INTRODUCTION

CedarBridge followed guidance as outlined in the Centers for Medicare and Medicaid Services (CMS) parity toolkit, "Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs."[1] The final Medicaid/CHIP parity rule requires analysis of (as depicted in Figure 1):

1. Aggregate lifetime and annual dollar limits (AL/ADLs); and
2. Financial requirements and treatment limitations, which include:
    a. Financial requirements (FRs) such as copayments, coinsurance, deductibles, and out-of-pocket maximums.
    b. Quantitative treatment limitations (QTLs), which are limits on the scope or duration of benefits that are represented numerically, such as day limits or visit limits.
    c. Non-quantitative treatment limitations (NQTLs) such as medical management standards, provider network admission standards and reimbursement rates, fail-first policies, and other limits on the scope or duration of benefits; and
3. Availability of information.[1]

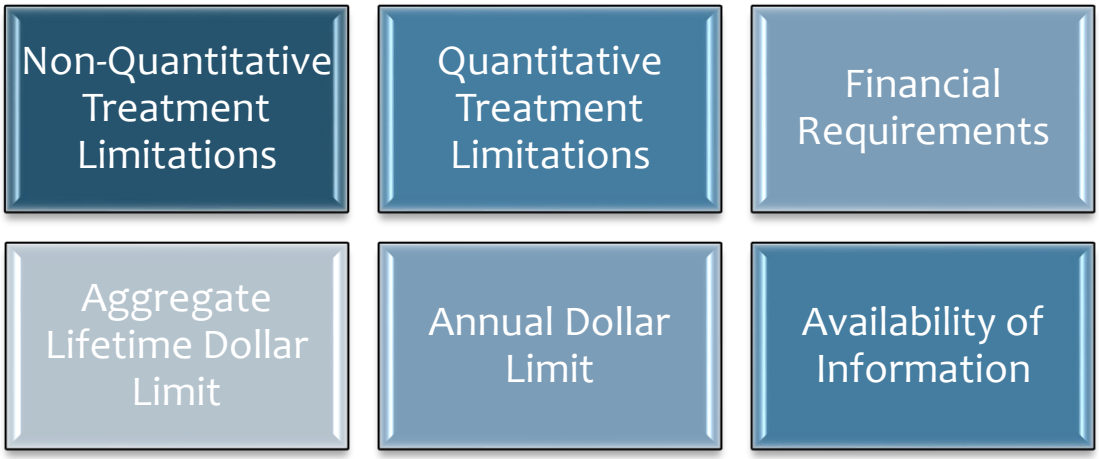

Figure 1. Required Components of Parity Analysis

In addition to the analysis required by CMS, Colorado HB 19-1269 imposes additional requirements:

1. The analysis should include public input from stakeholders who have competency in benefit and delivery systems, utilization management, managed care contracting, data and reporting, and compliance and audits; and
2. Each Managed Care Entity (MCE) must disclose all necessary information for the Department to prepare a report, regarding behavioral, mental health, and substance use disorder parity.

[1] CMS Parity Toolkit: https://www.medicaid.gov/sites/default/files/2019-12/parity-toolkit.pdf

DEFINITION OF MEDICAL/SURGICAL AND MENTAL HEALTH/SUBSTANCE USE DISORDER SERVICES

The federal statute and regulations do not identify specific conditions as MH/SUD or M/S; instead, states must look to "generally recognized independent standards of current medical practice" to define benefits.

For the purposes of the parity analysis, the Department of Healthcare Policy and Financing (Department) has adopted the current version (10) of the International Classification of Diseases, Clinical Modification (ICD-10-CM) as the standard for defining MH/SUD services and M/S services. The Department defines MH/SUD benefits as benefits specifically designed to treat a mental health or substance use disorder condition.

- Mental health conditions are those conditions listed in ICD-10 Chapter 5 (F), except for subchapter 1 (Mental disorders due to known physiological conditions), subchapter 8 (Intellectual disabilities) and subchapter 9 (Pervasive and specific developmental disorders). The etiology of these conditions is a medical condition – physiological or neurodevelopmental – and treatment would address medical concerns first.

