February 24, 2024 **Background for HCPF request for Parity comments by March 15, 2024**

Dear Parity Advocates,

Medicaid mental health care workers continue to seek compliance with MHPAEA Parity and HB19-1269 Parity federal and state laws by the Department of Health Care Policy and Finance and by the managed care entities.

Since 2019, when CCHA/Anthem (now Carelon after merger with Beacon) announced a 20% rate cut which was unopposed by HCPF, there has been little improvement for the Medicaid mental health care workforce. Of the improvements, SB22-156 stands out, although Parity was not involved. Relief from outpatient prior authorization was significant, as well as regulation of "claw back" periods.

Another move forward was the announcement by Colorado's Attorney General of support for the Wit Parity case in another state. Regretfully the AG has now supported Parity in other places than Colorado.

There is no question that the rate setting process is a Parity concern. The federal government has repeatedly discussed rate setting processes in its Parity rules. There is no question that med/surg rates are set by an entirely different process than mental health rates, which are in fact set differently from RAE to RAE. And there is no question that access to care is impacted by these various rate-setting processes. The status quo is non-compliance with federal and state law.

HCPF admits rate setting is a Parity issue in this 2022 report, "Non Quantitative Treatment Limitations are limits on the scope or duration of treatment that either cannot be expressed numerically or whose numeric value can be exceeded through medical management processes. These include: … Methods for determining usual, customary, and reasonable charges;"

The ongoing campaign by HCPF to deny this reality is plain and needs to be challenged and changed.

HCPF has called for comments for their annual Parity report, in compliance with HB19-1269.
Comments are due March 15, 2024 and can be submitted through this form.

You may read their past Parity reports here : https://hcpf.colorado.gov/Parity

Enforcement and the BH Ombuds office

From the 2018 establishment of the Ombuds office (BHOCO) in HB18-1357, to the 2019 extension of MHPAEA laws to Title 25-5 (Medicaid) in HB19-1269, until today, the mental health care workforce has struggled to see the promises of this important law enforced.

The BHOCO office is particularly important in the managed care dynamic, as every RAE publishes the BHOCO contact information on their websites, and HCPF - RAE contracts mandate that RAEs inform Medicaid members of BHOCO's existence.

Nevertheless BHOCO struggles. Fortunately the 2024 Department of Health Services Supplemental HB24-1187 restores funding for the BHOCO to (2) FTE. This is of course entirely inadequate for servicing the subset of 1 million Coloradans that have complaints about RAE choices.

Of BHOCO's limited powers is a mandate that HCPF must respond to Parity inquiries. BHOCO properly publishes these responses, found in annual reports. These are documented here. Herein we find the limited view that HCPF holds of Parity.

In their Feb 11, 2020 letter, responses from HCPF regarding RAE compliance with Parity regarding rate setting include, “The Department has determined this is not a Parity violation. RAEs have the ability to negotiate rates for the capitated behavioral health benefit.”

HCPF, seemingly without self-awareness of admitting to the Parity violation, also acknowledges the difference between med/surg and mental health care rate setting directly, “The RAEs negotiate rates with providers under the capitated behavioral health benefit. Med/surg services are paid under FFS according the [sic] Medicaid fee schedule.”

By paying medical/surgical through fee-for-service with an open rate setting process that includes the MPRRAC, versus allowing RAEs to set provider rates with no oversight, the managed care system that we operate under fundamentally violates the letter and spirit of the laws of the land and year after year. Along with strident denials by HCPF, there is no significant discussion of this reality within the legislature, the advocacy community, the executive branch including the AGs office, or the press.

Since 2020 COMBINE, a 501c3 trade association representing independently contracted mental health care providers for Medicaid, has advocated for enforcement of Parity and for changes in the rate setting process so that the over a million Coloradans enrolled in Medicaid can access basic outpatient mental health care. We are again asking for your support so Colorado can come into compliance with the federal and state laws and so Medicaid is not operated on the backs of university interns and pre-licensure externs.

