Introduction

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 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.

The Department followed the process for determining mental health parity compliance created by CedarBridge, the contractor selected to perform the State Fiscal Year 2019-2020 MHPAEA Report. The process created by CedarBridge was based upon federal parity guidance 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]

Definition of Medical/Surgical and Mental Health/Substance Use Disorder Services

The federal statute and regulations do not identify specific conditions or services 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 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.

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

- 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.

- Substance use disorder benefits are defined as benefits used in the treatment of 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, excluding nursing facilities.

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. The Department contracts with a third-party vendor to administer Colorado Medicaid's Utilization Management Program for FFS, referred to as the Colorado Prior Authorization Review (Colorado PAR).

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 Medical Plan, which is also contracted to function as the MH/SUD PIHP for all members enrolled in the MCO. Denver Health Medical Plan delegates administration of their MH/SUD PIHP to Colorado Access, including utilization management.

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. As of January 2021, there were 146,964 members in MCOs whose M/S and MH/SUD services are covered through capitation payments. Approximately 501,786 members in the Alternative Benefit Plan receive capitated MH/SUD services, but their M/S services are provided FFS.

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 complexity for the parity determination. 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 FFS 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, allowing for more flexible service provision. 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.

The Department goes beyond federal requirements by conducting the MHPAEA comparative analyses across all members enrolled with the seven RAEs and the two MCOs. The Department does not restrict its MHPAEA comparative analyses only to members eligible for the Medicaid Alternative Benefit Plan or in an MCO.

Methodology

Defining Member Scenarios for Analysis

Colorado Medicaid's unique structure for MH/SUD and M/S benefits creates a need to define the various potential member scenarios available. These scenarios are documented in Table 1. Furthermore, Table 2 defines the mechanism for payment of covered benefits by each of the benefit classifications. These steps define the scope of questions and data needed from each respective payer in order to complete a parity analysis.

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 inpatient and outpatient MH/SUD services, emergency MH services, and M/S benefits through fee-for-service (this is a service-by-service situation).
- **SCENARIO 2**: Member gets their inpatient and outpatient MH/SUD services, emergency 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 their inpatient and outpatient MH/SUD services, emergency MH services through a RAE under a capitated rate and M/S benefits through fee-for-service.
- **SCENARIO 4**: Member gets inpatient and outpatient MH/SUD services, emergency MH services from Denver Health PIHP 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 =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

The Department determined the scope of the parity analysis by researching each benefit plan for the presence of any FRs or QTLs that would require analysis. Colorado Medicaid benefit packages do not currently have any FRs, QTLs, or AL/ADLs for MH/SUD services.

Additionally, a 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). The Department utilizes tools and resources based upon those created by CedarBridge to collect and analyze the required NQTL data.

A data request was sent to the Regional Accountable Entities (RAEs), Managed Care Organizations (MCOs), and the Department's Utilization Management to collect policy and procedural detail 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 Criteria
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

The Department required responses to the data requests by March 1. The MPHAEA report is accurate and complete through March 1, 2021. Any policy or procedural changes made after that date will be reviewed in an ongoing basis and noted in the following year's MHPAEA Report.

Responses to the data requests were followed with a virtual interview with a team from each RAE and MCO. The interviews provide an opportunity for the Department to ask questions stemming from the review of the data request responses and gain additional insight into the implementation of the policies and procedures.

Review Process for Medical Necessity Criteria

The Department reviewed the medical necessity criteria collected from the RAEs and MCOs both through the written data requests and follow-up interviews to verify the criteria utilized to determine medical necessity for MH/SUD and M/S services. The Department analyzed differences in MH/SUD and M/S medical necessity determinations within the care delivery system.

Review Process for Non-Quantitative Treatment Limitations

The Department prepared a list of common NQTLs that may be in use by the RAEs and the Department for MH/SUD services from the illustrative list of NQTLs in the final Medicaid/parity rule, the parity toolkit, and written guidance from CMS and the Department of Labor regarding the commercial parity rule (including FAQs and related guidance). The

Department also gathered feedback through stakeholder written comments, which the Department used to inform the analysis by either affirming previously identified NQTLs or highlighting other areas that may require analysis. The final list included NQTLs applicable to categories such as medical management standards, network admission standards, and provider access.