ACRONYMS

AL – Aggregate Lifetime Dollar Limit

ADL – Annual Dollar Limit

FR – Financial Requirement

M/S – Medical/Surgical

MH/SUD – Mental Health/Substance Use Disorder

NQTL – Non-Quantitative Treatment Limitation

QTL – Qualitative Treatment Limitation

- Substance use disorder benefits means benefits for substance use disorder conditions listed in ICD-10 Chapter 5 (F), subchapter 2 (Mental and Behavioral disorders due to psychoactive substance use).

- Benefits used to treat all other ICD-10 diagnoses are considered M/S.

BENEFIT CLASSIFICATIONS

The final federal regulations specify requirements for FRs and treatment limitations apply to each benefit classification individually. Colorado Medicaid benefits were classified and mapped into four categories, as directed by the CMS Parity Toolkit. The following definitions were used to differentiate benefit classifications:

INPATIENT

Treatment as a registered bed patient in a hospital or facility and for whom room and board charges are made.

OUTPATIENT

All covered services or supplies not included in inpatient, emergency care, or prescription drug categories.

PRESCRIPTION DRUGS

Medications that have been approved or regulated by the Food and Drug Administration that can, under federal and state law, be dispensed only pursuant to a Prescription Drug order from a licensed, certified, or otherwise legally authorized prescriber.

EMERGENCY CARE

All covered emergency services or items (including medications) provided in an emergency department (ED) setting or to stabilize an emergency/crisis, other than in an inpatient setting.

COLORADO MEDICAID ACCOUNTABLE CARE COLLABORATIVE

The State of Colorado administers Colorado Medicaid through its Accountable Care Collaborative (ACC). The state is divided into seven geographic regions with a single Managed Care Entity, the Regional Accountable Entity (RAE), operating the ACC in each region. The ACC is a hybrid managed care program authorized through a Section 1915(b) waiver with the Centers for Medicare & Medicaid Services (CMS). The RAEs function as a Prepaid Inpatient Health Plan (PIHP) for the administration of all ACC members' capitated mental health and substance use disorder services, as well as a Primary Care Case Management Entity (PCCM Entity) accountable for the effective and coordinated utilization of fee-for-service M/S Medicaid benefits. The RAEs are responsible for administering Colorado Medicaid's capitated MH/SUD benefit, which includes paying claims under the capitated MH/SUD benefit and authorizing MH/SUD services. M/S services are paid fee-for-service (FFS) by the Department's fiscal agent.

In addition, two regions allow members in specific counties to participate in capitated M/S Managed Care Organizations (MCO). In Region 1, the MCO is operated by the RAE, Rocky Mountain Health Plans. In Region 5, the Department contracts directly with the MCO operated by the Denver Health Hospital Authority, which is also contracted to function as the MH/SUD PIHP for all members enrolled in the MCO.

The federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and related regulations require State Medicaid agencies that have implemented an Alternative Benefit Plan and/or that deliver services through Managed Care Organizations to ensure

MH/SUD benefits are not managed more stringently than M/S benefits. This analysis complies with 42 CFR § 438.910 and 42 CFR § 440.395.

As authorized by the Affordable Care Act of 2010, Colorado expanded Medicaid benefits to individuals ages 19 through 64 at or below 133% Federal Poverty Level (FPL) through an Alternative Benefit Plan that closely aligns, but does not exactly match, the Medicaid state plan adult benefit package. The Department has approximately 120,000 members in MCOs whose M/S and MH/SUD services are covered through capitation payments. Approximately 318,000 members in the Alternative Benefit Plan receive capitated MH/SUD services, but their M/S services are provided fee-for-service.

As MHPAEA is focused on ensuring members' MH/SUD benefits are not managed more stringently than M/S benefits, the Department's unique structure for the Alternative Benefit Plan creates an unusual situation. Instead of comparing managed care policies and procedures against each other, for the Alternative Benefit Plan the Department compares managed care policies and procedures for a MH/SUD program against a M/S fee-for-service program.

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 fee-for-service guidelines. It is only under the federal managed care authority that the Department is able to 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.

