human Services Committee
Senator Sonya Jaquez Lewis, Health and Human Services Committee
Senator Barbara Kirkmeyer, Health and Human Services Committee
Senator Cleave Simpson, Health and Human Services Committee
Representative Emily Sirota, Vice Chair, Public & Behavioral Health & Human Services
Representative Mary Bradfield, Public & Behavioral Health & Human Services
Representative Lisa Cutter, Public & Behavioral Health & Human Services
Representative Serena Gonzales-Gutierrez, Public & Behavioral Health & Human Services
Representative Richard Holtorf, Public & Behavioral Health & Human Services
Representative Iman Jodeh, Public & Behavioral Health & Human Services Committee
Representative Colin Larson, Public & Behavioral Health & Human Services Committee
Representative David Ortiz, Public & Behavioral Health & Human Services Committee

The2022 HCPF Parity report makes the claim, as seen in the past two years' reports, that the mental health RAE system, particularly because of rate setting processes, does not violate Parity law, when it plainly does. We must have respect for the Parity law and if not, access to the courts to press our claims.

The report begins:
"Mental Health Parity Report:
The annual Mental Health Parity Report for state fiscal year 2021-2022 was published on June 1 as required by C.R.S. section 25.5-5-421. The Department created this year's annual report following a process for determining mental health parity compliance based on the federal parity guidance outlined in the Centers for Medicare & Medicaid Services' Parity Toolkit and in accordance with all state requirements. The report's format and the process followed to create it was significantly updated to provide greater clarity and more thorough evaluation of policies and procedures.

The report includes findings from the external quality review audit which evaluates Regional Accountable Entity (RAE) and Managed Care Organization (MCO) policies and procedures in operation. The Department also contracted with Myers and Stauffer to perform an independent assessment of the processes followed for the creation of the 2022 Mental Health Parity Report."

Note that Myers and Stauffer has been contracted by HCPF for at least three years to produce various reports, including the incomplete "network adequacy reports."

The full document is available here:
https://hcpf.colorado.gov/sites/hcpf/files/2022%20MHPAEA%20Parity%20Report%20Combined.pdf

The report perpetuates a false narrative. This is mainly in the executive section and Appendix J and Appendix K (page 128)

Executive summary (p. 3) perpetuates HCPF's narrative that MHPAEA is concerned only about benefits: "The MHPAEA is designed to ensure Medicaid Managed Care Organizations (MCOs) and Medicaid alternative benefit plans providing mental health or substance use disorder (MH/SUD) benefits apply limitations on those benefits that are comparable to and no more stringent than those limitations imposed upon medical and surgical (M/S) benefits in the same classifications."

The MHPAEA and HB19-1269 are not simply concerned with benefits. The federal government and courts have decided and stated repeatedly that provider reimbursement impacts access, and is therefore a Parity concern, which should be obvious.

It should be plain to any interested, caring observer that paying Medical fee-for-service according to the MPRRAC schedule is completely different and in no way “similar” to RAEs making up fee schedules for any reason, with no governance from HCPF. The 20% cut in 2020 by CCHA/Anthem was unchallenged by HCPF and certainly did not happen to medical providers.

HCPF admits this arrangement, hiding the Parity violation in plain sight, "The RAEs are responsible for administering Colorado Medicaid’s capitated MH/SUD benefit, which includes paying claims and authorizing MH/SUD services. Physical health services are paid fee-for-service by the Department’s fiscal agent."

While HCPF claims to use federal guidance here, "The Department follows a process to determine parity compliance that is based on the federal parity guidance outlined in the CMS parity toolkit, “Parity Compliance in Mental Health and Substance Use Disorder Parity Requirements for Medicaid and Children's Health Insurance Programs,”" HCPF is actually cherry picking and ignoring the federal documentation about reimbursement rates.

The executive summary concludes with an apologia about the "complexity" of comparing capitated payments to managers versus fee-for-service.

"The Colorado Medicaid service delivery system has multiple components that add complexity to assessing parity. The analysis requires the comparison of a capitated MH/SUD payment structure to a FFS M/S payment structure. The Department chose to design its coverage in this manner to maximize the breadth of MH/SUD services available to its members. The comparison between MH/SUD and M/S benefits seeks to assess whether the written policies and procedures, in design and applied in practice, affect the ability of Medicaid members to access MH/SUD services"

Then there is an assertion that the capitated system "maximizes the breadth" of services. The fact, reported by Susan Greene in late 2021, that Centers are paid 500% or 700% more than independent providers makes this claim at least questionable.