The data request for the RAEs, MCOs, and Department's UM included the list of NQTLs identified and asked them to identify any additional NQTLs they apply to MH/SUD services. The request addressed processes, strategies, evidentiary standards and other factors for each of the NQTLs that apply to MH/SUD and M/S services, broken down by benefit classification. The request included prompts to help identify the type of information relevant to the parity analysis.

Review Process for Availability of Information

The requirements for availability of information are as follows:

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

These requirements apply to all Colorado Medicaid members receiving MH/SUD benefits, whether through FFS, RAEs, or MCOs. The MCEs were required to provide evidence that they are compliant with this parity requirement.

Determining if a FR, QTL, or AL/ADL Will Apply

Based on the information collected during the analysis, the Colorado Medicaid benefit packages impose no financial requirements (FR), quantitative treatment limitations (QTLs), or aggregate lifetime and annual dollar limits (AL/ADLs) on MH/SUD benefits. Should future financial, unit, or dollar limits be imposed, these limitations may need to be reviewed to ensure parity compliance.

Factors Used to Determine an NQTL Will Apply

Parity requires NQTLs 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, the Department used the information provided in the data request and interviews with the RAEs, MCOs, and the Department's FFS UM to determine if an NQTL applies and requires analysis. Any identified NQTL is tested for comparability and stringency to ensure it meets parity guidelines. During this analysis, multiple reference points are explored 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.

Evaluation of Parity Compliance in Operation

Colorado House Bill 19-1269, updated the Colorado Revise Statutes 25.5-5-421(4), which requires the Department to contract with an external quality review organization to perform an annual review of the RAEs' and MCOs' policies and procedures in operation:

- "25.5-5-421 (4). The State Department shall contract with an external quality review organization at least annually to monitor MCEs' utilization management programs and policies, including those that govern adverse determinations, to ensure compliance with the MHPAEA. The quality review report must be readily available to the public."

Health Services Advisory Group (HSAG) was the contractor selected to perform this year's annual review of the RAEs' and MCOs' policies and procedures in operation. HSAG's full report can be found on the Department's Regulatory Resource Center webpage.

Updates to the MHPAEA Report

The Department has made many improvements to the MHPAEA Report for State Fiscal Year 2020-2021 to improve the readability and clarity of the document, but more importantly, to increase the accuracy and thoroughness of the analysis.

- Findings from the external quality review are new this year, adding a detailed review of the RAEs and MCOs' policies and procedures in operation.
- The Department added inpatient substance use disorder treatment to the state's Medicaid benefit beginning January 1, 2021. The policies and procedures related to the new SUD benefit were reviewed for parity compliance in this report.
- The 2020 MHPAEA Report incorrectly included a member benefit scenario labeled Scenario 4, which was removed from this year's report. This scenario was determined to be impossible to occur given the Department's use of mandatory attribution and enrollment.

Stakeholder Engagement and Feedback

The Department considers stakeholder feedback vital to the monitoring of mental health and substance use disorder parity. Department staff engage and seek out input in multiple opportunities and formats throughout the year to ensure ongoing compliance with federal and state parity laws, but also to inform the NQTL analyses. Opportunities for engagement and reporting issues include:

- A quarterly hospital forum attended by the Colorado Hospital Association, urban and rural hospitals and the RAEs;
- Communications and complaints received by the Office of Behavioral Health Ombudsman of Colorado;
- Provider and stakeholder outreach to Department staff directly;
- Grievances filed by members that have been escalated to the Department; and
- An electronic form to provide written comments.

The Department received a total of 14 written comments submitted through the electronic form created specifically for this report. The majority of submissions were received from providers, with some feedback also received from advocates.