In Colorado, the Department goes above and beyond federal requirements and conducts its MHPAEA comparative analyses across all members enrolled with the seven (7) RAEs and the two (2) MCOs. The Department does not restrict its MHPAEA comparative analyses only to members eligible for the Medicaid Alternative Benefit Plan or in an MCO.

STAKEHOLDER ENGAGEMENT AND FEEDBACK

A key feature of Colorado HB 19-1269 (C.R.S. 25.5-5-421) requires the Department to consider stakeholder feedback received as a component of the NQTL analyses. Stakeholders shared concerns about utilization management, administrative burden, network adequacy, reimbursement rates, credentialing, accurate and timely payment, and Department oversight and communications. Some concerns, by definition, do not rise to the level of parity concerns (i.e. Department oversight and communications). Other concerns touched on parity-related topics. However, once CedarBridge analyzed the data, these concerns did not signal non-compliance with MHPAEA or Colorado law. These issues have been shared with the Department for further operational assessment with any eye towards program improvement.

For example, stakeholders voiced concern that the Department reimburses MH/SUD benefits through capitation and M/S benefits through fee-for-service, which theoretically could create inequities. There were at least two areas of the parity analysis that touched on this concern. First, it was determined that

the process used by the RAEs to establish charges/reimbursement rates for MH/SUD benefits is comparable and no more stringent then that used for M/S benefits in the same classification in writing and in operation. Second, this feedback was considered in analyzing network adequacy and it was determined that the process used to maintain network adequacy by the RAEs for MH/SUD benefits was also comparable and no more stringent than the process used for M/S benefits.

METHODOLOGY

DEFINING MEMBER SCENARIOS FOR ANALYSIS

Prior to beginning the parity analysis, CedarBridge documented the potential member scenarios available in the Colorado ACC for MH/SUD as well as M/S benefits (Table 1). Further, we defined the mechanism for payment of covered benefits by each of the benefit classifications (Table 2). This step was particularly important in defining the scope of questions and data needed from each respective payer.

Table 1. Potential Member Scenarios

Member Scenarios (the color of the highlighted bullet points matches the corresponding highlighted classifications in the table below)

- **SCENARIO 1**: Member gets their outpatient MH/SUD services, inpatient and emergency care MH services, and M/S benefits through fee-for-service (this is a service-by-service situation).
- **SCENARIO 2**: Member gets outpatient MH/SUD services and inpatient/emergency care MH services through a RAE (Rocky Mountain Health Plans) under a capitated rate and M/S benefits through a managed care organization (Rocky Mountain Health Plan Prime MCO).
- **SCENARIO 3**: Member gets outpatient MH/SUD services and inpatient/emergency care MH services through a RAE under a capitated rate and M/S benefits through fee-for-service.
- **SCENARIO 4**: Member gets outpatient MH/SUD services and inpatient/emergency care MH services through fee-for-service and M/S benefits through a managed care organization (this is a service-by-service situation).
- **SCENARIO 5**: Member gets outpatient MH/SUD services and inpatient/emergency care MH services from Denver Health PIHP (Prepaid Inpatient Health Plan) and M/S benefits through a managed care organization.

BENEFIT MAP – BY CLASSIFICATION

Table 2. Covered Benefits

	Inpatient	Outpatient	Emergency Care	Prescription Drugs
SCENARIO 1	Med/Surg = FFS MH/SUD = FFS	Med/Surg = FFS MH/SUD = FFS	Med/Surg = FFS MH/SUD = FFS	PBM
SCENARIO 2	Med/Surg = MCO MH/SUD = RAE	Med/Surg = MCO MH/SUD = RAE	Med/Surg = MCO MH/SUD = RAE	MCO Managed PBM
SCENARIO 3	Med/Surg = FFS MH/SUD = RAE	Med/Surg = FFS MH/SUD = RAE	Med/Surg = FFS MH/SUD = RAE	PBM
SCENARIO 4	Med/Surg = MCO MH/SUD = FFS	Med/Surg = MCO MH/SUD = FFS	Med/Surg = MCO MH/SUD = FFS	PBM
SCENARIO 5	Med/Surg = MCO MH/SUD =PIHP	Med/Surg = MCO MH/SUD = PIHP	Med/Surg = MCO MH/SUD = PIHP	MCO Managed PBM

TOOLS AND RESOURCES TO COLLECT AND ANALYZE REQUIRED DATA

In defining the scope of the parity analysis, CedarBridge began by researching each benefit plan to determine the presence of any FRs or QTLs that would require analysis. Colorado does not currently have any FRs or QTLs for MH/SUD services.