Our Medicaid clinics are overrun with demand. We see every day how poor people encounter “we’re full” when seeking care. There are over 25,000 licensed providers in this state who will not participate in Medicaid. The vision of a decent and respectful work environment, where a private practice therapist could take on one or two Medicaid clients, as many hands make light work, is distant.

Every single Medicaid provider has made a decision to accept lower pay in order to serve society. It is unconscionable that along with that decision comes disrespect and hostility, under a veneer of decorum, towards our workforce.

Since 2020, when law required HCPF to report on Parity, perennial concerns have gone unaddressed.

HCPF’s Parity Narrative

In the 2020 report various stakeholders from Mental Health Colorado, CCLP, CBHC, CCHN, BHOCO, and others reported Parity concerns (where the experience of med/surgical is different from mental health care and result in impacts to access) related to care and administrative burden because of attribution, multiple contracts, reimbursement, network adequacy, credentialing, unregulated rate setting processes, and lack of HCPF responses to RAE behaviors.

HCPF began an inaccurate narrative about what Parity means and how it should be treated in 2020 that continues today.

Examples of efforts to establish a narrative and influence legislators are “MH Parity Legislative Handout 1 Pager”, and “MH Parity Legislative Handout Overview”

Here HCPF explains away the Parity violating status-quo, “the majority of members have their MH/SUD benefits covered by the Regional Accountable Entity, and their M/S benefits covered through a fee-for-service arrangement. The involvement of multiple entities and payment mechanisms in the delivery of MH/SUD and M/S benefits does not inherently violate Parity,[highlight added] but does add complexity to the annual Parity evaluation.”

The multiple payment mechanism does inherently violate Parity. The system privileges med/surg with predictable and transparent rates, while allowing mental health care managers to set rates through entirely different processes, and all of this impacts access to care.

HCPF would like to consider "benefits" as the focus of Parity investigation, which is only part of what Parity is concerned about. For example, 2021 FAQ, states, "Parity means that it should not be more difficult for people to use benefits for mental health and substance use disorder (behavioral health) as they are able to use benefits for physical health." This is a narrow reading of Parity.

This FAQ refers readers to "Appendix L" of 2021 HCPF Annual Parity Reports for discussion of rate setting. Starting on page 125, HCPF asserts again and again, contrary to reality, that "Though the processes are different, both processes are industry standard and substantially similar in their application," and, "The rate setting process for MH/SUD and M/S services is identical," and for RAE 1/United Healthcare/ "Rocky", "...the process used by RMHP is industry standard, comparable and no more stringent than that used by the Department for FFS M/S services and is therefore compliant with Parity requirements." This language occurs again for other RAEs.

Year after year HCPF insists that different rate setting processes, that clearly limit access to care, are not Parity violations:

2020 executive summary states, "Our assessment and comparative analysis of MH/SUD benefit limitations compared to M/S benefit limitations found no instances of Parity compliance violations"

2021, "An assessment and comparative analysis of MH/SUD benefit limitations compared to M/S benefit limitations found the written policies and procedures to be Parity compliant in all
Non-Quantitative Treatment Limitations (NQTLs) except for one." (availability of information)

2022, "An assessment and comparative analysis of MH/SUD benefit limitations compared to M/S benefit limitations found the written policies and procedures to be Parity compliant in all
Non-Quantitative Treatment Limitations (NQTLs) except in two situations: the fee-for-service
inpatient hospital review program's compliance within one NQTL and Denver Health Medicaid
Choice's compliance within three NQTLs.

2023, "An assessment and comparative analysis of MH/SUD benefit limitations compared to M/S benefit limitations found the written policies and procedures to be Parity compliant in all
Non-Quantitative Treatment Limitations (NQTLs) except in only one situation: the fee-for-service inpatient hospital review program's compliance"

Stakeholder comments have disappeared from HCPF's Parity reporting process, and the public is left with comments such as this from the 2022 Myers and Stouffers report. "High frequency comments included topics such as establishing provider reimbursement/charges and the resulting impact to network adequacy. The Department's assessment of these comments appropriately included consideration of policies in place, procedures followed, and reimbursement provided. The Department oversees the MCE's network adequacy to ensure continued compliance."