Again HCPF wants readers to limit the concept of Parity to "benefits." This is a myopic vision of the law.

HCPF continues throughout its reports to maintain that "managed care" is necessary to "offer ...members services", like short-term inpatient, peer recovery services, and etc. We are confounded by this claim because there is no accounting for these "services not available under FFS."

Page 9 states, "The Department has chosen to provide behavioral health benefits through a managed care program in order to offer members a full continuum of behavioral health services that are not available under federal FFS guidelines, allowing for more flexible service provision. It is only under the federal managed care authority that the Department can offer reimbursement for short-term inpatient stays in Institutions for Mental Diseases, peer recovery services, clubhouse and drop-in centers, vocational services, intensive case management, and other alternative services."

Regarding Appendix J (p. 116) which discusses provider credentialing, the issue of contracting times is obscured.

It is the law that physicians are contracted in 60 days. See https://leg.colorado.gov/bills/sb21-126

We would like this law extended to mental health providers, and we would like RAEs to honor Parity law by contracting within 60 days. Contracting time is made invisible in this report.

Regarding Appendix K, which offers some explanation about reimbursement rates.

The processes each RAE uses is different, which is not a strict Parity concern, yet a concern. It is an obvious Parity concern that medical rates are set by a completely different process from all these RAE processes.

Read the descriptions of how rates are determined by the 4 RAEs on pages 129 to 136.

For example:
Page 129, describing how HCPF comes up with rates for its (tiny, 3% of all spending) fee-for-service component of Medicaid, which is in fact the only place where Parity in rate setting processes exists. This description of BH rate setting matches their description of Medical rate setting. (Note that there is very little HCPF directly billed fee-for-service work happening compared to the massive RAE spending).

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

Then, page 131, this is how Rocky reports a completely different rate setting :

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

Then, page 133, where Beacon, also with a completely different process, says,
"[Beacon] creates and maintains a fee schedule with Medicaid appropriate rates, uses available tools to determine usual and customary rates including, but not limited to, Colorado Fee For Services Medicaid Rates and standards, CMS Reimbursement Rates, or market standards."

Also on page 133, Colorado Access has their own way, giving a mention to value based arrangements
"COA utilizes established reimbursement methods such as: DRG for inpatient; RBRVS, EAPG, and Colorado Medicaid fee schedule for outpatient. In addition, provider contracts may also include value based arrangements that provide incentives for meeting quality of care KPI's."

Then Anthem/CCHA has their own thing :

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

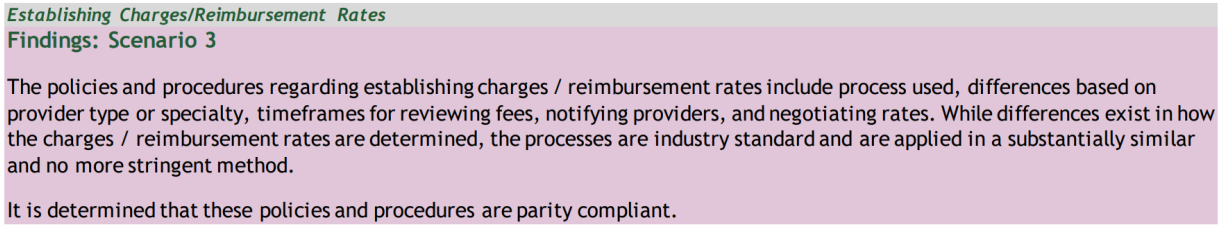
Not only are these not close to each other, none of them are similar to how rates are set for Medical, which makes this all out of compliance with Parity, which is a state law, and is violated every day these arrangements exist:

Again, HCPF describes how medical service rates are set :

"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."

Nowhere in the RAE descriptions is there mention of admin expenses or facility expenses or capital expenses.

After pages and pages of descriptions of rate setting processes that are not only different MH/SUD <-> Medical, but also comparing RAE processes that are completely different from one another, we get "the processes are industry standard and are applied in a substantially similar ... method."



Establishing Charges/Reimbursement Rates

Findings: Scenario 3

The policies and procedures regarding establishing charges / reimbursement rates include process used, differences based on provider type or specialty, timeframes for reviewing fees, notifying providers, and negotiating rates. While differences exist in how the charges / reimbursement rates are determined, the processes are industry standard and are applied in a substantially similar and no more stringent method.

It is determined that these policies and procedures are parity compliant.