Additionally, a broad set of NQTLs were identified by comparing each benefit plan, along with stakeholder feedback, to a list of NQTLs outlined in the final Medicaid/parity rule, the parity toolkit, written guidance from CMS, and the Department of Labor regarding the commercial parity rule (including FAQs and related guidance). CedarBridge developed tools and resources to collect and analyze the required NQTL data. Our process began with a data request for Regional Accountable Entities (RAEs), Managed Care Organizations (MCOs), and the Department for key areas, including:

1. Medical Management Standards
    a. Prior Authorization – identify services by name and service code
    b. Concurrent Review
    c. Retrospective Review
    d. Fail First/Step Therapy Protocols
    e. Conditioning Benefits on Completion of a Course of Treatment
    f. Medical Appropriateness Review
    g. Outlier Management
    h. Penalties for Noncompliance
    i. Coding Limitations
    j. Medical Necessity
2. Provider Admission Standards

   a. Network Provider Admission
   b. Establishing Charges/Reimbursement Rates
   c. Restrictions Based on Geographic Location, Facility Type, or Provider Specialty
3. Provider Access
   a. Network Adequacy Determination
   b. Out-of-Network Provider Access Standards

Responses to the data requests were followed with an interview with a team from each RAE and MCO, which focused on Medical Necessity and how the Provider Network is handled. The CedarBridge team also discussed with the RAEs and MCOs any possible improvements to the process.

During the interviews, we also addressed areas of HB19-1269 that are not in the CMS toolkit:

- "**25.5-5-421. Parity Reporting – State Department – Public Input (2)** By October 1, 2019, for purposes of obtaining meaningful public input during the assessment process, the state department shall seek input from stakeholders who may have competency in benefit and delivery systems, utilization management, managed care contracting, data and reporting, or compliance and audits. The department shall consider the input received in conducting the analyses and the report development."

- "**25.5-5-422. Medication-assisted treatment – limitations on MCEs – definition.**
  (1) As used in this section, "FDA" means the Food and Drug Administration in the United States Department of Health and Human Services"
  (2) Notwithstanding any provision of law to the contrary, beginning January 1, 2020, MCEs that provide prescription drug benefits for the treatment of substance use disorders shall, for prescription medications that are on the carrier's formulary:
    (a) Not impose prior authorization requirements on any prescription medication approved by the FDA for the treatment of substance use disorders.
    (b) Not impose any step therapy requirements as a prerequisite for coverage for a prescription medication approved by the FDA for the treatment of substance use disorders; and
    (c) Not exclude coverage for any prescription medication approved by the FDA for the treatment of substance use disorders and any associated counseling or wraparound services solely on the grounds that the medications and services were court ordered.

REVIEW PROCESS FOR MEDICAL NECESSITY CRITERIA

After collecting the medical necessity criteria used by the RAEs and MCOs, both through the written data request and the follow-up interviews, CedarBridge was able to review the medical necessity criteria used by each for MH/SUD and physical health services. It is important to note, any area of medical necessity could be an opportunity for exploration. The key is to look for differences in the way M/S and MH/SUD determine an individual meets the definition of requiring a medically necessary service/s within the care delivery system.

REVIEW PROCESS FOR NON-QUANTITATIVE TREATMENT LIMITATIONS

Based on the illustrative list of NQTLs in the final Medicaid/parity rule, the parity toolkit, written guidance from CMS and the Department of Labor regarding the commercial parity rule (including FAQs and related guidance), CedarBridge identified a list of common NQTLs that may be in use by the RAEs and HCPF for MH/SUD services. As outlined in HB 19-1269, additional feedback was received through stakeholder interviews, written comments, and public listening sessions. This feedback was used to either affirm previously discovered NQTLs or identify other areas that may require analysis.

