Executive Summary

The Colorado Department of Health Care Policy and Financing (Department) created the annual Mental Health Parity and Addiction Equity Act (MHPAEA) Report for State Fiscal Year 2020-2021 in accordance with Colorado Revised Statutes 25.5-5-421. The MHPAEA is designed to ensure that Medicaid managed care organizations 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 following comparative analysis was performed across Colorado Medicaid's statewide managed care system, consisting of seven (7) Regional Accountable Entities (RAEs) and two (2) Managed Care Organizations (MCOs), and the Department's fee-for-service (FFS) system to determine the status of parity compliance within the Colorado Medicaid delivery system.

The State of Colorado's Medicaid capitated behavioral health benefit is administered through the Accountable Care Collaborative (ACC). The state is divided into seven regions with a single Managed Care Entity (MCE), the RAE, operating the ACC in each region. The ACC is a hybrid managed care program authorized through a Section 1915(b) waiver approved by 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 MH/SUD 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 and authorizing MH/SUD services. Physical health services are paid fee-for-service by the Department's fiscal agent.

Colorado House Bill 19-1269 provided the Department with funding to contract with an external vendor, CedarBridge, to produce the State Fiscal Year 2019-2020 MHPAEA Report and create a template for the Department's future reports. The process created by CedarBridge was based upon 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," and in accordance with the requirements in HB19-1269. For this year's report, the Department followed the process for determining mental health parity compliance created by CedarBridge. The Department collected public input throughout the year to help assess how processes, strategies, evidentiary standards, and other factors operate in practice. This public input helped inform the comparative analysis.

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 fee-for-service 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.

Summary of Findings

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. Limited situations were also found where two RAEs were determined not to have followed their written policies, impacting compliance with Availability of Information parity requirements.

The Department's determination was based on the analysis of the following limitations.

Aggregate Lifetime and Annual Dollar Limits

Based on the information collected during the analysis, none of the Managed Care or FFS structures utilize aggregate lifetime or annual dollar limits for MH/SUD benefits and are therefore compliant with parity requirements for these limits.

Financial Requirements and Quantitative Treatment Limitations

Based on the information collected during the analysis, none of the RAEs, MCOs, or the Department utilize financial requirements (FRs) or quantitative treatment limitations (QTLs) for MH/SUD benefits and are therefore compliant with the parity requirements of these limitations.

Non-Quantitative Treatment Limitations

The Department completed an analysis of the non-quantitative treatment limitations (NQTLs) being used by each of the benefit packages. NQTLs are non-numerical limits on the scope or duration of benefits for treatment, such as preauthorization requirements. In accordance with CMS regulations and guidance, the Department conducted an analysis of how each NQTL is used within the broad benefit classifications of inpatient, outpatient, prescription drugs, and emergency care. While there may be differences between individual NQTL policies and procedures and their application to MH/SUD and M/S services within the benefit classifications, the federal requirement is to analyze whether the NQTLs used for MH/SUD within a benefit classification are comparable to and applied no more stringently than those used in the same M/S benefit classification. Written policies and procedures were determined to be parity-compliant in all NQTLs except for one.

During the analysis process, the Department identified that it is not currently in compliance with parity requirements regarding the Concurrent Review NQTL for inpatient hospitalizations, as a result of the temporary suspension of the Inpatient Hospital Review Program (IHRP).

At the beginning of the COVID-19 Public Health Emergency, the Department suspended M/S inpatient hospitalization concurrent reviews to address the surge in critical patient care needs and the risk of hospital system breach due to acute care demand exceeding our hospitals' medical capacity. During the M/S Concurrent Review program suspension, the IHRP underwent a performance review that identified operational and efficiency opportunities. This information ultimately led to the re-procurement of the IHRP vendor and was incorporated into the contractual requirements with the newly-selected vendor. The Department is currently working to finalize improvements to the program prior to IHRP reinstitution, with redesign efforts underway. As part of the redesign efforts, the Department will ensure the new IHRP concurrent review process is compliant with parity. To ensure parity compliance, the Department is also taking this opportunity to assess the MCEs' concurrent

review policies and procedures for MH/SUD inpatient hospitalizations. The target date for reinstituting the IHRP with the program improvements is January 2022, and the Department is working diligently to complete the work earlier if possible.

Mental health parity was not immediately identified as an issue when the IHRP program was paused. The focus at that time was on helping facilitate hospitals' capacity to treat individuals with COVID-19. The Department did not pursue a similar suspension to the MH/SUD inpatient authorization review process because it was not at risk of system capacity breach in the same way that the hospitals were. The Department also required real-time SUD review insights from tracking the use of the newly effective (January 1, 2021) SUD inpatient and residential benefit. These insights needed to be incorporated into the July 1, 2021 inpatient and residential SUD rate adjustments and were important to the Department's efforts to analyze network access, pinpoint areas needing technical assistance, monitor utilization against projections, identify variations in utilizations by RAE region, and confirm that members were being connected to the most effective treatment options. It was determined that continuing the MH/SUD inpatient authorization review process was the best course of action to ensure the health and effectiveness of the new SUD residential benefit and the MH/SUD system as a whole.

Availability of Information

Based on the information collected, the Department verified that the written polices of the RAEs and MCOs are compliant with both requirements for availability of information:

- Criteria for medical necessity determinations regarding MH/SUD benefits are made available to enrollees, potential enrollees, and contracting providers upon request.
- The reasons for any denial of reimbursement or payment for MH/SUD benefits are made available to the beneficiary.

The external quality review audit performed by Health Services Advisory Group (HSAG) identified limited situations where two RAEs had gone beyond the timeframes established in its policy for sending a notice of adverse benefit determination. Additionally, HSAG identified a small number of situations where the RAEs used confusing language in their determination letters or the reason for the denial was difficult to understand. Out of 1,239 combined applicable elements, the MCEs met 1,187 elements for a 96% combined compliance score. In these limited instances, the Department determined that the involved RAEs were not fully compliant with the Availability of Information parity requirements. The Department notified the RAEs of the issues, and the RAEs established plans to eliminate the delays and improve their documentation.