Stakeholders shared concerns about prior authorization, reimbursement rates, network provider admission, network adequacy determination, member attribution, a non-covered service, and the Department's parity reporting compliance and enforcement. Concerns that touched on parity-related topics were analyzed for compliance. The comments addressing the methods used by the Department for enforcing and reporting on parity compliance fall into other important areas of Medicaid operations, and will be considered for opportunities for process improvement. Additional concerns that covered topics such as member attribution, do not, by definition, rise to the level of parity concerns.

Provider reimbursement rate concerns are commonly raised by stakeholders, including specific concerns about reimbursement based on clinical licensure, and lower provider reimbursement rates for MH/SUD services in comparison to other states or M/S services. First, it was determined that the processes 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. Further still, reimbursement was analyzed for its impact on network adequacy and it was determined that the processes 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. The Department continually monitors the provider networks and requires the RAEs and MCOs to submit network adequacy plans annually and network adequacy reports quarterly.

Findings

The Department completed an analysis of the non-quantitative treatment limitations (NQTLs) being used in each of the member scenarios and an analysis of whether, for each NQTL, there are differences in policies & procedures, or the application of the policies & procedures for MH/SUD benefits and M/S benefits.

The 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 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.

Limited situations were found during the external quality review where two RAEs had gone beyond the timeframes established in their written policies for sending a notice of adverse benefit determination, and therefore were determined to be out of parity compliance with the Availability of Information parity requirements. Details are provided

in the External Quality Review Analysis section below. The RAEs were notified of the issues by the Department and a plan was established to address the delays.

Parity Monitoring During Reporting Year

In addition to the review and analysis of policies and procedures performed for the comprehensive annual MHPAEA Report, the Department continually monitors the parity compliance of the RAEs and MCOs throughout the year. Monitoring activities include regular communication with the RAEs and MCOs, meetings and events with stakeholder groups, or direct contact with the Behavioral Health Ombudsman office, practitioners, or members. Any concerns that are raised are analyzed and addressed as they are identified.

The following are some of the changes to policies and procedures made by the RAEs, MCOs, or the Department's FFS UM over the reporting year that warranted a review for parity compliance.

- Beginning March 1, 2021, Colorado Community Health Alliance requires authorization after 20 sessions for the following services: 90832 (30-min psychotherapy), 90834 (45-min psychotherapy), 90837 (60-min psychotherapy), 90846 (family psychotherapy w/o patient) and 90847 (family psychotherapy w/patient).
- Rocky Mountain Health Plans requires authorization on 60-minute psychotherapy (90837) sessions after 12 visits in a calendar year.

Each of these authorization requirements was evaluated and was found to be in-line with comparable prior authorization requirements for M/S services, similar RAE prior authorization requests, and consistent with flexibilities allowed with managed care.

External Quality Review Analysis

Health Services Advisory Group (HSAG) completed their annual review of the RAEs and MCOs' policies and procedures in operation on April 2021. **They determined the MCEs to have a combined 96% compliance score.** The score indicates the level at which the MCEs followed their internal policies related to prior authorization and the reason for denial, notification of determination, time frames for the sending of notices, notice of adverse benefit determinations including required content, use of qualified clinicians when making denial decisions, peer-to-peer review, and use of established authorization criteria. Out of 1,239 combined applicable elements, the MCEs satisfied 1,187 elements. All the MCEs use Department-approved template notices of adverse benefit determination that included the required information and notify members of their right to an appeal and all MCEs followed their policies and procedures regarding consistency and quality of utilization management decisions.

Limited situations were found where two RAEs had gone beyond the timeframes established in their policies for sending a notice of adverse benefit determination. Additionally, HSAG identified some situations of confusing language used by RAEs in their determination letters or the reason for the denial was difficult to understand. Those situations were determined to not be fully parity compliant with the Availability of Information requirements. The RAEs were notified of the issues, and plans were established to eliminate the delays and improve the documentation.

HSAG's full report can be found on the Department's Regulatory Resource Center webpage.

Appendices A through O present each NQTL, the member scenarios, benefit categories (IP - Inpatient; OP - Outpatient; 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.