This final list included NQTLs related to medical management, benefits coverage, provider network admission, and prescription drugs. Following this exploratory work, CedarBridge prepared a request for information to the RAEs, MCOs, and HCPF that included the list of NQTLs identified and asked them to identify any additional NQTLs they apply to MH/SUD services. The requests addressed processes, strategies, evidentiary standards and other factors in writing and operation for each of the NQTLs that apply to MH/SUD and M/S services, broken down by benefit classification. The requests included prompts to help identify the type of information relevant to the parity analysis.

COST ANALYSIS IF A FINANCIAL REQUIREMENT OR QUANTITATIVE TREATMENT LIMITATION APPLIES

The Colorado Medicaid benefit packages impose no quantitative treatment limitations (QTLs) for MH/SUD benefits. This negates the need to evaluate parity compliance with respect to quantitative treatment limits. Should future financial or unit limits be imposed, these limitations may need to be reviewed to ensure parity compliance.

FACTORS USED TO DETERMINE AN NQTL WILL APPLY

Parity requires NQTL's not be applied to MH/SUD benefits in any classification unless their application to MH/SUD benefits **are comparable** to and **no more stringent than** the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S benefits in the classification. The application standards for any NQTL must be clearly delineated under the policies and procedures of the state, MCO, or Prepaid Inpatient Health Plan (PIHP), as written and in operation.

The CMS Parity Toolkit divides this analysis into two parts:

1. Evaluate the *comparability* of the processes, strategies, evidentiary standards, and other factors (in writing and in operation) used in applying the NQTL to MH/SUD benefits and M/S benefits
2. Evaluate the *stringency* with which the processes, strategies, evidentiary standards and other factors (in writing and operation) are applied to MH/SUD benefits and M/S benefits

Following the process outlined in the CMS Parity Toolkit, we used the request for information and the interviews with the RAEs, MCOs, and representatives of HCPF to determine if an NQTL applies and requires further explanation. Anytime a NQTL is present, it must be tested for comparability and stringency to ensure it meets parity guidelines. During this analysis, CedarBridge looked at multiple reference points to determine compliance with parity guidelines including: policy follows standard

industry practice, when operationalizing procedures there is little to no exception or variation, policy and practice follows established state definitions and guidelines, the staff operationalizing the policy are qualified to make the decisions and complete the tasks assigned and appropriate supervision and oversight is in place to ensure the policy is operationalized as documented.

FINDINGS AND RECOMMENDATIONS

CedarBridge did not identify parity violations in its analysis. However, CedarBridge identified several changes that would be helpful in future parity analyses. These policies are differences in the system that would appear to bring inconsistency where it isn't necessary and could be rectified through contract or operational changes with minimal effort.

Prior Authorization

- While all RAEs utilize MH/SUD determination timelines in compliance with statute, it is recommended all RAEs are brought into alignment with comparable M/S timelines.

Medical Necessity

- For MH/SUD fee-for-service claims, consider contracting with the current FFS UM vendor, eQhealth or establishing another UM contract that follows the same process to handle MH/SUD claims that are paid fee-for-service.
- The Department should require the RAEs and MCOs to use the statutory definition of medical necessity in applying their policies and processes.

Restrictions Based on Geographic Location, Facility Type, or Provider Specialty

- The Department should require that MH/SUD providers not be restricted from participation in the network by geographic location, facility type, or specialty.

Out-of-Network Providers Access Standards

- It is not clear that both a provider and a member may request authorization for out-of-network services. We recommend the Department consider mandating through contract that both a provider and a member may request authorization for out-of-network services for specified reasons.

Appendices A through O present each NQTL, the member scenarios, benefit categories (IP - In Patient; OP - Out Patient; EC – Emergency Care; PD – Prescription Drugs), a summary of any differences found between M/S and MH/SUD benefits in the identified member scenario, and whether or not compliance was determined. Appendix P presents the Availability of Information analysis.