In fact, the department does not oversee the managed care entities network adequacy to ensure compliance. This is made plain by the most cursory examination of the "network adequacy reports" which are out of date, contain large black redaction squares, and show that CCHA/Anthem reports exactly the same network for Region 6 as Region 7, among other errors and omissions. COMBINE reported these irregularities in February of 2021.

Fundamental to network adequacy are astonishing ratios in RAE contracts. RAE networks are considered adequate by HCPF when RAEs contract with 1 provider per 1800 adult members. RAEs can claim they have met network adequacy standards, and have fulfilled their legal obligation, with sparse networks.

RAEs are required to comply with MHPAEA Parity, as seen in HCPF-RAE contracts, which are available here. There are various clauses, such as:

14.15.1. The Contractor shall maintain compliance with all relevant State and Federal laws regarding Mental Health Parity and Addiction Equity Act (MHPAEA).

14.15.2. 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.

Rate setting is a process. The outcome of that process limits access to benefits. The medical/surgical rate setting process is not comparable to the rate setting processes by the RAEs, which are not even comparable to each other. This situation is an ongoing violation of Parity law.

2024 Parity concerns

Reimbursement

In 2018 CCHA/Anthem offered 100% of the MPPRAC rate for counseling, which at the time was 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.

The contract itself contains a clause that allows the RAE to change compensation at any time, which is contrary to basic contract law. A contract is intended to fix compensation.

This behavior by Anthem went unanswered by HCPF as far as providers could see. Anthem's explanation, furthered in public meetings by HCPF (Jan 2020, Representative Jonathan Singer, Chair of House HHS) 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 years, there is no evidence that this policy change attracted psychiatrists.

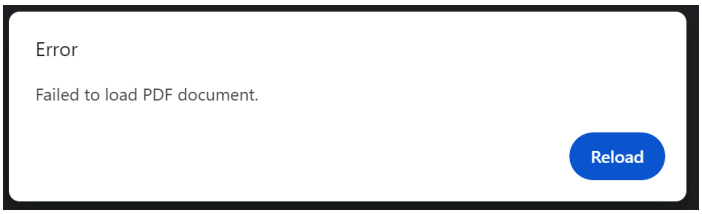
This increased providers' sense of vulnerability to essentially at-will rate changes and the sense that HCPF did not have providers' interest. The drop in participation was precipitous. CCHA reported 364 providers in Boulder County in October of 2019 and then 240 in October of 2020. This is a 1/3 drop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

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.

This document is no longer available (as of Feb 2024) from the HCPF webpage, which displays this:



Page 175 describes rate setting for Anthem's outpatient care as "mental healthcare reimbursement rates are set by an 'internal process' that prioritizes attracting an adequate network", and offers 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 for setting medical rates and setting behavioral health rates are obviously different. CedarBridge Group further compares the rate setting processes to HCPF's processes rather than comparing them to each other, as required for a proper analysis.

Member Attribution

The attribution process 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 the 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.

RAE Credentialing and Contracting Times

Access to carriers' networks is the core of network adequacy and the attribution process causes physicians to contract with a single RAE, while mental health care providers must contract with more in order to provide continuity of care. This is an unequal administrative burden that impacts access to care. Medical and surgical providers can bill HCPF directly after validation, which

HCPF reports as a five day process. Behavioral Health providers wait months and months to begin providing services. This is a Parity violation.

We hope that you and your organizations will take up or continue to press for improvements in the mental health care system through the leverage that Parity laws provide. Please take the time to express Parity concerns to the Department before March 15, 2024 through this form.

In kind regards,
Andrew Rose
COMBINE Policy Committee Chair
Director, Boulder Emotional Wellness